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

State/Territory ARIZONA

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* Forms Provided

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.

TN No. 92-25
Supersedes TN No. 84-2
Approval Date 3/30/93
Effective Date October 1, 1992
HCFA ID: 7982E

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).

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

OMB No.: 0938-0193

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) May 22, 1980

OMB No.: 0938-0193

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.

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

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. *

Tribal Consultation Requirements

SSA Section 1902(a)(73)

SSA Section 1902(a)(73) of the Social Security Act (the Act) requires a State in which one or more Indian Health Programs or Urban Indian Organizations furnish health care services to establish a process for the State Medicaid agency to seek advice on a regular, ongoing basis from designees of Indian health programs, whether operated by the Indian Health Service (IHS), Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act (ISDEAA), or Urban Indian Organizations under the Indian Health Care Improvement Act (IHCIA). Section 2107(e)(I) of the Act was also amended to apply these requirements to the Children's Health Insurance Program (CHIP). Consultation is required concerning Medicaid and CHIP matters having a direct impact on Indian health programs and Urban Indian organizations.

Please describe the process the State uses to seek advice on a regular, ongoing basis from federally-recognized tribes, Indian Health Programs and Urban Indian Organizations on matters related to Medicaid and CHIP programs and for consultation on State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals and proposals for demonstration projects prior to submission to CMS. Please include information about the frequency, inclusiveness and process for seeking such advice.

The State of Arizona seeks advice on a regular, ongoing basis from all of the federally-recognized tribes, Indian Health Service (IHS) Area Offices, tribal health programs operated under P.L. 93-638, and urban Indian health programs in Arizona regarding Medicaid and CHIP matters. These matters include but are not limited to State Plan Amendments, waiver proposals, waiver extensions, waiver amendments, waiver renewals, and proposals for demonstration projects. The AHCCCS Tribal Consultation Policy serves as a guidance document that includes the process by which reasonable notice and opportunity for consultation should occur and scenarios in which AHCCCS shall engage in the consultative process.

The frequency of consultation is dependent on the frequency in which policy changes are proposed. When a proposed policy change requires consultation, the State will to its best ability provide notice of the tribal consultation meeting date as well as a description of the proposed policy change to be discussed. Ideally, a consultation meeting, which provides an opportunity for discussion and verbal comments to be made regarding a proposed change, will occur either in-person or by conference call 45 days prior to the submission of the policy change to CMS. The State will also provide an opportunity for written comments. Ideally, during the 45-day period, tribes and I/T/U will be provided at least 30 days to submit written comments regarding the policy change for consideration. Verbal comments presented at the meeting as well as written comments will be included in an attachment to accompany the submission of a State Plan Amendment, waiver proposal, waiver renewal, or proposal for a demonstration project.

In situations that require immediate submission of a policy change to CMS, an expedited process may be implemented that will have the effect of lessening the time between the consultation meeting and submission of the policy change to CMS. This process may require for consultation to occur one day prior to the submission of the policy change to CMS. In order to expedite the process, written comments may be solicited in the meeting notification with a description of the policy change and the date when the change will be submitted to CMS. At least 14 days will be provided for the submission of written comments to be considered. This process would be completed prior to submission to CMS.

Please describe the consultation process that occurred specifically for the development and submission of this State Plan Amendment, when it occurred and who was involved.

A series of meetings with tribes as well as the IHS, tribal health programs operated under P.L. 93-638, and urban Indian health programs (collectively referred to as "I/T/U") have occurred and will continue to occur in order to make appropriate revisions to the AHCCCS Tribal Consultation Policy, which serves as a document that guides how the State will consult with tribes and I/T/U.

More specifically, the consultation process for the development and submission of this State Plan Amendment occurred on February 23, 2010. The attachment submitted to CMS describes in more detail which parties were notified of the consultation meeting and opportunity for comment, the meeting agenda, individuals that participated in the meeting, relevant materials that were discussed, and verbal comments received. It is important to note that this process was intended to be as inclusive as possible. The following entities in Arizona were notified of the consultation process regarding this State Plan Amendment.

- Tribal Leaders
- Tribal Health Directors
- Directors of Indian Health Service Area Offices
- Directors of Tribal Health Programs Operated under P.L. 93-638
- Directors of Urban Indian Health Programs
- Director of Inter Tribal Council of Arizona, Inc.
- Director of the Advisory Council on Indian Health Care

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

Revision: HCFA-PM-94-3
APRIL 1994

(MB)

State/Territory: ARIZONA

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.

Revision: HCFA-PM-94-3
APRIL 1994

(MB)

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

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

State: Arizona

Reserved

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.

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

State/Territory: Arizona

Reserved

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

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 on-line CMS version
4/30/03
BL

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

OMB No.: 0938-0193

State: Arizona

Citation

435.10 and 435.403, and 1902(b) of the Act, P.L. 99-272 (Section 9529) and P.L. 99-509 (Section 9405)

2.3 Residence

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.

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

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.

Revision: HCFA-PM-92-1 (MB)
FEBRUARY 1992

State: Arizona

Citation(s)

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

2.6 Financial Eligibility

(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.

Revision: HCFA-PM-86-20 (BERC)
SEPTEMBER 1986

OMB-No. 0938-0193

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.

Revision: HCFA-PM-94-5 (MB)
APRIL 1994

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.

-vision: 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 (10) 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			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.** CAN 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. CAN 3/30/93

** Note: Arizona has not elected this option.

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

OMB No.: 0938-

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:
(42 CFR 440.140 AND 440.160)

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

(i) If services 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) AUGUST 1991 OMB No.: 0938-

State/Territory: Arizona

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

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

(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.

N/A

☐ (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)

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

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).

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

OMB No.: 0938-0193

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

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

State/Territory: ARIZONA

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—

/X/ 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.

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

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

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

State: Arizona

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.

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

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.

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

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) AUGUST 1991 OMB No.: 0938-

State: Arizona

Citation 3.5 Families Receiving Extended Medicaid Benefits (Continued)

N/A

- ☐ Private duty nursing services.
- ☐ Physical therapy and related services.
- ☐ Other diagnostic, screening, preventive, and rehabilitation services.
- ☐ 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) AUGUST 1991 OMB No.: 0938-

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).

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

State: Arizona

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).

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

OMB No.: 0938-0193

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.

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

OMB No.: 0938-0193

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.

Revision: HCFA-AT-87-9 (BERC) OMB No.: 0938-0193
AUGUST1987

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) OMB No.: 0938-0193
MARCH 1987

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

NO 455.17 — .21 or .23

Revision: HCFA-PM-88-10 (BERC) 0938-0193
SEPTEMBER 1988

State/Territory: Arizona

Citation	4.5 Medicaid Agency Fraud Program
42 CFR 455.12 AT-78-90 48 FR 3742 52 FR 48817	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: State: Arizona

SECTION 4 – GENERAL PROGRAM ADMINISTRATION

4.5b Medicaid Recovery Audit Contractor Program

Citation

Section 1902 (a)(42)(B)(i) of the Social Security Act

___✓___The state has established a program under which it will contract with one or more recover audit contractors (RACs) for the purpose of identifying overpayments and underpayments of Medicaid claims under the State plan and under any waiver of the State plan.

_____The state is seeking an exception to establishing such program for the following reasons:.

Section 1902 (a)(42)(B)(ii)(I) of the Act

___✓___The State/Medicaid agency has contracts of the type(s) listed in section 1902(a)(42)(B)(ii)(I) of the Act. All contracts will meet the requirements of the statute by April 1, 2012. RACs are consistent with the statute.

Place a check mark to provide assurance of the following:

___✓___The State will make payments to the RAC(s) only from amounts recovered.

___✓___The State will make payments to the RAC(s) on a contingent basis for collecting overpayments.

Section 1902 (a)(42)(B)(ii)(II)(aa) of the Act

The following payment methodology shall be used to determine State payments to Medicaid RACs for identification and recovery of overpayments

___✓___The State attests that the contingency fee rate paid to the Medicaid RAC will not exceed the highest rate paid to Medicare RACs, as published in the Federal Register.

_____The State attests that the contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will only submit for FFP up to the amount equivalent to that published rate.

_____The contingency fee rate paid to the Medicaid RAC will exceed the highest rate paid to Medicare RACs, as published in the Federal Register. The State will submit a justification for that rate and will submit for FFP for the full amount of the contingency fee.

Section 1902 (a)(42)(B)(ii)(II)(bb) of the Act

___✓___The following payment methodology shall be used to determine State payments to Medicaid RACs for the identification of underpayments (e.g., amount of flat fee, the percentage of the contingency fee). The RACs compensation for underpayments will be based on the amount of the actual underpayment amounts paid to providers identified from the improper payment recovery review process. The Contractor will be paid a contingency fee of 10.5% of the underpayments paid to providers. The contingency fee for underpayments will be paid for underpayments of $250.00 or more on claims submitted on a UB04, and $100.00 or more on claims submitted on CMS 1500 and ADA forms. The automated review process will identify a clearly improper payment and the complex review will include a medical documentation review to verify the claim payment which will also look at the proper coding on claims submitted.

Section 1902 (a)(42)(B)(ii)(III) of the Act

___✓___The State has an adequate appeal process in place for entities to appeal any adverse determination made by the Medicaid RAC(s).

Section 1902 (a)(42)(B)(ii)(IV)(aa) of the Act

___✓___The State assures that the amounts expended by the State to carry out the program will be amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan.

Section 1902 (a)(42)(B)(ii)(IV)(bb) of the Act

___✓___The State assures that the recovered amounts will be subject to a State's quarterly expenditure estimates and funding of the State's share.

Section 1902 (a)(42)(B)(ii)(IV)(cc) of the Act

___✓___Efforts of the Medicaid RAC(s) will be coordinated with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, and/or State and Federal law enforcement entities and the CMS Medicaid Integrity Program.

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.

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

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.

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-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.

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

State/Territory: ARIZONA

Citation

42 CFR 431.105(b) 4.12 Consultation to Medical Facilities
AT-78-90

(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.

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

State/Territory: Arizona

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.

Revision: HCFA-PM-85-7 (BERC)
July 1985

OMB No.: 0938-0193

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

OMD 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.

TN # 03-009
Supersedes TN # 92-7

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

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.

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

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.

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

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.

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

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 ALTCS 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; for individuals age 55 and over, except for Medicare cost sharing identified at 4.17(b)(3)(Continued).

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

4.17 (b) Adjustments or Recoveries

(3) (Continued)

Limitations on Estate Recovery - Medicare Cost Sharing:

(i) Medical assistance for Medicare cost sharing is protected from estate recovery for the following categories of dual eligibles: QMB, SLMB, QI, QDWI, QMB+, SLMB+. This protection extends to medical assistance for four Medicare cost sharing benefits: (Part A and B premiums, deductibles, coinsurance, co-payments) with dates of service on or after January 1, 2010. The date of service for deductibles, coinsurance, and co-payments is the date the request for payment is received by the State Medicaid Agency. The date of service for premiums is the date the State Medicaid Agency paid the premium.

(ii) In addition to being a qualified dual eligible the individual must also be age 55 or over. The above protection from estate recovery for Medicare cost sharing benefits (premiums, deductibles, coinsurance, co-payments) applies to approved mandatory (i.e., nursing facility, home and community-based services, and related prescription drugs and hospital services) as well as optional Medicaid services identified in the State plan, which are applicable to the categories of duals referenced above.

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.

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

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.

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

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

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--

[X] 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.

[X] 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

(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 services, no more than one type of charge is imposed

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

[ ] 18 or older

[X] 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.

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

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)	✓	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.
	N/A		
1902(a)(52) and 1925(b) of the Act	4.18(b)(5)	✓	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.
	N/A		
1916(d) of the Act	4.18(b)(6)	✓	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.
	N/A		

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

☑ Age 21

N/A

Reasonable categories of individuals who are age 18, but under age 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)(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

/7 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.

/7 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:

N/A

/ 18 or older

/ 19 or older

/ 20 or older

/ 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

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

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

Waiver *

(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.

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

State/Territory: Arizona

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.

Revision: HCFA-PM-93- 6 (MB) OMB No.: 0938-
August 1993

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

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

4.19 (d)

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

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.

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

OMB No.: 0938-0193

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	4.19 (f)	The Medicaid agency limits participation to providers who meet the requirements of 42 CFR 447.15.
AT-78-90		
AT-80-34		
48 FR 5730		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.

Revision: HCFA-AT-80-60 (BPP) OMB No.: 0938-0193
August 12, 1980

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.

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

State: Arizona

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(l)	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 OF ARIZONA

Citation

1928(c)(2) of The Act 4.19(m) Medicaid Reimbursement for Administration of Vaccines Under the Pediatric Immunization Program

(i) A provider may impose a charge for the administration of a qualified pediatric (C)(ii) of vaccine as stated in 1928(c)(20)(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. The state's payment rate is $15.43.

_____ 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:

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

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.

Revision: HCFA-AT-81-34 (BPP) OMB No.: 0938-0193
October 1981

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.

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

(4) Sections 1902(a)(25)(H) and (I) of the

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.

TN # 03-009
Supersedes TN # 84-3

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

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.

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

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.

State/Territory: Arizona

Citation		
	4.26 Drug Utilization Review Program	
1927(g) 42 CFR 456.700	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.
	2.	The DUR program assures that prescriptions for CMS covered outpatient drugs are: - Clinically appropriate - Medically necessary
1927(g)(1)(A) 42 CFR 456.705(g) 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, inappropriate or medically unnecessary care among physicians, pharmacists, and patients or clinical parameters associated with specific drugs as listed below: - Potential and actual adverse drug reactions - Clinical 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 - Drug Facts and Comparisons - UpToDate - National Comprehensive Cancer Network Guidelines (NCCN) - Micromedex - MediSpan - FirstDataBank

State/Territory: Arizona

Citation	**4.26 Drug Utilization Review Program (Cont'd)**	
1927(g)(1)(D) 42 CFR 456.703(b) 42 CFR 483.60	D.	DUR is not required for drugs dispensed to Medicaid recipients located in skilled nursing facilities that are in compliance with drug regimen review procedures as 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)(1)(D) 42 CFR 456.705(b)	E.1.	The DUR program includes prospective review of drug therapy at the point of sale before a prescription is filled or dispensed to a Medicaid recipient.
1927(g)(2)(A)(i) 42 CFR 456.705(b) (1)-(7))	2.	Prospective DUR includes processing each prescription submitted for adjudication through point-of-sale edits prior to filling the prescription and dispensing it to the Medicaid recipient. The point-of-sale edits include the following: - Therapeutic duplication - Drug-disease contraindications - Drug-drug interactions - Drug-interactions with non-prescription or over-the-counter drugs - Incorrect drug dosage - Incorrect duration of drug treatment - Drug allergy interactions - Clinical abuse/misuse/overuse
1927(g)(2)(A)(ii) 42 CFR 456.705(c) and (d)	3.	Prospective DUR includes counseling for Medicaid recipients based on regulations and standards established by the Arizona State Board of Pharmacy..
1927(g)(2)(B) 42 CFR 456.709(a)	F.1.	The DUR program includes retrospective DUR through its electronic drug claims processing system and information retrieved from the system and 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.

State/Territory: Arizona

Citation		
	4.26 Drug Utilization Review Program (Cont'd)	
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/Pharmacy & Therapeutics Committee, 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: _X_ 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
1927(g)(3)(C) 42 CFR 456.716(d)	3.	The activities of the DUR Board may 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.

State/Territory: Arizona

Citation		
	4.26 Drug Utilization Review Program (Cont'd)	
1927(g)(3)(C) 42 CFR 456.711 (a)-(d)	G.4	The interventions may include the following in appropriate instances: - Information dissemination - Written, oral, or 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 the CMS Annual DUR Report shall be prepared and submitted to the Secretary, which incorporates a report for the State DUR Program, 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 for 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 on-line point of sale drug claims processing system.

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

State/Territory: Arizona

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.

1927(g)

K. AHCCCS will participate in the drug rebate program for the fee-for-service program.

1903(m)(2)(A)

L. AHCCCS will participate in the drug rebate program for its managed care program.

M. AHCCCS will contract with pharmaceutical manufacturers and collect supplemental drug rebates for the fee-for-service program. The State Supplemental Rebate Agreement was submitted to CMS on March 5, 2015.

N. AHCCCS will contract with pharmaceutical manufacturers and collect supplemental drug rebates for its managed care program. The State Supplemental Rebate Agreement was submitted to CMS on March 5, 2015.

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

State/Territory: Arizona

The State is in compliance with the new drug review and utilization requirements set forth in section 1902(oo) of the Act, as follows:

1902(a)(85) and Section 1004 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act (SUPPORT Act)

1. Claim Review Requirements

a. The following Safety Edits have been implemented at the Point-of-Sale including Early, Dosage, Duplicate, and Quantity Limits:

i. The state has implemented the following prospective opioid safety edits:

(1) Quantity limits, including days' supply limits:

(2) Length of therapy limits:

(3) Refill frequency (percent to refill) limits;

(4) Duplicate fills; and

(5) Maximum Morphine Milligram Equivalents (MME) per Day Limits.

ii. The state has implemented the following retrospective opioid safety reviews:

(1) Quantity limits, including days' supply limits;

(2) Length of therapy limits;

(3) Refill frequency (percent utilized to refill) limits:

(4) Duplicate fills: and

(5) Maximum MME/ Day reviews.

2. Concurrent Utilization Alerts

a. Opioid and Benzodiazepines Current Fill Reviews
   i. The state has implemented and monitors results of Point-of-Sale alerts for concomitant use of opioids and benzodiazepines.

b. Opioid and Antipsychotic Concurrent Fill Reviews
   i. The state has implemented and monitors results of Point-of-Sale alerts for concomitant use of opioids and antipsychotics.

c. Opioid and Antipsychotic and Benzodiazepine Current Fill Reviews

(i)The state has implemented and monitors results of Point-of- Sale alerts for concomitant use of opioids with an Antipsychotic and a Benzodiazepine.

3. Program to Monitor Antipsychotic Medication Use by Children

a. The state has implemented and monitors the following:
   i. Age restrictions;
   ii. Quantity limits;
   iii. Prior authorization for duplicate therapy; and
   iv. Medication use in Foster Children.

4. Fraud, Waste and Abuse Identification.

a. The State has implemented policy requirements and monitors the results including but not limited to the following:
   i. Number of opioid prescribers per member;
   ii. Number of pharmacies utilized per member for opioid fills;
   iii. Prior authorization requirements for long acting opioids;
   iv. Controlled Substances Prescription Monitoring Program, the State's PDMP, review for all prior authorization requests for opioids; and
   v. Controlled and Non-Controlled Utilization including the following:

      1. Atypical Antipsychotics;
      2. Benzodiazepines;
      3. Hypnotics;
      4. Muscle Relaxants;
      5. Opioids
      6. Stimulants; and
      7. Others as identified.

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

State/Territory: ARIZONA

Citation

42 CFR 431.115(c) 4.27 Disclosure of Survey Information and Provider or Contractor Evaluation
AT-78-90
AT-79-74

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	4.28 Appeals Process
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)).	(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).

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

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

Revision: HCFA-AT-87-14 (BERC) OMB No.: 0938-0193
OCTOBER 1987 4.30 Continued

State/Territory: ARIZONA

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.

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

State/Territory: Arizona

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 inn order to verify eligibility or the correct payment amount and the agencies and the State(s) from which that information will be requested. (c) The State has an eligibility determination system that provides for data matching through the Public Assistance Reporting Information System (PARIS), or any successor system, including matching with medical assistance programs operated by other States. The information that is requested will be exchanged with States and other entities legally entitled to verify Title XIX applicants and individuals eligible for covered Title XIX services consistent with applicable PARIS agreements.

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) OMB No.: 0938-0193
SEPTEMBER 1988

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

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

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.

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

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.

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

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.

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)).	(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).

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.

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)).	(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.

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

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 Sections		
1919(g)(1) thru (2) and 1919(g)(4) thru (5) of the Act P.L. 100-203 (Sec. 4212(a))	4.40 Survey & Certification Process (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.

State/Territory: Arizona

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.

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

State/Territory: Arizona

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory Arizona

4.46 Provider Screening and Enrollment

The State Medicaid agency gives the following assurances:

Citation
(a)77
1902(a)39
adds1902(kk);
P.L. 111-148 and
P.L. 111-152

42 CFR 455 Subpart E	PROVIDER SCREENING __X__Assures that the State Medicaid agency complies with the process for screening provider under section 1902(a)(39), 1902(a)(77) and 1902(kk) of the Act
42 CFR 455.410	ENROLLMENT AND SCREENING OF PROVIDERS __X__Assures enrolled providers will be screened in accordance with 42 CFR 455.400 et seq. __X__Assures that the State Medicaid agency requires all ordering or referring physicians or other professionals to be enrolled under the State plan or under a waiver of the Plan as a participating provider.
42 CFR 455.412	VERIFICATION OF PROVIDER LICENSES __X__Assures that the State Medicaid agency has a method for verifying providers licensed by a State and that such providers licenses have not expired or have no current limitations
42 CFR 455.414	REVALIDATION OF ENROLLMENT __X__Assures that providers will be revalidated regardless of provider type at least every 5 years.
42 CFR 455.416	TERMINATION OR DENIAL OR ENROLLMENT __X__Assures that the State Medicaid agency will comply with 1902(a)(39) of the Act and with the requirements outlined in 42 CFR 455.416 for all terminations or denials of provider enrollment.
42 CFR 455.420	REACTIVATION OF PROVIDER ENROLLMENT __X__Assures that any reactivation of a provider will include re-screening and payment of application fees as required by 42 CFR 455.460.

42 CFR 455.422	APPEAL RIGHTS __X__Assures that all terminated providers denied enrollment as a result of the requirements of 42 CFR 455.416 will have appeal rights available under procedures established by State law or regulation.
42 CFR 455.432	SITE VISITS __X__Assures that pre-enrollment and post-enrollment site visits of providers who are in "moderate" or "high" risk categories will occur.
42 CFR 455.434	CRIMINAL BACKGROUND CHECKS __X__Assures that providers, as a condition of enrollment, will be required to consent to criminal background checks including fingerprints if required to do so under State law or by the level of screening based on risk of fraud, waste or abuse for that category of provider.
42 CFR 455.436	FEDERAL DATABASE CHECKS __X__Assures that the State Medicaid agency will perform Federal database checks on all providers or any person with an ownership or controlling interest or who is an agent or managing employee of the provider.
42 CFR 455.440	NATIONAL PROVIDER IDENTIFIER __X__Assures that the State Medicaid agency requires the National Provider Identifier of any ordering or referring physician or other professional to be specified on any claim for payment that is based on an order or referral of the physician or other professional.
42 CFR 455.450	SCREENING LEVELS FOR MEDICAID PROVIDERS __X__Assures that the State Medicaid agency complies with 1902(a)(77) and 1902(kk) of the Act and with the requirements outline in 42 CFR 455.450 for screening levels based upon the categorical risk level determined for a provider.
42 CFR 455.460	APPLICATION FEE __X__Assures that the State Medicaid agency complies with the requirements for collection of the application fee set forth in section 1866(j)(2)() of the Act and 42 CFR 455.460
42 CFR 455.470	TEMPORARY MORATORIUM ON ENROLLMENT OF NEW PROVIDERS OR SUPPLIERS __X__Assures that the State Medicaid agency complies with any temporary moratorium on the enrollment of new providers or provider types imposed by the Secretary under section 1866(j)(7) and 1902(kk)(4) of the Act, subject to any determination by the State and written notice to the Secretary that such a temporary moratorium would not adversely impact beneficiaries' access to medical assistance.

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.

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

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.

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

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-AT-81- (BPP)

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.

TN # 82-4
Supersedes
TN # 82-1

Approval Date 21 SEP 1982 Effective Date 18 AUG 1982

Revision: HCFA-AT-80-38 (HPP)
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.

TN # 82-1
Supersedes
TN #

Approval Date 6/23/82 Effective Date 1/1/82

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

State/Territory: Arizona

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.

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

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.

Section 7 – General Provisions
7.4. Medicaid Disaster Relief for the COVID-19 National Emergency

On March 13, 2020, the President of the United States issued a proclamation that the COVID-19 outbreak in the United States constitutes a national emergency by the authorities vested in him by the Constitution and the laws of the United States, including sections 201 and 301 of the National Emergencies Act (50 U.S.C. 1601 et seq.), and consistent with section 1135 of the Social Security Act (Act). On March 13, 2020, pursuant to section 1135(b) of the Act, the Secretary of the United States Department of Health and Human Services invoked his authority to waive or modify certain requirements of titles XVIII, XIX, and XXI of the Act as a result of the consequences COVID-19 pandemic, to the extent necessary, as determined by the Centers for Medicare & Medicaid Services (CMS), to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in the respective programs and to ensure that health care providers that furnish such items and services in good faith, but are unable to comply with one or more of such requirements as a result of the COVID-19 pandemic, may be reimbursed for such items and services and exempted from sanctions for such noncompliance, absent any determination of fraud or abuse. This authority took effect as of 6PM Eastern Standard Time on March 15, 2020, with a retroactive effective date of March 1, 2020. The emergency period will terminate, and waivers will no longer be available, upon termination of the public health emergency, including any extensions.

The State Medicaid agency (agency) seeks to implement the policies and procedures described below, which are different than the policies and procedures otherwise applied under the Medicaid state plan, during the period of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), or for any shorter period described below:

N/A

The flexibilities described in this SPA shall be implemented throughout the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

The effective date for the SPA is January 1, 2023

NOTE: States may not elect a period longer than the Presidential or Secretarial emergency declaration (or any renewal thereof). States may not propose changes on this template that restrict or limit payment, services, or eligibility, or otherwise burden beneficiaries and providers.

Request for Waivers under Section 1135

X The agency seeks the following under section 1135(b)(1)(C) and/or section 1135(b)(5) of the Act:

a. X SPA submission requirements – the agency requests modification of the requirement to submit the SPA by March 31, 2020, to obtain a SPA effective date during the first calendar quarter of 2020, pursuant to 42 CFR 430.20.

b. X Public notice requirements – the agency requests waiver of public notice requirements that would otherwise be applicable to this SPA submission. These requirements may include those specified in 42 CFR 440.386 (Alternative Benefit Plans), 42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

c. X Tribal consultation requirements – the agency requests modification of tribal consultation timelines specified in [Arizona] Medicaid state plan, as described below:

Current state plan language provides for an expedited Tribal Consultation process in situations that require immediate submission of a policy change to CMS. However, the current language details the Agency soliciting written comment "in the meeting notification with a description of the policy change and the date when the change will be submitted to CMS" at least 14 days prior to submission to CMS. While the Agency will hold an emergency Tribal Consultation meeting to discuss these policy changes, AHCCCS was not able to meet this 14 day requirement prior to submission to CMS, and are thus seeking relevant flexibility.

Section A – Eligibility

1. _____ The agency furnishes medical assistance to the following optional groups of individuals described in section 1902(a)(10)(A)(ii) or 1902(a)(10)(c) of the Act. This may include the new optional group described at section 1902(a)(10)(A)(ii)(XXIII) and 1902(ss) of the Act providing coverage for uninsured individuals.

2. _____ The agency furnishes medical assistance to the following populations of individuals described in section 1902(a)(10)(A)(ii)(XX) of the Act and 42 CFR 435.218:
   a. _____ All individuals who are described in section 1905(a)(10)(A)(ii)(XX)
   Income standard: _____

   -or-
   b. _____ Individuals described in the following categorical populations in section 1905(a) of the Act:

   Income standard: _____

3. _____ The agency applies less restrictive financial methodologies to individuals excepted from financial methodologies based on modified adjusted gross income (MAGI) as follows.
   Less restrictive income methodologies:

Less restrictive resource methodologies:

4. _____ The agency considers individuals who are evacuated from the state, who leave the state for medical reasons related to the disaster or public health emergency, or who are otherwise absent from the state due to the disaster or public health emergency and who intend to return to the state, to continue to be residents of the state under 42 CFR 435.403(j)(3).

5. _____ The agency provides Medicaid coverage to the following individuals living in the state, who are non-residents:

6. _____ The agency provides for an extension of the reasonable opportunity period for non-citizens declaring to be in a satisfactory immigration status, if the non-citizen is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency is unable to complete the verification process within the 90-day reasonable opportunity period due to the disaster or public health emergency.

Section B – Enrollment

1. _____ The agency elects to allow hospitals to make presumptive eligibility determinations for the following additional state plan populations, or for populations in an approved section 1115 demonstration, in accordance with section 1902(a)(47)(B) of the Act and 42 CFR 435.1110, provided that the agency has determined that the hospital is capable of making such determinations.

Please describe the applicable eligibility groups/populations and any changes to reasonable limitations, performance standards or other factors.

2. _____ The agency designates itself as a qualified entity for purposes of making presumptive eligibility determinations described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L.

Please describe any limitations related to the populations included or the number of allowable PE periods.

3. _____ The agency designates the following entities as qualified entities for purposes of making presumptive eligibility determinations or adds additional populations as described below in accordance with sections 1920, 1920A, 1920B, and 1920C of the Act and 42 CFR Part 435 Subpart L. Indicate if any designated entities are permitted to make presumptive eligibility determinations only for specified populations.

Please describe the designated entities or additional populations and any limitations related to the specified populations or number of allowable PE periods.

4. __X___The agency adopts a total of __12___months (not to exceed 12 months) continuous eligibility for children under age __19___(not to exceed age 19) regardless of changes in circumstances in accordance with section 1902(e)(12) of the Act and 42 CFR 435.926.

5. _____The agency conducts redetermination of eligibility for individuals excepted from MAGI-based financial methodologies under 42 CFR 435.603(j) once every _____months (not to exceed 12 months) in accordance with 42 CFR 435.916(b).

6. _____ The agency uses the following simplified application(s) to support enrollment in affected areas or for affected individuals (a copy of the simplified application(s) has been submitted to CMS).

    a. _____ The agency uses a simplified paper application.

    b. _____ The agency uses a simplified online application.

    c. _____ The simplified paper or online application is made available for use in call-centers or other telephone applications in affected areas.

Section C – Premiums and Cost Sharing

1. __X___The agency suspends deductibles, copayments, coinsurance, and other cost sharing charges as follows:

Copays and premium requirements for all members are suspended for the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof).

2. __X___The agency suspends enrollment fees, premiums and similar charges for:

    a. __X___All beneficiaries

b. _____ The following eligibility groups or categorical populations:

Please list the applicable eligibility groups or populations.

3. _____ The agency allows waiver of payment of the enrollment fee, premiums and similar charges for undue hardship.

Please specify the standard(s) and/or criteria that the state will use to determine undue hardship.

Section D – Benefits

Benefits:

1. _____ The agency adds the following optional benefits in its state plan (include service descriptions, provider qualifications, and limitations on amount, duration or scope of the benefit):

2. ___X__ The agency makes the following adjustments to benefits currently covered in the state plan:

Home Health: The state allows physicians and other licensed practitioners, in accordance with State law, to order Medicaid Home Health services as authorized in the COVID-19 Public Health Emergency Medicare interim final rule (CMS-1744-IFC). Other Licensed Practitioners: Pharmacies are qualified providers of COVID-19 vaccinations per the HHS COVID-19 PREP Act Declaration and authorizations. Licensed Pharmacists employed by an AHCCCS-registered pharmacy and acting within the scope of their practice to order and administer AHCCCS covered vaccines and anaphylaxis agents to adults and children. As identified in their scope of practice, Licensed Pharmacists may order and prescribe Flu and COVID-19 related vaccines. Pharmacy Technicians and Pharmacy Interns employed by an AHCCCS-registered pharmacy and acting within the scope of their practice may also administer AHCCCS covered influenza and COVID-19 vaccines under the supervision of an immunizing pharmacist.

3. ___X__ The agency assures that newly added benefits or adjustments to benefits comply with all applicable statutory requirements, including the statewideness requirements found at 1902(a)(1), comparability requirements found at 1902(a)(10)(B), and free choice of provider requirements found at 1902(a)(23).

4. __X___ Application to Alternative Benefit Plans (ABP). The state adheres to all ABP provisions in 42 CFR Part 440, Subpart C. This section only applies to states that have an approved ABP(s).

   a. __X__ The agency assures that these newly added and/or adjusted benefits will be made available to individuals receiving services under ABPs.

   b. ____ Individuals receiving services under ABPs will not receive these newly added and/or adjusted benefits, or will only receive the following subset:

Please describe.

Telehealth:

5. _____ The agency utilizes telehealth in the following manner, which may be different than outlined in the state's approved state plan:

Please describe.

Drug Benefit:

6. __X___ The agency makes the following adjustments to the day supply or quantity limit for covered outpatient drugs. The agency should only make this modification if its current state plan pages have limits on the amount of medication dispensed.

The state is requesting to waive any signature requirements for the dispensing of drugs during the Public Health Emergency, effective March 1, 2020.

7. __X___Prior authorization for medications is expanded by automatic renewal without clinical review, or time/quantity extensions.

8. _____The agency makes the following payment adjustment to the professional dispensing fee when additional costs are incurred by the providers for delivery. States will need to supply documentation to justify the additional fees.

9. __X___The agency makes exceptions to their published Preferred Drug List if drug shortages occur. This would include options for covering a brand name drug product that is a multi-source drug if a generic drug option is not available.

Section E – Payments

Optional benefits described in Section D:

1. __X___ Newly added benefits described in Section D are paid using the following methodology:

    a. __X__ Published fee schedules –

    Effective date (enter date of change): _____

Location (list published location):
https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS (Physician fee schedule and Hospital Outpatient Fee Schedule (OPFS).)

a. ____ Other:

Describe methodology here.

Increases to state plan payment methodologies:

2. __X__ The agency increases payment rates for the following services:

1) In cases where vaccine administration is separately reimbursable at a fee amount, payment for administration of COVID-19 vaccinations is set at $83 per dose. 2) The Administration shall reimburse IHS/638 facilities non-FQHC clinics at the outpatient all-inclusive rate (AIR) for COVID-19 vaccine administration by registered nurses under an individual or standing order. 3) Payment for the Non-Emergency Medical Transportation (NEMT) services billable under HCPCS T2007 will be increased by $8.64 per unit for trips associated with a COVID-19 drive-through vaccination site. A COVID-19 drive-through vaccination site is any site at which an AHCCCS member arrives in vehicle and receives the COVID-19 vaccination without exiting the vehicle. The total payment for HCPCS T2007 will be $13.23 per unit when the TU modifier, denoting time spent at the COVID-19 drive-through vaccine site, is used.

a. _____ Payment increases are targeted based on the following criteria:

Please describe criteria.

b. Payments are increased through:

i. ____ A supplemental payment or add-on within applicable upper payment limits:

Please describe.

ii. __X__ An increase to rates as described below.

Rates are increased:
_____ Uniformly by the following percentage: _____
___X__ Through a modification to published fee schedules –
Effective date (enter date of change): _____
Location (list published location): _____
___ Up to the Medicare payments for equivalent services.
_____ By the following factors:

Please describe.

Payment for services delivered via telehealth:

3. _____ For the duration of the emergency, the state authorizes payments for telehealth services that:

    a. _____ Are not otherwise paid under the Medicaid state plan;

    b. _____ Differ from payments for the same services when provided face to face;

    c. _____ Differ from current state plan provisions governing reimbursement for telehealth;

Describe telehealth payment variation.

    d. _____ Include payment for ancillary costs associated with the delivery of covered services via telehealth, (if applicable), as follows:

        i. _____ Ancillary cost associated with the originating site for telehealth is incorporated into fee-for-service rates.

        ii. _____ Ancillary cost associated with the originating site for telehealth is separately reimbursed as an administrative cost by the state when a Medicaid service is delivered.

Other:

4. __X___ Other payment changes:

- *The Administration shall make interim payments to each hospital to reflect a preliminary, estimated amount for each GME component. The interim payment amount shall be computed as 80.0% of the actual distribution to each hospital for the service period of July 1, 2018, to June 30, 2019. The Administration will then compute the final, actual GME amounts for the service period July 1, 2019, to June 30, 2020, and adjust the final distribution amounts by the amount of the interim payments already made. The final computation, reconciliation, and distribution will occur no later than one year from June 30, 2020. The federal share of any overpayments are returned to CMS in accordance with 42 CFR 433, Subpart F.*

- The Administration shall make two rounds of lump sum payments to registered network providers who provide nursing facility services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use October 1, 2019 to December 31, 2019 as proxy utilization data for both rounds. Registered network providers which qualify for these increases include all Nursing Facilities (NF), except for Out-of-State nursing facilities, Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IIDs) and the Arizona Veteran's Homes. Both rounds of lump sum payments are to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. For each round of payments, each registered network provider's lump sum payment shall be determined as follows:

1. Determine each provider's actual Medicaid bed days based on approved and adjudicated FFS claims from October 1, 2019 to December 31, 2019.
2. The uniform dollar amount increase amount for nursing facilities is $30 per bed day
3. The Administration will multiply the appropriate uniform dollar increase amount listed in item two by the number of Medicaid bed days as determined in item one to calculate the lump sum payment for each provider

- The Administration shall make a lump sum payment to registered network providers who provide qualifying American Rescue Plan Act (ARPA) services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use October 1, 2020 to March 31, 2021 as proxy utilization data for the lump sum payment. The payment is intended to supplement services provided from April 1, 2022 to June 30, 2022. Registered network providers which qualify for these increases are outlined in the following link- https://azahcccs.gov/AHCCCS/downloads/Initiatives/ARPA/EligibleProviderTypesNon-DDD.pdf . The purpose of the lump sum payments is to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. Each registered network provider's lump sum payment shall be determined as follows:

1. Determine each provider's actual paid amounts for Medicaid state plan FFS utilization of qualifying services from October 1, 2020 to March 31, 2021.
2. Multiply the actual Medicaid utilization determined in item 1 by two.
3. The uniform percentage increase for providers will be 17.8%
4. The Administration will multiply the appropriate uniform percentage increase listed in item three by the total utilization determined in item two to calculate the lump sum payment for each provider.

   AHCCCS will not make any payments to providers that have a total lump sum payment of less than $1,000.

- The Administration shall make a second lump sum payment to registered network providers who provide qualifying American Rescue Plan Act (ARPA) services with Arizona Fee for Service (FFS) Medicaid utilization for service periods during the PHE, and will use March 1, 2022 to August 31, 2022 as proxy utilization data for the lump sum payment. The payment is intended to supplement services provided from January 1, 2023-March 31, 2023. Registered network providers which qualify for these increases are outlined in the following link- https://azahcccs.gov/AHCCCS/downloads/Initiatives/ARPA/EligibleProviderTypesNon-DDD.pdf . The purpose of the lump sum payments is to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve the member's experience of care. Each registered network provider's lump sum payment shall be determined as follows:

1. Determine each provider's actual paid amounts for Medicaid state plan FFS utilization of qualifying services from March 1, 2022, to August 31, 2022.
2. Multiply the actual Medicaid utilization determined in item 1 by two.
3. The uniform percentage increase for providers will be 11.48%
4. The Administration will multiply the appropriate uniform percentage increase listed in item three by the total utilization determined in item two to calculate the lump sum payment for each provider.

   AHCCCS will not make any payments to providers that have a total lump sum payment of less than $5,000.

Subsection F – Post Eligibility Treatment of Income

1. _____ The state elects to modify the basic personal needs allowance for institutionalized individuals. The basic personal needs allowance is equal to one of the following amounts:

    a. _____ The individual's total income
    b. _____ 300 percent of the SSI federal benefit rate
    c. _____ Other reasonable amount: _____

2. _____ The state elects a new variance to the basic personal needs allowance (Note: Election

42 CFR 447.57(c) (premiums and cost sharing), and 42 CFR 447.205 (public notice of changes in statewide methods and standards for setting payment rates).

of this option is not dependent on a state electing the option described the option in F.1. above.)

The state protects amounts exceeding the basic personal needs allowance for individuals who have the following greater personal needs:

Section G – Other Policies and Procedures Differing from Approved Medicaid State Plan /Additional Information

1) For the duration of the Presidential and Secretarial emergency declarations related to the COVID-19 outbreak (or any renewals thereof), payment for a reserved bed may be made if the absence does not exceed 30 days per contract year. This 30 day limit is cumulative of bed hold days and applies to all age groups. This change does not affect therapeutic leave policy, which remains at 9 cumulative days per contract year.

Payment for reserved beds is subject to all other requirements listed in Attachment 4.19-C.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148 (Expires 03/31/2021). The time required to complete this information collection is estimated to average 1 to 2 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. Your response is required to receive a waiver under Section 1135 of the Social Security Act. All responses are public and will be made available on the CMS web site. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ***CMS Disclosure*** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact the Centers for Medicaid & CHIP Services at 410-786-3870.

7.4.A. Rescissions to the State's Disaster Relief Policies for the COVID-19 National Emergency

Effective April 1, 2020, the agency rescinds the election at A.1. of section 7.4 (approved on 4/1/2020 in SPA Number AZ-SPA-20-0001 and approved on 5/22/2020 in SPA Number AZ-SPA-20-0005) of the state plan to furnish medical assistance to the optional eligibility group described at section 1902(a)(10)(A)(ii)(XXIII) of the Social Security Act.

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

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

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 [illegible] is

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

7-2-84
DATE

Bob Corbin
Signature

Attorney General
Title

84-2 APP: 07-26-84
EFF: 05-05-84

State of ARIZONA

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

Waiver #1.[1/] NOT APPLICABLE

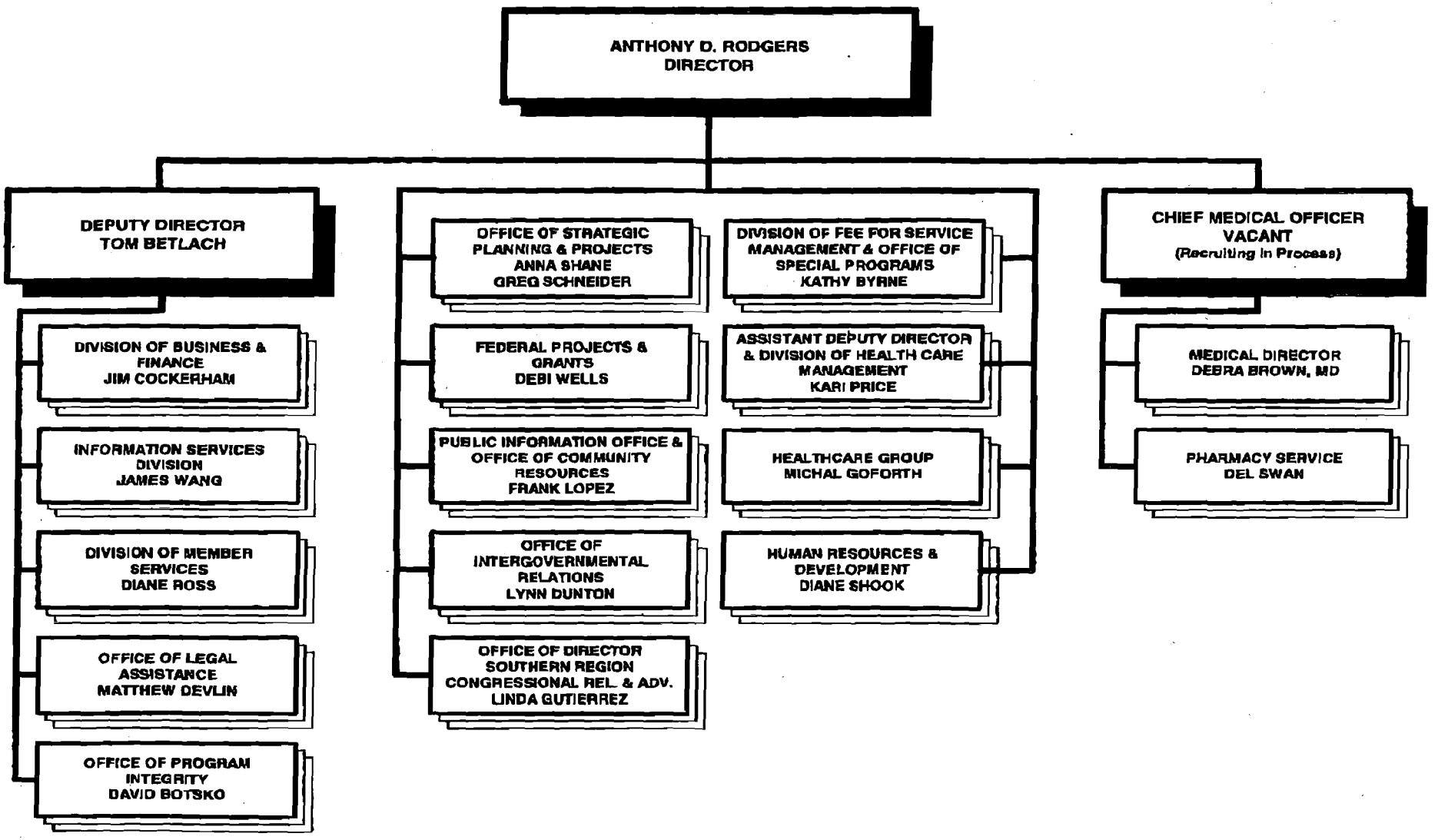
a. Waiver was granted on _____ (date)

b. The organizational arrangement authorized, the nature and extent of responsibility for program administration delegated to _____ (name of agency), and 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



TN No.: 04-001 Approval Date: APR 13 2004 Effective Date: 1/1/04
Supercedes
TN No.: 00-013

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**

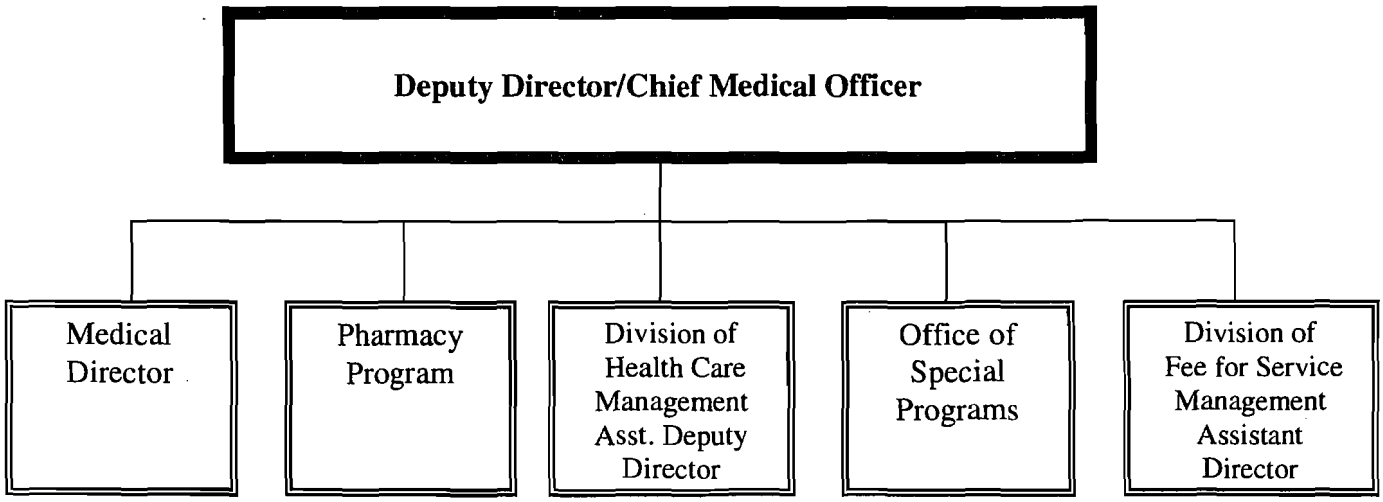
   (a) Oversight and coordination of the Fee For Service contract with a pharmacy administrator, including formulary review, provider network and any quality of care issues related to pharmacy.

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

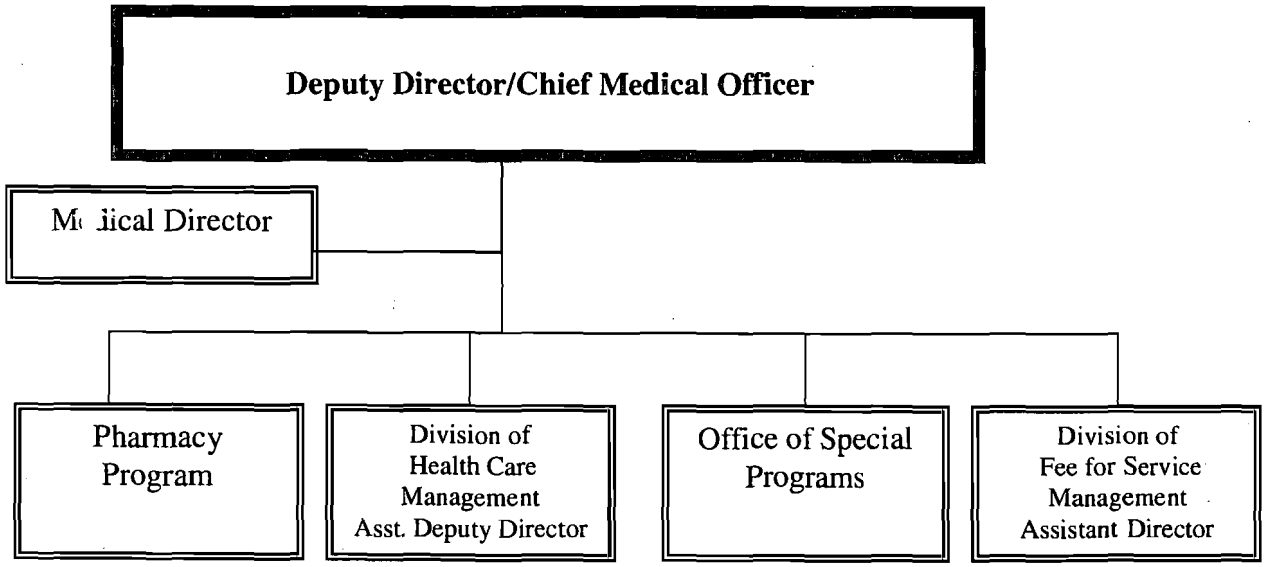
   (c) Resource of pharmacy expertise for policy development.

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(e) 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 ~~eoicty~~ 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	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.
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.

See MRM 91-10 Item 14

Reserved

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

Agency*	Citation(s)	Groups Covered

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

435.121

13. 17 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	/7	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.
		N/A	

*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 /7 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 /7 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.

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)

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.

N/A

☐ 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.

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.

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), 1905(p), and 1860D-14(a)(3)(D) 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 three times the resource limit, adjusted annually by the increase in the Consumer Price Index. (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(p), 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 two times the SSI resource limit. 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), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) 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 is greater than 100% but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the Consumer Price Index (CPI). (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

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

1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act

29. Qualifying Individuals --

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 is at least 120 percent but less than 135 percent of the Federal poverty level;

c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

(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

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.

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 ~~years of age or younger as~~ under the age 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 /7

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--

a. Based on need and paid in cash on a regular basis.

N/A

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	/_/	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 institution, and for whom
	N/A		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.

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.

Revision:

ATTACHMENT 2.2-A
PAGE 23d
OMB NO.:

State/Territory: Arizona

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. /7 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

/7 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.

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.

N/A

435.340 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, ~~intermediate care facilities~~ nursing facilities and intermediate care facilities for the mentally retarded, 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. AM.

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.)

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) Qualified disabled and working individuals. 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) Specified low-income Medicare beneficiaries. 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).

State/Territory: Arizona

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.

State/Territory: Arizona

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.

State/Territory: Arizona

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.

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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.

State/Territory: Arizona

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.

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.

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State/Territory: Arizona

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.

State/Territory: Arizona

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:

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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.)	Premiums and Other Cost-Sharing Charges 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 (Not Applicable)	3. Medically needy income levels (MNILs) are based on family size. 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.

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.
	(2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:
N/A	(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

/7 (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.

N/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
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	5. Methods for Determining Resources 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.
	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(l)(3)(C) 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.
1902(r)(2) of the Act	
	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. 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. 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.
1902(l)(3)(C) of the Act		
1902(r)(2) 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(l)(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(l)(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.

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.
	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.
1902(a)(10)(E), 1905(p)(1)(D) and (p)(2)(B), and 1860D-14(a)(3)(D)	8. Resource Standard - Qualified Medicare Beneficiaries and Specified Low-Income Medicare Beneficiaries and Qualifying Individuals For qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under section 1902(a)(10)(E)(iv)of the Act the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.
1902(a)(10)(E)(ii), and 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 two times the SSI resource limit.

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.

State: Arizona

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.

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 except that residency requirements must be met for the full month. Coverage for individuals moving to Arizona begins on the day the individual moves to Arizona.

_X_ Aged, blind, disabled.
_X_ AFDC-related.
_X_ All other Title XIX populations

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.
__ Aged, blind, disabled.
__ AFDC-related.
__ All other Title XIX populations

(2) For the retroactive period
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.
___ All other Title XIX populations

Coverage is available during any of the three months before the date of application if the following individuals would have been eligible for the month, had they applied. Coverage for individuals moving to Arizona begins on the day the individual moves to Arizona.
_X_ Aged, blind, disabled.
_X_ AFDC-related.
_X_ All other Title XIX populations

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.

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

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.

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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)(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 /_/ urban only /_/ urban & rural	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/]
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

/7/ Same as resource levels in the State's approved AFDC plan.

/7/ 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 -

/7 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 can be a type of care not covered under the State Plan or a type of service that is covered under the State Plan but that is not reimbursed by the State.

The expense must be for a medically necessary service or remedial care service rendered to the applicant or beneficiary and prescribed by a health care practitioner acting within the scope of practice as defined by State law. The applicant or recipient must have or have had a legal obligation to pay the medical or remedial expense. Deductions do not include the cost of services to the extent a third party paid for or is liable for the service. Deductions for expenses incurred prior to application are limited to expenses incurred during the three months prior to the filing of an application.

Documentation of expenses paid by the applicant or recipient must be provided to the State prior to the end of the month following the month during which the expense was paid.

With respect to services of a type covered under the State Plan but not reimbursed by the State, the amount of the deduction is limited to the amount of the reimbursement described in the State Plan. With respect to services of a type not covered under the State Plan, the amount of the deduction is the fair market value of the services provided.

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	IBILITY
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)(1O)(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:

- 1905(p) – QMB
- 1902(a)(10(E)(iii) – SLMB
- 1902(a)(10(E)(iv)(I) – QI
- 1902(a)(10)(A)(ii)(XV) – TWWIIA Basic Coverage Group
- 1902(a)(10)(A)(ii)(XVI) - TWWIIA Medically Improved Group
- 1902(a)(10)(A)(ii)(I) – SSI Non-Cash

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)(10)(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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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:

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

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
State: ARIZONA

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

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

For individuals with greater need, the following allowances are provided:

1. Individuals who have received institutional services less than 30 days:
   300% of the Federal Benefit Rate (allowed by waiver)

2. 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.)

3. Income garnished for child support under a court order, including administrative fees garnished for collection efforts, but only to the extent that the amount garnished is not deducted as a monthly allowance for the dependent under any other provision of the post-eligibility process. The allowance given shall not exceed the actual garnishment paid in the month for which the PNA is calculated;

4. Income garnished for spousal maintenance under a judgment and decree for dissolution of marriage, including administrative fees garnished for collection efforts. The allowance given shall not exceed the actual garnishment paid in the month for which the PNA is calculated

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 PROGRAM PER SECTION 1902(r)(2) OF THE SOCIAL SECURITY ACT.~~

1/10/92

SHINGTON v. BOWEN

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ASSET VERIFICATION SYSTEM

1940(a) of the Act

1. The agency will provide for the verification of assets for purposes of determining or redetermining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

A. The request and response system must be electronic:

(1) Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
(2) The system cannot be based on mailing paper-based requests.
(3) The system must have the capability to accept responses electronically.

B. The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

C. The system must establish and maintain a database of FIs that participate in the agency's AVS.

D. Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or redetermine the individual's eligibility.

E. The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ASSET VERIFICATION SYSTEM

2. System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

___ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

__X__ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

___ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

ASSET VERIFICATION SYSTEM

3. Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

AHCCCS will be joining the NESCSO consortium with Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont to obtain an Asset Verification System.

SUPPLEMENT 17 TO ATTACHMENT 2.6-A
Page 1

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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.

TN No. 07-001
Supersedes
TN No. N/A

Approval Date JUN 0 5 2007 Effective Date February 8, 2006

State Plan Under Title XIX of the Social Security Act

State: Arizona

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on 01/28/2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

TN – 13-015 Approval Date – MAR 3 1 2014 Effective Date – 01/01/2014

Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		Applicable Population Adjustment			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: • The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL. If a population group was not covered as of 12/1/09, enter "Not covered".	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Att. A, Table 1, Column G, Line 1 of part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Disabled Persons, non-institutionalized	Att. A, Table 1, Column G, Line 2 of part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Disabled Persons, institutionalized	Att. A, Table 1, Column G, Line 3 of part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	N/A	N/A	N/A	N/A
Children Age 19 or 20	Att. A, Table 1, Column G, Line 4 of part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No
Childless Adults	Att. A, Table 1, Column G, Line 5 of part 2 of the CMS approved MAGI conversion plan, including any subsequent CMS approved modifications to the MAGI Conversion Plan.	No	No	No	No

Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

A. Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))

1. The state:

   ☐ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   ■ Does NOT apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

   Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

   The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

2. Data source used for resource proxy adjustments:

   The state:

   ☐ Applies existing state data from periods before January 1, 2014.

   ☐ Applies data obtained through a post-eligibility statistically valid sample of individuals.

   Data used in resource proxy adjustments is described in Attachment B.

3. Resource Proxy Methodology: Attachment B describes the sampling approach or other methodology used for calculating the adjustment.

B. Enrollment Cap Adjustment (42 CFR 433.206(e))

1. ☐ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

   ■ An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

3. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

   ☐ Yes. The combined enrollment cap adjustment is described in Attachment C

   ☐ No.

4. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

C. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

1. The state:

   ☐ Applies a special circumstances adjustment(s).

   ■ Does not apply a special circumstances adjustment.

2. The state:

   ☐ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

   ■ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

3. Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

A. Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group

☒ Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

☐ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

A. Expansion State Designation

The state:

☐ Does NOT meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

☒ Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 10/30/2013.

B. Qualification for Temporary 2.2 Percentage Point Increase in FMAP.

The state:

☒ Does NOT qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

☐ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated _____. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

Part 5 - State Attestations

The State attests to the following:

A. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

B. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

- ■ Attachment A – Conversion Plan Standards Referenced in Table 1
- ☐ Attachment B – Resource Criteria Proxy Methodology
- ☐ Attachment C – Enrollment Cap Methodology
- ☐ Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- ■ Attachment E – Transition Methodologies

Attachment A
Most Recent Table 1 for Part 2 of the Modified Adjusted Gross Income (MAGI) Conversion Plan*

	Population Group	SIPP results used? (Yes/No)	Time Period	Sampling (Yes/No)	Net Income Standard	Income band used in conversion	Converted Standard
	A	B	C	D	E	F	G
Conversions for FMAP Claiming							
1	Parents/Caretaker Relatives (Expand number of rows for family size as needed for larger family size standards defined by the state)	**No**	**January, April, July 2012**	**No**	**100% FPL**	**75-100% FPL**	**100% FPL**
2	Noninstitutionalized Disabled Adults	**N/A****	**N/A****	**N/A****	**N/A****	**N/A****	**N/A****
3	Institutionalized Disabled Adults (This is a gross income category: fill in column G only)						**300% SSI FBR**

TN: 13-015
Supercedes
TN: N/A

Approval Date: MAR 3 1 2014

Effective Date: January 1, 2014

	Population Group	SIPP results used? (Yes/No)	Time Period	Sampling (Yes/No)	Net Income Standard	Income band used in conversion	Converted Standard
	A	B	C	D	E	F	G
4	Children age 19 and/or 20	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
5	Childless Adults	**No**	**January, April, July 2012**	**No**	**100% FPL**	**75-100% FPL**	**105% FPL**

**The converted standard applied for Non-Institutionalized disabled adults is 105% FPL, the same converted standard as applied for childless adults.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 20 per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

*The contents of this table will be updated automatically in the case of modification in the CMS approval MAGI Conversion Plan.

Arizona 1115 Demonstration Transition Plan

I. 2013 Renewal Process

For those members that have a renewal coming due between October 1 through December 31, they will go through the current renewal process. Thus, they will not get asked to update their information with the tax relationships in the household as the system will not yet be ready to send that style of renewal yet.

II. Coverage in 2014

For all populations currently served by Arizona's demonstration (this includes mandatory state plan, optional state plan, and expansion populations), you must map their coverage in 2014. Please:

- Identify the current authority for the population;
- Identify the 1/1/2014 authority for the population; and
- For each 1/1/2014 population, specify the benefits the population will receive and the delivery system for those benefits.

Eligibility Category	*Current* Coverage and Authority	*Jan. 1, 2014* Coverage and Authority	Benefits	Delivery System	Transition Required?
Mandatory Coverage Groups					
Infants Age 0-1	140% FPL; Mandatory State Plan (AZ covers FPL above minimum requirement of 133% FPL)	No change	State Plan	Managed Care	No
Children Age 1-5	133% FPL; Mandatory State Plan	No change	State Plan	Managed Care	No
Children Age 6-18	100% FPL; Mandatory State Plan	Increase to 133% FPL	State Plan	Managed Care	Yes – State Plan to State Plan

1 – *AZ transition plan as of 10-2-13*

Approval Date (for SPA): MAR 3 1 2014 Effective Date (for SPA): JAN 0 1 2014

Pregnant Women	150% FPL; Mandatory State Plan (AZ covers FPL above minimum requirement of 133% FPL)	No change	State Plan	Managed Care	No
Parents and Caretaker Relatives	100% FPL; Mandatory State Plan (AZ covers FPL above 1996 minimum level which averages 21.3% FPL)	No change	State Plan	Managed Care	No
Aged, Blind and Disabled	100% FPL; Mandatory State Plan	No change	State Plan	Managed Care	No
Young Adult Transitional Insurance (YATI)	Mandatory State Plan	Increase of coverage to Age 26	State Plan	Managed Care	Yes – State Plan to State Plan
Adoption Assistance and Foster Care Children	Mandatory State Plan	No change	State Plan	Managed Care	No
Optional Coverage Groups (State Plan)					
SSI-MAO	Income greater than 100% FBR and up to 100% FPL; Optional State Plan	No change	State Plan	Managed Care	No
Breast and Cervical Cancer Treatment Program	Optional State Plan	No change	State Plan	Managed Care	No
Freedom to Work	250% FPL; Optional State Plan	No change	State Plan	Managed Care	No

2 – *AZ transition plan as of 10-2-13*

State Adoption Subsidy	Optional State Plan	No change	State Plan	Managed Care	No
New Adult Group	100-133% FPL; Not currently covered	Coverage begins 1/1/14 at option of the State; State Plan authority	ABP	Managed Care	Yes – New State Plan
Optional Coverage Groups (1115 Waiver)					
Childless Adults	100% FPL; 1115 Waiver (Enrollment currently frozen)	No FPL change; restore coverage 1/1/14; transition authority from 1115 to State Plan	ABP	Managed Care	Yes – expansion to State Plan
Family Planning Extension Program	150% FPL; 1115 Waiver	No change	State plan	Managed Care	No
KidsCare II	100-200% FPL up to age 19; 1115 Waiver (authority expires 12/31/13)	***Transition to Medicaid***: Children with income between 100-133% FPL ***Transition to FFM***: Children with income over 133% FPL up to 200%	N/A	N/A	Yes – Expansion to State Plan; Expansion to FFM
CHIP/KidsCare					
KidsCare I	100-200% FPL up to age 19; Title XXI State Plan (enrollment currently frozen	***Transition to Medicaid***: Children with income between 100-133% FPL	State plan	Managed Care	Yes – Title XXI CHIP State Plan to Title XIX State Plan

3 – *AZ transition plan as of 10-2-13*

		Maintain KidsCare enrollment: Children with income over 133% FPL up to 200%; enrollment remains frozen (no new enrollment)			
Arizona Long Term Care System (ALTCS)					
Elderly & Physically Disabled	300% of FBR; Optional State Plan	No change	State Plan and 1115 Waiver	Managed Care	No
Division of Developmental Disabilities (DDD)	300% of FBR; Optional State Plan	No change	State Plan and 1115 Waiver	Managed Care	No

III. Process for Transition

Describe the state process for transitioning covered groups to appropriate Medicaid eligibility or to the Marketplace under the 2014 coverage options.

- Describe any actions (including proposed dates for those actions) the state will take to transition populations including the process the state will use to screen individuals for coverage under his/her existing category, and for other Medicaid eligibility categories (if he/she is not still eligible under the existing category);
- Describe any actions the beneficiary will need to take for his/her transition; and
- Describe how the state will communicate with and transfer cases to the Marketplace.

AHCCCS Populations Requiring Transition						
Eligibility Category	**Type of Transition**	**Impact to Member**	**State Action**	**Action Needed by AHCCCS Member?**	**Member Notice Needed?**	**Transfer of Case to FFM?**

TN: 13-015
Supercedes
TN: N/A

Approval Date (for SPA): MAR 3 1 2014

Effective Date (for SPA): JAN 0 1 2014

Children ages 6-18 (100-133% FPL)	State Plan to State Plan to reflect increase in FPL level from current maximum of 100% FPL to new of 133% FPL	None. Current members in this category retain their coverage. Enrollment opens for new members from 100-133% FPL on 10-1-13 for coverage effective 1-1-14.	System change to allow for new enrollment	No.	No.	No.
YATI	State Plan to State Plan to reflect increase in upper age limit for youth transitioning out of foster care from current age limit of 21 to new age limit of 26.	Members in this category will retain their coverage through age 26.	System change to maintain eligibility of member in this category through age 26.	No.	Yes to inform member they will retain coverage in this category through age 26. Notices to be sent 1-1-14.	No.
Childless adults (0-100% FPL)	1115 Waiver to State Plan	Current members retain coverage; enrollment will open to new members beginning 10-1-13 for coverage effective 1-1-14	System change to open enrollment 10-1-13 for coverage effective 1-1-14	None for existing members. Adults not currently enrolled must submit application to be considered for eligibility.	Yes to inform current members that enrollment is no longer frozen, their coverage is not being impacted and coverage is available to all adults from 0-133% FPL effective 1-1-14. Notice to be sent 1-1-14.	No.
New Adults (100-133% FPL)	New State Plan Amendment	None. Coverage category not currently available	System change to open enrollment 10-1-13 for	Yes. Must submit application to be considered for	Yes. This is a new notice to explain final eligibility determination (eligibility	No

			coverage effective 1-1-14	eligibility.	confirmed or denied). Notice sent once eligibility determination is made to inform applicant of disposition of case.	
KidsCare I (children 100-133% FPL)	CHIP State Plan to Medicaid State Plan for children in households with income between 100-133% FPL	Minimal. Coverage and health plan options are the same. Move to Medicaid means household will no longer have to pay premiums for coverage. Some copay requirements may apply.	AHCCCS will determine Medicaid eligibility using income data on file	No.	Yes to inform member they are now Medicaid eligible and impact of change in status regarding premiums. Notice to be sent 11-15-13.	No.
KidsCare II (children 100-133% FPL)	1115 Expansion to Medicaid State Plan for children in households with income between 100-133% FPL	Minimal. Coverage and health plan options are the same. Move to Medicaid means household will no longer have to pay premiums for coverage. Some copay requirements may apply.	AHCCCS will determine Medicaid eligibility using income data on file	No.	Yes to inform member they are now Medicaid eligible and impact of change in status regarding premiums. Notice to be sent 11-15-13.	No.
KidsCare II (children above 133% FPL)	Termination of 1115 Expansion program	Children in households with income above 133% FPL will no longer be eligible for KidsCare II. Household	AHCCCS will review for Medicaid eligibility using income data on file to confirm	Yes. Member will have to work with FFM to complete the application	Yes to inform member their KidsCare coverage is terminating and their case is being transferred to FFM for	Yes. Ideally the State will complete account transfer electronically but is awaiting

MAR 3 1 2014 JAN 0 1 2014

		will have to seek coverage on FFM or elsewhere.	household is above 133% FPL	following the account transfer.	disposition and availability of PTC or CSR Notice to be sent 11-15-13.	testing with FFM.

General Transition Information

1. Prepopulated forms will be used in 2014 for the renewal process. The prepopulated form will be used to collect additional income information. Notices will request that additional information be sent if your income has changed.
2. Between November and December 2013 a data conversion will take place to move data to the new system. In 2014, the new system will run household information thru MAGI rules.
3. The state will transfer accounts to the federal facilitated Marketplace.
4. Arizona will check all eligible categories before referring enrollee to the marketplace.

IV. Notification

Please describe the notification process the state will use to communicate with beneficiaries about changes to his/her coverage in 2014. This process description should include:

- A description of the review process used to develop the notices;
- The timing of notices to beneficiaries;
- How the notices will be sent to beneficiaries; and
- How the beneficiaries will be able to ask questions about the notice.

Notices are developed by AHCCCS staff. AHCCCS uses special software to identify base reading level and ease of reading. Also, the staff who complete final reviews have participated in multiple training sessions and webinars by Penny Lane and Maximus, and employ the principles from those sessions in development and review to ensure notices are clear and written at appropriate reading levels.

For those coverage groups whose transition will trigger a notice requirement, the timing of the notice was noted above. Notices will be sent via U.S. Mail to the address of record. A phone number will be provided on the notice for customers to call with questions. The AHCCCS Administration is currently working on a streamline call center targeting a 10-1-13 start date.

V. Content of the Notices

- Please provide drafts of the notices that will be sent to beneficiaries.

- Please provide an example of the draft notice for each type of transition (this should include examples of notices where the only change that will be apparent to a beneficiary is a change in benefits or delivery system).

Please note that all notices must comply with the notice requirements in 42 CFR 431.206, 431.210 and 431.213, and must include information on appeal and hearing rights as outlined in 42 CFR 431.220 and 431.221.

The State is working on its draft notices. The State's first goal is to complete work on the actual eligibility system to conform to required ACA changes for a 10-1-13 start date.

Kids CareII Notice: The state is trying to obtain a list of navigators to provide to the beneficiaries as part of their notice. The notice may reference a list of navigators and/or reference a website to obtain navigator information.

VI. Community Outreach

- Please describe all community outreach activities (such as public forums, webinars, flyers, websites, etc.) the state has or will undertake to inform beneficiaries about the transition and to support them during the transition period.
- This component of the transition plan must include information about tribal consultation activities for all states with federally recognized tribes.

HEA Plus Subscribers

The State has a robust community outreach and education effort. First, the State has 75 organizations with 300 different sites and over 1,000 employees trained as community assistors on the State's current and new eligibility system, Health-e-Arizona Plus (HEA Plus). These HEA Plus subscribers will be able to assist applicants and obtain real time eligibility determinations. The State engages with these subscribers in monthly meetings and has conducted various phases of testing on the new system. These subscribers represent FQHCs, other providers, community organizations and more.

In addition, the State is reaching out to new groups not currently subscribers. The State has a list of 20 new groups that will sign HEA Plus agreements beginning 10-1-13. The number of new subscribers is expected to grow.

Attached is a list of HEA Plus demonstrations and trainings conducted to date.

Website and Community Forums

TN: 13-015
Supercedes
TN: N/A

Approval Date (for SPA): MAR 3 1 2014

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The State developed a dedicated page on its website called Medicaid Moving Forward to provide updated information on the progress of the State in moving toward 2014. That page can be found here: http://www.azahcccs.gov/publicnotices/MovingForward.aspx .

The State also has developed a listserv that current has 1,366 individuals representing various organizations, Medicaid members or themselves.

The State is also hosting Community Forums across the State that are open to the public. The schedule is below, news of the update was sent via the AHCCCS listserv and is posted to the AHCCCS website here:
http://www.azahcccs.gov/publicnotices/Downloads/MedicaidCoverage/MMFCommunityForums.pdf

GENERAL – Sessions for Families, Advocates and Community Partners	
Tuesday, October 8, 2013 1p.m. – 3p.m. RSVP: ForwardTucson@azahcccs.gov	**Casino del Sol - Conference Center** 5655 W. Valencia Rd. **Tucson,** AZ 85757
Friday, October 11, 2013 1p.m. – 3p.m. RSVP: ForwardFlagstaff@azahcccs.gov	**Flagstaff Medical Center – McGee Auditorium** 1200 N. Beaver Street **Flagstaff**, AZ 86001
Wednesday, October 30, 2013 1p.m. – 3p.m. RSVP: ForwardPhoenix@azahcccs.gov	**The Disability Empowerment Center** 5025 E. Washington Street, Suite 200 **Phoenix**, AZ 85034

*Two additional sessions in Phoenix have been scheduled for October 30, 3:15 – 5:00 and November 4, 1:00-3:00. The website (link above) is updated as new forums are scheduled.

Tribal Consultation Activities

The State has been engaging with its tribal stakeholders throughout this process. Regular updates on HEA Plus and the transition of populations have been provided in tribal consultation. In addition, many tribal organizations are HEA Plus subscribers and have been part of the special trainings and demonstrations. These issues have been discussed as part of tribal consultation on the dates below:

Tribal Consultations and Meetings
2/6/13: Tribal Consultation meeting held in Phoenix
3/21/13: Special Meeting with I/T/U's held in Phoenix
6/25/13: Special ACA SPA Tribal Consultation via teleconference
7/12/13: Meeting with Vice-Chairwoman Catalina Alvarez of Pascua Yaqui Tribe to discuss Restoration Plan
8/5/13: Meeting with White Mountain Apache Tribal leaders and Health Program personnel re: Restoration Plan and HEA Plus
8/13/13: Inter-Tribal Council of Arizona Training: State Health Insurance Assistance Program (included update on restoration plan)
8/15/13: Tribal Consultation meeting off-site on the Hopi Reservation review of HEA Plus and 1115 Transition Plan

JAN 0 1 2014

TN: 13-015
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9/19/13: Tribal Consultation regarding restoration and expansion implementation, threat of legal challenges to implementation and extension of current supplemental payments waiver authority
9/26/13: Provided overview at Phoenix Indian Medical Center ACA kick-off event
9/30/13: Meeting with Navajo Nation Vice President and Councilmembers

Communications on Expansion/Restoration Updates/Information sent to tribal listserv:
1/15/13: Proposed Expansion of AZ Medicaid Program by Governor Brewer = 205 people
3/19/13: Governor Brewer's Medicaid Coverage Bill = 205
3/22/13: Yuma Public Forum Announcement sent to Colorado River Tribe Leaders, Tribal Council, Tribal Health Programs = 18
4/17/13: AHCCCS Public Forum at Eastern Arizona College in Thatcher sent to San Carlos Apache Tribal Leaders, Tribal Council, Tribal Health Programs = 20
5/1/13: AHCCCS Updates re: Medicaid Restoration = 205
5/2/13: Show Your Support - Rally for Restoration = 205
5/14/13: Rally for Restoration = 183
5/14/13: Rally for Restoration sent to Tribal Leaders = 22
6/14/13: Medicaid Restoration Approval Amendment Announcement = 205
6/14/13: Bill Signing Ceremony sent to Tribal Leaders = 22
6/17/13: AHCCCS Update – Thank you Follow-up to tribal stakeholders = 205

In addition, the schedule for upcoming forums, including dedicated tribal sessions outlined below, was sent to the tribal listserv.

TRIBAL – Sessions for Tribal Stakeholders	
Date	**Location**
Monday, September 16, 2013 and Monday, September 23, 2013 1p.m. – 3p.m. RSVP: ForwardPhoenix@azahcccs.gov	**Native American Community Service Center** 4520 N. Central Ave., 6th Floor Conference Room **Phoenix**, AZ 85012
Tuesday, October 8, 2013 10a.m. – 12p.m. RSVP: ForwardTucson@azahcccs.gov	**Casino del Sol - Conference Center** 5655 W. Valencia Rd. **Tucson**, AZ 85757
Friday, October 11, 2013 10:30a.m. – 12:30p.m. RSVP: ForwardFlagstaff@azahcccs.gov	**Flagstaff Medical Center – McGee Auditorium** 1200 N. Beaver Street **Flagstaff**, AZ 86001

*Additional sessions in Parker, Arizona and Western and Eastern Navajo Nation are being scheduled. The website (link above) is updated as new forums are scheduled.

Additional Outreach Activities

Although the AHCCCS Administration has limited staffing and resources to attend individual meetings, AHCCCS staff has provided or are scheduled to provide updates on these issues to the following groups:
6/11: Healthy Children Arizona Committee
8/11: Arizona Hemophilia Association Statewide Conference

TN: 13-015
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TN: N/A
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8/13: Alzheimer's Task Force Conference Call
8/20: Arizona Probation Court Administrators Monthly Meeting
9/6: Access Tucson – a panel discussion to be aired on local cable stations in the Tucson area
9/21: Philippine Nurses Association
9/24: Participated in Tele-Town Hall for small business owners and employees hosted by AZ Sen. Steve Farley
9/25: Participated in Tele-Town Hall for small business owners and employees hosted by AZ Sen. Steve Farley
9/27: Hosted two Webinars on implementation of restoration and expansion for HEA and HEAplus community partners and Cover AZ coalition members with over 600 people attending
10/22: Scheduled to speak at conference hosted by Mental Health America of Arizona
11/1: Arizona School Based Health Care Council Board annual meeting

Special communications and information are being provided as well to the hospital community working in cooperation with the Arizona Hospital and Healthcare Association. Additional outreach activities are anticipated throughout the Fall of 2013.

JAN 0 1 2014

TN: 13-015
Supercedes
TN: N/A

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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 PROVIDEDTO 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*

4.d. Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

Provided: X No limitations _ With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a nursing facility or elsewhere.

Provided: _ No limitations 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.

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.**

State/Territory: ARIZONA
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.

__X_ Provided: ___ No limitations _X__ With limitations*
__ Not provided.

d. Other practitioners' services.

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

7. Home health services.

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

Provided: _X__ No limitations __ With limitations*

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

Provided: _X__ No Limitation __ With limitations*

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

Provided: ___ No Limitations _X_ With limitations**

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State/Territory: ARIZONA

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

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.
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State/Territory: ARIZONA

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDEDTO 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.

_____ Provided: _____ No limitations _____ With limitations*
__X__ 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: X No limitations _____ With limitations*
_____ Not provided.

*Description provided in Limitations section of this Attachment.
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State/Territory: ARIZONA

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

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).

_X_ Provided: ____ No limitations _X_ With limitations in accordance with §2302 of the Affordable Care Act *

__ Not Provided.

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

State/Territory: ARIZONA

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.

State/Territory: ARIZONA

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

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.

State/Territory: ARIZONA

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 provided in Religious Non-Medical Health Care Institutions

__ Provided: ____ No limitations __ With limitations**
_X__ Not provided

c. Reserved

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.

State/Territory: ARIZONA

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

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.

State/Territory ARIZONA

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

Freestanding Birth Center Services

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

Provided: √ No limitations ☐ With limitations ☐ None licensed or approved

Please describe any limitations:

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

Provided: √ No limitations ☐ With limitations (please describe below)

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

Please describe any limitations:

Please check all that apply:

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

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

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

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

State/Territory:
ARIZONA

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED

CATEGORICALLY NEEDY GROUP(S)

28. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: ___X____

I. General Assurances:

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

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

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

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

Coverage Determination – Section 1905(gg)(3)

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

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unlessit displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 SecurityBoulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency ARIZONA

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

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	1. The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D. The following excluded drugs are covered: ☐ (a) agents when used for anorexia, weight loss, weight gain (see specific drug categories below) ☐ (b) agents when used to promote fertility (see specific drug categories below) ☐ (c) agents when used for cosmetic purposes or hair growth (see specific drug categories below) ☐ (d) agents when used for symptomatic relief of cough and colds (see specific drug categories below) ☐ (e) prescription vitamins and mineral products, except prenatal vitamins and fluoride (see specific drug categories below) ✓ (f) nonprescription drugs (see specific drug categories below)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State Agency ARIZONA

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

Citation(s)	Provision(s)
1927(d)(2) and 1935(d)(2)	☐ (g) covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee (see specific drug categories below) (The Medicaid agency lists specific category of drugs below) Medicaid continues to cover non-prescription medications in accordance with AHCCCS medical policy: an over-the-counter medication in place of a covered prescription medication, that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication. ☐ **No excluded drugs are covered**

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 shall be furnished by a licensed and certified hospital.

Inpatient hospital services include services in inpatient psychiatric facilities, provided to EPSDT-eligible persons < 21 years in accordance with 42 CFR 441.150.

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.

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. All medically necessary services coverable under 1905(a) of the Act are provided to EPSDT-eligible individuals. 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. All medically necessary dental services including routine, preventive, therapeutic and emergency dental services.

Personal Care Services:
Personal care services means 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:

- Authorized for the individual by a physician in accordance with a plan of treatment or otherwise authorized for the individual in accordance with a supervised plan approved by the State.
- Provided by an individual qualified to provide such services and who is not a member of the individual's immediate family (described as spouses of recipients and parents of minor recipients). For purposes of this section, family member means a legally responsible relative. Personal care providers must hold a current certification in cardiopulmonary resuscitation and first aid, have appropriate skills and training to meet the needs of each member assigned to them and submit three letters of reference. All references, skills and training must be verified and documented in the employee's personnel file when working for an agency. Personal care providers must follow the member's individualized care plan as approved by the case manager. The hiring agency is responsible for assuring that employees providing services to members are in compliance with Contractor standards and requirements and AHCCCS policy for personal care services.
- Personal care services are defined as services to assist in performing daily living tasks of assisting members with bathing, feeding, skin care, oral hygiene, toileting, ambulation, transferring, grooming, dressing, nail care, use of assistive devices, use of special appliances and/or prosthetic devices, and caring for other physical needs (excluding bowel care that can only be performed or delegated by a licensed registered nurse to a licensed practical nurse as necessary).
- Furnished in the home or other community locations outside of the home.

Hospice Services:

- Hospice services provide palliative and support care for terminally ill members and their family members or caregivers to ease the physical, emotional, spiritual and social stresses experienced during the final stages of illness and during dying and bereavement. Hospice services include nursing care; medical social services; physician services; counseling services; short-term inpatient care provided in a participating hospice inpatient unit, or participating hospital or nursing facility; medical appliances and supplies, included drugs and biological; home health aide services; physical therapy, occupational therapy and speech-language pathology services and bereavement services.
- Hospice services can be provided in the member's own home; a home and community based approved alternative residential setting; or a hospital, nursing care institution or free standing hospice facility when the conditions of participation are met as specified in 42 C.F.R. 418. The State of Arizona follows the amount, duration, and scope of services specified in the Medicare hospice program.
- The recipient must file a Medicaid election statement with a particular Medicaid hospice provider. In doing so, the recipient waives rights to other Medicare services that are related to the treatment of his or her terminal illness(es) with the exception of individuals less than 21 years of age. As required by section 2302 of the Affordable Care Act, individuals less than 21 years of age may receive concurrent curative and palliative hospice care treatment

- Hospice providers must be Medicare certified and licensed by the Arizona Department of Health Services, and have a signed AHCCCS provider agreement and meet the State licensure standards for hospice care. State licensure standards for hospice care require providers to include skilled nursing, respite and bereavement services. Hospice providers must also have social services, counseling, dietary services, homemaker, personal care and home health aide services and inpatient services available as necessary to meet the member's needs.
- Hospice services are available beyond six months provided additional physician certifications are completed. A physician must sign a certification that the illness is terminal and that life expectancy is six months or less in accordance with the State Medicaid Manual section 4305.1. The physician certification is only permitted for two 90 day periods with an unlimited number of physician certifications for 60 day periods thereafter.

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. Medically necessary services provided by a licensed Naturopathic Physician within their scope of practice as defined in state law in accordance with 42 CFR 440.60

ix. 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. Medicaid 1905(a) benefits can be furnished to Medicaid enrolled student beneficiaries that require medical or mental/ behavioral health services identified as medically necessary in an Individualized Education Program (IEP), Individualized Family Service Plan (IFSP), 504 Plan, other individualized health or behavioral health plan, or where medical necessity has been otherwise established.

Furthermore, any 1905(a) benefit/service listed in 4.19-B, page 10 is eligible for reimbursement. Services in a school-based setting must be performed by qualified practitioners as set forth in the State Plan for the services they are providing and shall meet applicable qualifications under 42 CFR Part 440. All enrolled recipients must be allowed the freedom of choice to receive services from any willing and qualified practitioner. Beneficiaries shall receive services delivered in the least restrictive environment consistent with the nature of the specific service(s) and the physical and mental condition of the client. Participation by Medicaid -eligible recipients is optional. Providers shall be registered in accordance with AHCCCS policies. 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

The reimbursement methodology for services provided under section 4(b)(viii) are detailed in Attachment 4.19-B of the State Plan. Medicaid covered services under section 4(b)(viii) will only be reimbursable for persons who are at least three years of age and less than 21 years of age and who have a documented medical need as described above. This age limitation is only for services provided to eligible children in schools. All children under age 21 are able to receive EPSDT services based on medical necessity. Those members age 21 to age 22 who are enrolled in Medicaid services are covered within the same service limitations that apply to all eligible AHCCCS members age 21 and older.

In addition to any service limitations detailed in 1905(a) or as otherwise detailed in Attachment 4.19-B, the following limitations are applicable to services provided by participating LEA under this section:

A. Personal Care Services.

Definition:

Personal care services are available to a Medicaid-enrolled beneficiary under the age of 21 for whom the services are medically necessary and documented in an IEP/IFSP, other medical plans of care, or other service plan approved by the state.

Services:
Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, or individuals with physical illnesses and conditions and/or behavioral health problems and conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Assistance may be in the form of hands-on assistance or cueing so that the person performs the task by him/herself.

Providers:
Personal care services must be provided by a qualified provider in accordance with 42 CFR § 440. 167.

B. Specialized Transportation

Definition:
Specialized transportation services are available to a Medicaid-enrolled beneficiary under the age of 22 for whom the transportation services are medically necessary and documented in an IEP/IFSP.

Services:
Services must be provided on the same date of service that a Medicaid covered service, required by the student' s IEP/ IFSP, is received. Transportation must be on a specially adapted school bus or van to and/or from the location where the Medicaid service is received. Special adaptations are designed to accommodate disabled beneficiaries and may include but are not limited to wheelchair lifts and special hooks/belts to secure wheelchairs.

All specialized transportation services provided must be documented in a transportation bus logs.

Providers:
The LEA is the only provider of specialized transportation. Based on the individualized needs of an individual child, an aide may provide assistance, such as mitigating behavioral issues while the beneficiary is being transported or ensuring that the

beneficiary remains physically secure while the bus driver is driving. The services of an aide are only provided as part of specialized transportation when Medicaid services are based on the individualized needs of the child and are not covered under another 1905(a) benefit during the school day.

E. Behavioral Health Services.

Services:
Medically necessary services are health care, diagnostic services, treatments and other measures to identify, correct or ameliorate any disability and/or chronic condition. Services are provided as health and behavior interventions to identify the psychological, behavioral, emotional, cognitive, and social factors important to the prevention, treatment, or management of physical and mental health problems. Behavioral health services include individual/group therapy and counseling.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.60 and 42 CFR § 440.50. Services may be provided by:

- State licensed psychiatrists;
- State licensed Ph.D. psychologists;
- Arizona Board of Behavioral Health Examiners licensed marriage and family therapists (LMFT), licensed professional counselors (LPC), and licensed clinical social workers (LCSW); all of whom must have current licensure by the Arizona Board of Behavioral Health Examiners as a LCSW, LPC or LMFT, or if outside Arizona, be licensed or certified to practice independently by the local regulatory authority.

F. Personal Care Services.

Services:
Personal care services are a range of human assistance services provided to persons with disabilities and chronic conditions, which enables them to accomplish tasks that they would normally do for themselves if they did not have a disability. Personal care services include assistance to eligible members in meeting essential personal physical needs, such as dressing, toileting, transfers, positioning, mobility, grooming, use of assistive device, and feeding.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.167. All licensed and qualified personnel may authorize personal care services contained within the IEP/service plan. Services may be provided by:

- School-based health attendants certified by the LEA in general care, to include first aid and CPR.

G. Audiological Services.

Services:
Audiology services include testing and evaluating hearing-impaired children that may or may not be improved by medication or surgical treatment. In accordance with Arizona Administrative Code, R9-22-213, annual audiological assessments will be provided to students with disabilities. These billable assessments are separate from the screenings offered to the general student population.

Providers:
These services are covered in accordance with the requirements in 42 CFR § 440.110 (c)(3). Services may be provided by:

- Arizona Department of Health Services (ADHS)-Licensed Audiologist.

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.

4.d. 1) Face-to-Face Tobacco Cessation Counseling Services provided (by):

(i) By or under supervision of a physician;

(ii) By any other health care professional who is legally authorized to furnish such services under State law and who is authorized to provide Medicaid coverable services other than tobacco cessation services;

(iii) Any other health care professional legally authorized to provide tobacco cessation services under State law and who is specifically designated by the Secretary in regulations. (None are designated at this time; this item is reserved for future use.)

2) Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women

(i) The State is providing at least four counseling sessions per quit attempt.

(ii) Cost Sharing is not imposed for Tobacco Cessation Services for pregnant women.

5 b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

The following dental services are not covered under this benefit and are not considered physician services: dental cleanings, routine dental examinations, dental restorations including crowns and fillings, extractions, pulpotomies, root canals, and the construction or delivery of complete or partial dentures.

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.

6b. Optometrists' Services Optometrists' services when they are provided by a licensed optometrist. See section l2d for limitations on eyeglasses and contact lenses.

6c. Chiropractors' Services
Coverage is available for evidence-based, medically necessary chiropractors' services within their scope of practice as defined by state law and subject to the following limitations. The service must be ordered by a primary care provider. The service is limited to twenty visits that include treatment, annually. Medically necessary chiropractic services beyond the twenty-visit annual limit, are subject to prior authorization requirements. Acupuncture is excluded. Beneficiaries of the EPSDT benefit are not subject to these limitations.

6d. Other practitioners' services.
Other practitioners' services provided by:

i. Services of a licensed respiratory therapist within the scope of practice according to state law.
ii. Services of a licensed Certified Nurse Practitioner within their scope of practice according to state law.
iii. Services of a licensed Certified Registered Nurse Anesthetist within their scope of practice according to state law.
iv. Services of a licensed Non-physician First Surgical Assistants and Physician Assistant within their scope of practice according to state law.
v. Services of a licensed midwife within their scope of practice according to state law.
vi. Services of a licensed affiliated practice dental hygienist within their scope of practice according to state law.
vii. Services of a licensed social worker within their scope of practice according to state law.
viii. Services of a licensed physician assistant within their scope of practice according to state law.
ix. Services of a licensed psychologist within their scope of practice according to state law.
x. Services of a licensed counselor within their scope of practice according to state law.
xi. Services of a licensed registered nurse within their scope of practice according to state law.
xii. Services of a licensed psychiatric nurse practitioner within their scope of practice according to state law.
xiii. Services of a licensed marriage and family therapist within their scope of practice according to state law.
xiv. Services of a licensed substance abuse counselor within their scope of practice according to state law.
xv. Services of an ADHS licensed Emergency Medical Care Technician (EMCT) within their scope of practice according to state law
xvi. Services of a licensed Clinical Nurse Specialist within their scope of practice according to state law

7. Home health services.

Home health services and supplies are provided by licensed home health agencies that coordinate in-home services, including home-health aide services, licensed nurse services, and medical supplies, equipment, and appliances and require prior authorization. Home health services meet the requirements of 42 CFR 440.70.

7c. Medical supplies, equipment and applicances suitable for use in the home.

Personal care items including items for personal cleanliness, body hygiene, and grooming are not covered unless needed to treat a medical condition.

7d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

The State offers physical therapy, occupational therapy, and speech pathology and audiology services under the home health benefit (item 7d). The limits for these therapies are the same as those described for items 11, 11b, 11c ofthis section of the State plan.

8. Private duty nursing services.

Private duty nursing services are provided for members who reside in their own home and must be ordered by a physician and provided by an RN or an LPN if provided under the supervision and direction of the recipient's physician. This service is limited to members enrolled in the Arizona Long Term Care System program who receive services provided under the 1115 Waiver and members under the age of 21.

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.

Dental services are limited to (1) the elimination of oral infections and the treatment of oral disease, which includes dental cleanings, treatment of periodontal disease, medically necessary extractions and the provision of simple restorations as a medically necessary pre-requisite to organ transplantation, (2) prophylactic extraction of teeth in preparation for radiation treatment of cancer of the jaw, neck or head, and (3)emergency dental services and extractions not to exceed $1000 annually per member.

11. Physical therapy and related services.

Physical therapies and related services as described in 11a, 11b and 11c for persons 21 years of age and older when a treatment plan demonstrates potential to prevent deterioration, or to assist an individual to maintain or regain a skill or function, or attain a skill or function never learned or acquired, or acquired and then lost or impaired, due to illness, injury or disabling condition. The duration, scope and frequency of each therapeutic modality must be prescribed by and documented in the treatment plan. Assessment, evaluation, and treatment services are included as part of this benefit.

Therapies and related services for persons under the age of 21 are covered without limitation. Providers meet the applicable requirements at 42 CFR 440.110.

11a. Physical therapy.

Physical therapy services are provided to prevent or alleviate movement dysfunction and related functional problems. For individuals over the age of 21, out-patient physical therapy is limited to 15 visits per contract year to restore an individual to a particular skill or function and 15 visits per contract year to assist an individual to maintain a skill or function, or attain a skill or function never learned or acquired. A "visit" is defined as all physical therapy services received on the same day.

Physical therapy services are provided by: 1) State-licensed physical therapists; and 2) state-licensed physical therapy assistants under the direction of State-licensed physical therapists. In addition, physical therapy services must and meet the requirements in 42 CFR 440.110.

11b. Occupational therapy.

Occupational Therapy services are provided to improve, or restore functions impaired or lost through illness or injury. For individuals over the age of 21, outpatient occupational therapy is limited to 15 visits per contract year to restore an individual to a particular skill or function and 15 visits per contract year to assist an individual to maintain a skill or function, or attain a skill or function never learned or acquired. A "visit" is defined as all occupational therapy services received on the same day. Members enrolled in the ALTCS program receive services provided under the 1115 Waiver.

Occupational Therapy services are provided by: 1) State-licensed occupational therapists; and 2) certified occupational therapy assistants under the direction of State-licensed occupational therapists and meet the requirements in 42 CFR 440.110.

11c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

Speech Pathology services are provided to diagnose, evaluate, and provide treatment for specific speech, language and hearing disorders. Services for adults over the age of 21 are limited to speech therapy services provided in an inpatient setting. Members enrolled in the ALTCS program receive services provided under the 1115 Waiver. Assessment, evaluation, and treatment services are included as part of this benefit. Providers meet the applicable requirements at 42 CFR 440.110.

Speech pathology services are provided by: 1) State-licensed speech-language pathologists; and 2) licensed speech-language pathologist assistants under the direction of State-licensed 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. All providers of speech pathology services meet the requirements of 42 CFR 440.110

Audiology

Audiology services are provided to evaluate hearing loss and rehabilitate persons who may or may not be improved by medication or surgical treatment. Members enrolled in the ALTCS program receive services provided under the 1115 Waiver.

Audiological services are provided by Audiologists licensed with the Arizona Department of Health Services (ADHS) and meet the requirements in 42 CFR 440.110.

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.

Medicare Part D drugs are not covered for full benefit dual eligible members, as coverage is provided through Medicare Part D PDPs and MAPDs

Prescription drugs for covered transplantation services shall be provided in accordance with AHCCCS transplantation policies.

AHCCCS only covers over-the-counter medications in place of a covered prescription medication that is clinically appropriate, equally safe and effective, and less costly than the covered prescription medication.

In compliance with Section 1927(b) of the Social Security Act (the Act), the State collects drug rebates in accordance with established policy for drug rebate agreements as provided in Exhibit 12(a) to Attachment 3.1-A.

CMS has authorized the state of Arizona to enter into Outcomes-Based contract arrangements with drug manufacturers for drugs provided to Medicaid beneficiaries. These contracts will be executed on the contract template titled "Outcomes-Based Supplemental Rebate Agreement" submitted to CMS and authorized for use beginning July 1, 2019.

12c. Prosthetic devices.

Prosthetic devices are limited to devices prescribed by a physician or other licensed practitioner to artificially replace missing, deformed or malfunctioning portions of the body and which are medically necessary to the rehabilitation of the member.

Covered prosthetic devices for members age 21 and older do not include hearing aids, cochlear implants, bone anchored hearing aids, percussive vests, microprocessors for controlled joints for the lower limbs in addition to microprocessor-controlled joints for the lower limbs, penile implants, and vacuum devices.

Orthotic devices, which are defined as devices that are prescribed by a physician or other licensed practitioner of the healing arts to support a weak or deformed portion of the body, are covered when the use of the orthotic is medically necessary as the preferred treatment option consistent with Medicare guidelines and the orthotic is less expensive than all other treatment options or surgical procedures to treat the same diagnosed condition.

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.

13a. Diagnostic Services.

Genetic testing is not covered unless the results of the genetic tests are necessary to differentiate between treatment options. Genetic testing is not covered to determine specific diagnoses or syndromes when such determination would not definitively alter the medical treatment of the member.

13b. Screening services.

Coverage is available for evidence-based medically necessary screening services for children based on guidelines from the American Academy of Pediatrics and CDC/IACIP for immunizations.

Coverage is available for evidence-based medically necessary screening services for adults which are based, in part, on guidelines from the U.S. Preventive Services Task Force.

13c. Preventive services.

Coverage is available for evidence-based medically necessary preventive services. Services must be recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to (1) prevent disease, disability, and other health conditions, (2) prolong life; and (3) Promote physical and mental health efficacy. Services for children are based on guidelines from the American Academy of Pediatrics and CDC/ACIP for immunizations. Services for adults are based, in part, on guidelines from the U.S. Preventive Services Task Force. In addition to the services specified under section 4106 of the Affordable Care Act, Arizona covers, without cost-sharing, services specified under PHS 2713 which is in alignment with the Alternative Benefit Plans.

Coverage is available for Diabetes Self-Management Training (DSMT) outpatient services. DSMT is a nationally recognized program that supports individuals with developing the knowledge and skills to self-care for their diabetes condition. DSMT consists of individual sessions or group sessions which may be furnished by a physician (MD or DO), Physician's Assistant, Registered Nurse Practitioner, or Registered Dietician. The services must be prescribed by a primary care practitioner in one of the following circumstances: 1) the member is initially diagnosed with diabetes or 2) the member was previously diagnosed with diabetes but a change has occurred in the member's diagnosis, medical condition or treatment regimen or the member is not meeting appropriate clinical outcomes. DSMT services are limited to 10 hours, annually. Beneficiaries of the EPSDT benefit may receive services in excess of the 10-hour limitation.

Community Health Worker Services

Arizona state certified Community Health Workers (CHW) may provide AHCCCS-covered patient education and preventive services to individuals with a chronic condition or at risk for a chronic condition or for individuals with a documented barrier that is affecting the individual's health. CHW services must be recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law. Services must be documented in the member's medical record and may include:

- Health system navigation and resource coordination,
- Health education and training. The purpose of this service is to train and/or increase the member's awareness of methods and measures that have been proven effective in avoiding illness and/or lessening its effects. The content of the education must be consistent with established or recognized healthcare standards, or
- Health promotion and coaching. The purpose of this service is to provide information and training to members that enables them to make positive contributions to their health status.

13d. Rehabilitative services.

Rehabilitative Services- Services to teach independent living, social and communication skills to persons or their families to promote the maximum reduction of behavioral health symptoms and/or restoration of an individual to his/her best age appropriate functional level for the purpose of maximizing the person's ability to live independently and function in the community. Services may be provided to a person, a group of persons or their families with the person(s) present. Rehabilitative services must be recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law; and be provided by individuals who are qualified behavioral health professionals, behavioral health technicians or behavioral health paraprofessionals as described in the following pages of Attachment 3.1-A Limitations, pages 9(b) – 9(j).

Screening/Evaluation/Assessment: Screening is an initial assessment to determine the need for behavioral health services. Assessment/evaluation is the assessment of a member's medical, psychological, psychiatric or social condition to determine if a behavioral health disorder exists and if so, to establish a treatment plan for all medically necessary services. This includes emergency/crisis evaluation and assessment.

Providers: Licensed practitioners of the healing arts and Behavioral Health Technicians (BHTs). Crisis assessment/evaluation includes Behavioral Health Paraprofessionals (BHPPs). (See Staff Qualifications Section)

Limitations: BHT's are limited to providing this service under an Arizona Department of Health Services Office of Behavioral Health Licensure (ADHS/OBHL) licensed agency. BHPP's conducting crisis evaluations/assessments are limited to providing this service under an ADHS/OBHL licensed agency.

As an additional limitation, these services can only be provided in the following settings: office, home, urgent care facility, inpatient hospital, outpatient hospital, emergency room, inpatient psychiatric facility, community mental health center, rural health clinic, outpatient clinic, including Federally Qualified Health Centers (FQHCs), rural substance abuse transitional agency, homeless shelter, medical day program, therapeutic day program, Level 2 behavioral health group home, and Level 3 behavioral health group home.

Individual, Group and/or Family Therapy and Counseling: Therapy and counseling services that address the therapeutic goals outlined in the service plan. Services may be provided to an individual, a group of persons, a family or multiple families. Family counseling may not include the member but must be for the direct benefit of the member.

Providers: Licensed practitioners of the healing arts and BHTs. (See Staff Qualifications Section)

Limitations: BHT's are limited to providing this service under an ADHS/DBHS licensed agency.

As an additional limitation, these services cannot be billed in combination with services in an institutional setting, residential treatment center, or Level 2/3 group home.

Living Skills Training: These services are provided for the restoration, enhancement, maintenance, and assistance in obtaining age appropriate independent living, social, and communication skills to members and/or their families in order to maximize the member's ability to live and participate in the community and to function independently. Examples of areas that may be addressed include self care, household management, social decorum, same-and opposite sex friendships, avoidance of exploitation, budgeting, recreation, development of social support networks and use of community resources. Services may be provided to a person, a group of persons or their families with the member present.

Providers: Licensed practitioners of the healing arts, BHT's, BHPP's, Home and Community Based Service (HCBS) Habilitation Providers (See Staff Qualifications Section)

Limitations: BHT's and BHPP's are limited to providing this service under an ADHS/OBHL licensed agency or a State Certified Community Service Agency.

As an additional limitation, these services can not be billed in combination with services in an institutional setting, residential treatment center, or Level 2/3 group home.

Health Promotion: Education and training provided to a group of persons and/or their families related to the enrolled member's treatment plan on health related topics such as the nature of illness, relapse and symptom management, medication management, stress management, safe sex practices, HIV education and healthy lifestyles.

Providers: Licensed practitioners of the healing arts, BHT's, BHPP's (See Staff Qualifications Section)

Limitations: BHT's and BHPP's are limited to providing this service under an ADHS/OBHL licensed agency or a State Certified Community Service Agency.

As an additional limitation, these services can not be billed in combination with services in an institutional setting, residential treatment center, or Level 2/3 group home.

Supported Employment Services: These services are designed to assist a person or group of persons with a medical/behavioral health condition that enables a member to function in the workplace. These services include supporting the member's ability to manage mental health related symptoms, facilitate recovery from mental illness; assist with personal, community and social competencies, and to aid members to establish and navigate environmental supports.

Providers: Licensed practitioners of the healing arts, BHT's, BHPP's (See Staff Qualifications Section)

Limitations: BHT's and BHPP's are limited to providing this service under an ADHS/OBHL licensed agency or a State Certified Community Service Agency.

As an additional limitation, these services can not be billed in combination with services in an institutional setting, residential treatment center, or Level 2/3 group home.

Family Support/Home Care Training: These services include face to face interactions with a member's family and are directed toward restoration, enhancement, or maintenance of the family functioning to increase their ability to effectively interact and care for the member in the home and community when relevant to the member's treatment plan. May involve support activities such as assisting the family to adjust to the member's disability, developing skills to effectively interact and/or manage the member, understanding the causes and treatment of behavioral health issues, understanding and effectively utilizing the system, or planning long term care for the member.

Providers: Licensed practitioners of the healing arts, BHT's, BHPP's, Habilitation providers. (See Staff Qualifications Section)

Limitations: BHT's and BHPP's are limited to providing this service under an ADHS/OBHL licensed agency or a State Certified Community Service Agency

As an additional limitation, these services can not be billed in combination with services in an institutional setting, residential treatment center, or Level 2/3 group home.

Home Care Training to Home Care Client (HCTC): These services are provided by behavioral health therapeutic home providers and are designed to maximize the member's ability to live and participate in the community and to function independently, including assistance in the self-administration of medication and any ancillary services (such as living skills and health promotion) indicated by the member's treatment plan as appropriate.

Providers: Behavioral health therapeutic home providers that are contracted with licensed behavioral health providers. Contractors are required to ensure that behavioral health therapeutic home providers have successfully completed pre-service training in the type of care and services required by the members being placed into the home. Behavioral health therapeutic home providers must have access to crisis intervention and emergency consultation services. A clinical supervisor must be assigned to oversee the care provided in the home.

Limitations: HCTC services can only be provided for no more than three adults in an Adult Therapeutic Foster Home licensed by ADHS/OBHL or home licensed by federally recognized Indian tribes that attest to CMS via AHCCCS that they meet equivalent requirements. HCTC services can only be provided for no more than three children in a Professional Foster Home licensed by ADES or home licensed by federally recognized Indian tribes that attest to CMS via AHCCCS that they meet equivalent requirements. HCTC providers are reimbursed through their contractual agreement with the licensed behavioral health provider. These services do not include reimbursement for the cost of room and board. Services such as living skills, health promotion and home care training family services that are provided at this setting and billed as a component of HCTC, cannot be billed for separately.

(As an additional limitation, these services can only be billed in the behavioral health therapeutic home).

Peer Support Services: Services provided by persons who have been consumers of the behavioral health system and who are at least 18 years old. Peer support may involve assistance with more effectively utilizing the service delivery system such as assisting with developing plans of care, accessing supports, partnering with professionals, overcoming service barriers or assisting the member to understand and cope with the member's disability, behavior coaching, role modeling and mentoring.

Providers: BHTs and BHPP's (See Staff Qualifications Section)

Limitations: BHT's and BHPP's are limited to providing this service under an ADHS/OBHL licensed agency or a State Certified Community Service Agency.

As an additional limitation, these services can not be billed in combination with services in an institutional setting, residential treatment center, or Level 2/3 group home.

Crisis Intervention Services: Community-based mobile crisis intervention services are items and services, that are--

1) furnished to an individual otherwise eligible for medical assistance under the State plan who is—
    a) outside of a hospital or other facility setting; and
    b) experiencing a mental health or substance use disorder crisis;

2) furnished by a multidisciplinary mobile crisis team—
    a) that includes:
        i. At least one Behavioral Health Professional (BHP) (see "Staff/Provider Qualifications" section) who is capable of conducting an assessment of the individual, in accordance with the professional's permitted scope of practice under State law and may also include a BHT or BHPP; and/or*
        ii. A Behavioral Health Technician (BHT) or a BHT and Behavioral Health Paraprofessional (BHPP) (see "Staff/Provider Qualifications" section) with expertise in behavioral health or mental health crisis response and acting within their scope of practice. If a BHT is providing the mobile crisis intervention service, a BHP shall be directly available for consultation 24/7/365.
    b) whose members are trained in trauma-informed care, de-escalation strategies, and harm reduction;
    c) that is able to respond in a timely manner and, where appropriate, provide—
        i. screening and assessment;
        ii. stabilization and de-escalation; and
        iii. coordination with, and referrals to, health, social, and other services and supports as needed, and health services as needed;
    d) that maintains relationships with relevant community partners, including medical and behavioral health providers, primary care providers, community health centers, crisis respite centers, and managed care organizations (if applicable); and
    e) that maintains the privacy and confidentiality of patient information consistent with Federal and State requirements; and

3) available 24 hours per day, every day of the year.

** AZ will claim increased FMAP only for two-person mobile crisis teams that meet requirements as described in section 1947(b)(2)(A).*

Staff/Provider Qualifications

Title of Licensed Practitioner of Healing Arts or Licensed Facility/Provider	Level of Education/Degree or Required Experience	License or Certification Required	State Law or Licensure
Licensed Behavior Analyst	Graduate degree, master's degree or doctoral degree from an accredited college or university or institution of higher learning accredited by a recognized accrediting agency. Minimum of 225 classroom hours of specific graduate level instruction that meet nationally recognized standards for behavior analysts as determined by the board.	Licensed by the Az Board of Behavioral Health Examiners	A.R.S 32-2091.14
Licensed Clinical Social Worker (LCSW)	Master degree or higher in social work from a regionally accredited college or university in a program accredited by the Council on Social Work Education or an equivalent foreign degree as determined by the Foreign Equivalency Determination Service of the Council on Social Work Education.	Licensed by the Az. Board of Behavioral Health Examiners	R4-6-401
Licensed Marriage/Family Therapist (LMFT)	Master degree or higher in a behavioral health science from a regionally accredited college or university whose program is accredited by the Commission on Accreditation for Marriage and Family Education or determined by the marriage and family credentialing committee to be substantially equivalent to a program accredited by the Commission on Accreditation for Marriage and Family Education.	Licensed by the Az. Board of Behavioral Health Examiners	R4-6-601
Licensed Professional Counselor (LPC)	Master degree or higher in counseling or related field from a regionally accredited college or university in a program that consists of 48 hours semester credit hours or a program accredited by CACREP or CORE in a program that consists of a minimum of 48 semester credit hours.	Licensed by the Az. Board of Behavioral Health Examiners	R4-6-501
Licensed Independent Substance Abuse Counselor (LISAC)	Master degree or higher from a regionally accredited college or university in a behavioral health service with a minimum of 24 semester credit hours of counseling related coursework as determined by the substance abuse credentialing committee.	Licensed by the Az. Board of Behavioral Health Examiners	R4-6-703
Behavioral Health Professional (BHP)	A licensed psychologist, a registered nurse with at least one year of full time behavioral health work experience, or a behavioral health medical practitioner, licensed social worker, counselor, marriage and family therapist, behavior analyst or substance counselor licensed according to A.R.S, title 32, Chapter 33, an individual who is licensed or certified to practice social work, counseling or marriage and family therapy by a government entity	Licensed by the respective professional discipline board.	R9-20-101

Title of Licensed Practitioner of Healing Arts or Licensed Facility/Provider	Level of Education/Degree or Required Experience	License or Certification Required	State Law or Licensure
	in another state and has documentation of submission of an application for Az certification per A.R.S , Title 32, Chapter 22 is licensed within one year of submittal of application.		
Registered Nurse (RN)	Satisfactory completion of basic curriculum in an approved registered nursing program and holds a diploma or degree from that program.	Licensed by the Az. Board of Nursing	A.R.S 32-1632
Licensed Practical Nurse (LPN)	Satisfactory completion of basic curriculum in an approved practical or professional nursing program and hold a diploma, certificate or degree from that program.	Licensed by the Az. Board of Nursing	A.R.S 32-1637
Nurse Practitioner (NP)	Registered nurse who is certified by the board and has completed a nurse practitioner educational program approved or recognized by the board and educational requirements prescribed by the board rule.	Certified by the Az. Board of Nursing	A.R.S. 3-1601
Physician Assistant (PA)	Graduate from a physician's assistant educational program approved by the board and licensed by the board.	Licensed by the Az. Regulatory Board of Physicians Assistants.	A.R.S. 32-2521
Psychologist	Doctoral degree from an institution of higher education in clinical or counseling psychology, school or educational psychology or any other subject area in applied psychology from an educational institution that has been accredited by a regional accrediting agency at the time of graduation.	Licensed by the Az. Board of Psychologists Examiners	A.R.S. 32-2071
Physician (MD, DO)	Graduate from an approved school of medicine or receive a medical education that the board deems to be of equivalent quality, successful completion of an approved 12 month hospital internship, residency or clinical fellowship program.	Licensed by the Az. Medical Board	A.R.S 32-1422
Psychiatrist (MD,DO)	Licensed physician who has completed three years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association	Licensed by the Az. Board of Medical Examiners.	Title 36-501

Title of Licensed Practitioner of Healing Arts or Licensed Facility/Provider	Level of Education/Degree or Required Experience	License or Certification Required	State Law or Licensure
Behavioral Health Medical Practitioner (BHMP)	An individual physician, physician assistant or nurse practitioner licensed by authorized by law to use the prescribe medication and devices, as defined in A.R.S. § 32-1901, with at least one year of full time behavioral health work experience.	Licensed by the respective professional board.	A.R.S 32-1901
Behavioral Health Out Patient Clinic	Licensed to provide services such as counseling, medication services, court ordered evaluation and treatment and opioid treatment.	Licensed by ADHS/ Office of Behavioral Health Licensure (services provided by staff who are not independent billers are billed by the agency using HCPCS codes.	R9-20-301
Behavioral Health Technician (BHT)	Master's degree or bachelor's degree in a field related to behavioral health; is a registered nurse, is a physician assistant who is not working as a medical practitioner, has a bachelor's degree and at least one year of full time behavioral health work experience; has as associate's degree and at least two years of full time behavioral health work experience; has a high school diploma or high school equivalency diploma and a combination of education in a field related to behavioral health and full time behavioral health work experience totaling at least two years; is licensed a practical nurse, according to A.R.S Title 32, Chapter 15, with at least three years of full time behavioral health work experience; or has a high school diploma or high school equivalency diploma at least four years of full time behavioral health work experience.	BHT's working full time receive at least four hours of clinical supervision by a BHP in a calendar month. Clinical supervision includes reviewing/discussing client behavioral health issues, services and records; recognizing and meeting the needs of clients who are seriously mentally ill or individuals with co-occurring disorders; reviewing/discussing other topics that enhance the skills and knowledge of staff members; providing a client with an assessment or treatment plan, determining whether an assessment or treatment plan is complete and accurate and meets the client's treatment needs.	R9-20-204

Title of Unlicensed Provider	Professional Requirements	Supervision	State or Licensure Law
Behavioral Health Paraprofessional (BHPP)	Associate's degree, a high school diploma or a high school equivalency diploma, must be at least 21 years old and has the skills and knowledge necessary to provide behavioral health services that the agency is authorized to provide and meet the needs of client populations served by the agency. The skills and knowledge of the BHPP are verified by a clinical director, BHP or BHT with a combination of at least 6 years of education in a field related to behavioral health and full time behavioral health work experience; and either visual observation of the BHPP interacting with another individual such as role playing or; verbal interaction with the BHPP such as interviewing, discussion or question and answer or; a written examination.	BHPP's working full time receive at least four hours of clinical supervision by a BHP or BHT in a calendar month. Clinical supervision includes reviewing/discussing client behavioral health issues, services and records; recognizing and meeting the needs of clients who are seriously mentally ill or individuals with co-occurring disorders; reviewing/discussing other topics that enhance the skills and knowledge of staff members.	R9-20-204
Community Service Agency (CSA)	CSA's must be State Certified by ADHS/DBHS and be registered with AHCCCS. Staff provider qualifications include BHP's, BHT's and or BHPP's with a Department of Public Safety Fingerprint Clearance Card, current First Aid training, current CPR training and must meet qualifications per ADHS/DBHS policy MI5.2.	CSA's are re-certified every year by ADHS/DBHS.	ADHS/DBHS policy MI 5.2
HCBS Certified Habilitation Provider	Certified by the Department of Economic Security and registered with AHCCCS administration. The Habilitation Provider must receive an orientation to the unique characteristics and specific needs of the eligible person under their care. Habilitation Providers must be informed regarding whom to contact in emergency, significant events or other incidents involving the eligible person. Habilitation Providers primarily provide habilitation	The behavioral health provider treatment team, as part of the service planning process, must periodically review services provided by Habilitation Providers. The behavioral health provider is responsible for the timely review and resolution of any known issues or complaints involving the member and a Habilitation Provider.	Certified by DES/DDD.

Title of Unlicensed Provider	Professional Requirements	Supervision	State or Licensure Law
	services under Arizona's 1115 Demonstration Waiver; however, Habilitation Providers are also authorized to provide rehabilitation services as described in specific settings above.		

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.

18. Hospice care

Refer to the limitation description provided on pages 2(a) and (b) of this subsection.

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 and limitations are described in Supp. 1 to Att. 3.1-A.

20. Extended services for pregnant women.

Extended services to pregnant women include all State Plan covered services, as described in Attachment 3.1-A Limitations, pages 1-11 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.

Pregnancy-related and postpartum services include all State Plan covered services, as described in Attachment 3.1-A Limitations, pages 1-11 if they are determined to be medically necessary and related to the pregnancy. 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 is provided to and from the nearest appropriate medical facility when the condition of the beneficiary is acute and poses an immediate risk to the beneficiary's life or long term health.Emergency ambulance transportation does not require prior authorization from an appropriate entity.

Non-emergency transportation is provided with limitations for individuals who have no other means of transportation to and from Medicaid covered services, as described in Attachment 3.1D.

24d Nursing facility services for patients under 21 years of age.

DRUG REBATE AGREEMENT:
The State is in compliance with Section 1927(b) of the Social Security Act (the Act) to collect rebates. Based on the requirements for Section 1927 of the Act, the State will collect rebates from manufacturers participating in the Medicaid drug Rebate Program. The State has the following policies for drug rebate agreements:

- The drug file permits coverage of participating manufacturers.
- The State is in compliance with reporting requirements for utilization and restrictions to coverage.
- The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification in accordance with Section 1927(b)(3)(D).
- All drugs invoiced to manufacturers for rebates will comply with the provisions of the National Drug Rebate agreement.
- The State shall remit the Federal Government's share required under the National Drug Rebate Agreement.

SUPPLEMENTAL DRUG REBATE AGREEMENT:
The State is in compliance with Section 1927(b) of the Social Security Act (the Act) to collect supplemental rebates. Based on the requirements for Section 1927 of the Act, the State has the following policies for the supplemental drug rebate program:

- A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid population has been authorized by CMS effective January 1, 2015.
- Supplemental rebates received by the state in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national drug rebate agreement.
- The supplemental rebate agreement is applicable only to Medicaid recipients. This includes Medicaid recipients enrolled in a managed care organization. (MCO).

AHCCCS recognizes and assures that it will comply with the confidentiality mandate of Section 1927(b)(3)(D) of the Social Security Act.

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 of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy

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

1905(a)(29) __X__MAT as described and limited in Supplement 3 to Attachment 3.1-A.

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy.

State of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (Continued)

i. General Assurance

MAT is covered under the Medicaid state plan for all Medicaid beneficiaries who meet the medical necessity criteria for receipt of the service for the period beginning October 1, 2020, and ending September 30, 2025.

ii. Assurances

a. The state assures coverage of Naltrexone, Buprenorphine, and Methadone and all of the forms of these drugs for MAT that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under section 351 of the Public Health Service Act (42 U.S.C. 262).

b. The state assures that Methadone for MAT is provided by Opioid Treatment Programs that meet the requirements in 42 C.F.R. Part 8.

c. The state assures coverage for all formulations of MAT drugs and biologicals for OUD that are approved under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) and all biological products licensed under Section 351 of the Public Health Service Act (42 U.S.C. 262).

iii. Service Package

The state covers the following counseling services and behavioral health therapies as part of MAT.

a) The following services are covered as required by 1905(a)(29):

- Individual Therapy: Therapy and counseling services that are provided individually and which address the therapeutic goals outlined in the service plan.

- Group Therapy: Therapy and counseling services that are provided in a group setting and which address the therapeutic goals outlined in the service plan.

- Family Therapy: Service that involves the participation of a non-Medicaid eligible individual but that is for the direct benefit of the beneficiary. There may be times when, based on clinical judgment, the beneficiary is not present during the delivery of the service, but remains the focus of the service.

From October 1, 2020 through September 30, 2025, the state assures that MAT to treat OUD as defined in section 1905(ee)(1) of the Social Security Act (the Act) is covered

State of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (Continued)

exclusively under section 1905(a)(29) of the Act.

b) The providers which may provide individual, group and family therapy are licensed practitioners of the healing arts and Behavioral Health Technicians. The title of each provider/facility and qualifications are described in the table below.

c) Staff/Provider Titles and Qualifications

Practitioner Type	Education/Degree Required	Requires Supervision	Notes
Physician (MD, DO)	Graduate from an approved school of medicine or receive a medical education that the board deems to be of equivalent quality.	No	
Psychiatrist (MD, DO)	Licensed physician who has completed three years of graduate training in psychiatry in a program approved by the American Medical Association or the American Osteopathic Association.	No	
Nurse Practitioner (NP)	Completed a nurse practitioner educational program approved or recognized by the board and educational requirements prescribed by the board.	No	
Physician Assistant (PA)	Graduate from a physician's assistant educational program approved by the board and licensed by the board.	Yes	
Licensed Practical Nurse (LPN)	Satisfactory completion of basic curriculum in an approved practical or professional nursing program and hold a diploma, certificate or degree from that program.	No	

State of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (Continued)

Practitioner Type	Education/Degree Required	Requires Supervision	Notes
Registered Nurse (RN)	Satisfactory completion of basic curriculum in an approved registered nursing program and holds a diploma or degree from that program.	No	
Licensed Clinical Social Worker (LCSW)	Master degree or higher in social work from a regionally accredited college or university in a program accredited by the Council on Social Work Education or an equivalent foreign degree as determined by the Foreign Equivalency Determination Service of the Council on Social Work Education.	No	
Licensed Marriage/Family Therapist (LMFT)	Master degree or higher in a behavioral health science from a regionally accredited college or university whose program is accredited by the Commission on Accreditation for Marriage and Family Education or determined by the marriage and family credentialing committee to be substantially equivalent to a program accredited by the Commission on Accreditation for Marriage and Family Education.	No	
Licensed Professional Counselor (LPC)	Master degree or higher in counseling or related field from a regionally accredited college or university in a program that consists of 48 hours semester credit hours or a program	No	

State of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (Continued)

Practitioner Type	Education/Degree Required	Requires Supervision	Notes
	accredited by CACREP or CORE in a program that consists of a minimum of 48 semester credit hours.		
Licensed Independent Substance Abuse Counselor (LISAC)	Master degree or higher from a regionally accredited college or university in a behavioral health service with a minimum of 24 semester credit hours of counseling related coursework as determined by the substance abuse credentialing committee.	No	
Licensed Behavior Analyst	Graduate degree, Master degree or doctoral degree from an accredited college or university or institution of higher learning accredited by a recognized accrediting agency. Minimum of 225 classroom hours of specific graduate level instruction that meet nationally recognized standards for behavior analysts as determined by the board.	No	
Behavioral Health Paraprofessional (BHPP)	Associate's degree, a high school diploma or a high school equivalency diploma, must be at least 21 years old and has the skills and knowledge necessary to provide behavioral health services	Yes	Supervision Required: BHPP's working full time receive at least four hours of clinical supervision by a BHP or BHT in a calendar month.

State of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (Continued)

Practitioner Type	Education/Degree Required	Requires Supervision	Notes
	that the agency is authorized to provide and meet the needs of client populations served by the agency.		
Behavioral Health Technician (BHT)	Master's degree or bachelor's degree in a field related to behavioral health; is a registered nurse, is a physician assistant who is not working as a medical practitioner, has a bachelor's degree and at least one year of full time behavioral health work experience; has as associate's degree and at least two years of full time behavioral health work experience; has a high school diploma or high school equivalency diploma and a combination of education in a field related to behavioral health and full time behavioral health work experience totaling at least two years; is licensed a practical nurse, according to A.R.S Title 32, Chapter 15, with at least three years of full time behavioral health work experience; or has a high school diploma or high school equivalency diploma at least four years of full time behavioral health work experience.	Yes	Supervision Required: BHT's working full time receive at least four hours of clinical supervision by a BHP in a calendar month.

State of Arizona

1905(a)(29) Medication-Assisted Treatment (MAT)
Amount, Duration, and Scope of Medical and Remedial Care Services Provided to the Categorically Needy (Continued)

iv. Utilization Controls

The state has drug utilization controls in place. (Check each of the following that apply)

____ Generic first policy
__X__ Preferred drug lists
_____ Clinical criteria
__X__ Quantity limits

v. Limitations

Limitations on the amount, duration and scope of MAT drugs, biologicals and counseling/behavioral therapies related to MAT are based on clinical necessity.

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing section 1006(b) of the SUPPORT for Patients and Communities Act (P.L. 115-271) enacted on October 24, 2018. Section 1006(b) requires state Medicaid plans to provide coverage of Medication-Assisted Treatment (MAT) for all Medicaid enrollees as a mandatory Medicaid state plan benefit for the period beginning October 1, 2020, and ending September 30, 2025. Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 60). Public burden for all of the collection of information requirements under this control number is estimated to take about 80 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/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).

_X_ The target group includes individuals transitioning to a community setting. Case management services will be made available for up to 180 consecutive days of a covered stay in a medical institution. The target group does not include individuals between ages 22 and 64 who are served in Institutions for Mental Disease or individuals who are inmates of public institutions (SMDL, July 25, 200).

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
CASE MANAGEMENT SERVICES

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 includes contacts with non-eligible individuals that are directly related to identifying the eligible individual's needs and care, for the purposes of helping the eligible individual access services; identifying needs and supports to assist the eligible individual in obtaining services; providing case managers with useful feedback, and alerting case managers to changes in the eligible individual's needs. 42 CFR 440.169(e). The State assures that providers of case management services do not exercise the agency's authority to authorize or deny the provision of other services under the plan.

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 d 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/Territory: ARIZONA

H. Case Records (42 CFR 441.18(a)(7))
Providers maintain case records that document for all individuals receiving case management as follows: (i) the name of the individual; (ii) the dates of the case management services; (iii) the name of the provider agency (if relevant) and the person providing the case management service; (iv) the nature, content, units of the case management services received and whether goals specified in the care plan have been achieved; (v) whether the individual has declined services in the care plan; (vi) the need for, and occurrences of, coordination with other case managers; (vii) a timeline for obtaining needed services; (viii) a timeline for reevaluation of the plan.

I. Limitations
Case Management does not include, and Federal Financial Participation is not available in expenditures for, services defined in §440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs, services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements. (42 CFR 441.18(c)).

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): _____

8. _____ 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.

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.

State: Arizona

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.

State: Arizona

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.

State: Arizona

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.

State: Arizona

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.

State: Arizona

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.

State: Arizona

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

State: Arizona

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.

State: Arizona

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.

State: Arizona

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

State: Arizona

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 (NOT COVERED)
MEDICALLY NEEDY GROUP(S): _____

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
MEDICALLY NEEDY GROUP(S): _____

Not Covered

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
(Medically Needy

State/Territory: ARIZONA

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*

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 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 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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

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.

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

METHODS OF PROVIDING TRANSPORTATION

Transportation Services

The State attests that all minimum transportation requirements outlined in 1902(a)(87) of the Social Security Act are met.

Transportation to an emergency destination for eligible persons is a covered service if medically necessary when the eligible person demonstrates life threatening circumstances according to the prudent layperson standard. Transportation to an alternative destination for eligible persons by an emergency transportation provider is a covered service only: (1) when the ambulance provider is already at the site of the reported emergency, (2) the ambulance provider determines that the member requires medically necessary treatment, but an alternative destination is appropriate. Payment is limited to the cost of transporting eligible persons in a ground ambulance to the nearest and most appropriate destination only when there is no other appropriate transportation available. Transportation to an alternative destination for eligible persons is only permitted by ground ambulance.

If the eligible person is enrolled with a Health Plan or Program Contractor, the ground or air ambulance provider shall notify the 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 to receive a covered AHCCCS service, nonemergency medical transportation is provided. The provider shall obtain prior authorization when the transportation is more than 100 miles.

If the eligible person is enrolled with a Health Plan or Program Contractor, the Health Plan or Program Contractor has the discretion to require prior authorization. However, all claims for medically necessary transportation are subject to review for medical necessity by the Health Plan or Program Contractor.

Individuals enrolled in managed care receive medically necessary transportation by contacting the health plan or the subcontracted transportation provider. The health plan or subcontractor is responsible for determining eligibility for medically necessary transportation, appropriateness of the request, and the most appropriate and least costly mode of transportation. Individuals enrolled in FFS request transportation by contacting the AHCCCS Administration.

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ARIZONA

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 person 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 authorized 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, unless they have entered into subcontracting agreements with AHCCCS contractors for medically necessary transportation services.

Prior Authorization

A provider shall obtain prior authorization from the Administration for transportation services provided for a FFS member for the following:

1. Medically necessary nonemergency transportation services not originated through a 911 call or other emergency response system when the distance traveled exceeds 100 miles (whether one way or round trip); and
2. All meals, lodging, and services of an escort accompanying the eligible person under this Section.

A provider shall obtain prior authorization from Contractors for eligible persons enrolled in managed care in accordance with the Contractors' requirements.

State/Territory: Arizona

Standards for the Coverage of Organ Transplant Services

Medically necessary transplant services are available to AHCCCS members as described in the AHCCCS Medical Policy Manual, meeting nationally recognized criteria for non-experimental, non-investigational organ or tissue transplants. All medically necessary, non experimental transplants are covered for EPSDT members. For persons age 21 and older, AHCCCS coverage of transplants is limited to the following:

- Heart
- Liver
- Kidney
- Simultaneous Pancreas/Kidney
- Autologous and Allogenic related and unrelated Hematopoietic Cell
- Cornea
- Bone
- Lung
- Pancreas after Kidney

AHCCCS does not cover the following transplants for persons age 21 years and older:

- Pancreas only transplants
- Partial pancreas transplants, including islet cell transplants
- Intestine transplants (Visceral)
- Any other transplant not listed in the covered transplants above.

All AHCCCS members are eligible to receive the medically necessary transplants and related services described in the AHCCCS Medical Policy Manual with the following exceptions:

- Title XIX SOBRA Family Planning Program members; and
- Federal Emergency Services Program (FESP) members.

AHCCCS has established specific prior authorization medical criteria for coverage of transplant and related services as specified in the AHCCCS Medical Policy Manual. The Manual, including all supplements and updates to the Manual are available to the public on the agency's web site:
http://www.azahcccs.gov/shared/MedicalPolicyManual/MedicalPolicyManual.aspx?ID=policymanuals

State: ARIZONA

Citation	Condition or Requirement

1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Arizona enrolls Medicaid beneficiaries on a **voluntary** basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐MCO
   a. ☐Capitation

2. ◪PCCM (individual practitioners)
   a. ◪ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐PCCM (entity based)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

Citation	Condition or Requirement

For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

☐d. Incentives will be made available to both public and private PCCMs.

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

The concept of primary care coordination model and a per member per month (PMPM) payment strategy as an American Indian Medical Home (AIMH) was initially brought forth by the Tucson area IHS and was the subject of formal AHCCCS tribal consultation in March and August of 2011. The proposal for an American Indian Medical Home was also placed on the AHCCCS website for public comment during this period.

AHCCCS refined the care coordination model for an AIMH to align this effort with the IHS Improving Patient Care (IPC) model to avoid duplication and confusion among care coordination models. This revised proposal was the subject of Tribal Consultation in August, 2013 and at the request of Tribal stakeholders was revised to include diabetes education in 2014. Additional revisions from tribes were included in

the model presented at a Tribal Consultation in August, 2015. As negotiations over the model progressed and substantial changes were made AHCCCS presented the current model at Tribal Consultation in January, April, July and October, 2016.

Public notice and Tribal Consultation for this State Plan Amendment occurred on February 9, 2017. In addition, AHCCCS has a website on which program changes are posted and comments are received. The State will continue to follow its State plan public notice and Tribal Consultation processes for all program changes affecting the AIMH.

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

State: ARIZONA

Citation		Condition or Requirement
1932(a)(1)(A)(i)(I)	1.	☐The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met
1932(a)(1)(A)(i)(I) 1905(t) 42 CFR 438.50(c)(2) 1902(a)(23)(A)	2.	⬓The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.
1932(a)(1)(A) 42 CFR 438.50(c)(3)	3.	☐The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met.
1932(a)(1)(A) 42 CFR 431.51 1905(a)(4)(C)	4.	☐ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.
1932(a)(1)(A)	5.	⬓The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i).
1932(a)(1)(A) 42 CFR 438 1903(m)	6.	⬓The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	7.	☐The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) CFR 447.362 42 CFR 438.50(c)(6)	8.	☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met.
45 CFR 92.36	9.	⬓The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Citation | Condition or Requirement

1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

Population	M	Geographic Area	V	Geographic Area	Excluded
Section 1931 Children & Related Populations – 1905(a)(i)					
Section 1931 Adults & Related Populations1905(a)(ii)					
Low-Income Adult Group					
Former Foster Care Children under age 21					
Former Foster Care Children age 21-25					
Section 1925 Transitional Medicaid age 21 and older					
SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv)					
Poverty Level Pregnant Women – 1905(a)(viii)					
SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv)					
SSI and SSI related Disabled children under age 18					
SSI and SSI related Disabled adults age 18 and older – 1905(a)(v)					
SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii)					

Citation Condition or Requirement

Population	M	Geographic	V	Geographic	Excluded
SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B)					
Recipients Eligible for Medicare					
American Indian/Alaskan Natives			X	State- wide	AI/AN enrolled in managed care, AI/AN enrolled in Tribal ALTCS, AI/AN enrolled through Hospital Presumptive Eligibility, AI/AN enrolled in FFS Temporary, AI/AN enrolled in FFS Regular, AI/AN enrolled in Prior Quarter, and AI/AN enrolled in Federal Emergency Services Only.
Children under 19 who are eligible for SSI					
Children under 19 who are eligible under Section 1902(e)(3)					
Children under 19 in foster care or other in-home placement					
Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v)					
Other					

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

XX Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

XX Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

Citation | Condition or Requirement

☐Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

XX Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☐ Other (Please define):

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. **XX** The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
      The AIMH PCCM program is a voluntary program. Individuals who elect to participate in the FFS American Indian Health Plan (AIHP) can select an AIMH site. Individuals can select an AIMH when they access a participating AIMH provider or by contacting AHCCCS. Selection forms will be available at AIMH sites and on the AHCCCS website and will be processed by AHCCCS on a monthly basis. Forms will be available both electronically and paper formats. The form will include the features and benefits of the program, the right to disenroll, and any other information required by federal and state regulations including 438.54(c)(3).

      ii. What action the state takes if the applicant does not indicate a plan

iii. selection on the application.
The AIMH PCCM program is a voluntary program. Individuals may select an AIMH provider at a later date through AHCCCS or by indicating participation through AIMH provider forms described above.

iv. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

Citation	Condition or Requirement

v. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence*.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☐The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO

Citation	Condition or Requirement

or PCCM does not have capacity to accept all who are seeking enrollment under the program.

b. **XX** The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

XX This provision is not applicable to this 1932 State Plan Amendment.

d. **XX** The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.56

G. Disenrollment

1. The state will☐/**will not XX** limit disenrollment for managed care.

2. The disenrollment limitation will apply for months (up to 12 months).

3. **XX** The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
The AIMH PCCM program is voluntary and includes no disenrollment limits. Individuals will be provided with information on selecting (enrolling) into an AIMH and information on disenrolling or selecting a different AIMH provider when they elect to participate in the FFS AIHP program.

Additionally, information on disenrollment or selecting a new AIMH provider will be available at AIMH clinics as well as forms to initiate such disenrollment or selection of a new AIMH provider.

5. Describe any additional circumstances of "cause" for disenrollment (if any).

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
438.10(e)

XX The state assures that its state plan program is in compliance with 42 CFR for information requirements specific to MCOs and PCCM programs 42 CFR 438.10 operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

AIMH PCCMs will provide coordination and monitoring of state plan services including, in some instances, self-management techniques for Diabetes Management.

The State AIMH PCCM will offer four levels of AIMH based on the level of case management/care coordination offered. The levels of case management described in PCCM contract language are:

1) American Indian Medical Home

2) American Indian Medical Home, with diabetes education

3) American Indian Medial Home, and participates in the state Health Information Exchange

4) American Indian Medical Home, with diabetes education, and participates in the state Health Information Exchange

An AIMH which qualifies for the first level of the AIMH program will have achieved Patient Centered Medical Home recognition through NCQA, Accreditation Association for Ambulatory Health Care, The Joint Commission PCMH Accreditation Program, or other appropriate accreditation body, or an IHS IPC may attest annually that the site has completed the following in the past year:

a. Submitted the SNMHI Patient-Centered Medical Home Assessment (PCMH-A) to

IHS IPC;

b. Submitted monthly data on the IPC Core Measures to the IPC Data Portal; AND

c. Submitted narrative summaries on IPCMH improvement projects to IHS IPC

quarterly

This first level of AIMH would provide primary care case management services as well as 24 hour telephonic access to the care team.

The second level of AIMH would provide all of the services described in the first level as well as diabetes education. This level will require an AIMH to have a diabetes education accreditation through a recognized accreditation agency. The state will not prescribe to AIMH entities what must be included in these educational programs.

The third level of AIMH includes all the services described in the first level as well as participation in the state Health Information Exchange.

The fourth level of AIMH will provide all services described in the first three levels.

The AIMH program is not a shared savings or value based purchasing program. AIMH PCCM payments to qualified IHS or Tribal owned 638 facilities are on a prospective enrollment basis with no retroactive eligibility adjustment and claimable at the 100 percent FMAP rate.

1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☐The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.206
42 CFR 438.207

K. Describe how the state has assured adequate capacity and services.

1932(a)(5)(D)(c)(1)(A)
42 CFR 438.240

L. ☐The state assures that a quality assessment and improvement strategy has been developed and implemented.

1932(a)(5)(D)(c)(2)(A)
42 CFR 438.350

M. ☐The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

1932 (a)(1)(A)(ii)

N. Selective Contracting Under a 1932 State Plan Option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state **will XX**/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. **XX** The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   All AHCCCS registered IHS and tribal 638 facilities can participate in the AIMH PCCM program. In order to qualify as an AIMH and be eligible to receive a per member per month (PMPM) for empaneled members, providers must demonstrate annually that they have met the AIMH criteria described in the PCCM AIMH contract.

   Under 42 CFR 438.14, IHS and Tribal 638 organizations are able to limit enrollment in a PCCM to American Indian/Native Alaskan enrollees. The state will offer this AIMH PCCM program only to IHS and Tribal 638 organizations meeting contract requirements and offering enrollment in PCCM only to individuals selecting and participating in the FFS AIHP program.

   The State AIMH PCCM will offer four levels of PMPM payment based on the level of case management/care coordination offered. The levels of case management described in PCCM contract language are:
   1) American Indian Medical Home
   2) American Indian Medical Home, with diabetes education

3) American Indian Medial Home, and participates in the state Health Information Exchange

4) *American Indian Medical Home, with diabetes education, and participates in the state Health Information Exchange*

4. ☐The selective contracting provision in not applicable to this state plan.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE ARIZONA

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

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:

- 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.

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

- 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

A. The following charges are imposed under section 1916 of the Social Security Act and 42 CFR 447.50-.60 with the exceptions specified at Section 1916(a)(2) and (j) of the Act and 42 CFR 447.53(b):

Type of Charge					
Group of Individuals	Item/Service	Ded.	Coins.	Copay	Method of Determining Family Income
All other individuals covered under the State Plan with the exception of those covered under the TMA group under Att. 4.18-F	Prescription drugs	N/A	N/A	$2.30/ drug	Same
	Outpatient visit, excluding emergency room visit if coded as non-emergent surgical procedures or evaluation and management services	N/A	N/A	$3.40/visit	Same
	If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	$2.30/visit	Same

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State:

B. The method used to collect cost sharing charges for categorically needy individuals:

_X_ 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:

By state administrative rule, all providers are required to accept the individual's self-declaration of the inability to pay the charge.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Arizona

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

Providers are able to access and track copayment information from the verification systems used by AHCCCS providers (excluding IVR) such as EVS, the web, and HIPAA transactions 270 and 271. The verification system will identify the member's eligibility category where a specific copay level is assigned by population. It will also identify whether the member is subject to a mandatory or nominal copayment and specify the copayment amount by service level. This system also identifies services which are exempt from copayments. Prior to implementation, AHCCCS provided information all providers and contractors which described the copayment requirements by eligibility category, including descriptions of exempt services and populations. This communication is posted on the website along with the rule, which sets forth the copayment requirements and prohibitions. Contracted health plans receive daily and monthly rosters from AHCCCS that identify each member's cost sharing designation (nominal, mandatory or exempt). In addition, AHCCCS sends the health plans a reference extract table which is used to identify the copay amounts for specific services by the member's cost sharing category.

Interim Plan: October 1, 2010-April 30, 2011: To ensure that American Indians are exempted from cost sharing, fee for service users, who represent the vast majority of American Indian (AI) AHCCCS recipients, will be exempted from cost sharing. Because some AI's choose to receive services through MCO's, the AHCCCS Client Advocate Office will work with managed care enrollees to exempt AI's served under managed care.

Final Plan: Effective no later than May 1, 2011:, As a result of an analysis of FFS claims and encounters, AHCCCS will identify all active and previous users of Indian Health Service Facilities, Tribally-Operated 638 Health Programs and Urban Indian Health Programs (I/T/Us) for which AHCCCS has provided reimbursement. All users identified though this analysis will be flagged and exempted from all cost sharing, and this information will be communicated to MCOs' and providers. The AHCCCS Client Advocate office will also work closely with the identified population to ensure that cost sharing is not applied to any American Indian who has ever utilized an I/T/U or received a service through referral by Contract Health Services.

E. Cumulative maximums on charges:

X State policy does not provide for cumulative maximums.

__ Cumulative maximums have been established as described below:

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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State: ARIZONA

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: ARIZONA

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

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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State/Territory: Arizona

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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 PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Alternative Premiums and Cost Sharing Charges

The following alternative premiums and cost sharing charges are imposed under section 1916A of the Social Security Act and 42 CFR 447.50 and 447.62 - 447.82. A State may select one or more options for cost-sharing (including copayments, coinsurance, and deductibles) and premiums.

A. For groups of individuals with family income at or below 100 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. __/ No cost sharing is imposed.

ii. _X/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

2. Premiums

a. Amount of Premiums

No premiums may be imposed for individuals with family income at or below 100 percent of the FPL.

B. For groups of individuals with family income above 100 percent but at or below 150 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. __/ No cost sharing is imposed.

ii. __/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

iii. _X/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including mthly or qtrly period)
		Deductible	Coinsurance	Copayment	
Individuals who receive Transitional Medical Assistance under §1925 of the Social Security Act above 100% FPL and at or below 150% FPL					
	Prescription Drugs	N/A	N/A	$2.30/drug	Same
	Outpatient visit, excluding emergency room visit if coded as evaluation and management services	N/A	N/A	$4.00/outpatient visit	Same
	If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	$3.00/visit	Same
	If not imposed above, any services rendered during a visit coded as non-emergent surgical procedures when provided in a physician's office, an ASC or any other outpatient setting, excluding an emergency room	N/A	N/A	$3.00	Same

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a __ monthly or X_ quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A(b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State:

N/A

c. Enforcement

_X_/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

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State/Territory: Arizona

Regardless of whether the State elects the above option to permit providers to enforce the collection of cost sharing payments, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, the State's payments to providers must be reduced by the amount of the beneficiary cost-sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums

a. Amount of Premiums

No premiums may be imposed for individuals with family income above 100 percent of the FPL but at or below 150 percent.

C. For groups of individuals with family income above 150 percent of the FPL:

1. Cost Sharing

a. Amount of Cost Sharing

i. __/ No cost sharing is imposed.

ii. __/ Nominal cost sharing is imposed under section 1916 of the Act (see Attachment 4.18-A and/or 4.18-C).

iii. _X/ Alternative cost sharing is imposed under section 1916A of the Act as follows (specify amounts by groups and services (see below)):

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

Group of Individuals	Item/Service	Type of Charge			*Method of Determining Family Income if different than for eligibility (including mthly or qtrly period)
		Deductible	Coinsurance	Copayment	
Individuals who receive Transitional Medical Assistance under §1925 of the Social Security Act above 150% FPL					
	Prescription Drugs	N/A	N/A	$2.30/drug	Same
	Outpatient visit, excluding emergency room visit if coded as evaluation and management services	N/A	N/A	$4.00/outpatient visit	Same
	If not imposed above, any services rendered during a visit coded as physical, occupational, or speech therapy services	N/A	N/A	$3.00/visit	Same
	If not imposed above, any services rendered during a visit coded as non-emergent surgical procedures when provided in a physician's office, an ASC or any other outpatient setting, excluding an emergency room	N/A	N/A	$3.00/visit	Same

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: Arizona

b. Limitations:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a __ monthly or X quarterly basis as specified by the State.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of the specific item or service.
- Cost sharing may not be imposed for the services, items, and populations specified at section 1916A(b)(3)(B) of the Act and 42 CFR 447.70(a).
- Additional limitations specified by the State:

N/A

c. Enforcement

_X/ Providers are permitted to require the payment of any cost sharing as a condition for the provision of care, items, or services.

Regardless of whether the State elects the above option, providers are permitted to reduce or waive cost sharing on a case-by-case basis. However, a State's payments to providers must be reduced by the amount of the beneficiary cost-sharing obligations, regardless of whether the provider collects the full cost sharing amount.

2. Premiums

a. Amount of Premiums

i. _X/ No premiums are imposed.

ii. __/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

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State/Territory: Arizona

b. Limitation:

- The total aggregate amount of cost sharing and premiums imposed for all individuals in the family under sections 1916 and 1916A of the Act may not exceed 5 percent of the family income of the family involved, as applied on a __ monthly or __ quarterly basis as specified by the State.
- Premiums may not be imposed for the populations specified at section 1916A(b)(3)(A) of the Act and 42 CFR 447.66(a).
- Additional limitations specified by the State:

N/A

c. Enforcement

i. __/ Prepayment is required for the following groups of applicants when they apply for Medicaid:

N/A

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ii. __/ Prepayment is required for the following groups of beneficiaries as a condition for receiving Medicaid services for the premium period:

N/A

iii. __/ Eligibility is terminated for failure to pay after a grace period of __ days after the premium due date (at least 60 days) for the following groups of Medicaid beneficiaries:

N/A

iv. __/ Payment will be waived by the State on a case-by-case basis if payment would create an undue hardship for the individual.

D. Period of determining 5 percent aggregate family limit for premiums and cost sharing:

Specify the period for which the 5 percent maximum will be applied.

_X/ Quarterly

__/ Monthly

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E. Method for tracking beneficiaries' liability for premiums and cost-sharing:

1. Describe the methodology used by the State to identify beneficiaries who are subject to premiums or to cost sharing for specific items or services.
Alternative cost sharing is only applied to persons determined eligible for Transitional Medical Assistance under section 1925 through the State's normal eligibility redetermination process, which includes reviews initiated by eligible persons who report an increase in income.

   Interim Plan: October 1, 2010- April 30, 2011:To ensure that American Indians are exempted from cost sharing, fee for service users, who represent the vast majority of American Indian (AI) AHCCCS recipients, will be exempted from cost sharing. Because some AI's choose to receive services through MCO's, the AHCCCS Client Advocate Office will work with managed care enrollees to exempt AI's served under managed care.

   Final Plan: Effective no later than May 1, 2011:As a result of an analysis of FFS claims and encounters, AHCCCS will identify all active and previous users of Indian Health Service Facilities, Tribally-Operated 638 Health Programs and Urban Indian Health Programs (I/T/Us) for which AHCCCS has provided reimbursement. All users identified though this analysis will be flagged and exempted from all cost sharing, and this information will be communicated to MCOs' and providers. The AHCCCS Client Advocate office will also work closely with the identified population to ensure that cost sharing is not applied to any American Indian who has ever utilized an I/T/U or received a service through referral by Contract Health Services.

2. Describe how the State identifies for providers, ideally through the use of automated systems, whether cost sharing for a specific item or service may be imposed on an individual beneficiary and whether the provider may require the beneficiary, as a condition for receiving the item or service, to pay the cost sharing charge.
Contracted health plans will be informed of the services subject to copayments and their corresponding dollar amounts. Health plans will make this information available to their network of providers through the 834- the Benefit Enrollment Maintenance Transaction, a HIPAA required format used as the roster to contracted health plans. Additionally, all providers will be able to access information from the verification systems used by AHCCCS providers (except IVR) such as EVS, the web, and HIPAA transactions 270 and 271. Information regarding whether the member is subject to a mandatory or nominal copayment, when copayments can not be charged and what a member's specific copayment level is by service type.

3. Describe the State's processes (that do not rely on beneficiaries) used for tracking beneficiaries' incurred premiums and cost sharing under sections 1916 and 1916A of the Act if families are at risk of reaching their total aggregate limit for premiums and cost sharing, how the State informs beneficiaries and providers when a beneficiary's family has incurred premiums and cost sharing up to its 5 percent aggregate limit, and how the State assures that the family is no longer subject to further premiums and cost sharing for the remainder of the monthly or quarterly cap period.
The State will use available Health Plan adjudicated encounters to identify beneficiaries reaching the 5% aggregate copayment amount in a quarter by using the lowest possible family income and calculating the applicable copayment amounts for reported services during the quarter. If it is determined that a beneficiary has reached the 5% cap, the State will identify this status in the verification systems described above to inform providers that the member is not be subject to further cost sharing.

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4. Describe the process through which beneficiaries may request that the State reassess the family's aggregate limit for premiums and cost sharing when the family's income has changed or if a family member's Medicaid enrollment is being terminated due to nonpayment of a premium. Members are informed of applicable cost sharing requirements through the member handbook, the public website, and special copay notices provided to members prior to implementation. Members are advised they can request a reassessment of the family's aggregate limit if they believe the family's income has changed.

F. Public Notice Requirements:

Explain how the State meets the following public notice requirements at 42 CFR 447.76.

1. The requirement at 42 CFR 447.76(a) and (b) for making available certain information about the State's premiums and cost sharing policies and procedures to the general public, applicants, beneficiaries, and providers:
   AHCCCS posted the cost sharing State Plan Amendment on the public website. Additionally, AHCCCS filed the Notice of Proposed rule making and final rule making with the Secretary of State, made this information available on the public website, and conducted a public hearing at the Agency. A matrix of all public comments as well as the Administration's responses to each of the comments were posted to the website. Furthermore, the rulemaking process allowed for public participation at the Governor's Regulatory Review Council prior to the adoption of the rule. Member handbooks were updated to include updated information about cost sharing. Additionally, members subject to the mandatory copayments received advanced notice of the mandatory copayment requirements. AHCCCS updated the member application to describe cost sharing requirements as well as exemptions from cost sharing.

2. The requirement at 42 CFR 447.76(c) to provide the public with advance notice and the opportunity to comment prior to submitting a State plan amendment (SPA) to establish or substantially modify alternative premiums and/or cost sharing under section 1916A of the Act:
   Notice of the proposed rule and the opportunity to provide written or oral comments on the rule were published in the State Administrative Register. Following publication of the proposed rule, the agency allowed a 30 day period for submission of public comments and conducted a public hearing where oral public comments were solicited at the close of the comment period. In addition, a public hearing was conducted by a separate executive branch agency, the Governor's Regulatory Review Council, at which public comment was solicited prior to finalization of the administrative rule. All of this information was published on both the AHCCCS and Secretary of State's websites.

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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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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

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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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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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1) **Outliers**: Effective with dates of admission 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 (CCR) and Medicare's statewide average capital CCR, 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 the rate year effective October 1, 2010, to September 30, 2011, AHCCCS will not apply the Global Insight hospital market basket index to adjust the outlier cost thresholds. For inpatient hospital admissions with begin dates of admission on and after October 1, 2011, AHCCCS will increase the outlier cost thresholds by 5% of the thresholds that were effective on September 30, 2011.

For calculations using the Medicare urban or rural CCRs, including outlier determination and threshold calculation, AHCCCS shall phase in the use of the Medicare urban or rural CCRs as follows: For outlier claims with dates of admission on or after October I, 2007 through September 30, 2008, AHCCCS shall adjust each hospital specific inpatient CCR in effect on September 30, 2007 by subtracting one-third of the difference between the hospital specific inpatient CCR and the sum of Medicare's urban or rural statewide average operating CCR and Medicare's statewide average capital CCR. For outlier claims with dates of admission on or after October 1, 2008 through September 30, 2009, AHCCCS shall adjust each hospital specific inpatient CCR in effect on September 30, 2007 by subtracting two-thirds of the difference between the hospital specific inpatient CCR and the sum of Medicare urban or rural statewide average operating CCR and Medicare's statewide average capital CCR.

For payment of outlier claims with dates of admission on or after October 1, 2007 through September 30, 2008, AHCCCS shall adjust the statewide inpatient hospital CCR in effect on September 30, 2007 by subtracting one-third of the difference between the statewide inpatient hospital CCR and the effective Medicare urban or rural CCR. For payment of outlier claims with dates of admission on or after October I, 2008 through September 30, 2009, AHCCCS shall adjust the statewide inpatient hospital CCR in effect on September 30, 2007 by subtracting two-thirds of the difference between the statewide inpatient hospital CCR and the effective Medicare urban or rural CCR.

For outlier claims with dates of admission on or after October 1, 2009, the full Medicare urban or rural CCR shall be utilized for all calculations. The three year phase-in does not apply to out of state or new hospitals.

For qualification and payment of outlier claims with begin dates of admission on or after April 1, 2011 through September 30, 2011, the CCR will be equal to 95% of the ratios in effect on October 1, 2010.

For qualification and payment of outlier claims with begin dates of admission on or after October 1, 2011, the CCR will be equal to 90.25% (95% of the previous 95% reduction = 95% x 95%) of the most recent published Urban or Rural Medicare CCR as of August of each year (e.g., 90.25% of the CCR published as of August 31, 2011 is used for the period of October 1, 2011 to September 30, 2012).

In addition, for qualification and payment of outlier claims with begin dates of admission on or after October 1, 2011 through September 30, 2012, AHCCCS will reduce the CCR for a hospital that filed a charge master with ADHS on or after April 1, 2011 by an additional percentage equal to the total percent increase reported on the charge master.

In addition, for qualification and payment of outlier claims with begin dates of admission on or after October 1, 2012, AHCCCS will reduce the CCR for a hospital that filed a charge master with ADHS on or after June 1 of the prior federal fiscal year, by an additional percentage equal to the total percent increase reported on the charge master.

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1) **Transplants**: AHCCCS shall negotiate contracts with hospitals qualified to perform covered organ and hematopoietic cell transplantation services. Reimbursement is based on a fixed price per type of transplant, by component, which may include stop-loss provisions. Component reimbursement is based on provider cost reports. At no time will payment for the entire case exceed a hospital's billed charges. Cornea transplants and bone graft transplantation are excluded from the component methodology and are reimbursed based on the tiered per diem rates.

2) **Specialty Services:** AHCCCS may negotiate contracts for specialized hospital services, including but not limited to: subacute, neonatalogy, neurology, cardiology and burn care. Rates are determined based on provider cost information and at no time will contracted rates exceed billed charges.

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. For rates effective on and after October 1, 2010, no inflation factor will be applied.

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 the service period July 1, 2022 through June 30, 2023, the Administration shall distribute $45,049,600 as described in this paragraph to the following hospitals: Abrazo Central Campus, Banner Boswell Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - Tucson, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, St. Joseph's Hospital – Phoenix, Tucson Medical Center, and Valleywise Health Medical Center. 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 DRI inflation factor. 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

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 14 and 16 through 18, Column 8. 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 21 & 22, 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, 2022, to June 30, 2023, the Administration shall distribute up to $44,192,299 under this paragraph to the following hospitals: Banner Behavioral Health Hospital, Banner Boswell Medical Center, Banner Del Webb Medical Center, Banner Desert Medical Center, Banner Estrella Medical Center, Banner Gateway Medical Center, Banner Heart Hospital, Banner Thunderbird Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, John C. Lincoln Medical Center, Kingman Regional Medical Center, Mayo Hospital, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare – Thompson Peak, St. Joseph's Hospital – Phoenix, Tucson Medical Center, and Valleywise Health Medical Center. 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.

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, 2022, to June 30, 2023, the Administration shall distribute up $26,759,075 under this paragraph to the following hospitals: Abrazo Arrowhead Campus, Abrazo West Campus, Banner Boswell Medical Center, Banner Del Webb Medical Center, Banner Desert Medical Center, Banner Estrella Medical Center, Banner Gateway Medical Center, Banner Thunderbird Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, Canyon Vista Medical Center, HonorHealth Deer Valley Medical Center, HonorHealth Rehabilitation Hospital, John C. Lincoln Medical Center, Mayo Hospital, Mountain Vista Medical Center, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare - Thompson Peak, St. Joseph's Hospital – Phoenix, Tucson Medical Center, Valleywise Health Medical Center and Yuma Regional Medical Center. In addition to the above amount, this pool also includes the payment amounts listed on page 9(g)(i) for other teaching hospitals. 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.

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 Medicaid IME cost for each hospital is to be calculated as follows:

1. Calculate each hospital's Medicare share by dividing the Medicare inpatient discharges on the Medicare Cost Report (Worksheet S-3 Part I, Column 13, Line 14 plus Line 2) by the total inpatient hospital discharges on the Medicare Cost Report (Worksheet S-3 Part I, Column 15, Line 14).
2. Calculate the ratio of the residents to beds by dividing the number of filled resident positions for each hospital derived from reporting by the GME programs to the Administration as described in paragraph B(2) by the bed days available divided by the number of days in the cost reporting period from the Medicare Cost Report (Worksheet E Part A, Line 4, Column 1).
3. Calculate the indirect medical education adjustment factor by using the following formula: 1.35 x $\{[(1+r)^{.405}]-1\}$ where r is the ratio of residents to beds calculated above.
4. Calculate each hospital's total indirect medical education cost by adding the DRG amounts other than outlier payments from the Medicare cost report and the managed care simulated payments from the Medicare Cost Report (Worksheet E Part A, Lines 1, 1.01, 1.02, 1.03, 1.04 and 3, Column 1), multiplying the total by the indirect medical education adjustment factor and dividing the result by the Medicare share.
5. Calculate each hospital's Medicaid indirect medical education cost by multiplying the hospital's total indirect medical education by the Medicaid Utilization Percent used to determine the direct GME component.

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 computed for a teaching hospital under this paragraph shall not exceed the greatest among the amounts described in paragraph F(1) through F(3).

A hospital that does not have any IME amount reported on the Medicare cost report, other than a children's hospital or a new teaching hospital whose latest available Medicare cost report used does not include the hospital's Medicare IME amount as a teaching hospital, will be ineligible for IME payment under this paragraph D.

For the service period of July 1, 2022, to June 30, 2023 the Administration shall distribute up to $9,414,351 under this paragraph to the following hospitals: Banner University Medical Center - South, Banner University Medical Center - Tucson, Canyon Vista Medical Center, Kingman Regional Medical Center, and Yuma Regional Medical Center. 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 – Second Payment Pool

Beginning July 1, 2007, the Administration establishes a second Indirect Medical Education payment pool. 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 (a) reimbursement with such funds includes resident positions or rotations other than those in counties with populations of less than five hundred thousand persons, and (b) the hospitals eligible to receive the funds are participating hospitals that incur indirect medical education costs. The total amount computed for a teaching hospital under paragraphs D and F combined shall be equal to the greatest among the following amounts:

1. The hospital's Medicaid IME costs calculated under paragraph D;
2. The median of all such costs if the hospital does not have an IME payment calculated on its Medicare Cost Report because the hospital is a children's hospital or a new teaching hospital and the latest available Medicare cost report used does not include the hospital's Medicare IME amount as a teaching hospital; and
3. The hospital's program allocation amount, as calculated under paragraph D but for the qualifying rotations in both paragraphs D and F counted at the participating hospital (rather than only rural rotations counted for the sponsoring or base hospital).

The amount that a teaching hospital receives under paragraph D will be subtracted from the total amount computed above to determine the calculated IME payment amount under this paragraph F.

A hospital that does not have any IME amount reported on the Medicare cost report, other than a children's hospital or a new teaching hospital described above, will be ineligible for IME payment under paragraphs D and F.

For the service period of July 1, 2016 to June 30, 2017, the Administration shall distribute up to $203,930,886 in total funds under this paragraph to the following hospitals: Abrazo Central Campus , Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, John C. Lincoln Medical Center, Kingman Regional Medical Center, Maricopa County Medical Center, Mayo Hospital, Mountain Vista Medical Center, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare - Thompson Peak, St. Joseph's Hospital - Phoenix, and Tucson Medical Center. Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed under this paragraph. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

All payments for GME and IME provided for in paragraphs B-F are payable annually at the end of the year.

A hospital that does not have any IME amount reported on the Medicare cost report, other than a children's hospital or a new teaching hospital described above, will be ineligible for IME payment under paragraphs D and F.

For the service period of July 1, 2022 to June 30, 2023, the Administration shall distribute up to $280,788,054 in total funds under this paragraph to the following hospitals: Abrazo Central Campus, Abrazo Arrowhead Campus, Abrazo West Campus, Banner Behavioral Health Hospital, Banner Boswell Medical Center, Banner Del Webb Medical Center, Banner Desert Medical Center, Banner Estrella Medical Center, Banner Gateway Medical Center, Banner Heart Hospital, Banner Thunderbird Medical Center, Banner University Medical Center - Phoenix, Banner University Medical Center - South, Banner University Medical Center - Tucson, Canyon Vista Medical Center, HonorHealth Deer Valley Medical Center, HonorHealth Rehabilitation Hospital, John C. Lincoln Medical Center, Mayo Hospital, Mountain Vista Medical Center, Phoenix Children's Hospital, Scottsdale Healthcare - Osborn, Scottsdale Healthcare - Shea, Scottsdale Healthcare - Thompson Peak, St. Joseph's Hospital - Phoenix, Tucson Medical Center, and Valleywise Health Medical Center. Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed under this paragraph. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

All payments for GME and IME provided for in paragraphs B-F are payable annually at the end of the year.

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ADDITIONAL POOL AMOUNTS

1. The methodology described in Paragraph B(1) applies to the following:

   For the service period July 1, 2010 through June 30, 2011, in addition to the payments in Paragraph B(1), the Administration shall distribute up to $4,036,624 as described in this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center.

2. The methodology described in Paragraph B(3) applies to the following:

   For the service period of July 1, 2010, to June 30, 2011, in addition to the payments in Paragraph B(3), the Administration shall distribute up to $2,586,973 under this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center. 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.

3. The methodology described in Paragraph B(4) applies to the following:

   For the service period of July 1, 2010, to June 30, 2011, in addition to the payments in Paragraph B(4), the Administration shall distribute up to $784,416 under this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center. If funds are insufficient to cover all calculated distributions, the Administration shall adjust the distributions proportionally.

4. The methodology described in Paragraph F applies to the following:

   For the service period of July 1, 2010 to June 30, 2011, in addition to the payments in Paragraph F, the Administration shall distribute up to $31,720,017 in total funds under this paragraph to the following hospitals: Scottsdale Healthcare Osborn, Scottsdale Healthcare Shea, St. Joseph's Hospital and Tucson Medical Center. Any unallocated authority remaining from paragraphs B(3), B(4) or D after any necessary redistribution under paragraph E may be distributed under this paragraph.

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G. For the period of July 1, 2022 to June 30, 2023, the AHCCCS Administration shall distribute $16,374,987 for hospitals located in counties with populations of five hundred thousand or more residents for new graduate medical education programs that began on or after July 1, 2020 or for positions that were expanded on or after July 1, 2020 These distributions are supplementary to and do not supplant the payments described in paragraphs B, C, D, and F above, with priority of the supplementary monies based on the number of residents and fellows in graduate medical education in the following manner:

1) Each eligible resident and fellow is placed into a tier with the following priority order:
   a) Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this section for the previous academic year, and who is continuing in the same GME program.
   b) Residents and fellows that are not a returning resident or fellow but are in a GME program for:
      i) Family medicine
      ii) Internal medicine
      iii) General pediatrics
      iv) Obstetrics and gynecology
      v) Psychiatry, including subspecialties
      vi) General surgery
   c) Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this section in a prior year.
   d) All other residents and fellows.

2) Funds shall be allocated based on the priority of each tier. Distributions for eligible positions in a tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher tier. If funding is insufficient to fully fund a tier, the remainder of funds will be prorated for eligible positions within that tier, based on the amount computed for each hospital that would have been reimbursable for that tier if full funding were available. Distribution is made for each tier, in priority order, before distribution to the next lower tier.

3) The amount of the distribution for each GME program for direct costs is calculated as the product of:
   a) The number of eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospitals; and
   b) The hospital's Arizona Medicaid utilization as determined in paragraph B(3) for the program year using the most recent as-filed Medicare cost report as proxy; and,
   c) The statewide average direct cost per resident determined in paragraph B(3)for the program year using the most recent as-filed Medicare cost reports as proxy.

4) If monies are still remaining after direct funding has been allocated, indirect funding shall be allocated based on the priority of each tier, consistent with (G)(2). The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a) The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital; and
   b) The Medicaid-specific statewide average indirect cost per resident per month calculated in paragraph D for the program year using the most recent as-filed Medicare cost reports as proxy; and
   c) Twelve months.

5) To ensure that the program receives accurate funding, residents/fellows which receive funding first in paragraph G may additionally receive funding through paragraphs B, C, D, and F, but total number of residents/fellows funded shall not be greater than 100% of the total FTEs in that program.

6) Payments are made to participating hospitals based on the FTEs who worked at their hospitals per academic year.

H. For the period of July 1, 2022 to June 30, 2023, the AHCCCS Administration shall distribute $2,685,716 for hospitals located in counties of less than five hundred thousand persons for graduate medical education for new programs that began or for positions that were expanded on or after July 1, 2020. These distributions are supplementary to and do not supplant the appropriated amounts prescribed in paragraphs B, C, D, and F and the supplementary distributions are to be made in the following order of priority based on the number of residents and fellows in graduate medical education in the following manner.

1) Each resident and fellow will be placed into a tier with the following priority order:

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a) Returning residents and fellows. A returning resident or fellow is a resident or fellow whose position received funding under this section for the previous year and who is continuing in the same GME program.
b) Residents and fellows that are not a returning resident or fellow but are in a GME program for Family Medicine, Internal Medicine, General Pediatrics, Obstetrics and Gynecology, Psychiatry including Subspecialties, and General Surgery.
c) Residents or fellows that are not returning residents or fellows and are not described in subsection (1)(b) but are in a GME program that received funding under this section in a prior year.
d) All other residents and fellows.

2) Residents and fellows in the tiers described in 1(a) through 1(d) are further divided into 4 sub-tiers with the following priority order based on the location of the participating hospital:
   a) Hospitals in a county designated by the Health Resource and Services Administration of the U.S. Department of Health & Human Services as a HPSA with a greater than 85% primary care shortage
   b) Hospitals in a county designated as a HPSA with a greater than 50% to 85% primary care shortage.
   c) Hospitals in a county designated as a HPSA with a 25-50% primary care shortage.
   d) Hospitals in a county designated as a HPSA with a less than 25% primary care shortage.

3) Funds shall be allocated based on the priority of each tier and sub-tier. Distributions for eligible positions in a sub-tier with a lower priority will not receive a distribution until distributions are allocated for the costs of all positions in a higher sub-tier. If funding is insufficient to fully fund a sub-tier, the remainder of funds will be pro-rated for eligible positions within that sub-tier, based on the amount computed for each hospital that would have been reimbursable for that sub-tier if full funding were available. Distribution is made for each sub-tier, in priority order, within a tier before distribution to the next lower tier.
   a) Distributions for eligible positions in a sub-tier with a lower priority will not receive a distribution until distributions are allocated for the direct and indirect costs of all positions in a higher sub-tier.
   b) Distributions are made for each sub-tier, in priority order, within a tier before distribution to the next lower tier.

4) For the specific purpose of the direct GME costs in this paragraph (H), each hospital will separately report actual direct costs per resident per academic year for the qualifying new programs and positions, following the same principles in the MCRs associated with existing graduate medical education programs. The recognized costs

will only be for the participating hospital's FTEs in the new programs and positions qualifying under paragraph (H). Such costs will be further apportioned to Medicaid using the actual Medicaid utilization ratio (Medicaid inpatient days divided by total inpatient days) for the program year. AHCCCS may adjust the reported costs to be consistent with applicable Medicare cost principles.

5) The amount of the distribution for each GME program for indirect costs is calculated as the product of:
   a) The number of allocated eligible residents and fellows adjusted for the number of months or partial months worked in each hospital or non-hospital setting under agreement between the non-hospital setting and the reporting hospital;
   b) The Medicaid-specific statewide average indirect cost per resident per month calculated in paragraph D for the program year using the most recent as-filed Medicare cost reports as proxy; and
   c) Twelve months.

6) To ensure that the program receives accurate funding, residents/fellows who receive funding first in paragraph H may additionally receive funding through paragraphs B, C, D, and F, but total number of residents/fellows funded shall not be greater than 100% of the total FTEs in that program.

7) Payments are made to participating hospitals based on the FTEs who worked at their hospitals per academic year.

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I. 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%

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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. For rates effective on and after October 1, 2010, no inflation factor will be applied.

H. 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. A new hospital's statewide operating and capital components shall be updated annually by the DRI inflation factor. For rates effective on and after October 1, 2010, no inflation factor will be applied.

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B. Out-of-State Hospitals

Out-of-state hospitals providing covered services (excluding organ and transplantation services) to persons eligible for AHCCCS are paid by multiplying covered charges by the most recent state-wide urban cost-to-charge ratio (CCR). The CCR is updated annually by AHCCCS, with an October 1 effective date, using the most current Medicare cost-to-charge ratios published or placed on display by CMS by August 31 of that year.

Out-of-state hospitals providing covered organ and transplantation services to persons eligible for AHCCCS are paid based upon a fixed price per type of transplant with stop-loss provisions. Reimbursement rates are negotiated using the out of state provider's home state Medicaid reimbursement as a benchmark. At no time will payment exceed the hospital's billed charges.

V. PAYMENT TO FREESTANDING PSYCHIATRIC HOSPITALS

Psychiatric hospitals are paid a statewide per diem fee. AHCCCS rates were set as of October 1, 2015, and are effective for dates of admission on or after that date. AHCCCS rates for payments to freestanding psychiatric hospitals, including freestanding psychiatric hospitals that function solely as detoxification facilities, are published on the agency's website at

https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/behavioralhealthrates.html?id=Inpatient

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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VII. Temporary Rate Reduction

Notwithstanding the methods and rates as otherwise described in this attachment, for claims with dates of admission between April 1, 2011 and September 30, 2011, payments in the following categories will be reduced by 5% of the payments that would otherwise have been made under the methodology in effect as of October 1, 2010 as described in this attachment:

- Tiered per diem payments including tiered per diem payments to new hospitals,
- Cost to Charge ratios used to qualify and pay inpatient outliers.
- Payments to out-of-state hospitals

The following payments described in this attachment will not be subject to this 5% rate reduction:

- Transplant services,
- Specialty services,
- Direct Medical Education payments,
- Indirect Medical Education payments,
- Payments for services provided by the Indian Health Service or Tribal 638 Health facilities
- Payments to freestanding psychiatric hospitals

For claims with dates of admission effective from October 1, 2011 to September 30, 2014, the following payments will be at the payment rates in effect as of September 30, 2011, reduced by 5%:

- Tiered per diem payments including tiered per diem payments to new hospitals,
- Cost to Charge ratios used to qualify and pay inpatient outliers. For more information about Cost to Charge ratios, refer to page 6 of this Attachment.
- Payments to out-of-state hospitals
- Payments to freestanding psychiatric hospitals

The following payments described in this attachment will not be subject to this 5% rate reduction:

- Transplant services,
- Specialty services,
- Direct Medical Education payments,
- Indirect Medical Education payments,
- Payments for services provided by the Indian Health Service or Tribal 638 Health facilities

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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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Citation

42 CFR 447, 434, 438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Health Care-Acquired Conditions

The State identifies the following Health Care-Acquired Conditions for non-payment under Section 4.19 (A)

__X__ Hospital-Acquired Conditions as identified by Medicare other than Deep Vein Thrombosis (DVT)/Pulmonary Embolism (PE) following total knee replacement or hip replacement surgery in pediatric and obstetric patients.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Section(s) 4.19 (A)

__X__ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

____ Additional Other Provider-Preventable Conditions identified below

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Adjustment of Inpatient Hospital Reimbursement to Account for Non-payment of HCACs and OPPCs

In accordance with 42 CFR 447.26(c), no reduction in payment for a PPC will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. AHCCCS will use the Point of Admission (POA) indicator, as used by Medicare, to identify when a condition was acquired in the hospital.

Reductions in provider payment are limited to the extent that the State can reasonably isolate for nonpayment, the portion of the payment directly related to treatment for, and related to, the provider preventable conditions that would otherwise result in an increase in payment.

For HCACs and OPPCs: AHCCCS reimburses hospitals on a per diem basis. AHCCCS will identify potential HCACs and OPPCs, and perform medical review to determine whether or not they resulted in a longer length of stay or higher level of care. If it is determined that a HCAC or OPPC resulted in a longer stay or higher level of care, reimbursement of the related claim will be reduced to an amount commensurate with a stay and level of care had there been no HCAC or OPPC. AHCCCS will not claim FFP for expenditures for HCACs or OPPCs.

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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VIII. INPATIENT HOSPITAL PAYMENTS EFFECTIVE OCTOBER 1, 2014

A. Applicability

Except as specified in this paragraph, the inpatient payment method applies to all inpatient stays in all acute care hospitals. It does not apply to the following:

1. Stays in Indian Health Services (IHS) hospitals, or hospitals operated as 638 facilities, which are paid the all-inclusive rate published annually by IHS.
2. Stays in rehabilitation hospitals and long term acute care hospitals which, for the period October 1, 2014 through September 30, 2015, are paid on a per diem basis using the per diem rates that were in effect for each hospital on September 30, 2014, and thereafter are paid in accordance with Att. 4.19-A, page 27, paragraphs X and IX respectively.
3. Stays in psychiatric hospitals, which are paid on a per diem basis in accordance with the methodology described in Att. 4.19-A, page 11, paragraph V.
4. Stays associated with organ transplant services that are paid under contract, which are paid in accordance with the contract between AHCCCS and the transplant hospital.
5. Stays where the principle diagnosis is a behavioral health diagnosis, which are covered by a Regional Behavioral Health or Tribal Regional Behavioral Health Authorities in accordance with state law and which are paid on a per diem basis in accordance with the methodology described in Att. 4.19-A, page 11, paragraph V.

B. APR-DRG Reimbursement

For dates of discharge on and after October 1, 2014, inpatient hospital services will be reimbursed using the diagnosis related group (DRG) payment methodology. Each claim for an inpatient hospital stay will be assigned a DRG code and a corresponding DRG relative weight based on the All Patient Refined Diagnosis Related Group (APR-DRG) classification system established by 3M Health Information Systems. DRG payments made using this methodology shall be the sole reimbursement to the hospital for all inpatient hospital services and related supplies provided by the hospital. A hospital will not be reimbursed separately for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the patient is admitted as an inpatient to the same hospital directly from the emergency room, observation or other outpatient department.

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C. DRG Relative Weights

The APR-DRG methodology classifies inpatient stays into categories based on similar clinical conditions and similar levels of hospital resources required for treatment. The categories are identified using diagnosis-related group codes, each of which is assigned a relative weight appropriate to the relative amount of hospital resources expected to be used to treat the patient. Each claim is assigned to a DRG based on the patient's diagnoses, surgical procedures performed, age, gender, birth weight, and discharge status. An APR-DRG payment is determined by multiplying the DRG base rate by the DRG relative weight and any applicable policy adjustors. The DRG relative weights are posted on the AHCCCS website as of October 1, 2023 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

D. DRG Base Rate for Arizona Hospitals

The DRG base rate for each hospital other than those described in paragraphs 1 and 2 below is a statewide standardized amount adjusted by applying the hospital's wage index to the hospital's labor-related share. The hospital wage index and labor-related share are those published by Medicare on September 18, 2020 for the Medicare inpatient prospective payment system for the fiscal year October 1, 2020 through September 30, 2021, and will not be subject to annual updates. For the following described hospitals, the DRG base rate will be calculated in the same manner except that an alternative standardized amount will be used in place of the statewide standardized amount:

1. Hospitals that are licensed by the state of Arizona Department of Health Services as short-term hospitals, indicated by a license number beginning with the letters "SH." These hospitals typically practice in a limited, specialized field.

2. Hospitals that are located in a city with a population greater than one million, which on average have at least 15% of inpatient days for patients who reside outside of Arizona and at least 50% of discharges reimbursed by Medicare as reported on the hospital's Medicare Cost Report for the hospital's cost reporting period ending between January 1, 2011 and December 31, 2011.

If a hospital qualifies for D.1 or D.2, it is not eligible for the alternative standardized amounts outlined in D.3, D.4 or D.5.

The following described hospitals will have a DRG base rate calculated in the same manner as above except that a separate alternative standardized amount unique to each category below will be used in place of the statewide standardized amount starting January 1, 2023:

3. Hospitals that have one hundred or fewer inpatient beds, that is located in a county with a population of less than five hundred thousand persons and has greater than twenty percent of Medicaid inpatient reimbursement with a primary diagnosis of behavioral health in the prior federal fiscal year as of April 30th.

4. Hospitals with two separate Arizona Department of Health Services (ADHS) acute care hospital licenses, with one hospital that has one hundred or fewer beds, that is located in a county with a population of less than five hundred thousand persons and has one single AHCCCS registration for both ADHS licenses.

5. Unless in a qualifying group above, Hospitals that have one hundred or fewer inpatient beds, and that are located in a county with a population of less than five hundred thousand persons; or a hospital that is licensed as a critical access hospital.

The statewide standardized amount, the alternative standardized amount, and the DRG base rates for all hospitals are posted on the AHCCCS website as of October 1, 2023 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

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E. DRG Base Rate for Out-of-State Hospitals

The DRG base rate for high volume out-of-state hospitals will be calculated in the same manner as for Arizona hospitals, using the Arizona statewide standardized amount. A high volume out-of-state hospital is a hospital that is located in a county that borders the state of Arizona and had 500 or more AHCCCS-covered inpatient days for the fiscal year beginning October 1, 2015. The DRG base rate for all other out-of-state hospitals is posted on the AHCCCS website that is referenced in paragraph D.

F. Policy Adjustors

Where AHCCCS has determined that an adjustment to the base payment is appropriate to ensure access to quality care, a policy adjustor will be applied to the base payment. Firstly, AHCCCS will apply a provider policy adjustor of 1.110 times the base rate to all claims from hospitals that are high volume Medicaid providers. A high volume Medicaid provider is a hospital that had AHCCCS-covered inpatient days during the fiscal year beginning October 1, 2015 equal to at least four hundred percent of the statewide average number of AHCCCS-covered inpatient days at all hospitals, and had a Medicaid utilization rate greater than 30% as reported in the hospital's Medicare Cost Report for the hospital's cost reporting period ending between January 1, 2016 and December 31, 2016, and received less than $2 million in add-on payment for outliers for the fiscal year beginning October 1, 2015.These calculations include both Fee-For-Service and Managed Care Organization data. Secondly, and in addition to the provider policy adjustor if it applies, Effective October 1, 2022 AHCCCS will apply one of nine service policy adjustors where the claim meets certain conditions. The nine service policy adjustors, the conditions to which they apply, and the adjustment values are described below:

1. Normal newborn DRG codes: 1.70
2. Neonates DRG codes: 1.10
3. Obstetrics DRG codes: 1.55
4. Psychiatric DRG codes: 1.65
5. Rehabilitation DRG codes: 1.65
6. Burns DRG codes: 4.00
7. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 6 above and with severity of illness level 1 or 2: 1.25
8. Claims for patients under age 19 assigned DRG codes other than those described in items 1 through 6 above and with severity of illness level 3 or 4: 2.40
9. All Other Adjustor: 1.025

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G. DRG Initial Base Payment

A claim for an inpatient hospital stay will be assigned both a DRG code derived from all diagnosis and surgical procedure codes included on the claim and a DRG code derived by excluding diagnosis and surgical procedure codes associated with health care acquired conditions or other provider-preventable conditions listed in Att. 4.19-A, page 13. The DRG code with the lower relative weight will be used to process the claim. For each hospital stay, the DRG initial base payment equals the DRG base rate multiplied by the DRG relative weight and any applicable policy adjustors.
The DRG initial base payment may be subject to additional adjustments as described in the following paragraphs to produce a DRG final base payment.

H. Outlier Add-on Payments

Cases which are extraordinarily costly in relation to other cases within the same DRG due to the severity of illness or complicating conditions may qualify for an outlier add-on payment. A claim will qualify for an outlier add-on payment if the claim cost exceeds the outlier cost threshold. The claim cost is determined by multiplying the covered charges by the hospital's outlier cost-to-charge ratio. The outlier threshold is equal to the DRG base payment plus the fixed loss amount, where the DRG base payment for this purpose is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I. The fixed loss amounts for critical access hospitals and for all other hospitals are posted on the AHCCCS website as of October 1, 2023 at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html.

The outlier cost-to-charge ratios for all hospitals will be determined as follows:

1. For children's hospitals in Arizona, the outlier cost-to-charge ratio will be calculated by dividing the hospital's total costs by its total charges using the most recent Medicare Cost Report available as of September 1st each year.
2. For Critical Access Hospitals in Arizona, the outlier cost-to-charge ratio will be the sum of the statewide rural default operating cost-to-charge ratio and the statewide capital cost-to-charge ratio contained in the Medicare inpatient prospective payment system data file available as of September 1st each year.

3. For all other Arizona hospitals and for high volume out-of-state hospitals, the outlier cost-to-charge ratio will be the sum of the operating cost-to-charge ratio and the capital cost-to-charge ratio established for the specific hospital and contained in the Medicare inpatient prospective payment system impact file available as of September 1st each year.
4. For all other out-of-state hospitals, the outlier cost-to-charge ratio will be the sum of the Arizona statewide urban default operating cost-to-charge ratio and the Arizona statewide capital cost-to-charge ratio contained in the Medicare inpatient prospective payment system data file available as of September 1st each year.

AHCCCS will update the cost-to-charge ratios annually on October 1st each year. AHCCCS will not adopt any Medicare updates that CMS publishes subsequently for that payment year. Where a claim qualifies for an outlier add-on payment, the payment is calculated by subtracting the outlier threshold from the claim cost and multiplying the result by the DRG marginal cost percentage. The DRG marginal cost percentage is 90% for claims assigned DRG codes associated with the treatment of burns and 80% for all other claims.

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I. Transfer Payments

A transfer payment adjustment applies when a patient is transferred from a hospital that is subject to DRG reimbursement to another hospital that is subject to DRG reimbursement for inpatient care. The transferring hospital will be reimbursed the lesser of the DRG initial base payment and the DRG transfer payment. The DRG transfer payment is equal to the DRG initial base payment divided by the DRG national average length of stay for the assigned DRG code, multiplied by the actual length of stay plus one day. The receiving hospital will not be impacted by the transfer payment adjustment unless it transfers the patient to another hospital.

J. Prorated Payments

When a patient has Medicaid coverage for fewer days than the actual length of stay, the DRG payment will be prorated. The proration factor is determined as follows:

1. Where the patient is ineligible for Medicaid on the first day of the inpatient stay but is eligible for subsequent days during the inpatient stay, the proration factor is equal to the number of Medicaid-eligible days divided by the DRG national average length of stay for the assigned DRG code.
2. Where the patient is eligible for Medicaid on the first day of the inpatient stay but is ineligible for one or more days prior to or on the date of discharge, the proration factor is equal to the number of Medicaid-eligible days plus one day divided by the DRG national average length of stay for the assigned DRG code.

If the calculated proration factor is greater than one, the proration factor used for the payment calculation will be one. The DRG prorated payment is equal to the DRG base payment multiplied by the proration factor, where the DRG base payment for this purpose is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I. The DRG prorated outlier add-on payment is equal to the outlier add-on payment determined under paragraph H multiplied by the proration factor. Notwithstanding paragraph K, for the purpose of paragraphs J.1 and J.2 above, the day of discharge is included in determining the number of Medicaid-eligible days during an inpatient stay.

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K. Length of Stay Defined

For purposes of inpatient hospital reimbursement, the length of stay is equal to the total number of calendar days of an inpatient stay beginning with the date of admission and ending with the date of discharge or transfer, but not including the date of discharge or transfer unless the patient expires. A claim for inpatient services with an admission date and discharge date that are the same calendar date will be processed and reimbursed as an outpatient claim, unless the patient expired on the date of discharge.

M. DRG Final Payment

The DRG final base payment is the lesser of the DRG initial base payment determined under paragraph G and the DRG transfer payment determined under paragraph I, and multiplied by a proration factor if applicable. The DRG final outlier add-on payment is the outlier add-on payment determined under paragraph H, and multiplied by a proration factor if applicable. The DRG final payment amount is equal to the DRG final base payment amount plus the DRG final outlier add-on payment amount.

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N. Interim Payments

For an inpatient stay with a length of stay greater than 29 days, the hospital may submit interim claims for each 30 day period during the inpatient stay. In this case, the hospital will be reimbursed for interim claims at a per diem rate of $500 per day. Following discharge of the patient, the hospital must void all interim claims and AHCCCS will recoup the interim payments. Final payment will be determined under the DRG payment methodology.

O. New Hospitals

The DRG base rate for a new hospital is calculated in the same manner as other Arizona hospitals if the hospital's wage index and labor-related share are available in the Medicare inpatient prospective payment system; otherwise, the DRG base rate is the statewide standardized amount adjusted by applying the wage index and labor-related share appropriate to the physical location of the hospital. Likewise, the outlier cost-to-charge ratio for a new hospital is determined in the same manner as other Arizona hospitals if the hospital's operating cost-to-charge ratio is contained in the Medicare inpatient prospective payment system impact file; otherwise, the Arizona statewide urban or rural default operating cost-to-charge ratio, whichever is appropriate to the physical location of the hospital, will be added to the Arizona statewide capital cost-to-charge ratio to derive the outlier cost-to-charge ratio.

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P. Administrative Days and Readmissions

1. Administrative days are days of a hospital stay in which a patient does not meet the criteria for an acute inpatient stay, but is not discharged because an appropriate placement outside the hospital is not available or the patient cannot be safely discharged or transferred. Administrative days are reimbursed at the rate the claim would have paid had the services not been provided in an inpatient hospital setting but had been provided at the appropriate placement. In certain circumstances, a member has unique medical or behavioral health needs, and the cost of the care for those unique needs is not factored into the rate otherwise established for the appropriate non-hospital inpatient placement. In such circumstances, AHCCCS negotiates with the hospital for a rate no less than the rate for the appropriate non-hospital inpatient placement and no more than the rate that would otherwise be paid for a hospital inpatient stay, taking into consideration the comparable fee for service rate for the unique services.

2. If a patient is readmitted, without prior authorization, to the same hospital that the patient was discharged from within 72 hours and the DRG code assigned to the claim for the prior admission has the same first three digits as the DRG code assigned to the claim for the readmission, then payment for the claim for the readmission will be disallowed if a medical review determines the readmission could have been prevented by the hospital.

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IX. PAYMENT TO LONG-TERM ACUTE CARE HOSPITALS

Effective October 1, 2015, long-term acute care hospitals are paid a per diem rate which will be an intensive care unit (ICU) rate, a surgery rate, or a routine rate. A hospital is eligible to receive an ICU rate or a surgery rate if the hospital is licensed by the Arizona Department of Health Services to provide ICU or surgical services.

The ICU rate applies to inpatient days associated on the claim with revenue codes in the ranges 200-204, 207-212, and 219. The surgery rate applies to inpatient days associated on the claim with revenue codes 360-369 in combination with valid procedure codes that are not on the AHCCCS excluded surgery procedures list. The routine rate applies to all other inpatient days.

An outlier is a hospital claim on which the covered charges exceed the outlier threshold, which will be an ICU threshold, a surgery threshold, or a routine threshold. The outlier thresholds for long-term acute care hospitals are the thresholds that were in effect for those hospitals on September 30, 2014. Outliers shall be reimbursed by multiplying covered charges by the outlier cost-to-charge ratio. The outlier ratios will be the Final Statewide Average Total Cost-to-Charge Ratios for LTCHs in the data file published by CMS as part of the Medicare Long-Term Care Hospital Prospective Payment System for the prior fiscal year. The urban cost-to-charge ratio applies to hospitals located in Maricopa County or Pima County, and to out-of-state hospitals. The rural cost-to-charge ratio applies to all other hospitals.

AHCCCS rates were set as of October 1, 2023, and are effective for dates of admission on and after that date. AHCCCS rates and outlier thresholds for payments to long-term acute care hospitals are published on the agency's website at: https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/LTACrehab.html

X. PAYMENT TO REHABILITATION HOSPITALS

Effective October 1, 2015, rehabilitation hospitals are paid a statewide per diem rate.

An outlier is a hospital claim on which the covered charges exceed the outlier threshold. The outlier threshold for rehabilitation hospitals is the threshold that was in effect for those hospitals on September 30, 2014. Outliers shall be reimbursed by multiplying covered charges by the outlier cost-to-charge ratio. The outlier cost-to-charge ratios will be the Final Statewide Average Total Cost-to-Charge Ratios for LTCHs in the data file published by CMS as part of the Medicare Long-Term Care Hospital Prospective Payment System for the prior fiscal year. The urban cost-to-charge ratio applies to hospitals located in Maricopa County or Pima County, and to out-of-state hospitals. The rural cost-to-charge ratio applies to all other hospitals.

AHCCCS rates were set as of October 1, 2023, and are effective for dates of admission on and after that date. AHCCCS rates and outlier thresholds for payments to rehabilitation hospitals are published on the agency's website at: https://azahcccs.gov/PlansProviders/RatesAndBilling/FFS/LTACrehab.html

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XI. Hospital Rapid Whole Genome Sequencing (RWGS) Testing Reimbursement

Effective October 30, 2023 – July 30, 2026
Rapid whole genome sequencing testing provided in the inpatient hospital setting is excluded from the DRG payment. An additional payment for medically necessary RWGS will be made to a hospital when established clinical criteria is met. Costs associated with RWGS are to be billed separately from the inpatient episode. Hospital reimbursement will be made according to the Medicaid laboratory fee schedule. Rates for the period of October 30, 2023 – September 30, 2024 are posted at the following link: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

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A. **Overview**

As of October 1, 2023, through September 30, 2024 (Contract Year Ending (CYE) 2024), AHCCCS registered Arizona hospitals (other than the facilities described in section C. below) which meet Agency established value-based performance metrics requirements in section B. below will receive a Differential Adjusted Payment described in section D. below. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS Fee-For-Service reimbursement rates. These payment adjustments will occur for all dates of discharge in CYE 2024 (October 1, 2023 through September 30, 2024) only. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

B. Applicability

To qualify for the Inpatient Differential Adjusted Payment (DAP), a hospital providing inpatient hospital services must meet one of the following criteria:

1. Hospitals Subject to APR-DRG reimbursement (Up to 3.0%)

Hospitals, Provider Type 02, are eligible for DAP increases on all inpatient services under the following criteria:

Domain / % Increase	Description
a. Health Information Exchange Participation (1.5%)	Hospitals that meet the following milestones are eligible to earn a 1.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier (NPI), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the

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qualifying HIE on their behalf.

iv. Milestone #4: No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination.

v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital.

vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024.

For any milestone that includes electronic submission of patient information, the information transferred to the HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 and or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. All electronic submissions must be received through standard HL7 document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received.

If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.

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b. Social Determinants of Health Closed Loop Referral Platform (0.5%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: (For Hospitals that have participated in the DAP SDOH requirements for CYE 23) 1. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. 2. After go-live and through September 30, 2024, the hospital must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the hospital) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the hospital's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly. (For hospitals that have not participated in DAP SDOH requirements in CYE 2023) 1. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required and

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	2. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
c. Arizona Health Directives Registry (AzHDR) (0.5%)	Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. ii. Milestone #2: 1. For hospitals that have participated in DAP HIE requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization. b. After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry. 2. For hospitals that have not participated in DAP HIE requirements in CYE 2023: a. No later than November 1, 2023, complete the AzHDR Participant Agreement, and

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	b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Naloxone Distribution Program (0.5%)	Hospitals with an Emergency Department that meet the following milestones are eligible to earn a 0.5% DAP increase on all inpatient services. i. Milestone #1: No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP. iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.

2. Other Hospitals and Inpatient Facilities (Up to 4.5%)

Psychiatric Hospitals, with the exception of public hospitals, Provider Type 71; Subacute Facilities (1-16 Beds), Provider Type B5; Subacute Facilities (17+ beds), Provider Type B6; Rehabilitation Hospitals, Provider Type C4; Long Term Acute Care Hospitals, Provider Type C4 are eligible for DAP increases on all inpatient services under the following criteria. For purposes of Section 2, other inpatient facilities will be referred to as hospitals.

Domain / % Increase	Description
a. Health Information	Hospitals that meet the following milestones are eligible to earn a 1.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE)

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Exchange Participation (1.5%)	organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf. iv. Milestone #4: No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital. vi. Milestone #6: Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the

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	transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 and or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.
b. Social Determinants of Health Closed Loop Referral Platform (0.5%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: 1. For hospitals that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live, and through September 30, 2024, the hospital must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the hospital) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the hospital's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by

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	the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, tracked monthly. 2. For hospitals that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
c. Arizona Health Directives Registry (AzHDR) (0.5%)	Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: 1. For hospitals that have participated in DAP HIE requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization. b. After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024 Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry.

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	2. For hospitals that have not participated in DAP HIE requirements in CYE 2023: a. No later than November 1, 2023, complete the AzHDR Participant Agreement, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Inpatient Psychiatric Facility Quality Reporting Program (2.0%)	Hospitals that meet the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) performance measure will qualify for a DAP increase. On March 15, 2023, AHCCCS will download the most current data from the QualityNet.org website to identify Medicare's Annual Payment Update (APU) recipients. APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.
e. Long-term Care Hospital Pressure Ulcers Performance Measure (2.0%)	Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On March 15, 2023, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
f. Inpatient Rehabilitation Pressure Ulcers Performance Measure (2.0%)	Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On March 15, 2023, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.

3. **Critical Access Hospitals (up to 10.5%)**

Hospitals designated as a Critical Access Hospital (CAH), Non-IHS/638 hospitals by March 15, 2023 are eligible for up to a 10.5% DAP increase on all inpatient services under the following criteria.

Domain / % Increase	Description

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a. Health Information Exchange Participation (8.0%)	Hospitals that meet the following milestones and performance criteria are eligible to participate in this DAP initiative and earn a 8.0% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the facility's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf. iv. Milestone #4: No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital.

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	vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 and or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a hospital has already achieved one or more of the CYE 2023 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.
b. Social Determinants of Health Closed Loop Referral Platform (1.0%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: 1. For hospitals that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023.

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	b. After go-live, and through September 30, 2024, the hospital must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month , including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the hospital)per registered AHCCCS ID that resulted from utilizing the social-needs screening tool in CommunityCares or within the hospital's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements and tracked monthly. 2. For hospitals that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
c. Arizona Health Directives Registry (AzHDR) (1.0%)	Hospitals that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: 1. For hospitals that have participated in DAP HIE requirements in CYE 2023:

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	a. No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization. b. After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry. 2. For hospitals that have not participated in DAP HIE requirements in CYE 2023: a. No later than November 1, 2023, complete the AzHDR Participant Agreement, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Naloxone Distribution Program (0.5%)	Hospitals with an Emergency Department that meet the following milestones are eligible to earn a 0.5% DAP increase on all inpatient services. i. Milestone #1: No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP.

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	iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.

C. IHS/638 Facilities: DAP for IHS and 638 tribally owned and/or operated hospitals are described on page 28(o).

D. Payment Methodology

For hospitals receiving APR-DRG reimbursement (described in Section B.1 above), fee-for-service reimbursement rates may be increased up to a maximum of 3.0%. Reimbursement rates for inpatient services will be increased by 1.5% if they meet the HIE requirements, by 0.5% if they meet the AzHDR requirements, by 0.5% if they meet the SDOH closed loop referral platform requirements, and by 0.5% if they meet the Naloxone Distribution Program. These increases do not apply to supplemental payments.

For other hospitals and inpatient facilities (described in Section B.2 above), fee-for-service reimbursement rates may be increased up to a maximum of 4.5%. Payment rates for inpatient services will be increased by 1.5% if they meet the HIE requirements detailed in B.2.a., by 0.5% if they meet the SDOH closed loop referral platform requirements in B.2.b, and by 0. 5% if they meet the AzHDR requirements detailed in B.2.c. For inpatient psychiatric facilities, payment rates for services will be increased by 2.0% if they meet the Quality Reporting requirements detailed in B.2.d. For Long-Term Care Hospitals, payment rates for services will be increased by 2.0% if they meet the Pressure Ulcers Performance requirements detailed in B.2.e. For Inpatient Rehabilitation Hospitals, payment rates for services will be increased by 2.0% if they meet the Pressure Ulcers Performance requirements detailed in B.2.f. These increases do not apply to supplemental payments.

For critical access hospitals (described in Section B.3 above), fee-for-service reimbursement rates may be

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increased up to a maximum of 10.5%. Reimbursement rates for inpatient services will be increased by 8.0% if they meet the HIE requirements, by 1.0% if they meet the SDOH closed loop referral platform requirements, by 1.0% if they meet the AzHDR requirements, and by 0.5% if they meet the Naloxone Distribution Program requirements. These increases do not apply to supplemental payments.

Hospitals which submitted an HIE LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the HIE LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a hospital receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that hospital will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

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The following is a description of methods and standards for determining Differential Adjusted Payments for IHS/638 Tribally owned and/or operated facilities. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS rates. These payment adjustments will occur for all dates of service in Contract Year Ending (CYE) 2024 (October 1, 2023 through September 30, 2024) only.

1. IHS and 638 Tribally Owned and/or Operated Facilities (Up to 3.0%)

A. Applicability

Indian Health Service and/or Tribally owned and/or operated hospitals (Provider Type 02), by March 15, 2023, are eligible for a DAP increase on all services under the following criteria.

Domain / % Increase	Description
a. Health Information Exchange Participation (1.5%)	Hospitals that meet the following milestones are eligible to earn a 1.5% DAP. i. Milestone #1: No later than April 1, 2023 the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf. iv. Milestone #4: No later than May 1, 2023 the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information),

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	including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, the deadline for this milestone will be June 30, 2023. v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital. vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023 the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.
b.	Hospitals that meet the following milestones are eligible to earn a 0.5% DAP.

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Arizona Health Directives Registry (AzHDR) (0.5%)	i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. ii. Milestone #2: No later than November 1, 2023, complete the AzHDR Participant Agreement. iii. Milestone #3: No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
c. Social Determinants of Health Closed Loop Referral System (0.5%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required. iii. Milestone #3: No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.

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	If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Naloxone Distribution Program (0.5%)	Hospitals with an Emergency Department that meet the following milestones are eligible to earn a 0.5% DAP increase on all inpatient services. i. Milestone #1: No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for a NDP. iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.

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B. **Payment Methodology**

All payments may be increased up to a maximum of 3.0%. Payments will be increased by 1.5% if the IHS/Tribal 638 facility meets the HIE requirements, by 0.5% if it meets the AzHDR requirements, by 0.5% if it meets the SDOH requirements, and by 0.5% if it meets the Naloxone Distribution Program requirements. The proposed DAP for IHS/638 facilities would be applicable to the All- inclusive Rate (AIR). The DAP is not applicable to supplemental payments.

IHS/Tribal 638 facility which submitted an HIE LOI and received a DAP increase for CYE 2023 but failed to achieve one or more milestone in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a hospital receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that hospital will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

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Disproportionate Share Hospital Program

Congress established the Medicaid Disproportionate Share Hospital (DSH) program in 1981 to provide financial support to hospitals that serve a significant number of low-income patients with special needs.

This section sets forth the criteria by which Arizona defines DSH hospitals and the methodology through which DSH payments are calculated and distributed. The section is divided into the following major topics:

- Hospital eligibility requirements
- Data on a State Plan Year Basis
- Timing of eligibility determination
- Medicaid Inpatient Utilization Rate (MIUR) calculation (Overall and Group 1 and 1A eligibility)
- Low Income Utilization Rate (LIUR) calculation (Group 2 and 2A eligibility)
- Governmentally-operated hospitals (Group 4 eligibility)
- Obstetrician Requirements
- Payment
- Group 5 Eligibility Determination
- Aggregate Limits
- Reconciliations
- Certified Public Expenditures (CPEs)
- Grievances and appeals
- Other provisions

Hospital Eligibility Requirements

In order to be considered a DSH hospital in Arizona, a hospital must be located in the state of Arizona, must submit the information required by AHCCCS by the specified due date, must satisfy one (1) of the conditions in Column A, AND must satisfy one (1) of the conditions in Column B, AND must satisfy the condition in Column C.

COLUMN A	COLUMN B	COLUMN C
1. The hospital has a Medicaid Inpatient Utilization Rate (MIUR) which is at least one standard deviation above the mean MIUR for all hospitals	1. The hospital has at least two (2) obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric services to Medicaid	The hospital has an MIUR of at least 1 percent

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receiving a Medicaid payment in the state and is an IHS facility, tribally owned and/or operated facility, or an other federally owned or operated facility ("Group 1") 1.A. The hospital has a MIUR which is at least one standard deviation above the mean MIUR for all hospitals receiving a Medicaid payment in the state and is a privately owned or privately operated hospital licensed by the state of Arizona ("Group 1A") 2. The hospital has a Low Income Utilization Rate (LIUR) that exceeds 25% and is an IHS facility, tribally owned and/or operated facility, or an other federally owned or operated facility ("Group 2") 2.A. The hospital has a LIUR that exceeds 25% and is a privately owned or privately operated hospital licensed by the state of Arizona ("Group 2A")	patients 2. The hospital is located in a rural area, defined in accordance with Section 1923(d)(2)(B) of the Social Security Act, and has at least two (2) physicians with staff privileges to perform non-emergency obstetric procedures 3. The patients of the hospital are predominantly under 18 years of age 4. The hospital was in existence on December 22, 1987 but did not offer non-emergency obstetric services as of that date	

3. The hospital is a governmentally- operated hospital and is not an IHS facility, tribally owned and/or operated facility, or an other federally owned or operated facility. ("Group 4")		

Medicare Certification

In addition to the eligibility requirements outlined above, in order to receive payment under Medicaid, hospitals must meet the requirements for participation as a hospital in Medicare (except in the case of medical supervision of nurse-midwife services). Therefore, for purposes of DSH, the facility must be Medicare-certified during the state plan rate year for which the initial DSH payment is made.

If a facility is Medicare-certified for the full state plan rate year for which the initial DSH payment is made, but subsequently loses that certification, the facility remains eligible to receive the payment (together with any payment adjustments). If a hospital is only Medicare-certified for part of the state plan rate year for which the initial DSH payment is made, the eligibility and the payment will be calculated based on the period for which the hospital was Medicare- certified.

Data on a State Plan Year Basis

DSH payments are made based on the State Plan Year. The State Plan Year (or State Plan Rate Year or SPY) is equivalent to the Federal Fiscal Year and runs from October 1 to September 30 of each year. The calculations to determine eligibility for, and the amount of, DSH payments, will be made on the basis of the State Plan Year. When data is not available based on a State Plan Year, the calculations to determine eligibility for, and the amount of, DSH payments, will be performed separately for each hospital's fiscal year which encompass the SPY and these results will be prorated based on the distribution of months from each of the two years. For example, for SPY 2019(10/1/18 to 9/30/19), for a hospital that has a CMS 2552 Report year that runs from 7/1 to 6/30, the proration of the results of the calculations from the 2552 Report will be derived by summing:

1. $9/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/19, and
2. $3/12^{th}$ of the result of the calculations performed for the fiscal/CMS Report year ending 6/30/20.

Timing of Eligibility Determination

The eligibility determination calculations will be performed annually for all hospitals located in the state of Arizona that are registered as providers with AHCCCS that have submitted the information required by this document and/or as otherwise requested by AHCCCS during the application process. In order to be considered "submitted during the application process," the information must be received by AHCCCS by the due date specified in a request for information communicated to the Chief Financial Officer of the hospital. This does not preclude AHCCCS from using other information available to AHCCCS to verify or supplement the information submitted by the hospitals. The calculations will be performed with the information submitted by hospitals, or available to AHCCCS on the due date specified as the deadline for the submission of information.

The eligibility determination will be made in at least two steps:

1. The first step of the eligibility process will occur in the state plan year of the initial DSH payment. To determine initial eligibility, AHCCCS will:
    a. Extract from PMMIS all inpatient and outpatient hospital claims and encounters from the state plan year two years prior
    b. to the state plan year of the initial DSH payment. Based on the extracted claims and encounters data and data provided by the hospitals, determine for each hospital whether or not that hospital has a Medicaid Inpatient Utilization Rate (MIUR) of at least 1%. Based on certifications filed by each hospital, determine if the hospital satisfies the criteria in Column B above. For hospitals that qualify under this criteria, determine if the hospital:
        i. Meets the criteria for Group 1
        ii. Meets the criteria for Group 1A
        iii. Meets the criteria for Group 2
        iv. Meets the criteria for Group 2A
        v. Meets the criteria for Group 4
2. The second step of the eligibility process will occur in the state plan rate year two years after the state plan rate year of the initial DSH payment using the same steps above except that the data will be from the actual state plan year for which the DSH payment is made.

3. AHCCCS may redetermine any hospital's eligibility for any DSH payment should the agency become aware of any information that may prove that the hospital was not eligible for a DSH payment.

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MIUR Calculation (Overall Eligibility Criteria and Group 1 and Group 1A Eligibility)

A hospital's Medicaid Inpatient Utilization Rate (MIUR) will determine the hospital's overall eligibility for DSH (Column C above) as well as the hospital's eligibility for Group 1 and Group 1A. A hospital's MIUR is calculated using the following equation:

$$MIUR = \frac{\text{Total Medicaid Inpatient Days}}{\text{Total Number of Inpatient Days}}$$

The calculation will be performed based on the state plan year. AHCCCS will perform this calculation twice. The first calculation will be performed using data for the state plan year two years prior to the year of the initial DSH payment. The second calculation will be performed using data for the state plan year of the initial DSH payment. The CMS 2552 form(s) to be used is/are the most recent available cost report(s) that encompass the relevant state plan years.

AHCCCS may apply trending factors for the initial calculation to account for changes in utilization and/or population (e.g., due to changes in Medicaid eligibility criteria). The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

If a hospital has a MIUR of at least 1%, and the obstetrical criteria of Column B above are satisfied, it will meet the overall eligibility criteria. If a hospital has a MIUR which is at least one standard deviation above the mean MIUR for all Arizona hospitals receiving a Medicaid payment in that State Plan Year, it will meet the eligibility for Group 1 or 1A. Note that meeting overall eligibility criteria does not ensure that a hospital will meet the eligibility criteria for any Group.

In performing the calculations:

1. "Inpatient Days" includes:
    a. Fee-for-service and managed care days, and
    b. Each day in which an individual (including a newborn) is an inpatient in the hospital, whether or not the individual is in a specialized ward, and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.
2. AHCCCS will extract claims and encounter data for "Medicaid Inpatient Days" from PMMIS. The data extraction will be performed using dates of service as specified in the earlier section titled "Timing of Eligibility Determination," found in both step 1(a) and step 2.

    "Medicaid Inpatient Days" includes all adjudicated inpatient days for Title XIX beneficiaries, including days paid by Medicare.

3. For "Total number of inpatient days" data should be taken from hospital cost reports. The specific figures to be used are found on Worksheet S-3, Lines 1 and 8 through 13, Column 8 plus Line 16 through 18, Column 8 for hospital subprovider days.

Calculation of the mean MIUR and the Standard Deviation

In calculating the mean MIUR, the MIUR calculated for the state plan year for all Arizona hospitals that have received a Medicaid payment will be used. The mean MIUR – the average of the individual MIURs – will be calculated based on all the individual state plan year MIURs greater than zero (i.e. including the MIURs that are less than 1%). The standard deviation will be calculated based on the same list of individual hospital MIURs.

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LIUR Calculation (Group 2 and 2 A Eligibility)

A hospital's Low Income Utilization Rate (LIUR) will determine the hospital's eligibility for Group 2. A hospital's LIUR is calculated by summing the following two equations:

$$\text{LIUR} = \left| \frac{\text{Total Medicaid Patient Services Charges + Total State and Local Cash Subsidies for Patient Services}}{\text{Total Charges for Patient Services}} \right| + \left| \frac{\text{Total Inpatient Charges Attributable to Charity Care-Cash Subsidies Portion Attributable to Inpatient}}{\text{Total Inpatient Charges}} \right|$$

The calculation will be performed based on the state plan year.

If a hospital has a LIUR that exceeds 25% it will meet the eligibility for Group 2 or 2A. AHCCCS will perform this calculation twice. The first calculation will be performed using data for the state plan year two years prior to the year of the initial DSH payment. The second calculation will use data for the state plan year of the initial DSH payment. The CMS 2552 form(s) to be used is/are the most recent available report(s) that encompass the relevant state plan year.

AHCCCS may apply trending factors for the initial calculation to account for changes in utilization, population (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and/or Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid data and/or uninsured information. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

In performing the calculations:

1. "Total Medicaid Patient Services Charges" includes Title XIX charges for inpatient and outpatient services (both fee-for-service and managed care) extracted from PMMIS.

2. "Total Medicaid Patient Services Charges" does not include DSH payments or payments made for GME, Critical Access Hospitals, Rural Hospital Inpatient Payments or any other Title XIX supplemental payments authorized by the

Legislature as these amounts are effectively included in charges.

3. "Total State and Local Cash Subsidies for Patient Services" includes payments made with state-only or local-only funds. These payments include, but are not limited to
    a. Payments made for:
        i. Non-Title XIX and Non-Title XXI enrollees in the Comprehensive Medical and Dental Program (CMDP), this information is provided to AHCCCS from CMDP
        ii. Non-Title XIX and Non-Title XXI enrollees in the Behavioral Health Services Program
        iii. The support of trauma centers and emergency departments
    b. Payments reported by hospitals to AHCCCS which are made by:
        i. An appropriation of state-only funds
        ii. The Arizona State Hospital
        iii. Local governments including (but not limited to):
            (1) Tax levies dedicated to support a governmentally-operated hospital
            (2) Tax levies from a hospital district organized pursuant to A.R.S. § 48-1901 et seq.
            (3) Subsidies for the general support of a hospital

4. "Total State and Local Cash Subsidies for Patient Services" does not include payments for or by:
    a. Inpatient or outpatient services for employees of state or local governments
    b. Governmentally-operated AHCCCS health plans or program contractors
    c. Tax reductions or abatements

5. "Total Charges for Patient Services" includes total gross patient revenue for hospital services (including hospital subprovider charges) from hospital cost report(s). The specific figures to be used are found on Worksheet C Part I, Column 8 Line 200 less Lines 44 to 46, less Lines 88 to 89, less Lines 94 to 101, less Lines 105 to 112, and less Lines 115 to 117. If charges for Rural Health Clinics or Federally Qualified Health Centers appear anywhere other than on Lines 88 to 89, these charge amounts should also be deducted from Line 200.

6. "Total Inpatient Charges Attributable to Charity Care" includes the amount of inpatient services – stated as charges – that is provided free to individuals who cannot afford health care due to inadequate resources as determined by the hospital's charity care policy and do not otherwise qualify for government subsidized insurance. In order to qualify as charity care, payment may neither be received nor expected. This data is taken from the hospital claims and financial records submitted with information requested by AHCCCS during the application process.

7. "Total Inpatient Charges Attributable to Charity Care" does not include bad debt expense or contract allowances and discounts offered to third party payers or self pay patients that do not qualify for charity care pursuant to the hospital's charity care policy.

8. "Cash Subsidies Portion Attributable to Inpatient" means that portion of "Total state and Local Cash Subsidies for Patient Services" that is attributable to inpatient services. Data should be taken from the hospital claims and financial records submitted with information requested by AHCCCS during the application process. If the hospital receives subsidies for the general operation of the hospital, allocation between outpatient and inpatient should be based on the percentage of total inpatient charges to total charges from patient services.

9. "Total Inpatient Charges" includes total inpatient and hospital subprovider charges without any deductions for contract allowances or discounts offered to third party payers or self pay patients. Data should be taken from hospital cost report(s). The specific figures to be used are found in Worksheet C, Part I, Column 6 Line 200 less Lines 44 to 46, less Lines 88 to 89, less Lines 94 to 101, less Lines 105 to 112, and less Lines 115 to 117. If charges for Rural Health Clinics or Federally Qualified Health Clinics appear anywhere other than on Lines 88 to 89, these charge amounts should also be deducted from Line 200.

Governmentally-Operated Hospitals (Group 4 Eligibility)

Because the state has designated all governmentally-operated hospitals (represented in Group 4) as DSH hospitals, no eligibility calculations are required other than the minimum qualifications in columns B and C.

Obstetrician Requirements

In order to ensure that hospitals receiving DSH payments meet requirements related to obstetricians, all hospitals that are determined to have a MIUR of at least 1% must file a completed certification statement indicating their compliance with the requirements. Any hospital that fails to return the certification statement by the date specified by AHCCCS will not be eligible to receive DSH payments for the state plan year of the initial DSH payment.

For the determination of a hospital's compliance with the obstetrician requirement, the certification will be based on the state plan year of the initial DSH payment from the start of the state plan year to the date of certification.

The certification statement shall incorporate the following language:

I certify that the hospital indicated below currently has and has had since the beginning of the current state plan year at least two (2) obstetricians with staff privileges who have agreed to provide obstetric services to individuals eligible for Medicaid, OR

I certify that the hospital indicated below is located in a rural area and currently has and has had since the beginning of the current state plan year at least two (2) qualified physicians with staff privileges who have agreed to provide non-emergency obstetric services to individuals eligible for Medicaid, OR

I certify that the hospital indicated below did not offer non-emergency obstetric services to the general population as of December 22, 1987, or that the inpatients of the hospital are predominantly individuals under 18 years of age.

Payment

Pools and Changing Payment Levels

The DSH program in Arizona is funded through a six pool system. With the exception of Group 5, each of the pools correlates to one of the hospital eligibility Groups. The amounts of funding for the pools for the current state plan year are contained in Exhibit 3.

When determining the payment amounts, hospitals in Group 1 and 2 will be calculated concurrently, and if a hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment. When determining the payment amounts, hospitals in Group 1A and 2A will be calculated concurrently, and if a hospital qualifies for more than one pool, the hospital will be categorized into the pool that maximizes its DSH payment.

There are five instances where the initial DSH payment to one or more non-governmental hospitals may change:

1. A hospital is found on the second eligibility determination (or any subsequent eligibility check) to not be eligible for a DSH payment in the state plan year of the initial DSH payment. In this instance, the amount of payment to the hospital will be recouped and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the ineligible hospital was placed in the state plan year of the initial DSH payment, up to each hospital's OBRA limit (see discussion below).

2. A hospital is found to have exceeded its finalized OBRA limit (see discussions below). In this instance, the amount of payment to the hospital in excess of its finalized OBRA limit will be recouped, and the recouped amount will be distributed proportionately based on the initial DSH payments to the eligible hospitals remaining in the pool in which the hospital was placed in the state plan year of the initial DSH payment, up to each hospital's finalized OBRA limit.

3. In the event of a recoupment of an initial DSH payment and as a result of the process of distributing the recoupment to the pool to which the recouped payment was originally made, the distribution would result in all the hospitals in the pool receiving a total DSH payment in excess of their finalized OBRA limit, the amount of recoupment will be proportionately allocated among the remaining non-governmental hospital pools based on the initial DSH payments and distributed proportionately based on the initial DSH payments to the hospitals in the remaining non-governmental pools up to each hospital's finalized OBRA limit.

4. In the event that litigation (either by court order or settlement), or a CMS audit, financial review, or proposed disallowance requires AHCCCS to issue DSH payment amounts to one or more hospitals in a pool in excess of the initial DSH payment amount, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement. This process will be followed to ensure that the annual federal DSH allotment is not exceeded.

5. In the event that a hospital qualifies for a DSH payment in the second (or any subsequent) eligibility determination that did not qualify in the initial eligibility determination, that hospital will receive the minimum payment under the DSH program which is $5,000. AHCCCS may set aside monies from the initial payment to make these minimum payments. AHCCCS may use monies which were set aside for hospitals which did not qualify for the initial determination but qualified in subsequent determinations. In the event that monies set aside are insufficient to provide the minimum payments, AHCCCS will proportionately recoup funds based on the initial DSH payments from the remaining hospitals in the pool or pools effected to satisfy the requirement.

The payment amount to each governmentally-operated hospital will be determined during the state plan year of the initial DSH payment. The payment amount will only change if the total DSH payment to a hospital in the pool would be in excess of its finalized OBRA limit (see discussion below). To the extent that the excess amount recouped from a governmentally-operated hospital can be distributed to other hospitals in the pool without exceeding the interim or finalized OBRA limits of the remaining governmentally-operated hospitals, the excess amount will be distributed to the other governmentally-operated hospitals.

Recoupment of Pool 5 payments for any of the above instances, however, would not be redistributed

Determination of Payment Amounts

The amount that each non-governmental hospital receives as an initial DSH payment from the pool for which it qualifies is determined by a weighting method that considers both the amounts/points over the Group threshold and the volume of services. The volume of services is either measured by Title XIX days or net inpatient revenue, depending upon the group being considered.

Hospitals that qualify for Group 1, 1A, 2, or 2A

There are ten steps to determining the DSH payment amount for hospitals that qualify for Group 1, 1A, 2, or 2A. After determining the initial DSH payment amount through the ten step process, there is a final adjustment that may be made depending on the result of the hospital's OBRA limit. These steps will need to be performed separately: once for Groups 1 and 2 and once for Groups 1A and 2A.

1. Determine Points Exceeding Threshold.
   Each of the Groups 1 and 2 has thresholds established for qualification of the hospital. For Group 1 it is one standard deviation above the mean MIUR; for Group 2 it is greater than 25% LIUR. Step 1 merely determines the difference between each hospital's "score" for the Group measure and that Group's threshold.

2. Convert Points Exceeding Threshold into a Value.
   Each of the Groups 1 and 2 are measuring a value: for Group 1 the value is Medicaid days; for Group 2 it is charges. Step 2 multiplies the Points Exceeding Threshold by the value of the associated Group.

3. Determine Relative Weight of Each Hospital in Each Group.
   The relative weight of each hospital in each Group is determined by dividing each hospital's value for a Group determined in Step 2 by the total of all hospital values for that Group.

4. Initial Allocation of Dollars to Each Hospital in Each Group.
   The amount of funds available to each of the Groups 1 and 2 is determined by AHCCCS as authorized by the Legislature. The funding amount for the current state plan year is contained in Exhibit 3. The initial allocation to each hospital in each group is determined by multiplying each hospital's relative weight in a Group (determined in Step 3) by the amount of funds available for that Group.

5. Maximize Allocation of Dollars Between Group 1 and Group 2.

This step selects the greater of the allocation to each hospital between Group 1 and Group 2.

6. Recalculating the Relative Weights of Each Hospital in Group 1 and Group 2.
   Since Step 5 eliminated hospitals from both Group 1 and Group 2, it is necessary to redetermine the weight for each remaining hospital. This is accomplished by dividing the value of each hospital remaining in Group 1 and Group 2 after Step 5 by the total of the remaining hospitals.

7. Second Allocation of Dollars Within Group 1 and Group 2.
   The second allocation to each hospital remaining in Group 1 and Group 2 is determined by multiplying each hospital's recalculated relative weight pursuant to Step 6 by the amount of funds available for that Group.

8. Identifying Minimum Payment.
   It is policy that the minimum payment made to any hospital qualifying for DSH is $5,000. This step identifies any amount thus far determined for any hospital that is less than $5,000.

9. Ensuring Minimum Payment.
   This step replaces any amount thus far determined for any hospital that is less than $5,000 with a $5,000 amount.

10. Determining Penultimate Payment Amount.
    With the replacement of values with the $5,000 minimum amounts, it is necessary to recalculate and redistribute the values within any Group where the minimum payment amount was imposed in order to ensure that the total funding for a Group is not exceeded. Step 10 accomplishes this.

After determining the penultimate initial DSH payment amount for each hospital that qualifies for Group 1, 1A, 2, or 2A a check of the determined amount is made against the hospital's initial OBRA limit. The description of that limit follows in a subsequent section. If the initial DSH payment amount exceeds the initial OBRA limit, the initial DSH amount is set to the OBRA limit and the excess amount is distributed to the remaining hospitals in the Group, with a recheck of the initial DSH amounts against the OBRA limit. This process is repeated until all amounts are distributed or all hospitals in the Group are at their OBRA limit.

Hospitals that qualify for Group 4

To determine the initial DSH payment amount for each governmentally-operated hospital, the relative allocation percentage for each hospital is computed based on the lesser of the hospital's CPE and the amount of funding specified by the Legislature. The total funding amount for the current state plan year for Group 4 is contained in Exhibit 3. The funding amount for the IMD hospital in Group 4 is the IMD DSH limit for Arizona. The funding amount for the other governmentally-operated hospital in Group 4 is the remainder of the Group 4 pool amount, including any amount unclaimed by the IMD hospital.

OBRA Limits

The DSH payment ultimately received by qualifying non-governmental hospitals is the *lesser* of the amount calculated pursuant to the above-described methodologies or the hospital's OBRA limit. The DSH payment ultimately received by governmentally-operated hospitals is the *lesser* of the amount funded and specified by the Legislature or the hospital's finalized OBRA limit. All DSH payments are subject to the federal DSH allotment.

The OBRA limit is calculated using the following equation:

Uncompensated Care Costs Incurred Serving Medicaid Recipients
+
Uncompensated Care Costs Incurred Servicing the Uninsured

Pursuant to the above equation, the OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The OBRA limit for the state plan year of the initial DSH payment will be computed for each hospital up to three times:

1. The OBRA limit will be calculated in the state plan year of the initial DSH payment for all eligible hospitals based on the cost report(s) and days and charges and other program data for the state plan rate year two years prior to the state plan year of the initial DSH payment
2. For governmentally-operated hospitals, the OBRA limit will be recalculated when the cost report for the state plan year of the initial DSH payment is filed
3. The final calculation of each hospital's OBRA limit will be performed when the cost report for the state plan year of the initial DSH payment is finalized

The steps to computing the OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine cost center-specific per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.

2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by each hospital from its claims and financial records, other systems, and the cost report.

The sum of each hospital's Medicaid shortfall (whether positive or negative) and uninsured costs (whether positive or negative) is that hospital's OBRA limit.

The Medicaid Shortfall

The data used to calculate the Medicaid shortfall is extracted from the cost report(s) as well as from the AHCCCS PMMIS and other AHCCCS financial reporting systems.

The information from AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days for each inpatient routine service cost center on the cost report
2. The number of Medicaid managed care inpatient hospital days for each inpatient routine service cost center on the cost report
3. The Medicaid inpatient and outpatient hospital FFS charges for each ancillary cost center on the cost report
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for each ancillary cost center on the cost report
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by managed care organizations for inpatient and outpatient hospital services

9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan year under review (e.g. GME, CAH, etc.)
10. AHCCCS may apply trending factors for the initial payment to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid and/or uninsured information. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

For each hospital, the cost-center-specific per diems and ratios of cost to charges (RCC) from the cost report will be applied to the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services. The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B, Part I Column 24 Lines (and where applicable Subscript Lines) 30 to 35 and Lines 40 to 43
- By
- The corresponding day totals on Line 1, Lines (and where applicable Subscript Lines) 8 through 13 and Lines 16 to 18(for inpatient hospital subproviders) from Worksheet S-3, Part I Column 8.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet B, Part I Column 24
2. By
3. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet C, Part I Column 8

Costs will be offset by the payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services as well as payments made by AHCCCS including FFS payments and payments by managed care

organizations, made for the state plan year. Amounts for supplemental payments (such as GME, Rural Hospital Inpatient Payment and CAH) will be those made for the SPY. During the initial calculation, AHCCCS may use actual data if available as opposed to two years prior payments.

Uninsured Costs

Each hospital will collect and submit to the state uninsured days and charges and program data for the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the DSH calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state are subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (under either Title XIX or Title XXI) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payer types that are included in the uninsured data compilation, and

- An electronic file that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted during the application process to the financial records of the hospital

The uninsured costs will be calculated for each hospital. The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (this will be accumulated for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (this will be accumulated for each ancillary cost center on the cost report)
3. The amounts of payments received during the state plan year by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)
4. AHCCCS may apply trending factors for the initial payment to account for changes in utilization (e.g., due to changes in Medicaid eligibility criteria), supplemental payments, and Medicaid payments and rates. The adjustments may increase or decrease the days, costs, charges, or payments reflected on the cost reports, Medicaid and/or uninsured information. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior.

For each hospital the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid) will be applied to the data collected by the hospital to determine the uninsured costs.

Costs will be offset by the payments received during the state plan year from or on behalf of patients and payments received during the state plan year from third parties related to all uninsured inpatient and outpatient hospital services. Payments made by state or local government are not considered a source of third party payment.

The OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured

costs (whether positive or negative) is the hospital's OBRA limit.

Group 5 Eligibility Determination

The Administration will make additional payments, as specified in Exhibit 3, for hospitals that qualify for funding in Groups 1, 1A, 2, 2A, or 4. Group 5 DSH payments are in addition to the Groups 1, 1A, 2, 2A, and 4 DSH payments, but no individual hospital will receive aggregate DSH payments that exceed its OBRA limit. For hospitals that qualify for Group 5, a "LOM" score will be calculated by multiplying the hospital's LIUR times the hospital's full OBRA limit, times the hospital's MIUR.

Example: Hospital A
OBRA = $50,000,000, MIUR = 0.3500, LIUR = 0.3000
Group 5 LOM score for Hospital A = $50,000,000 x 0.3500 x 0.3000 = $5,250,000

For the first round of distributions, each participating hospital's percentage of the total LOM score will be calculated using the hospital's LOM score as the numerator and the total of all participating hospitals' LOM scores as the denominator. Allocations will initially be provided to qualifying hospitals located outside of the Phoenix and Tucson metropolitan statistical areas.

The total amount of DSH available for Group 5, as specified in Exhibit 3 to Attachment C, will be multiplied by each hospital's LOM percentage of this first round. If the allocation is higher than a hospital's OBRA limit (remaining after Group 1, 1A, 2, 2A, and 4 DSH distributions) or higher than the maximum amount allocated for the hospital in Exhibit 3 in Attachment C, the lower of those three limits will be recorded as the allocation for round one.

For subsequent rounds which will be also open to qualifying hospitals located in the Phoenix and Tucson metropolitan statistical areas, only the hospitals that have not hit their OBRA limit or the maximum amount allocated for the hospital in Exhibit 3 in Attachment C will be considered. The LOM score for those hospitals will be totaled. Each hospital's percentage of the total LOM score for that round will be calculated. The total amount of Group 5 DSH funds remaining for that round, as specified in Exhibit 3 in Attachment C, will be multiplied by each hospital's LOM percentage for that round. If any allocation from any round is higher than a hospital's remaining OBRA limit remaining total computable matching funds for that hospital or the maximum amount allocated for the hospital in Exhibit 3 in Attachment C, the lower of those three limits will be recorded as the allocation for that round. Distribution rounds will continue until all Group 5 DSH funds for the hospitals are distributed, or all hospitals have reached their individual OBRA limits or the maximum amount allocated for the hospital in Exhibit 3 in Attachment C, whichever comes first.

The Administration will specify the hospitals which may be eligible for Group 5 and the amount of funding in Exhibit 3 to Attachment C. The Administration may include multiple pools within Group 5, to be specified in Exhibit 3.

Any Group 5 payment made to a hospital which qualifies for Group 4 will be accounted for as an offset in the CPE computation under Group 4.

Aggregate Limits

IMD Limit

Federal law provides that aggregate DSH payments to Institutions for Mental Diseases (IMDs) in Arizona is confined to the *lesser* of $28,474,900 or the amount equal to the product of Arizona's current year total computable DSH allotment and 23.27%. Therefore, DSH payment to IMDs will be reduced proportionately to the extent necessary to ensure that the aggregate IMD limit is not exceeded.

"Institutions for Mental Diseases" includes hospitals that are primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

Overall Total Limit

The federal government shares in the cost of Medicaid DSH expenditures based on the Federal Medical Assistance Percentage (FMAP) for each state. However, for each fiscal year, the amount of federal funds available to states for DSH payment is fixed. As such, the total amount of DSH payments for a state plan rate year will not exceed the federal allotment divided by the FMAP.

Reconciliations

The initial DSH payment issued to a hospital by AHCCCS is considered "interim" and is subject to different reconciliation methodologies depending upon whether the hospital is non-governmental or governmentally-operated. The payments to hospitals are generally made as a single lump sum payment that is made once the calculations of the payment amounts are completed. The purpose of the interim DSH payment is to provide reimbursement that approximates the Medicaid and uninsured inpatient hospital and outpatient hospital uncompensated care costs eligible for Federal Financial Participation (FFP).

The reasons for a change in the initial (or interim) DSH payment for both non-governmental and governmentally-operated hospitals are outlined above under "Pools and Changing Payment Levels".

If it is determined that the total amount of payments made to non-governmental hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of all finalized non-governmental hospital OBRA limits, the amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

If it is determined that the total amount of payments made to governmentally-operated hospitals under the methodology outlined in the "Pools and Changing Payment Levels" exceeds the amount of either:

1. All governmentally-operated hospital OBRA limits calculated based on the "finalized" cost report, or
2. The total amount of certified public expenditures of governmentally-operated hospitals, then
3. The amount in excess will be recouped by AHCCCS and any associated federal funding claimed will be properly credited to the federal government.

Certified Public Expenditures

Expenditures by governmentally-operated hospitals shall be used by AHCCCS in claiming FFP for DSH payments under Pool 4 to the extent that the amount of funds expended are certified by the appropriate officials at the governmentally-operated hospital.

The method for determining a governmentally-operated hospital's allowable uncompensated care costs eligible for DSH reimbursement when such costs are funded through the certified public expenditure (CPE) process will be the same as the method for calculating and reconciling the OBRA limit for governmentally-operated hospitals set forth above.

However, because governmentally-operated hospitals are certifying expenditures for the state plan year of the initial DSH payment and final expenditures may not be known at the time of initial certification of public expenditures, governmentally owned hospitals may certify an amount of expenditures for the initial DSH payment based on an estimate of the OBRA limit for the state plan year of the initial DSH payment.

In certifying estimates of public expenditure for the initial DSH payment, the governmentally operated hospital will first calculate its expenditures based on the methodology for calculating the OBRA limit for the state plan year two years before the state plan year of the initial payment (as specified in the protocols in Exhibit 1 or Exhibit 2) and then provide for adjustments to such OBRA limit. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS.

In order to use CPE, the certifying governmentally-operated hospital must follow the protocol in Exhibit 1 or Exhibit 2 and provide a certification as to the amount of allowable uncompensated care costs eligible for DSH reimbursement. If CPE is used, the amount of expenditures used to determine the FFP will not exceed the amount of the CPE.

The payment of FFP to governmentally-operated hospitals is subject to legislative appropriation.

Grievances and Appeals

The state considers a hospital's DSH eligibility and DSH payment amount to be appealable issues. A DSH eligibility list along with the initial DSH payment amounts that eligible hospitals have been calculated to receive will be distributed. Hospitals will be permitted thirty (30) days from distribution to appeal their DSH eligibility and payment amounts. Because the total amount of DSH funds is fixed, the successful appeal of one DSH hospital will reduce DSH

payment amounts to all other providers. Once the final reconciliation process is completed, no additional DSH payment will be issued.

Other Provisions

Ownership

DSH payment will only be issued to the entity which is currently registered with AHCCCS as a participating hospital provider. Therefore, it is expected that facilities will consider this information when negotiating ownership changes.

AHCCCS Disproportionate Share Hospital (DSH) Payments
Exceptions

An exception to the use of the Medicare Cost Report (Form CMS 2552-10) as a data source shall apply to:

I. Hospitals that:

- Serve patients that are predominantly under 18 years of age, and
- Are licensed for fewer than 50 beds, and
- Do not file a comprehensive Form CMS 2552-10 (Medicare Cost Report), and
- Receive an acceptance letter from the CMS fiscal intermediary for the portion of the CMS 2552-10 (Medicare Cost Report) that the hospital does file with the fiscal intermediary, and
- Receive written permission from AHCCCS to invoke the provisions of this exception.

Such hospitals may extract data from their financial records in lieu of extracting data from the Form CMS 2552-10 (Medicare Cost Report) as provided in this Attachment C.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-10. All other non-Medicare Cost Report data and documentation as described in this Attachment C shall be required from such hospitals.

II. Indian Health Service (IHS) Hospitals and tribally-operated 638 hospitals who do not file a full Form CMS 2552-10 Medicare Cost Report but rather file an abbreviated Medicare cost report in accordance with Medicare Provider Reimbursement Manual, Part I, Section 2208.1.E (Method E cost report).

Such IHS Hospitals and tribally-operated 638 hospitals can submit a Private Facility Information Sheet (PFIS) to AHCCCS using data from the IHS Method E report that is filed with CMS aswell as supporting hospital financial reports, as necessary.

The method of extracting and compiling the data from the hospital's financial records shall conform to the instructions for the Form CMS 2552-10. All other non-Medicare Cost Report data and documentation as described on the PFIS cover sheet will be required by such hospitals.

DSH Exhibit 1:
AHCCCS
Disproportionate Share Hospital Payment Methodology
Calculation of OBRA Limits for
Governmentally-Operated Hospitals for the Purpose of
Certified Public Expenditures

Each governmentally-operated hospital certifying its expenditures for Disproportionate Share Hospital (DSH) payments shall compute and report its OBRA limit as prescribed by this Exhibit. The governmentally-operated hospital's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient and outpatient hospital services to individuals with no source of third party coverage for the inpatient and outpatient hospital services they received (uninsured costs).

The steps to computing the governmentally-operated hospital's OBRA limit are[3]:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). Each hospital must complete the cost report to determine per diems (for inpatient routine services) and ratios of cost to charges (RCC) (for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and charges and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.

Finally, the governmentally-operated hospital will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, the governmentally-operated hospital may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All

adjustments must be supported by adequate explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS during the application process, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan year(s) under review.

The Medicaid Shortfall

AHCCCS will provide each governmentally-operated hospital with a report from PMMIS and other agency financial reporting systems to assist each governmentally-operated hospital in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days for each inpatient routine service cost center on the cost report
2. The number of Medicaid managed care inpatient hospital days for each inpatient routine service cost center on the cost report
3. The Medicaid inpatient and outpatient hospital FFS charges for each ancillary cost center on the cost report. Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
4. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital FFS services
5. The amounts of Medicaid payments made by AHCCCS for inpatient and outpatient hospital FFS services
6. The Medicaid inpatient and outpatient hospital managed care charges for each ancillary cost center on the cost report. Inpatient and outpatient Medicaid charges will not include charges reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.
7. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services for health plans and program contractors
8. The amounts of Medicaid payments made by managed care organizations for inpatient and outpatient hospital services
9. Other amounts of Medicaid payments for Medicaid inpatient and outpatient services furnished during the Medicaid state plan year under review (e.g. GME, CAH, etc.)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data extracted from PMMIS (days and charges) to determine the cost of providing inpatient and outpatient Medicaid services. Inpatient and outpatient Medicaid services will not include services reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services.

The per diem amounts will be calculated by dividing:

- The individual amounts on Worksheet B, Part I Column 24 Lines (and where applicable Subscript Lines) 30 to 35 and Lines 40 to 43
- By
- The corresponding day totals on Line (and where applicable Subscript Line) 1, Lines 8 through 13 and Lines 16 to 18 (for inpatient hospital subproviders) from Worksheet S-3, Part I, Column 8.

Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part I, Column 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary RCCs will be calculated by dividing:

1. The individual Line and Subscript amounts for each of the Lines 50 to 76 and Lines 90 to 93 taken from Worksheet B, Part I, Column 24
2. By
3. The individual Line and Subscript amounts for each of the Lines 50 to 76and Lines 90 to 93 taken from Worksheet C, Part I, Column 8

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient and outpatient hospital services,
3. The Medicaid inpatient and outpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments related to inpatient and outpatient hospital services (e.g., GME and CAH, etc.)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall

for a future state plan year.

Uninsured Costs

Each governmentally-operated hospital will collect and submit to the state uninsured days and charges and program data for the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient and outpatient days and charges and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient and outpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days, charges and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When providing uninsured days, charges and program information hospitals should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient and outpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (under either Title XIX or Title XXI) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

When submitting uninsured days, charges and program information hospitals should accompany the submission with:

- A listing of all payer types that are included in the uninsured data compilation, and

- An electronic file that contains sufficient claims or other information (e.g. ICNs) to enable an auditor to tie the amounts submitted during the application process to the financial records of the hospital

The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for each inpatient routine service cost center on the cost report)
2. The uninsured inpatient and outpatient hospital ancillary charges (for each ancillary cost center on the cost report)
3. The amounts of payments received during the the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services. The information collected shall:
    a. Include payments received during the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

Each governmentally-operated hospital will use the cost center-specific per diems and ratios of cost to charges (RCC) from the cost report (as determined for Medicaid), the uninsured days and charges, and other program data collected by the governmentally-operated hospital to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The governmentally-operated hospital specific uninsured inpatient and outpatient cost data,
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient and outpatient hospital services, and
3. The uninsured inpatient and outpatient cost.
4. Adjustments to the calculated uninsured inpatient and outpatient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA

Limit and CPE Schedule.

Certification

The appropriate official of the governmentally-operated hospital will sign the certification statement on the Governmentally-Operated Hospital OBRA Limit and CPE Schedule. A certification will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan year of the initial DSH payment will be computed for each governmentally-operated hospital three times:

1. The OBRA limit will be calculated in the state plan year of the initial DSH payment based on the cost report(s) and days and charges and other program data for the state plan year two years prior to the state plan year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan year two years prior to the state plan year of the initial DSH payment in order to estimate the OBRA limit of the state plan year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as- filed cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan year of the initial DSH.
3. The final calculation of each governmentally-operated hospital's OBRA limit will be performed when the cost report(s) for the state plan year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days, charges, and payments) from the actual cost reporting period(s) will be used in the calculation.

DSH Exhibit 2:
AHCCCS
Disproportionate Share Hospital Payment Methodology
Calculation of OBRA Limits for
Arizona State Hospital
A Hospital with a Per Diem Ancillary Cost Allocation Method
Approved by Medicare

Arizona State Hospital (ASH), a governmentally-operated hospital that is an all-inclusive rate provider under Medicare, shall compute, report and certify its OBRA limit as prescribed by this Exhibit. Because ASH only provides inpatient services, the OBRA limit will by calculated based only on inpatient information. ASH's OBRA limit is comprised of two components:

1. The amount of uncompensated care costs associated with providing inpatient hospital services to Medicaid individuals (the Medicaid shortfall), and
2. The amount of uncompensated care costs associated with providing inpatient hospital services to individuals with no source of third party coverage for the inpatient hospital services they received (uninsured costs).

The steps to computing ASH's OBRA limit are:

1. The hospital shall prepare its CMS 2552 Report (cost report(s)). The hospital must complete the cost report to determine per diems (for inpatient routine services and for ancillary services). The cost reports must be completed based on Medicare cost principles and Medicare cost allocation process as specified in the CMS 2552 instructions and the CMS Provider Reimbursement Manual, volumes 15-1 and 15-2, including updates.
2. Medicaid shortfall will be calculated based on information available from PMMIS, other AHCCCS financial systems, and the cost report.
3. Uninsured costs will be calculated based on uninsured days and other program data collected by the hospital from its claims and financial records, other systems, and the cost report.

4. Finally, ASH will compile and summarize the calculations on The OBRA Limit and CPE Schedule. In compiling and summarizing the OBRA calculations, ASH may make adjustments to the calculated OBRA limit to estimate the OBRA limit for a future state plan year. The adjustments may increase or decrease the days, costs, charges or payments reflected on the cost reports, Medicaid and/or uninsured information used to calculate the OBRA limit. The adjustments will reflect increases and decreases resulting from changes in operations or circumstances that are not reflected in the information from the state plan year two years prior to the state plan year of the initial payment, but will be reflected in the final information for the state plan year of the initial payment. All adjustments must be supported by adequate

explanation/justification and is subject to review by AHCCCS and CMS. The Schedule will be submitted to AHCCCS during the application process, with backup documentation, for the cost reporting period(s) covered by the Medicaid state plan year(s) under review.

The Medicaid Shortfall

AHCCCS will provide ASH with a report from PMMIS and other agency financial reporting systems to assist ASH in completing required schedules. The information to be provided by AHCCCS will include, but not be limited to:

1. The number of Medicaid fee for service (FFS) inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The number of Medicaid managed care inpatient hospital days (for the single inpatient routine service cost center on the cost report)
3. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital FFS services
4. The amounts of Medicaid payments made by AHCCCS for inpatient hospital FFS services
5. The amounts of payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services for health plans and program contractors
6. The amounts of Medicaid payments made by health plans and program contractors for inpatient hospital services for health plans and program contractors
7. Other amounts of Medicaid payments for Medicaid inpatient services furnished during the Medicaid state plan year under review (e.g. GME, CAH, etc.)

ASH will use a single total per diem calculated from the cost report and the inpatient days extracted from PMMIS to determine the cost of providing inpatient Medicaid services. The single total per diem amount will be calculated by summing the inpatient per diem amount and the ancillary per diem amount.

The inpatient per diem amount will be found by dividing the amounts from Worksheet B, Part I Column 24, Line 30 by the day total on Line 1 from Worksheet S-3, Part I Column 8. Note: when calculating the Adults and Pediatrics (General Routine Care) per diem, the amount on Worksheet B, Part I, Column 24, Line 30 should have deducted the amounts appearing on Worksheet D-1, Part I, Lines 26 and 36 and the amount on Worksheet S-3, Part

I, Column 8, Line 1 should have added the amount appearing on Line 28 (observation bed days).

The ancillary per diem amount will be calculated by:

1. Summing the Line and Subscript amounts for each of the Lines 50 to 76and Lines 90 to 93 (but excluding Subscript Lines 88 to 89) taken from Worksheet B Part 1 Column 24ividing the amount determined in step 1 above by the amount determined in step 3 below
2. Summing Line 1 and 28 from Worksheet S-3, Part I, Column 8

ASH will use the single total per diem calculated from the cost report and the data supplied by AHCCCS to compile the Medicaid Schedule of Costs on the OBRA Limit and CPE Schedule. The Medicaid Schedule of Costs depicts:

1. The governmentally-operated hospital specific Medicaid inpatient cost data (determined by multiplying the single total per diem by the number of inpatient Medicaid days),
2. The payments made by or on behalf of patients and payments made by third parties related to Medicaid inpatient hospital services,
3. The Medicaid inpatient net cost data,
4. Payments made by AHCCCS including FFS and payments by health plans and program contractors
5. The amount of supplemental Medicaid payments (e.g., GME and CAH, etc.)
6. The Medicaid shortfall
7. Adjustments to the calculated Medicaid shortfall to estimate a Medicaid shortfall for a future state plan year.

Uninsured Costs

ASH will collect and submit to AHCCCS uninsured days and program data for the state plan year from the hospital's claims and auditable financial records. Only hospital inpatient days and program data for medical services that would otherwise be eligible for Medicaid should be included in the calculation. Inpatient uninsured services will not include services that would be reimbursed as Rural Health Clinic or Federally Qualified Health Clinic services if the patient were eligible for Medicaid. The uninsured days and program information provided to the state is subject to the same audit standards and procedures as the data included in the cost report.

When collecting uninsured days and program information ASH should be guided by the following:

The Uninsured are defined as:

- Self pay and self insured patients
- Individuals with no source of third party coverage for inpatient hospital services
- Third party coverage does not include state and local government subsidized care (i.e. individuals covered by indigent programs without other forms of third party coverage are uninsured)
- Payments made by state or local government are not considered a source of third party payment
- It is permissible to include in the Uninsured individuals who do not possess health insurance which would apply to the service for which the individual sought treatment.
- Individuals with AHCCCS coverage (under either Title XIX or Title XXI) are not considered uninsured
- Individuals participating in a Ryan White HIV/AIDS Program that have no source of third party coverage for the services provided other than the Ryan White program are considered uninsured. However, the funding provided under the program must be considered payments received from or on behalf of patients or payments received from third parties.

The uninsured costs will be calculated for ASH for the state plan year.
The information to be collected will include, but not be limited to:

1. The number of uninsured inpatient hospital days (for the single inpatient routine service cost center on the cost report)
2. The amounts of payments received during the state plan year made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services. The information collected shall:
    a. Include payments received during the state plan year under Section 1011, Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens, of the MMA,
    b. Not include payments, funding and subsidies made by the state or a unit of local governments (e.g., state-only, local-only or state-local health program)

ASH will use the total inpatient per diem calculated from the cost report (as determined for Medicaid), the uninsured days, and other program data collected by ASH to compile the Uninsured Schedule of Costs on the OBRA Limit and CPE Schedule. The Uninsured Schedule of Costs depicts:

1. The ASH specific uninsured inpatient cost data (determined by multiplying the single total per diem by the number of uninsured inpatient days),
2. The payments made by or on behalf of patients and payments made by third parties related to uninsured inpatient hospital services, and
3. The uninsured inpatient cost.
4. Adjustments to the calculated uninsured inpatient and outpatient cost to estimate the uninsured inpatient and outpatient cost for a future state plan year.

The Governmentally-Operated Hospital OBRA Limit

The summation of the Medicaid shortfall (whether positive or negative) and the uninsured costs (whether positive or negative) is the hospital's OBRA limit and is depicted on the OBRA Limit and CPE Schedule.

The summation of the estimated Medicaid shortfall (whether positive or negative) and the estimated uninsured costs (whether positive or negative) is the hospital's OBRA limit for a future state plan year and is depicted on the Calculation of OBRA Limit and CPE on the OBRA Limit and CPE Schedule.

Certification

The appropriate official of ASH will sign the certification statement on the OBRA Limit and CPE Schedule. A certification statement will be signed for each of the three times the OBRA limit for the state plan year of the initial DSH payment is calculated as described below under "Reconciliation".

Reconciliation

The OBRA limit for the state plan year of the initial DSH payment will be computed for ASH three times:

1. The OBRA limit will be calculated in the state plan year of the initial DSH payment based on the cost report(s) and days and other program data for the state plan year two years prior to the state plan year of the initial DSH payment. This calculation may include an adjustment to the calculated OBRA limit of the state plan year two years prior to the state plan year of the initial DSH payment in order to estimate the OBRA limit of the state plan year of the initial DSH payment.
2. The OBRA limit will be recalculated when the cost report(s) for the state plan year of the initial DSH payment are filed. In recalculating the OBRA limit the cost data from the as- filed cost report(s) and program data (days and payments) from the actual cost reporting period(s)

will be used in the calculation. This calculation may not include any adjustment to the calculated OBRA limit of the state plan year of the initial DSH.

3. The final calculation of ASH's OBRA limit will be performed when the cost report(s) for the state plan year of the initial DSH payment are finalized. In finalizing the OBRA limit the cost data from the finalized cost report(s) and program data (days and payments) from the actual cost reporting period(s) will be used in the calculation.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
INPATIENT HOSPITAL CARE

DSH Exhibit 3:
AHCCCS
Disproportionate Share Hospital Payment
Methodology Pool Funding Amount

This Exhibit contains the amount of funding for six pools in the Arizona DSH pool methodology.

For State Plan Year (SPY) 2008 and 2009, funding will be allocated among six pools (pools 1, 1A, 2, 2A, 3, and 4). For SPY 2010, funding will be allocated among seven pools (pools 1, 1A, 2, 2A, 3, 4, and 5). Thereafter, the funding will be allocated among six pools (pools 1, 1A, 2, 2A, 4, and 5).

Pools 1, 1A, 2, 2A, and 3 - Non-governmentally-operated hospitals
The funding for pools 1 and 2 will be sufficient to provide an average payment amount of $6,000 for all hospitals qualifying for both of the two pools. No hospital in pools 1 or 2 will receive less than $5,000. Therefore, the amount of funding for pools 1 and 2 will be determined by multiplying the number of hospitals qualifying for pools 1 and 2 by $6,000.

The funding for pools 1A, 2A and 3 (if applicable) will be derived by subtracting the total amount allocated for pools 1 and 2 from the amount of DSH authorized by the Legislature for nongovernmentally operated hospitals. Beginning SPY 2024, 15% of the remaining funds will be allocated to Pool 1A and 85% to Pool 2A. If the expended 1A fund is less than the 15% (such as when the hospitals in Pool 1A collectively have uncompensated care costs less than the 15%), the remainder will transfer to 2A.

- For SPY 2018, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2019, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2020, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2021, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2022, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2023, the funding for pools 1, 2, 1A, and 2A will be $884,800.
- For SPY 2024, the funding for pools 1, 2, 1A, and 2A will be $884.800.
- For SPY 2025, the funding for pools 1, 2, 1A, and 2A will be $884.800.

Pool 4 – Governmentally-operated hospitals
The funding for pool 4 is the amount authorized by the Legislature for governmentally operated hospitals.

- For SPY 2018, the funding for pool 4 is $142,293,400.
- For SPY 2019, the funding for pool 4 is $142,293,400.
- For SPY 2020, the funding for pool 4 is $142,293,400.
- For SPY 2021, the funding for pool 4 is $142,293,400.
- For SPY 2022, the funding for pool 4 is $142,293,400.
- For SPY 2023, the funding for pool 4 is $142,293,400.
- For SPY 2024, the funding for pool 4 is $142,293,400.
- For SPY 2025, the funding for pool 4 is $142,293,400.

Pool 5 - The funding for pool 5 is specified below.

- For SPY 2018, the funding for Pool 5 is the FY 2018 Arizona DSH allotment total computable amount minus $143,178,200.
- For SPY 2019, the funding for Pool 5 is the FY 2019 Arizona DSH allotment total computable amount minus $143,178,200.
- For SPY 2020, the funding for Pool 5 is the FY 2020 Arizona DSH allotment total computable amount minus $143,178,200.
- For SPY 2021, the funding for Pool 5 is the FY 2020 Arizona DSH allotment total computable amount minus $143,178,200.
- For SPY 2022, the funding for Pool 5 is the FY 2020 Arizona DSH allotment total computable amount minus $143,178,200.

For SPY 2018, the pool 5 hospitals are:

- Benson Hospital
- Holy Cross Hospital
- Kingman Regional Medical Center
- Little Colorado Medical Center
- Mt. Graham Regional Medical Center
- Northern Cochise Community Hospital
- Page Hospital
- Yuma Regional Medical Center
- Canyon Vista Medical Center
- Banner Payson Medical Center

For SPY 2019, the pool 5 hospitals are:

- Benson Hospital
- Holy Cross Hospital
- Kingman Regional Medical Center
- Little Colorado Medical Center
- Mt. Graham Regional Medical Center
- Northern Cochise Community Hospital
- Page Hospital
- Yuma Regional Medical Center
- Canyon Vista Medical Center
- Banner Payson Medical Center

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For SPY 2020, the pool 5 hospitals are:

- BENSON HOSPITAL
- KINGMAN REGIONAL MEDICAL CENTER
- LITTLE COLORADO MED CTR
- MT. GRAHAM REGIONAL MEDICAL CENTER
- NORTHERN COCHISE HOSPITAL
- PAGE HOSPITAL
- YUMA REGIONAL MEDICAL CENTER

Upon reconciliation, Pool 5 funds will be recouped due to changes in hospital qualification or payment limits; Pool 5 overpayments are not redistributed to other hospitals.

For SPY 2022, the pool 5 hospitals are:

Priority Group 1	
Benson Hospital	$606,947
Mt. Graham Regional Medical Center	$602,530
Yuma Regional Medical Center	$5,884,826
Priority Group 2	
Banner Casa Grande	$9,866,280
Banner Ironwood Medical	$4,450,648
Priority Group 3	
Abrazo Central Campus	$124,578
Abrazo Scottsdale Campus	$325,502
Abrazo West Campus	$272,848
Banner Estrella Medical	$2,385,561
Banner- UMC Phoenix Medical Campus	$3,594,311
Dignity Health AZ General	$302,967
St. Joseph's Hospital – PHX	$2,744,701
St. Mary's Hospital	$318,797
Tucson Medical Center	$2,492,009

Upon reconciliation, Pool 5 funds will be recouped due to changes in hospital qualification or payment limits; Pool 5 overpayments are not redistributed to other hospitals.

For SPY 2020, excess pool 4 funding not allocated due to OBRA limits will be reallocated to Pool 5 by December 31, 2021 or soon after the SPA is approved. The reallocation will be based proportionately according to the hospital's LOM scores, subject to each hospital's remaining OBRA limit. The amount to be reallocated to DSH pool 5 is $18,122,533.

The participating Pool 5 hospitals that will receive the pool 4 funding reallocation are:

- Yuma Regional Medical Center

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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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. State developed fee schedule rates are the same for both governmental and non-governmental providers, unless otherwise noted on the reimbursement pages. AHCCCS rates are effective for dates of service on or after October 1, 2023. AHCCCS rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/ and apply to the following services: 1) Outpatient Hospital; 2) Laboratory; 3) Pharmacy; 4) Hospice; 5) Clinic Services, including Freestanding Ambulatory Surgery Centers and Freestanding Dialysis Centers; 6) Migrant Health Center, Community Health Center and Homeless Health Center Services, Home Health Services, including Durable Medical Equipment, Supplies and Prosthetic Devices; 7) Diagnostic, Screening and Preventive Services; 8) EPSDT Services; 9) Freestanding Birth Centers; 10) Behavioral Health; 11) Family Planning; 12) Physician; 13) Nurse-Midwife; 14) Pediatric and Family Nurse Practitioner; 15) Other Licensed Practitioner; 16) Dental; 17) Vision; 18) Respiratory Care; 19) Transportation; 20) Private Duty Nurse; 21) Other Practitioners; 22) Physical Therapy; 23) Occupational Therapy; 24) Services for individuals with speech, hearing and language disorders; 25) Prosthetic devices; 26) Screening; 27) Preventative; 28) Rehabilitation.

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.

For dates of service beginning 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, pediatric emphasis, 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.

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. For dates of service July 1, 2005 through September 30, 2011, the statewide outpatient cost-to-charge ratio is computed from hospitals' 2002 Medicare Cost Reports.

For dates of service beginning October 1, 2011, the statewide cost-to-charge ratio calculation shall equal either the CMS Medicare Outpatient Urban or the CMS Medicare Outpatient Rural Cost to Charge Ratio for Arizona. The urban cost-to-charge ratio will be used for hospitals located in a county of 500,000 residents or more and for out-of-state hospitals. The rural cost-to-charge ratio will be used for hospitals located in a county of fewer than 500,000 residents.

Hospitals shall not be reimbursed for emergency room treatment, observation hours, or other outpatient hospital services performed on an outpatient basis, if the eligible person 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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Rate Updates

Notwithstanding the methods and rates as otherwise described, for claims with dates of service between April 1, 2011 and September 30, 2011, all payments for outpatient hospital services will be reduced by 5% of the payment that would otherwise have been made under the methodology in effect as of October 1, 2010, as described above.

For claims with dates of service effective from October 1, 2011 to September 30, 2015, all payments for outpatient hospital services will be reduced by 5% under the methodology in effect as of October 1, 2011. For claims with dates of service effective October 1, 2015 to September 30, 2016, all payments for outpatient hospital services will be made using the methodology in effect as of September 30, 2015 resulting in a year to year 0% aggregate impact on Outpatient Hospital Rates. For claims with dates of service effective on or after October 1, 2023, outpatient hospital services will be made according to the AHCCCS fee schedule located on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/. These fees were updated October 1, 2023 for a 0% aggregate impact.

Effective for dates of service September 1, 2020 through September 30, 2020, AHCCCS is implementing a 10% rate increase to the FFS fee schedules identified above for in office vaccination codes, and administration codes related to influenza.

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OTHER TYPES OF CARE

Out-of-State Hospitals

Out-of-state hospitals will be paid for covered outpatient services by applying the outpatient hospital fee schedule and methodology.

Specialty Rates

- **Laboratory Services**

AHCCCS'' outpatient hospital fee schedule will not exceed the reimbursement amounts authorized for clinical laboratory services under Medicare as set forth in 42 CFR 447.362. AHCCCS' rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

- **Pharmacy Services**

1. CMS covered outpatient drugs including specialty drugs, that are prescribed by an authorized prescriber and dispensed by a Retail Community, Long-term Care or Specialty Pharmacies, will be reimbursed at the lesser of:
    a. The usual and customary charge to the public, or
    b. The AHCCCS Fee-For-Service's established Maximum Allowable Cost (MAC) for the drug plus a professional dispensing fee, or
    c. The current National Average Drug Acquisition Cost (NADAC) for the drug plus a professional dispensing fee, or
    d. The contracted rates between AHCCCS and the FFS Pharmacy Benefit Manager plus a professional dispensing fee.

All of the above logic will apply to:

1. Drugs Dispensed by an Urban Indian Health Center not participating in the 340B Drug Pricing Program
2. Drugs not dispensed by a Retail Community Pharmacy and dispensed primarily through the mail,
3. 340B entities submitting claims for drugs purchased that are not available for purchase through the 340B Drug Pricing Program.
4. 340B entities dispensing medication to a member and the member is not a patient of the 340B entity.

For drugs purchased through the 340B Drug Pricing Program for members who qualify under the 340B program (FR Vol. 61 #207):

1. 340B entities are required to submit 340B claims at their Actual Acquisition Cost (AAC) for physician administered drugs and drugs dispensed to members.
2. The 340B entity shall be reimbursed at the lesser of AAC or the 340B Ceiling Price plus a professional dispensing fee.
3. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B Contract Pharmacies are not covered, unless the AHCCCS Administration has a contractual arrangement or there is a demonstrated need approved by AHCCCS that requires participation by a 340B Entity Contracted Pharmacy.

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For Federal Supply Schedule purchased drugs, the provider shall be reimbursed at no more than their actual acquisition cost plus a professional dispensing fee.

For drugs purchased at Nominal Pricing, the provider shall be reimbursed at the actual acquisition cost plus a professional dispensing fee.

The professional dispensing fee for all of the above pharmacy reimbursement methodologies is $10.11 for CMS Covered Outpatient Drugs including specialty medications, $15.34 for compounded prescriptions when a CMS Covered Outpatient Drug is an ingredient in the compound.

All Indian Health Service and Tribal 638 pharmacies are paid according to the methodology in Attachment 4.19B "REIMBURSEMENT FOR INDIAN HEALTH SERVICE AND TRIBAL 638 HEALTH FACILITIES" section.

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Physician Administered Drugs will be reimbursed using the following methodology:

1. Physician billing:
   For non-chemotherapy drugs that are priced on the Medicare Part B Drug Schedule, AHCCCS sets its FFS rates as 95% of the Medicare Part B rate. For chemotherapy drugs and drugs that are not priced on the Medicare Part B Drug Schedule, AHCCCS sets its rates as 80.75% of the Average Wholesale Price.

2. Outpatient Hospital billing:
   For all drugs that are priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates as 80% of the Medicare OPPS rate. For drugs that are not priced on the Medicare Outpatient Prospective Payment System fee schedule, AHCCCS sets its FFS rates equal to the FFS rates for physician billing methodology as defined in subsection 1- Physician billing.

3. Ambulatory Surgery Center billing:
   For all drugs that are priced on the Medicare Ambulatory Surgery Center Fee Schedule, AHCCCS sets its FFS rates as 95% of the Medicare ASC Fee Schedule rate.

4. Investigational/experimental drugs are not reimbursed by AHCCCS.

5. AHCCS will meet the reimbursement requirements of Federal Upper Limit (FUL) defined drugs in the aggregate by reviewing that the NADAC does not exceed the FUL levels.

- **EPSDT Services Not Otherwise Covered in the State Plan**

AHCCCS reimburses for chiropractor services and personal care services using a capped fee schedule. Personal care services are described in Attachment 3.1-A Limitations, page 2(a). Payment is the lesser of the provider's charge for the service or the capped fee amount established by AHCCCS. AHCCCS' rates are published on the agency's website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

- **Hospice**

AHCCCS reimburses for the hospice benefit, including routine home care, continuous home care, inpatient respite care and general inpatient care at the AHCCCS Fee Schedule rates published on the agency's website described on page 1, first paragraph of Attachment 4.19B. Effective January 1, 2016:

- Routine Home Care (RHC) will be reimbursed at one of two rates depending on the number of days in the episode of care, such that a higher rate will apply to the first 60 days of RHC and a lower rate will apply to days sixty-one and beyond. A gap of sixty days or more in hospice care will begin a new episode of care.
- A Service Intensity Add-On (SIA) add-on payment will be made for a visit by a social worker or registered nurse when provided during RHC in the last seven days of a member's life for up to 4 hours per day of service. The SIA will be an hourly rate equal to the hourly rate for continuous home care.

The hospice rates are developed based on the Medicaid Hospice Payment Rates and Hospice Wage Indices authorized by section 18 14(i)(c)(ii) of the Social Security Act, and published annually by CMS.

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OTHER TYPES OF CARE

Medication-Assisted Treatment (MAT) Pursuant to section 1905(a)(29) of the Social Security Act

1905(a)(29) MAT counseling therapy and services are reimbursed using the methodology found in Attachment 4.19-B page 5c.

Reimbursement for unbundled MAT prescribed drugs and biologicals used to treat opioid use disorder will be reimbursed using the same methodology as described for covered outpatient drugs in Attachment 4.19-B, page 2- 2(b) for drugs that are dispensed or administered.

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- **Organ Transplantation**

AHCCCS shall negotiate contracts with hospitals qualified to perform covered organ and hematopoietic cell transplantation services. Reimbursement is based on a fixed price per type of transplant, by component, which may include stop-loss provisions. Component reimbursement is based on provider cost reports. At no time will payment for the entire case exceed a hospital's billed charges. The follow-up time period lasts until the transplant team releases the member, not to exceed 60 days post-transplant.

- **Specialty Services**

AHCCCS may negotiate contracts for specialized hospital services, including but not limited to: subacute, neonatalogy, neurology, cardiology and burn care. Rates are determined based on provider cost information and at no time will contracted rates exceed billed charges

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
OTHER TYPES OF CARE

Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

A. BIPA Methodology: AHCCCS will utilize the following payment methodology from January 1, 2001, forward.

1) **Prospective Payment System Baseline Rates.** AHCCCS will establish a baseline Prospective Payment System effective January 1, 2001. The calculation will conform to section 1902(bb) 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. If the FQHC/RHC rates are based on 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. 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:

$$\frac{\text{Total Medicaid costs 1999 + Total Medicaid costs 2000}}{\text{Total visits 1999 + Total visits 2000}} = \text{Average Cost Per Visit}$$

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 will be applied to these rates at the beginning of the federal fiscal year (October 1st).

2) **Prospective Payment System Baseline Rate for New Center/Clinic.** 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 2 CFR Part 200 as implemented by 45 CFR Part 75, and 42 CFR Part 413. If a center/clinic has inadequate cost data for one of the base periods, that 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) **Change in Scope of Service.** For all dates of services, if the FQHC/RHC elects the BIPA or the APM 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 are not reflected in the base rate and are not temporary in nature.

If an FQHC/RHC requests a change in scope due to a change in type, intensity, duration, and/or amount of services included in the PPS or APM, the new scope of services will be compared to the scope of services used in the calculation for 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.

Managed Care Wrap

4) **Quarterly Supplemental Payments.** Beginning January 1, 2001, 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. Those payments 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 methodology.

5) **Annual Reconciliation.**

i. The following method applies from January 1, 2001 through September 30, 2018: 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 or APM 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 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.

ii. The following method applies for dates of service beginning October 1, 2018 : In September of each year, AHCCCS will perform a reconciliation of reimbursements from the prior fiscal year to ensure that each FQHC and RHC was reimbursed for that fiscal year an amount equal to the number of eligible visits times the applicable PPS per-visit rate calculated for the FQHC or RHC under this state plan. The reconciliation will be performed by calculating the total allowable payment each FQHC/RHC would receive under the per-visit rate established under the state plan for the fiscal year being reconciled and comparing it to the total amount of supplemental and MCE payments received for that fiscal year. The total allowable payment will be initially calculated by totaling the number of visits from AHCCCS approved claims and adjudicated encounter data for all dates of service from October 1 through September 30 of the fiscal year being reconciled and multiplying those visits by the FQHC's/RHC's applicable per-visit rate. Using the same claim and adjudicated encounter data, the total payments received will be initially calculated as the sum of all amounts paid on encounters by AHCCCS and its contracted MCEs, Medicare, and other third party payers, plus any quarterly supplemental payments made under Paragraph 4. AHCCCS will notify each FQHC/RHC in writing of the results of the comparison by the end of September. Following the notification, each FQHC/RHC may submit additional data or information to AHCCCS, including any payable visits, payments, or recoupments that the FQHC/RHC believes are not reflected in the AHCCCS approved claims and adjudicated encounter data, for consideration in calculating the final reconciliation amount. AHCCCS may adjust the calculated total allowable payment amount and/or the total payments received amount, based on the additional data or information and calculate the resulting final reconciliation for that fiscal year. For each FQHC/RHC, if the calculated total allowable payment is greater than the total payments received, the FQHC/RHC will be paid the difference by AHCCCS; if the calculated total allowable payment is less than the total payments received, the FQHC/RHC will refund the

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difference to AHCCCS. Out-of-state FQHCs are exempt from this requirement. Out of State FQHC's are exempt from the reconciliation process and will not receive payments from AHCCCS or pay back overpayments.

B. Alternative Payment Methodologies

For any fiscal year after FY 2002, an FQHC/RHC may continue being paid under the baseline methodology under 1902(bb)(6) or may use an APM methodology other than the Medicaid BIPA PPS. In order for the APM methodology to be used, the following statutory requirements must be met. First, the APM must be agreed to by the State and by each individual FQHC/RHC to which the State wishes to apply the methodology. Second, the methodology must result in a payment to the center or clinic that is at least equal to the amount to which the center or clinic is entitled under Medicaid BIPA PPS rate. The PPS rate used for the comparison must include any modifications that occurred due to scope of service changes per 1902(bb)(3)(B) and must be increased by MEI per 1902(bb)(3)(A).

1. Alternative Payment Methodology (APM #1)

Effective October 1, 2001 FQHCs/RHCs electing APM 1 will be paid with the following methodology. For the period October 1, 2018 through September 30, 2023, only FQHCs that are Urban Indian Health Program (UIHP) and RHCs are eligible to be paid under this methodology.

a) **APM 1 Baseline Rates**. AHCCCS will establish a baseline APM 1 rate effective January 1, 2001. The calculation will conform to section 1902(bb) 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. 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. 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:

$$\frac{\text{Total Medicaid costs 1999} + \text{Total Medicaid costs 2000}}{\text{Total visits 1999} + \text{Total visits 2000}} = \text{Average Cost Per Visit}$$

Every 3rd year, beginning with the federal fiscal year beginning October 1, 2004, AHCCCS will recalculate the base APM rate. The calculation will conform to section 1902(a)(15)(c) of the Social Security Act. 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. AHCCCS will use the data from the center/clinic's fiscal years that end during the two previous calendar years for the rebase APM rate calculations. The baseline APM 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 APM rebase rate calculation will include Medicaid covered services provided by the FQHC/RHC.

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The two calculated previous year APM 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:

$$\frac{\text{Total Medicaid costs previous year 1 + Total Medicaid costs previous year 2}}{\text{Total visits previous year 1 + Total visits previous year 2}} = \text{Average cost per visit}$$

The APM base rates calculated using the center/clinic's cost data will then be indexed forward from the midpoint of the cost report periods being used, to the midpoint of the initial rate period utilizing the Physician Service Index (PSI) subcomponent of the Medical Care component of the Consumer Price Index. For the next two years thereafter where a rebase to the APM does not occur, the PSI will be applied to the inflated based APM rates at the beginning of each federal fiscal year (October 1st). If the rate calculated under this Alternative Payment Methodology during any year is less than what the FQHC or RHC would receive under the BIPA including any scope of service adjustments per 1902(bb)(3)(B) and increased by MEI per 1902(bb)(3)(A), the rate for the FQHC or RHC will be the PPS rate.

b) **Baseline Rate for New Center/Clinic**. For a center/clinic that becomes a FQHC or RHC after FY 2000, AHCCCS will calculate the initial rate using the APM 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 2 CFR Part 200 as implemented by 45 CFR Part 75, and 42 CFR Part 413. If a center/clinic has inadequate cost data for one of the base periods, that 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.

c) **Change in Scope of Service**. See Paragraph A3

d) **Quarterly Supplemental Payments**: See Paragraph A4

e) **Annual Reconciliation**. See Paragraph A5.

2. Alternative Payment Methodology (APM #2) for Dates of Service October 1, 2018 – September 30, 2023 for in-state Non-UIHP FQHCs.

a) Baseline APM rate. AHCCCS will establish a baseline APM rate for each FQHC. The baseline APM 2 rate will be equal to the greater of the FQHC's federal fiscal year 2018 APM 1 rate or the FQHC's federal fiscal year 2016 APM 1 rate and must include any changes attributable to Scope Changes, multiplied by the inflation statistic for the Physicians' Services Index (PSI) subcomponent of the Medical Care Services Component of the Consumer Price Index (CPI) published by the Bureau of Labor Statistics for the 12-month period ending March 31, 2018. This methodology must result in a payment to the center or clinic that is *at least equal* to the amount to which the center or clinic is entitled under Medicaid BIPA PPS rate. The PPS rate used for the comparison must include any modifications that occurred due to scope of service changes per 1902(bb)(3)(B) and must be increased by MEI per 1902(bb)(3)(A).

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Current Individual FQHC APM 2 Rate x (1.000 + PSI inflation) = Next Year's Individual FQHC APM 2 Rate.

Annually thereafter, the rate for each FQHC will be adjusted effective October 1 of the given year by multiplying the current rate by the PSI for the 12-month period ending March 31 of that year.

b) Differential Adjusted Payment Calculation. For an FQHC that demonstrates attainment of the Minimum Performance Standard (MPS) for one or more of the selected clinical quality measures described in paragraph B2c, as reported for each FQHC in the Uniform Data System (UDS) Report to the Bureau of Primary Health Care of the Health Resources and Services Administration (HRSA), the previous year's rate will be adjusted by a Differential Adjusted Payment factor in accordance with paragraph B2c. Annually thereafter, the rate for each FQHC will be adjusted effective October 1 of the given year by multiplying the current rate by the PSI for the 12-month period ending March 31 of that year, and multiplying the result by the sum of 1.000 plus the applicable Differential Adjusted Payment (DAP) factor for the current year. This methodology must result in a payment to the center or clinic that is at least equal to the amount to which the center or clinic is entitled under Medicaid BIPA PPS rate. The PPS rate used for the comparison must include any modifications that occurred due to scope of service changes per 1902(bb)(3)(B) and must be increased by MEI per 1902(bb)(3)(A). The calculation is as follows:

Current Individual FQHC APM 2 Rate for FQHCs that attain the DAP= (The previous years' rate) x (1.000 + PSI inflation for the 12-month period ending 3/31 of the current year) x (1.000 + Applicable DAP)

In any given year, if the PSI for the 12-month period ending March 31 is less than 0%, the PSI adjustment will be 0%, or if greater than 5%, the PSI adjustment will be 5%. If the rate calculated under APM 2 is less than the rate the FQHC would receive under the Prospective Payment System (PPS), increased by MEI per 1902(bb)(3)(A) and including any scope of service adjustments per 1902(bb)(3)(B), the rate for that FQHC will be the PPS rate.

c) Differential Adjusted Payment Qualification. Differential Adjusted Payment factors will be based on the FQHC's demonstrated attainment of the MPS for one or more of the selected clinical quality measures, as reported for each FQHC in the UDS Report to HRSA. Each FQHC will receive a DAP value of 0.005 for each MPS attained, for a total DAP factor of 0.000, 0.005, 0.010, or 0.015. The clinical quality measures, minimum performance standards, and their DAP values are published on the AHCCCS website at this location: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/FQHC-RHC.html and are effective 10/1/18.

In order to be considered for a DAP factor effective October 1 annually, no later than April 30 of the same year, an FQHC will provide AHCCCS with its UDS Report submitted to HRSA for calendar year 2017. Annually thereafter, on or before April 30 of each year, the FQHC will provide AHCCCS with its UDS Report submitted to HRSA for the prior calendar year. All determinations necessary for application of the DAP for an FQHC will be based on the UDS submitted to AHCCCS by the FQHC. UDS Table 4 data will be utilized to identify FQHCs that

meet the threshold for identified patient characteristics, and performance on clinical quality measures cited at the website above will be extracted from UDS Table 6B and UDS Table 7.

d) Baseline Rate for New Center/Clinic. For a provider that becomes a FQHC after September 30, 2018 and elects this APM, AHCCCS will calculate the initial rate using the baseline APM 2 rate for an established FQHC in the same or an adjacent area with a similar caseload and applying the annual PSI adjustments which have occurred since the establishment of that baseline rate. To ensure that the current baseline APM rate is greater than or equal to the PPS rate, a calculation will be performed to compare the two rates. If the newly established rate is less than the PPS rate, the PPS rate will be used. On October 1 of the first federal fiscal year in which the new FQHC is able to provide AHCCCS with its cost reports for two full years of operation as an FQHC, AHCCCS will calculate a new baseline APM 2 rate using the provider's Medicare Cost Report data. Costs included in the new baseline APM 2 rate calculation will include Medicaid covered in-scope FQHC services provided by the FQHC. The two calculated previous year APM 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:

Average cost per visit=
(Total Medicaid costs previous year 1 + Total Medicaid costs previous year 2)/ (Total visits previous year 1 + Total visits previous year 2)

The APM 2 baseline rate calculated using the center/clinic's cost data will then be indexed forward from the midpoint of the cost report periods being used, to the midpoint of the initial rate period utilizing the Medicare Economic Index. A new FQHC will become eligible to be considered for a DAP factor, in accordance with Paragraph B2b and B2c, in the first year in which the new FQHC provides to AHCCCS by April 30 of that year a full year UDS Report submitted to HRSA. If the rate calculated under this Alternative Payment Methodology during any year is less than what the FQHC would receive under the BIPA including any scope of service adjustments per 1902(bb)(3)(B) and increased by MEI per 1902(bb)(3)(A), the rate for the FQHC or RHC will be the PPS rate.

e) Change in Scope of Service. See Paragraph A3
f) Quarterly Supplemental Payments: See Paragraph A4.
g) Annual Reconciliation. See Paragraph A5 ii.

3**. Out-Of-State FQHC/RHC's that Elect Alternative Payment Methodology (APM #3)**

Beginning with dates of service on and after October 1, 2018, AHCCCS will utilize the following payment methodology for out-of-state Federally Qualified Health Centers and Rural Health Clinics that elect the Alternative Payment Methodology. For any out-of-state FQHC/RHC, during both the initial and annual rate setting process, if the rate calculated under the APM is less than the rate the out-of-state FQHC or RHC would receive under the Prospective Payment System (PPS), increased by MEI per 1902(bb)(3)(A) and including any scope of service adjustments per 1902(bb)(3)(B), the rate for that FQHC or RHC will be the PPS rate. The rate for an out-of-state FQHC or RHC that does not

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elect the Alternative Payment Methodology will be determined in accordance with paragraphs A1 through A2.

a) For an out-of-state FQHC, AHCCCS will calculate the initial rate as the baseline APM rate for an established FQHC in the bordering Arizona county adjusted by the annual PSI adjustments which have occurred since the establishment of that baseline rate. Annually thereafter, the rate for the FQHC will be adjusted effective October 1 of the given year by multiplying the current rate by the PSI for the 12-month period ending March 31 of that year. If there is more than one FQHC in the bordering Arizona County, or if there are no FQHCs in the bordering Arizona county, AHCCCS will use the baseline rate for the established FQHC that is nearest in distance to the out-of-state FQHC. In any given year, if the PSI for the 12-month period ending March 31 is less than 0%, the PSI adjustment will be 0%, or if greater than 5%, the PSI adjustment will be 5%.

b) For an out-of-state RHC, AHCCCS will calculate the initial rate as the fiscal year 2019 APM rate for an established RHC in the bordering Arizona county adjusted by the annual PSI adjustments which have occurred since the establishment of the fiscal year 2019 rate. Annually thereafter, the rate for the RHC will be adjusted effective October 1 of the given year by multiplying the current APM rate by the PSI for the 12-month period ending March 31 of that year. If there is more than one RHC in the bordering Arizona county, AHCCCS will use the fiscal year 2019 rate for the established RHC that is nearest in distance to the out-of-state RHC. If there are no RHCs in the bordering Arizona county, the out-of-state RHC will be treated as an out-of-state RHC. In any given year, if the PSI for the 12-month period ending March 31 is less than 0%, the PSI adjustment will be 0%, or if greater than 5%, the PSI adjustment will be 5%.

___ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for a Prospective Payment System.

_x_ The payment methodology for FQHCs/RHCs will conform to the BIPA 2000 requirements for an alternative payment methodology.

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When AHCCCS reimburses for the following public and private provider services, payment is the lesser of the provider's charge or the capped fee amount established by AHCCCS. The current Arizona Medicaid Fee Schedule is located at www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx.

For both private and public providers, AHCCCS reimburses the following services as described in Attachment 3.1-A Limitations, using this methodology:

- **Clinic Services, including Freestanding Ambulatory Surgery Centers and Freestanding Dialysis Centers**
- **Freestanding Birth Centers**
- **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**: Effective CYs 2013 and 2014, reimbursement rates for services meeting the requirements of 42 CFR 447.400(a) can be found at Attachment 4.19-B, pages 5(d-g).
- **Nurse-Midwife services**
- **Pediatric and Family Nurse Practitioner Services**

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- **Other Licensed Practitioner Services**
  - OLP-Pharmacist: AHCCCS-registered pharmacies will be reimbursed for all AHCCCS covered immunizations and anaphylaxis agents administered by licensed pharmacists within the scope of their practice. AHCCCS will provide an administration fee for pharmacies administering the vaccine. The administration fee can be found on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/pharmacy.html
  - OLP-Emergency Medical Care Technician: EMCT personnel providing Treat and Refer services through an AHCCCS-registered Treat and Refer entity whereby the entity will be reimbursed for Treat and Refer services subject to the available rates located at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
- **Dental Services**
- **Vision Services** (including eye examinations, eyeglasses and contact lenses)
- **Diagnostic, Screening and Preventive Services**
- **Respiratory Care Services**
- **Transportation Services (see page 5h for information about ambulance rates)**
- **Private Duty Nurse Services**
- **Other practitioner's services**
- **Physical therapy**
- **Occupational therapy**
- **Services for individuals with speech, hearing and language disorders**
- **Prosthetic devices**
- **Screening services**
- **Preventative services**
- **Rehabilitation services**
- **EPSDT services**
- **Face-to-Face Tobacco Cessation Counseling Services Benefit Package for Pregnant Women: The rates for these services are included in the fee schedules listed under this Attachment associated with the relevant provider services.**

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Rate Update:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers for other types of care. The agency's fee schedule rates are effective for services provided on or after October 1, 2023. All rates are published at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

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Attachment 4.19-B: Physician Services 42 CFR 447.405 Amount of Minimum Payment

The state reimburses for services provided by physicians meeting the requirements of 42 CFR 447.400(a) at the Medicare Part B fee schedule rate using the Medicare physician fee schedule rate in effect in calendar years 2013 and 2014 or, if greater, the payment rates that would be applicable in those years using the calendar year 2009 Medicare physician fee schedule conversion factor. If there is no applicable rate established by Medicare, the state uses the rate specified in a fee schedule established and announced by CMS.

☒ The rates reflect all Medicare site of service and locality adjustments.

The rates do reflect Medicare site-of-service adjustments. There are no locality adjustments applicable to Arizona.

☐ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.

☒ The rates reflect all Medicare geographic/locality adjustments.

The rates do reflect the Medicare geographic adjustment for Arizona. There are no locality adjustments applicable to Arizona.

☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

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Method of Payment

☒ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.

Arizona will use a fee schedule calculated by the state based on the January 2013 release in conjunction with the 2009 conversion factor. Arizona will not further adjust the fee schedule to account for Medicare changes throughout the year.

☐ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on July 1, 2009 and the minimum payment required at 42 CFR 447.405.

Supplemental payment is made: ☐ monthly ☐ quarterly ☐semi-annually ☐annually

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.

☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

90465-90468, 99261-99263, 99271-99275, 99289-99290, 99293-99303, 99311-99313, 99321-99323, 99331-99333, 99351-99353, 99361-99362, 99371-99373, 99376, 99406-99409, 99431-99433, 99435-99436, 99438, 99440, 99444, 99450, 99455-99456.

☒ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

90460; 99224-99226: added January 1, 2011;

99485-99486: added January 1, 2013;

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Physician Services – Vaccine Administration

For calendar years (CYs) 2013 and 2014, the state reimburses vaccine administration services furnished by physicians meeting the requirements of 42 CFR 447.400(a) at the lesser of the state regional maximum administration fee set by the Vaccines for Children (VFC) program or the Medicare rate in effect in CYs 2013 and 2014 or, if higher, the rate using the CY 2009 conversion factor.

☐ Medicare Physician Fee Schedule rate

☒ State regional maximum administration fee set by the Vaccines for Children program

☐ Rate using the CY 2009 conversion factor

Documentation of Vaccine Administration Rates in Effect 7/1/09

The state uses one of the following methodologies to impute the payment rate in effect at 7/1/09 for code 90460, which was introduced in 2011 as a successor billing code for billing codes 90465 and 90471.

☒ The imputed rate in effect at 7/1/09 for code 90460 equals the rate in effect at 7/1/09 for billing codes 90465 and 90471 times their respective claims volume for a 12 month period which encompasses July 1, 2009. Using this methodology, the imputed rate in effect for code 90460 at 7/1/09 is: $15.97.

☐ A single rate was in effect on 7/1/09 for all vaccine administration services, regardless of billing code. This 2009 rate is: _____.

☐ Alternative methodology to calculate the vaccine administration rate in effect 7/1/09:_____

Note: This section contains a description of the state's methodology and specifies the affected billing codes.

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Effective Date of Payment

E & M Services
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on _December 31, 2014_____ but not prior to December 31, 2014. All rates are published at http://www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx

Vaccine Administration
This reimbursement methodology applies to services delivered on and after January 1, 2013, ending on _December 31, 2014_____ but not prior to December 31, 2014. All rates are published at http://www.azahcccs.gov/commercial/ProviderBilling/rates/rates.aspx

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The following is a description of methods and standards for determining the payment rates for ambulance transportation services included in the transportation bullet listed in Attachment 4.19-B, page 5b. Except as otherwise noted below, AHCCCS uses a uniform methodology in reimbursing both governmental and private providers for ambulance emergency and non-emergency transportation services.

1) Ground Ambulance Rates set by the Arizona Department of Health Services (ADHS)

ADHS regulates ambulance companies in Arizona (except for those owned and operated by American Indian tribes and federal agencies) licensing and rate setting. ADHS sets rates based on data submitted by providers including direct and indirect costs, reimbursable and non reimbursable charges, utilization data, and public payer settlements. ADHS offers annual provider rate adjustments based upon the Arizona Ambulance Inflation factor (AIF). The AIF is comprised of the average annual change in the CPI-U for transportation (50%) and for medical care (50%). The transportation category is composed of such things as motor vehicles (new and used), motor fuel, parts and equipment, maintenance and repair and public transportation The medical care category is composed of such things as medical care commodities, medical care services – professional, hospital and related services.

For dates of service prior to October 1, 2009, AHCCCS will reimburse ambulance companies at 80.0% of the ADHS established rate. For dates of service beginning October 1, 2009 through March 31, 2011, AHCCCS will reimburse those providers at 76% of the ADHS established rate. For dates of service beginning April 1, 2011 through September 30, 2011, AHCCCS will reimburse those providers at 72.2% of the ADHS established rate. For dates of service beginning October 1, 2011 through September 30, 2012, AHCCCS will reimburse those providers at 68.6% of the ADHS established rate in effect as of July 7, 2011. For dates of service beginning October 1, 2012 through September 30, 2013, AHCCCS will reimburse those providers at 68.6% of the ADHS established rate in effect as of August 2, 2012 and are posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

For dates of service beginning October 1, 2013 through September 30, 2014, AHCCCS will reimburse those providers at 68.6% of the ADHS established rate in effect as of August 2, 2013 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2014 through September 30, 2015, AHCCCS will reimburse those providers at 74.74% of the ADHS established rate in effect as of August 2, 2014 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2015 through September 30, 2016, AHCCCS will reimburse those providers at 68.59% of the ADHS established rate in effect as of August 2, 2015 and are posted at www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2016 through September 30, 2017, AHCCCS will reimburse those providers at 68.59 % of the ADHS established rate in effect as of July 1, 2016 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2017 through September 30, 2018, AHCCCS will reimburse those providers at 68.59 % of the ADHS established rate in effect as of July 1, 2017 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2018 through September 30, 2019, AHCCCS will reimburse those providers at 68.59 % of the ADHS established rate in effect as of July 1, 2017 and are posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS
For dates of service beginning October 1, 2019 through September 30, 2020, AHCCCS will reimburse those providers at 68.59% of the ADHS established rate in effect as of July 1, 2019 and are posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/.
For dates of service beginning October 1, 2020 through September 30, 2021, AHCCCS will reimburse those providers at 68.59% of the ADHS established rate in effect as of July 1, 2020 and are posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/.
For dates of service beginning October 1, 2021 through September 30, 2022, AHCCCS will reimburse providers at 68.59% of the ADHS established rate in effect as of July 1, 2021, and posted at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2022 through September 30, 2023, AHCCCS will reimburse providers at 68.59% of the ADHS established rate in effect as of July 1, 2022, and posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/
For dates of service beginning October 1, 2023 through September 30, 2024, AHCCCS will reimburse providers at 68.59% of the ADHS established rate in effect as of July 1, 2023, and posted at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

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2) Ground Ambulance Rates set by AHCCCS

a) AHCCCS establishes ground ambulance rates for out-of-state companies, companies operated by American Indian tribes except those described in paragraph b or which have a CON and are reimbursed according to reimbursement methodology 1), and federal agencies such as the National Park Service that operates ambulances in Grand Canyon National Park and Lake Mead National Recreation Area. Rates were initially established in 1994 based on the average (mean) reimbursement rates paid by commercial insurance companies. Ground Ambulance Fee Schedule Rates are posted on the AHCCCS website at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/ , effective October 1, 2023

b) Effective October 1, 2018, rates for ground ambulance services provided by an I.H.S. provider or a tribally owned or operated provider with a section 638 agreement that does not have a Certificate of Necessity (CON) issued by the Arizona Department of Health Services (ADHS), will be the higher of:

(1) the weighted average of the provider-specific rates as set by ADHS that are in effect on July 1, 2018, for each provider that has been issued a CON weighted by utilization of each ground transportation service code derived from both paid claims and encounters for the 12 months ending September 30, 2017; and (2) the weighted average of the provider-specific rates as set by ADHS that are in effect on July 1, 2018, for each provider that has been issued a CON weighted by utilization of each ground transportation service code derived from only paid claims for the 12 months ending September 30, 2017. The higher of the two methodologies will then be multiplied by 68.59% to establish the AHCCCS rate for each ambulance service. Beginning

October 1, 2021, if the methodology produces a rate for the Basic Life Support (BLS) that is equal to or exceeds the Advanced Life Support (ALS) rate, the ALS rate shall be set at 107.5% of the calculated BLS rate. This is applicable to Basic Life Support Codes A0428 & A0429 and Advanced Life Support Codes A0426, A0427, A0433, and A0434. Ground ambulance services provided by an I.H.S. provider or a tribally owned or operated provider with a section 638 agreement that have a Certificate of Necessity (CON) issued by the Arizona Department of Health Services (ADHS) will be reimbursed according to reimbursement methodology 1). These rates will be adjusted with an effective date of October 1 of each subsequent year using the provider-specific rates in effect on July 1 as set by ADHS for each ground ambulance provider that has been issued a CON and utilization data for paid claims and encounters for the 12 months ending September 30th of the previous year.

The methodology described in paragraph 2(b) is the following:

- AHCCCS FFS rate = the greater of (Methodology 1 weighted average rate * 0.6859) or (Methodology 2 weighted average rate * 0.6859).
- Methodology 1 weighted average rate = (C + D) / (A + B)
- Methodology 2 weighted average rate = C / A

Where:

A = FFY 2017 total units billed for the service on FFS claims

B = FFY 2017 total units billed for the service on MCO encounters

C = FFY 2017 total reimbursements for the service on FFS claims

D = FFY 2017 total reimbursements for the service on MCO encounters

After the above methodology is calculated if BLS is = to/or greater than ALS, then BLS Rate * 1.075 = ALS Rate

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3) Air Ambulance Rates

AHCCCS establishes reimbursement rates for air ambulance services. For claims with dates of service on or before December 31, 2015, the reimbursement rates are based on a cost study of Air Ambulance Costs conducted in 2000 to establish the initial rates for specialty and non-specialty transports, and are adjusted periodically based on the Consumer Price Index for Other Medical Professionals, the CPI for Transportation, and the Federal Aviation Administration forecast of jet fuel prices. For claims with dates of service from January 1, 2016 through September 30, 2016, the reimbursement rates are based on a study of non- specialty transport and mileage ambulance rates in other western states, setting the AHCCCS rates for non-specialty transports and mileage only equal to the average rate among the states studied. However, rates for specialty transports remain unchanged from those in effect on December 31, 2015. Reimbursement rates for air ambulance services were increased by 8.1% for dates of service after October 1, 2019. Reimbursement rates for base rate Fixed Wing Transport and Rotary Wing Transport were increased by 17.7% and the Neonatal Transport base rate was increased by 7.9%. For dates of service after October 1,2023, air ambulance rates can be found at https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/

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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, through the 1115 Demonstration Waiver, 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 a blend of an AHCCCS-developed case management model and historical cost information for this specific population. The model considers case management case load requirements and costs and is rebased annually.

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
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AHCCCS will reimburse the Indian Health Service (IHS) and tribal facilities based on the following reimbursement methodologies reflected in Tables 1 and 2. The AHCCCS capped fee schedule can be found at the following link: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/. The Effective date for the AHCCCS fee schedule can be found on 4.19B page 1.

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 CMS guidance (transportation).

TABLE 1 - IHS OUTPATIENT REIMBURSEMENT METHODOLOGY

Eligibility Type	Service	Billing Form/Codes	Reimbursement
Title XIX (Acute)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center	1500 / 00090-00098	AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
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Title XIX (Long Term Care)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Ambulatory Surgery Center	1500 / 00090-00098	AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	
Title XIX (Behavioral Health)	Outpatient Hospital	1500 / 00099	Outpatient All-inclusive Rate
	Clinic	1500 / 00099	Outpatient All-inclusive Rate AHCCCS Capped Fee Schedule
	Professional Services	1500 / HCPCS/CPT codes	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	

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	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive 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	AHCCCS Capped Fee Schedule)
	Professional Services (services included in procedure bill)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Long Term Care)	Outpatient Hospital (including professional services (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
AND TRIBAL 638 HEALTH FACILITIES

	Clinic(including professional services (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive Rate (or) AHCCCS Capped Fee Schedule
	Professional Services (services included in procedure billed)	1500 / HCPCS/CPT codes	AHCCCS Capped Fee Schedule
	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
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost
Title XIX (Behavioral Health)	Outpatient Hospital (including professional services) (or) Outpatient Hospital (excluding professional services)	1500 / 00099 (or) UB-92 / Specific revenue codes	Outpatient All-inclusive Rate (or) Statewide Cost to Charge Rate
	Clinic (including professional services) (or) Clinic (excluding professional services)	1500 / 00099 (or) 1500 / HCPCS/CPT codes	Outpatient All-inclusive 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
	Specialty Drugs	National Council for Prescription Drug Programs (NCPDP) Claims Adjudication Standard	Professional Fee plus the Lesser of the Federal Supply Schedule Unit Price or Wholesale Acquisition Cost

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
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The published rate is paid for up to five (5) encounters/visits per recipient per day. Encounters/visits are limited to the AHCCCS-registered facilities that provide covered services to Medicaid members in an IHS or tribal 638 health facility. The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

REIMBURSEMENT FOR INDIAN HEALTH SERVICE
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Alternative Payment Methodology for Tribal Facilities Recognized as 638 FQHCs

If a 638 FQHC elects an Alternative Payment Methodology then the 638 FQHC will be reimbursed an outpatient all-inclusive rate for all FQHC services. The published rate is paid for up to five encounters/visits per recipient per day. Encounters/visits are limited to the AHCCCS-registered facilities that provide covered services to Medicaid members in a 638 FQHC. The encounters/visits will be differentiated based on the patient account numbers that are assigned for each encounter/visit. Encounters/visits include covered telemedicine services.

AHCCCS will establish a Prospective Payment System (PPS) methodology for the 638 FQHCs so that the agency can determine on an annual basis that the published, all inclusive rate is higher than the PPS rate. The PPS rate will be established by reference to payments to one or more other clinics in the same or adjacent areas with similar caseloads. The 638 FQHCs would not be required to report its costs for the purposes of establishing a PPS rate.

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DIRECT MEDICAID REIMBURSEMENT FOR CERTAIN MEDICAID SERVICES PROVIDED BY A PARTICIPATING LOCAL EDUCATION AGENCY (LEA)

A. Reimbursement Methodology for School-Based Health and Related Services.

Local Education Agencies (LEAs) that elect to participate are reimbursed for certain medical services on a cost basis. These services are:

1. Speech-Language Pathology Services
2. Occupational Therapy Services
3. Physical Therapy Services
4. Nursing Services
5. Specialized Transportation Services
6. Behavioral Health Services
7. Personal Care Services
8. Audiology Services
9. Physician Services
10. Nurse Practitioner Services

All costs described within this methodology are for Medicaid services provided by qualified personnel or a qualified healthcare professional listed in Attachment 3.1-A Limitation, paragraph 4.b.ix of the Medicaid state plan.

All reimbursable services must meet the service definitions as described in the AHCCCS Medical Policy Manual (AMPM) and the AHCCCS Fee-For-Service Provider Manual. These services must be:

- Identified in:
    - An Individualized Education Program (IEP);
    - An Individualized Family Service Plan (IFSP);
    - Other Medical Plans of Care:
        - A Section 504 plan;
        - Any other documented individualized health or behavioral health plan or as otherwise determined medically necessary otherwise

B. Direct Medical Payment Methodology

LEAs will be reimbursed on a cost basis consistent with a certified public expenditure (CPE) reimbursement methodology. On an interim basis, LEAs will be reimbursed the federal share of the lesser of the rate contained in the AHCCCS fee-for-service (FFS) schedule or the amount billed by the LEA, minus an AHCCCS administrative fee and a TPA processing fee as identified in the LEA's participation agreement with the TPA.

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In accordance with the annual cost reconciliation process, the sum of the interim payments before fees are deducted will be reconciled with the federal share of the Medicaid portion of the total costs certified by the LEA.

C. Data Capture for the Cost of Providing Health-Related Services
Total direct and indirect costs, less any federal payments for these costs, will be captured utilizing the following data:
   a. Medicaid School Based Claiming Cost Reports received from LEAs;
   b. Arizona Department of Education (ADE) Unrestricted Indirect Cost Rate (UICR);
   c. The results of the Random Moment Time Studies (RMTS) including:
      i. The calculated Direct Medical Services IEP/IFSP RMTS percentage;
      ii. The calculated Direct Medical Service provided under Other Medical Plans of Care RMTS percentage.
   d. LEA specific Medicaid IEP Ratios.
      i. Medicaid IEP or IFSP Ratio;
      ii. Medicaid Ratio for Other Medical Plans of Care.

D. Data Sources and Cost Finding Steps

The following provides a description of the data sources and steps to complete the cost finding and reconciliation:

1) Allowable Costs: Direct costs for direct medical services include unallocated payroll costs and other unallocated costs that can be directly charged to direct medical services. Direct payroll costs include total compensation (i.e., salaries and benefits and contract compensation) of direct services personnel listed in the descriptions of the covered Medicaid services delivered by LEAs excluding transportation personnel (costs for transportation personnel are reported as defined in Section E). These direct costs will be calculated on a LEA-specific level and will be reduced by any federal payments for these costs (other than the interim payments), resulting in net direct costs.

   The source of this financial data will be audited by the Uniform System of Financial Records (USFR) Chart of Accounts kept at the LEA level. Costs will be reported on an accrual basis.

2) Indirect costs are determined by applying the LEA's specific UICR to its net direct costs. The Arizona Department of Education is the cognizant agency for LEAs and approves unrestricted indirect cost rates for LEAs for the United States Department of Education. LEAs are not permitted to certify indirect costs that are outside their unrestricted indirect cost rate. An indirect cost rate is not applied to purchased or contracted costs that already include an indirect cost component. The indirect cost rate is calculated from costs that are not included in the allowable reported expenditures so there is no duplication of costs.

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Indirect Cost Calculation:
Multiply the ADE UICR by the net direct costs applicable for dates of service in the rate year.

3) Time Study Percentages: A CMS-approved time study is used to determine the percentage of time that medical service personnel spend on IEP/IFSP and Other Medical Plans of Care, Direct Medical Services, general and administrative time, and all other activities.

   The RMTS methodology will utilize two cost pools.
   - Cost pool A for Direct Medical Services (other than personal care services) provided by eligible staff and other medical services providers.
   - Cost pool B for Direct Medical Services provided by personal care service providers only.

   The RMTS will generate the Direct Medical Services Time Study percentages for each cost pool and percentages for each cost pool will be applied separately to the costs associated with:
   - Direct Medical Services provided pursuant to an IEP/IFSP.
   - Direct Medical Services provided pursuant to Other Medical Plans of Care.

   The use of the CMS-approved time study methodology assures that no more than 100 percent of time and costs are captured and that the time study is statistically valid per 2 CFR Part 200.

4) Medicaid Enrollment Ratio Determination
   Two distinct Medicaid Enrollment Ratios will be established for each participating LEA - the Medicaid IEP/IFSP Enrollment Ratio and the Medicaid Enrollment Ratio for Other Medical Plans of Care.

   Medicaid IEP/IFSP Enrollment Ratio:
   To determine the Medicaid IEP/IFSP Enrollment Ratio, the names, gender, and birthdates of students with a Direct Medical Service prescribed on an IEP/IFSP identified from the AHCCCS LEA's Enrollment October 1 Count Report are matched against the Medicaid enrollment file. The numerator will be the number of Medicaid enrolled students with a Direct Medical Service prescribed on an IEP/IFSP and the denominator will be the total number of students with a Direct Medical Service prescribed on an IEP/IFSP. The Medicaid IEP/IFSP Ratio will be calculated for each participating LEA on an annual basis.

   Medicaid Enrollment Ratio for Other Medical Plans of Care:
   To determine the Medicaid Enrollment Ratio for Other Medical Plans of Care, the names, gender, and birthdates of all students from the AHCCCS LEA's Enrollment October 1 Count Report are matched against the Medicaid enrollment file. The numerator will be the number of Medicaid enrolled students in the LEA and the denominator will be the total number of students in the LEA. The Medicaid Enrollment Ratio will be calculated for each participating LEA on an annual basis.

5) Calculation Medicaid Portion of Costs Associated with Direct Medical Services

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Calculation of the Medicaid Direct Medical Service costs pursuant to an IEP/IFSP:
Multiply the sum of net LEA direct costs and indirect costs by the statewide IEP/IFSP time study percentages for each cost pool, then multiply those products by the Medicaid IEP/IFSP Enrollment Ratio.

Calculation of the Medicaid Direct Medical Service costs pursuant to Other Medical Plans of Care:
Multiply the sum of net LEA direct costs and indirect costs by the statewide Other Medical Plans of Care time study percentages for each cost pool, then multiply those products by the Medicaid Enrollment Ratio for Other Medical Plans of Care.

E. Specialized Transportation Services Payment Methodology

School based specialized transportation is defined as a medically necessary service (as outlined in the IEP/IFSP of an enrolled Medicaid beneficiary) provided in a specially-adapted vehicle that has been physically-adjusted or designed (e.g., wheelchair lifts, ramps, etc.,) to accommodate special needs children in the school-based setting. Note: The presence of only an aide (on a non-adapted bus/vehicle) or seat belts does not make a vehicle specially-adapted.

LEAs will be reimbursed for specialized transportation services on a cost basis consistent with a CPE reimbursement methodology. On an interim basis, LEAs will be reimbursed the federal share of the lesser of the rate contained in the AHCCCS FFS schedule or the amount billed by the LEA, minus an AHCCCS administrative fee and a TPA processing fee as identified in the LEA's provider participation agreement.

In accordance with the cost reconciliation process, the sum of the interim payments before fees are deducted will be reconciled with the federal share of the Medicaid portion of the total costs certified by the LEA.

Transportation to and from school may be claimed as a Medicaid service when the following conditions are met:

1) Specialized transportation is specifically listed in the IEP/IFSP as a required service;
2) The child requires specialized transportation in a vehicle with physical adaptations designed to accommodate an individual with a disability;
3) A Medicaid eligible service is provided on the day that the specialized transportation is billed; and
4) The service billed only represents one-way trip(s) on the specially adapted transportation for a Direct Medical Service listed in the IEP/IFSP;
5) The LEA must be registered with AHCCCS as a transportation provider and must meet the same provider qualifications as all AHCCCS transportation providers (e.g., proof of insurance and licensure of school bus drivers).

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Transportation costs included on the Cost Report worksheet will only include those personnel and non-personnel costs associated with specialized transportation reduced by any federal payments for these costs (other than the interim payments), resulting in net costs for transportation. The Cost Report includes costs for the following:

1. Bus Drivers/Aides
2. Mechanics/Mechanic Assistant
3. Substitute Drivers
4. Fuel/Oil
5. Repairs & Maintenance
6. Lease/Rentals
7. Insurance Costs
8. Purchased Professional Transportation Services and/or Equipment
9. Depreciation

The source of this financial data will be audited by the Uniform System of Financial Records (USFR) Chart of Accounts kept at the LEA level. Costs will be reported on an accrual basis.

When LEAs are not able to discretely identify the specialized transportation costs from the general education transportation costs, a specialized transportation cost discounting methodology will be applied. A rate will be established and applied to the total transportation cost of the LEA. This rate will be based on the Total IEP/IFSP Special Education Students in LEA Receiving Specialized Transportation divided by the Total Students in the LEA Receiving General Transportation. The result of this rate (% of total students receiving transportation that are IEP/IFSP students requiring specialized transportation) multiplied by the Total LEA Transportation Cost will be included on the cost report.

This cost will be further discounted by the ratio of eligible Medicaid Enrolled Special Education IEP/IFSP One-Way Trips divided by the total number of Special Education IEP/IFSP One-Way Trips. This data will be provided from bus logs. The process will ensure that only one-way trips for Medicaid enrolled Special Education children with IEP/IFSP's are billed and reimbursed.

F. The Cost Reconciliation Process

The cost reconciliation process must be completed within twenty-four months of the end of the Cost Report due date (up to 5 months after the state fiscal year ends). Effective with reporting of SFY 2023 activity, the cost reconciliation and settlement processes are to be completed within nineteen months of the Cost Report due date (up to 5 months after the state fiscal year ends). The total CMS-approved, Medicaid allowable scope of costs based on CMS-approved cost allocation methodology procedures are compared to the LEA’s Medicaid interim payments during the reporting period as documented in the

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Medicaid Management Information System (MMIS).

1. Annual Cost Report Process

The annual Cost Report process is the first step in the cost reconciliation process. For Medicaid services provided in schools during the state fiscal year (July 1 through June 30) each LEA must complete an annual Cost Report. The Cost Report is due up to five months after the fiscal year ends. At the discretion of AHCCCS, LEAs may be granted up to a one month extension.

The primary purposes of the LEA provider's cost report are to:

1) Document the LEA provider's total CMS approved Medicaid-allowable costs of delivering Medicaid coverable services using a CMS approved cost allocation methodology.
2) Reconcile the annual interim payments to the LEA provider's total CMS approved, Medicaid-allowable costs using a CMS approved cost allocation methodology.

The annual Medicaid Cost Report includes a Certification of Funds Public Expenditure Form certifying the LEA's actual, incurred costs/expenditures. All filed annual Cost Reports are subject to desk review by AHCCCS or its designee.

2. The Cost Settlement Process

- If the sum of the interim payments to a LEA (before fees are deducted) exceeds the federal share of the Medicaid portion of the actual, certified costs for the delivery of school based health services, the LEA is required to return an amount equal to the overpayment (less the associated AHCCCS administrative fee) to the State. Overpayments will be paid by the LEAs promptly to AHCCCS.

- If the federal share of the Medicaid portion of a LEA's actual, certified costs exceed the sum of the interim payments before fees are deducted, AHCCCS will pay the LEA the difference (less the AHCCCS administrative fee)

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Reserved for future use.

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METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES
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Citation

42 CFR 447,434,438, and 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustments for Provider Preventable Conditions

The Medicaid Agency meets the requirements of 42 CFR Part 447, Subpart A, and sections1902(a)(4), 1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions

The State identifies the following Other Provider-Preventable Conditions for non-payment under Sections 4.19-B

__X__Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

_____Additional Other Provider Preventable Conditions identified below.

For OPPCs: AHCCCS will identify potential OPPCs via codes and modifiers used on outpatient and professional claims, and perform medical review. The OPPC services identified through medical review will not be reimbursed. AHCCCS will not claim FFP for expenditures for OPPC services.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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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).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: ARIZONA

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.

4/30/03
CMS Website
has additional
pages - 4, 5, & 6
BZ

* Pursuant to an August 29, 1996 agreement with HCFA.

RC
6/20/97

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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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STATE OF ARIZONA

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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A. **OVERVIEW**

The following is a description of methods and standards for determining Differential Adjusted Payments for the AHCCCS-registered provider types specified in Section B., "Applicability," below. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS Fee-For-Service reimbursement rates. These payment adjustments will occur for all dates of service in Contract Year Ending (CYE) 2024 (October 1, 2023 through September 30, 2024) only. The payment adjustments do not apply to supplemental payments.

B. **Applicability**

To qualify for the Outpatient Differential Adjusted Payment (DAP), a facility or provider providing non-institutional services must meet one of the following criteria:

1. **Physicians, Physician Assistants, and Registered Nurse Practitioners** (Up to 3.5%)
   Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 18, 19, and 31) are eligible for DAP increases under the following criteria

Domain	Description
a. Electronic Prescriptions (1.0%)	A provider that has written at least 80 prescriptions for AHCCCS members and has written at least 85% of its total AHCCCS prescriptions as Electronic Prescriptions (E-Prescriptions) will qualify for a 1.0% DAP for all services billed on the CMS Form 1500. E-Prescription statistics will be identified by the AHCCCS provider ID for the prescribing provider, and computed by AHCCCS based on the following factors: i. Only approved and adjudicated AHCCCS claims and encounters for July 1, 2022, through December 31, 2022 dispense dates will be utilized in the computations. ii. AHCCCS will compute claims and encounters for this purpose as of March 15, 2023 to determine which providers meet the minimum threshold. iii. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase. iv. E-Prescriptions include those prescriptions generated through a computer-to-computer electronic data interchange protocol, following a national industry standard and identified by Origin Code 3.

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	v. Refills of original prescriptions whereby the original prescriptions meet the definition of E-Prescriptions shall not be counted as E-Prescriptions. The DAP will apply to claims for covered AHCCCS services where the rendering provider ID on the claim is the same as the prescribing provider ID that was identified and found to meet the criteria described above.
b. 6-Week Postpartum Visits (1.0%)	An obstetrician or gynecologist that meets the criteria for provision of 6-week postpartum visits will qualify for a 1.0% DAP. A provider qualifies if it has delivered and discretely billed for 6-week postpartum visit services for at least 25% of the members for whom it delivered in the CYE 2021 period. AHCCCS will review claims and encounters for the period October 1, 2021 through September 30, 2022 to determine eligibility for the DAP in CYE 2024. Only approved and adjudicated AHCCCS claims and encounters as of March 15, 2023 will be utilized in determining providers that meet this criteria. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.
c. Social Determinants of Health Closed Loop Referral Platform (1.0%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Providers that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the provider must submit a Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each qualifying rendering provider, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the facility requests to participate in the DAP. 1. For providers that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: 1. For providers that have participated in DAP SDOH requirements in CYE 2023:

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	a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live and through September 30, 2024, the provider must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the provider) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the provider's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the clinic will be counted toward volume requirements, and tracked monthly. 2. For providers that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a provider has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the provider to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.

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d. American Society of Addiction Medicine (ASAM) Continuum Software Integration (0.5%)	Providers that bill for behavioral health assessments will be eligible for a 0.5% DAP by integrating or maintaining integration of the ASAM CONTINUUM in their electronic health record (EHR) system. i. Milestone # 1: By April 30, 2023, providers must submit an LOI to AHCCCS indicating that they agree to complete integration or maintain integration with the ASAM CONTINUUM with their EHR system to the following email address: AHCCCSDAP@azahcccs.gov. The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the provider requests to participate in the DAP. ii. Milestone #2: By April 30, 2024, the EHR vendor must submit a letter to AHCCCS stating the integration has been completed. The letter must include a project contact for the facility, the EHR vendor, and a contact for the EHR.

e. IHS and638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

f. Payment Methodology
Physicians, physician assistants, and registered nurse practitioners will qualify for a 1.0% increase on all services billed on the CMS Form 1500 for each measure outlined in B.2.a, B.2.b and B.2.c ., and a 0.5% increase on all services billed on the CMS Form 1500 for the measure outlined in B.2.d. The DAP increase will apply to claims with service dates from October 1, 2023 to September 30, 2024.

Providers which submitted an HIE LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the HIE LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

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If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

2. **Dental Providers** (Up to 3.0%)
Dental Providers (Provider Types 07 and 54) are eligible for DAP increases under the following criteria.

Domain	Description
a. Dental Sealants for Children Performance Measure (1.0%)	A provider that meets the criteria for the dental sealants for children performance measure will qualify for a 1.0% DAP. Providers that increased the number of AHCCCS child members from 5 through 15 years of age to whom they provided dental sealants from CYE 2021 (October 1, 2020 through September 30, 2021) to CYE 2022 (October 1, 2021 through September 30, 2022) are considered to meet this measure. AHCCCS will review only approved and adjudicated claims and encounter data in order to compute a count of the number of AHCCCS members who are children aged 5 through 15 years who received a dental sealant for each time period. Only approved and adjudicated AHCCCS claims and encounters as of March 15, 2023 will be utilized in determining providers that meet this criteria. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.
b. Provision of Dental Services on Weekends (1.0%)	A provider that meets the criteria for the provision of dental services on weekends will qualify for a 1.0% DAP. A provider qualifies if 2.0% or more of its services were incurred for dates of service on a weekend for the period October 1, 2021 through September 30, 2022. Only approved and adjudicated AHCCCS claims and encounters as of March 15, 2023 will be utilized in determining providers that meet this criteria. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.
c. Bundled Services (1.0%)	A provider that meets the criteria of billing bundled services will qualify for a 1.0% DAP. A bundled service is defined as concurrently billing for an exam and cleaning and then adding on a third service of either fluoride or sealants, utilizing the codes referenced in Attachment A. Providers that increased the amount of bundled services by 5.0% will qualify for this DAP. AHCCCS will review claims and encounters for the period of July 1, 2021, through December 31, 2021, and again from July

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	1, 2022, through December 31, 2022, and if there is a 5.0% increase in bundled services the provider will be eligible for the DAP increase. Only approved and adjudicated AHCCCS claims and encounters as of March 15, 2023 will be utilized in determining providers that meet these criteria. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.

d. IHS and 638 Tribally Owned and/or operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 10 below for IHS/638 DAP details.

e. Payment Methodology
For the contracting year October 1, 2023 through September 30, 2024, eligible providers will qualify for a 1.0% increase on all services billed for meeting the measures in B.3.a, a 1.0% increase on all services billed for meeting the measure in B.3.b., and a 1.0% increase on all services billed for meeting the measure in B.3.c.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

3. **Behavioral Health Outpatient Clinics and Integrated Clinics** (Up to 16.5%)
Behavioral Health Outpatient Clinics, Provider Type 77, and Integrated Clinics, Provider Type IC, are eligible for DAP increases under the following criteria.

Domain	Description
a. Partnership with Schools to Provider Behavioral Health Services (1.0%)	A clinic that meets the criteria for partnering with schools to provide behavioral health services will qualify for a 1.0% DAP. i. Milestone #1: By April 30, 2023, a clinic must submit an LOI to AHCCCS, to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they agree to the following criteria for partnering with schools to provide behavioral health services. The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s),

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	that the clinic requests to participate in the DAP. ii. Milestone #2: By June 30, 2024, a clinic must have accepted at least 10 referrals on the AHCCCS Universal Referral Form from a school that led to subsequent service provision for the student. iii. Milestone #3: By June 30, 2024, a clinic must have provided services on a school campus, or to a student referred for services by a school, as identified by the use of the CTDS number on the claim.
b. Autism Centers of Excellence (3.0%)	A clinic that meets the criteria to be considered an Autism Center of Excellence (COE) will qualify for a 3.0% DAP. An Autism COE is defined as a provider that has been identified as such by any AHCCCS MCO in the "Value Based Providers/Centers of Excellence" attachment to its "Provider Network Development and Management Plan," submitted by November 15, 2022. Providers that have been identified as an Autism COE in this manner will qualify for the DAP.
c. Provision of Services to Members in a Difficult to Access Location (3.0%)	A clinic that meets the criteria for provision of services to members in a difficult to access location that cannot be accessed by ground transportation due to the nature and extent of the surrounding Grand Canyon terrain will qualify for a DAP increase of 3.0% on all non-institutional claims. Provision of services is defined as a provider that has a MOA or MOU with a tribal government to access tribal territory in order to provide behavioral health services to members located in the Grand Canyon. The signed MOA or MOU must be in place by April 1, 2023 and submitted to AHCCCS by email to AHCCCSDAP@azahcccs.gov. On April 15, 2023, AHCCCS will review such documents as have been submitted by each provider in order to determine providers that meet this requirement and will qualify for this DAP increase.
d. American Society of Addiction Medicine Continuum	Clinics that bill for behavioral health assessments will be eligible for a 0.5% DAP by integrating or maintaining integration of the ASAM CONTINUUM in their electronic health record (EHR) system. i. Milestone # 1: By April 30, 2023, providers must submit an LOI to AHCCCS, to the following email address,

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Software Integration (0.5%)	AHCCCSDAP@azahcccs.gov, indicating that they agree to complete integration or maintain integration with the ASAM CONTINUUM with their EHR system. The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the clinic requests to participate in the DAP. ii. Milestone #2: By April 30, 2024, the EHR vendor must submit a letter to AHCCCS stating the integration has been completed. The letter must include a project contact for the clinic, the EHR vendor, and a contact for the EHR.
e. Social Determinants of Health Closed Loop Referral Platform (1.0%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Clinics that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the clinic must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the clinic requests to participate in the DAP. 1. For clinics that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than April 1, 2022: 1. For clinics that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live and through September 30, 2024, the clinic must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be

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	measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the clinic) per registered AHCCCS ID that resulted from utilizing a PRAPARE social-needs screening tool in CommunityCares or within the clinic's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the clinic will be counted toward volume requirements, and tracked monthly. 2. For clinics that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a clinic has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the clinic to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
f. Continuous Behavioral Health Services to American Indian Health Program (AIHP) Members with a Serious Mental Illness (SMI) Who Transitioned from RBHA Enrollment	Clinics that provide continuous services to AHIP members designated with an SMI, who transitioned from enrollment with a Regional Behavioral Health Authority (RBHA)to integrated AIHP on October 1, 2022, will be eligible for a 7.0% DAP on all Fee-For-Service claims. AHCCCS reviewed claims for FFY 2022 on December 29, 2022, and will again review claims on September 1, 2023, for claims with dates of service between December 1, 2022, and July 1, 2023, to identify eligible providers. Clinics that were providing services in FFY 2022, to AIHP-RBHA members designated with a SMI and that continue to provide services to these members with a SMI from December 1, 2022, through July 1, 2023, will be eligible for this DAP.

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(7.0%)	
g. Health Information Exchange Participation (1.0%)	Clinics that meet the following milestones and performance criteria are eligible to earn up to a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the clinic must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the clinic requests to participate in the DAP. 1. For clinics that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than May 1, 2023, the clinic must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the clinic's EHR system. If it is the clinic's first year in the DAP HIE initiative, then it must meet this milestone no later than January 1, 2024. iii. Milestone #3: No later than May 1, 2023, clinics that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE, if required by the external reference lab, to have all outsourced lab test results flow to the HIE organization on their behalf. iv. Milestone #4: No later than May 1, 2023, the clinic must electronically submit actual patient identifiable information to the production environment of the HIE organization, including encounter information and an encounter summary as well as data elements specific to individuals with a serious mental illness (SMI) designation, as defined by the HIE organization. If a clinic is in the process of integrating a new Practice Management and/or electronic health record (EHR) system, or if it is the clinic's first year in the DAP HIE

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	initiative, then it must meet this milestone no later than June 30, 2023. v. Milestone #5: No later than May 1, 2023, the clinic must have or obtain a unique Object Identifier (OID) created by a registration authority, the clinic, and HL7. The OID is a globally unique International Organization for Standardization identifier for the clinic. Contact the HIE's Quality Improvement Team for instructions and to ensure you are compliant. vi. Milestone #6: No later than July 1, 2023, the clinic must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the clinic's HIE connection to the new HIE platform. The clinic must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes the electronic submission of patient information, the information transferred to the HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a clinic has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the clinic to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.

h. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

i. Payment Methodology
For Behavioral Health Outpatient Clinics, Provider Type 77, and Integrated Clinics, Provider Type IC, all payment rates for Fee for Service non-institutional services will be increased by: 1.0% if they meet the requirements in B.3.a, 3.0% if they meet the requirements in B.3.b, 3.0% if they meet the requirements in B.3.c, 0.5% if they meet the requirements in B.3.d, 1.0% if they meet the requirements in B.3.e, 7.0% if they meet the requirements in B.3.f, and 1.0% if they meet the requirements in B.3.g.

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Clinics which submitted an LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a clinic receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that clinic will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

4. **Critical Access Hospitals (Up to 10.5%)**
Hospitals designated as a Critical Access Hospital (CAH) by March 15, 2022 are eligible for DAP increases under the following criteria.

Domain	Description
a. Health Information Exchange Participation (8.0%)	Hospitals that meet the following milestones are eligible to earn a 8.0% DAP i. Milestone #1: No later than April 1, 2023, the hospital must have an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work HIE SOW) the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org.

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	ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the facility's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf. iv. Milestone #4: No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure you are compliant. vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the

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	new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 and or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 C.F.R. Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.
b. Social Determinants of Health Closed Loop Referral System (1.0%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: 1. For hospitals that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended

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	onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live and through September 30, 2024, the hospital must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the hospital) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the hospital's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, and tracked monthly. 2. For hospitals that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
c. Arizona Health Directives Registry (1.0%)	Hospitals that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including

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	AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: 1. For hospitals that have participated in DAP HIE requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization. b. After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry. 2. For hospitals that have not participated in DAP HIE requirements in CYE 2023: a. No later than November 1, 2023, complete the AzHDR Participant Agreement, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.

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d. Naloxone Distribution Program (0.5%)	Hospitals with an Emergency Department that meet the following milestones are eligible to earn a 0.5% DAP increase on all outpatient services. i. Milestone #1: No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP. iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.

e. IHS and 638 Tribal Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

f. Payment Methodology
For critical access hospitals, payment rates for outpatient services, for the service date range of October 1, 2023-September 30, 2024, will be increased by 8.0% if they meet the HIE requirements, by 1.0% if they meet the AzHDR requirements, by 1.0% if they meet the SDOH closed loop referral system requirements, and by 0.5% if they meet the Naloxone Distribution Program requirements.

Hospitals which submitted an LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed

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milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a hospital receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that hospital will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

5. **Hospitals Subject to APR-DRG Reimbursements and Other Hospitals/Provider Types**

A. **Hospitals, Provider Type 02**, are eligible for DAP increases under the following criteria (Up to 3.5%)

Domain	Description
a. Health Information Exchange Participation (Up to 2.0%)	Hospitals that meet the following milestones are eligible to earn a 1.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system.

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	iii. Milestone #3: No later than May 1, 2022, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE organization, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE on their behalf. iv. Milestone #4: No later than May 1, 2022, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure the hospital is compliant. vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be

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	actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.
b. Social Determinants of Health Closed Loop Referral Platform (0.5%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org ii. Milestone #2: 1. For hospitals that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023.

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	b. After go-live and through September 30, 2024, the hospital must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the hospital) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the hospital's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, and tracked monthly. 2. For hospitals that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
c. Arizona Health Directives Registry	Hospitals that meet the following milestones are eligible to earn a 0.5% DAP.

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(0.5%)	i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: 1. For hospitals that have participated in DAP HIE requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization. b. After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024. Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry. 2. For hospitals that have not participated in DAP HIE requirements in CYE 2023: a. No later than November 1, 2023, complete the AzHDR Participant Agreement, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital

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	to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Naloxone Distribution Program (0.5%)	Hospitals with an Emergency Department that meet the following milestones are eligible to earn a 0.5% DAP increase on all outpatient services. i. Milestone #1: No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP. iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.

B. **Other Hospitals and Provider Types**

1. Psychiatric Hospitals, with the exception of public hospitals, Provider Type 71; Secure Residential Treatment Centers (17+ beds), Provider Type B1; Non-Secure Residential Treatment Centers (17+ beds), Provider Type B3; Subacute Facilities (1-16 Beds), Provider Type B5; Subacute Facilities (17+ beds), Provider Type B6; Rehabilitation Hospitals, Provider Type C4; Long Term Acute Care Hospitals, Provider Type C4 are eligible for DAP increases under the following criteria.

Domain	Description
a. Health Information Exchange Participation (1.5%)	Hospitals that meet the following milestones are eligible to earn a 1.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must have in place an active

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	participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements for CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf. iv. Milestone #4: No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge and transfer information (generally known as ADT information), including data from the hospital emergency department if the provider has an emergency department, laboratory and radiology information (if the provider has these services),

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	transcription, medication information, immunization data, and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure you are compliant. vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE integration requirements through September 30, 2024. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must

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	include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.
b. Inpatient Psychiatric Facility Quality Reporting Program (2.0%)	Inpatient psychiatric facilities that meet the Inpatient Psychiatric Facility Quality Reporting Program (IPFQR) performance measure will qualify for a 2.0% DAP increase. On March 15, 2023, AHCCCS will download the most current data from the QualityNet.org website to identify Medicare's Annual Payment Update (APU) recipients. APU recipients are those facilities that satisfactorily met the requirements for the IPFQR program, which includes multiple clinical quality measures. Facilities identified as APU recipients will qualify for the DAP increase.
c. Long-Term Care Hospital Pressure Ulcers Performance Measure (2.0%)	Long Term Care Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On March 15, 2023 Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
d. Inpatient Rehabilitation Pressure Ulcers Performance Measure (2.0%)	Inpatient Rehabilitation Hospitals that meet or fall below the national average for the pressure ulcers performance measure will qualify for a 2.0% DAP increase. On March 15, 2023, AHCCCS will download the most current data from the Medicare Provider Data Catalog website for the rate of changes in skin integrity post-acute care: Pressure Ulcer/Injury. Facility results will be compared to the national average results for the measure. Hospitals that meet or fall below the national average percentage will qualify for the DAP increase.
e. Arizona Health Directives Registry (0.5%)	Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE

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	organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: 1. For hospitals that have participated in DAP HIE requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the AzHDR platform operated by the HIE organization. b. After all the onboarding requirements have been met and the provider has access to the platform (Go-Live), the hospital must regularly utilize the AzHDR platform which will be measured by facilitating at least 10 patient document uploads or queries of advance directives per month per registered AHCCCS ID from the Go-Live date through September 30, 2024 Both uploads entered into the system and queries of the system by the hospital will be counted toward volume requirements, tracked monthly, and reported as a final deliverable by June 1, 2024. Uploading is defined by submitting a document or multiple documents for a patient into the registry and a query is defined as querying for documents within the Registry. 2. For hospitals that have not participated in DAP HIE requirements in CYE 2023: a. No later than November 1, 2023, complete the AzHDR Participant Agreement, and b. No later than April 1, 2024, have onboarding completed by working with

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	the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has already achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
f. Social Determinants of Health Closed Loop Referral Platform (0.5%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: 1. For hospitals that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live and through September 30, 2024, the hospital must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10

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	referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the hospital) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the hospital's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the hospital will be counted toward volume requirements, and tracked monthly. 2. For hospitals that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.

g. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

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h. Payment Methodology

For hospitals receiving APR-DRG reimbursement (described in Section B.5.A above), fee-for-service reimbursement rates for outpatient services will be increased by 2.0% if they meet the HIE requirements, by 0.5% if they meet the SDOH Closed Loop Referral Platform requirements, by 0.5% if they meet the AzHDR requirements, and by 0.5% if they meet the Naloxone Distribution Program reporting requirements. These increases do not apply to supplemental payments.

For other hospitals and facilities (described in Section B.5.B above), fee-for-service reimbursement rates for outpatient services will be increased by 1.5% if they meet the requirements detailed in B.5.B.1.a., by 2.0% if they meet the requirements described in B.5.B.1.b, by 2.0% if they meet the requirements described in B.5.B.1.c, by 2.0% if they meet the requirements described in B.5.B.1.d, by 0.5% if they meet the requirements described in B.5.B.1.e, and by 0.5% if they meet the requirements described in B.5.B.1.f.

Hospitals which submitted an LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a hospital receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that hospital will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

2. **Freestanding Emergency Departments (5.0%)**

Freestanding Emergency Departments (Provider Type ED) are eligible for a DAP increase on all inpatient and outpatient services under the following criteria.

Domain	Description

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a. Naloxone Distribution Program (5.0%)	Freestanding Emergency Departments that meet the following milestones are eligible to earn a 5.0% DAP. i. Milestone #1: No later than April 30, 2023, the facility must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the facility requests to participate in the DAP. ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP. iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy.

b. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

c. Payment Methodology
Freestanding Emergency Departments will qualify for a 5.0% increase on all services for Naloxone Distribution Program participation.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a facility receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its

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participation in the milestone activities in CYE 2024, that facility will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

3. **Home and Community Based Services Providers (6.25%)**
Home and Community Based Services (HCBS) Providers are eligible for DAP increases under the following criteria. The DAP increase will be applicable to the specified services described below when provided on a FFS basis.

Domain	Description
a. Electronic Visit Verification (EVV) Visit Status Compliance (0.5%)	The DAP Increase will be applicable to the following services: S5125, S5135, S5136, T2017, G0299, G0300, S9123, S9124, T1021, G0151, S9129, S5181, G0153, S9128, S5130, T1019. S5150, S5151. The DAP increase will be applicable to the specified services as outlined in Attachment B.
b. Health Information Exchange Participation (1.0%)	Assisted Living (AL) Centers (Provider Type 49), and Home Health Agencies (Provider Type 23) that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the provider must have an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each provider location, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the provider requests to participate in the DAP. 1. For providers that have not participated in DAP HIE requirements for CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than May 1, 2023, the provider must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the provider's EHR system. If it is the provider's first year in the DAP HIE initiative, then

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	the provider must meet this milestone no later than January 1, 2024. iii. Milestone #3: No later than July 1, 2023, the provider must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the provider's HIE connection to the new HIE platform. The provider must continue to meet the HIE integration requirements through September 30, 2024. If the provider has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the provider to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024. No later than July 1, 2023, the provider must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the provider's HIE connection to the new HIE platform. The provider must continue to meet the HIE integration requirements through September 30, 2024.
c. Social Determinants of Health Closed Loop Referral Platform (2.0%)	The DAP increase will be applicable to the specified services as outlined in Attachment B-2. In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Providers that meet the following milestones are eligible to earn a 2.0% DAP. The following services are eligible for a DAP increase: Attendant Care (S5125), Companion Care (S5135 and S5136), Habilitation (T2017), Nursing (G0299, G0300, S9123, S9124), Home Health Aide (T1021). Physical Therapy (G0151), Physical Therapy (S9131), Occupational Therapy (G0152, S9129), Respiratory Therapy (S5181), Speech Therapy (G0153 and S9128), Homemaker (S5130), Personal Care (T1019), Respite (S5150 and S5151), Skills Training (H2014). i. Milestone #1: No later than April 1, 2023, the provider must submit a signed Health Information Exchange Statement of Work and the CommunityCares Access Agreement

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	indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the provider requests to participate in the DAP. ii. Milestone #2: 1. For providers that have participated in DAP SDOH requirements in CYE 2023: a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live and through September 30, 2024, the provider must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the provider) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the provider's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the provider will be counted toward volume requirements, and tracked monthly. 2. For providers that have not participated in DAP SDOH requirements in CYE 2023:

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	a. No later than November 1, 2023, complete the CommunityCares Access Agreement and HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system. If a provider has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the provider to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Electronic Visit Verification (EVV) Visit Status Compliance (2.75%)	HCBS providers that participate in the EVV system will qualify for a DAP increase of 2.75% if the provider has at least 70% of processed visits with dates of service from September 1, 2022, to November 30, 2022. A visit is considered "processed" when the visit has passed claims validation. The claim must have been either an auto-verified visit at the time of service delivery or the provider must have been able to reconcile missing or incomplete visits in accordance with the audit documentation guidelines prior to claims submission. The DAP increase will be applicable to the specified services as outlined in Attachment B.

e. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

f. Payment Methodology
For Eligible HCBS providers (identified in section B.5.B.3), fee for service rates for services specified in B.5.B.3 are eligible for the following increases: 0.5% for meeting the criteria described in B.5.B.3.a, 1.0% for meeting the criteria described in B.5.B.3.b, 2.0% for meeting the criteria described in B.5.B.3.c, and 2.75% for meeting the criteria described in B.5.B.3.d.

Providers which submitted an LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

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If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

4. **Behavioral Health Providers (1.0%)**
Community Service Agencies (A3), Independent Substance Abuse Counselors (A4), Behavioral Health Therapeutic Homes (A5), and Rural Substance Abuse Transitional Agencies (A6) are eligible for DAP increases on all services billed on CMS 1500 Form under the following criteria.

Domain	Description
a. Social Determinants of Health Closed Loop Referral Platform (1.0%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Providers that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2023, the provider must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the provider requests to participate in the DAP. ii. Milestone #2: 1. For providers that have participated in DAP SDOH requirements in CYE 2023:

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	a. No later than September 30, 2023, initiate use of the CommunityCares referral system operated by the HIE organization or are engaged and have completed an onboarding launch plan that outlines the extended onboarding timeline, required steps, and commitment to completion of onboarding by 12/31/2023. b. After go-live and through September 30, 2024, the provider must regularly utilize the CommunityCares referral system operated by the HIE organization. This will be measured by facilitating at least 10 referrals per month, including closed-loop referral, tracked out-of-network referrals (utilizing CommunityCares resource directory), or tracked internal cases (referrals for social services provided by the provider) per registered AHCCCS ID that resulted from utilizing a social-needs screening tool in CommunityCares or within the provider's EHR. Closed-loop referrals, out-of-network referrals, and internal cases all need to be documented/tracked within the CommunityCares platform. The referral is created by the provider or support staff member and sent directly to a social service provider. All referrals entered into the system by the provider will be counted toward volume requirements, and tracked monthly. 2. For providers that have not participated in DAP SDOH requirements in CYE 2023: a. No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required, and b. No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system.

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	If a provider has achieved one or more of the CYE 2024 as of April 1, 2023, the HIE SOW must include a commitment by the provider to maintain its participation in those milestone activities for the period April 1, 2023, through September 30, 2024.

b. IHS and Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS/638 DAP details.

c. Payment Methodology
Behavioral Health Providers (Provider Types A3, A4, A5 and A6) who met the SDOH Closed Loop Referral System requirements will qualify for a 1.0% increase on all non-institutional services.

Providers which submitted an LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

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5. **Physicians, Physician Assistants, and Registered Nurse Practitioners Specialty Types (Obstetrics and Gynecology, Pediatrics, Cardiology and Nephrology) (1.0%)**
Physicians, Physician Assistants, and Registered Nurse Practitioners (Provider Types 08, 18, 19, and 31) specialty types obstetrics and gynecology, pediatrics, cardiology and nephrology are eligible for DAP increases under the following criteria.

Domain	Description
a. Health Information Exchange (1.0%)	Providers that meet the following milestones are eligible to earn a 1.0% DAP. i. Milestone #1: No later than April 1, 2022, the provider must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each qualifying rendering provider, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the facility requests to participate in the DAP. 1. For providers that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than May 1, 2023, , the provider must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the provider's EHR system. 1. If it is the provider's first year in the DAP HIE initiative, then the provider must meet this milestone no later than January 1, 2024. iii. Milestone #3: No later than July 1, 2023, 2023, the provider must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition the provider's HIE connection to the new HIE platform. The provider must continue to meet

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	the HIE integration requirements through September 30, 2024. If a provider has achieved one or more of the CYE 2023 milestones as of April 1, 2023, the HIE SOW must include a commitment by the provider to maintain its participation in those milestone activities for the period April 1, 2023 through September 30, 2024.

b. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS and 638 DAP details.

c. Payment Methodology
Providers, as identified in Section B.5.B.5 above, qualify for a 1.0% increase on services for meeting the HIE requirements described in B.5.B.5.a.

Providers which submitted an LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive the respective DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

6. **Therapeutic Foster Homes (up to 20.0%)**
Therapeutic Foster Home providers (Provider Type A5) are eligible for DAP increases under the following criteria.

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Domain	Description
a. New Therapeutic Foster Homes (10.0%)	Newly licensed Therapeutic Foster Homes will qualify for a DAP increase of 10.0% on codes S5140 and S5145 if the provider has an AHCCCS registration date between April 1, 2022 and March 31, 2023.
b. Therapeutic Foster Home Continuous Therapeutic Foster Care (TFC) Services (10.0%)	Therapeutic Foster Homes will qualify for a DAP increase of 10.0% on codes S5140 and S5145, as identified by the AHCCCS Provider ID based on the following factors: i. A member was provided at least 60 days of continuous services between October 1, 2021, and December 31, 2022. ii. Only approved and adjudicated AHCCCS claims and encounters will be utilized in the computations. iii. AHCCCS will compute claims and encounters for this purpose as of March 15, 2023, to determine which providers meet the minimum threshold. iv. AHCCCS will not consider any other data when determining which providers qualify for the DAP increase.

c. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS and 638 DAP details.

d. Payment Methodology
Therapeutic foster home providers, as identified in Section B.5.B.6 above, qualify for a possible maximum increase of 20% on services listed in Section B.5.B.6. They may receive an increase of 10.0% for meeting the New Therapeutic Foster Homes criteria in Section B.5.B.6.a and an increase of 10.0% for meeting the Therapeutic Foster Home TFC Services criteria in Section B.5.B.6.b.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's

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eligibility for the DAP, effective immediately and for the remainder of the year.

7. **Multiple Provider Types**
Adult Day Health (Provider Type 27), Assisted Living Home (Provider Type 36), Attendant Care (Provider Type 40), Behavioral Health Outpatient Clinic (Provider Type 77), Community Service Agency (Provider Type A3), EPD HCBS (Provider Type 81), Habilitation Provider (Provider Type 39), Home Health Agency (Provider Type 23), Integrated Clinics (Provider Type IC), Non-Medicare Certified Home Health Agency (Provider Type 95), Rural Substance Abuse Transitional Agency (Provider Type B5), Subacute Facility (Provider Type A6) are eligible for DAP increases under the following criteria.

   a. Providers that participated in the CYE 2023 Provider Workforce Development Plan (P-WFDP) Under Part 'B' or did not participate in the CYE 2023 P-FWDP DAP, and meet the following milestones are eligible to earn 1.0% DAP increase on all services billed on CMS 1500 Form.
      i. Milestone #1: No later than March 15, 2023, submit a Provider Workforce Goal Setting and Data Reporting Compliance Attestation to the following email address: WFD@azahcccs.gov. The attestation must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the provider requests to participate in the DAP.

      ii. Milestone #2:
         1. For providers that have participated in the CYE 2023 P-WFDP under Part 'B':
            a. By April 30, 2023, a P-WFDP will be submitted. The P-WFDP must satisfy the requirements of both the CYE 2023 P-WFDP DAP and the MCO's requirements regarding the development and submission of Provider Workforce Development Plans.
         2. For providers that did not participate in the CYE 2023 P-WFDP DAP attest that:
            a. By April 30, 2024 they will have developed a Workforce Development Plan for the agency and that it will satisfy the following requirements:
               i. The MCO's contract requirements regarding the development and submission of Provider Workforce Development Plans and;
               ii. The Provider's Workforce Development Plans must specify three types of goals the provider intends to achieve during the time period beginning January 1, 2023 and ending December 31, 2023. The three required goals are for improving or

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maintaining workforce; *Retention, Turnover,* and *Time to Fill* difficult to hire staff positions.

iii. The strategies the provider intends to use to improve or maintain workforce; *Retention, Turnover,* and *Time to Fill* difficult to hire staff positions.

iii. Milestone #3: No later than April 30, 2024, the provider will submit the following benchmark metrics using the formulas found on the AZ Association of Health Plans website (https://azahp.org/azahp/awdfc/az-healthcare-workforce-goals-and-metrics-assessment/ under Data Collection) to calculate the provider's workforce for the time period beginning January 1, 2023, and ending December 31, 2023:

a. Average Retention Rate (e.g., 50%)
b. Average Turnover Rate (e.g., 60%)
c. Time to Fill the most difficult positions (e.g., RNs 28 days, DCWs 12 days, etc.).
d. Submit the workforce; *Retention, Turnover,* and *Time to Fill* goals the provider intended to achieve during the time period beginning January 1, 2023, and ending December 31, 2023:

- Providers can determine the eligibility of their agency to participate in the CYE 2024 Provider Workforce Goal and Data Reporting DAP by checking the CYE 2023 P-WFD Qualifying Provider list.
- Providers that participated in the CYE 2023 P-WFDP under Part B will see a notation next to the agency's name stating: "Not Submitted - Part B".
- Providers that did not participate in the CYE 2023 P-WFDP DAP will not see the name of their agency listed.
- Providers participating in the CYE 2023 P-WFDP DAP under Part "A" DO NOT qualify for this DAP.
- The CYE 2024 Provider Workforce Goal and Data Reporting Attestation template can be found on the AHCCCS website at the following location: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/qualifyingproviders.html

b. Employment Staff Training (2.0%)
Habilitation providers (Provider Type 39), Behavioral Health Outpatient Clinics (Provider Type 77), Community Service Agencies (Provider Type A3) and Integrated Clinics (Provider Type IC) that meet the following milestones are eligible to earn a 2% DAP increase on codes T2019, H2025, H2026, and H2027.

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i. Milestone #1: No later than April 1, 2023, submit an Employment Staff Training Attestation to the following email address: AHCCCSDAP@azahcccs.gov. The attestation must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the provider requests to participate in the DAP.

ii. Milestone #2: No later than December 31, 2023, employment provider staff must complete an ACRE approved (Association of Community Rehabilitation Educators) training provided by a single, third-party entity and must be, at a minimum, 40 hours in duration.

iii. For providers that participated in Employment Staff Training requirements for CYE 2023:
   a. In order to continue receiving this DAP, the provider must submit a roster of staff who have completed the training, with the staff names and dates of completion, along with the copy(ies) of the "Certificate of Achievement" by April 30, 2023.

iv. For providers that have not participated in Employment Staff Training requirements in CYE 2023:
   a. The provider must submit to AHCCCS, no later than December 31, 2023, a roster of staff who have completed the training, with the staff names and dates of completion, along with the copy(ies) of the "Certificate of Achievement".

v. The Employment Staff Training Attestation can be found on the AHCCCS website at the following location: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/qualifyingproviders.html

vi. If a provider submits the attestation and receives the DAP increase for CYE 2024, but does not train its staff by December 31, 2023, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

c. Pipeline AZ (1.0%)

Adult Day Health (Provider Type 27), Assisted Living Home (Provider Type 36), Attendant Care (Provider Type 40), Behavioral Health Outpatient Clinic (Provider Type 77), Community Service Agency (Provider Type A3), EPD HCBS (Provider Type 81), Habilitation Provider (Provider Type 39), Home Health Agency (Provider Type 23), Integrated Clinics (Provider Type IC), Non-Medicare Certified Home Health Agency (Provider Type 95), Rural Substance Abuse Transitional Agency (Provider Type B5), Subacute Facility (Provider Type A6) that meet the following milestones are eligible to earn a 1.0% DAP increase on all services.

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i. Milestone #1: No later than April 1, 2023, the provider must be registered with Pipeline AZ at: https://pipelineaz.com/page/DAP.
ii. Milestone #2: No later than August 30, 2023, the provider must have developed the company page by completing the Company Details, Overview, Culture, Perk, and Benefits sections.
iii. Milestone #3: No later than January 31, 2024, the provider must post relevant current open roles with 50% of the posts being entry-level roles to the provider's Pipeline AZ page.
iv. Milestone #4: Between February 1, 2024, and August 31, 2024, the provider must maintain at least 10 employment interactions per month. Employment interactions may consist of, viewing matched candidate profiles, messaging candidates within the platform, documenting hires, and/or renewing or editing existing job posts. All interactions will be counted toward volume requirements, tracked monthly, and reported to AHCCCS.

d. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS and 638 DAP details.

e. Payment Methodology
Providers that participated on the CYE 2023 Provider Workforce Development Plan Under 'Part B' or did not participate in the CYE 2023 P-WFDP may qualify for an increase of 1.0% on all AHCCCS-covered, fee for service non-institutional services, by meeting the criteria in Section B.5.B.7.a. Habilitation providers, behavioral health outpatient clinics, community service agencies and integrated clinics are eligible for a 2.0% increase on employment codes by meeting the Employment Staff Training requirements described in Section B.5.B.7.b and a 1.0% increase on all services for meeting the criteria described in B.5.B.7.c.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

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If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

8. **Crisis Providers (3.0%)**

Subacute Facilities 1-16 Beds (Provider Type B5), Subacute Facilities 17+ beds (Provider Type B6), Crisis Services Providers (Provider Type B7), Psychiatric Hospitals, with the exception of public hospitals (Provider Type 71), Behavioral Health Outpatient Clinics (Provider Type 77), and Integrated Clinics (Provider Type IC), that are contracted to provide crisis services. For the purposes of this DAP, a crisis provider is defined as an AHCCCS registered provider that is participating in the Bed Registry Project.

Domain	Description
a. Crisis Bed Registry (3.0%)	In order to qualify, the provider must have submitted an executed Crisis Bed Registry Statement of Work (SOW) to the HIE by December 31, 2022. Crisis providers that have submitted the SOW and who meet the following milestones are eligible for a 3.0% DAP increase on all services under the following criteria: i. Milestone #1: No later than April 1, 2023, the provider must have in place an active participation agreement with the HIE organization and submit a Health Information Exchange Statement of Work (HIE SOW) indicating Crisis Bed Registry participation, in which it agrees to achieve the following milestones by the specified dates or maintain its participation in the milestone activities if they have already been achieved. ii. Milestone #2: No later than April 30, 2023, the provider shall work with the HIE organization and their EHR vendor to attend a vendor discovery call and the provider and EHR vendor must complete the Crisis Bed Registry Attestation which agrees to send HL7 and customized data to the HIE organization and the provider agrees to any EHR vendor fees for vendor customization. iii. Milestone #3: No later than November 30, 2023, the provider will work with the HIE organization and their EHR vendor to have their EHR customize HL7 data and send test messages to the HIE

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	that meets the required Crisis Bed Registry specifications, which is defined by the HIE organization. iv. Milestone #4: No later than March 31, 2024, the provider must electronically submit Crisis Bed Registry HL7 messages to the production environment of the HIE organization.

b. IHS and 638 Tribally Owned and/or Operated Facilities
IHS and 638 tribally owned and/or operated facilities are not eligible for this DAP. Please see Section 9 below for IHS and 638 DAP details.

c. Payment Methodology
Crisis Providers, as identified in Section B.5.B.8.a, are eligible for a 3.0% increase on services for meeting the Crisis Capacity Data Exchange criteria described in section B.5.B.8.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

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The following is a description of methods and standards for determining Differential Adjusted Payments for IHS/638 Tribally owned and/or operated facilities. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS rates. These payment adjustments will occur for all dates of service in Contract Year Ending (CYE) 2024 (October 1, 2023 through September 30, 2024) only.

9. IHS and 638 Tribally Owned and/or Operated Facilities (Up to 3.0%)

Indian Health Service and/or Tribally owned and/or operated hospitals, Provider Type 02, by March 15, 2023 are eligible for a DAP increase on all services under the following criteria

Domain	Description
a. Health Information Exchange Participation (Up to 1.5%)	Hospitals that meet the following milestones are eligible to earn a 1.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW). The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than May 1, 2023, the hospital must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the hospital's EHR system. iii. Milestone #3: No later than May 1, 2023, hospitals that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the qualifying HIE, if required by the external reference lab, to have all outsourced lab test results flow to the qualifying HIE organization on their behalf.

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	iv. Milestone #4: No later than May 1, 2023, the hospital must electronically submit the following actual patient identifiable information to the production environment of a qualifying HIE organization: admission, discharge, and transfer information (generally known as ADT information), including data from the hospital emergency department if the facility has an emergency department; laboratory and radiology information (if the provider has these services); transcription; medication information; immunization data; and discharge summaries that include, at a minimum, discharge orders, discharge instructions, active medications, new prescriptions, active problem lists (diagnosis), treatments and procedures conducted during the stay, active allergies, and discharge destination. If the hospital has ambulatory and/or behavioral health practices, then the facility must submit the following actual patient identifiable information to the production environment of a qualifying HIE: registration, encounter summary, and SMI data elements as defined by the qualifying HIE organization. For hospitals that have not participated in DAP HIE requirements in CYE 2022, the deadline for this milestone will be November 1, 2022. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, the deadline for this milestone will be June 30, 2023 v. Milestone #5: No later than May 1, 2023, the hospital must have or obtain a unique Object Identifier (OID) created by a registration authority, the hospital, and HL7. The OID is a globally unique International Organization for Standardization identifier for the hospital. Contact the HIE's Quality Improvement Team for instructions and to ensure you are compliant. vi. Milestone #6: No later than July 1, 2023, the hospital must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition to the hospital's HIE connection to the new HIE platform. The hospital must continue to meet the HIE integration requirements through September 30, 2024. For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be

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	actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 CFR Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period April 1, 2023through September 30, 2024.
b. Social Determinants of Health Closed Loop Referral System (0.5%)	In relation to this DAP initiative only, the Social Determinants of Health Closed Loop Referral System is CommunityCares. Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) and the CommunityCares Access Agreement indicating SDOH participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than November 1, 2023, complete the CommunityCares Access Agreement and the HIE Participant Agreement, as required. iii. Milestone #3: No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the system If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024. Additionally, if a hospital

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	submits a HIE SOW and receives the DAP increase for CYE 2024 but fails to achieve one or more of the milestones by the specified date or fails to maintain its participation in the milestone activities, that hospital will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.
c. Arizona Health Directives Registry (0.5%)	Hospitals that meet the following milestones are eligible to earn a 0.5% DAP. i. Milestone #1: No later than April 1, 2023, the hospital must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP. 1. For hospitals that have not participated in DAP HIE requirements in CYE 2023, send an email requesting an HIE SOW to DAP@contexture.org. ii. Milestone #2: No later than November 1, 2023, complete the AzHDR Participant Agreement. iii. Milestone #3: No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform. If a hospital has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the hospital to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.
d. Naloxone Distribution Program (0.5%)	Hospitals with an Emergency Department that meet the following milestones are eligible to earn a 0.5% DAP increase on all inpatient and outpatient services. i. Milestone #1: No later than April 30, 2023, the hospital must submit a Letter of Intent (LOI) to AHCCCS to the following email address: AHCCCSDAP@azahcccs.gov, indicating that they will participate in the Naloxone Distribution Program (NDP). The LOI must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the hospital requests to participate in the DAP.

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	ii. Milestone #2: No later than November 30, 2023, develop and submit a facility policy that meets AHCCCS/ADHS standards for an NDP. iii. Milestone #3: No later than January 1, 2024, begin distribution of Naloxone to individuals at risk of overdose as identified through the facilities' policy

e. Payment Methodology

All payments will be increased by 1.5% if the IHS/638 facility meets the above criteria for HIE participation in B.5.B.9.a, by 0.5% if the IHS/Tribal 638 facility meets the above criteria for the AzHDR requirements in B.5.B.9.c, by 0.5% if the IHS/Tribal 638 facility meets the above criteria for SDOH in B.5.B.9.b, and by 0.5% of the IHS/Tribal 638 facility meets the above criteria for the Naloxone Distribution Program in B.5.B.9.d. The DAP for IHS/638 facilities would be applicable to the All-inclusive Rate (AIR).

IHS/Tribal 638 facility which submitted an HIE LOI and received a DAP increase for CYE 2023 but failed to achieve one or more milestone in the LOI or failed to maintain its participation in the milestone activities are ineligible to receive DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification

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must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a provider receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that provider will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

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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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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.

Nursing facility services provided by facilities owned or operated by the Indian Health or tribes under PL 93-638 are reimbursed for each Medicaid day at the outpatient All-Inclusive Rate as published in the Federal Register.

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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- 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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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 will 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. For rates effective from October 1, 2011 to September 30, 2013, and from October 1, 2015 and thereafter, no inflation factor will be applied.

Below are the AHCCCS FFS Nursing Facility Per Diem Rates effective on and after January 1, 2024:

Level of Care	Revenue Code	Urban Rate	Rural Rate	Flagstaff
LOA/Therapeutic**	0183	$209.37	$202.84	$208.85
LOA/Nursing Home**	0185	$209.37	$202.84	$208.85
Level I	0191	$209.37	$202.84	$208.85
Level II	0192	$228.89	$221.05	$227.58
Level III	0193	$271.50	$262.81	$270.59

*AHCCCS has designated nursing facilities in the Arizona counties of Pima, Pinal, and Maricopa as Urban to be paid at the AHCCCS Urban Rate. All other counties inside or outside of Arizona are designated as Rural and are paid at the AHCCCS Rural Rate (except Flagstaff ,which is paid at the rate specified above).
**This LOA rate only applies to reserved beds at Nursing Facilities

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.

E. Nursing Facility Supplemental Payments

Effective October 1, 2012, nursing facilities that are located in Arizona with Arizona Medicaid utilization will receive a quarterly supplemental payment to compensate providers for costs of covered services furnished to Arizona Medicaid beneficiaries to improve access to care.

1. Each nursing facility's supplemental payment shall be determined as follows:

a) On a quarterly basis, AHCCCS shall determine the aggregate supplemental payment amount for all nursing facilities by:

i. Determining the total amount from the nursing facility provider assessment fund for the quarter, which is the assessment amount collected from providers in accordance with paragraph E.2.
ii. Subtracting one percent of the total estimated assessments, and
iii. Dividing the difference of subsections (a)(i) and (a)(ii) by (1 minus the appropriate federal medical assistance percentage (FMAP).

b) AHCCCS shall calculate the quarterly supplemental payment to each nursing facility that has Arizona Medicaid utilization per paragraph (b)(i) below, excluding facilities outside of Arizona, ICF/IIDs and Arizona Veteran's Homes, by:

i. Determining each facility's proportion of Medicaid resident bed days to total nursing facility Medicaid resident bed days for all facilities by utilizing adjudicated claims and encounter data for the most recent 12 month period, including appropriate claims lag. The most recent 12 month period is defined as the contiguous 12-month period that ends six months prior to the month in which the Medicaid resident bed days are pulled. AHCCCS will pull the Medicaid resident bed day data in the first quarter of each payment year.
ii. Multiplying subsections (b)(i) and (a)(iii)
iii. Determining the fee-for-service share of the amount in (b)(ii) by applying a ratio of the facility's Medicaid fee-for-service bed days to the facility's total Medicaid bed days. The remaining share pertains to Medicaid managed care services; Medicaid managed care services are reimbursed separately by AHCCCS through capitation payments.

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(c) AHCCCS shall make quarterly supplemental payments to eligible nursing facility providers after the assessment quarter. The fee-for-service quarterly supplemental payment will be made directly to each eligible nursing facility. If the fee-for-service quarterly supplemental payment amount is less than $25 for an individual facility, no fee-for-service quarterly supplemental payment will be made.

(d) A facility must be open on the date the supplemental payment is made in order to receive a payment.

(e) During the quarter ending March 31, 2015, an additional quarterly payment adjustment will be made that is equal to the difference between what the quarterly payment would be if the pool amount was determined under paragraph 2 below effective January 1, 2015 and what the quarterly payment would be if the pool amount was determined based on paragraph 2 as it was in effect prior to January 1, 2015.

2. The nursing facility assessment to be collected from each nursing facility is as follows:

(a) The assessment is imposed on non-Medicare patient days as allowed for under 42 CFR 433.68(d);
(b) The assessment imposed is $15.63 per non-Medicare day except:
   i. Continuing Care Retirement Communities, ICF/IIDs, IHS and Tribal 638 nursing facilities, Arizona Veteran's Homes, and facilities located outside of Arizona will not be assessed;
   ii. Facilities with 58 or fewer total beds will not be assessed; and
   iii. Facilities with annual Medicaid days greater than or equal to the number required to achieve a slope of at least 1 applying the uniformity tax waiver test described in 42 CFR 433.68(e)(2) will be assessed at a rate of $1.80 per non-Medicare day.

The patient days used in the computations are derived from the Nursing Facility Uniform Accounting Report (UAR) Cost Reports filed with the Arizona Department of Health Services. Calculations for the assessment will be made once per year in August, using the most recently filed UAR as of August 1 immediately preceding the start of the assessment year. Only those facilities with a full year UAR will be assessed. The computed annual assessment amount will be divided by four and imposed on a quarterly basis.

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Nursing Facility Differential Adjusted Payment

As of October 1, 2023 through September 30, 2024 (Contract Year Ending (CYE) 2024), provider type 22 nursing facilities that are located in Arizona with Arizona Medicaid utilization that meet AHCCCS established value-based performance metrics requirements below will receive one or both of the Differential Adjusted Payments described below. The Differential Adjusted Payment Schedule represents a positive adjustment to the AHCCCS Fee-For-Service reimbursement rates. These payment adjustments will occur for all dates of service in CYE 2024 only. The purpose of the Differential Adjusted Payment is to distinguish facilities which have committed to supporting designated actions that improve patients' care experience, improve members' health, and reduce cost of care growth.

a. Health Information Exchange

Nursing facilities that meet the following milestones are eligible to earn a 0.5% DAP.

i. *Milestone #1:* No later than April 1, 2023, the facility must have in place an active participation agreement with the Health Information Exchange (HIE) organization and submit a signed Health Information Exchange Statement of Work (HIE SOW) to the HIE. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding National Provider Identifier(s) (NPI), that the facility requests to participate in the DAP.

ii. *Milestone #2:* No later than May 1, 2023, the facility must have actively accessed, and continue to access on an ongoing basis, patient health information via the HIE organization, utilizing one or more HIE services, such as the HIE Portal, ADT Alerts, Clinical Notifications, or an interface that delivers patient data into the facility's EHR. System. If it is the facility's first year in the DAP HIE initiative, then the facility must meet this milestone no later than January 1, 2024.

iii. *Milestone #3:* No later than September 30, 2023, facilities that utilize external reference labs for any lab result processing must submit necessary provider authorization forms to the HIE, if required by the external reference lab, to have all outsourced lab test results flow to the HIE organization on their behalf.

iv. *Milestone #4:* No later than September 30, 2023, the facility must electronically submit the following actual patient identifiable information to the production environment of the HIE organization: admission, discharge, and transfer information (generally known as ADT information) from within the nursing facility; continuity of care documents reflecting a summary of care within the nursing facility including (if applicable): laboratory and radiology information; medication information; immunization data; active problem lists (diagnosis); social history; treatments and procedures conducted during the stay; advance directives; active allergies; and basic patient demographic data including assigned provider, emergency contact and payer.

v. Milestone #5: No later than September 30, 2023, the facility must have or obtain a unique Object Identifier (OID) created by a registration authority, the facility, and HL7. The OID is a globally unique International Organization for Standardization identifier for the facility.

vi. Milestone #6: No later than July 1, 2023, the facility must sign a DAP SOW amendment to include HIE integration requirements. which will include the steps and expectations and timeline to transition the facility's HIE connection to the new HIE platform. The facility must continue to meet the HIE integration requirements through September 30, 2024.

For any milestone that includes electronic submission of patient information, the information transferred to the qualifying HIE must be actual patient data; the transfer of test data does not fulfill these requirements. All electronic submissions must be received through standard HL7 or CCD document architecture. It must include all patient data, including behavioral health data and data covered by 42 C.F.R. Part 2. Data is expected to be live throughout the year, any downtime will be reported and an effort to provide data to the HIE is required for the period in which the data was not received.

If a nursing facility has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the facility to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.

b. Arizona Health Directives Registry (AzHDR) (0.5%)
Nursing facilities that meet the following milestones are eligible to earn a 0.5% DAP.

i. Milestone #1: No later than April 1, 2023, the facility must submit a signed Health Information Exchange Statement of Work (HIE SOW) indicating AzHDR participation to the HIE organization. The HIE SOW must contain each facility, including AHCCCS ID(s) and corresponding NPI(s), that the facility requests to participate in the DAP.

ii. Milestone #2: No later than November 1, 2023, complete the AzHDR Participant Agreement.

iii. Milestone #3: No later than April 1, 2024, have onboarding completed by working with the HIE to submit all HIE requirements prior to gaining access to the platform.

If a nursing facility has achieved one or more of the CYE 2024 milestones as of April 1, 2023, the HIE SOW must include a commitment by the facility to maintain its participation in those milestone activities for the period of April 1, 2023, through September 30, 2024.

c. Urinary Tract Infection Performance Measure (1.0%)

Nursing facilities that meet or fall below the statewide average percentage for the Urinary Tract Infection (UTI) performance measure will qualify for a 1.0% DAP increase. On March 15, 2023,

AHCCCS will download data from the Medicare Provider Data Catalog website for the percent of long-stay residents with a UTI. Facility results will be compared to the Arizona average results for the measure. Facilities with percentages less than or equal to the statewide average score will qualify for the DAP increase.

Exemptions

IHS and 638 tribally owned and/or operated facilities, including nursing facilities are exempt from this initiative based on payments primarily at the all-inclusive rate.

Payment Methodology

For provider type 22 nursing facilities, the fee-for-service payment rates will be increased by 1.0% if they meet the UTI requirements, by 0.5% if they meet AzHDR requirements, and by 0.5% if they meet the HIE requirements. A Provider Type 22 facility meeting UTI, AzHDR, and HIE requirements will receive a combined 2.0% increase. These increases do not apply to supplemental payments.

Facilities which submitted an HIE LOI and received an increase for CYE 2023 but failed to achieve one or more milestones in the HIE LOI or failed to maintain its participation in the milestone activities are ineligible to receive a DAP in CYE 2024.

If a provider is receiving a DAP in CYE 2024 and cannot meet a milestone and/or cannot maintain its participation in milestone activities, the provider must immediately notify AHCCCS. This notification must be made prior to the milestone deadline and must state the reason the milestone cannot be met. When applicable, DAP participants are subject to audits, at the discretion of AHCCCS. Within 30 days of AHCCCS being notified of a missed milestone, becoming aware of the provider's failure to maintain participation, and/or determining that the provider has failed a DAP audit, AHCCCS will remove the participant's eligibility for the DAP, effective immediately and for the remainder of the year.

If a facility receives a DAP increase for the entire CYE 2024 but it is determined subsequently that it did not meet the CYE 2024 milestones or failed to maintain its participation in the milestone activities in CYE 2024, that facility will be ineligible to receive this DAP for CYE 2025 if a DAP is available at that time.

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STATE: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

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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STATE: ARIZONA

METHODS AND STANDARDS FOR ESTABLISHING FEE-FOR-SERVICE PAYMENT RATES FOR LONG TERM CARE FACILITIES

IV. Temporary Rate Reduction

Notwithstanding the methods and rates as otherwise described in this attachment, for dates of service effective from October 1, 2011 to September 30, 2013, payments will be at the payment rates in effect as of September 30, 2011, reduced by 5%.

Payments for services provided by the Indian Health Service or Tribal 638 Health facilities are not subject to this 5% rate reduction.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: ARIZONA

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.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: Arizona

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 Information is provided by the Arizona Department of Administration's Office of Employment and Population Statistics (EPS), which is the State Wage Information Collection Agency. The eligibility systems (AZTECS and HEAplus) of the Arizona Department of Economic Security and AHCCCS matches with the State Wage file during the application and renewal process. It also searches for a match every six months for families that report no income during their application or renewal. AHCCCS and DES collect SSA income and Medicare information from the SVES and SOLQI processes provided by SSA. DES collects SSA income information from the BENDEX file provided by SSA.

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.

AHCCCS conducts quarterly data exchanges with the Industrial Commission of Arizona (ICA) to match Medicaid recipients with records of those with employment related injuries or illnesses.

Frequency of data exchange required by 42 CFR 433.138(d)(4)(ii), State Motor Vehicle accident report files.

AHCCCS conducts quarterly data matches with the Arizona Department of Transportation (ADOT) to identify Medicaid recipients with motor vehicle accident reports.

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STATE: Arizona

Frequency of the diagnosis and trauma code edits per 42 CFR 433.138(e).

Diagnosis and trauma code edits are conducted monthly. AHCCCS contracts with a TPL Contractor to perform the required diagnosis and trauma code edits matches and recovery.

The TPL Contractor is provided, via the secure FTP server, a monthly extract of fee-for-service (FFS) paid claims that include the claim specific diagnosis codes. The TPL Contractor conducts diagnosis and trauma code edits for codes identified in AHCCCS's published Trauma Code Set, for all fee-for-service claims, and removes all beneficiaries with any previous trauma code if the date of service is within six months of the previously reported date of service. The Contractor then returns a file of matched members not previously identified in a trauma code data match. Each member identified in the data match is sent a questionnaire, and they are asked to respond within ten days.

4.22(b)(2)
Methods used for meeting the follow-up requirements contained in 42 CFR 433.138(g)(l)(i), SWICA, SSA Wage and Earnings Files, and IV-A Agency.

AHCCCS and the DES Division of Benefits and Medical Eligibility (DBME) workers identify potential TPL based on information obtained from the SWICA and SSA Wage and Earnings files. Eligibility workers also obtain other insurance information if it is reported by the applicant through the CMS-approved application. The DES Division of Child Support Enforcement verifies coverage through the absent parent's employer via the National Medical Support Part B Medical Support Notice to Plan Administrator. The TPL information is inputted into the Arizona Technical Eligibility Computer System (AZTECS), ACE, or HEAplus eligibility systems. AZTECS is the DES eligibility system for various public assistance programs; AHCCCS Customer Eligibility (ACE) is the eligibility system used by AHCCCS for ALTCS enrollment; Health-e-Arizona Plus (HEAplus) is the state's new eligibility system designed to comply with the Affordable Care Act. Medical eligibility is currently being transitioned to HEAplus. Eventually, the state plans to use HEAplus to determine eligibility for all of the state's public assistance programs. This information is transmitted daily to the AHCCCS Prepaid Medical Management Information System (PMMIS). Once entered into the PMMIS, the information is sent to the AHCCCS TPL Contractor for verification. The Contractor verifies the health insurance information through its data matching processes with insurance carriers throughout the country. Once verified, the information is communicated to the AHCCCS Managed Care Contractors via the enrollment roster which provides the insurance carrier information.

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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 health insurance information to AHCCCS when medical support is secured. Information is verified through the absent parent's employer and is then entered into the Arizona Tracking and Location Automated System (ATLAS). DCSE transmits a daily file 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.

Health Insurance Data Exchanges:
Identifying Members with other medical coverage information begins with the initial eligibility process and continues throughout the Member's Medicaid eligibility. Commercial insurance coverage information is maintained in the Pre-paid Medical Management Information System (PMMIS). AHCCCS utilizes its TPL Contractor to perform insurance verifications and data matches. New insurance referrals and updates to existing commercial insurance coverage information are batched daily and placed on the secure FTP server. The TPL Contractor picks-up the file and verifies the changes. When the verifications are completed the TPL Contractor returns the coverage information to the secure FTP server. The Contractor is expected to complete the file pick-up, verification, and return of coverage information to the FTP server within a month. In addition to verifying new segment information received from AHCCCS, the TPL Contractor monthly matches the entire Medicaid membership with their national database of commercial insurance policy information and verifies the coverage of potential matches and returns the verified information to the secure FTP server. Upon receipt of the verified coverage information, AHCCCS updates PMMIS and, if appropriate, transmits verified coverage information to the appropriate health plan (MCO) using the secure FTP server.

Monthly, the TPL Contractor matches AHCCCS FFS paid claims with the contractor's national medical insurance coverage database and if a Member match is found the responsible insurance carrier is billed for paid claims that may have been overlooked by the State's internal TPL activities. All recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

Workers' Compensation Data Exchanges:
AHCCCS conducts a quarterly data match with the ICA. The TPL Contractor conducts the data match of AHCCCS Members with individuals who have filed a claim with the ICA. Quarterly, the ICA places a file containing all of the Workers Compensation claims opened within the last

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24 months on the AHCCCS secure FTP server. The TPL Contractor picks up the file, matches the data with AHCCCS Membership, and then uses the file of the matched FFS members in either the diagnosis and trauma code edit recovery process (see diagnosis and trauma code edits below) or for a more specialized recovery effort. Again if appropriate, workers compensation information is transmitted to the appropriate health plan (MCO) using the AHCCCS secure server, to be used in their recovery effort. Workers compensation recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

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 conducts a quarterly data match with the ADOT. AHCCCS provides ADOT a file containing the AHCCCS ID number, SSN and other required information for members who would have been at least 16 years old at any time during that last 24 months.

ADOT conducts the matching process and returns a file that contains the AHCCCS ID number and any matched "crash" data. The ADOT data match is limited to eligible drivers since ADOT does not capture passenger information. Since ADOT only has the ability to match the AHCCCS members with licensed drivers, AHCCCS expands the ADOT returned file to include AHCCCS Members who are part of the Member's household, or otherwise associated with the ADOT matched member in the AHCCCS eligibility system, before sending it to the TPL contractor for follow-up. Upon receipt of the file, the TPL Contractor removes all beneficiaries with any previously identified trauma code service if the date of service is within six months of the previously identified date of service. The Contractor uses the FFS matches as a referral to the Trauma Edit Code Edit process (see diagnosis and trauma code edits below), or sends them to the appropriate health plan (MCO) using the AHCCCS secure FTP server, to be used in their recovery effort. Recoveries from the ADOT data matches are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

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STATE: Arizona

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 the required diagnosis and trauma code edits for AHCCCS. The TPL Contractor conducts diagnosis and trauma code edits for codes identified in AHCCCS's published Trauma Code Set, for all fee-for-service claims.

AHCCCS provides the TPL Contractor, via the AHCCCS secure FfP server, a monthly extract of the AHCCCS paid claims which include the claim specific diagnosis codes. The TPL Contractor matches an extract of those claims, that contain specific trauma codes, with the database of AHCCCS Members, and returns a file of matched members not previously identified in a trauma code data match. Each Member identified in the current data match is sent a questionnaire and are asked to respond within 10 days. 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 mail a new questionnaire using the corrected address information.

The TPL Contractor will review the response to the questionnaire and determine if a casualty case should be opened. A casualty case is opened if the returned questionnaire includes TPL or attorney information. Arizona does not specify a dollar threshold or minimum period of accumulation of claims. If a case is opened a medical lien is filed against the member for possible third party recovery within 60 days of a notification of injury and the TPL Contractor actively pursues recovery from the liable source. All recoveries are reported in the year of the AHCCCS paid claim using appropriate reporting categories.

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.

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STATE: Arizona

If after 30 days there is no response to this letter there are no additional attempts to contact the member unless the member is later identified through either the ADOT or ICA data matched (see above.) The AHCCCS TPL Office reviews at least 25% of the open and closed cases on a monthly basis to ensure the Contractor's efforts are compliant with the terms of the contract. If the member is identified in either of these data matches a new round of questionnaires begins using the information identified in the ADOT 'crash data" or from the ICA workers compensation file.

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STATE: ARIZONA

State: _____

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I)
Pursuant to the Deficit Reduction Act of 2005, Arizona adopted A.R.S. § 36-2923, with an effective date after June 30, 2009, that requires third parties to provide the State with coverage, eligibility and claims data that is outlined in 25 USC § 1902(a)(25)(I).

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STATE: Arizona

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, but not prohibited, from billing 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):
Method used in determining cost effectiveness as specified in 42 CFR 433.139(f)(2).

AHCCCS considers the cost effectiveness principle in determining what the estimated net recovery amount to be pursued based on the likelihood of collections. Net recovery amount is defined as that amount of recovered dollars to apply to Medicaid costs. In determining the estimated recovery amount, the following factors will be considered:

- Settlement as may be affected by insurance coverage or other factors relating to the liable party;
- Factual and legal issues of liability as may exist between the client and liable party;
- Problems of proof faced in obtaining the award or settlement; and
- The estimated attorney's fee and costs required for AHCCCS to pursue the claim.

After considering the above factors, AHCCCS may pursue a lesser recovery amount to the extent that it determines it to be cost effective to do so.

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4.22(d)(3):

Method used for determining billing accumulation as specified in 42 CFR 433.139(f)(3).

Specific member claims must generally total $250.00, or more, in order for a case to be considered for potential recovery. Claims expenses are accumulated beginning with the date of injury to, whichever occurs first, the last date of treatment or the case is settled.

4.22(d)(4)

The State attests that the Third Party Liability requirements outlined in 1902(a)(25)(E) and 1902(a)(25)(F)(i) of the Social Security Act are met. These requirements are:

1. For the State to apply cost avoidance procedures to claims for prenatal services, including labor, delivery, and postpartum care services;
2. For the State to make payments without regard to potential TPL for pediatric preventive services, unless the state has made a determination related to cost-effectiveness and access to care that warrants cost avoidance for 90 days; and
3. The State's flexibility to make payments without regard to potential TPL for up to 100 days for claims related to child support enforcement beneficiaries.

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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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State: ARIZONA

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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State/Territory: ARIZONA

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.

State law allows for health care powers of attorney, allows flexibility when drawing up living wills and permits 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 cardiopulmonary resuscitation in the event of cardiac or respiratory arrest.

The Arizona Attorneys General's office maintains and updates the Arizona's Advance Directives brochure (also referred to as the "Life Care Planning Packet"). A copy of the most recent brochure, printed in both English and Spanish can be accessed on the following webpage:

https://www.azag.gov/seniors/life-care-planning.

Additionally, AHCCCS policy detailing Advance Directives requirements can be found at the following webpage:

https://www.azahcccs.gov/shared/Downloads/MedicalPolicyManual/640AdvanceDirectives.pdf

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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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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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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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State/Territory: ARIZONA

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.

* U.S. Government Printing Office : 1991 - 312-149/40413

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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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State: Arizona

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.

Attachment 4.43

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.

Attachment 4.44

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/ Territory: Arizona

GENERAL PROGRAM ADMINISTRATION

4.44 Medicaid Prohibition on Payments to Institutions or Entities Located Outside of the United States

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Citation: Section 1902(a)(80) of the Act, P.L. 111-148 (Section 6505)

X The State shall not provide any payments for items or services provided under the State plan or under a waiver to any financial institution or entity located outside of the United States.

TN No. 11-003
Supersedes
TN No. N/A

Approval Date: MAR 3 1 2011 Effective Date: January 1, 2011

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.

Vaccine and Vaccine Administration at Section 1905(a)(4)(E) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

__X __ The state assures coverage of COVID-19 vaccines and administration of the vaccines.[1]

__X__ The state assures that such coverage:

1. Is provided to all eligibility groups covered by the state, including the optional Individuals Eligible for Family Planning Services, Individuals with Tuberculosis, and COVID-19 groups if applicable, with the exception of the Medicare Savings Program groups and the COBRA Continuation Coverage group for which medical assistance consists only of payment of premiums; and
2. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(H) and section 1916A(b)(3)(B)(xii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

__X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing or similar charge, pursuant to section 1937(b)(8)(A) of the Act.

_X__The state provides coverage for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to §§1902(a)(11), 1902(a)(43), and 1905(hh) of the Act.

__X__ The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration, with respect to the providers that are considered qualified to prescribe, dispense, administer, deliver and/or distribute COVID-19 vaccines.

Additional Information (Optional):

[1] The vaccine will be claimed under this benefit once the federal government discontinues purchasing the vaccine.

Reimbursement

__X__ The state assures that the state plan has established rates for COVID-19 vaccines and the administration of the vaccines for all qualified providers pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

List Medicaid state plan references to payment methodologies that describe the rates for COVID-19 vaccines and their administration for each applicable Medicaid benefit:

- Payment Methodology for Vaccine Administration during the PHE: State Plan page 96 as established by DR SPA AZ-20-0031 from 3/11/21 through 8/8/21 and by DR SPA AZ-21-0007, from 8/9/21 through the end of the PHE.
- The state has checked the "establishing" box below to set the vaccine administration rate from one day after the end of the PHE to the end of the ARP period.
- 4.19-B, page 7-9: IHS/638 Facilities are paid at the Outpatient all-inclusive rate (AIR)
- 4.19-B, page 3a-5: FQHC/RHCs are paid at the PPS Rate when vaccine administration is provided as part of a clinic visit
- 4.19-B, page 5c: Payment Methodology for EPSDT Vaccine Counseling

_X__ The state is establishing rates for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

__X__ The state's rates for COVID-19 vaccines and the administration of the vaccines are consistent with Medicare rates for COVID-19 vaccines and the administration of the vaccines, including any future Medicare updates at the:

____ Medicare national average, OR

__X__ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 vaccines and the administration of the vaccines pursuant to sections 1905(a)(4)(E) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location :

__X__ The state's fee schedule is the same for all governmental and private providers.

___ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

__ The payment methodologies for COVID-19 vaccines and the administration of the vaccines for providers listed above are described below:

___The state is establishing rates for any medically necessary COVID-19 vaccine counseling for children under the age of 21 pursuant to sections 1905(a)(4)(E), 1905(r)(1)(B)(v) and 1902(a)(30)(A) of the Act.

___The state's rate is as follows and the state's fee schedule is published in the following location :

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Testing at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage

_X__ The states assures coverage of COVID-19 testing consistent with the Centers for Disease Control and Prevention (CDC) definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

_X__ The state assures that such coverage:

1. Includes all types of FDA authorized COVID-19 tests;
2. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
3. Is provided to the optional COVID-19 group if applicable; and
4. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(l) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

Please describe any limits on amount, duration or scope of COVID-19 testing consistent with 42 CFR 440.230(b).

_X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 testing consistent with the CDC definitions of diagnostic and screening testing for COVID-19 and its recommendations for who should receive diagnostic and screening tests for COVID-19.

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 testing for each applicable Medicaid benefit:

- State Plan Attachment 4.19-B, page 1a: Outpatient Hospital Benefit
- State Plan Attachment 4.19-B, page 5c: Testing under all other non-institutional benefits
- Attachment 4.19-B, page 7-7(a): IHS/638 Facilities - When provided as part of a clinic visit, testing at IHS/638 Facilities is paid at the Outpatient All Inclusive Rate (AIR).
- Attachment 4.19-B, page 3a-5: FQHCs/RHCs - When provided as part of a clinic visit, testing at FQHCs/RHCs is paid at the PPS rate.

____ The state is establishing rates for COVID-19 testing pursuant to pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates for COVID-19 testing are consistent with Medicare rates for testing, including any future Medicare updates at the:

____ Medicare national average, OR

____ Associated geographically adjusted rate.

____ The state is establishing a state specific fee schedule for COVID-19 testing pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

The state's rate is as follows and the state's fee schedule is published in the following location:

____ The state's fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 testing is described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

____The payment methodologies for COVID-19 testing for providers listed above are described below:

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

COVID-19 Treatment at section 1905(a)(4)(F) of the Social Security Act

During the period starting March 11, 2021 and ending on the last day of the first calendar quarter that begins one year after the last day of the emergency period described in section 1135(g)(1)(B) of the Social Security Act (the Act):

Coverage for the Treatment and Prevention of COVID

_X__ The states assures coverage of COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

__X_ The state assures that such coverage:

1. Includes any non-pharmacological item or service described in section 1905(a) of the Act, that is medically necessary for treatment of COVID-19;
2. Includes any drug or biological that is approved (or licensed) by the U.S. Food & Drug Administration (FDA) or authorized by the FDA under an Emergency Use Authorization (EUA) to treat or prevent COVID-19, consistent with the applicable authorizations;
3. Is provided without amount, duration or scope limitations that would otherwise apply when covered for purposes other than treatment or prevention of COVID-19;
4. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
5. Is provided to the optional COVID-19 group, if applicable; and
6. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(l) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Coverage for a Condition that May Seriously Complicate the Treatment of COVID

_X__ The states assures coverage of treatment for a condition that may seriously complicate the treatment of COVID-19 during the period when a beneficiary is diagnosed with or is presumed to have COVID-19.

_X__ The state assures that such coverage:

1. Includes items and services, including drugs, that were covered by the state as of March 11, 2021;
2. Is provided without amount, duration or scope limitations that would otherwise apply when covered for other purposes;
3. Is provided to all categorically needy eligibility groups covered by the state that receive full Medicaid benefits;
4. Is provided to the optional COVID-19 group, if applicable; and
5. Is provided to beneficiaries without cost sharing pursuant to section 1916(a)(2)(I) and 1916A(b)(3)(B)(xiii) of the Act; reimbursement to qualified providers for such coverage is not reduced by any cost sharing that would otherwise be applicable under the state plan.

_X__ Applies to the state's approved Alternative Benefit Plans, without any deduction, cost sharing, or similar charge, pursuant to section 1937(b)(8)(B) of the Act.

_X__The state assures compliance with the HHS COVID-19 PREP Act declarations and authorizations, including all of the amendments to the declaration.

Additional Information (Optional):

Reimbursement

__X__ The state assures that it has established state plan rates for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies).

List references to Medicaid state plan payment methodologies that describe the rates for COVID-19 treatment for each applicable Medicaid benefit:

- 4.19-A Inpatient benefit
- 4.19-B, page 1a: Outpatient benefit
- 4.19-B, page 5c: Other Types of Care
- 4.19-B, page 2-2(a): Methodology for outpatient drugs including specialty drugs
- 4.19-D: Long term care facility benefit
- Page 97, Section 7.4, Section E.4: Lump sum nursing facility supplemental payments to compensate providers for the costs of covered services to improve the member's experience of care, during the COVID-19 PHE

- 4.19-B, page 7-9: IHS/638 Facilities are paid at the All-Inclusive Rate
- 4.19-B, page 3a-5: FQHCs/RHCs are paid at the PPS Rate

____ The state is establishing rates or fee schedule for COVID-19 treatment, including specialized equipment and therapies (including preventive therapies) pursuant to sections 1905(a)(4)(F) and 1902(a)(30)(A) of the Act.

____ The state's rates or fee schedule is the same for all governmental and private providers.

____ The below listed providers are paid differently from the above rate schedules and payment to these providers for COVID-19 vaccines and the administration of the vaccines are described under the benefit payment methodology applicable to the provider type:

Additional Information (Optional):

PRA Disclosure Statement *Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 # 75). Public burden for all of the collection of information requirements under this control number is estimated to take up to 1 hour per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

AFDC Income Standards — S14

Enter the AFDC Standards below. All states must enter:

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988 and
AFDC Payment Standard in Effect As of July 16, 1996

Entry of other standards is optional.

MAGI-equivalent AFDC Payment Standard in Effect As of May 1, 1988

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (•) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1		X
+	2	247	X
+	3	312	X
+	4	376	X
+	5	441	X
+	6	505	X

Additional incremental amount

(•) Yes ( ) No

Increment amount $ 64

The dollar amounts increase automatically each year

( ) Yes (•) No

AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option — S13a

The standard is as follows:

- (●) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	204	X
+	2	275	X
+	3	347	X
+	4	418	X
+	5	489	X
+	6	561	X
+	7	632	X
+	8	703	X

Additional incremental amount
(●) Yes ( ) No

Increment amount $ 72

The dollar amounts increase automatically each year
( ) Yes (●) No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- (●) Statewide standard
- ( ) Standard varies by region
- ( ) Standard varies by living arrangement
- ( ) Standard varies in some other way

Enter the statewide standard

	Household size	Standard ($)	
+	1	214	X
+	2	289	X
+	3	365	X
+	4	440	X
+	5	516	X
+	6	591	X
+	7	667	X

Additional incremental amount

(●) Yes ( ) No

Increment amount $ 76

The dollar amounts increase automatically each year

( ) Yes (●) No

AFDC Need Standard in Effect As of July 16, 1996

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

( ) Standard varies by living arrangement

( ) Standard varies in some other way

The dollar amounts increase automatically each year

( ) Yes ( ) No

AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date.

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

( ) Statewide standard

( ) Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent AFDC Payment Standard in Effect As of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

○ Statewide standard

○ Standard varies by region

○ Standard varies by living arrangement

○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

MAGI-equivalent TANF payment standard

Income Standard Entry - Dollar Amount - Automatic Increase Option S13a

The standard is as follows:

- ○ Statewide standard
- ○ Standard varies by region
- ○ Standard varies by living arrangement
- ○ Standard varies in some other way

The dollar amounts increase automatically each year

○ Yes ○ No

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Parents and Other Caretaker Relatives S25

42 CFR 435.110
1902(a)(10)(A)(i)(I)
1931(b) and (d)

■ **Parents and Other Caretaker Relatives** - Parents and other caretaker relatives of dependent children with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are parents or other caretaker relatives (defined at 42 CFR 435.4), including pregnant women, of dependent children (defined at 42 CFR 435.4) under age 18. Spouses of parents and other caretaker relatives are also included.

The state elects the following options:

☒ This eligibility group includes individuals who are parents or other caretakers of children who are 18 years old, provided the children are full-time students in a secondary school or the equivalent level of vocational or technical training.

☐ Options relating to the definition of caretaker relative (select any that apply):

☒ Options relating to the definition of dependent child (select the one that applies):

◉ The state elects to eliminate the requirement that a dependent child must be deprived of parental support or care by reason of the death, physical or mental incapacity, or absence from the home or unemployment of at least one parent.

○ The child must be deprived of parental support or care, but a less restrictive standard is used to measure unemployment of the parent (select the one that applies):

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard

The minimum income standard used for this group is the state's AFDC payment standard in effect as of May 1, 1988, converted to MAGI-equivalent amounts by household size. The standard is described in S14 AFDC Income Standards.

☑ The state certifies that it has submitted and received approval for its converted May 1, 1988 AFDC payment standard.

An attachment is submitted.

■ Maximum income standard

Medicaid Eligibility

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for parents and other caretaker relatives to MAGI-equivalent standards and the determination of the maximum income standard to be used for parents and other caretaker relatives under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

◉ The state's effective income level for section 1931 families under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for section 1931 families under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL or amounts by household size.

○ The state's effective income level for any population of parents/caretaker relatives under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL or amounts by household size.

Enter the amount of the maximum income standard:

◉ A percentage of the federal poverty level: 106 %

○ The state's AFDC payment standard in effect as of July 16, 1996, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ The state's TANF payment standard, converted to a MAGI-equivalent standard. The standard is described in S14 AFDC Income Standards.

○ Other dollar amount

■ Income standard chosen:

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

◉ The maximum income standard

○ The state's AFDC payment standard in effect as of July 16, 1996, increased by no more than the percentage increase in the Consumer Price Index for urban consumers (CPI-U) since such date. The standard is described in S14 AFDC Income Standards.

○ Another income standard in-between the minimum and maximum standards allowed

Medicaid Eligibility

The amount of the income standard for this eligibility group is:

○ A percentage of the federal poverty level: [ ] %

○ A dollar amount

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Pregnant Women **S28**

42 CFR 435.116
1902(a)(10)(A)(i)(III) and (IV)
1902(a)(10)(A)(ii)(I), (IV) and (IX)
1931(b) and (d)
1920

■ **Pregnant Women** - Women who are pregnant or post-partum, with household income at or below a standard established by the state.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must be pregnant or post-partum, as defined in 42 CFR 435.4.

Pregnant women in the last trimester of their pregnancy without dependent children are eligible for full benefits under this group in accordance with section 1931 of the Act, if they meet the income standard for state plan Parents and Other Caretaker Relatives at 42 CFR 435.110.

◉ Yes ○ No

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for this group

■ Minimum income standard (Once entered and approved by CMS, the minimum income standard cannot be changed.)

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for pregnant women, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for this eligibility group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for pregnant women to MAGI-equivalent standards and the determination of the maximum income standard to be used for pregnant women under this eligibility group.

An attachment is submitted.

The state's maximum income standard for this eligibility group is:

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

○ The state's highest effective income level for coverage of pregnant women under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified pregnant women), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related pregnant women), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related pregnant women), 1902(a)(10)(A)(ii)(I) (pregnant women who meet AFDC financial eligibility criteria) and 1902(a)(10)(A)(ii)(IV) (institutionalized pregnant women) in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of pregnant women under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 185% FPL

■ Income standard chosen

Indicate the state's income standard used for this eligibility group:

○ The minimum income standard

○ The maximum income standard

◉ Another income standard in-between the minimum and maximum standards allowed.

The amount of the income standard for this eligibility group is: 156 % FPL

■ There is no resource test for this eligibility group.

■ Benefits for individuals in this eligibility group consist of the following:

◉ All pregnant women eligible under this group receive full Medicaid coverage under this state plan.

○ Pregnant women whose income exceeds the income limit specified below for full coverage of pregnant women receive only pregnancy-related services.

■ Presumptive Eligibility

The state covers ambulatory prenatal care for individuals under this group when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage Infants and Children under Age 19 — S30

42 CFR 435.118
1902(a)(10)(A)(i)(III), (IV), (VI) and (VII)
1902(a)(10)(A)(ii)(IV) and (IX)
1931(b) and (d)

■ **Infants and Children under Age 19** - Infants and children under age 19 with household income at or below standards established by the state based on age group.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Children qualifying under this eligibility group must meet the following criteria:

■ Are under age 19

■ Have household income at or below the standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ Income standard used for infants under age one

■ Minimum income standard

The state had an income standard higher than 133% FPL established as of December 19, 1989 for determining eligibility for infants under age one, or as of July 1, 1989, had authorizing legislation to do so.

○ Yes ◉ No

The minimum income standard for infants under age one is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for infants under age one to MAGI-equivalent standards and the determination of the maximum income standard to be used for infants under age one.

An attachment is submitted.

The state's maximum income standard for this age group is:

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

Medicaid Eligibility

○ The state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 185% FPL

■ Income standard chosen

The state's income standard used for infants under age one is:

○ The maximum income standard

◉ If not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of infants under age one under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(IV) (mandatory poverty level-related infants), 1902(a)(10)(A)(ii)(IX) (optional poverty level-related infants) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of infants under age one under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

The amount of the income standard for infants under one is: 147 % FPL

■ Income standard for children age one through age five, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

☑ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age one through five to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age one through five.

An attachment is submitted.

The state's maximum income standard for children age one through five is:

◉ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

Enter the amount of the maximum income standard: 141 % FPL

☑ Income standard chosen

The state's income standard used for children age one through five is:

◉ The maximum income standard

○ If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age one through five under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VI) (mandatory poverty level-related children age one through five), and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children age one through five under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ Income standard for children age six through age eighteen, inclusive

■ Minimum income standard

The minimum income standard used for this age group is 133% FPL.

■ Maximum income standard

☑ The state certifies that it has submitted and received approval for its converted income standard(s) for children age six through eighteen to MAGI-equivalent standards and the determination of the maximum income standard to be used for children age six through age eighteen.

An attachment is submitted.

The state's maximum income standard for children age six through eighteen is:

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children), 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

○ The state's effective income level for any population of children age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

◉ 133% FPL

■ Income standard chosen

The state's income standard used for children age six through eighteen is:

Medicaid Eligibility

◉ The maximum income standard

If not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
○ 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's highest effective income level for coverage of children age six through eighteen under sections 1931 (low-income families), 1902(a)(10)(A)(i)(III) (qualified children),
○ 1902(a)(10)(A)(i)(VII) (mandatory poverty level-related children age six through eighteen) and 1902(a)(10)(A)(ii)(IV) (institutionalized children), in effect under the Medicaid state plan as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children
○ age six through eighteen under a Medicaid 1115 demonstration as of March 23, 2010, converted to a MAGI-equivalent percent of FPL.

If higher than the highest effective income level for this age group under the state plan as of March 23, 2010, and if not chosen as the maximum income standard, the state's effective income level for any population of children
○ age six through eighteen under a Medicaid 1115 demonstration as of December 31, 2013, converted to a MAGI-equivalent percent of FPL.

○ Another income standard in-between the minimum and maximum standards allowed, provided it is higher than the effective income standard for this age group in the state plan as of March 23, 2010.

■ There is no resource test for this eligibility group.

■ Presumptive Eligibility

The state covers children when determined presumptively eligible by a qualified entity.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Mandatory Coverage
Adult Group S32

1902(a)(10)(A)(i)(VIII)
42 CFR 435.119

The state covers the Adult Group as described at 42 CFR 435.119.

◉ Yes ○ No

■ **Adult Group** - Non-pregnant individuals age 19 through 64, not otherwise mandatorily eligible, with income at or below 133% FPL.

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Have attained age 19 but not age 65.

■ Are not pregnant.

■ Are not entitled to or enrolled for Part A or B Medicare benefits.

■ Are not otherwise eligible for and enrolled for mandatory coverage under the state plan in accordance with 42 CFR 435, subpart B.

Note: In 209(b) states, individuals receiving SSI or deemed to be receiving SSI who do not qualify for mandatory Medicaid eligibility due to more restrictive requirements may qualify for this eligibility group if otherwise eligible.

■ Have household income at or below 133% FPL.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

■ There is no resource test for this eligibility group.

■ Parents or other caretaker relatives living with a child under the age specified below are not covered unless the child is receiving benefits under Medicaid, CHIP or through the Exchange, or otherwise enrolled in minimum essential coverage, as defined in 42 CFR 435.4.

◉ Under age 19, or

○ A higher age of children, if any, covered under 42 CFR 435.222 on March 23, 2010:

■ Presumptive Eligibility

The state covers individuals under this group when determined presumptively eligible by a qualified entity. The state assures it also covers individuals under the Pregnant Women (42 CFR 435.116) and/or Infants and Children under Age 19 (42 CFR 435.118) eligibility groups when determined presumptively eligible.

○ Yes ◉ No

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TABLE 1: Arizona MAGI income conversion Plan as submitted to CMS on 6/11/13

Coverage Category	SIPP Results used (Yes/No)	Time Period	Sampling (yes/no)	Net Income Standard	Income band used in conversion (Alternative Method states to fill out only if applicable)	Converted Standard
Parents and other caretaker relatives (mandatory under Section 1931)	No	January, April, July 2012	No	100% FPL	75% - 100% FPL	106% FPL
Pregnant women, pregnancy only coverage	No	January, April, July 2012	No	150% FPL	125% - 150% FPL	156% FPL
Children under age 1	No	January, April, July 2012	No	140% FPL	115% - 140% FPL	147% FPL
Children ages 1 to 5	No	January, April, July 2012	No	133% FPL	108% - 133% FPL	141% FPL
Children ages 6 to 18	No	January, April, July 2012	No	100% FPL	75% - 100%	104% FPL
Family planning services	No	January, April, July 2012	No	150% FPL	125% - 150% FPL	156% FPL

Coverage Category	SIPP Results used (Yes/No)	Time Period	Sampling (yes/no)	Net Income Standard	Income band used in conversion (Alternative Method states to fill out only if applicable)	Converted Standard
Other Medicaid section 1115 demonstration (e.g., childless adults). Insert more rows if needed.	**No**	**January, April, July 2012**	**No**	**100% FPL**	**75% - 100% FPL**	**105% FPL**
AFDC payment standard 5/1/1988	**No**	**January, April, July 2012**	**No**	Fixed dollar standards Family size 1_____ 2 **$233** 3 **$293** 4 **$353** 5 **$412** 6 **$472** 7_____ Add-on for additional family members if relevant **$60**	% FPL by family size 1_____ 2 **0 – 19%** 3 **0 – 19%** 4 **0 – 19%** 5 **0 – 19%** 6 **0 – 19%** 7 **0 – 19%** Add-on for additional family members if relevant **0 – 19%**	Fixed dollar standards Family size 1_____ 2 $247 3 $312 4 $376 5 $441 6 $505 7_____ Add-on for additional family members if relevant $64
AFDC payment standard 7/16/1996	**No**	**January, April, July 2012**	**No**	Fixed dollar standards Family size 1 **$204** 2 **$275** 3 **$347** 4 **$418** 5 **$489** 6 **$561** 7 **$632** Add-on for additional family members if relevant **$72**	% FPL by family size 1 **0 – 22%** 2 **0 – 22%** 3 **0 - 22%** 4 **0 – 22%** 5 **0 – 22%** 6 **0 – 22%** 7 **0 – 22%** Add-on for additional family members if relevant **0 – 22%**	Fixed dollar standards Family size 1 $214 2 $289 3 $365 4 $440 5 $516 6 $591 7 $667 Add-on for additional family members if relevant $76

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals above 133% FPL	S50

1902(a)(10)(A)(ii)(XX)
1902(hh)
42 CFR 435.218

Individuals above 133% FPL - The state elects to cover individuals under 65, not otherwise mandatorily or optionally eligible, with income above 133% FPL and at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.218.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Coverage of Parents and Other Caretaker Relatives	S51

42 CFR 435.220
1902(a)(10)(A)(ii)(I)

Optional Coverage of Parents and Other Caretaker Relatives - The state elects to cover individuals qualifying as parents or other caretaker relatives who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.220.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Reasonable Classification of Individuals under Age 21	S52

42 CFR 435.222
1902(a)(10)(A)(ii)(I)
1902(a)(10)(A)(ii)(IV)

Reasonable Classification of Individuals under Age 21 - The state elects to cover one or more reasonable classifications of individuals under age 21 who are not mandatorily eligible and who have income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.222.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Children with Non IV-E Adoption Assistance

S53

42 CFR 435.227
1902(a)(10)(A)(ii)(VIII)

Children with Non IV-E Adoption Assistance - The state elects to cover children with special needs for whom there is a non IV-E adoption assistance agreement in effect with a state, who were eligible for Medicaid, or who had income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.227.

(●) Yes ( ) No

[☑] The state attests that it operates this eligibility group in accordance with the following provisions:

[■] Individuals qualifying under this eligibility group must meet the following criteria:

[■] The state adoption agency has determined that they cannot be placed without Medicaid coverage because of special needs for medical or rehabilitative care;

[■] Are under the following age (see the Guidance for restrictions on the selection of an age):

(●) Under age 21
( ) Under age 20
( ) Under age 19
( ) Under age 18

[■] MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

(●) Yes ( ) No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

(●) Yes ( ) No

[■] Individuals qualify under this eligibility group if they were eligible under the state's approved state plan prior to the execution of the adoption agreement.

The state used an income standard or disregarded all income for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

( ) Yes (●) No

[■] There is no resource test for this eligibility group.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Optional Targeted Low Income Children	S54

1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4
1905(u)(2)(B)

Optional Targeted Low Income Children - The state elects to cover uninsured children who meet the definition of optional targeted low income children at 42 CFR 435.4, who have household income at or below a standard established by the state and in accordance with provisions described at 42 CFR 435.229.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals with Tuberculosis	S55

1902(a)(10)(A)(ii)(XII)
1902(z)

Individuals with Tuberculosis - The state elects to cover individuals infected with tuberculosis who have income at or below a standard established by the state, limited to tuberculosis-related services.

○ Yes ◉ No

PRA Disclosure Statement

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage
Independent Foster Care Adolescents

S57

42 CFR 435.226
1902(a)(10)(A)(ii)(XVII)

Independent Foster Care Adolescents - The state elects to cover individuals under an age specified by the state, less than age 21, who were in state-sponsored foster care on their 18th birthday and who meet the income standard established by the state and in accordance with the provisions described at 42 CFR 435.226.

◉ Yes ○ No

☑ The state attests that it operates this eligibility group in accordance with the following provisions:

■ Individuals qualifying under this eligibility group must meet the following criteria:

■ Are under the following age

◉ Under age 21

○ Under age 20

○ Under age 19

■ Were in foster care under the responsibility of a state on their 18th birthday.

■ Are not eligible and enrolled for mandatory coverage under the Medicaid state plan.

■ Have household income at or below a standard established by the state.

■ MAGI-based income methodologies are used in calculating household income. Please refer as necessary to S10 MAGI-Based Income Methodologies, completed by the state.

The state covered this eligibility group under its Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

The state also covered this eligibility group in the Medicaid state plan as of March 23, 2010.

◉ Yes ○ No

■ The state covers children under this eligibility group, as follows (selection may not be more restrictive than the coverage in the Medicaid state plan as of March 23, 2010 until October 1, 2019, nor more liberal than the most liberal coverage in the Medicaid state plan as of December 31, 2013, or under a Medicaid 1115 demonstration as of March 23, 2010 or December 31, 2013):

◉ All children under the age selected

○ A reasonable classification of children under the age selected:

■ Income standard used for this eligibility group

■ Minimum income standard

The minimum income standard for this classification of children is the AFDC payment standard in effect as of July 16, 1996, not converted to MAGI-equivalent. This standard is described in S14 AFDC Income Standards.

Medicaid Eligibility

☒ Maximum income standard

No income test was used (all income was disregarded) for this eligibility group either in the Medicaid state plan as of March 23, 2010 or December 31, 2013, or under a Medicaid 1115 Demonstration as of March 23, 2010 or December 31, 2013.

◉ Yes ○ No

☒ No income test was used (all income was disregarded) for this eligibility group under (check all that apply):

- ☒ The Medicaid state plan as of March 23, 2010.
- ☒ The Medicaid state plan as of December 31, 2013.
- ☐ A Medicaid 1115 demonstration as of March 23, 2010.
- ☐ A Medicaid 1115 demonstration as of December 31, 2013.

The state's maximum standard for this eligibility group is no income test (all income is disregarded).

☒ Income standard chosen

Individuals qualify under this eligibility group under the following income standard:

This eligibility group does not use an income test (all income is disregarded).

☒ There is no resource test for this eligibility group.

PRA Disclosure Statement

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Eligibility Groups - Options for Coverage Individuals Eligible for Family Planning Services	S59

1902(a)(10)(A)(ii)(XXI)
42 CFR 435.214

Individuals Eligible for Family Planning Services - The state elects to cover individuals who are not pregnant, and have household income at or below a standard established by the state, whose coverage is limited to family planning and related services and in accordance with provisions described at 42 CFR 435.214.

○ Yes ◉ No

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
State Residency S88

42 CFR 435.403

State Residency

☑ The state provides Medicaid to otherwise eligible residents of the state, including residents who are absent from the state under certain conditions.

Individuals are considered to be residents of the state under the following conditions:

- ■ Non-institutionalized individuals age 21 and over, or under age 21, capable of indicating intent and who are emancipated or married, if the individual is living in the state and:
  - ■ Intends to reside in the state, including without a fixed address, or
  - ■ Entered the state with a job commitment or seeking employment, whether or not currently employed.
- ■ Individuals age 21 and over, not living in an institution, who are not capable of indicating intent, are residents of the state in which they live.
- ■ Non-institutionalized individuals under 21 not described above and non IV-E beneficiary children:
  - ■ Residing in the state, with or without a fixed address, or
  - ■ The state of residency of the parent or caretaker, in accordance with 42 CFR 435.403(h)(1), with whom the individual resides.
- ■ Individuals living in institutions, as defined in 42 CFR 435.1010, including foster care homes, who became incapable of indicating intent before age 21 and individuals under age 21 who are not emancipated or married:
  - ■ Regardless of which state the individual resides, if the parent or guardian applying for Medicaid on the individual's behalf resides in the state, or
  - ■ Regardless of which state the individual resides, if the parent or guardian resides in the state at the time of the individual's placement, or
  - ■ If the individual applying for Medicaid on the individual's behalf resides in the state and the parental rights of the institutionalized individual's parent(s) were terminated and no guardian has been appointed and the individual is institutionalized in the state.
- ■ Individuals living in institutions who became incapable of indicating intent at or after age 21, if physically present in the state, unless another state made the placement.
- ■ Individuals who have been placed in an out-of-state institution, including foster care homes, by an agency of the state.
- ■ Any other institutionalized individual age 21 or over when living in the state with the intent to reside there, and not placed in the institution by another state.
- ■ IV-E eligible children living in the state, or

▣ Otherwise meet the requirements of 42 CFR 435.403.

Medicaid Eligibility

Meet the criteria specified in an interstate agreement.

◉ Yes ○ No

■ The state has interstate agreements with the following selected states:

☒ Alabama	☒ Illinois	☒ Montana	☒ Rhode Island
☒ Alaska	☒ Indiana	☒ Nebraska	☒ South Carolina
☒ Arizona	☒ Iowa	☒ Nevada	☒ South Dakota
☒ Arkansas	☒ Kansas	☒ New Hampshire	☒ Tennessee
☒ California	☒ Kentucky	☒ New Jersey	☒ Texas
☒ Colorado	☒ Louisiana	☒ New Mexico	☒ Utah
☒ Connecticut	☒ Maine	☐ New York	☒ Vermont
☒ Delaware	☒ Maryland	☒ North Carolina	☒ Virginia
☒ District of Columbia	☒ Massachusetts	☒ North Dakota	☒ Washington
☒ Florida	☒ Michigan	☒ Ohio	☒ West Virginia
☒ Georgia	☒ Minnesota	☒ Oklahoma	☒ Wisconsin
☒ Hawaii	☒ Mississippi	☒ Oregon	☐ Wyoming
☒ Idaho	☒ Missouri	☒ Pennsylvania	

■ The interstate agreement contains a procedure for providing Medicaid to individuals pending resolution of their residency status and criteria for resolving disputed residency of individuals who (select all that apply):

- ☒ Are IV-E eligible
- ☐ Are in the state only for the purpose of attending school
- ☐ Are out of the state only for the purpose of attending school
- ☐ Retain addresses in both states
- ☐ Other type of individual

The state has a policy related to individuals in the state only to attend school.

○ Yes ◉ No

■ Otherwise meet the criteria of resident, but who may be temporarily absent from the state.

The state has a definition of temporary absence, including treatment of individuals who attend school in another state.

○ Yes ◉ No

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Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

Non-Financial Eligibility
Citizenship and Non-Citizen Eligibility

S89

1902(a)(46)(B)
8 U.S.C. 1611, 1612, 1613, and 1641
1903(v)(2),(3) and (4)
42 CFR 435.4
42 CFR 435.406
42 CFR 435.956

Citizenship and Non-Citizen Eligibility

☑ The state provides Medicaid to citizens and nationals of the United States and certain non-citizens consistent with requirements of 42 CFR 435.406, including during a reasonable opportunity period pending verification of their citizenship, national status or satisfactory immigration status.

■ The state provides Medicaid eligibility to otherwise eligible individuals:

■ Who are citizens or nationals of the United States; and

■ Who are qualified non-citizens as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. §1641), or whose eligibility is required by section 402(b) of PRWORA (8 U.S.C. §1612(b)) and is not prohibited by section 403 of PRWORA (8 U.S.C. §1613); and

■ Who have declared themselves to be citizens or nationals of the United States, or an individual having satisfactory immigration status, during a reasonable opportunity period pending verification of their citizenship, nationality or satisfactory immigration status consistent with requirements of 1903(x), 1137(d), 1902(ee) of the SSA and 42 CFR 435.406, and 956.

The reasonable opportunity period begins on and extends 90 days from the date the notice of reasonable opportunity is received by the individual.

The agency provides for an extension of the reasonable opportunity period if the individual is making a good faith effort to resolve any inconsistencies or obtain any necessary documentation, or the agency needs more time to complete the verification process.

○ Yes ◉ No

The agency begins to furnish benefits to otherwise eligible individuals during the reasonable opportunity period on a date earlier than the date the notice is received by the individual.

◉ Yes ○ No

The date benefits are furnished is:

○ The date of application containing the declaration of citizenship or immigration status.

○ The date the reasonable opportunity notice is sent.

◉ Other date, as described: First day of the month of application containing the declaration of citizenship or immigration status.

Medicaid Eligibility

The state provides Medicaid coverage to all Qualified Non-Citizens whose eligibility is not prohibited by section 403 of PRWORA (8 U.S.C. §1613).

◉ Yes ○ No

The state elects the option to provide Medicaid coverage to otherwise eligible individuals under 21 and pregnant women, lawfully residing in the United States, as provided in section 1903(v)(4) of the Act.

○ Yes ◉ No

☑ An individual is considered to be lawfully residing in the United States if he or she is lawfully present and otherwise meets the eligibility requirements in the state plan.

☑ An individual is considered to be lawfully present in the United States if he or she:

1. Is a qualified non-citizen as defined in 8 U.S.C. 1641(b) and (c);

2. Is a non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or otherwise under the immigration laws (as defined in 8 U.S.C. 1101(a)(17));

3. Is a non-citizen who has been paroled into the United States in accordance with 8 U.S.C. 1182(d)(5) for less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;

4. Is a non-citizen who belongs to one of the following classes:

   ☑ Granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a, respectively;

   ☑ Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;

   ☑ Granted employment authorization under 8 CFR 274a.12(c);

   ☑ Family Unity beneficiaries in accordance with section 301 of Pub. L. 101-649, as amended;

   ☑ Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;

   ☑ Granted Deferred Action status;

   ☑ Granted an administrative stay of removal under 8 CFR 241;

   ☑ Beneficiary of approved visa petition who has a pending application for adjustment of status;

5. Is an individual with a pending application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C.1231, or under the Convention Against Torture who -

   ☑ Has been granted employment authorization; or

   ☑ Is under the age of 14 and has had an application pending for at least 180 days;

6. Has been granted withholding of removal under the Convention Against Torture;

7. Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. 1101(a)(27)(J);

8. Is lawfully present in American Samoa under the immigration laws of American Samoa; or

9. Is a victim of severe trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Pub. L. 106-386, as amended (22 U.S.C. 7105(b));

10. Exception: An individual with deferred action under the Department of Homeland Security's deferred action for the childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

☐ Other

☑ The state assures that it provides limited Medicaid services for treatment of an emergency medical condition, not related to an organ transplant procedure, as defined in 1903(v)(3) of the SSA and implemented at 42 CFR 440.255, to the following individuals who meet all Medicaid eligibility requirements, except documentation of citizenship or satisfactory immigration status and/or present an SSN:

- ■ Qualified non-citizens subject to the 5 year waiting period described in 8 U.S.C. 1613;
- ■ Non-qualified non-citizens, unless covered as a lawfully residing child or pregnant woman by the state under the option in accordance with 1903(v)(4) and implemented at 435.406(b).

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid Eligibility

OMB Control Number 0938-1148
OMB Expiration date: 10/31/2014

General Eligibility Requirements Eligibility Process	S94

42 CFR 435, Subpart J and Subpart M

Eligibility Process

☑ The state meets all the requirements of 42 CFR 435, Subpart J for processing applications, determining and verifying eligibility, and furnishing Medicaid.

Application Processing

Indicate which application the agency uses for individuals applying for coverage who may be eligible based on the applicable modified adjusted gross income standard.

☐ The single, streamlined application for all insurance affordability programs, developed by the Secretary in accordance with section 1413(b)(1)(A) of the Affordable Care Act

☒ An alternative single, streamlined application developed by the state in accordance with section 1413(b)(1)(B) of the Affordable Care Act and approved by the Secretary, which may be no more burdensome than the streamlined application developed by the Secretary.

An attachment is submitted.

☒ An alternative application used to apply for multiple human service programs approved by the Secretary, provided that the agency makes readily available the single or alternative application used only for insurance affordability programs to individuals seeking assistance only through such programs.

An attachment is submitted.

Indicate which application the agency uses for individuals applying for coverage who may be eligible on a basis other than the applicable modified adjusted gross income standard:

☐ The single, streamlined application developed by the Secretary or one of the alternate forms developed by the state and approved by the Secretary, and supplemental forms to collect additional information needed to determine eligibility on such other basis, submitted to the Secretary.

An attachment is submitted.

☒ An application designed specifically to determine eligibility on a basis other than the applicable MAGI standard which minimizes the burden on applicants, submitted to the Secretary.

An attachment is submitted.

The agency's procedures permit an individual, or authorized person acting on behalf of the individual, to submit an application via the internet website described in 42 CFR 435.1200(f), by telephone, via mail, and in person.

The agency also accepts applications by other electronic means:

◉ Yes ○ No

Medicaid Eligibility

Indicate the other electronic means below:

	Name of Method	Description	
+	Fax	An individual can fax an application to the Medicaid or Human Services Agency	X

☑ The agency has procedures to take applications, assist applicants and perform initial processing of applications for the eligibility groups listed below at locations other than those used for the receipt and processing of applications for the title IV-A program, including Federally-qualified health centers and disproportionate share hospitals.

Parents and Other Caretaker Relatives

Pregnant Women

Infants and Children under Age 19

Redetermination Processing

☑ Redeterminations of eligibility for individuals whose financial eligibility is based on the applicable modified adjusted gross income standard are performed as follows, consistent with 42 CFR 435.916:

■ Once every 12 months

■ Without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency

■ If the agency cannot determine eligibility solely on the basis of the information available to it, or otherwise needs additional information to complete the redetermination, it provides the individual with a pre-populated renewal form containing the information already available.

■ Redeterminations of eligibility for individuals whose financial eligibility is not based on the applicable modified adjusted gross income standard are performed, consistent with 42 CFR 435.916 (check all that apply):

☒ Once every 12 months

☐ Once every 6 months

☐ Other, more often than once every 12 months

Coordination of Eligibility and Enrollment

☑ The state meets all the requirements of 42 CFR 435, Subpart M relative to coordination of eligibility and enrollment between Medicaid, CHIP, Exchanges and other insurance affordability programs. The single state agency has entered into agreements with the Exchange and with other agencies administering insurance affordability programs.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | AZ2023MS0002O | AZ-23-0007

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

Package ID AZ2023MS0002O
Submission Type Official
Approval Date 06/15/2023
Superseded SPA ID AZ-19-0023
System-Derived

SPA ID AZ-23-0007
Initial Submission Date 3/27/2023
Effective Date 1/1/2023

View Implementation Guide

Mandatory Coverage

A. The state provides Medicaid to mandatory groups of individuals. The mandatory groups covered are:

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Infants and Children under Age 19		☑	☐	○	CONVERTED
Parents and Other Caretaker Relatives		☑	☐	○	CONVERTED
Pregnant Women		☑	☐	○	CONVERTED
Deemed Newborns		☑	☐	○	NEW
Children with Title IV-E Adoption Assistance, Foster Care or Guardianship Care		☑	☐	○	NEW
Former Foster Care Children		☑	☑	○	APPROVED
Transitional Medical Assistance		☑	☐	○	NEW

Medicaid State Plan Eligibility

Mandatory Eligibility Groups

MEDICAID | Medicaid State Plan | Eligibility | AZ2023MS0002O | AZ-23-0007

CMS-10434 OMB 0938-1188

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Extended Medicaid due to Spousal Support Collections		☑	☐	○	NEW

Aged, Blind and Disabled

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
SSI Beneficiaries		☑	☐	○	NEW
Closed Eligibility Groups		☑	☐	○	NEW
Individuals Deemed To Be Receiving SSI		☑	☐	○	NEW
Working Individuals under 1619(b)		☑	☐	○	NEW
Qualified Medicare Beneficiaries		☑	☐	○	APPROVED
Qualified Disabled and Working Individuals		☑	☐	○	NEW
Specified Low Income Medicare Beneficiaries		☑	☐	○	APPROVED
Qualifying Individuals		☑	☐	○	APPROVED

B. The state elects the Adult Group, described at 42 CFR 435.119.

◉ Yes ○ No

Families and Adults

Eligibility Group Name		Covered In State Plan	Include RU In Package	Included in Another Submission Package	Source Type
Adult Group		☑	☐	○	CONVERTED

C. Additional Information (optional)

Eligibility Groups Deselected from Coverage

The following eligibility groups were previously covered in the source approved version of the state plan and deselected from coverage as part of this submission package:

- N/A

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | AZ2023MS0002O | AZ-23-0007

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

Package ID AZ2023MS0002O

Submission Type Official

Approval Date 06/15/2023

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SPA ID AZ-23-0007

Initial Submission Date 3/27/2023

Effective Date 1/1/2023

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VIEW ALL RESPONSES

The state covers the mandatory former foster care children group in accordance with the following provisions:

A. Characteristics

Collapse

Individuals qualifying under this eligibility group must meet the following criteria:

1. Are under age 26

2. Were in foster care upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21).

3. Are described under either Section B. or C.

B. Individuals Covered

Collapse

For individuals who turn 18 before January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration; and

b. Are not otherwise eligible for and enrolled for mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

Medicaid State Plan Eligibility

Eligibility Groups - Mandatory Coverage

Former Foster Care Children

MEDICAID | Medicaid State Plan | Eligibility | AZ2023MS0002O | AZ-23-0007

Individuals under the age of 26, who were in foster care and on Medicaid when they turned age 18 or aged out of foster care.

CMS-10434 OMB 0938-1188

Not Started | In Progress | Complete

Package Header

Package ID	AZ2023MS0002O	**SPA ID**	AZ-23-0007
Submission Type	Official	**Initial Submission Date**	3/27/2023
Approval Date	06/15/2023	**Effective Date**	1/1/2023
Superseded SPA ID	AZ-13-0007-MM		

2. In addition to B.1., the state elects to cover individuals who were in foster care under the responsibility of the state or a Tribe within the state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

- [ ] a. They were enrolled in Medicaid under the state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
- [x] b. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.
- [ ] c. They were placed by the state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which the state's or Tribe's foster care assistance ends.

C. Individuals Covered

Collapse

For individuals who turn 18 on or after January 1, 2023:

1. The state covers individuals who:

a. Upon attaining age 18 or a higher age at which the state's or Tribe's foster care assistance ends under title IV-E of the Act (up to age 21) were:

i. In foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to the state under the unaccompanied refugee minor program); and

ii. Enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration; and

b. Are not enrolled in mandatory coverage under the state plan, except that eligibility under this group takes precedence over eligibility under the Adult Group.

2. In addition to C.1., the state elects to cover individuals who were in foster care under the responsibility of any state or a Tribe within any state (including children who were cared for through a grant to a state under the unaccompanied refugee minor program) when they turned 18 or a higher age at which that state's or Tribe's foster care assistance ends under title IV-E of the Act, and meet the following criteria:

- [ ] a. They were enrolled in Medicaid under a state's Medicaid state plan or 1115 demonstration at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
- [x] b. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project when they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.
- [ ] c. They were placed by a state or Tribe in another state and were enrolled in Medicaid under the other state's Medicaid state plan or 1115 demonstration project at any time during the foster care period in which they turned 18 or a higher age at which a state's or Tribe's foster care assistance ends.

D. Additional Information (optional)

Collapse