Health and Mental Health Care

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INDIGENT HEALTH CARE

I. AHCCCS

Introduction

Historical Background

Indigent health care in Arizona was traditionally the full responsibility of the counties. Because each county set its own standards for eligibility and services, there was substantial disparity among the counties as to who received indigent health care and what services were provided.

Numerous attempts were made to enact Medicaid, the federal-state entitlement program that provides basic health services to low-income persons. The legislature actually passed a Medicaid statute in 1974, but then refused to appropriate any funding. The legislature voted to delay implementation in 1975 and 1976, and in 1977 passed an act repealing the Medicaid statute. That bill was vetoed, however, and the legislature did not override the veto. Another legislative effort to repeal the statute failed in 1978.

In 1977, the Arizona Department of Health Services (DHS) attempted to force implementation of Medicaid by ordering the counties to budget and levy funds to finance the program. The counties brought a special action against DHS to enjoin this order. The Arizona Supreme Court, noting that "the history of Medicaid in Arizona has been one of false starts and delays," held that the Medicaid legislation was merely "authorizing" legislation which would remain dormant until such time as the legislature voted to appropriate money for the program. *Cochise County v. Dandoy*, 116 Ariz. 53, 567 P.2d 1182 (1977).

From 1979 to 1981, Governor Babbitt introduced several ``Medicaid Alternative" proposals, none of which gained legislative support. Meanwhile, as a result of an explosion in catastrophic and other indigent health care costs, the counties began introducing alternative indigent health care legislation of their own. On November 18, 1981, the legislature yielded to the increasing demand for federal financial participation and Senate Bill 1001 was signed into law as Arizona's alternative Medicaid program. That year, AHCCCS was authorized as a prepaid, capitated managed care demonstration project within DHS. In 1984, AHCCCS became an independent state agency.

AHCCCS implemented the Arizona Long Term Care System (ALTCS) program to provide long term care for persons with developmental disabilities in 1988. The following year, AHCCCS implemented a program to provide additional services to the elderly and physically disabled (EPD) such as long term care and home health care.

On November 1, 1998, the KidsCare program was implemented in Arizona as its version of the State Children's Health Insurance Program (SCHIP), a federal program funded under Title XXI pursuant to the Balanced Budget Act of 1997. The KidsCare Program provides medical coverage to children under 19 who are not eligible for Medicaid.

In January 2001, Arizona received permission from the Center for Medicare and Medicaid Services (CMS) to expand eligibility for its Medicaid acute care program to 100% of the Federal Poverty Level (FPL). This request was made as a result of Proposition 204, a state initiative approved by the voters to expand medical assistance eligibility. On October 1, 2001, the counties' responsibility for health care was relieved by the expansion of the AHCCCS acute care program.

In December 2001, Arizona received permission to further expand Medicaid eligibility under the Health Insurance Flexibility and Accountability Act (HIFA). This waiver allows the State to use Medicaid funds to provide coverage to certain men, women and couples without children with incomes below 100% of the FPL and to parents of Medicaid and KidsCare children with incomes between 100% and 200% of the FPL. This waiver is approved through September 30, 2006.

As of September 30, 2002, 791,655 persons were enrolled in the acute care program and 35,645 were enrolled in the long term care program. In 2002, the total state and federal expenditures were over $3 billion dollars for the Title XIX program and $140 million for the Title XXI program.

Overview of Arizona Health Care Cost Containment System (AHCCCS)

The Arizona Health Care Cost Containment System (AHCCCS), the state's method of providing indigent health care, began serving indigents on October 1, 1982. AHCCCS currently administers the Medicaid program which is funded by state and federal funds. Federal financial participation (FFP) is available to reimburse the State for services covered under the Medicaid state plan and for administrative costs associated with operating the AHCCCS program. 42 U.S.C. § 1396b(a), 1396d(b). In Arizona, the federal government pays approximately 64% of the total Medicaid costs. The State pays the remaining costs. AHCCCS also administers the KidsCare program which is 75% federally funded, and other health care programs which are wholly state-funded and/or funded by tobacco tax dollars.

From the beginning, AHCCCS has differed from traditional Medicaid programs in several important respects. In the traditional Medicaid program, a patient could choose a doctor or other health care provider in the same way he or she would if paying for the services personally. The provider would receive a fee for the services that were rendered. Under AHCCCS managed care system, members are enrolled with a health plan that has contracted with the state to be an AHCCCS provider. A member is assigned to primary care physician

within the plan who provides the member with general health services and who refers the member for specialized services. AHCCCS pays the provider a set amount for each member, regardless of the services the member actually receives.

State Plan. All states, including Arizona, are required to have a comprehensive, written state plan for medical assistance that has been approved by the Secretary of Health and Human Services (HHS) in order to receive federal funding. The state plan must be amended whenever necessary to reflect changes in federal or state statute, regulation or policy and court decisions. It also must be amended to reflect organizational or operational changes. States may request waivers of certain state plan requirements. A copy of Arizona's state plan and amendments may be obtained from AHCCCS and CMS websites.

Medicaid Waivers. For many years, Arizona has had a waiver under Section 1115 of the Social Security Act to relieve the state of several Medicaid requirements. A.R.S. § 36-2901. These waivers were sought by the Arizona legislature to reduce the cost of the program and enhance its flexibility. The current waivers have been approved through September 30, 2006 by the CMS.

Some of Arizona's Section 1115 waiver provisions include delivering services through a managed care system, expanding eligibility for acute care services to 100% of the FPL for individuals and families, offering Medicaid coverage to persons who have medical bills sufficient to reduce their income below 40% of the FPL, waiving the resource limit for several programs, waiving the prior quarter coverage requirement, restricting a member's freedom to choose a provider, imposing nominal co-payments on certain services except that services can not be refused based on a member's inability to pay and offering benefits to enrolled members that are not offered to Medicaid beneficiaries not enrolled in a plan. In addition, there are several waiver provisions related to program expenditures.

HIFA amendment. Arizona's waiver under the Health Insurance Flexibility Act (HIFA) is approved through September 30, 2006. Under this waiver, Arizona may use Title XXI funds to cover services for SCHIP and HIFA populations in the following order:

1. Individuals eligible under the Title XXI State Plan.

2. Individuals with adjusted net family income above 100% of the FPL and at or below 200% of the FPL who are parents of children enrolled in the Medicaid or KidsCare programs but who themselves are not eligible for either program.

3. Single adults and childless couples with income at or below 100% of the FPL who are also eligible under the Medicaid section1115 eligibility expansion. These persons are defined as individuals over age 18 without dependent children.

However, if the State determines that Title XXI funding will be exhausted, the available Title XXI funds must be first used to cover the costs of the Title XXI State Plan population. The waiver prohibits the State from closing enrollment, instituting waiting lists or decreasing eligibility standards for Title XXI children while the HIFA amendment is in effect.

Generally, *unless* the requirements have been specifically amended by a waiver, the Medicaid portion of AHCCCS must meet the minimum standards for eligibility and services required under the federal statutes and regulations applicable to the Medicaid program. CMS waiver approval letters and other documents relevant to Arizona's waiver can be found on the AHCCCS website.

Prepaid Capitation Payment Mechanism. AHCCCS is based on a pre-paid capitation payment mechanism. Under this system, a contractor receives a pre-determined amount from the State, based on the number of patients enrolled under the contractor's supervision. The capitation rates are determined by competitive bid. The rate of payment is not related to the actual cost of an individual patient's care. Costs may be higher, lower, or equal to the monthly allowance paid to a provider for any one member. It is the provider's job to manage all its members' care within those financial limits.

In exchange for receipt of the predetermined amount, the contractor and its sub-contractual provider team promise to deliver a basic set of services to a specified number of persons who are enrolled as "members."

"Providers" are those health care practitioners who contract or subcontract with the State to deliver services under AHCCCS; they may be entities, e.g., hospitals, health maintenance organizations, or physician groups, or they may be individual physicians, nurses, etc.

Thus, AHCCCS consists of a network of contracts between providers and the State to provide health services to enrolled persons called members. Each member chooses, or is assigned to a primary care physician who is the gatekeeper physician within the provider plan. The goal of gatekeeper theory is to assure a high quality of care while keeping down costs by reducing unnecessary services and encouraging preventive care, which is less expensive over time.

AHCCCS awards provider contracts by Geographical Service Area (GSA). There are nine GSAs. The majority of the GSAs cover two counties each. Pima, Maricopa and Yuma counties are each a single GSA. All members have a choice of at least two health plans within a GSA. The AHCCCS network also includes 12 Federally Qualified Health Centers.

Capped Fee-for-Service Payments. Under some circumstances AHCCCS will reimburse a health care provider for a specific covered service. For example, AHCCCS pays on a capped fee-for-service basis for services that are rendered to an enrolled member who lives in an area that is not served by a health plan. AHCCCS also pays on a fee-for-service basis when emergency services are provided to a member by a provider who does not have a prepaid capitated contract with AHCCCS for that member. The rate of reimbursement for such services is set by the AHCCCS Director.

Administration. The AHCCCS Administration is an independent agency within the state government. It is designated as the single state agency that is ultimately responsible for ensuring that the AHCCCS programs are in compliance with federal and state law. It develops regulations, awards provider contracts, enrolls members in health plans, and monitors providers. It also administers Arizona's Long-Term Care System.

Other Agencies. (1) *Center for Medicare and Medicaid Services (CMS), formally the Health Care Financing Administration (HCFA),* is the federal agency within the Department of Health and Human Services that dispenses federal funds for AHCCCS and other states' Medicaid programs. It monitors the programs for compliance with federal Title XIX (Medicaid) and Title XXI (SCHIP) regulations.

(2) *Social Security Administration (SSA).* SSA determines eligibility for Supplemental Security Income (SSI). People who receive SSI are automatically eligible for AHCCCS. A.R.S. § 36-2903.01(B)(2).

(3) *Department of Economic Security (DES).* DES determines eligibility for some of the programs funded by Medicaid such as the SOBRA programs for children and pregnant women, the 1931 Medicaid category for families with children, the AHCCCS care program for individuals with no children with income under 100% of the FPL, the Medical Expense Deduction program and Emergency Services Programs for persons who do not meet the requirements for non-citizens.

(4) *Department of Health Services (DHS).* AHCCCS contracts with DHS to provide all medically necessary behavioral health services to persons who are eligible for AHCCCS services under A.R.S. 36-2901.6(a).

Legal Framework and Resources

Federal Statutes and Regulations. The federal Medicaid statutes are found in Title XIX of the Social Security Act, 42 U.S.C. § 1396a et seq. with the applicable regulations at 42 C.F.R. § 430 et seq. The State's Children Health Insurance Program (SCHIP) statutes are found in Title XXI of the Social Security Act at 42 U.S.C. § 1397aa et seq.

State Statutes. The relevant Arizona statutes are: A.R.S. § 36-2901 et seq. (Arizona Health Care Cost Containment System).

State Administrative Rules. The program rules promulgated by AHCCCS can be found in the Arizona Administrative Code (A.A.C.). Proposed and final changes to these rules are published in the Arizona Administrative Register. The rules applicable to the Medicaid acute care programs are at R9-22-101 et seq., the Long Term Care rules are at R9-28-101 et seq., the Medicare Beneficiary rules are at R9-29-101 et seq. and the KidsCare rules are at R9-31-101 et seq. These rules are available on the internet through the Arizona Secretary of State's website at www.sosaz.com for free. A copy of the rules and updates may also be purchased through the Secretary of State's office. Because the rules change frequently, both the administrative code and the register should be checked for the most current version of the rule.

Eligibility Manuals. Both AHCCCS and DES have developed manuals to give specific guidance to their workers regarding eligibility for the various medical assistance programs. Policy in these manuals must be consistent with federal, state and administrative requirements. Many of the manuals are in electronic format and are available on the agencies' websites. The AHCCCS website is at www.ahcccs.state.az.us and the DES website is at www.de.state.az.us. The DES policy manual, called AIMBIG, is only available to the

public through the internet. Upon request, the agencies are required to provide applicants and recipients with copies of relevant policies. Also, the manuals that are still in paper form can be found at the library or purchased directly from the agency.

AHCCCS Members

AHCCCS members are persons approved for medical services who are enrolled in an AHCCCS health plan. The member may choose a health plan at the time of application. If a health plan is not chosen, the member is assigned a health plan at the time of approval. The member may change the health plan within the first few days of enrollment or assignment. The member can also change his/her health plan each year during their "annual enrollment" date. Each member chooses his Primary Care Physician (PCP) through the health plan and that PCP monitors and coordinates the member's health care. Members, except for those enrolled with Indian Health Services or the DES Comprehensive Medical and Dental Program, are guaranteed eligibility for an initial five-month continuous period plus the month that the member was enrolled.

Native-American Eligibility for AHCCCS

Native-Americans who are eligible for AHCCCS are entitled to full AHCCCS coverage, just as any other Arizona resident, whether the Native-American lives on or off the reservation. In the past, it has been difficult for Native-Americans to apply for and enroll in AHCCCS medical assistance programs.

In addition to AHCCCS, Native-Americans may receive services through Indian Health Services (IHS). The federal government has a separate obligation to provide health care for Native-Americans based on the trust relationship between the federal government and the Native-American peoples, the Snyder Act of 1921, 25 U.S.C. § 13 et seq., and the Indian Care Improvement Act of 1976, 25 U.S.C. § 1601 et seq. IHS is funded by Congress, however, it is generally under-funded so services are limited. It is not an entitlement program such as Medicaid and it does not have an established benefits package.

IHS provides health care at two levels. "Direct" coverage refers to the services that are provided at an IHS facility. These include many, but not all, basic services. IHS currently provides direct services to all Native-Americans who come to an IHS facility, whether or not they live on a reservation, are AHCCCS eligible, or are enrolled with another AHCCCS provider. The range and quality of direct services is limited.

The second level of health care is called "contract services." An eligible Native-American who needs care that is not available as a direct service, such as kidney dialysis, is referred off-reservation to a non-IHS facility. There is a finite amount of money budgeted for contract services. IHS limits eligibility for contract services to Native-Americans living on or near a reservation in geographic areas called Contract Service Health Delivery Areas (CSHDA). The eligibility requirements for CSHDAs are stricter for contract services that direct care.

Native Americans who are AHCCCS members have the option of choosing IHS as their health care provider or an AHCCCS health plan located off-reservation for acute care services. An IHS facility, however, may not provide the range of services that are available

from an AHCCCS provider. A member who has chosen IHS is not locked-in and may change to an AHCCCS health plan at any time.

AHCCCS is financially responsible for covered services provided to enrolled members by their health care provider. When the member is enrolled with the IHS as his or her AHCCCS provider, AHCCCS pays the IHS on a fee-for-service basis. *See,* A.A.C. R9-22-708. When the IHS must refer the patient to another provider for services, AHCCCS is responsible for those services as well.

AHCCCS Medical Assistance Programs

Mandatory and Optional Eligibility Groups

Under federal law, certain categories of individuals are mandatorily eligible for Medicaid-related AHCCCS programs. This includes low income families described in Section 1931 of the Social Security Act, SSI recipients, infants born to Medicaid-eligible pregnant women, children under six and pregnant women with income at or under 133% of FPL, children born after September 30, 1983 with income at or under the FPL, foster care and adoption assistance recipients, certain Medicare beneficiaries and families who lose Medicaid eligibility under Section 1931 due to increased earnings or increased child support. Arizona defines mandatorily eligible persons at A.R.S. §§ 36-2901(i)-(iii), 36-2934.

Medicaid-optional categories for which Arizona has chosen to provide coverage include certain aged, blind and disabled persons and low-income, uninsured women in need of treatment for breast or cervical cancer. *See*, 42 U.S.C. § 1396a(a)(10)(A).

AHCCCS Care for SOBRA Children and Pregnant Women

"SOBRA" (Section 9401 of the Sixth Omnibus Budget Reconciliation Act of 1986) is used to designate the federally funded programs that provide medical coverage for children under age 19 and pregnant women, as described in this section. 42 U.S.C. § 1396a(a)(10)(A)(i)(IV), (VI), (VII). DES determines eligibility for the SOBRA category.

All pregnant women with income under 133% of the federal poverty level are eligible for the full range of AHCCCS-covered services. A.R.S. § 36-2901.6(a)(ii), A.A.C. R9-22-1421. Although federal law only mandates coverage of pregnancy related services, AHCCCS does not restrict the range of services available to these members.

A woman continues to be eligible for AHCCCS coverage through the end of the month of a sixty-day period that begins when her pregnancy ends, regardless of whether she would otherwise be eligible. 42 U.S.C. § 1396a(e)(5). For example, if the baby is born on April 15, the sixty days runs from April 15 to June 14; the woman remains eligible for all AHCCCS services through June 30. A.A.C. R9-22-1423. After that, she remains eligible for family planning services pursuant to A.R.S. §36-2907.04 even if she no longer qualifies for AHCCCS. A.A.C. R9-22-1424. Her baby is enrolled automatically for twelve months as long as he or she is in the mother's household, whether or not the mother remains eligible

for services. DES will conduct an informal review at six months to determine whether the child continues to live with his or her mother. A.A.C. R9-22-1422.

Any child is eligible for AHCCCS under the SOBRA category if he or she is under six years old with a family income under 133% of the FPL, or age six though the month the child turns nineteen with a family income under 100% of the FPL. A.R.S. § 36-2901.6(a)(ii). There is no resource limit for the SOBRA category.

Baby Arizona. Baby Arizona is an AHCCCS initiated project that promotes early access to prenatal care and streamlines eligibility for Medicaid coverage for pregnant women. The project focuses on hard-to-reach and uninsured women.

AHCCCS Care for Families with Children – Section 1931

Another Medicaid category referred to by AHCCCS as Section 1931 provides medical assistance to families with children whose family income is below 100% of the FPL. 42 U.S.C. § 1396u-1. Eligibility in this category was expanded to 100% of the FPL as a result of the Proposition 204 initiative. To qualify for this program, the family unit must contain a dependent child under eighteen or a dependent child who is eighteen and a full time student that is reasonably expected to complete school by age nineteen. AHCCCS provides applicants with monthly deductions from their income including a $90 earned income deduction, a $50 child support deduction and a deduction for the care of a child or disabled spouse. There is no resource limit. A.A.C. R9-22-1420. DES determines eligibility for this category.

In the past, persons who received cash assistance under the Aid to Families with Dependent Children (AFDC) program were automatically linked to the Medicaid program. The AFDC program was replaced by the Transitional Assistance for Needy Families (TANF) program under the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, commonly known as the Welfare Reform Act. There is no automatic link between TANF and Medicaid. However, persons who receive TANF cash benefits in Arizona are eligible for Medicaid because cash assistance payments are paid at thirty-six percent of the 1992 FPL. A.R.S. § 46-207.01.

Pursuant to a waiver granted by CMS under the Health Insurance Flexibility and Accountability Act (HIFA), parents of Medicaid and KidsCare children with incomes between 100% and 200% of the FPL are eligible for AHCCS coverage.

AHCCCS coverage can be terminated for a parent who refuses, without good cause, to cooperate with the Division of Child Support Enforcement to establish paternity. In this situation, the children remain eligible for AHCCCS coverage. A.A.C. R9-22-1406.

Transitional Medical Assistance. Even if the family unit's income exceeds 100% of the FPL, a family may receive continuing medical assistance for up to twenty-four months if they have lost AHCCCS medical coverage due to an increase in earnings of a caretaker relative. A family also may receive continuing medical assistance for up to four months if they have lost AHCCCS coverage due to an increase in child support or spousal maintenance. To qualify for transitional medical assistance, the family must continue to

include a dependent child and the family must have received medical coverage for three months out of the most recent six months. A.A.C. R9-22-1420.F.

AHCCCS Care for Persons with No Children

Individuals with income below 100% of the FPL who are not approved in a family unit may be eligible for medical coverage under the AHCCCS care program. This category does not have an age limit or a resource limit. Income deductions similar to those provided in the Section 1931 program are available to applicants for this program. A.A.C. R9-22-1421. DES determines eligibility for this category.

AHCCCS Care for Adopted and Foster Care Children

AHCCCS medical coverage is provided to children eligible for a foster care or an adoption subsidy under Title IV-E pursuant to 42 C.F.R. 435.145 and to children who are eligible for a state adoption subsidy under 42 C.F.R. 435.227. A.A.C. R9-22-1426. Foster children are enrolled in the DES Comprehensive Medical and Dental Program (CMDP).

The Young Adult Transitional Program provides AHCCCS medical coverage for persons under age 21 who were in state foster care on their 18th birthday. A.R.S. § 36-2901.6(a) (iii); A.A.C. R9-22-1425.

SSI-Related Medical Assistance Programs

SSI Cash Recipients. Persons who currently receive Supplemental Security Income (SSI) cash payments from the Social Security Administration (SSA) are automatically eligible for AHCCCS medical coverage. An application is not required for this SSI linked coverage.

SSI-Medical Assistance Only (SSI-MAO). Persons who are aged (65 or older), blind or disabled, who have income below 100% of the FPL and who meet the SSI requirements are eligible for AHCCCS coverage under the SSI-MAO category. This includes persons who have been determined blind or disabled by SSA but who are not currently receiving SSI cash payments. A.R.S. §§ 36-2971, 36-2974; A.A.C. R9-22-1501 et seq.

*"Special groups" - other SSI and Title II related categories***.** Persons who receive or have received benefits from SSA that may be eligible for AHCCCS coverage are:

(1) *Persons residing in the U.S. under color of law on 8/21/96*. Certain aged, blind or disabled immigrants who received SSI or AHCCCS coverage on or before August 21, 1996 and who were residing in the U.S. under color of law on or before that date may be eligible for AHCCCS coverage. A.A.C. R9-22-1505.A.1.

(2) *Disabled Child under 42 U.S.C. § 1396a(a)(10)(A)(i)(II).* A disabled child is defined as a child (a) who was receiving SSI benefits as a disabled child on August 22, 1996, (b) who lost SSI cash benefits effective July 1, 1997, or later, to due to a disability determination pursuant to Section 211(d)(2)(B) of Subtitle B of P.L. 104-193 (Welfare Reform Act), and (3) who continues to meet the disability requirements for a child which were in effect on August 21, 1996 may be eligible for AHCCCS coverage. A.A.C. R9-22-1505.A.2.

(3) *Disabled Adult Child under 42 U.S.C. § 1383c(c).* Disabled persons who (a) are 18 or older, (b) were determined disabled by SSA before age 22; (3) were entitled to or received an increase in Title II benefits for blindness or a disability, and (d) have lost their SSI benefits because they are entitled to or received an increase in Title II benefits may be eligible for AHCCCS coverage. A.A.C. R9-22-1505.A.3.

(4) *Disabled Widows or Widowers under 42 U.S.C.A. § 1383c(d).* A widow or widower (a) who is blind or disabled, (b) who is ineligible for Medicare Part A benefits and (c) who received a SSI cash payment in the month before Title II disabled widows or widowers benefits began may be eligible for AHCCCS coverage. A.A.C. R9-22-1505.A.4.

(5) *Persons who have received concurrent SSI and Title II benefits in the past.* A person who is aged, blind or disabled (a) who receives Title II benefits, (b) who received SSI benefits in the past, (c) who received SSI and Title II benefits concurrently for at least one month anytime after April 1977 and (d) who became ineligible for SSI while receiving SSI and Title II benefits concurrently may be eligible for AHCCCS coverage. A.A.C. R9-22-1505.A.5.

Resource limit for special groups. There is resource limit of $2000 for an individual and $3000 for a couple to qualify for medical coverage as a member of one of the special groups listed above in number 1 through 5. Some resources are excluded from the resource limit. Certain SSA income is disregarded in determining eligibility for these special groups. A.A.C. R9-22-1505.B, C. Eligibility for these categories is determined by AHCCCS.

Medical Expense Deduction (MED) Program

Persons not eligible for medical coverage under any other Medicaid category may be eligible for medical coverage under the Medical Expense Deduction (MED) program. A.R.S. § 36-2901.04; A.A.C. R9-22-1427. DES determines eligibility for this category.

The MED program is available to single adults, couples without children and families with children. To qualify for this program, an applicant must be over the income limit for all Medicaid categories and must have incurred medical expenses which are the applicant's responsibility to pay. Eligibility is determined by subtracting medical expenses to reduce the countable monthly income to 40% of the FPL. This is often referred to as "spend-down."

A specific three month period for income and expenses is considered to determine eligibility under this category. The three month income period includes the application month and the next two months. The three month medical expense period includes the application month and the months before and after the application month. Applicants also receive income deductions such as a $90 earned income deduction and a deduction for the care of a child or disabled spouse. Certain income is also excluded. A.A.C. R9-22-1429.

The MED program has a resource limit of $100,000 of which no more than $5,000 can be liquid assets. To be counted, the resource must be available. Home equity is counted toward the resource limit, but certain resources are excluded such as household furnishings and one vehicle. A.A.C. R9-22-1430.

A person is eligible for AHCCCS medical coverage under the MED category on the date that the income and resource requirements are met, but no earlier than the first day of the month of application. For example, if a person applies for medical coverage on January 3rd but does not incur sufficient medical expenses to reduce her income to 40% of the FPL until January 10th, the first day of eligibility is January 10th. However, if a person applies on January 3rd but incurred a sufficient amount of medical expenses to reduce to her income to 40% of FPL in the month before the application month, then her eligibility will start January 1st. A.A.C. R9-22-1431.A.

Also, if a person meets the income criteria in the application month but does not meet the resource criteria until the next month, the date of eligibility is the first day of the month following the application month. A.A.C. R9-22-1431.A. The effective date of eligibility can be adjusted within sixty days of approval for the MED program if the recipient provides proof of additional allowable medical expenses. A.A.C. R9-22-1431.B-D.

Long Term Care

The Arizona Long Term Care System (ALTCS) is a program for persons who are aged, blind or disabled who need ongoing services at a nursing facility level of care. However, ALTCS participants do not have to live in a nursing home. They can live in their own home or in an assisted living facility and receive in-home care. Medical care such as doctor visits, hospitalization, prescriptions, lab work and behavioral health services are covered. Case management is also available to all eligible persons. A.A.C. R9-28-101 et seq.

The income limit is 300% of the SSI federal benefit rate (FBR). The FBR is the maximum monthly amount paid to a SSI individual or a married couple. A.A.C. R9-22-101.B. In 2003, the FBR for an individual is $552 a month. The resource limit is $2000 for a single person. However, when an applicant has a spouse who lives in the community, the spouse can retain one-half of the couple's resources up to approximately $90,000. Certain resources such as a person's home, vehicle and irrevocable burial plan do not count against the resource limit. A.R.S. § 36-2931-2959; A.A.C. R9-28-101 et seq.

Once financial eligibility has been established, a person must also qualify for services pursuant to a test called the "Pre-admission Screening" or "PAS" to determine whether a person is at immediate risk of institutionalization. A person's functional, medical, nursing and social needs are assessed by a registered nurse or a social worker. If deemed necessary, the nurse or social worker may refer a case to a physician for a final determination. A specific weighted score must be attained to qualify for these services. The ALTCS program is further discussed in Part II of this section.

Medicare Beneficiary Cost Sharing Programs

Medicare. Medicare provides hospitalization and medical insurance for persons who are aged, blind or disabled pursuant to Title XVIII of the Social Security Act. 42 U.S.C. 1395 et seq. Medicare is a federal program administered by the Social Security Administration (SSA). Medicare Part A covers hospitalization related services. Part B covers outpatient services such as doctor visits, lab work, and x-rays. A monthly premium must be paid to SSA by the Medicare recipient to obtain Part B coverage. (See Medicare section for further discussion.)

Qualified Medicare Beneficiaries (QMB). Under the QMB program, AHCCCS pays for the Medicare Part A and B premiums as well as the deductibles and co-insurance associated with this coverage. Such Medicare recipients are called "Quimbys." To qualify for QMB, an applicant must be eligible for Medicare Part A and must have income at or below 100% of the FPL. There is no resource limit. A.R.S. § 36-2973; A.A.C. R9-29-101 et seq. AHCCCS determines eligibility for the Medicare cost-sharing programs.

A person who is eligible for the QMB program is also eligible for AHCCCS medical coverage because his or her income is less than 100% of the FPL. These persons are called "dual-eligible." A.R.S. § 36-2974. This AHCCCS coverage is in addition to the Medicare coverage. If the AHCCCS member's Medicare HMO doctor also participates with the AHCCCS health plan that the member has chosen, the member will get full AHCCCS benefits. If the Medicare doctor does not participate in the AHCCCS health plan, then the doctor must contact AHCCCS to coordinate care to ensure that the member receives the AHCCCS benefits. Also, if prescriptions are filled at a pharmacy that participates in the AHCCCS program, there are no prescription co-pays and no annual limit on prescriptions for QMB participants. A.A.C. R9-29-302.

Specified Low-Income Medicare Beneficiary (SLMB). The SLMB program pays for the Medicare Part B premium only. To qualify for this program, a person's income must be below 120% of the FPL. There is no resource limit. A.R.S. § 36-2975.

Qualified Individual-1 (QI-1). Similar to the SLMB program, this program pays for the Medicare Part B premium only. However, a person can have income up to 135% of the FPL to qualify for this program. There is no resource limit. A.R.S. § 36-2976.

KidsCare Program

In 1997, Congress passed the State Children's Health Insurance Program (SCHIP) to provide a low-cost health insurance program for children who are not eligible for Medicaid due to excess income. 42 U.S.C. § 1397aa et seq. Arizona calls its SCHIP program the "KidsCare" program. AHCCCS determines eligibility for the KidsCare program. A.R.S. § 36-2981-2998; A.A.C. R9-31-101 et seq.

A screening and referral process is used by AHCCCS and DES to determine whether a child is eligible for Medicaid prior to determining whether a child is eligible for KidsCare. Also, when an application for a child is denied under any of the Medicaid categories, it is referred to AHCCCS to determine if the child is eligible for KidsCare. A.R.S. § 36-2903.05.

The income limit for the KidsCare program is 200% of the FPL. Families with income between 150% and 200% of the FPL may be required to pay a $10-25 premium for coverage. There is no resource limit. Eligible children must be under the age of nineteen, not eligible for health insurance provided by the State of Arizona, and not have current health insurance coverage or coverage within the past three months. This three month period can be waived if the child is chronically or seriously ill or the parent did not voluntarily terminate the insurance or cause it to end.

Health care services are provided to KidsCare recipients through the established AHCCCS health plans. Native Americans can elect to receive KidsCare services through the Indian Health Centers or through an AHCCCS health plan.

Breast and Cervical Cancer Treatment Program

A woman under age 65 who needs treatment for breast or cervical cancer may be eligible for AHCCCS coverage under the Breast and Cervical Cancer Treatment program. To qualify, she must be screened for breast and cervical cancer through the well woman health check program administered by the Department of Health Services; she can not be eligible for Medicaid coverage for families and individuals, or for persons who are aged, blind or disabled; and she can not have other creditable coverage. She must meet the income requirements of the A.R.S. § 36-2901.05; A.A.C. R9-22-2001-2007.

Freedom to Work Program

Persons with disabilities between ages 16 and 65, who have lost eligibility for medical assistance under the other medical assistance categories due to employment income, may continue to be eligible for medical coverage under this program. A person's countable income can not exceed 250% of the FPL; unearned income and income of a spouse or other family member is disregarded. A premium must be paid for this coverage. Also, persons who cease to be eligible for medical coverage due to a finding of medical improvement may be eligible for AHCCCS under the "Medically Improved Group" category. A.R.S. § 36-2929; A.A.C. R9-22-1901 et seq.

Emergency Service Programs for Non-citizens

The Federal Emergency Services (FES) program provides emergency services to undocumented immigrants and immigrants who are lawfully residing in the U.S. but do not meet the "qualified alien" requirements to qualify for full-coverage medical assistance. A.R.S. § 36-2903.03(D); A.A.C. R9-22-1418. These individuals must be Medicaid eligible but for their immigration status. Medicaid eligible includes persons who are aged, blind, disabled, a pregnant woman, a child, or a parent of a dependent child. To qualify for FES, an immigrant must meet the Medicaid income and resource limits. An immigrant does not have to provide a social security number to establish eligibility for the emergency services programs. 42 U.S.C. § 1320b-7(f).

If a person is not Medicaid eligible, he may be eligible for the State Emergency Services (SES) program. To qualify for SES, a person must meet the MED income and resource requirements. A.R.S. § 36-2901.06; A.A.C. R9-22-1434.

AHCCCS covers only emergency services that meet the applicable federal definition. *See*, 42 U.S.C. § 1396b(v) and 42 C.F.R. § 440.255. AHCCCS defines emergency medical services at A.A.C. R9-22-217 as services necessary to treat the sudden onset of 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: (1) placing the patient's health in serious jeopardy, (2) serious impairment to bodily functions, or (3) serious dysfunction of any bodily organ or

part. This is a case by case decision. The issue of what constitutes an emergency medical condition for purposes of this program has been litigated in Arizona. *Mercy Healthcare Arizona v. AHCCCS*, 181 Ariz. 95, 887 P.2d 625 (App. 1994); *AHCCCS v. Carondelet Health Services*, 183 Ariz. 266, 935 P.2d 844 (App. 1996).

Persons can apply for the emergency services program at a DES Family Assistance Administration (FAA) office or at the hospital during an emergency episode.

Special Eligibility Rules for Non-citizens

In 1996, Congress passed welfare and immigration laws which substantially changed Medicaid eligibility for legal immigrants. The Act created two categories of immigrants, "qualified" and "not qualified." Not qualified immigrants include undocumented immigrants as well as some immigrants who are lawfully present in the U.S. Congress further restricted eligibility by distinguishing between those who entered the U.S. before or "on or after" the date the welfare reform law was enacted, August 22, 1996. Congress also imposed additional eligibility restrictions on immigrants who have sponsors that have signed an enforceable affidavit of support. Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105 (Aug. 22, 1996); Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRIRA) enacted as Division C of the Defense Department Appropriations Act, 1997, Pub. L. 104-208, 110 Stat. 3008 (Sept. 30, 1996).

In passing these laws, Congress transferred power to state and local governments which was traditionally held by the federal government. Each state was given the power to decide Medicaid eligibility for immigrants within the framework of the federal law. 8 U.S.C. §§ 1612(b)(1), 1622(a). All AHCCCS programs require that A.R.S. § 36-2903.03 be met to qualify for full coverage AHCCCS. A.R.S. §§ 36-2903.03, 36-2983.E, 36-2931.5(a), 36-2932.K, 36-2929. If such requirements are not met, immigrants remain eligible for emergency services only. A.R.S. § 36-2903.03.D, F.

Arizona has elected to provide full AHCCCS coverage to immigrants who meet the federal definition of "qualified alien" and who also meet one of the following criteria: (1) is designated as one the exception groups pursuant to 8 U.S.C. § 1613(b), (2) has been a qualified alien for at least five years, or (3) has been continuously present in the U.S. since August 21, 1996. A.R.S. § 36-2903.03.B.

In Arizona, qualified alien is defined by federal law at 8 U.S.C. §§ 1641, 1612(b)(2)(e) and by the U.S. attorney general under the authority of Public Law 104-208, section 501. A.R.S. § 36-2903.G. Federal law defines qualified aliens as (1) lawful permanent residents, (2) refugees, asylees, persons granted withholding of deportation or removal, conditional entry (in effect prior to 4/1/80), persons paroled into the U.S. for at least one year, Cuban and Haitian entrants and (3) battered spouses and children with a pending or approved (a) self-petition for an immigrant visa, or (b) immigrant visa filed for a spouse or child by a U.S. citizen or a LPR, or (c) application for cancellation of removal or suspension of deportation, whose need for medical benefits has a substantial connection to the battery or cruelty. 8

U.S.C. § 1641. Indians born in Canada and members of Indian Tribes defined by the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) are also defined as qualified aliens. 8 U.S.C. § 1612(b)(2)(e). A.R.S. § 36-2903.03.G.3.

Members of the "exception groups" are refugees, asylees, persons granted withholding of deportation, Cuban and Haitian entrants, Amerasians, and veterans and active duty personnel, their spouses, un-remarried surviving spouses and children. 8 U.S.C. § 1613(b); A.R.S. § 36-2903.03.B.1. Also, immigrants receiving SSI are eligible for full coverage AHCCCS. 8 U.S.C. § 1612(b)(2)(F).

Thus, an immigrant who has been a qualified alien for at least five years is eligible for full services. An immigrant is also eligible for full services if he has not been a qualified alien for five years but he is a member of the one of the exception groups listed above.

Further, lawful permanent residents, who entered the U.S. before 8/22/96, who have forty qualifying quarters of Social Security work and who did not receive any federal means-tested public benefit during any quarter after December 31, 1996 may qualify for full coverage Medicaid without any time limitation. 8 U.S.C. § 1612(b)(2)(B). A person may receive credit for work quarters earned by the person, the person's spouse, or the person's parent before he or she turns age eighteen. 8 U.S.C. § 1645.

Otherwise, a qualified alien may be eligible for full services by proving that he has been continuously present in the U.S. since before August 21, 1996. On November 17, 1997, the Department of Justice issued Interim Guidance on Verification of Citizenship, Qualified Alien status and eligibility under the Personal Responsibility and Work Opportunity Reconciliation Act. 62 FR 61344-61416. AHCCCS and DES generally follow the interim guidance to verify continuous presence. They require an immigrant to present proof of his or her presence in the U.S. prior to August 21, 1996 by providing documents such as tax returns, bills, rent receipts, proof of employment, etc. Continuous presence is defined by the Interim Guidance as presence in the U.S. since the latest date of entry prior to August 22, 1996. Generally, any single absence from the U.S. of more than thirty days, or a total of aggregated absences of more than ninety days will interrupt continuous presence. 62 F.R. 61415.

Equal protection cases have been brought in Arizona and in other states to challenge the constitutionality of the five year bar as it applies to legal permanent residents. *Kurti v. Biedess*, 201 Ariz. 165, 33 P.3d 499 (App. 2001); *Avila v. Biedess*, 1 CA-CV 02-0648 (App. 2003); *Aliessa v. Novello*, 96 N.Y.2d 418, 754 N.E.2d 1085 (2001)(New York law denying state-funded medical services to a subgroup of immigrants violates the Equal Protection Clause of the U.S. and N.Y. State Constitutions.)

Persons residing in the U.S. under color of law. Aged, blind or disabled persons who were residing in the U.S. "under color of law" on or before August 21, 1996 and who were receiving AHCCCS services based on SSI eligibility criteria may be eligible for state-funded AHCCCS services. Such persons must meet the current SSI-MAO income and resource criteria except for the immigration requirements to be eligible for services. A.R.S. § 36-2903.03.C; A.A.C. R9-22-1505.A.1. It should be noted that "permanently residing in the U.S. under Color of Law" (PRUCOL) is not an immigration status. It generally means that

the Bureau of Citizenship and Immigration Services (BCIS), formerly INS, is aware of the person's presence, but has no plans to deport or remove him or her from the U.S.

Generally, the receipt of Medicaid does not have "public charge" consequences for a person's future immigration status, unless the person is institutionalized for long-term care. *See*, 8 U.S.C. 1182(a)(4).

General Eligibility Requirements

Definition of Family Unit. Parents and children comprise a family unit only if the *children* are dependent. This means that elderly parents living with their adult children apply as a separate household. A family unit includes a natural or adopted child under age 18, a dependent child age 18 who is full-time student that is reasonably expected to complete school by age 19, a natural or adoptive parent of a dependent child, and an unborn child. SSI recipients are not included in the family unit. A.A.C. R9-22-1420.B.

The spouse of a dependent child's parent can be included in the family unit if he or she wants to apply for medical coverage. Also, a child's non-parent caretaker relative and his or her spouse may be included in the household unit if (1) they provide the child with physical care, support, guidance and control, and (2) the parent of the child does not live in the home; or is also a dependent child who lives with the caretaker relative; or is physically or mentally unable to function as a parent. A.A.C. R9-22-1420.C, D.

Dependent children who are absent from the home because they are residing in a hospital or a residential facility may continue to be eligible for medical assistance as a member of the household if he or she is expected to return home. Also, specified relatives or children who are temporarily absent from the home because of school attendance may continue to be eligible for medical assistance if they return home at least once a year and they intend to return home at the end of their education and training. (DES AIMBIG policy)

Citizenship and Immigrant Status. Applicants must be a U.S. citizen or meet the qualified alien requirements at A.R.S. § 36-2903.03 to be eligible for full coverage. A.A.C. R9-22-1418, 1502, R9-28-404, R-29-201, R9-31-303. If an immigrant does not provide proof of his immigration status, it is presumed that he does not meet the non-citizen requirements and his application for full coverage AHCCCS will be denied. However, the application should be processed to determine whether the remaining family members who are U.S. citizens or "qualified aliens" are eligible for full services.

Arizona Residency. A person must be an Arizona resident to qualify for medical coverage. A.A.C. R9-22-1417, 1502.B, R9-28-403, R9-29-201.D, R9-31-303. The common law definition of "residence" is adopted for purposes of AHCCCS. The applicant must be currently residing (physically present) in the state and must intend to remain in Arizona indefinitely. There is no durational requirement for residency, that is, a person is not required to live in Arizona for a specific period of time to be eligible for medical. Such a requirement would be unconstitutional. Arizona's prior durational requirement for indigent

health care was found unconstitutional in *Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974).

Migrant farm workers. Migrant farm workers are deemed to have met the Arizona residency requirement if they are living in Arizona when they apply for medical assistance and they entered Arizona with a job commitment or to seek employment. DES AIMBIG policy.

Social Security Number. Most programs require a Social Security Number (SSN). DES and AHCCCS must assist applicants who can not recall their SSN or who have not been issued a SSN. A.A.C. R9-22-1416, 1502.A.1, R9-28-405, R9-31-303. The requirement is met when the applicant can show that he or she has applied for a SSN and will be issued a card. A person who can not legally obtain a SSN is not required to furnish one. A.A.C. R9-22-1416. Also, person who has religious objection to obtaining or providing a SSN is not required to furnish one. DES AIMBIG policy.

Non-work Social Security Numbers for Immigrants. An immigrant may not apply for a regular SSN until he or she has received employment authorization from the BCIS. However, certain qualified aliens are eligible for AHCCCS medical benefits prior to obtaining work authorization. Under these circumstances, a person can apply for a non-work SSN for the specific purpose of qualifying for public benefits. A regular SSN application is used. An original letter from DES or AHCCCS to the Social Security Administration which states that the applicant is eligible for public benefits except for the SSN requirement must be presented to SSA with the application. The agency should provide this letter to the applicant after all other eligibility requirements are met. When an immigrant obtains employment authorization from BCIS, he or she must apply for a regular SSN in order to work. A different SSN is then assigned to the immigrant. At that point, the new SSN should be reported to DES or AHCCCS and the non-work number should not be used for any reason.

Income. In determining eligibility, all earned and unearned income is considered. Income generally includes gross earnings from employment, self-employment income minus business expenses, retirement funds, pensions, annuities, child and spousal support, Social Security retirement and disability benefits (not SSI), Railroad retirement benefits, unemployment insurance, Veteran's Administration benefits, worker's compensation, interest, dividends and certain cash contributions.

Acute Care for Families and Individuals. For these programs, income which is actually received or which is reasonably expected to be received during the month is counted. Child support is considered income of the child for whom the support is intended. Child support is counted as income after deducting $50 per child. Also, a one time lump sum payment is considered income only in the month the payment is received. A.A.C. R9-22-1419.D, E.

Income of the following persons is considered: (1) the applicant, (2) the applicant's spouse, (3) the applicant's parent if the applicant is an unmarried minor child and (4) an immigrant's sponsor and his or her spouse. Also, if applying as a family that includes a dependent child, the income of a specified relative, or a non-parent caretaker relative, his or her spouse and their unmarried children is also considered. The income of a SSI cash recipient is not included for the acute care program. A.A.C. R9-22-1419.B. A specified relative is defined as a natural or adoptive parent or a step-parent and any other non-parent

relative related by blood or adoption, including a spouse of any of these persons if death or divorces terminates the marriage. A.A.C. R9-22-114.

KidsCare. Countable income for the KidsCare Program is all income received by specified household members. Disregarded income includes income specified in 20 C.F.R. 416, Appendix to subpart K as of June 6, 1997, income paid pursuant to federal law that is prohibited from being counted when determining eligibility for public benefits, money received when an asset is converted and income tax refunds. Net income from self-employment is counted, however, income taxes and capital investments may not be deducted as a self-employment expense. A.A.C. R9-31-304.

SSI-MAO. The financial eligibility criteria for persons who are aged, blind or disabled are found at A.A.C. R9-22-1503. AHCCCS refers to the SSI federal statute and regulations at 42 U.S.C. 1382a and 20 C.F.R. 416 Subpart K to determine countable income for this program. There are a few exceptions to the SSI rules regarding the counting of income for married couples and children. In-kind income is excluded. A.A.C. R9-22-1503.

Long Term Care. Income rules for the long term care program are explained in Part II.

Excluded income. Excluded income for families and individuals is specifically listed at A.A.C. R9-22-1419.C. It includes such things as burial benefits, cash contributions not intended to cover basic living expenses such as food, shelter or utilities, energy assistance, educational grants or scholarships funded by the U.S. Department of Education, Veteran's Education assistance program, or BIA student assistance program, earnings from high school on-the-job training programs, earned income of dependent children who are in enrolled in school at least half-time, food stamps, governmental housing or rental subsidies, some foster care maintenance payments, income tax refunds, loans, reimbursements, TANF or SSI payments, vendor payments, WIC benefits, Jobs Program training related expenses and other income specifically excluded by federal law. A.A.C. R9-22-1419.C.

Earned Income disregards. For the acute care programs for families and individuals, each employed person receives a $90 cost of employment (COE) allowance which is subtracted from his or her gross monthly earnings. A deduction for child care or adult care expenses is also available to the employed person who is responsible for the expense. A full time employed person is allowed a monthly deduction up of to $200 per child under two, and up to $175 for other dependents. A part time employed person may receive a monthly deduction up to $100 per child under two, and up to $88 for other dependents. A person could lose the income disregards if he or she fails to report a change of income to DES within 10 days of the change. A.A.C. R9-22-1419.F.

Income standard. With a few exceptions, the countable income must be at or below 100% of the FPL to qualify for acute care coverage. The FPL is based on the number of persons in the family unit. The FPL is adjusted annually. The exceptions include SOBRA children under age six and pregnant women who qualify for medical coverage if their income is at or below 133% of the FPL, MED applicants who qualify for medical coverage if their income is at or below 40% of the FPL and the KidsCare program whose income limits are up to 200% of the FPL. A.A.C. R9-22-1421, 1429, R9-31-304.

Prorating income for SOBRA categories. For SOBRA, an adult's income is prorated among the adult and his or her spouse and children. Siblings are not counted when determining a child's eligibility under this program. As such, a SOBRA child's family unit never has more than three members. For a SOBRA pregnant woman, household size is always at least two, the mother and the expected child. A.A.C. R9-22-1421.

Resources. Resources are defined as real or personal property including liquid assets. A.A.C. R9-22-114. There is no resource limit for the AHCCCS acute care programs for families and individuals. This includes medical coverage provided under the SOBRA and Section 1931 categories, the AHCCCS Care program for persons without children, the SSI-MAO program, the KidsCare program and the Medicare cost sharing programs.

There are resource limits for the MED program, the Long Term Care program and the SSI/SSA "special groups." There are numerous exceptions to these resource limits. The MED program has a resource limit of $100,000 of which no more than $5,000 can be liquid assets. A.A.C. R9-22-1430. The long term care program has a resource limit of $2000 for an individual; however, a community spouse can retain one-half of the couple's resources up to approximately $90,000. A.A.C. R9-28-101 et seq. There is also a resource limit of $2000 for an individual and $3000 for a couple who qualify for coverage as a member of one of the special groups specified in A.A.C. R9-22-1505.

Application Process

Where to Apply

Eligibility for families and individuals, Section 1931, SOBRA children and pregnant women, emergency services, and the MED program is determined by DES. A person may apply for AHCCCS medical services by submitting a signed application to a DES Family Assistance Administration (FAA) office or an approved outstation such as Children's Rehabilitation Services (CRS), Behavioral Health Services, Federally Qualified Health Centers, a hospital or a Baby Arizona approved provider's office (if the applicant is pregnant). Applications may be made by mail, fax or in-person. A.A.C. R9-22-1405. Applications are available in English and Spanish on the DES website or at any local office.

Eligibility for SSI-related groups, KidsCare, Medicare cost sharing groups, long term care and the Breast and Cervical Cancer Treatment program is determined by AHCCCS. Application for the SSI-related groups, KidsCare and the Breast and Cervical Cancer Treatment program may be made to AHCCCS by mail or fax. Application for the Medicare cost sharing programs and for the long term care program can be made to the local ALTCS office by mail, fax or in-person. Applications are available in English and Spanish on the AHCCCS website or the local ALTCS office, including a universal application which may be used to apply for several of the AHCCCS medical programs.

Medical eligibility for SSI recipients is determined by the Social Security Administration. A separate application is not necessary.

Routine Applications

Filing an Application. An applicant, a minor applicant's parent, or a legal or authorized representative may apply for AHCCCS medical coverage. An authorized representative may be designated by the applicant either verbally to an agency employee or in writing. A.A.C. R9-22-1405.B, 1501.C. The agency must permit the applicant to choose another person to help him or her throughout the application process. A.A.C. R9-22-1405.E. If an applicant signs an application with a mark, it must be witnessed and signed by a third party. A.A.C. R9-22-1501.C.2.

A person acting responsibility for an incompetent or incapacitated applicant may apply for medical coverage for the applicant. Incapacity must be verified by a medical professional such as a doctor or a registered nurse. A.A.C. R9-22-1405.B.3. If an applicant dies while the application is pending, a determination of eligibility must be completed for all applicants listed on the application, including the deceased person. A.A.C. R9-22-1405.F, G, 1501.C.

The authorized representative or the person acting responsibly for an incapacitated or incompetent person is responsible for providing complete and accurate information and cooperating with the agency. An application can be denied or medical benefits can be terminated if such a person refuses or fails to cooperate with the agency in completing the application. A.A.C. R9-22-1406.B.

Written Application. Everyone has the unrestricted right to apply for medical coverage. Eligibility workers may not pre-screen applicants or require them to come back another day to apply. An application must be accepted by the agency if it has at least the date, legible names and addresses of each person applying for coverage and the signature of the person filing the application. A.A.C. R9-22-1405.C.2, R9-31-302.C. An application must also be accepted for an incapacitated or incompetent person or a person without an address. In such cases, the agency will assign a name and address for the applicant. An application with at least this information is considered filed on the date it is received at the location where applications are accepted. A.A.C. R9-22-1405.C.1. Applicants should keep proof of the mailing or faxing of the application to protect their filing date in case of a problem. If they file it in person, they should ask the agency for a date-stamped copy or receipt.

An application is deemed completed when it contains the previously listed information as well as the names of all persons living with applicant, their relationship to the applicant and the other eligibility information requested on the application. A.A.C. R9-22-1405.D, R9-31-302.D. This information may be provided after the protected filing date as required by the agency.

If an applicant is determined ineligible but later becomes eligible, he or she must submit a new application. There is no limit to the number of applications that can be filed by an applicant. This is especially important to persons with unsteady incomes or persons who incur substantial medical bills who may qualify under the MED program. As previously discussed, the income and medical expense periods for the MED program change each time an application is filed in a different month.

Hospital applications. DES has outstation offices in the hospitals so that an application can be immediately taken when a person is hospitalized. If the hospitalized person is an incompetent or incapacitated person, an application may be taken from a person who is acting responsibility for that person. Incapacity must be verified by a medical professional such as a doctor or a registered nurse. A.A.C. R9-22-1405.B.3. An interview must be conducted and an eligibility determination must be made within seven days of the application date unless additional information or verification is required. If so, DES has up to 45 days to determine eligibility. A.A.C. R9-22-1411.A.

Interviews. A face-to-face interview with the applicant or the designated representative must be conducted for most programs. A face to face interview is not required for the KidsCare, SSI-MAO or Medicare cost-sharing programs. The interview takes place at the agency's office or during a home visit for a homebound applicant. A.A.C. R9-22-1408.A.1. The applicant must be provided with a written notice of the interview date. A.A.C. R9-22-1408.A.1.b. A separate interview may not be required if an application is received from a Baby Arizona provider, a KidsCare or Children's Rehabilitation Services office or another agency or entity approved by AHCCCS and no further information is required to determine eligibility. A.A.C. R9-22-1408.A.2.

At the interview, the eligibility worker must offer to help the applicant complete the application form and obtain any information that must be verified. The worker must review the information provided by the applicant and obtain his or her signature on any releases of information necessary for the verification process. The worker also must explain the eligibility requirements including whose income is counted, the social security number requirement, the applicant's rights and responsibilities including the right to appeal and the responsibility to report changes in a timely manner, the eligibility review process, coverage and types of services available under each program, family planning services, the AHCCCS pre-enrollment process and the availability of continued AHCCCS coverage. The worker must inform the applicant how the agency exchanges eligibility and income information with other agencies through its data system. Prior to completing the interview process and signing the application, the worker must explain the applicant's responsibility to provide truthful information under penalty of criminal prosecution. A.A.C. R9-22-1405.C

If additional information must be verified after the interview, the eligibility worker must give the applicant a written list of the specific items that need verification. The worker must give the applicant ten days to provide this information. A.A.C. R9-22-1410.C, 1502.F, R9-31-308.E.2. If the applicant is having problems obtaining these items, he or she should contact the eligibility worker to request assistance prior to the expiration of the ten day period as the worker has a duty to assist the applicant under these circumstances. A.A.C. R9-22-1408.C. An applicant or recipient may also request an extension of time to provide the requested information. If the applicant does not provide verification of the requested information and does not contact the worker for assistance prior to the ten-day deadline, the application may be denied or benefits may be terminated. A.A.C. R9-22-1410.C, R9-31-302.E.2.

Verification of Information. The applicant or member has the primary responsibility to provide the agency with all the information that is necessary to verify and determine

eligibility. A.A.C. R9-22-1410, R9-31-305. The type of information that must be verified includes income, deductions from income, resources, citizenship or immigration status, residency and household composition. Applicants frequently have problems with the verification process. Eligibility workers may require too much documentation and may refuse acceptable alternative methods of verification. The regulations and policies should be carefully checked to make sure that the eligibility worker is not making unauthorized demands.

There are three types of verification sources. The agency will accept verification of information in the following order: (1) documented verification, that is, written evidence or an official document from an agency or person qualified to have such information, (2) information obtained from a collateral contact which is a verbal statement from a person or agency qualified to have this information, or (3) an applicant's statement when such information is not documented, a collateral contact is not available, and the statement is not inconsistent with other information. A.A.C. R9-22-1410.A. However, documented verification of social security number and immigration status is the only acceptable verification. Also, if U.S. citizenship or another person's relationship with the applicant is questionable, only documented verification will be accepted. A.A.C. R9-22-1410.B.

Applicant and Member Responsibilities. As a condition of eligibility, applicants and members are responsible for providing truthful and accurate information to the agency and for cooperating with the Division of Child Support Enforcement (DCSE) to establish paternity and enforce medical support obligations. They must give DES any medical support payments received for an AHCCCS eligible child, cooperate with requests by quality control employees, and report changes within ten days of the date the change is known. Changes that must be reported include changes in address, marital status, household composition, income, resources for the MED program, Arizona state residency, citizenship or immigration status, first or third party liability and any other changes which may affect a person's eligibility. A.A.C. R9-22-1406.C, 1501.G, R9-31-308. Changes may be reported orally or in writing. However, it is recommended that an applicant or recipient report such changes in writing to create a record of the report.

Application Processing Time Frames. After the application has been completed and all information has been provided and verified, the eligibility worker must make an eligibility determination. The determination must be made within forty-five days of the application date unless it is an application for a pregnant woman, a hospitalized person, or the KidsCare program. If the applicant is pregnant, a decision must be made within twenty days of the application date unless additional information is needed to make a decision. If the applicant is in the hospital at the time of the application, DES must complete an interview and make an eligibility determination within seven days of the application date unless additional information or verification is required. A.A.C. R9-22-1411.A. If the application is for the KidsCare program, the decision must be made within thirty days except in an emergency beyond AHCCCS' control. A.A.C. R9-31-302.E.

Waiting List. Under the KidsCare program, AHCCCS can stop processing an application and place the applicant on a waiting list if monies are insufficient to continue. When funds

become available, the applicant will be required to submit a new application if the original application is more than 60 days old. A.A.C. R9-31-302.F.

Notice of Decision. The agency must provide the applicant or member with a written notice of the decision which is both adequate in content and timely. 42 C.F.R. §§ 431.206(b), 431.210. If the application is approved, the notice must state the name of each approved person, the effective date of eligibility, the reason for approval, the legal citation if a person is only approved for emergency services and the appeal rights. A.A.C. R9-22-1411.B and 1501.F, R9-31-310.A.1.

If the decision denies the application, the notice must contain a statement of the intended action, reasons for the action, specific legal support for the action, and an explanation of the individual's hearing rights. 42 C.F.R. §§ 431.206, 431.210. The notice must name each ineligible person; give the effective date of ineligibility and list the income and/or resource calculation as compared to the income and/or resource standard. A.A.C. R9-22-1411.C and 1501.F, R9-31-310.A.2.

Applications may be denied for a variety of reasons including failure to meet the eligibility requirements, to provide verification, to cooperate with the agency or to participate in a mandatory face to face interview. The agency also may deny an application if the applicant withdraws the application orally or in writing or if the applicant has been determined eligible for coverage in another category or program. A.A.C. R9-22-1409, 1413.

Review of Eligibility. AHCCCS members must have their continued eligibility reviewed at least once every twelve months. A.A.C. R9-22-1412, 1501.H, R9-31-308.C. However, a review must be conducted when a pregnant woman's pregnancy terminates and at least every three months for persons who were approved for emergency services only or the MED program. Also, a review can be requested any time there is a change in circumstances that may affect the household's eligibility. A.A.C. R9-22-1412.B.

A new application is submitted to review continued eligibility. The same application and verification procedures are followed as at the time of initial application. When the item is not subject to change, the documentation and verification contained in the file may be used for the review. A written notice of continued eligibility must be sent to the member if he or she continues to be eligible for coverage. A.A.C. R9-22-1412.C.

If a member is no longer eligible, a written notice of discontinuance must be sent to the member. A member's coverage may end if he fails to cooperate with the review process or meet the eligibility requirements. A.A.C. R9-22-1412.D, R9-29-203.A, R9-31-308.D. The adverse action notice must be sent no later than ten days before the effective date of the discontinuance. 42 C.F.R. §§ 431.206, 431.211, 431.214. The notice must state the name of each ineligible member, the reason for discontinuance, supporting legal citations and where a person can review those citations, the financial calculations compared to the financial standards, the effective date of the discontinuance, the member's right to appeal, and the right to continued medical coverage pending the appeal. A.A.C. R9-22-1413.C.

A ten day advance notice of discontinuance is not required if the agency receives a request to withdraw the application, verification that the member is not eligible due to institutionalization, has documented information that a person has died, has returned mail with no forwarding address and the member's whereabouts are unknown, or verified that the member has been approved for Medicaid in another state. A.A.C. R9-22-1413.B, R9-29-203.

Continuation of AHCCCS Coverage for SSI Terminations. Because SSI recipients are categorically eligible for AHCCCS coverage, they are not required to independently apply for such coverage. However, if a member's SSI cash payments are terminated, AHCCCS must continue coverage until a redetermination of AHCCCS eligibility is completed. During this "ex-parte" process, AHCCCS must determine if the recipient is eligible for Medicaid on any other basis. 42 C.F.R. § 435.930; A.A.C. R9-22-1501.D. If AHCCCS needs additional information to make this determination, they must contact the member for the information prior to rendering a decision of continuing coverage. Extended coverage may continue for to up ninety days while the redetermination is in process.

Reporting Changes. All applicants and members must report changes within 10 days of the date the change is known to the applicant or member. Changes that must be reported include changes in address, marital status, household composition, income, resources for the MED program, Arizona state residency, citizenship or immigration status, first or third party liability and any other changes which may affect a person's eligibility. Changes may be reported verbally or in writing. Reported changes are evaluated by the eligibility worker, using the same verification procedure as for routine applications, to determine if there is a change in eligibility. A.A.C. R9-22-1406.C, 1501.G, R9-31-308.

Effective Date of Eligibility

The effective date of eligibility for the acute care program for families and individuals is (1) the first day of the month that the application is filed if the applicant is eligible that month or (2) the first day of the first eligible month following the month of application. A.A.C. R9-22-1405.C.3, 1501.E.

For *newborns*, the first day of eligibility is the child's date of birth. If the child is born to a mother who is receiving AHCCCS coverage, the child is automatically eligible for AHCCCS medical coverage for twelve months if he continually lives in Arizona with his or her mother. Eligibility ends on the last day of the month in which the child turns one. Prior to this date, a new application can be filed to continue eligibility. An informal review is conducted at six months to ensure the child is still living with the mother. A.A.C. R9-22-1422, R9-31-309.

The effective date of coverage under the *MED* category is the date that the income and resource requirements are met, but no earlier than the first day of the month of application. A.A.C. R9-22-1431.A. If a person meets the income criteria in the application month but does not meet the resource criteria until the next month, the date of eligibility is the first day of the month following the application month. A.A.C. R9-22-1431.A. The effective date of eligibility can be adjusted within 60 days of approval for the MED program if the recipient provides proof of additional allowable medical expenses. A.A.C. R9-22-1431.B-D.

Eligibility for the *KidsCare* program is effective the first day of the month following a determination of eligibility if the decision is made by the 25th day of the month. If a decision is made after the 25th day of the month, eligibility starts on the first day of the second month following the determination of eligibility. A.R.S. § 36-2983.

The effective date of eligibility for the *Medicare Cost Sharing* programs is the first day of the month following the month in which an eligibility decision was made. A.A.C. R9-29-201.

Enrollment

Generally, an AHCCCS member may choose a health plan within the member's GSA within sixteen days of the date of the initial application interview. A.A.C. R9-22-1701.A.1, R9-31-306. Native-Americans may choose IHS or another available AHCCCS health plan. A member can enroll by selecting a plan on the application or by calling an AHCCCS toll free number to pre-enroll. Generally, the effective date of enrollment is the date that AHCCCS actually takes the enrollment action. A.A.C. R9-22-1702.A.

For the KidsCare program, the effective date of enrollment is the first day of the month following a determination of eligibility if the eligibility determination was made by the twenty-fifth of month. Otherwise, enrollment is effective the first day of the second month following the determination of eligibility. A.A.C. R9-31-306. There are specific enrollment rules for members whose eligibility changes between the Medicaid (Title XIX) program and the KidsCare program (Title XXI). A.A.C. R9-31-306.A.4.

If a health plan is not chosen, the member is automatically assigned a health plan. The automatic assignment process takes some factors into account in assigning a provider. For example, if other family members are already enrolled in a health plan, the new members will be assigned to the same plan. Certain patients under active care will be assigned to their current health care provider if possible. Native-Americans who live on reservation are automatically assigned to IHS if they have not chosen otherwise. A.A.C. R9-22-1701.A.3. Foster children are automatically enrolled with the Comprehensive Medical and Dental Program (CMDP). A.A.C. R9-22-1701.C. Newborns are automatically assigned to the same plan as the baby's eligible mother. Mothers have up to sixteen days to change the baby's health plan. A.A.C. R9-22-1703. A member not enrolled with health plan may receive covered services from an AHCCCS-registered provider on a fee-for-service basis. A.A.C. R9-22-1701.B.

Guaranteed enrollment period. Members, except for those enrolled with IHS or CMDP, are guaranteed eligibility for an initial five-month continuous period plus the month that the member was enrolled. A.A.C. R9-22-1704.A. Guaranteed enrollment terminates when it is determined that a member was factually ineligible when enrolled, an inmate of a public institution, died, moved out-of-state, voluntarily withdrew or was adopted. A.A.C. R9-22-1704.B, C.

Transferring to Other Health Plans. Once enrolled in a health care plan, a member's opportunity to transfer to another plan is limited. Generally, AHCCCS members may change their health plans only during their "annual enrollment" period. However, Native-Americans can switch between IHS and the health plans available in their area anytime.

A.A.C. R9-22-1701.E.1. Otherwise, a member can only change health plans for good cause such as he or she moves out of an area served by the plan or there is a breakdown in the relationship between the provider and the patient. Members have the right to appeal a denial of a request to change health plans. A.A.C. R9-22-1701.E.2-4, R9-31-306.C.

Assignment of Rights

A member determined eligible for AHCCCS coverage assigns his or her rights to all types of medical benefits to which the member is entitled under operation of law under A.R.S. §36-2903.03. A.A.C. R9-22-1415, 1501.L.

Dates of Coverage

Unless benefits are discontinued, members are covered until the end of the certification period. Certification may last up to twelve months. A.A.C. R9-22-1412.A, 1501.H. A child eligible under the KidsCare program is guaranteed a one-time, 12-month period of continuous eligibility unless a change causes ineligibility. A.A.C. R9-31-307.

Medical Services Provided Through AHCCCS

Scope of Services

Range of Services. A broad range of services is covered under AHCCCS. Federal Medicaid regulations require that services be "sufficient in amount, duration, and scope to reasonably achieve their purpose." 42 C.F.R. § 440.230(b). In addition, the regulations prohibit states from arbitrarily denying or reducing the amount, duration, or scope of such services to an otherwise eligible person solely because of the diagnosis, type of illness, or condition. 42 C.F.R. § 440.230(c).

State law permits AHCCCS to adopt rules that limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services, however, these limitations must be consistent with federal regulations under title XIX of the Social Security Act. This may include adopting rules that require the prior authorization of medically necessary services. A.R.S. § 36-2907.D.

AHCCCS limits covered services for its full service programs to those which are medically necessary, cost effective, and federally and state reimbursable. A.A.C. R9-22-201.B.1, R9-28-201, R9-31-201. Primary physicians, attending physicians, practitioners, and dentists are required to provide or direct an AHCCCS member's covered services. A primary care physician's role or responsibility is not diminished if he or she delegates the provision of care to a practitioner. A.A.C. R9-22-201.B.4, R9-31-201.D.3. Prior authorization is required for some services. A.A.C. R9-22-201.C-E, 204.B.1. Under certain circumstances, if a member requests a service that is not covered or authorized by AHCCCS from an AHCCCS registered provider, the provider may render the service and request payment from the member. A.A.C. R0-22-201.J.

AHCCCS services that must be provided include outpatient health services; laboratory, x-ray and medical imaging services; pharmacy services; medical supplies, equipment and prosthetic devices; inpatient hospital services; specialty services; emergency services; emergency ambulance and medically necessary transportation; emergency dental care and extractions; medically necessary dentures; early and periodic screening, diagnosis and treatment services (EPSDT) for children under 21; podiatry services; non-experimental transplants approved for Medicaid reimbursement; AHCCCS services provided in home or in a skilled nursing facility; room and board in a skilled nursing facility; home health services; and family planning services that do not include abortions or abortion counseling. A.R.S. § 36-2907.A.1-12; A.A.C. R9-22-201, 204-213, 215-216. Similar services are available through the KidsCare program. A.A.C. R9-31-201 et seq.

The following list highlights AHCCCS services that are of general interest.

The EPSDT program. Under federal Medicaid law, children and adolescents under age 21 are entitled to receive regular check-ups pursuant the Early and Periodic Screening, Diagnosis, and Treatment program (EPSDT). EPSDT check-ups include immunizations, screening of dental, vision, hearing and speech problems, nutritional and developmental assessments, and laboratory tests including lead blood tests. Children up to 21 years old may receive hearing aids, eye examinations, prescriptive lenses, and dental care, including orthognathic surgery. Any condition identified through screening must be treated, even if the service is not otherwise covered in the state plan. Outreach and education on the importance of preventative care is a required component of the EPSDT program. Assistance with appointment scheduling and transportation must also be offered. EPSDT, 42 U.S.C. §§ 1396a(a)(10)(A), 1396a(a)(43), 1396d(a)(4)(B), 1396d(r) (as added or amended by Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6403, *reprinted* in 1989 U.S.C.C.A.N., 103 Stat. 2262-2264 (effective April 1, 1990); A.R.S. § 36-2907(A)(8); A.A.C. R9-22-213. Similar services are provided under the KidsCare program. A.A.C. R9-31-207, 213.

Periodic Examinations. Adults can receive periodic health examinations to detect or determine the risk of disease. A.A.C. R9-22-205.A.

Dental, Hearing and Eye Care Limitations for Adults. Routine dental care, prescriptive lenses, and hearing aids are not covered for adults. AHCCCS will cover emergency dental care, medically necessary dentures, and eye exams when they are the sole visual prosthetic device used by the member after a cataract extraction. A.R.S. § 36-2907.A.5, 7; A.A.C. R9-22-207, 212.E.8. Covered dental care includes relief from pain, extractions, initial treatment for acute infection, treatment for acute crano-mandibular problems and traumatic injuries, and fillings, crowns, and root canals as needed to treat pain or infection. A.A.C. R9-22-207.

Prescriptions, Labs, X-rays and Medical Supplies. AHCCCS covers prescribed medications, laboratory and x-ray services, medical supplies, equipment, and prosthetic devices. A.R.S. § 2907; A.A.C. R9-22-208, 209, 212; R9-31-208, 209, 212. Over-the-counter medications may be covered if they are appropriate, equally effective, safe, and less costly than prescribed medications. A.A.C. R9-22-209.D.4. Other specialized services are covered when referred by the member's primary care physician. A.A.C. R9-22-205.B; R9-31-205. A second opinion

from another doctor may be required by AHCCCS before surgery is covered. A.R.S. § 36-2907(H).

Long-Term Care. Long term care is available for people who are developmentally disabled, physically disabled, or elderly under the Arizona Long Term Care System (ALTCS).

Home Health Services. Home health services are available under AHCCCS in lieu of hospitalization. Such services include nursing, home health aides, supplies, equipment, and appliances, if provided intermittently or part-time by a licensed home health agency and under a doctor's orders. A.R.S. § 36-2907.D. The KidsCare program also provides nursing facility care and home-and-community based services. A.A.C. R9-31-216.

Maternity and Childbirth. Maternity care and childbirth are covered. A.A.C. R9-22-204.1. Midwifery services provided by a certified nurse practitioner in midwifery and midwifery services for low risk pregnancies and home deliveries that are provided by a licensed midwife are covered. A.A.C. R9-22-215.A.4, 5. Also, if a mother is enrolled on the date of her newborn's birth, the health plan is financially liable under the mother's capitation rate to provide all AHCCCS-covered services to the newborn from the date of birth until such time that AHCCCS is notified of the birth. A.A.C. R9-22-707. Midwife services are not covered by the KidsCare program. A.A.C. R9-31-205.C.3.f.

Family Planning. Family planning services that do not include abortion or abortion counseling are covered by AHCCCS. A.R.S. § 36-2907.A.9.

Mental Health Services. AHCCCS contracts with the Department of Health Services to provide all medically necessary behavioral health services to persons eligible for services pursuant to A.R.S. § 36-2901.6(a). A.R.S. § 36-2907.F. Emergency behavioral health services may be covered by AHCCCS including a behavioral health evaluation by a psychiatrist or psychologist if the evaluation is required to evaluate or stabilize an acute episode of a mental disorder or substance abuse. A.A.C. R9-22-210, R9-31-210.D. (See below for more detailed information.)

Excluded Services. Excluded services include occupational or speech therapy for adults, and non-emergency adult dental care. A.R.S. § 36-2907.A.2, 5.

Emergency Care

Right to Receive Emergency Services. Every person is entitled to receive emergency care at any facility equipped to provide such care. This is true regardless of ability to pay, eligibility for AHCCCS or any other medical coverage program, residency or citizenship.

This broad principle is not based on statute or regulation but rather is the "public policy" of the state, declared by the Arizona Supreme Court in *Guerrero v. Copper Queen Hospital*, 112 Ariz. 104, 537 P.2d 1329, 1331 (1975) (hospitals have a duty to provide emergency care to all persons presenting themselves including nonresident aliens), and reaffirmed in *Thompson v. Sun City Community Hospital, Inc.*, 141 Ariz. 597, 688 P.2d 605, 609-611 (1984); *St. Joseph's Hospital and Medical Center v. City of Phoenix*, 158 Ariz. 540, 764 P.2d 25, 26-27 (App. 1988).

Thompson holds that all hospitals licensed in Arizona are required to render emergency care to all patients who present themselves in need of such care. An emergency patient may not be transferred until the indicated emergency care has been completed and the patient's condition has stabilized.

This state-based duty to provide emergency care coincides with the same duty under federal law. Those hospitals with a Hill-Burton community service obligation (which is perpetual) must provide emergency care. Also, the federal anti-dumping statute requires hospitals to provide, without prior inquiry as to ability to pay, necessary emergency medical services to all patients requiring such services. 42 U.S.C. § 1395dd.

AHCCCS defines emergency medical service as "services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. A.A.C. R9-22-102. However, emergency services under the KidsCare Program shall be provided to a member based on the prudent layperson standard. A.A.C. R9-31-210.

Emergency services are covered by AHCCCS regardless of where treatment takes place or whether a person determined eligible has been enrolled in a plan. A.R.S. § 36-2908. An AHCCCS health plan is required to provide full emergency services to its members. Access to an emergency room and emergency medical and behavioral health services must be available twenty-four hours a day, seven days a week, in each contractor's service area. A.A.C. R9-22-210.C, R9-31-210.C.

Prior authorization is not required for emergency services; however, a provider or a non-contracting provider furnishing emergency services to an AHCCCS member must notify the member's health plan within 12 hours of the time the member presents himself for services. The provider is not required to notify AHCCCS. A.A.C. R9-22-210.E. If the condition is deemed not to be an emergency, the provider must contact the health plan prior to treatment and follow prior authorization requirements or protocols for non-emergent conditions. Failure to provide timely notice or to comply with prior authorization requirements may be grounds for denying payment to the provider. A.A.C. R9-22-210.E.

Transportation

AHCCCS is responsible for assuring that members receive medically necessary non-emergency transportation to and from their providers. A.R.S. § 36-2907.A.12, G. This responsibility is primarily met by giving members information about available transportation and enrolling them with easily accessible providers. In addition, when the patient cannot provide his or her own transportation and free services are not available, then contractors should arrange for or provide transportation. A.A.C. R9-22-211.C, R9-31-211.

When a member needs care that is not available in the provider's service area, AHCCCS will pay for the patient's travel expenses (including meals, transportation, and lodging) plus the travel expenses of an attendant. The primary care physician must order the services of

the attendant in writing. The attendant may be a member of the patient's family. If the attendant is not a family member, then AHCCCS will pay a salary up to the federal minimum wage. A.A.C. R9-22-211.D-F.

Emergency ambulance service is covered by AHCCCS. A.R.S. § 36-2909.A.12. Payment is limited to cost of air or ground ambulance to the nearest appropriate provider when no other means of transport is both appropriate and available. A.A.C. R9-22-211.A, B. The transportation company must notify the health plan within ten working days from the date of the transport. Failure to notify the health plan may cause the payment to be denied to the provider. *Id.*

Mental Health Services under AHCCCS

Overview. All Title XIX members are entitled to comprehensive behavioral health benefits. Title XIX members may be enrolled in acute care health plans, acute care or long-term care Indian Health Services, or Arizona Long Term Care Plans (ALTCS). Comprehensive acute care medical services are provided through contracted health plans using a previously discussed managed care model. However, behavioral health services for acute care Title XIX members are "carved out" and are delivered through Regional Behavioral Health Authorities (RBHAs). By statute, AHCCCS contracts with the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) who then sub-contracts with the RBHAs to provide these mental health services. The RBHAs are community-based organizations and function in a fashion similar to health maintenance organizations. Currently, Arizona has six geographical service areas and each geographical area is assigned to a RBHA. For more information on how behavioral health services are delivered under the ALTCS system, see page 45.

Resources. The following is a list of behavioral health resources for AHCCCS members.

> The AHCCCS Behavioral Health Covered Services Guide and its appendices are available online at www.ahcccs.state.az.us or at www.hs.state.az.us/bhs/.
>
> ARS § 36, Chapter 5 (ADHS) and Chapter 29 (Acute and Long Term AHCCCS) can be found online at www.azleg.state.az.us.
>
> A.A.C. R9-22 (AHCCCS Acute Care Rules) and R9-28 (ALTCS Rules) can be found at www.sosaz.com.

Covered Mental Health Services. Arizona has recently expanded the behavioral health covered services for Title XIX Adults and Children to include more support and rehabilitation services. The following is a partial list of behavioral health services that are now covered:

> Screening, Evaluation and Diagnosis
> Case Management
> Inpatient Services
> Individual therapy and counseling

Group and/or family therapy and counseling
Psychotropic medication adjustment and monitoring
Partial Care (Supervised, Therapeutic and Medical Day Programs)
Crisis Intervention Services (24 hours a day)
Behavior Management (Personal Assistance, Peer Support)
Psychosocial Rehabilitation
Transportation (emergency and non-emergency medically necessary transportation to and from settings to provide Title XIX covered behavioral health services
Laboratory/Radiology Services (used for diagnosis and medication regulation)
Respite Care

Title XIX Children's System. Not only are Title XIX-eligible children entitled to the above covered behavioral health services, but in certain instances, the child may be entitled to more comprehensive and individualized behavioral health services if medically necessary. The JK v. Eden lawsuit filed several years ago by the Arizona Center for Disability Law against the State of Arizona reached a settlement agreement in March of 2001. The Center filed the lawsuit to improve the delivery of behavioral health services for Title XIX-eligible children in accordance with the requirements of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT). EPSDT requires comprehensive health care, including behavioral health services for Medicaid members under that age of 21. Out of the settlement agreement came the "Arizona Vision" for how behavioral health services should be delivered to children as well as the 12 Principles to govern the implementation of the Arizona Vision. For more information on the Arizona Vision and the Twelve Principles, visit the AHCCCS website at www.ahcccs.state.az.us.

Members' Payments

AHCCCS requires members pay providers a nominal co-payment for some services. The provider is responsible for collecting the co-payment, however, a member can not be denied services if he or she is unable to pay the co-payment. Co-payments are $1 for a doctor's home or office visit including the x-ray and laboratory services associated with that visit, $5 for non-emergency surgery and $5 for non-emergency use of the emergency room. A.A.C. R9-22-711.A.

A co-payment may not be required for EPSDT or well-baby services, prenatal care including all obstetrical visits, care in nursing facilities or intermediate care facilities for the developmentally disabled, visits scheduled by the physician and not at the request of the member, drugs, medications or family planning services. A.A.C. R9-22-711.A.

KidsCare. KidsCare program recipients with income between 150% and 200% of the FPL are required to pay monthly premiums which range from $10 to $25 a month. Also, a $5 co-payment must be assessed for non-emergency use of the emergency room. However, a member can not be denied services if he or she can not pay the co-payment. The household's premium payment and the household's co-payments can not exceed five percent of the household's gross income. The head of the household can request a hardship exemption from paying the premium for a child. Coverage can be discontinued for non-payment of monthly premiums. A.A.C. R9-31-711, 1401 et seq.

Collection Attempts. Unless services are not covered or without first receiving verification from the AHCCCS Administration that a person was ineligible for AHCCCS on the date of service, an AHCCCS-registered provider shall not charge, submit a claim to, demand, or collect payment from a member or a person claiming to be AHCCCS eligible. A.R.S. § 36-2903.01.L; A.A.C. R9-22-702.A, R9-31-702. A provider may collect authorized co-payments, charges for non-covered services and certain third party payments from members. A.A.C. R9-22-702.B.

Submission of Claims. AHCCCS registered providers must submit claims for covered services to the AHCCCS Administration no later than six months from the date of service or the date of eligibility posting, whichever is later. A.A.C. R9-22-703.B.

Grievance and Appeal Process

AHCCCS provides a formal process of notice, hearing, and appeal whenever an applicant or member is adversely affected by an action regarding eligibility, enrollment, or covered services. A.R.S. § 36-2903.01.B.4, § 41-1092 et seq.

Appeals from Eligibility Decisions

As a general rule, applicants or members who wish to appeal an adverse action must request a grievance or hearing with the agency that rendered the decision. An appeal may be filed to challenge (1) a complete or partial denial of eligibility, (2) a suspension, termination, or reduction of AHCCCS medical coverage, or (3) delay in the eligibility determination. A.A.C. R9-22-1433; A.A.C. R9-31-803, 1301. The time limit for requesting a hearing is determined by the date of the decision notice called the Notice of Action. Generally, the deciding agency must render a decision and send a Notice of Action within forty-five days of the date of application. A.A.C. R9-22-1411. KidsCare applications must be decided within thirty days. A.A.C. R9-31-302. A decision on a long-term care application must be made within thirty days unless it is based on disability which extends the time to ninety days. A.A.C. R9-28-401. The date of the Notice of Action is the date that it was mailed or personally delivered to the applicant or member. A.A.C. R9-22-1433. For eligibility appeals, a timely request for a hearing must be filed with the agency within thirty days of the date of the adverse notice. A.A.C. R9-22-1433; A.A.C. R9-31-803.C.3, 1301.A.2.

Benefits Pending Appeal. When medical benefits are being discontinued or terminated, the Notice of Action must be mailed at least ten days before the effective date of the termination. If a member requests a hearing within the ten-day period and specifically requests continuation of benefits, AHCCCS coverage can continue during the appeal. However, if the decision to terminate medical benefits is upheld, the member may be financially liable for any AHCCCS benefits he or she received pending the appeal. A member may specifically waive the right to continuing benefits during the appeal period. Continuing benefits may not be available when a change in federal or state law mandates an automatic adjustment for all classes of recipients and the law was not misapplied by the agency. A.A.C. R9-22-1303, 1433.E; A.A.C. R6-12-1004.

An applicant who is appealing a denial of an initial application may not be covered by AHCCCS during the appeal. However, if it is decided on appeal that the member or applicant was wrongly determined to be ineligible, the administration should reimburse him or her for all covered services received between the date of the incorrect determination and the date he or she is enrolled with a provider (or becomes ineligible, whichever first). A.R.S. § 36-2905.02.B.

DES Fair Hearings

DES conducts hearings for the medical assistance programs that it is responsible for determining eligibility. These hearings must be conducted in accordance with DES' appeal procedures at A.A.C. R6-12-1002-1003, 1005-1013. Any reference to "benefits" or "cash assistance" in these rules refers to AHCCCS medical coverage. A.A.C. R-22-1433.D.

Filing a Fair Hearing Request (Appeal). A request for hearing or appeal is defined by Medicaid regulations as a clear expression by the applicant, recipient or his representative for an opportunity to present his or her case to a reviewing authority. 42 C.F.R. § 431.201. An applicant or member may appeal to DES by filling out the fair hearing request form on the back side of the Notice of Action and returning it to any DES office within the specified appeal period. If an applicant or member requests a fair hearing orally, DES must reduce the request to writing. The appeal is deemed filed with DES when mailed. If the date of mailing can not be determined, the appeal is deemed filed when it is actually received by DES. A.A.C. R6-12-1002.

Untimely Appeals. An untimely appeal may be filed and will be determined timely if the applicant or member can show that the U.S. Postal Service or DES made an error that caused the appeal to be filed late. A.A.C. R6-12-1002. Also, because DES is required to follow federal civil rights laws that protect persons with disabilities, an applicant or member could file an untimely appeal on the basis of his or her disability if the disability prevented him or her from filing a timely appeal. Americans with Disabilities Act, 42 U.S.C. § 12101 et seq.; Rehabilitation Act of 1973, 29 U.S.C. § 701 et seq.

Pre-hearing. After the appeal is filed, the local DES office staff must prepare a pre-hearing summary which explains the basis for the decision. A copy of this summary must be provided to the appellant and the DES Appeals Office. A.A.C. R6-12-1004. The hearing must be scheduled between twenty and forty-five days of the appellant's notice of appeal. DES must give at least ten days advance written notice of first hearing and advance notice of any continued hearing. A.A.C. R6-12-1006. The hearing notice must state the time, place, and nature of the hearing; the legal authority and jurisdiction under which the hearing is to be held; a reference to the particular sections of the statutes and rules involved; and a short and plain statement of the issues. A.R.S. § 41-1061(B).

Prior to the hearing, the appellant has the right to request a change in the hearing officer within ten days of hearing, request postponement of hearing within five days of hearing for good cause reasons, review the evidence and get copies of relevant documents. The appellant may request that the Judge subpoena witnesses or evidence relevant to the appeal.

A.A.C. R6-12-1005. The appellant has the right to be represented by counsel. At the hearing, the appellant must be allowed to present arguments and evidence and to cross-examine adverse witnesses. A.A.C. R6-12-1011.C.

Limited English Proficiency or Disability. If the appellant does not speak English, DES must provide an appropriate language interpreter to ensure meaningful participation in the hearing process. See, Title VI of the Civil Rights Act of 1964, Policy Guidance on the Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, 65 F.R. 52762 (2000). DES also must provide sign language interpreters for hearing impaired persons and must accommodate persons with disabilities to ensure full participation in the process. 42 U.S.C. § 12101 et seq., 29 U.S.C. § 701 et seq.

DES Administrative Law Judge Hearing. The hearing is conducted de novo by a DES Administrative Law Judge (ALJ). The ALJ rules on the admissibility of the evidence and controls the conduct of the hearing. A.R.S. § 41-1062. The hearing is informal and does not adhere to the judicial rules of evidence. *Id.* DES has initial burden of going forward; the appellant must prove his or her eligibility by the preponderance of the evidence. A.A.C. R6-12-1011.

The appellant can appear for the hearing in person, by telephone or by submitting a written statement. A.A.C. R6-12-1011. If the appellant fails to appear at the hearing, the ALJ may proceed with the hearing; reschedule the hearing with further notice; make a decision based on the evidence in the record; or issue a default decision.

A written decision, based solely on the evidence at the hearing, must be provided to the appellant within ninety days of the request for a hearing. 42 C.F.R. §§ 431.242(b)-(e), 431.244 (a), (f); A.A.C. R6-12-1012. The local DES office staff must implement the ALJ decision within ten days of the date of the decision. A.A.C. R6-12-1013. Despite this requirement, DES often does not implement the decision within ten days, so follow up with the local office may be necessary to ensure timely implementation.

DES Appeals Board Review. The appellant has the right to appeal an adverse ALJ decision to DES Appeals Board within fifteen days of the decision. When a timely appeal is filed with the Board, implementation of the adverse decision is stayed. There are two levels of appeal within the DES Appeals Board structure. If deemed necessary, the Board may conduct another hearing to take additional evidence. The Board has the power to affirm, reverse or remand an ALJ decision. The Board must issue a final written decision to the appellant. A.A.C. R9-22-1433.G, R6-12-1014.B.

Judicial Review of Appeals Board Decisions. The appellant has the right to seek judicial review of a final written decision of the Appeals Board pursuant to Title 41, Chapter 14, Article 3 of the Arizona Revised Statutes. A.A.C. R6-12-1015, R9-22-1433.G. Any party aggrieved by an Appeals Board decision may file an application for appeal to the court of appeals with the clerk of the Appeals Board. The court of appeals shall deny or grant the application for appeal. If the application is denied, the appeals board decision is final and no further appeal may be taken. If the appeal is granted, the rules for appeals in civil actions apply. The appeal is limited to record that was before the Department unless the court orders otherwise.

Only issues raised on review before the Appeals Board may be raised on appeal. A.R.S. § 41-1993.

AHCCCS Grievances and Hearings

AHCCCS provides a hearing and appeal process for adverse decisions involving medical services and for programs in which AHCCCS determines eligibility. The Office of Administrative Hearings (OAH) conducts hearings for AHCCCS pursuant to A.R.S. § 41-1092 et seq. The administrative rules for AHCCCS grievances and requests for hearing can be found at A.A.C. R9-22-802 et seq. AHCCCS also provides an expedited hearing process for adverse decisions involving medical services that require prior authorization. A.A.C. R-22-1301 et seq.

Adverse Eligibility Decisions. An applicant or member must file a request for hearing with the AHCCCS program that denied or terminated his or her medical assistance. To be considered timely, the appeal must be filed within thirty days of the date of the adverse action notice. A.A.C. R9-22-801.C. A grievance or a request for hearing is deemed filed when it is received by the agency. A.A.C. R9-22-801. AHCCCS can deny a request for hearing for certain reasons such as the request is untimely, the hearing is moot, the subject matter is not within OAH's jurisdiction, or the sole issue is a federal or state law that requires an automatic change which adversely affects some or all applicants or members. A.A.C. R9-22-801.E.2. A request for hearing can be withdrawn by the complainant prior to the hearing. A.A.C. R9-22-801.E.1. (See below for the OAH hearing process.)

Grievances of Adverse Decisions Involving Medical Services. Prior to a request for hearing, a grievance may be filed by a recipient or member if his or her medical services are denied, reduced, suspended or terminated. Filing a grievance prior to a hearing is not mandatory. A hearing may be filed directly with AHCCCS if the complainant chooses not to go through the grievance process. In the grievance process, the respondent is the AHCCCS Administration if it made the adverse decision. If the adverse decision was made by an AHCCCS contractor, the contractor is the respondent. A grievance may be filed orally or in writing and it must be filed within sixty days of the date of the adverse action. A.A.C. R9-22-802.B.1, 2.

Prior to a decision on the grievance, the complainant may provide evidence to support his or her claim for services and the respondent should investigate the issues and consider any new evidence in an attempt to resolve the grievance. AHCCCS or its contractor must make a final decision within thirty days of the filing of the grievance unless a longer period is agreed to in writing. The final decision must include the date of the decision, the factual and legal basis for the decision, the complainant's right to request a hearing under A.R.S. § 41-1092, and the manner in which to request a hearing. The complainant may request a hearing through the health plan or the AHCCCS Office of Legal Assistance within thirty days of the final decision of the grievance. A.A.C. R9-22-802.B.

Continuing AHCCCS Coverage and Benefits. If a member requests a hearing prior to the effective date of a discontinuance action that requires ten-day advance notice, he may continue to receive AHCCCS coverage until a final decision is rendered. A member may

waive this coverage. If the discontinuance is upheld, the member may be financially liable for the services he received during the hearing process. A.A.C. R9-22-803.C, 1307.E, F.

Expedited Hearings. An expedited hearing is available when the AHCCCS Administration or an AHCCCS contractor denies, reduces, suspends or terminates a service that requires prior authorization. A.A.C. R9-22-1301 et seq. If a requested service is denied, written notice must be provided to the member within three days of the denial. If a service is reduced, suspended or terminated, written notice must be provided to the member at least ten days before the effective date of the action. Under certain circumstances such as death or institutionalization of a member, ten day advance notice is not required. A.A.C. R9-22-1302, 1303, 1305. Notice may be reduced to five days in cases of probable fraud. A.A.C. R9-22-1306.

A request for an expedited hearing must be filed no later than ten business days after personal delivery of the notice or fifteen business days after a postmark date. A.A.C. R9-22-1307.A.1. A member may receive continued benefits if a request for continued services is filed at the same time as the request for an expedited hearing. A.A.C. R9-22-1307.A.2. An expedited hearing is held between twenty and forty days of the request. A hearing may be held sooner than twenty days if all parties agree or upon motion of one of the parties. A.A.C. R9-22-1307.B. The hearing is conducted pursuant to A.R.S. § 41-1092 et seq. A.A.C. R9-22-1307.G. If the decision to reduce, suspend or terminate services is upheld, the member is financially liable for the continued services he received during the hearing. A.A.C. R9-22-1307.F.

Office of Administrative Hearings. AHCCCS hearings are conducted by the Office of Administrative Hearings (OAH), another state agency. A notice of hearing must be served on all parties to the appeal at least thirty days before the hearing. The notice must include a statement of the time, place and nature of the hearing, the legal authority and jurisdiction under which the hearing is held, the relevant statutes and rules, and a statement of the matters asserted or the issues involved. A.R.S. § 41.1092.05.B, C. A pre-hearing conference may be held. A.R.S. § 41.1092.05.F. The complainant has the right to appear for the hearing in person or by telephone.

A party may file a request that an Administrative Law Judge (ALJ) be disqualified from conducting a hearing for bias, prejudice, personal interest or a lack of technical expertise necessary for the hearing. A.R.S. § 1092.07.A. The parties have the right to be represented by counsel and to submit evidence and cross-examine witnesses. A.R.S. § 41-1092.07.B. The ALJ may issue subpoenas to compel the attendance of witness or the production of documents and may permit a deposition to be taken under certain circumstances. A.R.S. § 41-1092.07.C, F.4.

The complainant must be given the opportunity to review all documents and records that will be used at the hearing by AHCCCS or its contractor. 42 C.F.R. § 431.242(a). A party may obtain copies of any relevant documents from the respondent at the complaint's expense. A.A.C. R9-22-801.D. However, due process may require the respondent to provide certain documents without cost to the complainant. *Goldberg v. Kelly*, 397 U.S. 254 (1970).

The hearing is recorded. If the appellant wants a written transcript, he or she must pay for it. A.R.S. § 41-1092.07.E. The hearing is conducted in an informal manner and without adherence to the rules of evidence required in judicial proceedings. A.R.S. 41-1092.07.F.1. All relevant evidence is admissible, but the ALJ may exclude evidence if its probative value is outweighed by the danger of unfair prejudice, by confusion of the issues or by considerations of undue delay, waste of time or needless presentation of cumulative evidence. A.R.S. § 41-1092.07.D.

Informal disposition of the hearing may be made by stipulation, agreed settlement consent order or by default. A.R.S. § 41-1092.07.F.5.

Hearing Decision. Within twenty days of the hearing, the ALJ must issue a written decision to the AHCCCS Director. The Director may then review the decision and accept, reject or modify the recommended decision within thirty days. If the Director does not act within thirty days, the ALJ's decision becomes the final decision. A copy of the final written decision must be personally delivered or mailed to all parties. A.R.S. § 41-1092.08.

Final decisions must include findings of fact and conclusions of law. The decision must include an explicit statement of the underlying facts which support the findings, and finding of facts must be based exclusively on the evidence and matters officially noticed. A.R.S. § 41-1092.07.F.6, 7. The Director's final decision must include written justification of the reasons the ALJ's decision was rejected or modified. A.R.S. § 41-1092.08.B.

Effective Date of Coverage. When an eligibility denial is overturned, the decision must state the effective date of coverage. A.A.C. R9-22-803.D. If an eligibility denial is affirmed, the decision must state that the complainant may reapply for AHCCCS coverage. A.A.C. R9-22-801.G.

Motion for Rehearing or Review. A party can petition the Director for a rehearing or review of the decision within thirty days of the date that the decision is mailed or delivered. A.R.S. § 41-1092.09.A.1. The grounds for the petition include irregularity in the proceedings, misconduct by a party or the agency, newly discovered evidence, the decision was the result of passion or prejudice, or the decision is not justified by the evidence or is contrary to law. A.A.C. R9-22-801.F. The opposing party may file a response to the motion for rehearing within fifteen days after the petition is filed. Filing a petition for rehearing or review is not required to exhaust administrative remedies. A.R.S. § 41-1092.09.A.2, 3.

Judicial Review

Final decisions of the AHCCCS Director are subject to review by the superior court. An action for judicial review is initiated by filing a complaint within thirty-five days after the Director's decision is served on the party. If a party has petitioned the Director for a rehearing or review, then he or she must wait until a decision on the petition is rendered. A.R.S. § 12-901 *et seq*. Either the Director or AHCCCS must be named as a defendant, as well as all the parties in the administrative action. A.R.S. § 12-908. The complaint should

state the portion of the record to be reviewed and whether a transcript will be designated as part of the record. A.R.S. § 12-909.A.

If requested by a party within thirty days after filing a complaint, an evidentiary hearing may be held, including testimony and argument. Relevant and admissible exhibits and testimony not offered during the administrative hearing shall be admitted and objections that a party failed to make to evidence offered at the administrative hearing shall be considered unless the exhibit, testimony or objection was withheld for purposes of delay, harassment or other improper purpose or substantial prejudice to another party would result if the evidence is admitted or the objection is considered. A.R.S. § 12-910.A, B.

The Superior Court may affirm, reverse, modify, or vacate and remand the decision. The court shall affirm the decision unless the action is not supported by substantial evidence, is contrary to law, is arbitrary and capricious or is an abuse of discretion. A.R.S. § 12-910.E.

Section 1983 Claims

Applicants and/or members also may go directly to court to enforce Medicaid provisions pursuant to 42 U.S.C. § 1983, which allows a plaintiff to sue a party acting "under color of state law." Exhaustion of administrative remedies is not generally required in Medicaid actions based on §1983. See, *Patsy v. Board of Regents*, 457 U.S. 496 (1982) (exhaustion not required in §1983 action); but see, *Arden House, Inc. v. Heinz*, 612 F. Supp. 81 (D. Conn. 1985) (exhaustion required in §1983 cases asserting violations of the Medicaid Act.) If the Medicaid Act provision is enforceable under this law, beneficiaries may obtain prospective relief against state officials. *Ex Parte Young*, 209 U.S. 123, 159-160 (1908).

II. ARIZONA LONG TERM CARE SYSTEM

Introduction

The Arizona Long Term Care System (ALTCS) provides institutional services and services in the home to members, who are either elderly, blind, physically disabled or have a developmental disability. Medicaid statutes and regulations are applicable to all ALTCS members. ALTCS is administered by AHCCCS.

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Relevant statutes and regulations include:

A.R.S. § 36-2931 *et seq.*
R9-28-101 *et seq.*
42 U.S.C. §§ 1396a and 1396d
42 C.F.R. 430 *et seq.* (general)
435 *et seq.* (eligibility)
440 *et seq.* (services)
441 *et seq.* (limits)
442 *et seq.* (SNF, ICF)
440.180 (HCBS)

The ALTCS program is funded by federal, state and county funds. As of October 1, 2002, the ALTCS program served 35,645 members; 13,720 were persons who are developmentally disabled (DD) and 21,925 were persons who are elderly or physically disabled (EPD). ALTCS members receive services through Program Contractors.

ALTCS offers an array of services including acute medical care services, institutional services, home-and-community based services, behavioral services and case management services. Program contractors coordinate and manage services. They provide services for ALTCS members in the same manner that Health Plans provide acute care services to AHCCCS enrolled members. Services are paid on a pre-paid capitation basis. Program contractors receive a designated amount of money from the state for each enrolled member regardless of the cost of the services that are actually provided. Beginning October 1, 2002, the capitation rate was $2,514 per month for the elderly or physically disabled population and $2,560 a month for the developmentally disabled population.

There is no cap on home-and-community based services. As of September 30, 2002, approximately 56 per cent of the EPD population and almost all of the DD population were being served within the community (as opposed to being institutionalized for services).

In Cochise, Maricopa, Pima, Pinal and Yavapai counties, the program contractor is the county government. Pima County also provides services in Santa Cruz County; Cochise County provides services in Graham and Greenlee Counties; and Pinal County provides services in Gila County. Evergreen Select, a private entity, provides services in Apache, Coconino, La Paz, Maricopa, Mohave, Navajo and Yuma Counties. Maricopa County is also served by Mercy Healthcare Arizona.

The Division of Developmental Disabilities (DDD), a division of the Department of Economic Security, is the program contractor for all counties for persons with developmental disabilities. DDD contracts with AHCCCS to provide acute care services. DDD also administers a state-funded program for developmentally disabled persons who do not qualify for ALTCS.

Native American members may opt to receive services through a Program Contractor or through the IHS system. Six tribes have Intergovernmental Agreements with AHCCCS to deliver case management services and to provide or arrange for home-and-community based services for persons who live on-reservation. As of October 1, 2002, Arizona tribes and the Native American Community Health Center, a tribal organization, case managed 1,485 Native American persons.

Application

Applications may be made with ALTCS by the applicant or by an authorized representative. Except when there is an emergency beyond the Administration's control, ALTCS must make a decision on the application within 90 days for persons applying on the basis of disability and within 45 days for all other applicants. A.A.C. R9-28-401.

Eligibility

The determination of eligibility for ALTCS can be divided into three stages. First, the applicant must be potentially eligible for membership by being in one of the covered groups, and must meet the citizenship, residency, and social security requirements. Second, the applicant must meet the financial eligibility requirements. Third, the applicant must pass the Pre-Admission Screening (PAS) test and be found in need of an institutional level of care.

Requirements for Potential Eligibility

Covered Groups. To be eligible for ALTCS services, applicants must first meet one of the categorical eligibility requirements. Categorically eligible persons include individuals who are aged, blind, disabled, pregnant, a child, or a specified relative who is the caretaker of a child. A.A.C. R9-28-402.A. A person's disability must be established either by the Social Security Administration's determination of disability or through an independent examination and determination by AHCCCS. A.A.C. R9-28-402. Applicants also must be in one of the ALTCS coverage groups required by state law at A.R.S. 36-2934.A.1-5. A.A.C. R9-28-402.B. (See below for coverage groups.)

General Requirements. ALTCS applicants must meet the same citizenship and qualified alien requirements as AHCCCS acute care members. A.R.S. § 36-2932.K, 36-2931.5(a). In addition to the categories of non-citizens that are eligible for acute care, a non-citizen who received ALTCS services on or before August 21, 1996 remains eligible for services. A.R.S. § 36-2903.03, A.A.C. R9-28-404. Applicants must be residents of Arizona. A.A.C. R9-28-403. In some circumstances, coverage is available for out of state residents. 42 C.F.R. § 435.403. Applicants are also required to have a social security number or to apply for one. A.A.C. R9-28-405, 42 C.F.R. §§ 910, 920.

Financial Eligibility

To receive ALTCS Services, a person must be eligible for Medicaid pursuant to Title XIX of the Social Security Act or the state's section 1115 waiver. A.R.S. § 36-2934.D. A person is eligible for ALTCS services if he or she satisfies one of the following:

(1) Eligible pursuant to A.R.S. § 36-2901.6(a)(i) or (ii) and meets the resource limits prescribed by federal law;

(2) Would be eligible for SSI for the aged, blind or disabled or for AFDC[1] but is not receiving a cash payment;

(3) Would be eligible for SSI or under Section 1931 of the Social Security Act except for the person's institutional status, and the person's income does not exceed 300% of the SSI federal benefit rate established by Section 1611 of the Social Security Act.

[1] The Aid to Families with Dependent Children (AFDC) program was replaced by the Temporary Assistance to Needy Families (TANF) program pursuant to the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

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Deleted: **Cash Recipients**. An applicant is financially eligible for ALTCS if he or she receives cash assistance or SSI payments; is otherwise eligible for AHCCCS through one of the MAO categories; or has been terminated from AFDC because of increased earnings. ¶

(4) Is in a medical institution for less than thirty consecutive days and the person would be eligible for SSI or AFDC except for his or her income, and the person's income does not exceed 300% of the SSI federal benefit rate;

(5) Would be eligible for medical assistance under the state plan if the person was institutionalized and a determination has been made that except for the provision of home-and-community based services, the person would require the level of care provided in a hospital, a skilled nursing facility or an intermediate care facility. A.R.S. 36-2934.A.1-5; A.A.C. R9-28-408.

Income. Income such as Social Security income, SSI payments, pensions, retirement income, dividends, interest, annuity payments and wages is counted. Income of a married couple can be looked at in one of two ways. The income can be added together, divided in half and the result compared to 300% of the SSI federal benefit rate. However, if half of the joint income is more than 300% of the federal benefit rate, only the income of the person applying for ALTCS will be considered. A.A.C. R9-28-410.C. Certain types of income are excluded. A.A.C. R9-28-408.

Resources. A person receiving SSI, Title IV-E Foster Care or Adoption Assistance payments, or described as a person eligible for Medicaid under Section 1931 of the Social Security Act is deemed to have met the resource criteria for ALTCS eligibility. A.A.C. R9-28-407.A. There is no resource limit for a person eligible under the Medicaid SOBRA category (pregnant women and certain children). A.A.C. R9-28-407.E.

If a person is not receiving cash benefits but his or her Medicaid eligibility is closely related to SSI or Section 1931 Medicaid, the resource limits for those programs will apply. A.A.C. R9-28-407.B, C. The resource limit for a SSI-related person is $2000 or $3000 for a couple. A Medicaid-related person may have resources up to $2000. There are exceptions to the resource limits applicable to persons whose eligibility is closely related to SSI or Section 1931. A.A.C. R9-28-407.D. These exceptions include resources owned by a parent or spouse on the first day of the month that the member is institutionalized, household goods and personal effects, term insurance, burial insurance, up to $1500 that has been designated as a burial fund, a burial space, and the appreciation of the exempted assets owned by a continuously eligible member. A.A.C. R9-28-407.D.1-4.

Community Spouse Resource Deduction. Under the Community Spouse Resource Deduction (CSRD) rule, if the spouse of an applicant lives in the community and does not receive ALTCS services, some of the applicant's resources can be "set aside" for the spouse's needs and not be counted against the appropriate resource limit. Resources owned by a member and the community spouse are valued on the first day of the member's institutionalization. The total value of these resources is divided equally and compared to the applicable resource limit. Alternatively, the CSRD can be subtracted from the total resources to determine the amount of resources available to the institutionalized spouse. Resources in excess of the CSRD must be equal to or less than the resource standard specified in A.A.C. R9-28-407. As of January 1, 2002, the CSRD is $89,280 or half of the combined resources, whichever is less but not less than $17,856. A.A.C. R9-28-410.B. In addition to the resources excluded at A.A.C. R9-28-407, one vehicle is totally excluded regardless of its value and the equity value of additional vehicles is included. A.A.C. R9-28-410.B.2.

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. **Institutionalized Applicants**. (1) *AFDC/SSI Eligible Group*. If an applicant would have been eligible for AFDC or SSI benefits but for being institutionalized, he or she will be financially eligible provided that the applicant has been in an institution for at least one day before approval of the application. ¶
¶
. (2) *300% Group*. For an applicant who is in a medical facility at the time the application is made, and has received thirty consecutive days of care in the facility, the financial eligibility requirements for ALTCS are significantly easier to meet than the requirements for AHCCCS:

Trusts. "Special needs trusts" are often created for the benefit of a Medicaid or SSI recipient with funds that are set aside or bequeathed by a donor, commonly, a parent for a child. The trust is established so that it does not jeopardize the beneficiary's eligibility for public benefits. Distributions from the principal and income of the trust are made at the sole discretion of the trustee to supplement, but not to replace, the public benefits that the beneficiary receives. AHCCCS considers income and resources that are assigned to a trust under state and federal law. A.A.C. R9-28-407.D.6, 408.F.4.

Transfer of Assets Rule. The transfer of assets for less than full market value may make an applicant temporarily ineligible for institutionalized care. If an applicant or a spouse transfers an asset for less than fair market value within the thirty-six month "look back" period before entering a nursing home, there is a presumption that the transfer was made to become eligible for ALTCS.[2] Unless the presumption is rebutted, the applicant will not be eligible for ALTCS for the number of months equal to the uncompensated value divided by the average monthly cost for a private pay patient for nursing care services at the time of application. A person disqualified for ALTCS due to a transfer remains eligible for acute care services. 42 U.S.C. § 1396p(c); A.R.S. § 36-2934(B); A.A.C. R9-28-409.

There are some exceptions to the transfer of assets rule:

(1) A home can be transferred without penalty by an applicant to a spouse, a child under 21, a disabled child, a child who was residing in the home for at least two years before the applicant's institutionalization and who provided care which allowed the applicant to live at home rather than in an institution, or a sibling who has an equity interest in the home and who was residing in the home at least one year before the applicant became institutionalized. 42 U.S.C. § 1396p(c) (2) (A).

(2) Other assets may be transferred without penalty to or from the institutionalized person's spouse or to another for the sole benefit of the spouse. 42 U.S.C. § 1396p(c) (2)(B)(i) and (ii).

(3) Transfers to certain types of trusts may be exempt from disqualification. 42 U.S.C. § 1396p(c) (2)(B)(iii) and (iv).

Rebuttal of Disqualification. An applicant will not be penalized for a transfer of assets if the presumption that it was done to become eligible for ALTCS can be rebutted. For example, the applicant or spouse may show that they intended the transfer to be for fair market value or show some other reason why the transfer was for less than full value. A.A.C. R9-28-409.G. The applicant may also avoid the penalty if the state determines that denial of eligibility would work an undue hardship. To show undue hardship, the member must show that he or she is unable to obtain necessary medical care without ALTCS eligibility and he or she is in imminent danger of death. A.A.C. R9-28-409.H.

Pre-Admission Screening (PAS)

[2] If a trust is involved, the look back period is sixty months. 42 U.S.C. § 1396p(c)(1)(B)(i).

Deleted: . (a) Income must be within 300% of the SSI benefit amount.¶ ¶ . (b) If the applicant is elderly or disabled, the resource limit is $2,000 for a household of one and $3,000 for a household of two. If the applicant's eligibility is based on AFDC criteria, the resource limit is $1,000. ¶ ¶ *See* 42 CFR 435.231, 435.722, and 435.1005. ¶ ¶ . The general rule is that when a spouse is in an institution or receiving home and community based services, only his or her income is included in determining ALTCS eligibility. The ALTCS manual talks in great detail about whether to use the institutional rules or the community rules in a given case. If a client's eligibility depends on the distinction, one should refer to the manual, as the rules are ... [1]

Deleted: ¶ . Example: An otherwise eligible applicant gave away an asset with a value of $5,000 on July 1, 1990, moved into a nursing home on August 1, and applied for ALTCS on September 1. The average cost of nursing home care in the community is $1,000 per month. Since the uncompensated value of the asset is five times the average cost of a one-month stay in a nursing home, the applicant is ... [2]

Deleted: . (1) Except for houses, any asset that is not counted as a resource for purposes of SSI eligibility is exempt. See 42 U.S.C. § 1382b(a). ¶ ¶ 2… …Houses… t…o… a spouse,…a…n adult… … …has lived with the applicant se…has enable…d the … …stay out of the nursing home, or a sibling who has an equity interest in the house and who has lived with the applicant for one yea ... [3]

Deleted: 3… …resources…to a spouse. H ... [4]

Deleted: owever, the applicant will be penalized if the spouse subsequently transfers the resource for less than fair market value. The home spouse also risks a penalty if he or she needs nursing home care within thirty months and has transferred an asset for less than fair market value. ¶ ¶ . (4) An applicant or spouse can transfer any resource to a son or daughter w ... [5]

Deleted: ¶ . **Special Resources Rule for Institutionalized, Married Applicants**. 42 U.S.C. § 1396r-5(c) provides a special rule for allocating the resources of an institutionalized, married applicant who enters a nursing home on or after September 30, 1989. All of the resources owned by both spouses at the time of institutionalization are combined and divided by two. The result is called ... [6]

If the applicant is otherwise eligible, a nurse or social worker will evaluate his or her medical and functional needs to determine if the applicant is in immediate risk of institutionalization in either a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR). A.A.C. R9-28-302.A. There are five PAS instruments; one is used to screen elderly and/or disabled individuals and the remaining four age-specific instruments are used to screen persons with developmental disabilities. A.A.C. R9-28-302.B. An individual's ability to perform activities related to developmental milestones, activities of daily living, communication and behaviors is considered in the functional assessment. A.A.C. R9-28-301.A.7. The PAS instrument assigns weighted scores to an individual's functional, medical, nursing and social needs. The calculated PAS score is then compared to an established threshold score. The score must be at or below the threshold score to qualify for ALTCS services. (See A.A.C. R9-28-303 and 304 for threshold scores.) If necessary, the nurse or social worker may refer the case to a physician for a final determination of eligibility. PAS scores may be appealed under the appeal process.

ALTCS Transitional Program. Individuals enrolled in ALTCS who fail to meet the "immediate risk of institutionalization" requirement when their eligibility is re-determined may continue to receive institutional services for up to ninety days. Other services that may be provided persons in the transitional program include medically necessary acute care services, home-and-community based services, behavioral health services and case management services. A.A.C. R9-28-306.

Post-Eligibility Treatment of Institutionalized Members' Income

Share of Cost. Institutionalized ALTCS members are expected to contribute to the cost of their own care. This is called the "share-of-cost." All members are allowed certain deductions from their income before the share-of-cost is set. A.A.C. R9-28-408.E. When a married member has a spouse who is still living at home (the community spouse), a different definition of income is used to determine the share-of-cost and additional deductions are allowed to provide the spouse at home with enough money to live on. 42 USC § 1396r-5(d); A.R.S. § 36-2932(O).

SSI benefits paid to an institutionalized individual are excluded from the share-of-cost determination. Other income specified in 42 U.S.C. § 1382a(b) is also excluded. A.A.C. R9-28-408.F.1, 2.

The following items are deducted to calculate the share-of-cost:

(1) A personal needs allowance equal to 15% of the SSI federal benefit rate for a person residing in a medical institution for a full calendar month; or equal to 300% of the SSI federal benefit rate for a person who receives or intends to receive home-and-community based services or who resides in a medical institution for less than a full calendar month.

(2) A spousal allowance, equal to the SSI federal benefit rate minus the income of the spouse, if the spouse lives at home without children;

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Deleted: . Institutionalized ALTCS members are expected to contribute to the cost of their own care. This is called the ``share of cost.'' All members, whether married or not, are allowed certain deductions from their income before the share of cost is set. When a married member has a spouse who is still living at home (called the ``community spouse''), a different definition of income is used to determine his or her share of costs and additional deductions are allowed to provide the spouse at home with enough money to live on. ¶
¶
Post-Eligibility Income of Married Institutionalized Members ¶
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. Once an ALTCS member is institutionalized, the income of the two spouses is treated as separate income. Arizona's community property laws are disregarded. The income of the community spouse (the spouse still living at home) is not considered available to the institutionalized spouse. ¶
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. To whom income is attributable usually depends on the name on the check. If both spouses are named payees, the income will be evenly divided, unless it can be shown that one of the spouses has a greater interest. ¶
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(3) A family allowance equal to the standard for the Section 1931 coverage group specified in R9-22-1406(B) for the number of family members. Income of the family members is not included if a spouse and children live at home;

(4) All members are allowed to deduct any expenses incurred for medical or remedial care that are not covered by ALTCS or a third party payor;

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(5) An amount determined by the Director to be necessary to maintain a person's home for not longer than six months if a doctor certifies that the person is likely to return home within six months; and

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(6) An allowance for Medicare and other health insurance premiums, co-payments or deductibles if these expenses are not subject to third party reimbursement. A.A.C. R9-28-408.F.5.a – f.

The share-of-cost of a person with a spouse is calculated as follows:

(1) If an institutionalized person has a community spouse, share-of-cost is calculated under R9-28-410 (see below);

(2) If an institutionalized person has a spouse who does not live at home but is absent due to marital estrangement, resides in a medical institution or in another approved setting, only the institutionalized person's income is used for the share-of-cost. The spousal deductions are not allowed;

(3) For all other persons, the share-of-cost in calculated by dividing the combined income of the spouses in half. A.A.C. R9-28-408.F.3.

Under R9-28-410, a community spouse is allowed the following deductions from his or her income in determining the share-of-cost:

(1) A personal needs allowance pursuant to R9-28-408.F.5.A;

(2) A community spouse monthly income allowance but only to the extent that the institutionalized spouse's income is available to or for the benefit of the community spouse;

(3) A family allowance for each family member equal to 1/3 of the amount remaining after deducting the countable income of the family member from a minimum monthly-needs allowance;

(4) An amount for medical and remedial services specified in R9-28-408; and

(5) An amount for Medicare and other health insurance premiums, co-payments or deductibles if these expenses are not subject to third party reimbursement. A.A.C. R9-28-410.C.4.

Services

After an applicant is determined eligible for ALTCS services, he or she is assigned to a Program Contractor. Once enrolled with a Program Contractor, the member chooses a primary care provider who will coordinate their care and act as a gatekeeper. The member is also assigned to a case manager. The case manager, the member, and affected family members together develop an individual case management plan that includes goals for the member and the services needed to achieve the goals. The primary care physician must approve the plan and authorize the services, which are obtained through the Program Contractor. Federal regulations require that all of the services listed in the plan should be available promptly once the plan is developed. 42 CFR § 435.930.

Covered services must be medically necessary, cost effective, and federally reimbursable. The services must be coordinated by a case manager and prior authorization may be required for some services by the Program Contractor or by the Administration. A.A.C. R9-28-201.

Institutional Care Services. In addition to the services available under the AHCCCS acute care program, ALTCS provides institutional care services at intermediate care facilities (ICF), skilled nursing facilities (SNF), and intermediate care facilities for the mentally retarded (ICF/MR). Services provided in these facilities must include nursing care services, rehabilitative services prescribed as a maintenance regime, restorative services such as range of motion, social services, nutritional and dietary services, recreational therapies and activities, medical supplies and non-customized durable medical equipment, care plans, observation and assessment of a member's changing condition, room and board services including food, laundry and housekeeping, non-prescription and stock pharmaceuticals, and respite care services not to exceed thirty days per contract year. These facilities also must coordinate the delivery of physician services, pharmaceutical services, diagnostic services, emergency medical services, and emergency and medically necessary transportation. A.A.C. R9-28-204.

Home and community based services (HCBS). HCBS are provided to ALTCS members in their own home or in an alternative residential setting on a part-time or intermittent basis. These services include home heath care services such as nursing care, home health aides and medical supplies, equipment and appliances. Habilitation services such as physical therapy, respiratory therapy, occupational therapy, and speech and audiology services are also covered. Other services which may be provided include private duty nursing, medically necessary transportation, adult day care, personal care services, homemaker services and home delivered meals. Respite care for up to 720 hours a year is covered. A.A.C. R9-28-205. Also, a member in need of ventilator dependent services may receive an array of appropriate home and community based services. A.A.C.R9-28-206.3.

Services for the Developmentally Disabled. Except for adult day health and home delivered meals, all of the above services are available to members with developmental disabilities. In addition, day care for developmentally disabled persons and supported employment services for persons participating in the transitional program are available. A.A.C. R9-28-205.11, 12.

Hospice Services. Hospice services are covered for an ALTCS member who is in the final stages of a terminal illness and who has a prognosis of death within six months. Medical

Deleted: . A monthly income allowance is deducted for a member's spouse who is still living at home. Computation of the home spouse's monthly income allowance is described below.¶
¶
. A family allowance is deducted for any minor children or any dependent children, parents, or siblings. Computation of the family allowance is described below. ¶
¶
Spouse's Monthly Income Allowance ¶
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. The amount of money considered necessary to meet the basic living expenses of the home spouse is called the ``monthly maintenance of needs allowance.'' If the home spouse's own income is not sufficient to provide the maintenance of needs allowance, then the balance can be deducted from the institutionalized spouse's income. The deduction from the institutionalized spouse's income is called the ``monthly income allowance.'' ¶
¶
. The maintenance of needs allowance equals either $1,500 or the sum of the standard maintenance allowance + any excess shelter cost + utilities, whichever is less. It is computed as follows:¶
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$902.80(This is the standard maintenance allowance. It equals 122% of the income for a family of two at the federal povery level.)+The amou ... [7]

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. (a) Elderly and Disabled --- A.R.S. § 36-2939(C).¶
¶ ... [10]

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services which are not related to the terminal illness and home delivered meals are not covered. Medicare is the primary payor of hospice services. A.A.C. R9-28-206.4.

Mental Health Services. All ALTCS members are Title XIX and enrolled with ALTCS Program Contractors. Program contractors for EPD members provide not only medical services and HCBS services, but behavioral health services as well. Unlike under the acute care program, behavioral health services are "carved in" and the ALTCS program contractors contract with licensed behavioral health professionals and/or agencies to provide services. By statute, ALTCS services for the developmentally disabled population (DDD) are delivered by the Department of Economic Security/Division of Developmental Disabilities (DES/DDD). DES/DDD contractors provide the medical services, HCBS and the behavioral health services. Currently, DES/DDD has an Intergovernmental Agreement (IDA) with the Department of Health Services to have comprehensive Title XIX behavioral health services for their members provided by the RBHAs in each area of state. See page 31 (covered services under the acute care program) for a list of covered behavioral health services under the ALTCS plan.

Limitations on Available Services

Not all of the above services are available to every member. For an individual to receive these services, the following requirements must be met:

(1) The service must be medically necessary, cost effective and federally reimbursable. The package of HCBS must cost less than the cost of the institutionalization that would be necessary if the client did not receive them;

(2) The service must be authorized by the program contractor or AHCCCS;

(3) The service must be included in the member's Individual Case Management Plan prepared by the client and his or her case manager;

(4) The service must be rendered by AHCCCS registered providers within their scope of practice and must be provided in a licensed or certified facility; and

(5) The level of care must be appropriate. For example, a member needing only intermediate nursing care should be in an intermediate care facility rather than a skilled nursing facility. A.A.C. R9-28-201.

Grievances and Hearings

When a member has a grievance about the availability or quality of services, the member should first contact his or her case manager, whose job is to coordinate and oversee the services. A.R.S. § 36-2938; A.A.C. R9-28-510. Because the case manager's authority is limited, the case manager may be unable to resolve the issue. If so, the member should request a grievance or hearing with AHCCCS or its Program Contractor.

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Application¶
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Applications may be made with ALTCS by the applicant or by an authorized representative. ALTCS must make a decision on the application within 90 days for persons applying on the basis of disability and 45 days for all other applicants. A.A.C. R9-28-401.¶
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If the potential ALTCS member is determined to be financially eligible for admission, then a pre-admission screening evaluation, or PAS, is conducted by a nurse or social worker. The PAS purports to be an objective scoring mechanism for determining the level of an applicant's need for care, but in fact results can vary widely depending on the fairly arbitrary numbers assigned by the person completing the form.¶
¶
Most appeals from the PAS determination are not successful. The best remedy may simply be to reapply. To determine if an appeal may be appropriate, it is useful to have someone with adequate training and familiarity with your client rate your client on the same PAS criteria. If the PAS examiner failed to take significant factors into account or made obvious mistakes, his or her conclusions may be subject to challenge.¶
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An applicant can request an informal conference and submit additional evidence, but AHCCCS has the discretion to deny the request and usually uses the informal conference to dissuade the applicant from pursuing the appeal.¶
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Obtaining Services¶
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After an applicant is determined eligible for ALTCS services, he or she is assigned to a Program Contractor. Once enrolled with a Program Contractor, the member chooses a primary care provider who will coordinate their care and act as a gatekeeper. The member is also assigned to a case manager. The case manager, the member, and affected family members together develop an individual case management plan that includes goals for the client and the services needed to achieve the goals. The primary care physician must approve the plan and authorize the services, which are obtained through the Program Contractor.¶
¶
The regulations require that all of the services listed in the plan should be available promptly once the plan is developed. 42 CFR § 435.930. In practice, this is rarely the case.¶
¶

Grievances and requests for hearings involving ALTCS eligibility and services must comply with the requirements of R9-22-801 et seq. A.A.C. R9-28-801-803. An applicant or member may request a hearing to dispute an adverse eligibility action specified in R9-22-803 or a share-of-cost determination. If a hearing is requested before the effective date of a share-of-cost increase, the share-of-cost can not be increased until a final administrative decision is rendered. A.A.C. R9-28-803. The expedited hearing process is available to ALTCS members pursuant to R9-22-1301 et seq.

III. Adults with Serious Mental Illness

Introduction

In 1981, the Arizona Center for Law in the Public Interest filed a lawsuit in Maricopa County on behalf of five indigent, chronically mentally ill individuals. This lawsuit alleged that the state and county failed to provide adequate community-based mental health services. In 1989, the Arizona Supreme Court held that the state and county have a duty to provide mental health services to indigent, chronically mentally ill persons (now referred to as persons who are "seriously mentally ill"). *Arnold vs. Sarn,* 160 Ariz. 593, 775 P.2d 521. As a result of *Arnold,* individuals with serious mental illness have a state entitlement to comprehensive mental health services. The Division of Behavioral Health Services (DBHS) is responsible for ensuring individuals with serious mental illness receive mental health services.

The Division of Behavioral Health Services (DBHS) was created within ADHS by A.R.S. § 36-3402. DBHS serves as the single state authority to provide coordination, planning, administration and regulation of all facets of the state public behavioral health system. Arizona statutes authorize DBHS to contract with community-based organizations, commonly referred to as Regional Behavioral Health Authorities (RBHAs), to administer the behavioral health services at the local level. These RBHAs function in a fashion similar to a health maintenance organization. Arizona is divided into six geographic regions and each region is assigned to a RBHA.

RBHAs are responsible for assessing the service needs in their region and developing a plan to meet those needs. Each RBHA contracts with a network of service providers to deliver a full range of behavioral health care services. American Indians who live off the reservation may access services through the RBHA system in the same manner as any other Arizona resident. For American Indians who live on a reservation, the Tribe has the option of entering into an Intergovernmental Agreement with DBHS to deliver behavioral health services on the reservation, with the reservation acting as its own RBHA (called a TRBHA), contracting with the local RBHA to provider services or allowing on-reservation Tribal members to obtain behavioral health services with through HIS or going off the reservation to receive services. Currently, the DBHS has Intergovernmental Agreements with four Arizona Indian Tribes to provide covered behavioral health services for the Tribe members on the reservations. For more information and a list of RBHAs/TRBHAs, go to www.hs.state.az.us/bhs/.

Legal Framework and Resources

A.R.S. § 36-550(4) (defines "seriously mentally ill")
A.R.S. § 36-501(22) (defines "mental disorder")
A.A.C. R9-21-101 (Definitions)
R9-21-201 (Civil & Other Legal Rights)
R9-21-302 (Identification, Application & Referral for Services)
R9-21-303 (Eligibility)
R9-21-307 (Individual Service Planning)
R9-21-401 (Appeals)
R9-21-403 (Initiating a Grievance or Investigation)
R9-21-407 (Administrative Appeal)
R9-21-408 (Further Appeal to Administrative Hearing)
www.hs.state.az.us/bhs (ADHS/BHS Policy & Procedure Manual)
www.azoah.com (information on administrative law hearings)
Diagnostic and Statistical Manual of Mental Disorders (DSM IV), 4th Ed.

Eligibility Requirements

To be eligible for services as an individual with a serious mental illness, an applicant must be "seriously mentally ill" as defined by statute. Under Arizona statute, a person is defined as "seriously mentally ill" when the person is 18 years of age or older and exhibits impaired emotional or behavioral functioning. The impaired emotional or behavioral functioning must: (1) be a result of a mental disorder as defined in A.R.S. § 36-501(22); (2) must substantially interfere with the person's ability to remain in the community without long-term or indefinite supportive treatment or services; and (3) must be severe and persistent and result in a long-term limitation of the person's ability to engage in primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and/or recreation. A.R.S. §36-550(4) and A.A.C. R9-21-303. The statute does exclude conditions that are primarily those of drug abuse, alcoholism or mental retardation, unless in addition to one or more of these conditions, the person has a mental disorder. A.R.S. § 36-501(22). In order for clinicians to determine if a person meets the definitions under the statute, the state promulgated a policy referred to as the "SMI Determination Summary." *See* ADHS Policy 1.10. This policy is commonly referred to as the "SMI Checklist." This checklist lists several qualifying SMI diagnoses and functional limitations. Under this policy, the person must be diagnosed with a qualifying diagnosis and then, *as a result of* the qualifying diagnosis, must exhibit functional limitations or if the person is not currently exhibiting functional limitations, must be expected to deteriorate without treatment.

Enrollment Process

All non-Title XIX persons who need behavioral health services should submit an eligibility application to their local RBHA. The RBHA or one of their providers will then conduct an interview and assessment to determine if the person meets the eligibility requirements. The RBHA will also gather the person's mental health records (if any) to use in determining eligibility. If the person has already been receiving treatment in the community either through private pay or another funding source, then the person should ask that provider to fill out and submit the SMI Checklist to the RBHA to include in considering eligibility.

Additionally, the person should ask the RBHA to contact his/her treating physician for a "treating physician" consultation if there is a disagreement with the RBHA regarding eligibility. For more information on the eligibility and enrollment process (including information on treating physician consultations), see the ADHS/DBHS Policy and Procedure Manual available online at www.hs.state.az.us/bhs.

Covered Mental Health Services

The following is a partial list of covered mental health services for individuals with serious mental illness. For a comprehensive list of services, go online to www.hs.state.az.us/bhs or www.sosaz.com (for a list of covered services under A.A.C., Title 9, Chapter 21). It should be noted that the only mental health services for individuals with serious mental illness that are not also covered under AHCCCS are housing and some vocational rehabilitation type services.

Screening, Evaluation and Diagnosis
Case Management
Inpatient Services
Individual therapy and counseling
Group and/or family therapy and counseling
Psychotropic medication adjustment and monitoring
Partial Care (Supervised, Therapeutic and Medical Day Programs)
Crisis Intervention Services (24 hours a day)
Behavior Management (Personal Assistance, Peer Support)
Psychosocial Rehabilitation
Transportation (emergency and non-emergency medically necessary transportation to and from settings to provide covered behavioral health services)
Laboratory/Radiology Services (used for diagnosis and medication regulation)
Housing
Vocational Rehabilitation

SMI Eligibility Denials and Treatment Grievances/Appeals

SMI Eligibility Denials. If an applicant is denied eligibility as a person with a serious mental illness, the applicant should immediately file an appeal with the RBHA. The RBHA will have forms for the person to use for filing the appeal. An eligibility appeal may be initiated by the person applying for services, a guardian, advocate or designated representative of the applicant. A.A.C. R9-21-401(D)(1). The appeal must be initiated within 60 days of the decision letter informing the person of the RBHA's denial. A.A.C. R9-21-401(E)(3). The RBHA has seven (7) days to respond to the request for an appeal and schedule an "informal conference" between the parties. A.A.C. R9-21-401(E). To prepare for the informal conference, the applicant should find out the reason for the denial. Most common reasons for denying eligibility are that the applicant has a diagnosis that does not qualify or is not documented well enough or that the applicant's functional level is too high to qualify or the RBHA decision maker did not have the necessary records when evaluating the application. At the informal conference, the applicant needs to bring any and all documents detailing psychiatric history. If the applicant is currently under treatment for mental illness, the treating physician/clinician can tell the RBHA why the applicant meets

the eligibility criteria. The treating doctor can attend the informal conference or can participate by phone. The RBHA doctor should have spoken to the treating physician already if there is a difference of opinion, but this does not always happen prior to the first informal conference. The RBHA will then evaluate any new information and will render a decision. If, after this informal conference, the applicant is still not found to qualify for services, the applicant has the right to appeal this denial to an administrative hearing. A.A.C. R9-21-401(E)(5). ADHS/BHS shall then hold an administrative hearing on the appeal in a manner consistent with A.R.S. §§ 36-111, 36-112 and 41-1061. A.A.C. R9-21-401(G)(3).

At an administrative hearing, the applicant and his/her advocate or representative will be presenting information to an administrative law judge at the Office of Administrative Appeals. The applicant will have the burden of proof in the hearing and will be able to present evidence such as records and testimony from a treating physician. A.A.C. R9-21-401(G). The applicant can and should attempt to find an advocate, representative or attorney in advance of the hearing. Frequently, the RBHA will have an attorney presenting their case with a psychiatrist testifying as to why the applicant does not qualify for eligibility. Most often, the testifying RBHA psychiatrist has not even met the applicant, so it is best to have the treating physician attend the hearing to provide testimony. After the hearing, the administrative law judge will render a written decision to the director of the ADHS within 5 days. A.A.C. R9-21-401(G)(10). Within 15 days of the conclusion of the administrative law hearing, the ADHS director shall accept, reject or modify the recommended decision and issue a final decision to the parties involved. A.A.C. R9-21-401(G)(11). If the decision is unfavorable to the applicant, the applicant can then choose to file a Motion for Rehearing or can request Judicial Review. A.A.C. R9-401(J).

Treatment Appeals/Grievances

Individuals with serious mental illness have a right to an Individual Service Plan (ISP) that is developed to meet their individual and unique needs. A.A.C. R9-21-307 *et seq.* If an individual with serious mental illness is denied treatment or disagrees with their treatment, they have a right to file an appeal. A.A.C. R9-21-401. An individual should file an "*appeal*" in the following circumstances:

*The person disagrees with the services offered by the provider
*The person disagrees with a change to existing services
*A request or a service is denied by the RBHA
*There are unreasonable delays in getting services

The person may file an appeal in writing or orally to the RBHA and the appeal must state the person's complaint and reason(s) for the appeal. A.A.C. R9-21-401(D)(2). The appeal must be filed with the RBHA within 60 calendar days of the action the person is appealing. A.A.C. R9-21-401(D)(3). If the person appeals, the services currently in the Individual Service Plan must remain in place during the appeal, unless there is an emergency where the person presents an immediate danger to him/herself or a court order directs otherwise. Within 7 working days (2 working days for an expedited appeal) of receipt of the appeal, the RBHA director must hold an informal conference to try to resolve the dispute. A.A.C. R9-21-401(E). If the dispute is not resolved after the informal conference, the RBHA must forward the appeal to DBHS. A.A.C. R9-21-401(F). DBHS must then hold a second informal conference within 15 calendar days of receiving the appeal to try to again resolve the dispute. The person has the right to waive the second informal conference with DBHS

and proceed directly to an administrative law hearing before the Office of Administrative Hearings. A.A.C. R9-21-401(E)(5). The administrative law judge will then render a proposed decision to the ADHS director who will then issue a final decision. If the person disagrees with the final decision, the person (or his/her advocate or attorney) can file a Motion for Rehearing or file for Judicial Review in Superior Court. *See* above for more information and procedure at administrative law hearings.

Title 9, Chapter 21 outlines numerous civil rights of individuals with serious mental illness as well as their right to support and treatment in the community. A.A.C. R9-21-201 and 202. These rights are comprehensive including the right to live in the least restrictive setting, the right to be treated with dignity and respect and the right to be free of abuse or neglect. If a individual believes their rights were violated, they have a right to file a "*grievance".* A.A.C. R9-21-402(A). Additionally, any person may file a "*request for investigation"* about alleged dangerous, inhumane or illegal conditions or any other case where an investigation would be in the public interest. A.A.C. R9-231-402(A). Examples of situations where a *"grievance*" or "*request for investigation*" should be filed include the following circumstances:

*An allegation of a rights violation such as abuse, neglect or injury to a person receiving services;

*Unauthorized disclosure of a person's mental health records;

*Unauthorized use of seclusion or restraint;

*Any other rights violations contained in A.A.C. R9-21-101 *et seq*.

A grievance or request for investigation is initially filed with the RBHA unless: (1) the grievance is alleging physical or sexual abuse or the death of person are filed directly with DBHS; or (2) the grievance is against a mental health agency operated by a governmental entity (such as the Arizona State Hospital) if filed directly with the director of that agency. A.A.C. R9-21-404. If the individual needs assistance in filing the grievance, the RBHA must assist in getting the appeal filed and to the appropriate agency if the individual files with the wrong entity. If the matter complained of cannot be resolved without a formal investigation, the RBHA or assistant director of DBHS must appoint an impartial investigator to investigate the grievance within 7 working days of filing the grievance or request for investigation. A.A.C. R9-21-405(D). The investigator will then meet with the person filing the grievance as well as the person(s) complained about in the grievance. A.A.C. R9-21-406. Within 30 calendar days of the appointment, the investigator must issue a written report. A.A.C. R9-21-406(D). The RBHA or assistant director of DBHS will then review the report and issue a written decision with findings and conclusions within five days. A.A.C. R9-21-406(E). The person has a right to appeal the grievance decision within 30 calendar days by filing a Notice of Appeal with the assistant director of DBHS. A.A.C. R9-21-407(A). The assistant director will then review the record and may meet with any persons involved in the grievance and issue a Final Decision within 15 calendar days of filing the appeal. A.A.C. R9-21-407(B). If the grievance is still not resolved at this point, the person may file a request with DBHS for an administrative hearing at the Office of Administrative Hearings. A.A.C. R9-21-408. The administrative law judge will then render a proposed decision to the ADHS director who will then issue a final decision. If the person disagrees with the final decision, the person (or his/her advocate or attorney) can file a Motion for Rehearing or file for Judicial Review in Superior Court. *See* above for more information and procedure at administrative law hearings.

IV. State Funded Children's Mental Health Services

Overview
The mission of the DBHS Bureau of Children's Services is to support and monitor a statewide system for the delivery of comprehensive community-based behavioral health services for all of Arizona's children and adolescents. In 1988, Arizona enacted legislation mandating the development and delivery of a comprehensive continuum of coordinated behavioral health care for children. Previously, these services had been provided by different agencies according to individual mandates addressing specific populations of children. A.R.S. § 36-3431 requires interdepartmental collaboration for a single system to address the behavioral health needs of all Arizona's children. DBHS Bureau of Children's Services was designated as the lead agency for the development for the development of the children's system.

Eligibility
Children who have a "serious emotional disturbance" (SED) or a "serious emotional handicap" (SEH) may be eligible for the limited state-funded children's mental health services. For more information on the availability of state-funded children's mental health services, the parent or guardian should contact the ADHS Bureau of Children's Services or the local RBHA. *See also* **www.hs.state.az.us**.

V. Children's Rehabilitative Services (CRS)

Overview
The mission of CRS is to provide for medical treatment, rehabilitation and related support services to medically and financially qualified children. The child must have a certain medical, disabling or potentially disabling condition(s) that have the potential for functional improvement. CRS provides medical treatment and services for individuals from birth to age 21 to those who qualify. Currently, there are 4 CRS clinic locations around the state (Phoenix, Tucson, Yuma and Flagstaff). For more information on the history of CRS in Arizona, visit the ADHS website at www.hs.state.az.us/phs/ocshcn/crs/.

Eligibility
CRS will accept children who are chronically ill or who have physically disabling conditions that have the potential for cure or significant improvement through medical, surgical or therapy treatments. To be eligible for services, the child must (1) be an Arizona resident under 21 years of age and (2) have a physical disability, chronic illness or condition that is potentially disabling. Conditions accepted at CRS include, but are not limited to: deformities present at birth or acquired (such as cleft palate, scoliosis, spina bifida), some conditions of epilepsy, heart conditions due to congenital deformities, many muscle and nerve disorders, cerebral palsy, cystic fibrosis, PKU, hydrocephalus and rheumatoid arthritis.

Anyone may refer a child to CRS. The CRS Pediatric History and Referral Form and the CRS Financial Application need to be completed to apply for services. These forms are available by calling the applicant's local clinic. A confidential interview with a CRS or Department of Economic Security interviewer stationed at the CRS clinic is required. A

Medical Assistance screening (except for full pay families) is conducted to determine potential eligibility for AHCCCS.

Services Provided

The following is a partial list of services that a CRS clinic may provide:

1. Surgical (general pediatric surgery, cardiovascular and thoracic, ENT, neurosurgery, ophthalmology, orthopedic, plastic surgery)
2. Medical (cardiology, neurology, rheumatology, general pediatrics, genetics, urology)
3. Dental (oral surgery, orthodontia, prosthetic dentistry)
4. Multi-Disciplinary (spina bifida, cerebral palsy, craniofacial, rhizotomy, neurofibromatosis)

Denials

If there are issues concerning financial eligibility, these issues can often be resolved by working closely with the eligibility interviewer. If the issues cannot be resolved, the patient advocate at the clinic can provide information to the parent about how to file a grievance with the Arizona Department of Health Services (ADHS).

The responsibility for a medical eligibility denial is shared between the CRS clinic site and the ADHS. If the patient is found no longer medically eligible at the CRS clinic for either a sub-specialty clinic or for CRS services, the first step of the parent is to submit an appeal to the clinic. If the outcome is still a medical eligibility denial, the next step is to submit a grievance to the ADHS. A detailed, written grievance must be submitted within 15 days of receipt of an unsatisfactory financial or medical eligibility decision to the Office of Medical Director, Children's Rehabilitative Services, 1740 W. Adams, Phoenix, Arizona 85007. If an unsatisfactory reply is received to this grievance, a request for formal appeal can be submitted within 15 days to the following: Director, Arizona Department of Health Services, 1740 W. Adams, Room 407, Phoenix, Arizona 85007. An administrative hearing will be set and notice will be sent to the person requesting the formal appeal. For more information on administrative hearings at the Office of Administrative Hearings, see page 36 or go online to www.azoah.com.

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(a) Income must be within 300% of the SSI benefit amount.

(b) If the applicant is elderly or disabled, the resource limit is $2,000 for a household of one and $3,000 for a household of two. If the applicant's eligibility is based on AFDC criteria, the resource limit is $1,000.

See 42 CFR 435.231, 435.722, and 435.1005.

The general rule is that when a spouse is in an institution or receiving home and community based services, only his or her income is included in determining ALTCS eligibility. The ALTCS manual talks in great detail about whether to use the institutional rules or the community rules in a given case. If a client's eligibility depends on the distinction, one should refer to the manual, as the rules are too convoluted to summarize.

See page 6- for a more detailed discussion of the separate treatment of spouses' income.

Applicants Receiving Home or Community-Based Care. An applicant who is not institutionalized is eligible for ALTCS if (1) he or she would be eligible under the 300% test if institutionalized; (2) a determination has been made that institutionalization in at least an intermediate care facility would be necessary but for the home- or community-based services that the applicant is receiving; and (3) he or she has received home- and community-based services paid by some other source at some time during the preceding twelve months.

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Resources

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resource

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Prior to July 1, 1988, the general rule was that the uncompensated portion of the asset's value would be treated as a resource for twenty-four months after the transfer. Effective July 1, 1988, a transfer of assets only affects ALTCS eligibility if the applicant becomes institutionalized.

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either thirty months after the transfer or a

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of a one-month stay in a comparable

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institution

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Example: An otherwise eligible applicant gave away an asset with a value of $5,000 on July 1, 1990, moved into a nursing home on August 1, and applied for ALTCS on September 1. The average cost of nursing home care in the community is $1,000 per month. Since the uncompensated value of the asset is five times the average cost of a one-month stay in a nursing home, the applicant is ineligible for ALTCS until December 1, 1990, five months after the asset was transferred. The date on which the application is made does not effect the computation.

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(1) Except for houses, any asset that is not counted as a resource for purposes of SSI eligibility is exempt. See 42 U.S.C. § 1382b(a).

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Houses

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t

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o

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a spouse,

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a

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n adult

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has lived with the applicant

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se

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has enable

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stay out of the nursing home, or a sibling who has an equity interest in the house and who has lived with the applicant for one year.

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resources

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to a spouse. H

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owever, the applicant will be penalized if the spouse subsequently transfers the resource for less than fair market value. The home spouse also risks a penalty if he or she needs nursing home care within thirty months and has transferred an asset for less than fair market value.

(4) An applicant or spouse can transfer any resource to a son or daughter who is blind or disabled.

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Special Resources Rule for Institutionalized, Married Applicants. 42 U.S.C. § 1396r-5(c) provides a special rule for allocating the resources of an institutionalized, married

applicant who enters a nursing home on or after September 30, 1989. All of the resources owned by both spouses at the time of institutionalization are combined and divided by two. The result is called the spousal share. This remains the spousal share even if the application to ALTCS is not made until much later. The spouse at home is allowed a spousal resource deduction, which means he or she may keep resources up to that amount.

The spousal resource deduction is computed as follows: Take the lesser of the spousal share or $60,000 to equal ``X.'' The spousal resource deduction is either X or $12,000, whichever is more. That is, the spouse at home is allowed a spousal resource deduction that is equal to his or her spousal share, but in no case more than $60,000 and, if the total of all their resources is less than $24,000, the spouse at home may keep up to $12,000.

The only assets that are included are those that are not exempt under SSI. *See* 42 U.S.C. § 1382(b)(2). Unlike SSI, there is no limit on the value of the exempt assets. 42 U.S.C. § 1396r-5(c)(5). The statute specifies that assets acquired by the spouse at home after the institutionalized spouse is found eligible are protected. 42 U.S.C. § 1382(b)(4). The statute is silent as to assets acquired between institutionalization and the determination of eligibility, but since they do not enter into the computation presumably they are protected as well.

Examples: The total value of both the husband's and the wife's resources were worth $18,000 on the day the husband went into the nursing home. The wife's spousal share is $9,000. The wife is allowed $12,000 as a spousal resource deduction and may keep resources with a value up to that amount.

The husband and wife have $140,000 in resources when the husband goes into the nursing home. The wife's spousal share is $70,000. Her spousal resource deduction, however, is limited to $60,000. Her husband will not be eligible for ALTCS until she has resources worth $60,000 or less and he has spent all but $2,000 of his share of the resources.

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A monthly income allowance is deducted for a member's spouse who is still living at home. Computation of the home spouse's monthly income allowance is described below.

A family allowance is deducted for any minor children or any dependent children, parents, or siblings. Computation of the family allowance is described below.

Spouse's Monthly Income Allowance

The amount of money considered necessary to meet the basic living expenses of the home spouse is called the ``monthly maintenance of needs allowance.'' If the home spouse's own income is not sufficient to provide the maintenance of needs allowance, then the balance can be deducted from the institutionalized spouse's income. The deduction from the institutionalized spouse's income is called the ``monthly income allowance.''

The maintenance of needs allowance equals either $1,500 or the sum of the standard maintenance allowance + any excess shelter cost + utilities, whichever is less. It is computed as follows:

$902.80(This is the standard maintenance allowance. It equals 122% of the income for a family of two at the federal povery level.)+The amount the home spouse's actual shelter cost exceeds $270.84 ($270.84 = 30% of the standard maintenance allowance.)+Utilities(Either the standard utility allowance used by the local DES office in computing food stamp eligibility or, if there is none, the actual utility expenses.)=Maintenance of Needs Allowance (or $1,500, whichever is less)!Income of home spouse=Monthly income allowance

When the income of the spouse at home is equal to or more than his or her maintenance needs allowance, then he or she receives no monthly income allowance.

The figures used above are for the first half of 1991. The federal poverty level is adjusted annually. The percentage used increases from 122% to 133% on July 1, 1991, and to 150% on July 1, 1992. 42 U.S.C. § 1396r-5(d)(3)(B). The $1,500 maximum will be ad-justed for cost of living increases. It is possible to get the $1,500 maximum waived in individual cases.

Family Allowance

Any minor children or dependent children, siblings, or parents of the institutionalized member are allowed a family allowance from the member's income. The family allowance equals one-third of the difference between the standard maintenance allowance and any income of the dependent family member. It is computed as follows:

$$\frac{\$902.80 \text{ ! Income of the family member}}{3}$$

Example

An institutionalized, elderly husband has an income of $700 a month. His wife, who still lives at home, has an income of $500 a month. The rent on their house is $350, which is less than 30% of their combined income.

$ 902.80Standard maintenance allowance+ 79.16$350 - $270.84+ 40.00Utilities=$1,021.96Wife's maintenance of needs allowance! 500.00Wife's income=$ 521.96Balance to be paid from husband's income$ 700.00Husband's income! 57.90Personal needs allowance! 521.96For wife's maintenance of needs allowance=$ 120.14Amount that must be paid out of husband's income for his care in the nursing home

Services Provided

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;

(2) hospice care;

(3)

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include a panoply of services for the client who is ``at risk of institutionalization'' if they were not provided. 42 U.S.C. § 1396n(c). The services available differ slightly depending on whether the client is developmentally disabled or is either elderly or disabled.

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(a) Elderly and Disabled --- A.R.S. § 36-2939(C).

(i) Home health care --- nursing services, home health aids, medical supplies, equipment, appliances.

(ii) Homemaker.

(iii) Personal care.

(iv) Adult day health.

(v) Respite care to provide time off for the person who is usually responsible for the client's care. May be a few hours in the home or up to a month's temporary stay in an institution.

(vi) Transportation.

(vii) Home delivered meals.

(viii) Other services may be available if necessary, cost effective, and authorized by the case manager.

(b) Developmentally