Arizona Long Term Care System (ALTCS)

A Self-Advocacy Guide

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Federal and state law can change at any time. If there is any question about the continued validity of any information in this guide, contact the Arizona Center for Disability Law or an attorney in your community.

The purpose of this guide is to provide general information to individuals regarding their rights and protections under the law. It is not intended as a substitute for legal advice. You may wish to contact the Arizona Center for Disability Law or consult with a lawyer in your community if you need further information.

- This guide is available in alternative formats upon request.

ARIZONA LONG TERM CARE SYSTEM (ALTCS)

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A. Introduction to the Arizona Long Term Care System and This Guide

1. What is the Arizona Long Term Care System?

The Arizona Long Term Care System (ALTCS) is a federal Medicaid program administered by the Arizona Health Care Cost Containment System (AHCCCS). The ALTCS program provides long-term care services to financially and medically eligible persons who are elderly, physically disabled, or developmentally disabled, and who have a medical need for the services. The ALTCS program includes medical, behavioral, institutional, and home and community based services. The AHCCCS Administration contracts with health plans, state agencies and Native American tribes to coordinate and manage ALTCS services through case management. Contractors must provide medically necessary covered services to ALTCS members consistent with state law and federal Medicaid law and regulations.

2. Introduction to this Guide

This guide focuses on the rights of elderly and disabled persons eligible for ALTCS services. The purpose of the guide is to provide you with general information about the ALTCS program and to explain the program's basic requirements such as: (1) who is eligible for services; (2) what services are provided; (3) what the eligibility factors are; (4) how to apply for ALTCS; (5) how to establish medical eligibility through the Pre-admission Screening Process (PAS); and (6) how the state of Arizona recovers payments for long-term care services provided to persons eligible for ALTCS.

This is a guide only. For specific information about applying or qualifying for the ALTCS program, you should contact the AHCCCS Administration, an ALTCS office, the Arizona Center for Disability Law, or an attorney. The Arizona Center for Disability

Law will not be able to help you with the application process; however, they will provide you with referrals to organizations or persons that can help you.

This guide is not a substitute for legal advice. The Arizona Center for Disability Law recommends that you seek legal advice if you are unable to resolve a dispute involving eligibility or services under the ALTCS program. You should ask for legal advice as soon as the dispute arises, as there are strict timelines to challenge a decision of the AHCCCS administration or an ALTCS contractor.

B. The AHCCCS Health Insurance Program in Arizona

1. What is the Medicaid program?

Medicaid is a federal health insurance program that makes medical, behavioral health and long-term care services available to eligible low-income persons. Medicaid is Title XIX (Title 19) of the Social Security Act. The federal government pays about 67% of the cost of Medicaid services, and Arizona pays the remaining costs. The AHCCCS Administration operates its Medicaid program through a "state plan," which is approved by the federal Medicaid agency. AHCCCS is required to administer Arizona's Medicaid program consistent with state and federal Medicaid law, unless the federal government has "waived" compliance with a specific provision of the federal law.

2. How does AHCCCS deliver health care services?

There are several AHCCCS health insurance programs, including the ALTCS program. AHCCCS is a statewide "managed care" system, which means that AHCCCS contracts with health plans, Native American tribes and state agencies, referred to as program contractors, to deliver health care services. AHCCCS has two groups of health plans: acute care plans and long-term care plans. To deliver health care services, health plans and other AHCCCS contractors contract with medical providers, such as primary

care physicians, specialists, pharmacies, laboratories, and hospitals in specific geographic service areas. The health plans and contractors must ensure there are enough service providers, provide medically necessary covered services and case management, process and pay claims, and have a grievance and appeal process. A list of the AHCCCS and ALTCS health plans and tribal contractors is attached to this guide as Appendix A.

When you apply for AHCCCS health insurance, you must choose a health plan in your area. If you do not choose a health plan within a specific period of time, AHCCCS automatically assigns a plan to you. Generally, you may only change your health plan once a year, on your "anniversary date." You may ask to change your health plan at a different time for certain reasons, such as for the "continuity of care." After you are enrolled in a health plan, you must choose a primary care physician (PCP) to coordinate your health services. The health plan assigns a PCP to you if you do not pick one by a certain date. You may change your PCP anytime by contacting the health plan.

3. What services are covered by AHCCCS health insurance?

For adults eligible for AHCCCS health insurance programs funded by Medicaid, AHCCCS must cover all Medicaid *mandatory* medical services, but can choose to cover Medicaid *optional* services. AHCCCS must provide covered services for adults that are medically necessary, cost-effective, not experimental, federally reimbursable and included in the AHCCCS state plan for Medicaid. A list of AHCCCS and ALTCS covered health services is attached to this guide as Appendix B.

Children are eligible for a greater range of Medicaid services than adults. Under the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, AHCCCS must cover all Medicaid *mandatory and optional* services for children and youth under age 21, whether or not the services are covered for adults. This includes

children eligible for ALTCS services. A list of EPSDT covered services for chidren is attached to this guide as Appendix C.

4. How does AHCCCS and DES work together?

Several divisions of the Arizona Department of Economic Security (DES) participate with AHCCCS to coordinate and deliver a variety of services to AHCCCS members. Below is a brief summary of some of the DES programs:

- The DES Disability Determination Services Administration (DDSA) makes medical determinations of blindness and disability for AHCCCS.
- The DES Division of Developmental Disabilities (DDD) provides services to persons with developmental disabilities. DDD is the ALTCS program contractor for all developmentally disabled (DD) individuals statewide.
- The DES Comprehensive Medical and Dental Program (CMDP) operates as an AHCCCS contracted health plan to provide medical services to foster children.
- The DES Family Assistance Administration (FAA) determines Medicaid eligibility for children, families and non-disabled adults under age 65.
- The DES Division of Child Support Enforcement (DCSE) establishes and enforces child and medical support orders.

5. How do persons with developmental disabilities get ALTCS services?

The DES Division of Developmental Disabilities (DDD) provides services to persons with developmental disabilities. DDD is the ALTCS program contractor for all developmentally disabled (DD) individuals statewide. Both DDD and ALTCS must screen individuals for developmental disabilities and if appropriate, refer them to the other agency to apply for services. To be determined developmentally disabled and eligible for DDD services, you must: (1) be diagnosed as having autism, cerebral palsy,

epilepsy, or mental retardation before age 18 and have substantial functional limitations; or (2) be under age six and exhibit a significant delay in one or more areas of development; or (3) be under age three and at risk of having a developmental disability if supports and services are not provided to you. Once you are found eligible for DDD and ALTCS services, DDD manages your ALTCS services. DDD also administers a state-funded program to provide services to persons with developmental disabilities who do not qualify for ALTCS services.

For more information about ALTCS services for persons with DD, see the DDD Member Handbook under the Arizona Long Term Care tab at www.azdes.gov/ddd/.

6. How do Native Americans get ALTCS services?

The AHCCCS Administration has agreements with certain Native American tribes to provide case management and other ALTCS services to elderly and/or physically disabled Native American persons who live on-reservation. If you live on the reservation but you do not have tribal membership, your ALTCS services are provided by a non-tribal ALTCS health plan. AHCCCS also has an agreement with the Native American Community Health Center (NACHC) to provide case management services to elderly and/or physically disabled Native Americans who live on-reservation, but who do not get ALTCS case management from a tribe. However, all Native Americans with developmental disabilities must receive ALTCS services from DDD, whether they live on or off the reservation.

7. What is a "dual-eligible" AHCCCS/Medicare member?

If you are eligible for both Medicare and a Medicaid program such as ALTCS, you are a "dual-eligible" AHCCCS member. Medicare is a federal health insurance program for individuals who are 65 or older, individuals under age 65 with certain

disabilities, and individuals of all ages with End-Stage Renal Disease. The Social Security Administration (SSA) determines eligibility and processes Medicare enrollment. Medicare services include Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance), or Medicare Part D (Prescriptions). If you are a "dual-eligible" member, AHCCCS pays your Medicare premiums, co-payments, and deductibles through its Medicare cost-sharing program. This includes persons eligible for ALTCS services.

For more information about dual health insurance coverage, see the Arizona Center for Disability Law's advocacy guide entitled "Managing Dual Insurance Coverage," which may be found at www.azdisabilitylaw.org.

8. What is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services program for children?

The EPSDT program is a preventative and treatment program for Medicaid eligible children and youth under age 21. Under EPSDT, all health plans and AHCCCS contractors must provide children and youth under age 21 with periodic medical, dental, vision and hearing screenings; immunizations; laboratory tests (including blood level tests); and health education. In addition, a broad range of medical, behavioral health and long-term care services is available to children and youth under the EPSDT program. Federal EPSDT law requires health plans and program contractors to cover all Medicaid *mandatory and optional* services for children and youth under age 21, whether or not the services are covered for adults under the AHCCCS state plan. See Appendix C.

Under EPSDT, children and youth under 21 are eligible for more services than adults. The medical necessity standard for covered services under EPSDT is broader than the adult medical necessity standard. Federal EPSDT law requires health plans and program contractors to cover "all necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate [make better] defects and physical and

mental illnesses and conditions" for all Medicaid-eligible children and youth under age 21. If a health plan determines a particular service is needed for a child, then the service must be covered to the extent it is needed and allowed under federal Medicaid law. Thus, health plans and other program contractors may not apply the adult standard for Medicaid services to limit the type or amount of services provided to a child or youth under age 21. This includes all AHCCCS and ALTCS medical, behavioral and long-term care services.

Advocacy tip: If your child is denied a medical service, make sure the health plan has applied the EPSDT standard to the decision. You should request an appeal right away if the adult standard was used, and you should ask the plan to apply the EPSDT standard. For more information, see the guides for AHCCCS administrative appeals and hearings on the Arizona Center for Disability Law's website at www.azdisabilitylaw.org.

C. The Arizona Long Term Care System (ALTCS)

To be eligible for the ALTCS program, you must be age 65 and over, blind, or disabled, and in need of long-term care in a nursing home or other residential setting. ALTCS health plans provide medical, behavioral health, and long-term care services; case management; and home and community based services to persons eligible for the ALTCS program. If your child is eligible for Children's Rehabilitation Services (CRS), your child may receive specialty care through CRS, in addition to services provided to through the ALTCS health plan.

1. What groups are covered by ALTCS?

First, you must meet a "categorical requirement" to be eligible for ALTCS. You must be aged, blind, disabled, a child, a pregnant woman or the caretaker relative of a deprived child to meet this requirement. You must be age 65 or older to be considered "aged" or elderly. To establish blindness for ALTCS eligibility, you must be (1) determined "blind" by the DDSA; or (2) under age 65 and receive disability benefits from

SSA on the basis of your blindness. To meet the disability requirement for the ALTCS program, ALTCS staff must determine you are medically in need of long-term care services under the Pre-Admission Screening (PAS) process. For ALTCS, you are a child through the month you turn age 19. If you are a caretaker relative of a "deprived" child, you also may meet the categorical requirement for ALTCS eligibility.

Second, you must be a member of an ALTCS "coverage group" to be eligible for the ALTCS program. State and federal law define the ALTCS coverage groups. These groups are based on factors such as age, income, disability and/or family unit. ALTCS staff decides which coverage group you belong to based on these factors. A list of the ALTCS coverage groups is attached to this guide as Appendix D.

2. What services are covered by ALTCS?

Services covered by ALTCS include medical, behavioral, long-term care and EPSDT services; case management; family planning; and Medicare cost sharing. An ALTCS case manager coordinates your health services, which must be medically necessary, cost-effective, and reimbursable by the federal government. ALTCS services may be provided to you in an institutional setting such as a nursing home, or in your home or other residential setting. Below is a brief explanation of the ALTCS services:

a. Medical Services

Medical services are provided to ALTCS members to prevent, diagnose, and treat health problems. See Appendix B for a list of ALTCS covered services.

b. Institutional Services

Institutional services may be provided to you in a nursing facility; Intermediate Care Facility for the Mentally Retarded (ICF-MR); Institution for Mental Diseases (IMD); residential treatment center for psychiatric services; or hospice. Each facility is

responsible for managing your health care. ALTCS health plans pay "per diem" rates to the facility to cover your health-related services such as room and board, nursing care, non-prescription pharmaceuticals, rehabilitation and restorative services, social services, nutritional and dietary services, recreational therapies, ventilator dependent services, medical supplies, durable medical equipment and respite care. ALTCS health plans also must pay for ALTCS covered services that are not included in the per diem rate if the health service is medically necessary and a doctor has ordered the service for you. Facility staff must coordinate health care services for you such as attending physicians; diagnostic, pharmaceutical, therapy and emergency medical services; and emergency and medically necessary transportation.

c. Home and Community Based Services (HCBS)

Home and Community Based Services (HCBS) are provided in your home or in another residential setting such as an assisted living home, adult foster care home or group home for persons with developmental disabilities. The cost of providing HCBS services to you in a residential setting cannot be greater than the cost of providing health care to you in an institutional setting such as a nursing home. HCBS services include:

- Nursing care, including private duty nursing services;
- Home health aide;
- Medical supplies, appliances and durable medical equipment (DME) including customized DME;
- Occupational, physical and respiratory therapies;
- Speech and audiology services;
- Transportation services;
- Personal care and homemaker services;
- Home-delivered meals;

- Habilitation services including physical and occupational therapy, speech and audiology services, training in independent living, special development skills, sensory-motor development, behavior intervention and orientation and mobility training;
- Developmentally disabled day care provided in a group setting including supervision of activities, personal care, activities of daily living skills, and habilitation services;
- Supportive employment services for persons with developmental disabilities in a transition program;
- Adult day health services including supervision of activities, personal care, personal living skills training, meals and health monitoring, preventative, therapeutic and restorative health-related services, and behavioral health services;
- Respite care services; and
- Hospice services.

Homemaker services such as cleaning, shopping, meal preparation, and laundry may be provided to you as a HCBS. Personal care services include assisting you with activities of daily living such as bathing, dressing, and eating. Home modifications are covered by ALTCS if the physical modifications are medically necessary and would help you function more independently. ALTCS also pays for periodic respite care for family members and other persons who care for individuals who receive ALTCS services.

d. Behavioral Health Services

The AHCCCS Administration has an agreement with the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) to provide behavioral health services to most persons eligible for AHCCCS health insurance. However, ADHS/DBHS does not provide behavioral health services to elderly or disabled persons eligible for ALTCS services. Instead, ALTCS health plans contract

directly with licensed behavioral health professionals and/or agencies to provide behavioral health services to persons eligible for ALTCS.

Behavioral health services are provided to ALTCS members in inpatient hospitals; inpatient psychiatric facilities such as residential treatment facilities and sub-acute facilities; institutions for mental disease; partial care supervised day programs, therapeutic day programs, medical day programs; and behavioral health therapeutic homes. Covered behavioral health services include:

- Emergency/crisis behavioral health services;
- Evaluation and screening;
- Case management;
- Laboratory and radiology services for psychotropic medication regulation and diagnosis;
- Behavior management (behavior health personal assistance, family support, peer support);
- Psychosocial rehabilitation (living skills training, health promotion, pre-job training, education and development, job coaching and employment support);
- Group, individual, and family therapy;
- Emergency and non-emergency transportation; and
- Respite care.

e. Case Management

When you are enrolled with an ALTCS health plan or program contractor, a case manager is assigned to you. The case manager is responsible for identifying, planning, coordinating, monitoring and reassessing your long-term care needs. Along with your primary care doctor, the case manger must develop a care plan for you. Other case manager responsibilities include:

- Reviewing your current placement and services and the PAS assessment results to develop your initial care plan;
- Making sure you participate in the preparation of the plan;
- Making sure the ALTCS placement and services are provided to you within 30 days of enrolling with the health plan;
- Arranging behavioral health services and working with behavioral health professionals to review your treatment plan;
- Giving written reasons to the case manager's supervisor if the care plan's HCBS costs exceed 80% of institutional costs;
- Helping you maintain or progress toward the highest level of functioning;
- Making sure your health records are transferred when necessary; and
- Resolving problems you have regarding your ALTCS services.

Your care plan must state the scope, duration and frequency of the service, the service provider, and the period of time the services will be provided to you. You and your guardian or representative must agree with the care plan.

Advocacy tip: You or your representative should first contact the case manager to resolve any problems you have with your care plan. If the case manager cannot resolve the issue, you should file an appeal with the health plan. If the health plan denies your appeal, you should ask for a hearing with the AHCCCS Administration to resolve the dispute and to get appropriate services in your care plan.

D. What are the basic eligibility requirements for the ALTCS program?

You must meet all non-financial, financial, and medical eligibility requirements to qualify for ALTCS services. Described below are some of the eligibility requirements:

1. What are the non-financial eligibility requirements for ALTCS?

To qualify for the ALTCS program, you must be an Arizona resident and a U.S. citizen or qualified immigrant; have a Social Security Number (SSN) or apply for one; apply for all benefits you may be entitled to receive such as a pension, or disability

benefits from the Social Security Administration; and live in an institutional setting such as a nursing home or an HCBS setting such as your home.

a. Arizona Residency

You are an Arizona resident if you live in Arizona and you intend to remain in Arizona "indefinitely." AHCCCS may not require you to live in Arizona for a certain period of time to establish your residency in the state.

b. Social Security Number

Only persons applying for an AHCCCS health insurance program, such as ALTCS, must provide a Social Security Number (SSN). If you do not have a SSN, you may meet this requirement by providing documentation from the Social Security office that shows you have applied for one.

c. U.S. Citizenship

Federal law requires you to provide proof of your identity and U.S. citizenship. AHCCCS also requires you to sign a Declaration of Citizenship form stating you are a U.S. citizen. You are a U.S. citizen if you were born in the U.S. or a U.S. territory, born to U.S. citizen parents, or became a citizen through the naturalization process. Documents you may use to prove your U.S. citizenship include birth certificates, U.S. passports, Certificates of Naturalization, tribal membership documents, final adoption decrees and certain medical or school records. Federal law now requires AHCCCS to approve health insurance while Medicaid applicants are in the process of documenting their citizenship, if they have met all other eligibility requirements.

Certain AHCCCS and ALTCS applicants are not required to document their U.S. citizenship. If you are entitled to or enrolled in Medicare or receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits, you do not

have to document your citizenship. Also, children who receive Title IV-B or IV-E foster care or subsidized adoption benefits, and newborns who were born in the U.S. and who are under age one, do not have to document citizenship.

d. Immigration Status

If you are not a U.S. citizen, you must provide documentation of your immigration status. Only persons who are "qualified immigrants" and who meet certain other requirements for immigrants may be eligible for full service AHCCCS health insurance, such as ALTCS. You are a qualified immigrant if you are a lawful permanent resident (LPR); refugee; asylee; parolee for at least one year; conditional entrant; Cuban-Haitian entrant; Amerasian; or your deportation has been withheld or removed. Other qualified immigrants include foreign born U. S. Indian tribal members; American Indians born in Canada; Iraqi and Afghan special immigrants; Hmong or Laotian Highlanders; "battered" immigrants under the Violence Against Women Act; and trafficking victims.

If you are a LPR, parolee, or battered immigrant, you must meet additional requirements to be eligible for AHCCCS health insurance. These requirements are: (1) you have been a qualified immigrant for at least five years; or (2) you came to the U.S. before August 22, 1996, and you continuously resided in the U.S. until you became a qualified immigrant; (3) or you have a military connection. To meet the military connection, you must be an active duty member or an honorably discharged veteran of the U.S. Armed Forces; the spouse or dependent child of an active duty member or veteran; or the surviving spouse or child of a veteran.

Some immigrants that do not qualify for AHCCCS or ALTCS due to their immigration status may be eligible for the Federal Emergency Services program.

e. ALTCS Living Arrangements

If you live in a nursing home, IMD, ICF-MR or a hospice, you may receive ALTCS institutional services. If you live at home or in an alternate residential setting, you may receive ALTCS services as in-home HCBS. Alternative HCBS settings for persons with DD include community residential homes, group homes, and group foster homes. For EPD persons, alternate HCBS settings include assisted living homes and adult foster care homes. Other alternate HCBS settings include licensed residential facilities for persons with traumatic brain injuries, behavior health adult therapeutic homes, Level 2 or Level 3 behavioral health residential agencies, and rural substance abuse transitional centers for persons who are DD or EPD.

2. What are the financial eligibility requirements for ALTCS?

Countable income and resources are considered in determining if you qualify for ALTCS. The maximum amount of income or resources you may have and be eligible for ALTCS depends on certain factors such as age, residence, marital status, if your spouse lives in the community or an institution, and your AHCCCS coverage group.

a. What is income?

Income is money you receive to obtain food, clothing, or shelter. Income is divided into two major categories: earned and unearned. Earned income includes wages, salaries, commissions or profits earned as an employee or a self-employed person. Unearned income is income received from sources other than employment or self-employment. Within each category, there are numerous types of income and each type of income is either counted or excluded. If you receive Supplemental Security Income (SSI) or Title IV-E foster care or adoption assistance, you are automatically considered income eligible for ALTCS, unless you have trust that disqualifies you.

b. What are the income tests?

There are three income tests for ALTCS. The income test that applies to your case depends on your circumstances. Certain types of income and resources are excluded, and specific deductions are allowed, in these tests.

The *gross income test* is used to calculate your income unless you are living in an alternative residential setting where ALTCS services cannot be provided; you refuse HCBS services; or you are under age 19 or pregnant and you have resources greater than $2,000. Under the gross income test, your total income cannot be more than 300% of the Federal Benefit Rate (FBR). The FBR is the maximum monthly amount paid to an individual or a married couple who receives SSI benefits. For ALTCS, this amount changes on April 1st of every year. As of April 1, 2009, the ALTCS gross monthly income limit for one person is $2022 per month. If you live in the community, both your income and your spouse's income are considered in the gross income test.

Under some circumstances, the *net income test* is used to determine ALTCS eligibility. The net income test is used if you are *under age 19* and you have resources equal to or less than $2,000 and you refuse HCBS services or you live in an alternative residential setting where ALTCS services cannot be provided. The net income test also is used when you *are age 19 or older* and you live in an alternative residential setting where ALTCS services cannot be provided or you refuse HCBS services. The net income test is calculated by subtracting certain deductions from the gross countable income. The net income under this test cannot exceed 100% of the FBR for an individual or couple.

The third income test, called the *"SOBRA" income test*, is used when you are under age 19 or pregnant and your resources are greater than $2,000. The SOBRA income test is calculated by subtracting allowable deductions from the gross countable

income. The SOBRA income limits range from 100% to 150% of the Federal Poverty Level (FPL). The income limit that applies to your case depends on your age, the number of people in the household that are responsible for you, and whether you are pregnant.

If your total countable income is over the appropriate income limit for ALTCS under these tests, you may still qualify for ALTCS services by setting up a special type of trust that excludes a portion of your income from the calculation. For more information on trusts, you should consult an attorney who specializes in ALTCS eligibility and trusts.

c. What are the resource limits?

To qualify for ALTCS services, your countable resources cannot exceed $2,000 if you are not married. If you are married, the community spouse resource rules allow a certain amount of a couple's resources to be excluded in an initial eligibility decision for ALTCS when the applicant/spouse is institutionalized. (See below for community spouse resource rules.) You are automatically considered "resource eligible" if you receive SSI or Title IV-E foster care or adoption assistance payments.

Resources, called assets, are determined on a month-by-month basis. Resources are real or personal property, including cash, which may be used to meet basic needs such as food or shelter. Resources may be considered available, unavailable, or excluded during a specific month. AHCCCS evaluates each resource separately to determine if the resource is actually available to you to meet basic needs. Only resources that are actually available are counted. Resources are evaluated at equity value unless there is an exception for a specific type of resource. Depending on the type of trust, a trust may be counted or excluded as a resource. Countable resources are things such as cash, stocks, bonds, certificates of deposit, bank accounts, cash value of some life insurance policies, non-exempt vehicles, and certain real property. Some resources do not count against the

resource limit. This includes the home you live in (unless it is held in a trust), your household and personal belongings, one vehicle, burial plots, irrevocable burial plans, up to $1500 in a burial fund and various other resources.

Generally, parents' resources do not count when determining if a child is eligible for ALTCS. However, parental resources may be counted when an ALTCS eligible child lives at home, but the parents refuse HCBS services.

d. What are the community spouse rules?

The community spouse income, resource, and share of cost rules are used when you apply for ALTCS, you are institutionalized, and your spouse lives in the community. A "community spouse" is defined by ALTCS as a person who is the legally married spouse of an institutionalized person, who resides in the community, and who does not reside in a medical institution for more than 30 consecutive days. Under some circumstances, both spouses may be evaluated under the community spouse rules.

e. How is income counted in a community spouse case?

The gross income test is the only income test that is used in a community spouse case. Countable income is determined by using two budgeting methods, the "community property" rule and the "name-on-check" rule. Income is first calculated using the community property rule. The name-on-check rule is used only when you are determined not eligible for ALTCS based on the community property rule.

To calculate income using the community property rule, gross countable earned and unearned income belonging to you and your spouse is combined and divided by two. The result is then compared to 300% of the FBR. If the amount is less than or equal to 300% of the FBR, you are income eligible for ALTCS. If the amount is greater than 300% of the FBR, your countable income is calculated using the name-on-check rule.

Under the name-on-check rule, the person for whom a payment is made is counted as the income of that person, even if his or her name is not on the payment. To determine financial eligibility for ALTCS under the name-on-check rule, only the applicant's earned and unearned income is combined and compared to 300% of the FBR. To qualify for ALTCS, the total countable income must be less than 300% of the FBR.

f. How are resources counted in a community spouse case?

Resources in a community spouse case are budgeted using the community spouse initial rules, community spouse post-initial rules, or non-community spouse rules. Under these rules, a certain amount of a couple's resources, called the Community Spouse Resource Deduction (CSRD), is not counted in the initial eligibility decision for ALTCS. For 2009, the minimum CSRD amount is $21,912 and the maximum CSRD amount is $109,560. These amounts change on January 1st of every year. First, a couple's combined resources are assessed to determine which resources are countable. Then, the countable resources are compared to the appropriate CSRD amount to determine whether the couple's countable resources are within the ALTCS resource limit.

However, a complete resource assessment is not required in every case. For example, if a couple's total combined countable resources are less than $23,912, the couple is resource eligible when the minimum CSRD amount of $21,912 is subtracted from the combined countable resources of both spouses and the remainder is $2000 or less. But if the combined countable resources of both spouses are more than the minimum CSRD amount of $21,912 plus $2,000 ($23,912), a complete evaluation of the couple's resources must be done to determine which resources should be counted.

A couple's countable resources are assessed during the month the applicant first becomes institutionalized for 30 consecutive days. This period is called the "First Continuous Period of Institutionalization" (FCPI). It does not matter where the non-institutionalized spouse lives during the FCPI period. The FCPI must begin on or after September 30, 1989, and the FCPI is established by the date the applicant (1) became medically institutionalized; or (2) received home and community based services (HCBS), either separately or in combination with a period in a medical facility, which kept the applicant from being medically institutionalized. A FCPI also may be established when a potential applicant asks the AHCCCS Administration to conduct a resource assessment or when there is a Pre-Admission Screening (PAS) approval and the applicant intends to receive HCBS services after a period of institutionalization.

Community spouse initial rules are applied to the case for no more than 12 consecutive months. The 12-month period begins with the first month that eligibility is determined using the community spouse rules, and it continues through the next eleven consecutive calendar months. After the 12-month period, the resource value of the institutionalized spouse's separate property must be under the individual resource limit of $2000 to continue to be eligible for the ALTCS Program. Therefore, if you are found eligible for ALTCS using the community spouse initial rules, you may need to transfer some of your resources during the initial 12-month period to continue to be eligible for ALTCS services. Under the ALTCS rules, you may transfer resources in your name that are over the $2,000 limit to your community spouse after your ALTCS application is initially approved. The resources in your name must be transferred before the post-initial rules apply to your case to remain eligible for ALTCS. You may transfer any amount of

resources to the following persons without adversely affecting your eligibility for ALTCS: (1) your community spouse; (2) someone other than your community spouse if the resources are for the sole benefit of your community spouse; or (3) your child (of any age) who is blind or permanently and totally disabled as determined by the DDSA.

The "post-initial resource" rules apply to your case when your case is reviewed to determine if you continue to be eligible for ALTCS services. Under these rules, the CSRD is not used, none of the community spouse's resources are considered available to you, and your resources are compared to the individual resource limit of $2000. If you lose your eligibility for ALTCS using the initial rules during the first 12 months, but you are eligible for ALTCS using the post-initial rules, ALTCS must allow you to convert your case before the initial 12-month period is up so you can use the post-initial rules.

Advocacy tip: The institutional spouse or the community spouse may request a hearing with AHCCCS to dispute a computation of income or resources, or the CSRD. Under exceptional circumstances, an administrative law judge or a court may order an increase in the Minimum Monthly Maintenance Allowance (MMMNA) or the CSRD to allow eligibility for ALTCS services.

g. What is the share of cost?

Once you have been determined eligible for ALTCS, a calculation is made to determine if, and how much, you need to pay toward the cost of institutional or HCBS services. This amount is called the Share of Cost. Specific deductions are allowed in the share of cost calculation. These deductions are explained below.

h. What are the non-community spouse deductions?

If your eligibility is determined using non-community spouse policy, you may qualify for the following share of cost deductions from your income:

- Personal needs allowance;
- One of the following maintenance needs allowances:

    - Spousal needs allowance;
    - Family needs allowance; or
    - Home maintenance needs allowance;
- Medicare and health insurance premiums;
- Remedial or non-covered medical expenses; and
- Special deduction for some residents of the Arizona State Veterans Home.

i. What are the community spouse deductions?

You may qualify for the following share of cost deductions when your eligibility was determined using the community spouse policy. These deductions are subtracted from your total countable income:

- Personal needs allowance;
- Community spouse monthly income allowance (CSMIA). The income of the institutionalized spouse must actually be made available to the community spouse to allow this deduction;
- Family allowance. The income of each family member must be verified to allow this deduction. Family members include only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse;
- Medicare and other health insurance premiums;
- Remedial or non-covered medical expenses; and
- Special deduction for some residents of the Arizona State Veterans Home.

j. What rules apply to the transfer of assets?

An asset may be either a resource or income. If you transfer an asset without receiving "fair consideration" in return, you may not be eligible for ALTCS long-term care services for a specific period of time. If the transfer makes you not eligible for ALTCS long-term care services, you may still receive acute care health services through the ALTCS program. The penalty period for improperly transferring an asset may be

waived if you convince AHCCCS that the penalty should not apply to you or if you meet the requirements for an undue hardship waiver. If ALTCS waives the penalty period, you are eligible for ALTCS long-term care services.

You can transfer ownership of an asset by changing a title or deed; selling or buying; trading or exchanging; making a loan; giving away a resource or income; assigning your income to another person or entity; or any other action that causes income or resources not to be received or available to you and/or your spouse. AHCCCS must identify and document a transfer of assets that took place on or after a "look-back" date, including a transfer that happened after the application date. The look-back date is used to calculate the penalty period. There are three look-back dates:

- If a transfer of assets was made *before* July 1, 2006, the look-back period is 36 months before the most recent ALTCS application date;
- If a transfer of assets was made *on or after* July 1, 2006, the look-back period is 60 months before the most recent ALTCS application date; or
- If a transfer of assets is to a trust, the look-back period is 60 months before the most recent ALTCS application date.

E. What is the Preadmission Screening Process (PAS)?

Once you are determined financially eligible for the ALTCS program, a registered nurse or social worker conducts a face-to-face interview with you to determine if you are medically eligible for ALTCS services. You are medically eligible if you are determined "at immediate risk of institutionalization" under the Preadmission Screening (PAS) process. There are five PAS assessment tools. The PAS tool is selected based on the applicant's age or disability and whether the applicant is living in an institution. One PAS tool is used to evaluate persons who are elderly and/or physically disabled (EPD), and four PAS tools are used to evaluate persons with developmental disabilities (DD).

1. Who conducts the PAS assessment?

A nurse or social worker, called the medical eligibility specialist, conducts the PAS assessment. The medical eligibility specialist must conduct an interview with you, get information from you, your caregiver and/or authorized representative, verify your major medical conditions and other relevant medical information, and determine if a physician's review is required. The PAS assessment must be done within the 45-day application period for ALTCS services.

2. How is the PAS assessment scored?

The PAS assessment results are used to calculate three scores: the functional score, the medical score, and the total score. Based on the ALTCS rules, a number of points is assigned to each scored item and then multiplied by a "weighted" number. The result is a weighed score for each area. The weighted scores are totaled and assigned to either the functional score or the medical score. Then the functional score and medical score are added together for the total score. The total score is compared to the threshold score for the EPD and DD categories, which is set by ALTCS rules. You are eligible for ALTCS services if your total score equals or exceeds the threshold score.

3. When is a physician's review required?

Under certain circumstances, the ALTCS medical eligibility specialist must ask a physician to review your PAS assessment results and your medical records to determine if you have a developmental disability or non-psychiatric medical condition that places you at risk of institutionalization. A physician's review must be requested when the PAS score is below the threshold score, but:

- There is at least a score of 56 for EPD applicants;
- There is at least a score of 38 for DD applicants;

- There is reasonable cause to believe your unique functional abilities or medical condition place you at immediate risk of institutionalization; or
- You have a documented diagnosis of autism, autistic-like behavior, or pervasive developmental disability.

Also, a physician's review must be requested when you score above the threshold score but you are seriously mentally ill or there is reasonable cause to believe your condition requires less than 90 days of institutional care. A physician's review is required for all children under six months old and for physically disabled children under age 12. If the physician cannot make a decision based on the documentation, the physician may meet with you and/or contact other persons familiar with your needs such as your primary care physician or your caregiver.

Your eligibility is reassessed periodically to make sure you continue to be eligible for ALTCS services. If you no longer meet the PAS test, but you continue to meet all the other requirements for ALTCS, you may be transferred to the ALTCS transitional program where you are eligible for all medically necessary covered services. If you were living in an institution when you transferred to the transitional program, your health plan must move you to a HCBS setting within 90 days of your enrollment with the transitional program. After that, if your condition worsens, you may be admitted to a facility for 90 days while your medical condition is reassessed for the regular ALTCS program.

4. What is the PAS test for the elderly and physically disabled?

There is four parts to the PAS assessment tool for the elderly and physically disabled (EPD): intake information, functional assessment, emotional and cognitive functioning, and medical assessment. Intake information includes demographic factors such as age, marital status or family members. The functional assessment reviews your need for assistance with activities of daily living such as bathing, dressing, grooming,

eating, mobility, transferring and toileting; continence; and communication and sensory skills. To assess your emotional and cognitive functioning, your orientation to person, place and time as well as wandering, self-injurious, aggressive, resistive, or disruptive behavior is reviewed. To complete the medical assessment, information is collected about your ability to independently perform activities of daily living; medical conditions that require medical or nursing treatments; medications; treatments; allegories; diet; the specific services and treatments you need and the frequency of those treatments; and the PAS summary. For EPD, the threshold score is 60.

5. What is the PAS test for persons with developmental disabilities?

There are four PAS tools designed to assess persons with developmental disabilities (DD) according to age group: 12 years and older; 6 to 11 years old; 3 to 5 years old; and less than 3 years old. The PAS assessment for DD has three assessment categories: intake information, functional assessment, and medical assessment. Intake information includes the applicant's demographic background, such as age, martial status and family members. The functional assessment differs by age group. Generally, age-appropriate information regarding the need for assistance with independent living skills, communication skills, cognitive abilities and behavior are assessed for children up to twelve years old. For children ages three to five, developmental milestones, independent living skills, communication skills, and behavior are assessed. Only age-specific developmental milestones are assessed for children ages six months to three years. There is no functional assessment for a child less than six months old. The medical assessment for all age groups includes an evaluation of the applicant's medical condition, specific services and treatments, current medication, medical stability, sensory functioning,

physical measurements, current placement, ventilator dependency and eligibility for DDD services. For DD, the threshold score is 40.

F. How does a person apply for ALTCS?

You have the right to apply for the ALTCS program without delay. Unlike other AHCCCS health insurance programs, an application is not required to start the application process for ALTCS. Rather, a person may call an ALTCS office to start the process and submit a written application at a later time. A written ALTCS application may be submitted in-person, by mail or fax, or during a home visit. The date of the application is the date the ALTCS office receives the application verbally or in writing. This date is used to establish the date of eligibility. A list of ALTCS offices is attached to this guide as Appendix E.

Advocacy tip: An ALTCS application form may be obtained at any ALTCS office or downloaded from AHCCCS' website at www.azahcccs.gov.

1. Who can apply for ALTCS?

You may apply for yourself or another person may act on your behalf during the application process. If so, your representative is responsible for providing timely and accurate information about you and your circumstances to the ALTCS office.

When a person is incapacitated, anyone may start the application for that person. An incapacitated applicant is a person who is physically and/or mentally unable to apply for ALTCS and who is unable to authorize someone in writing to act as a representative. In this case, ALTCS may need to get a physician's statement of the applicant's incapacity to complete the application process.

Usually, the ALTCS office that serves the geographic area where you live processes the application. However, if you have a representative, the application may be processed at the office closest to the representative.

2. What if you are eligible for DDD services?

ALTCS staff must screen every application to determine if the applicant has a developmental disability and is potentially eligible for DDD services. If so, ALTCS must refer the applicant to the DDD office for a DDD eligibility determination early in the ALTCS application process.

3. What happens at the ALTCS interview?

A personal interview is required for all ALTCS applications. The interview may be in person or by telephone. The interview may be with you and/or your representative. In-person interviews are scheduled at the ALTCS office, your home, or your current place of residence such as a nursing home. The appointment for the interview may be rescheduled, if necessary. The interviewer must explain certain information at the interview such as the 45-day decision period; the eligibility and PAS requirements; proof you need to verify eligibility; your responsibility to provide information, report changes and cooperate with the application process; your appeal rights and the hearing process; how the SSN is used; enrolling with an ALTCS health plan; fraud and penalties; the renewal application process; the Estate Recovery Program and TEFRA liens; and share of cost payments. The interviewer also must explain that a nurse or social worker will complete a medical assessment of you at your residence and the representative and/or caregiver may participate in the assessment. You or your representative must sign the application. If you have a legal guardian, only the legal guardian or an authorized

representative who has been appointed in writing by the legal guardian can sign the ALTCS application.

4. What if ALTCS asks for more information?

ALTCS must make all requests for information or documentation in writing and must give you at least 10 days to provide the information. The due date may be extended if more time is needed. You may ask ALTCS staff for help to get the information. When you cannot communicate or verify identity, residency, citizenship, or immigrant status because you are homeless, comatose, amnesiac or mentally impaired, and there is no reliable information or documentation of these basic eligibility factors, ALTCS must try to obtain the information for you.

5. When does ALTCS have to make a decision?

ALTCS must approve or deny your application in writing within 45 days of the date of the application. This period may be extended beyond 45 days under some circumstances. ALTCS must send you or your representative written notice of the decision, which states if the application was approved or denied and the reason for the decision. If approved, the notice must state the effective date of eligibility and provide you with information about the share of cost payment. If denied, the notice must state the reason for the denial, include the specific financial calculation and the financial eligibility standard, cite the legal authority supporting the decision and explain your hearing rights.

G. What if your ALTCS application is approved?

If the application is approved, you are eligible for ALTCS services starting on the first day of the month of application.

1. How do you get ALTCS services?

Once approved, you are enrolled with a "program contractor" to receive ALTCS services. There are three types of ALTCS program contractors: DDD, Native American and EPD contractors. ALTCS members with DD must be enrolled with DDD to receive ALTCS services. EPD contractors are health plans that contract with AHCCCS to deliver ALTCS services. Only EPD members in Maricopa County have a choice of ALTCS health plans. In all the other counties, there is only one ALTCS health plan for persons who are EPD. If there is no Tribal or EPD health plan in your area, AHCCCS enrolls you in the AHCCCS Fee-For-Service program.

2. How do you choose a primary care physician?

After enrollment, the ALTCS health plan will send you written information about the plan. You choose a primary care physician (PCP) from the plan's list of participating providers to coordinate your health care. You also receive an AHCCCS ID card, which includes the name and phone number of your health plan. You should present this ID card to providers such as doctors, hospitals and laboratories whenever you request or are provided with medical services.

3. What changes do you have to report to ALTCS?

You or your representative must report events that could affect your ALTCS eligibility or your share of cost amount. Changes in circumstances that must be reported include a change in address, admission or discharge from a facility, income, resources, transfer of assets, marital status, approval for other benefits, other health insurance, or any other change that may affect your eligibility or share of cost payment amount. The changes must be reported within 10 days of the date the change occurred.

4. How often do you have to renew your ALTCS eligibility?

ALTCS must complete a financial review your eligibility at least once every 12 months. ALTCS will contact you when it is time to do this review.

H. What if your application is denied or your services are stopped?

If your ALTCS application is denied or your current ALTCS services are stopped, ALTCS must send you a notice of adverse action. The notice must explain the action ALTCS has taken or intends to take; the reasons for the action; financial calculations and the financial standard, if applicable to the decision; the specific laws or regulations that support the action; the right to request a hearing; and how to continue ALTCS services until a decision is made on the hearing request.

1. How do you dispute a denial of an ALTCS application?

You have the right to request a hearing to challenge the decision to deny or stop your ALTCS benefits. You have 30 days from the date of the decision to ask for a timely hearing. If you request the hearing before the date your current ALTCS benefits stop, you can ask that your ALTCS benefits continue until there is a hearing decision. However, if you lose the hearing, you may be financially liable for the health care payments made by the AHCCCS Administration for you during the hearing process. You may request a hearing by sending a written request for hearing to the ALTCS office.

2. How do you dispute a denial of ALTCS services?

There is an appeal and hearing process to dispute decisions made by ALTCS health plans and other contractors. The plan or contractor must send you a notice of adverse action when it suspends, reduces, stop or denies your ALTCS services. The notice must explain the decision, give you specific reasons for the decision, and tell you what laws or regulations it relied on to make the decision. It also must inform you of your right to a standard appeal, an expedited appeal, and continuing medical services. If

you do not agree with the decision, you may appeal it within 60 days of the date of the notice by calling or sending a written request to the plan or contractor. If you lose the appeal, you may request a hearing with the AHCCCS Administration. For more information about the AHCCCS appeal and hearing process, you should go to Arizona Center for Disability Law's website at www.azdisabilitylaw.org.

3. What if your application is denied because you failed the PAS test or you have excess resources?

If your ALTCS application was denied because you failed the PAS assessment, you did not provide enough information to verify your resources, or ALTCS decided that you have excess resources, you may still be eligible to receive acute care health services from ALTCS. You must be age 65 or older, blind or disabled to receive ALTCS acute care medical services only. If you think you should have passed the PAS test or you do not have excess resources, you may request a hearing to dispute the ALTCS denial.

I. Liens and Recoveries for ALTCS Services

1. What is estate recovery?

Under certain circumstances, the AHCCCS Administration must file a claim (legal demand) against your estate to recover the costs of providing Medicaid (ALTCS) services to you. The claim against your estate is for the ALTCS benefits you received after you were age 55 or older. ALTCS also may make a claim against your estate or your property if state law requires it. Estate recovery applies to any ALTCS member who is deceased, not a Native American, received ALTCS nursing home or HCBS benefits, was 55 years or older when the ALTCS benefits were received, and the ALTCS benefits were received on or after January 1, 1994. AHCCCS may waive a claim against

the estate if certain undue hardship requirements are met. AHCCCS also may reduce the amount of an estate claim.

2. What is a TEFRA lien?

The AHCCCS Administration also may file a TEFRA (Tax Equity and Fiscal Responsibility Act) lien against your real property. The purpose of the TEFRA lien is to recover the cost of your ALTCS benefits when you die or your property is transferred. A TEFRA lien may be filed against your real property if you are age 55 or older, receiving ALTCS services, and "permanently institutionalized." There is a presumption that you are permanently institutionalized if you have lived in a medical institution for at least 90 consecutive days. You can rebut this presumption by providing ALTCS with a doctor's written opinion that your medical condition is likely to improve to the point that you will be discharged from the facility and you will return to your home by a certain date.

ALTCS will not file a TEFRA lien if the following persons lawfully reside in your home: your spouse; your child if he or she is under age 21, blind, or permanently disabled; or your sibling if he or she has an equity interest in your home and was living in your home at least one year immediately before you were institutionalized. If a TEFRA lien is filed and the property is sold or transferred after you die, ALTCS will not pursue the lien if your spouse or your child who is under 21, disabled, or blind, survives you. Also, ALTCS will not pursue the lien if your sibling or child currently lives in your home and (1) your sibling lived there for at least one year before you were institutionalized; or (2) your child lived there at least two years before you were institutionalized and he or she provided care that allowed you to live in your home rather than in an institution.

At least 30 days before filing a TEFRA lien, ALTCS must send you or your family member a written notice of ALTCS' intent to file a lien. You may request an

exemption with ALTCS if you think they should not have a lien on your property. If the exemption is denied or you receive a Notice of TEFRA Lien, you or your family member may ask for a hearing with the AHCCCS Administration to determine if ALTCS should have a lien on your property.

J. Legal Resources for this Guide

AHCCCS staff determine your eligibility for the ALTCS program by following agency policies developed by the AHCCCS Administration. These policies must be based on the federal and state laws and regulations. There are links to these laws, regulations and policies under a heading called "Laws and Regulations" on AHCCCS' website at www.azahcccs.gov. Also, the AHCCCS Eligibility Policy Manual, which contains policies that apply to the AHCCCS and ALTCS health insurance programs, may be found at http://azahcccs.gov/Publications/Eligibility/default.asp. If you cannot get a copy of these laws and policies on-line or in the library, you should call the ALTCS office to get a copy of the laws or policies relevant to your case.

Appendix A
AHCCCS and ALTCS Health Plans and Tribal Contractors

Health Plans	**Phone Number**
AHCCCS Acute Care Health Plans	
Phoenix Health Plan	1-800-747-7997
Health Choice AZ	1-800-322-8670
Pima Health Plan	1-800-423-3801
Bridgeway Acute Plan	1-866-475-3129
University Family Care	1-800-582-8686
APIPA	1-800-348-4058
Maricopa Health Plan	1-800-582-8686
Care 1st Arizona	1-866-560-4042
Mercy Care Plan	1-800-624-3879
ALTCS Health Plans	
Pima Health Plan	1-800-423-3801
Yavapai Long Term Care	1-800-850-1020
Mercy Care Plan	1-800-624-3879
LTC DD DES	1-800-624-4964
Bridgeway Health Solution	1-866-475-3129
Scan - LTC	1-888-540-7226
Evercare Select	1-800-293-0039
Cochise Health Systems	1-800-285-7485
Pinal/Gila LTC	1-800-831-4213
ALTCS Tribal Contractors	
Gila River Indian Community	1-602-528-1200
Hopi Tribe	1-928-734-3552
Navajo Nation/Chinle	1-928-674-2236
Navajo Nation/Fort Defiance	1-928-729-4084
Navajo Nation/Tuba City	1-928-283-3250
Navajo Nation/Leupp	1-928-686-3200
Navajo Nation/Dilkon	1-928-657-8030
Pascua Yaqui Tribe	1-520-879-6000
San Carlos Apache Tribe	1-928-475-2798
Tohono O'Odham Nation	1-520-383-6075
White Mountain Apache Tribe	1-928-338-1808
Behavioral Health Plans	
Arizona Dept. of Health Services	1-800-392-2222

Appendix B
AHCCCS and ALTCS Covered Health Services
Ariz. Admin. Code R9-22-201 to 218 and R9-28-201 to 206

AHCCCS Acute Care Covered Services	ALTCS Covered Services
➢ Physician services ➢ Inpatient and outpatient hospital services ➢ Outpatient clinics, including Rural Health Clinic or Federally Qualified Health Center services ➢ Prescription drugs ➢ Laboratory, X-ray and medical imaging services ➢ Nursing facility services in lieu of hospitalization not to exceed 90 days per contract year ➢ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under age 21. EPSDT includes all medically necessary Medicaid services ➢ Family planning services, including drugs, supplies, devices and surgical procedures provided to delay or prevent pregnancy ➢ Emergency dental services ➢ Nurse-midwife and nurse practitioner services ➢ Home health services in lieu of hospitalization ➢ Emergency ambulance and medically necessary non-emergency transportation ➢ Emergency room services ➢ Other licensed practitioner services, including respiratory therapists, physician assistants, certified nurse anesthetists, licensed midwives and non-physician behavior health professionals ➢ Medical supplies, durable medical equipment and prosthetic and orthotic devices ➢ Physical, occupational, audiology and speech therapies. Occupational and speech therapy in outpatient setting only for acute care members under age 21. No limitation for ALTCS members ➢ Podiatry services ➢ Private duty nursing services ➢ Dialysis services ➢ Non-experimental transplants approved for Medicaid reimbursement ➢ Optometrist services ➢ Eyeglasses and contract lenses for members age 21+ as the sole external prosthetic device after cataract extraction ➢ Home health therapy services ➢ Screening, diagnostic, rehabilitation and preventative services for members age 21+	➢ All AHCCCS acute care services ➢ Nursing facility services ➢ Case management ➢ Speech, physical and occupational therapies ➢ Respiratory care services for ventilator dependent members ➢ Services provided in Christian Science Sanatoria ➢ Hospice ➢ Adult day health (EPD only) ➢ Intermediate Care Facility for Mentally Retarded (DD only) ➢ Developmentally Disabled day care (DD only) ➢ Home delivered meals (EPD only) ➢ Home health agency services, including nursing services and home health aide ➢ Homemaker ➢ Personal care ➢ Respite care ➢ Habilitation ➢ Group respite services as an alternative to adult day health (EPD only) ➢ Attendant care services ➢ In home private duty nursing services ➢ Environmental modifications ➢ Life line alert ➢ Supported employment ➢ Other services, if approved by CMS and the Director of AHCCCS ➢ Services provided in the following settings: ▪ Adult foster care home ▪ Assisted living home ▪ Assisted living center (choice of single occupancy) ▪ Center for Traumatically Brain Injured ▪ DD group home ▪ Adult development home ▪ Child development foster home ▪ Level l behavioral facility ▪ Level ll behavioral facility ▪ Level lll behavioral facility

EPD–Elderly and Physically Disabled
DD–Developmentally Disabled

Appendix C
Covered Services for the EPSDT Program for Children

Medical Service	**Federal Statute 42 U.S.C. §§**	**Federal Regulation 42 C.F.R. §§**	**Medicaid Mandatory Services**	**Medicaid Optional Services**
Inpatient – hospital	1396d(a)(1)	440.10(a)	X	
Outpatient – hospital	1396d(a)(2)(A)	440.20(a)	X	
Rural health clinic	1396d(a)(2)(B) 1396d(l)(1)	440.20(b), (c)	X	
Federally qualified health center services	1396d(a)(2)(C); 1396d(l)(2)		X	
Laboratory & X-ray	1396d(a)(3)	440.30	X	
Nursing facility for persons age 21+	1396d(a)(4)(A); 1396d(f)	440.40(a); 440.155	X	
Early & Periodic Screening, Diagnostic and Treatment (EPSDT) services for children	1396a(a)(10)(A); 1396a(a)(43); 1396d(a)(4)(B); 1396d(r)	440.40(b) 441.50 *et seq*.	X	
Pregnancy-related services, including pre-natal services	1396a(a)(10)(c)(ii)(II) and (c)(iii)	440.210(a)(2); 440.220(a)(1) and (5)	X	
Family planning & supplies	1396d(a)(4)(C)	440.40(c); 441.20	X	
Physician services	1396d(a)(5)(A) 1396d(e)	440.50(a)	X	
Medical & surgical services of a Dentist	1396d(a)(5)(B)	440.50(b)	X	
Medical care & any other type of remedial care by licensed practitioners	1396d(a)(6)	440.60(a)		X
Chiropractic services	1396d(a)(6); 1396d(g)	440.60(b)		X
Home health services (HHS)	1396d(a)(7) 1396a(a)(10)(D)	440.70; 440.220(a)(3); 441.15	X	
HHS: nursing service	1396d(a)(7)	440.70(b)(1)	X	
HHS: home health aide	1396d(a)(7)	440.70(b)(2)	X	
HHS: medical supplies, equipment and appliances	1396d(a)(7)	440.70(b)(3)	X	
HHS: Physical therapy	1396d(a)(7)	440.70(b)(4)		X

Medical Service	Federal Statute 42 U.S.C. §§	Federal Regulation 42 C.F.R. §§	Medicaid Mandatory Services	Medicaid Optional Services
HHS: Occupational therapy	1396d(a)(7)	440.70(b)(4)		X
HHS: Speech pathology	1396d(a)(7)	440.70(b)(4)		X
HHS: Audiology services	1396d(a)(7)	440.70(b)(4)		X
Private duty nursing services	1396d(a)(8)	440.80		X
Clinic services	1396d(a)(9)	440.90		X
Dental services	1396d(a)(10)	440.100		X
Physical therapy	1396d(a)(11)	440.110(a)		X
Occupational therapy	1396d(a)(11)	440.110(b)		X
Services for persons with speech, hearing & language disorders	1396d(a)(11)	440.110(c)		X
Prescribed drugs	1396a(a)(54); 1396d(a)(12); 1396r-8	440.120(a)		X
Dentures	1396d(a)(12)	440.120(b)		X
Prosthetic devices	1396d(a)(12)	440.120(c)		X
Eyeglasses	1396d(a)(12)	440.120(d)		X
Optometrist	1396d(a)(12)	440.120(d); 442.30		X
Diagnostic, screening, preventative & rehabilitation services for maximum reduction of physical or mental disability and restoration of an individual to the best possible function	1396d(a)(13)	440.130		X
Inpatient hospital services for persons age 65+ in an institution for mental diseases	1396d(a)(14)	440.140(a); 441.100-.106		X
Nursing facility services for persons age 65+ in an institution for mental diseases	1396d(a)(14)	440.140(b); 441.100-.106		X

Medical Service	Federal Statute 42 U.S.C. §§	Federal Regulation 42 C.F.R. §§	Medicaid Mandatory Services	Medicaid Optional Services
Intermediate care facility services for the mentally retarded	1396d(a)(15)	440.150; 483.400 *et seq.*		X
Nursing facility services other than in institutions for mental diseases	1396d(a)(4)(A)	440.155		X
Inpatient psychiatric services for person under age 21	1396d(a)(16); 1396d(h)	440.160; 441.150-.182; 483.350-.376		X
Nurse-midwife services	1396d(a)(17)	440.165; 441.21	X	
Nurse practitioner services	1396d(a)(21)	440.166(a); 441.22	X	
Certified pediatric nurse practitioner services	1396d(a)(21)	440.166(b) 441.22	X	
Certified family nurse practitioner	1396d(a)(21)	440.166(c) 441.22	X	
Personal care services	1396d(a)(24)	440.167		X
Primary care case management services	1396d(a)(25)	440.168		X
Case management services	1396d(a)(19)	440.169; 441.18		X
Targeted case management services	1396d(a)(19); 1396n(g)			X
TB-related services	1396d(a)(19)			X
PACE program services	1396d(a)(26); 1396u-4			X
Treatment and services for persons with Sickle Cell disease	1396d(a)(27)			X
Any other medical care or remedial care recognized under State law & specified by the Secretary of HHS	1396d(a)(28)	440.170		X

Medical Service	**Federal Statute 42 U.S.C. §§**	**Federal Regulation 42 C.F.R. §§**	**Medicaid Mandatory Services**	**Medicaid Optional Services**
Transportation	1396d(a)(28)	440.170(a); 441.62; 483.55(a)(3)(iii) 483.75(k)(2)(iii)		X
Services furnished in a religious nonmedical health care institution	1396d(a)(28)	440.170(b)		X
Skilled nursing facility services for persons under age 21	1396d(a)(28)	440.170(d)		X
Emergency hospital services	1396d(a)(28)	440.170(e)		X
Critical access hospital services	1396d(a)(28)	440.170(g)		X
Home or community based services	1396d(a)(7)	440.180(a), (b)		X
Expanded habilitation services	1396d(a)(7)	440.180(c)		X
Services for the chronically mentally ill	1396d(a)(7)	440.180(d)		X
Home and community care for persons age 65+	1396d(a)(22); 1396t	440.181		X
Respiratory care for ventilator-dependent persons	1396d(a)(20)	440.185		X
Hospice Care	1396a(a)(13)(B); 1396d(a)(18); 1396d(o)			X
Organ transplants	1396b(i)(1)	441.35		X
End-stage renal disease services	*See generally*, 1396d(a)(6); 1396d(a)(13); 1396d(a)(28)	441.40		X
Community supported living arrangement services	1396d(a)(23); 1396u	441.400 *et seq.*		X

Appendix D
ALTCS Coverage Groups

Coverage Groups	Description
S.O.B.R.A. Pregnant Women	Pregnant women with income less than or equal to 150% of the FPL.
S.O.B.R.A. Children under age 1	Infants with income less than or equal to 140% of the FPL.
S.O.B.R.A. Children ages 1 - 5	Children age 1+ but not yet age 6 with income at or below 133% of the FPL.
S.O.B.R.A. Children age 6 - 18	Children age 6+ but not yet age 19, born after 9-30-83, with income less than or equal to 100% of the FPL.
SSI Cash Recipients	Persons who are aged (age 65+), blind or disabled who receive SSI cash.
SSI – Medical Assistance Only	Persons who are aged, blind or disabled who do NOT receive SSI cash.
Foster Care & Adoption Subsidy	Children in adoption subsidy or foster care Title IV-E programs.
210 Group	Persons who meet AFDC, SSI or State supplement income & resource criteria.
211 Group	Persons who would be eligible for cash assistance if they were not institutionalized.
236 Group	Persons in medical institutions for 30 consecutive days whose income is less than or equal to 300% of the FBR.
Home and Community Based Services (HCBS) Group	Persons who receive HCBS under a waiver whose income is less than or equal to 300% of the FBR.
Freedom to Work Basic Coverage Group	Employed persons ages 16 to 64 with a disability who would be eligible except for earnings for SSI, with income up to and including 250% of the FPL.
Freedom to Work Medical Improvement Group	Employed individuals ages 16 to 64 with a medically improved disability with income up to and including 250% of the FPL.

FPL = Federal Poverty Limit (100% of the FPL for 1 person is $903 per month)
FBR = Federal Benefit Rate (100% of the FBR for 1 person is $674 per month)

Appendix E

Arizona Long Term Care System (ALTCS) Offices

Long Term Care Offices	
Casa Grande ALTCS Office 500 N. Florence Street Casa Grande, AZ 85222	Phone: 520-421-1500 Fax: 877-666-0874
Chinle ALTCS Office Tseyi Shopping Center, Hwy. 191 P.O. Box 1942 Chinle, AZ 86503	Phone: 928-674-5439 Toll Free: 1-888-800-3804 Fax: 877-660-1450
Cottonwood ALTCS Office 1 N. Main Street Cottonwood, AZ 86326	Phone: 928-634-8101 Fax: 877-666-5208
Flagstaff ALTCS Office 3480 E. Route 66 Flagstaff, AZ 86004	Phone: 928-527-4104 Toll Free: 1-800-540-5042 Fax: 877-663-5213
Globe/Miami ALTCS Office Cobre Valle Plaza 2250 Highway 60, Suite H Miami, AZ 85539-9700	Phone: 928-425-3165 Toll Free: 1-888-425-3165 Fax: 877-666-5219
Kingman ALTCS Office 519 E. Beale Street, Suite 150 Kingman, AZ 86401	Phone: 928-753-2828 Toll Free: 1-888-300-8348 Fax: 877-667-5239
Lake Havasu ALTCS Office 2160 N. McCulloch Blvd., Suite 105 Lake Havasu City, AZ 86403	Phone: 928-453-5100 Toll Free: 1-800-654-2076 Fax: 877-664-5264
Mesa ALTCS Office 460 N. Mesa Drive, Suite 101 Mesa, AZ 85201	Phone: 602-417-6400 Fax: 602-253-4484
Phoenix ALTCS Office 2830 W. Glendale Avenue Suite 19,34 & 8 Phoenix, AZ 85051	Phone: 602-417-6000 Fax: 602-253-4871

Prescott ALTCS Office 1519 W. Gurley Street, #11 Prescott, AZ 86305	Phone: 928-778-3968 Toll Free: 1-888-778-5600 Fax: 877-666-5269
Show Low ALTCS Office 580 E. Old Linden Road, Suite 3 Show Low, AZ 85901	Phone: 928-537-1515 Toll Free: 1-877-537-1515 Fax: 877-666-5286
Sierra Vista ALTCS Office (ALTCS is sharing space with DES) Street Address: 2981 E. Tacoma, Sierra Vista Mailing address: 1010 N. Finance Center, Suite 201, Tucson, AZ 85710	Phone: 520-459-7050 Fax: 877-660-5342
Tucson ALTCS Office 1010 N. Finance Center Drive Suite 201 Tucson, AZ 85710	Phone: 520-205-8600 Toll Free: 1-800-824-2656 Fax: 877-666-5353
Yuma ALTCS Office 3850 W. 16th Street, Suite B Yuma, AZ 85364	Phone: 928-782-0776 Fax: 877-666-5382