Medical Assistance Policy Manual (Archive) Part 2 of 4

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Medical Assistance Eligibility Policy Manual

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Last Updated: 12/18/2023

Getting Started

Welcome to Arizona's Medical Assistance Eligibility Policy Manual.

View the **Quick Start** page for basic instructions.

View the **Navigating This Manual** page for additional instructions and tips.

Quick Start

To get to a specific policy manual section use the Table of Contents to the left and open the policy section followed by the appropriate chapter.

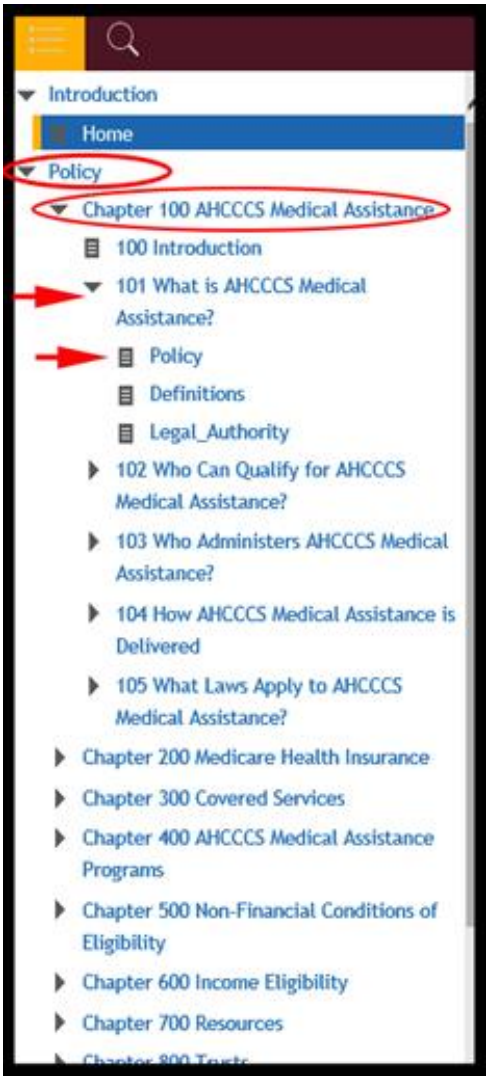
Example: To get to “Chapter 101 - What is AHCCCS Medical Assistance?” you would need to:

Click on policy

Click on Chapter 100 - Introduction

Click to open subchapter 101 - What is Medical Assistance

Click on subsections>> Policy>> Definitions>> Legal Authority…



For more instructions on navigating this manual, click on the topic "Navigating This Manual" from the Table of Contents on the left.

Navigating this manual

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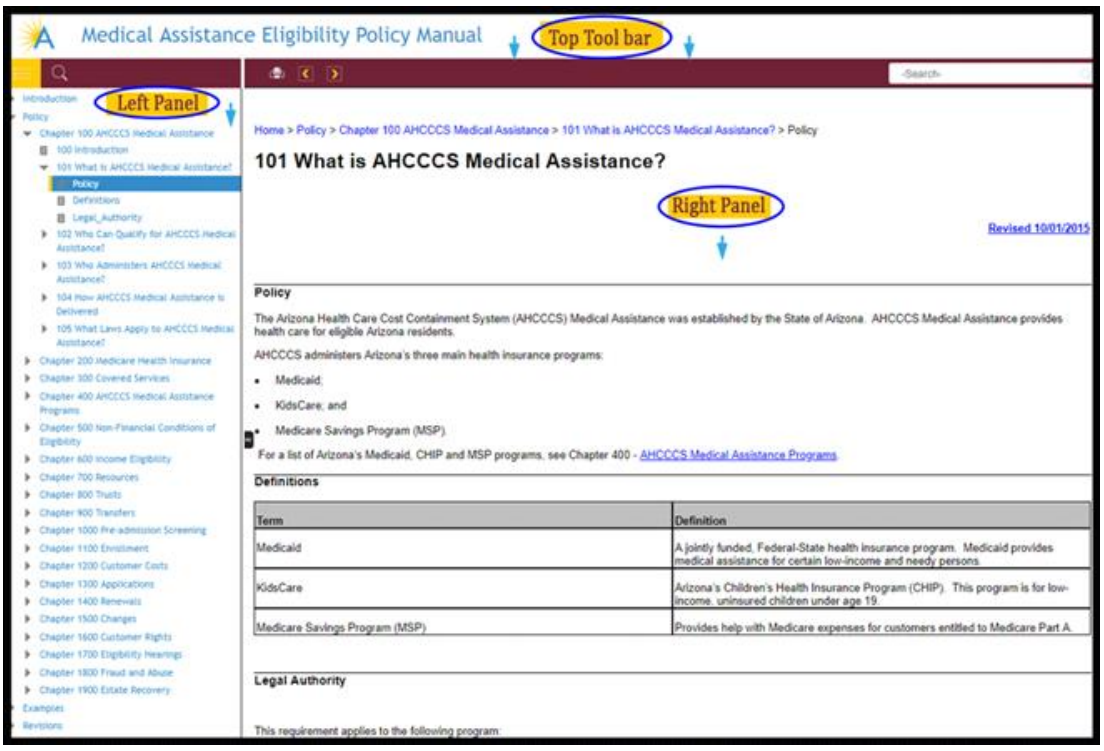
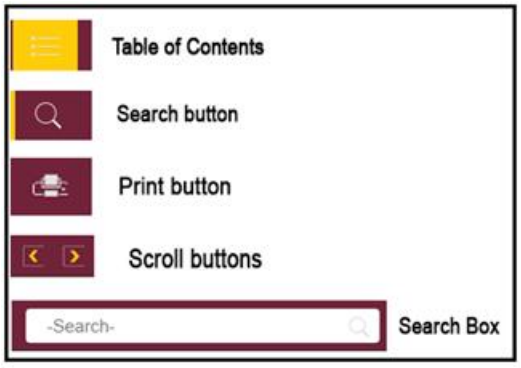
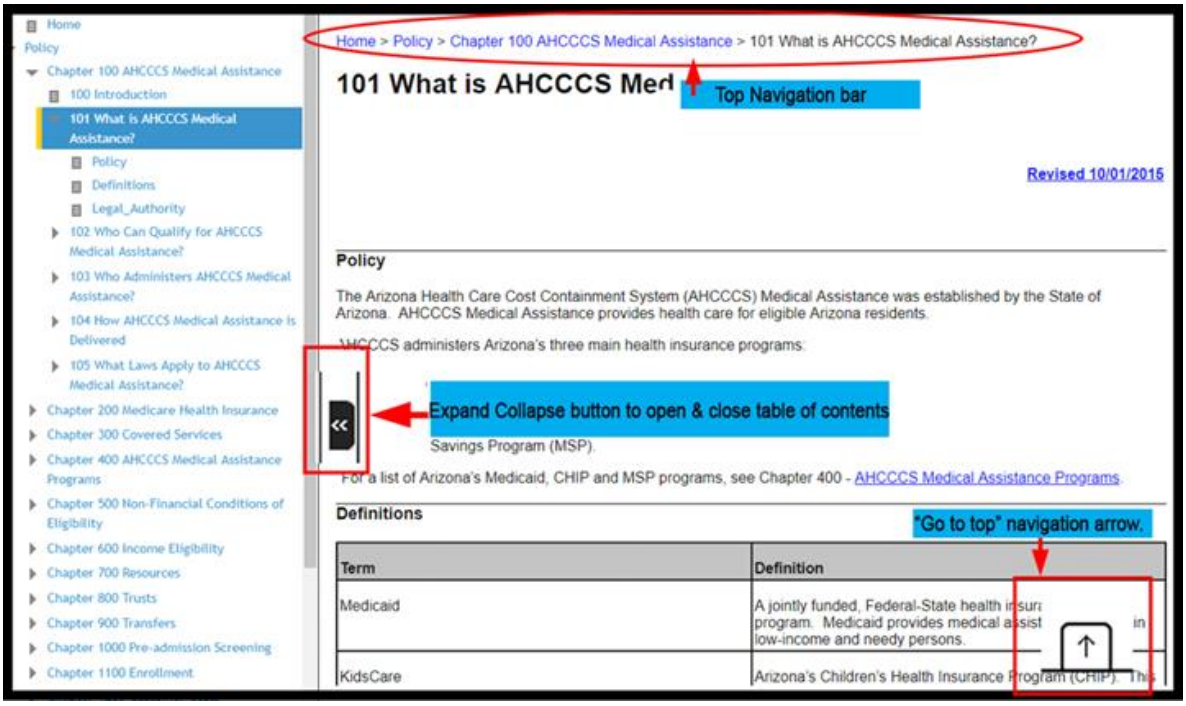


The top panel of the manual contains the following icons:



The left panel of the manual contains the table of contents and the search button.

The right panel is the main display window for the eligibility policy manual.

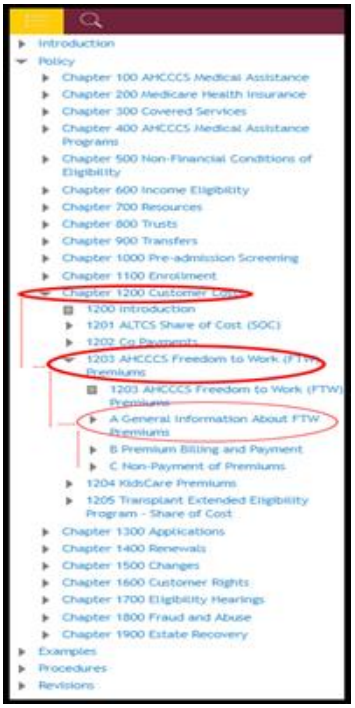


The expand and collapse button allows the user to hide or open the table of contents. This page also provides a secondary navigation at the top of the page.

At the bottom of the page there is a cursor arrow to navigate to the top of the page

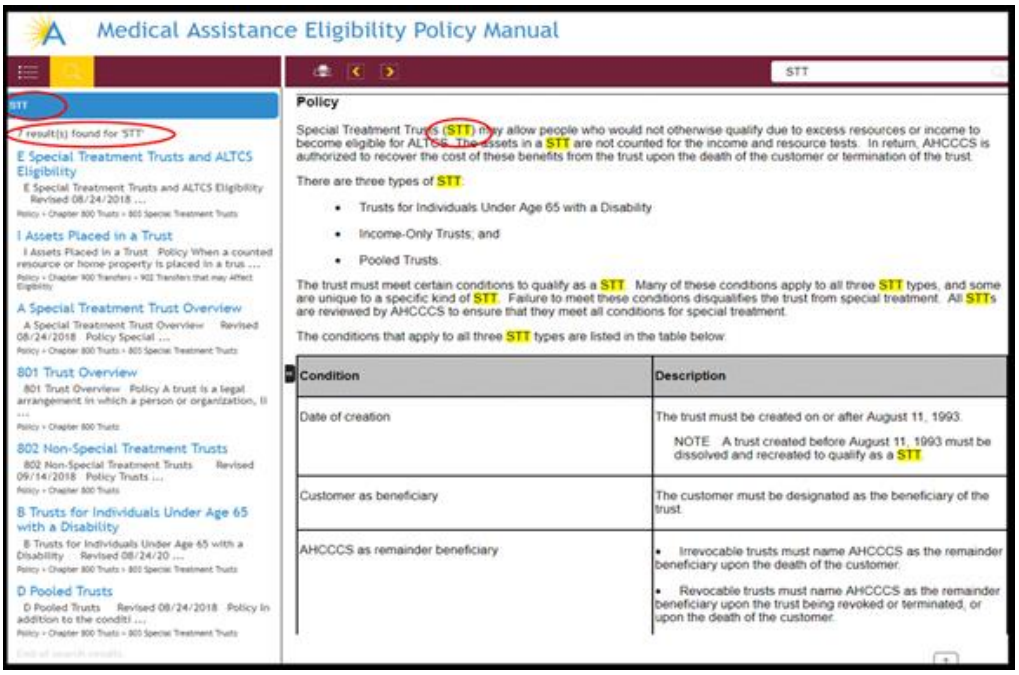
Table of Contents

The Table of Contents can be accessed by clicking the “Contents” button, if it’s not already displayed. It is organized into three levels. The first two levels are “books” and the third level contains “pages”. Books organize content by chapters (1st level) and subchapters/topics (2nd level), while pages contain the actual policy. Clicking on a book will load the pages related to that section of the chapter.



Search

The search option allows you to find all policy sections that contain a word or phrase. You can use the search button on the left of the screen of the search box. Type the word or phrase you are looking for in the Search field and click enter. (When you start typing a word or topic, a set of suggestions will start appearing and you may not have to enter the full search string).



The results of the search is displayed below the search box. A ranking system displays the most relevant sections first. Click on the title of results you want to look at and the manual section will open in the right panel. Your search term will be highlighted wherever it appears on the page.

Cash Assistance and Nutrition Assistance Policy

Please see the Cash and Nutrition Assistance Policy Manual located at https://DBMEFAAPolicy.azdes.gov for policy and procedures.

800 Introduction

This chapter describes how trusts impact eligibility for ALTCS and explains how to identify and treat different trusts.

For each requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement.

801 Trust Overview

Policy

A trust is a legal arrangement in which a person or organization, like a bank, manages assets for someone else. There are several different kinds of trusts. Income and resources that are assigned or titled to a trust may be counted differently when determining if someone qualifies for AHCCCS.

This Chapter focuses on how trusts impact eligibility for the ALTCS program. For information on how trust income or income assigned to a trust affects other AHCCCS programs, see MA606MMM.

Trusts are created for many reasons. Trusts can be used to transfer ownership of resources to someone to avoid probate, reduce estate taxes or provide for a person's future needs. There are also a group of trusts that can allow people who would not otherwise qualify due to excess resources or income to become eligible for ALTCS. These trusts must follow strict federal and state rules to qualify for this special treatment, which is why they are often called "Special Treatment Trusts" (STT).

How the trust's income, resources and disbursements are treated when determining ALTCS eligibility depends on:

- Whether the trust qualifies as a Special Treatment Trust;
- Whose income or resources were used to fund the trust;
- Who created the trust; and
- Whether the trust is revocable or irrevocable.

The chart below describes how to identify the common types of trusts:

If the Trust…	**Then the Trust Is Probably…**
Created before August 11, 1993 with the income or resources of the customer, the spouse, or both	Medicaid Qualifying Trust (MA802.3)
• Created on or after August 11, 1993; • The customer or spouse is listed as the trustor, trustee, and beneficiary of the trust; and • Does not include language or terms used for STTs.	Revocable non-special treatment trust (MA802.1)
• Does not allow the person who created the trust to revoke it; and • Does not include language or terms used for STTs.	Irrevocable non-special treatment trust (MA802.2)
Is funded from the proceeds of a Will or with the income, resources or both of someone other than the customer or the customer's spouse. NOTE May be referred to as a "special needs trust".	Testamentary or Non-Grantor (MA802.4)

• Created on or after August 11, 1993; • Lists AHCCCS, Arizona or another State as a beneficiary of the trust; • References 42 USC §1396p(d)(4) or Section 1917(d)(4) of the Social Security Act; • States that disbursements must not be made for purposes other than those described in ARS §36-2934.01; and • Has conditions concerning the trust corpus, trust creator, trust manager, trust purpose, or the beneficiary's age.	Special Treatment Trust See MA803 for policy on the three types of STT.

Trusts are reviewed for impact to eligibility, and sent for a legal review if needed.

NOTE All potential Special Treatment Trusts are sent for a legal review to see if the trust qualifies for special treatment.

Important!

Some financial accounts look like trusts and even include the word "trust" in the title, but are not actual trusts. Examples include patient trust accounts and accounts maintained by a representative payee or conservator. For these accounts see MA704.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income or both from a trust.
Disbursement	A payment or distribution from the trust corpus or trust earnings.
Irrevocable	Means the grantor or the grantor's representative may not end the trust after it is made. NOTE A trust that states it is irrevocable but will end by some action taken by the grantor is a revocable trust.
Non-grantor trust	A trust funded with the assets of someone other than the beneficiary. For example, a grandparent creates a trust funded with her own money for the benefit of her grandchild. Sometimes called Special Needs Trusts.

Revocable	Means the person who set up the trust has the right to end it. A revocable trust can be ended by: • Withdrawal; • Recall; • Restatement; • Reversal or revocation; and • Transferring all trust resources out of the trust. A trust that says it can be changed or ended by a court is considered a revocable trust.
Trust Corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer, but are no longer owned by the customer. NOTE The trust corpus may also be called the trust principal.
Trustee	A person or organization that manages the trust resources and income for the benefit of the beneficiaries.
Trust document	The formal document that created the trust. It contains the powers of the trustees and rights of the beneficiaries. It may be a will, a deed in trust or a formal declaration of trust.
Trustor	One who creates a trust. Also called a settlor or grantor.

Proof

Proof needed to identify trusts and assets titled to the trust includes:

- The complete trust instrument or document setting up the trust. This includes all amendments, restatements and schedules to date;
- Court records relating to the trust;
- Court approved injury settlement;
- Will;
- Proof of income or resources assigned to the trust like a quit claim deed, vehicle title or bank statements showing accounts titled to the trust.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407 AAC R9-28-408

802 Non-Special Treatment Trusts

Revised 01/25/2023

Policy

Trusts that were not created to qualify for special treatment or that do not qualify as a Special Treatment Trust are known as non-special treatment trusts.

The policy for counting the income and resources of these trusts applies regardless of any of the following:

- Purpose for which the trust was created;
- Whether or not the trustee has the ability to make payments to the customer, or the trustee actually makes any payments;
- Restrictions on when or if payments may be made; and
- Restrictions on the use of payments from the trust.

NOTE Trust policy in this section may be waived in cases of undue hardship. See MA804 for information about undue hardship for trusts.

Trust Ownership:

Non-special treatment trusts may be jointly owned. When a trust is jointly owned, only the percentage owned by the customer and spouse is used to determine resource eligibility, even when the entire trust corpus could be paid to the customer, the spouse or both.

Disbursements from a jointly-owned trust must be made to or for the benefit of the customer in at least the same percentage as the customer's ownership interest. For example, if the customer owns 50% of the trust assets, 50% of any disbursements must be made to or for the benefit of the customer. When the customer receives less than his or her ownership percentage, the difference is reviewed as a transfer.

Treatment of Trust Assets:

Excluded assets assigned to a trust remain excluded, except for home property. When home property is assigned to the trust the equity value is a counted resource (MA705K.1).

Types of Non-special Treatment Trusts:

There are four kinds of non-special treatment trusts:

- Revocable;
- Irrevocable;
- Medicaid Qualifying Trusts (MQT); and
- Testamentary and Non-Grantor Trusts.

The specific treatment and policy for each of the four types of trusts are discussed in the following sections.

1) Revocable Trusts

Resources

The person's entire ownership interest in the trust corpus is considered a resource.

Income and Share of Cost

Income received by the trust or payments from the trust to or for the benefit of the customer, whichever is greater, are counted for the income test and when determining the customer's Share of Cost (SOC).

NOTE Trust income does not include dividends and interest earned by the trust corpus and added to the principal.

2) Irrevocable Trusts

Resources

When payment can be made from the trust principal to or for the benefit of the customer, the maximum amount that is available for payment is a counted resource.

Income and Share of Cost

Income received by the trust or payments from the trust to or for the benefit of the customer, whichever is greater, are counted for the income test and when determining the customer's SOC.

NOTE Trust income does not include dividends and interest earned by the trust corpus and added to the principal.

3) Medicaid Qualifying Trusts (MQT)

A MQT is a trust created other than by a will that meets all of the following:

- Created on or before August 10, 1993;
- Created and funded by the customer, the customer's spouse or both; and
- The customer or spouse is listed as beneficiary.

Although called a Medicaid Qualifying Trust (MQT), this type of trust may actually cause a customer to not qualify for ALTCS.

Resources

The maximum amount allowed by the terms of the trust to be paid to the customer is a counted resource.

The maximum amount considered available includes only amounts that can be distributed from the trust income or principal. This applies even if the trustee is not actually distributing these amounts.

Income and Share of Cost

Trust income that is counted for the income test and Share of Cost includes:

- Income assigned to the MQT that would otherwise have been paid to the customer; and

NOTE Since income assigned to the trust is already counted, it is not counted again when disbursed in the same month.

- Payments made from trust principal that is NOT being counted in the resource test.

NOTE Payment from trust principal that IS counted as a resource is a conversion of a resource (MA701.3). See MA705 for policy on how to treat specific resource types.

Petition for Release of Funds

To qualify for ALTCS, the beneficiary of an MQT must petition the court for disbursements of trust funds when either of the following applies:

- The terms of the trust only allow trust funds to be paid to or for the benefit of the beneficiary under a court order; or
- The terms of the trust allow the beneficiary to petition the court for trust funds to be disbursed when the trustee refuses to disburse them.

4) Testamentary and Non-Grantor Trusts

Testamentary and non-grantor trusts are funded by the assets of someone other than the customer or the customer's spouse.

If the customer's or spouse's assets have funded any part of the trust, it is not a non-grantor trust. It is one of the trusts in sections 1) through 3) above.

NOTE For trusts created by a will, if the grantor is still living, the testamentary trust does not yet exist.

Resources

The treatment of the trust principal depends on whether the customer is the trustee or the beneficiary and the terms of the trust.

If a customer is the...	**Then...**
Trustee	• The trust is NOT a resource when the trustee cannot legally access the trust principal for personal use. • The trust IS a resource when the terms of the trust allow the trustee to use the income and resources for his or her own benefit. The maximum amount that can be accessed by the trustee for personal use is counted as a resource.
Beneficiary	The trust is a resource when the beneficiary can terminate the trust to access the trust assets, or can access the trust principal directly or through an order to the trustee. The maximum amount that can be accessed by the beneficiary is counted as a resource. NOTE If the beneficiary cannot terminate the trust, directly access the funds or order the trustee to make payments, the trust principal is not a resource, even if the trust otherwise allows for payments from the principal .

Income and Share of Cost

Use the table below to determine how to treat income or disbursements for a testamentary or non-grantor trust.

NOTE Any trust income or disbursements that are counted as income to the customer are counted for both the income test and for SOC.

If a customer is the...	**And...**	**Then…**
Trustee	The trustee may legally access the trust principal for personal use	• Interest or dividends earned by the trust principal are counted as income in the month earned. • Additions to principal from a third party are counted as income. NOTE Disbursements from the trust principal are not counted as income.
	The trustee may NOT legally access the trust principal for personal use	• Any disbursements made to the trustee are counted as income. • Interest or dividends earned by the trust principal are not counted as income unless the terms of the trust state that they belong to the trustee. • Additions to trust principal made directly to the trust are not counted as income.

Beneficiary	The beneficiary may do ANY of the following: • Terminate the trust; • Order the trustee to make payments from the trust; or • Legally access the trust principal	• Interest or dividends earned by the trust principal are counted as income in the month earned. • Additions to principal from a third party are counted as income. NOTE Disbursements from the trust principal are not counted as income.
	The beneficiary may NOT do ANY of the following: • Terminate the trust; • Order the trustee to make payments from the trust; or • Legally access the trust principal	• Disbursements made directly to the beneficiary are counted as income. NOTE Disbursements that are made on behalf of but not directly to the beneficiary are not counted as income. • Interest or dividends earned by the trust are not counted as income unless the terms of the trust state that the beneficiary has a right to the trust earnings. • Additions to trust principal made directly to the trust are not counted as income.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income or both from a trust.
Disbursement	A payment or distribution from the trust corpus or trust earnings.
Irrevocable	A trust that is irrevocable cannot be changed or ended by the grantor or the grantor's representative after it is made. NOTE A trust that states it is irrevocable but will end by some action taken by the grantor or the grantor's representative is a revocable trust.
Non-grantor trust	A trust funded with the assets of someone other than the beneficiary. For example, a grandparent creates a trust funded with her own money for the benefit of her grandchild. Non-grantor trusts are sometimes called "Special Needs Trusts".
Revocable	A trust that may be changed or ended. NOTE A trust that says it can be changed or ended by a court is considered a revocable trust.

Testamentary trust	A trust created by a will upon the person's death.
Trust Corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. NOTE The trust corpus may also be called the trust principal.
Trustee	A person or organization that manages the trust resources and income for the benefit of the beneficiaries.
Trust document	The formal document that created the trust. It contains the powers of the trustees and rights of the beneficiaries. It may be a will, a deed in trust or a formal declaration of trust.

Proof

The proof needed for non-special treatment trusts may depend on whose assets funded the trust and whether the customer or spouse has access to the trust funds.

Proof needed for non-special treatment trusts includes:

If the trust is…	**Then the proof needed is…**
All Non-Special Treatment Trusts	• All of the pages of the trust document. This includes all amendments, restatements and schedules from the date the trust was created to the current month; • Any court records relating to the trust; • Proof of all resources and income transferred into or out of the trust during the application period. Examples include: ◦ Title transfer documents; ◦ Quit-claim deeds; and ◦ Financial account statements; • Proof of the source of all income or resources assigned to the trust; and • Proof that all income or resources assigned to the trust are legally titled to the trust. NOTE Assets that do not have a legal title, such as personal effects, do not require proof.

Irrevocable trust or MQT	• All of the proof needed for all non-special treatment trusts; and • Proof of the maximum amount that may be disbursed from the trust. NOTE The trust document may not state the maximum amount that may be disbursed from the trust. In this case, a statement from the financial institution of entity holding the trust funds is acceptable.
Testamentary Trust	• All of the proof needed for all non-special treatment trusts; and • A copy of the will that created the trust.

In addition to the proof listed above, the table below lists other proof needed in special circumstances:

If the trust is...	**Then the proof needed is...**
Funded with the customer's or spouse's assets	• Power of Attorney, legal guardianship or conservatorship documents when someone other than the beneficiary, spouse, or parent of a minor beneficiary created the trust; and • Proof of the value of the income or resources used to fund the trust when the trust was established.
A counted resource to the customer (customer has access to the principal)	• Proof of the value of income and resources currently assigned to the trust; and • Proof of all transfers made from the trust to someone other than the customer during the past five years.
No longer funded	Proof that all items assigned to the trust have been transferred out of the trust. Examples include: • Title transfer documents; • Quit-claim deeds; and • Bank statements showing the trust account is closed.
Revoked	A written statement signed and dated by a person with the authority to revoke the trust, such as the trustee or the person who created the trust. A trust will normally be revoked in the same method that created it: • When the trust document was notarized, the written statement revoking the trust must be notarized. • When a court initially approved the trust, the revocation must be approved by the court.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407 AAC R9-28-408

803 Special Treatment Trusts

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Special Treatment Trust Overview

Revised 08/17/2021

Policy

Special Treatment Trusts (STTs) may allow people who would not otherwise qualify due to excess resources or income to become eligible for ALTCS. The assets in a STT are not counted for the income and resource tests. In return, AHCCCS recovers the cost of these benefits from the trust upon the death of the customer or termination of the trust.

There are three types of STT:

- Trusts for Individuals Under Age 65 with a Disability;
- Income-Only Trusts; and
- Pooled Trusts.

The trust must meet certain conditions to qualify as a STT. If a trust does not meet these conditions, it does not qualify for special treatment. All STTs are reviewed by AHCCCS to ensure that they qualify for special treatment.

The conditions that apply to all three STT types are listed in the table below:

Condition	Description
Date of creation	The trust must be created on or after August 11, 1993. NOTE A trust created before August 11, 1993 must be dissolved and recreated to qualify as a STT.
Customer as beneficiary	The customer must be designated as the beneficiary of the trust.
AHCCCS or “State Medicaid Agency” as remainder beneficiary	• Irrevocable trusts must name AHCCCS or the State Medicaid Agency as the remainder beneficiary upon the death of the customer. • Revocable trusts must name AHCCCS or the State Medicaid Agency as the remainder beneficiary upon the trust being revoked or terminated, or upon the death of the customer.
Restrictions on disbursements	The trust must state that disbursements cannot be made for purposes other than those described in ARS §36-2934.01. Additionally, the trust cannot allow the trustee to make disbursements which are prohibited by ARS §36-2934.01. As one example, a trust cannot allow a trustee to make loans to other people. Thus, a trust that generally allows a trustee to make “loans” is too vague and does not comply with ARS §36-2934.01.

Restrictions on trust expenses	The trust must state that it will allow disbursements for reasonable and necessary administrative expenses as approved by AHCCCS, or by the Probate Court with advance notice to AHCCCS. Further, any provision allowing for such reasonable and necessary administrative expenses must state that it will allow for those expenses as approved by AHCCCS, or by the Probate Court with advance notice to AHCCCS.
Share of cost	The trust must state that on a monthly basis, the trustee is to pay any share of cost amount from the trust income. NOTE This only applies when the trust receives income that is counted in the share of cost calculation.
References to moves out of state	To retain Arizona's beneficiary rights, the trust cannot require all references to Arizona, ALTCS or AHCCCS to be replaced by parallel references to a Medicaid agency in another state.
Direct deposit	The trust must require that all income assigned to the trust by the grantor be directly deposited, when legally allowed, into an account titled to the trust.
Financial account with trust assets	Any financial account created with trust assets must be titled to show that the account is held by the trust. Example: • Bob Smith Income Only Trust- Mary Smith Trustee. • Billy Jones Supplemental Needs Trust.
Reference to federal law	The trust must contain reference to: • Title 42 of the United States Code; 42 USC §1396p(d); or • Section 1917(d)(4) of the Social Security Act.

The conditions and proof that are unique to each type of STT are covered in the following sections:

• MA803B - Trusts for Individuals Under Age 65 with a Disability;
• MA803C - Income-Only Trusts; and
• MA803D - Pooled Trusts.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income or both from a trust.

Disbursement	A payment or distribution from the trust corpus or trust earnings.
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer, but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The proof needed to show the trust document meets all of the conditions for special treatment includes:

- All pages of the trust document, including any schedules, amendments, restatements and signature pages;
- Power of Attorney, legal guardianship or conservatorship documents when someone other than the beneficiary, spouse, or parent of a minor beneficiary created the trust;

  NOTE When the customer's spouse signs the trust for the customer as POA, guardian, or conservator, the POA, guardianship, or conservatorship documents are required.

- Any court documents related to the trust;
- For any income assigned to the trust, a copy of the request to the income source for direct deposit to the trust account;
- For financial accounts containing trust assets, all account statements from the date the trust account was opened through the current month; and
- Documents like quit claim deeds, vehicle titles, and bank statements showing that items assigned to the trust have been titled to the trust.

Being listed on the Trust Assets Schedule does not automatically make an item an asset of the trust. It must also be legally titled to the trust.

Proof needed for a trust that has been revoked - If the trust has been revoked, a written statement signed and dated by a person with the authority to revoke the trust. A trust will normally be revoked by the same method that created it:

- When the trust document was notarized, the written statement revoking the trust must be notarized.
- When a court initially approved the trust, the revocation must be approved by the court.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS § 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

B Trusts for Individuals Under Age 65 with a Disability

Revised 04/26/2022

Policy

In addition to the conditions listed in MA803A, this type of trust has the following conditions:

Condition	Description
Trustor	The trust must be set up by one of the following: • the customer; • the customer's parent; • the customer's grandparent; • the customer's legal guardian; or • a court.
Trust corpus	The trust corpus contains only the customer's income and resources. A trust that contains income or resources of another person cannot qualify as a STT. Thus, a trust which allows the trustee to accept additions without clearly stating that those additions can only include the customer's income and resources does not comply with this requirement. NOTE The customer's income and resources may be freely added to the trust until the customer turns 65.
Age	The customer must have been under age 65 when the trust was created. NOTE When the trust meets all of the conditions and is created before the customer turns 65, the trust can keep its special treatment status after the customer turns 65. However, any additions to the trust after the customer turns 65 are reviewed as transfers (MA902I).
Disability	The customer must have a disability at the time that the trust is created. Disability can be determined by: • The Disability Determination Services Administration (DDSA) using the same criteria used for the SSI-Cash program; • A Medical Eligibility Specialist using the Preadmission Screening (PAS) to determine a medical need for long term care services; or • A diagnosis of Serious Mental Illness (SMI) determined by the Arizona Department of Health Services. When the customer was not receiving SSI or SSA disability benefits at the time the trust was created, a retroactive disability determination is requested.

Definitions

Term	Definition
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The trust document itself is used for proof of who created the trust and the age of the customer at the time it was created.

In addition to the proof listed in MA803A, other proof needed for this type of trust includes:

Proof of disability

The following items can be used for proof that the customer has a disability and the date the disability began:

- A Pre-Admission Screening (PAS) decision showing that the customer has been determined to be medically in need of long-term care.
- Records from SSA showing the person is receiving SSA or SSI disability payments or has been determined disabled.
- An SMI Determination Summary Report or SMI Eligibility Outcome form that includes a SMI diagnosis of functional inability to live in an independent setting or risk of serious harm to self or others.

Proof of the source of trust assets

Proof that the trust corpus contains only the customer's assets includes documents and written statements showing the customer owned the item before it was titled to the trust. Examples of some documents that may be used include:

- Deed and title transfer documents;
- Records from the County Assessor or County Recorder; and
- Financial account statements.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407 AAC R9-28-408

C Income Only Trusts

Revised 04/26/2022

Policy

An Income-Only Trust (IOT) can allow a customer to qualify for ALTCS when income eligibility is determined using the 300% Federal Benefit Rate (FBR) Gross Income Test. This includes when the customer only qualifies for acute care services due to a transfer penalty period or the customer's living arrangements. See MA521B for detailed policy on the income test used based on living arrangements.

NOTE An IOT cannot help a customer qualify for ALTCS when the Net Income Test is used or to qualify for any other AHCCCS program.

This kind of trust is sometimes known as a stream-of-income, income-cap, or Miller trust.

In addition to the conditions listed in MA803A, this type of trust has the following conditions:

Condition	Description
Trustor	The trust must be created by the: • Customer; • Customer's parent, if the customer is a minor child; • Customer's spouse; or • Legal representative, including a court or administrative body with legal authority to act on behalf of the customer or spouse.
Trust corpus	The trust can only be funded with the customer's income. Resources cannot be added to or used to fund the trust. When resources are added to an IOT, the trust loses its special treatment until the resources are removed. Thus, a trust which allows the trustee to accept additions without clearly stating that those additions can only include the customer's income does not comply with this requirement. The IOT account must be set up with all or a part of the customer's current monthly income and have a $0 balance at the time it is set up.
Income assigned to an IOT	An IOT should only be created when *counted* income is more than 300% of the FBR. Income that is not counted should not be assigned to or deposited into the trust. However, if it is deposited into the trust, it is subject to the same requirements as any other income deposited into the trust. NOTE See MA902I for policy on income transferred to an IOT.

Assignment of gross income to the IOT	The full amount of any source of income must be assigned to and deposited into the trust account. The trust document or Schedule A must list the customer's gross income from the assigned source. The trust document or Schedule A may state "gross" income is assigned from the source instead of listing the actual gross payment amount.
Ending tax withholding	Since tax payments are not an allowed trust disbursement until there is an actual tax liability, taxes may not be deducted from income assigned to the trust. The customer must ask the income source to stop tax withholding.
Ending other income deductions	Since union dues, life insurance premiums, or insurance premiums to cover other people are not allowed trust disbursements, these expenses may not be deducted from income assigned to the trust. The customer must ask the income source to stop deductions for these items.
Income may not be higher than the Private Pay Rate (PPR)	For an IOT to qualify for special treatment, the customer's counted income not assigned to the trust plus the income assigned to the trust must be equal to or less than the private pay rate for the geographic area in which the customer lives (see MA905.6). NOTE Interest and dividends earned by the trust and added to the principal are not counted.
Undue hardship for income higher than the PPR	When the trust meets all other conditions except the customer's total counted income is higher than the PPR, an exception may be made on a case-by-case basis when the customer claims that the private pay rate is not enough to meet his or her needs.

Definitions

Term	Definition
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The trust document itself is used for proof of who created the trust and that the full amount of the gross income is assigned to the IOT.

In addition to the proof listed in MA803A, other proof needed for an IOT includes:

- A copy of the request to stop deductions for withholding taxes, life insurance premiums, and union dues from the income going into the trust, if applicable;
- The account statements from the date the trust account was opened to show that the account was funded with all or part of the customer's current monthly income and previously had a zero balance;
- For financial accounts containing trust assets, all account statements from the date the trust account was opened through the current month; and
- Proof of total countable income.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

D Pooled Trusts

Revised 04/26/2022

Policy

In addition to the conditions listed in MA803A, this type of trust has the following conditions:

Condition	Description
Trustor	The trust must be set up by the customer, the customer's parent, grandparent, legal guardian, or a court. A Pooled Trust is considered created on the date that the Joinder Agreement is signed by the customer or representative and the non-profit association that manages the trust.
Trust corpus	The trust corpus contains only the customer's income and resources. A trust that contains income or resources of another person cannot qualify as a STT. Thus, a trust which allows the trustee to accept additions without clearly stating that those additions can only include the customer's income and resources does not comply with this requirement. NOTE The customer's income and resources may be freely added to the trust until the customer turns 65.
Age	The customer can be any age when the trust is created NOTE When the trust meets all of the conditions and is created before the customer turns 65, the trust can keep its special treatment status after the customer turns 65. However, any additions to the trust after the customer turns 65 are reviewed as transfers (MA902I).
Disability	The customer must have a disability at the time that the trust is created. Disability can be determined by: • The Disability Determination Services Administration (DDSA) using the same criteria used for the SSI-Cash program; • A Medical Eligibility Specialist using the Preadmission Screening (PAS) to determine a medical need for long term care services; or • A diagnosis of Serious Mental Illness (SMI) determined by the Arizona Department of Health Services. • When the customer was not receiving SSI or SSA disability benefits at the time the trust was created, a retroactive disability determination is requested.
Management of the trust	The trust must be managed by a non-profit association. While the income or resources of all trust beneficiaries may be pooled for investment and management purposes, a separate trust account must be kept for each person.

Definitions

Term	Definition
Beneficiary	A person or entity entitled to receive the principal, income, or both from a trust.
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

The trust document itself is used for proof of who created the trust and the age of the customer at the time the trust was created.

In addition to the proof listed in MA803A, other proof needed for a pooled trust includes:

Proof of disability

The following items can be used for proof that the customer has a disability and the date the disability began:

- A Pre-Admission Screening (PAS) decision showing that the customer has been determined to be medically in need of long-term care.
- Records from SSA showing the person is receiving SSA or SSI disability payments or has been determined disabled.
- An SMI Determination Summary Report or SMI Eligibility Outcome form that includes a SMI diagnosis of functional inability to live in an independent setting or risk of serious harm to self or others.

Proof of the source of trust assets

Proof that the trust corpus contains only the customer's assets includes documents and written statements showing the customer owned the item before it was titled to the trust. Examples of some documents that may be used include:

- Deed and title transfer documents;
- Records from the County Assessor or County Recorder; and
- Financial account statements.

Proof of Pooled Trust Management

- Documents showing that the company or organization managing the Pooled Trust is a non-profit association; and
- Accounting statements showing that a separate trust account is being kept for the customer.

Legal Authority

Program	Legal Authorities

ALTCS	42 USC 1396p(d) ARS 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

E Special Treatment Trusts and ALTCS Eligibility

Revised 04/26/2022

Policy

This section covers the following ALTCS policies for Special Treatment Trusts (STTs):

• Disbursements;

• How income is counted for Special Treatment Trusts;

• Requirements for trustees;

• Penalties for late reporting; and

• Violations of Special Treatment Trust requirements.

1) Disbursements

Disbursements can only be made for the benefit of the customer and for purposes listed in state law at ARS §36-2934.01.

NOTE For household expenses or any other shared expense, only the customer's proportionate share is an allowed disbursement. The total expense divided by the number of people who share the benefit of the expense equals the customer's share.

The following table lists examples of allowed disbursements:

Disbursement type	Description
Share of cost payment (SOC)	The amount an ALTCS customer must pay toward the cost of long-term care services.
Personal Needs Allowance (PNA)	The amount allowed for the customer's personal needs (see MA1201C.1). A PNA may only be disbursed from an Income Only Trust. The PNA is considered a payment for food or shelter. It may be paid as a lump sum or for individual items.
Legal and professional expenses related to administering the trust or for the trust beneficiary	• Income taxes owed on income earned by the trust or assigned to the trust. • Investment fees related to administering the trust. • Reasonable professional expenses, for example accounting and attorney fees, related to administering the trust • Guardianship and conservatorship fees for the trust beneficiary based on the fair market value of the services provided.

Medical expenses	• Health insurance premiums, medically necessary medical expenses, and special medical needs of the customer, including: • Expenses to make the home accessible to the customer. • Purchase and maintenance of a specially equipped vehicle, if titled to the trust or a lien is placed on the title by the trust for the purchase price of the vehicle. • Durable medical equipment. • Over the counter supplies and medications including diapers, lotions, and cleansing wipes. • Personal care service when determined medically necessary by the beneficiary's physician. The services must be provided by an AHCCCS-registered provider, including a financially responsible relative. NOTE Payments for personal care services provided by a financially responsible relative cannot be higher than the AHCCCS fee for service rate.
Spouse or family maintenance allowance:	Payment for the maintenance needs of a spouse or other dependent as described in MA1201C from the trust income.
Burial expenses for the customer	Disbursements for the customer's burial expenses are limited to one of the following: • Purchase of a prepaid burial plan funded by an irrevocable life insurance policy, irrevocable burial account, irrevocable trust account or irrevocable escrow account. ◦ Any amount of the disbursement that exceeds the itemized burial expenses is an uncompensated transfer. • Purchase of life insurance to fund a burial plan for the customer with a face value of not more than $1,500 after allowing deductions for burial plot items. • A burial fund account of not more than $1,500.
Other expenses for the customer's benefit	• Costs for food, clothing, and shelter. • Home property and other real property purchased by and titled to the trust. • Items for entertainment, education, or vocational needs consistent with the customer's ability to use these items. • Travel expenses for a companion, including a financially responsible relative, when a companion is needed to allow the customer to travel for non-medical reasons. • For Pooled and Disabled Under 65 trusts, disbursements to qualified Achieving a Better Life Experience (ABLE) accounts established for the customer's benefit. • Other expenses personally approved by the Director.

Disbursements that do not meet the requirements in ARS §36-2934.01 are not allowed.

Some examples of disbursements that are not allowed from an STT include:

- Gifts, payments, or loans to or for the benefit of anyone other than the beneficiary, including reimbursements to third parties for the customer's expenses;
- Child support and alimony payments that are not garnished;
- Paying all the shelter costs for a shared household;
- Income taxes when there is no actual tax liability;
- Vacation expenses for family members;
- Payments on past debts, including paying down credit cards;
- Health insurance premiums for other people; and
- Burial funds that do not meet the requirements listed in the table above.

When non-allowed disbursements have been made, the trust may lose its entitlement to special treatment. The disbursements may also need to be reviewed as a transfer with uncompensated value (see Chapter 900 – Transfers).

2) How Income is Counted for Special Treatment Trusts

Trust income and disbursements are counted as described in this section, regardless of the terms of the trust document.

The following table describes how income and disbursements are treated for income eligibility and for Share of Cost (SOC).

NOTE For the ALTCS Income Test, the total countable income outside the trust plus the total countable disbursements from the trust may not exceed the ALTCS income limit.

Income Type	Counted for the income test?	Counted for SOC?
• Counted income received by the customer that is not assigned to the trust; or • Counted income assigned to the trust but not deposited to the trust account in the month received.	Yes	Yes
Amounts from the trust paid directly to the customer for any reason.	Yes	No
Any payments from the trust on behalf of the customer for food or shelter. This includes room and board in a boarding home or an alternative Home and Community Based Services (HCBS) arrangement.	Yes	No
Income assigned to the trust that is manually or direct deposited into the trust account in the month received. **Exception**: Excluded income deposited into the trust is not counted for SOC.	No	Yes

For Pooled and Disabled Under 65 trusts, structured settlement annuity payments irrevocably assigned to the trust. NOTE These payments are considered income to the trust, not the customer.	No	No
Interest or dividends earned by the trust corpus and added to the trust principal.	No	No
Payments from the trust that are not paid directly to the customer or are not payments for the customer's food or shelter.	No	No
Payments from the trust for the customer's PNA NOTE The increased portion of the PNA for garnished child support or spousal support is not counted for income eligibility.	Yes	No

For examples, see STTs and Income Calculations and STTs and SOC Calculations.

3) Requirements for Trustees

The trustee of a STT has specific responsibilities related to providing proof and reporting changes. If the trustee fails or refuses to cooperate with these requirements, the trust can lose its special treatment status.

A trustee must:

• Provide proof needed to determine if the trust qualifies as a STT;

• Provide proof of disbursements and the related expenses;

• Report changes in trust income or disbursements;

• Report changes in trustees, as well as changes to an existing trustee's phone number or address;

• Report if the trust purchases real or personal property; and

• Report when the trust is revoked or terminated.

Other trustee responsibilities depend on whether the trust is still in its initial review to see if it qualifies as a STT, or it has already been approved as a STT.

Initial Special Treatment Trust Review

The trustee must provide the following documents for the trust review:

• The entire trust document;

• Proof of trust assets and disbursements from the date the trust was created to the current month;

• Proof of the source of the initial funding of the trust; and

• The Acknowledgment of Responsibilities as Trustee for a Special Treatment Trust form (DE-522).

The trustee must also provide one of the following forms:

• For trusts for individuals under age 65 with a disability or Pooled Trusts, the Special Treatment Trust Anticipated Disbursements (DE-312) form; or

• The Income Only Trust Anticipated Disbursements (DE-313) form.

The Anticipated Disbursement forms are used to state what costs and expenses will be paid from the trust.

For IOTs, the SOC MUST be paid from the trust. When the SOC is greater than the total income assigned to the trust, the full amount of the income deposited to the trust must be disbursed for the SOC. The SOC disbursement cannot be reduced to allow for other trust expenses.

Reporting Changes

After the STT is approved, the trustee must report any new trust funding or changes to the planned disbursements listed on the DE-312 or DE-313 forms at least 45 days in advance.

See Disbursement Request Examples

When the trustee cannot report changes by this due date because of circumstances beyond his or her control, the trustee must report the change within 30 calendar days from the date of the change or emergency disbursement. However, the notice is still considered late. See section 4 below for penalties that may be applied.

A major change, such as the customer moving from an HCBS living arrangement to a nursing facility, may change the trust disbursements needed, especially with an IOT. When this happens, the trustee must provide trust account records and complete a new DE-312 or DE-313 form listing anticipated disbursements for the next 12 months.

Reporting Requirements at a Renewal

At renewal, the trustee must provide information and update forms as described in the table below:

Type of Trust	**Requirements**
Trusts for a Person Under Age 65 with a Disability OR Pooled Trust	The trustee must report any changes to the trust corpus and provide all of the following documents: • Court ordered annual accounting documents or trust account records showing the actual trust income and disbursements since the last renewal; • A report of expected trust income and disbursements over the next twelve months, using the Special Treatment Trust Anticipated Disbursements (DE-312) form; • Titles for any new trust assets; and • Proof for any assets removed from the trust.
Income-Only Trust	The trustee must report the amount of the trust corpus at the time of the renewal and provide both of the following: • Trust account records showing the actual trust income and disbursements since the last renewal; and • A completed Income Only Trust Anticipated Disbursements (DE-313) form for the next 12 months.

Annual Accounting Statements Placed with the Court

Trustees of STTs with a large trust corpus (usually Trusts for Individuals Under Age 65 with a Disability) are sometimes required to file quarterly, semi-annual, or annual accounting statements with the court that approved the trust creation.

4) Penalties for Late Reporting

Changes to income or trust disbursements can result in the customer losing eligibility or paying an increased share of cost for one or more months.

The trustee of an STT must report changes in income assigned to the trust or to disbursements from the trust at least 45 calendar days before the change happens. This is to allow enough time, if needed, to process any change in the SOC or eligibility for the month the change will happen.

When the trustee reports these changes late, the change is reviewed to see if the SOC would have been higher, or eligibility would have been affected for past months. If so, the adverse action that would have been applied if the change had been reported on time is applied to the next month possible allowing for advance notice.

When an adverse action is taken to stop ALTCS eligibility or increase the customer's SOC due to late reporting, the customer may appeal the decision. This may result in eligibility or SOC being continued at the previous level during the appeal. If the Agency decision is upheld at the hearing, the adverse action is applied for future months.

5) Violations of Special Treatment Trust Requirements

Violating the terms or conditions of a STT can result in the trust losing its Special Treatment status. Actions that violate the terms of a STT include:

- Depositing resources into an income-only trust;
- Depositing income or resources belonging to someone other than the customer into the trust;
- Breaches of "spendthrift" restrictions such as assigning, pledging, or otherwise obstructing the trust resources for certain personal debts or other obligations;
- Issuing disbursements from the trust that are not for the benefit of the customer;
- Giving false information about trust income or disbursements; and
- Failing to cooperate with trust reporting or proof requirements.

When a violation has occurred and the trust is no longer entitled to special treatment, it is treated as either a revocable or irrevocable non-special treatment trust (see MA802), until the trustee corrects the violation.

NOTE If counting the trust resources and income as available due to losing special treatment would cause an undue hardship, the situation is reviewed by the agency on a case-by-case basis.

Definitions

Term	Definition
Advance notice	A period of at least 10 days before the date the adverse action will be taken.
Adverse action	A change to decrease or stop benefits or to increase the customer's costs.
Disbursement	A payment or distribution from the trust corpus or trust earnings.

Financially responsible relative	Includes the following: • Customer's spouse; or • If the customer is under age 18, the customer's parents.
Trust corpus	The income and resources that fund the trust. The resources or income in the trust corpus may be available to the customer but are no longer owned by the customer. The trust corpus may also be called the trust principal.

Proof

Proof of disbursements

• Anticipated Disbursements form (DE-312 or DE-313) with all 12 months completed, signed by the trustee;

See Special Treatment Trust Anticipated Disbursements Form (DE-312) and Income-Only Trust Anticipated Disbursements Form (DE-313) for examples.

• Check registers or other records of payments that were made from the trust. The records should show the payments date, amount paid, and what was received. Include explanations for changes made to the trust assets, such as accounts closed, properties sold, or titles changed;

• Receipts, invoices, or billing statements for any legal or professional services to be disbursed from the trust;

• Proof of health insurance premium amounts that will be paid from the trust;

• Proof of any shelter expenses that will be paid from the trust;

• For burial expenses, a quote or estimate from the burial provider showing the type of pre-need burial plan and costs, unless the request is for a life insurance policy or designated burial account of $1,500 or less; and

• A written explanation of any planned medical expenses, payments to the trust beneficiary, entertainment, vocational, or transportation expense disbursements.

Proof of Trustee agreement to abide by the STT requirements

• Acknowledgement of Responsibilities as Trustee for a Special Treatment Trust form (DE-522) signed by the trustee.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC § 1396p(d) ARS 36-2934.01 AAC R9-28-407.E AAC R9-28-408.F

804 Undue Hardship Claims for Trusts

Revised 02/14/2020

Policy

The trust provisions may be waived when denying eligibility for long term care services creates an undue hardship. Undue hardship exists when applying the trust provisions would deprive the customer of:

- Medical care such that his or her health or life would be endangered; or
- Food, clothing, shelter, or other necessities of life due to the customer's income at or below 100% of the federal poverty level (FPL). See MA615.2 Income Standards for FPL limits.

Undue hardship does not exist when application of the trust provisions only causes inconvenience or restricts the customer's lifestyle but would not put him or her at risk of serious deprivation.

To qualify for an undue hardship, ALL of the following conditions must be met:

- The customer does not have the income or resources to pay for the medical care that he or she needs;
- The customer does not have any other means of obtaining the medical care that he or she needs, including other insurance, benefits or third-party liability; and
- The customer qualifies for ALTCS except for trust policy.

Undue hardship decisions are made on a case-by-case basis.

Definitions

Term	Definition
Other benefits	Benefits that entitle the customer to medical care, such as VA benefits.

Proof

Proof includes:

- A written statement from the customer that he or she is requesting an undue hardship determination, and the reason the customer believes an undue hardship exists;
- Proof of the customer's medical needs and expenses;
- Proof of income and resources for all months for which the customer is requesting an undue hardship;
- Proof of any medical insurance the customer has; and
- Any other information to support the customer's claim of undue hardship.

Legal Authority

Program	Legal Authorities

All Programs	42 USC § 1396p(d)(5) ARS 36-2934.01

900 Introduction

This chapter explains how to evaluate transfers of income or resources that could impact a customer's eligibility to get long-term care services.

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed; and
- A list of the federal and state laws that apply to the requirement.

901 Transfers Overview

Revised 07/17/2020

Policy

Transfer policy applies to customers who are applying for or receiving long-term care services, including customers who receive SSI Cash or Freedom to Work.

Transferring ownership of an asset for less than current market value may result in a period of time where the customer cannot get long-term care services. This period is called the “transfer penalty period”.

This policy applies to all transfers made during the look-back period.

See Example Establishing the Look-Back Period.

A transfer that happened before the look-back period does not affect the customer’s eligibility unless a penalty period was established by an earlier application and has not expired. In this case, the penalty period applies to the current application.

See Example Previous penalty period in effect at new application.

Any transfers that occurred during the look-back period or after the application was submitted must be reviewed to see if the customer received compensation for the full value of the asset. If the customer did not receive compensation for the full value of the asset, it is considered an “uncompensated transfer”. The uncompensated value is used to determine the length of any penalty period.

ALTCS eligibility is not stopped or denied due to an uncompensated transfer. If all other eligibility requirements are met, the customer will receive the limited ALTCS service package (MA302.2) during the penalty period.

Definitions

Term	Definition
Transfer	Giving legal ownership of an asset in whole or in part, to someone else. Some actions that cause a change in legal ownership include: • Changing the title or deed; • Selling or purchasing a resource; • Trading or exchanging one asset for another; • Making a loan; • Giving away a resource or income; • Assigning assets to another person or entity; and • Buying an annuity. After a transfer occurs, the asset no longer belongs to the former owner to the same degree that it did before the transfer. The former owner’s total assets have a different value, or have been converted from one type of asset to another.
Assets	A person’s income and resources. This includes income and resources the person is entitled to get, even if the person takes action to avoid receiving them.

Assignment of Assets	Designating or setting aside an asset for a specific purpose. An assignment may be revocable or irrevocable. • A revocable assignment of income or resources is not a transfer. Instead, the assets are considered "constructively received". See MA604B and MA703C for additional information about constructively received assets. • An irrevocable assignment of income or resources is a transfer.
Compensation	Money, real or personal property, food, shelter, or services received in exchange for a transferred asset. Compensation does not include either of the following: • Items or services with no cash value. For example, "love and consideration" is not compensation; or • Any part of a payment specifically identified as paying for interest.
Current Market Value (CMV)	Also known as “Fair Market Value”. For a resource, the actual dollar amount of the resource if sold on the open market at the time of the transfer. For income, the actual dollar amount of the income at the time it was transferred. See Determining the Uncompensated Value of a Transferred Stream of Income for additional information.
Equity value	The CMV of an asset less any outstanding loans, mortgages, or other legal encumbrances.
Look-Back Period	The 60-month period before the month the customer applies for ALTCS. The look-back period begins on the first day of the 60th month prior to the month of application.
Uncompensated Value	The difference between the equity value of an asset at the time it is transferred, and the amount of compensation that the customer received in exchange. The uncompensated value of a transfer may never be less than $0.00.

Proof

When a countable income or resource has been transferred, documents need to be provided to prove:

- The date of the transfer. For transfers of real property, the date of transfer is the date the transfer document is signed and notarized, not the date the document is recorded;
- The person who owned the item both before and after the transfer;
- Any legal debts and liens against the transferred item at the time of the transfer;
- The CMV of the transferred item at the time of the transfer; and
- Any compensation received for the transfer.

NOTE For proof of a resource’s CMV see the specific policy for that type of resource in MA705.

Legal Authority

Program	Legal Authorities
ALTCS FTW-ALTCS	42 USC 1396p(c) 42 CFR 435.1005 ARS 36-2934(B) AAC R9-28-401 and 409

902 Transfers That May Affect Eligibility

In general, a transfer assets may affect the customer's eligibility for long term care services under the ALTCS program when the transfer:

• Is made without receiving full compensation; and
• Is not described in MA903 - Transfers That Do Not Affect Eligibility.

The customer may still be eligible for acute medical services under ALTCS Acute Care if all other requirements are met.

The transfers described in the following sections may affect the customer's eligibility:

• Actions that would cause income or resources not to be received (MA902A);
• Creating joint ownership giving another person an ownership interest in the asset (MA902B);
• Withdrawal of funds from a financial account by a joint owner (MA902C);
• Adding a joint owner to home property (MA902D);
• Transferring home property (MA902D);
• Transferring real property and retaining a life estate interest (MA902D);
• Transferring the right to receive income (MA902E);
• Purchase of a life estate in another person's home (MA902F);
• Purchasing an Irrevocable Annuity (MA902G);
• Loans, including promissory notes and property agreements (MA902H);
• Transferring assets to certain types of trusts (MA902I); and
• Making disbursements from certain trusts that are not to or for the benefit of the customer (MA902I).

A Actions That Would Cause Income or Resources Not To Be Received

Policy

An action or failure to take action that results in the customer or customer's spouse not receiving income or resources may be a transfer with uncompensated value.

Examples of actions that would cause income or resources not to be received include:

- Waiving or refusing an inheritance;
- Waiving or assigning pension income;
- Refusing to take legal action to get a court ordered payment that is not being paid;
- Refusing to accept or receive an injury settlement; and
- Diverting insurance awards or court settlements into a trust or similar device to be held for the benefit of the person who won the settlement.

Actions or inactions of any of the following persons result in uncompensated transfers:

- The customer;
- The customer's spouse;
- A person, including a court or administrative body, with legal authority to act in place of or on behalf of the customer or the customer's spouse; and
- Any person, including a court or administrative body, acting at the direction of or upon the request of the customer or the customer's spouse.

EXCEPTION:

If the person cannot afford to take the action required to get the income or resource, or if the cost of getting the income or resource is greater than what the income or resource is worth, there may be no uncompensated value.

Definitions

Term	Definition
Equity value	The asset's current market value (CMV) less any outstanding loans, mortgages, or other legal encumbrances.
Uncompensated value (UV)	The difference between the asset's equity value, and the amount of compensation received as a result of the transfer.

Proof

When there is action or failure to take action that causes income or resources not to be received by the customer or the customer's spouse, the following proof is needed:

- That the customer or customer's spouse was or is entitled to receive the income or resource; and
- The value of the resource or income at the time that it was refused.

If the customer claims that the cost to get the resource or income is greater than the its value, the customer will also need to provide proof of:

- The cost of getting the resource or income; or
- That the person cannot afford to take the action needed to get the resource or income.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c) AAC R9-28-401 and 409

B Creating Joint Ownership

Revised 11/02/2021

Policy

Placing another person's name on an asset may limit the availability of the resource or the customer's right to sell or dispose of the resource. For example, this may happen when adding the other person's name requires that the person agree to the sale or disposal of the resource where no such agreement was needed before.

When the customer places another person's name on real property as a joint owner, the value of the other owner's interest in the property is a transfer.

> NOTE Adding another person's name to the title of a financial account usually does not change the customer's access to the funds. However, the title change must be reviewed to ensure that the customer's access has not been restricted, and the actual use of the funds must be reviewed for possible transfers.

Review how resources are titled to determine whether or not a transfer has occurred. The following table includes common title language and how it may affect the customer's ownership and access to the resource:

When the jointly owned asset is titled…	**Then…**
• The customer "or" another person; • The customer "and/or" another person; or • No designation; just multiple names listed.	The customer's right to sell or otherwise use or dispose of the asset has not been limited and does not result in a transfer with uncompensated value. NOTE However, it is a transfer when the other person sells, or uses up, the jointly titled resource.
Customer "and" another person	There is a transfer. The customer's right to sell or otherwise use or dispose of the asset has been limited because the customer must now get the other owner to agree to the sale, use or disposal of the asset. NOTE The transfer occurs when the other person's name is added to the title.

See Creating Joint Ownership - Examples

Definitions

Term	**Definition**
Joint Ownership	More than one person has legal right to use, sell or dispose of a resource. See MA704B for more policy on jointly owned resources.

Proof

When a countable income or resource has been transferred, documents need to be provided to prove:

- The date of the transfer. For transfers of real property, the date of transfer is the date the transfer document is signed and notarized, not the date the document is recorded;
- The person who owned the item both before and after the transfer;
- The Current Market Value (CMV) of the transferred item or the actual future cash value of income at the time of the transfer; and
- Any and all legal encumbrances such as debts and liens against the transferred item at the time of the transfer.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(3) AAC R9-28-401 and 409

C Withdrawals from Jointly Owned Accounts

Policy

A withdrawal of money from a financial account titled to the customer by a joint account owner other than the owner's spouse may be a transfer with uncompensated value.

The date of transfer is the date the funds were withdrawn or spent to make payments or purchases that were not for the benefit of the customer.

Exception:

Although funds held in a jointly owned account are considered the property of the customer, the customer has the opportunity to prove that the customer did not deposit some or all of the funds in the account.

A person who wants to rebut ownership of the funds in the account may present evidence to prove that all or part of the funds are the property of another person. See MA705I for more details.

If either the customer or the other owner can prove that the funds withdrawn were deposited into the account by the co-owner and did not belong to the customer, withdrawal of those funds is not considered a transfer.

Definitions

Term	Definition
Rebuttal of Account Ownership	An opportunity to provide proof of the actual ownership of funds in a financial account.

Proof

The customer must also provide all of the following:

- Account records showing deposits and withdrawals for all months in which ownership is being rebutted;
- Proof of the source and ownership of the deposits;
- Account records or a statement from the financial institution showing that the customer's portion of the funds have been removed from the account, and that the customer is no longer listed as an owner or signer.

When the customer is rebutting account ownership, the customer and each other account owner must provide a written statement, under penalty of perjury, of all of the following:

- Who owns the funds in the account;
- Why there is a joint account;
- Who has made deposits to and withdrawals from the account; and
- How withdrawals have been spent.

NOTE If the only other account holder is incompetent or a minor, the customer must provide a statement that meets these requirements from a person who was aware of the circumstances surrounding establishment of the account.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(3) AAC R9-28-401 and 409

D Transfers of Real Property

Policy

1) Transfer of Home Property

Transfer of home property is not treated as a transfer of an excluded resource under MA905. Transferring ownership without full compensation may result in a penalty period.

2) Property Transfer with Retention of a Life Estate Interest

When the customer or spouse transfers property to another individual but retains a life estate interest in the transferred asset, a transfer has occurred. The current market value of the life estate interest (See MA705T) is subtracted from the equity value of the property. The difference is the amount of uncompensated value.

NOTE The value of the customer's life estate interest may be excluded as home property if the property is the customer's principal residence.

Definitions

Term	Definition
Life Estate	A life estate is ownership by a right to the use of the property without title to the property (see MA705T).

Proof

When real property has been transferred, the person must provide proof of:

- The date of the transfer; and ownership before and after the transfer. Some examples of proof include the following:
  - Sales contracts;
  - Deeds;
  - Property titles.
- Documentation to prove the Current Market Value (CMV) of the property. Primary proof of a property's CMV is the assessed value from current tax bills or County Assessor records. If these assessments cannot be used or the customer disagrees with the assessment, current written estimates of the property's CMV must be obtained from two knowledgeable sources.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(A) AAC R9-28-401 and 409

E Transfer of an Income Stream

Policy

When a person gives up the right to a stream of income (for example, a pension), the amount of uncompensated value is the lifetime value of the income that would have been received.

The transfer date is the date that the income stream was assigned to someone else or otherwise given up.

Whether or not the assignment results in a transfer depends on whether the assignment is revocable or irrevocable.

A revocable assignment of income or resources is not a transfer. Instead, the assets are considered "constructively received".

- Constructively received resources (MA703C).
- Constructively received income (MA604B).

Irrevocable Assignment: "Irrevocably assigned" means a resource or income has been placed in another's name and only that person can take the action needed to make the resource or income available to the customer.

- If a customer irrevocably assigns a resource to another party, the assignment is a transfer. When a person irrevocably assigns the right to all future payments from a source, the total long-term value of the transferred income is added together to determine the amount of the transfer.
- When a person irrevocably assigns some income payments, but does not assign the right to all future payments from that source, the assigned payments are considered constructively received income and are counted as the customer's income.

Definitions

Term	Definition
Assignment	To designate or set a resource aside for a specific purpose. It may result in the customer no longer owning all or part of an asset. An assignment might be revocable or irrevocable.

Proof

When a countable stream of income has been transferred, documents need to be provided to prove:

- The date of the transfer;
- The person who owned the item both before and after the transfer;
- The type of assignment; revocable or irrevocable assignment.

Legal Authority

Program	Legal Authorities

ALTCS	42 USC 1396p(c)(1)(A) AAC R9-28-401 and 409

F Purchase of a Life Estate in Another Person's Home

Policy

The purchase of a life estate in another person's home is a transfer of assets for less than fair market value unless the purchaser resides in the home for 12 consecutive months after the date of the purchase.

NOTE The one year residency requirement does not replace other policy on how life estates are treated. The amount used to purchase the life estate will still need to be evaluated to determine if compensation is received for the purchase of the life estate.

For example, if the customer uses $100,000 to purchase a life estate in another customer's home that provides the person with a life estate value of $60,000, there is an uncompensated value of $40,000.

Definitions

Term	Definition
Life Estate	A life estate is ownership by a right to the use of the property without title to the property (see MA705T).

Proof

When a life estate has been purchased in another person's home, documents need to be provided to prove:

- The date of the purchase;
- The amount paid to purchase the life estate; and
- The equity value of the other person's home.

Proof may include, but is not limited to, the following:

- Deeds;
- Wills; and
- Other legal documents.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(J) AAC R9-28-401 and 409

G Purchase of an Irrevocable Annuity

Policy

In general, an irrevocable annuity bought in the look-back period, or a revocable annuity that becomes irrevocable in the look-back period may be a transfer of assets for less than full value.

Exception:

Full value is considered to be received when the annuity meets the requirements in the table below:

The annuity must…	AND meet all conditions below...
• Name AHCCCS as the primary beneficiary; or • If the owner has a spouse, disabled child or minor child, AHCCCS must be listed as beneficiary in the second position after the spouse, disabled child or minor child.	• Was created using funds in a ROTH IRA, 408 or other employer sponsored plan; OR • Was purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business; AND • Provides equal monthly payments with no balloon, deferred or increasing or decreasing monthly payments (small differences due to changes in interest rates are allowed); • The annuitant is the customer or the customer's spouse; • Is a "Period Certain" annuity that that will return the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table (from socialsecurity.gov); and • The number of months that annuity payments will be issued should be less than the number of months of the person's life expectancy (multiply figure from the Period Life Table (from socialsecurity.gov) by 12).

When the annuity does not meet all requirements above, the value of the annuity on the date it became irrevocable is a transfer with uncompensated value.

See Example Annuities Which are a Compensated Transfer

See Example An Annuity that is an Uncompensated Transfer

Definitions

Term	Definition
Annuitant	A person entitled to payments from an annuity
Annuity	A financial product that in return for premium payments issues periodic payments to the person over a period of time once it is annuitized.
Annuitized	An annuity account or fund that has become irrevocable and is issuing payments according to the terms of the annuity contract.
Beneficiary	A person entitled to any remaining pay-out of an annuity upon the death of the annuitant.
Irrevocable annuity	An annuity issuing payments in accordance with the annuity contract, and cannot be cashed in. Also called an “immediate” annuity.
Revocable	An annuity contract that can be surrendered and the funds in the account withdrawn. Also called a “deferred” annuity.

Proof

Proof of contract terms, including length of the contract, payment amounts, annuitant’s name, and beneficiary, may include one or more of the following documents:

• Copies of the annuity contract and account statements from the annuity or insurance company;
• A Request for Verification of Annuity (DE-235) form, completed by the annuity company or life insurance company;
• A copy of the annuity application the customer signed at the time the annuity was purchased; or

NOTE Generally the beneficiary is listed in the annuity application and not in the annuity contract itself.

• Other written statement completed by the annuity company or life insurance company, containing the terms of the contract.

Legal Authority

Program	**Legal Authorities**
ALTCS	42 USC 1396p(c)(1)(F) and (G) AAC R9-28-401 and 409

H Loans

Policy

When a person loans money or other resources it is a transfer of that resource. Promissory notes, loan agreements and property agreements must be reviewed to see if the person received full value for the resource, or if the transfer was uncompensated. The date of the transfer is the date the note, loan or agreement was created or when it became non-negotiable, whichever is later.

How loan agreements are treated for transfer policy may depend on the type of loan and whether the person is the lender or the borrower.

See the following policy for more details:

Customer is the lender:

Promissory notes, loan agreements and property agreements that cannot be sold have no value as a resource, and the amount loaned is an uncompensated transfer.

Loans agreements may be in writing or oral. However, since they cannot be sold, oral loan agreements are all uncompensated transfers until the debt is paid back in full.

Customer is the borrower:

Under Arizona law, oral loans are only legally valid for a one year period. Any payments the customer makes after the one-year period is considered a transfer.

See example Oral loan payments made more than a year after the agreement.

Definitions

Term	Definition
Negotiable	Means the promissory note, loan, or property agreement can be sold. Generally an agreement of this type can be sold when it meets all of the following: • It can be assigned or transferred to someone else; • The terms of the agreement can be enforced; and • It does not contain terms which make it unmarketable. The value is the amount of the outstanding principal balance.
Non-negotiable	Non-negotiable means that there is a legal barrier to the transfer of ownership. If the note, loan or property agreement is not negotiable, it has no value as a resource.
Marketable	Means something that a reasonable purchaser would accept.
Outstanding principal balance	Means the original amount of the note, loan or property agreement, minus any payments made on the principal.

For more information about loans see MA705R.

Proof

Negotiable/Not negotiable

Proof may include, but it not limited to, any of the following:

• Court order saying that the resource may or may not be sold; or
• Language in the note, loan or agreement document that it cannot be sold, assigned or transferred to someone else.
• Written statement from a knowledgeable source that the note, loan or agreement can or cannot be sold.

NOTE No proof is needed that an oral loan is not negotiable.

Terms of an Oral Loan Agreement

For proof of the terms of an oral loan agreement, the person who made the loan must complete a Request for Verification of Money Loaned (DE-231) form. The person who received the loan must complete a Request for Verification of Money Borrowed (DE-230) form.

Unpaid Principal Balance of the Loan

Proof of the unpaid principal balance of a promissory note, loan or property agreement includes proof of the original principal balance **and** proof of any payments made on the principal.

Proof of the original principal balance includes but is not limited to the following types of documents:

• Bank notes;
• Bills of sale;
• Mortgage contracts;
• Sales agreements;
• Bank statements; or
• Letter from a bank officer.

Proof of payments includes but is not limited to the following types of documents:

• Payment books;
• Bank or other financial account statements; and
• Letter from bank officers that provide the unpaid principal balance or the original balance and all principal payments made.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(I) AAC R9-28-401 and 409

I Assets Placed in a Trust

Policy

When a counted resource or home property is placed in a trust, a transfer for less than fair market value is usually considered to have taken place. A person placing a resource in a trust generally gives up ownership of the resource to the trust. If the person does not receive fair compensation in return, a transfer penalty may be imposed.

How a transfer to a trust is treated depends on the type of trust. This section provides policy for reviewing trusts to determine whether a transfer with uncompensated value has happened and any transfer penalty period. This section discusses:

- Transfers to Special Treatment Trusts;
- Transfers to Revocable Trusts;
- Transfers to Irrevocable Trusts; and
- Irrevocable Burial Trusts.

1) Transfers to Special Treatment Trusts (STT)

The transfer of income or resources to a STT may affect the customer's ALTCS eligibility. The affect of a transfer depends on the type of Special Treatment Trust:

If the trust is a…	Then…
Trust for Disabled Individual Under Age 65	Transfer policy does not apply to income or resources transferred to the trust while the customer is under age 65. NOTE Any income or resources added to the trust after the customer turns 65 years of age must be reviewed as a transfer.
Income-only Trust	Transfer policy applies to income transferred to an Income-only trust. The amount of uncompensated value is the difference between the amount of monthly income put into the trust and the monthly amount paid out on behalf of the customer. See Example Income-only Trust.
Pooled Trust	Transfer policy does not apply to income or resources transferred to the trust while the customer is under age 65. NOTE Any income or resources added to the trust after the customer turns 65 years of age must be reviewed as a transfer.

2) Transfers to Revocable Trusts

A transfer of resources into a revocable trust is not considered an uncompensated transfer because the resources in the trust are still available to the customer.

See Examples Transfers to Revocable Trusts.

3) Transfers to Irrevocable Trusts

When a customer creates an irrevocable trust where any part of the trust assets cannot be paid to or on behalf of the customer, that part is reviewed as a transfer for less than fair market value.

The date of transfer is the latest of the following:

- The date the trust was created;
- The date when payments to could no longer be made from the trust; or
- The date the resource was assigned to the trust.

See Example Irrevocable Trust Transfers.

4) Irrevocable Burial Trust

Since the funds placed into a burial trust are not tied to specific good and services, they must be evaluated as a transfer. Up to $9,000 in a burial trust may be considered a compensated transfer when the burial trust meets both of the following conditions:

- The individual does not already have an irrevocable burial plan; and
- The burial trust contract specifies that any amount not used for burial will revert to the person's estate, where it would be subject of the Estate Recovery program.

Any amount placed into a burial trust that does not meet both conditions shall be evaluated as a transfer with uncompensated value.

If the burial trust that meets both conditions but the amount in the trust is more than $9,000, the amount over $9,000 is a transfer with uncompensated value.

Definition

Term	Definition
Revocable	The person who establishes the trust reserves the right to revoke it. A revocable trust can be nullified by: • Withdrawal; • Recall; • A restatement of the trust; • Reversal or revocation; or • The transfer of all trust assets out of the trust. A trust, which provides that the trust can be modified or terminated by a court, is considered to be a revocable trust.
Irrevocable	The trust may not be revoked after its creation, by the grantor or a representative. NOTE A trust instrument, which states that the trust is irrevocable but which will terminate by some action taken by the grantor, is considered a revocable trust.

Proof

See MA802 for the proof needed for revocable and irrevocable trusts. See MA803 for the proof needed for Special Treatment Trusts (STT).

When assets have been placed in a trust, documents need to be provided to prove:

- The date of the transfer. Proof includes, but is not limited to, the following:
  - Copy of the trust document;
  - Court documents;
  - Deeds; and
  - Proof of disbursements.
- The equity value of the transferred item or the actual future cash value of income at the time of the transfer.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c) and (d) AAC R9-28-401 and 409

903 Transfers That Do Not Affect Eligibility

Revised 08/07/2020

In general, a transfer of assets may not affect the customer's eligibility for long term care services under the ALTCS program when the transfer:

- Was made before the lookback date (MA903A)
- Was made by certain other people (MA903B)
- Does not include the customer's resources (MA903C)
- Was adding another person's name to a financial account (MA903D)
- Was made to pay the customer's legal debt (MA903E)
- Was a transfer of an excluded resource, with some exceptions. (MA903F)
- Was a transfer of a home property to specific people (MA903G)
- Was a transfer of resources for the benefit of specific individuals (MA903H)

A Transfer Before the Look-Back Period

Revised 08/07/2020

Policy

A transfer that happened before the look-back period (MA901) does not affect the customer's eligibility for long term care services.

Exception:

The transfer may have been established within the look-back period of an earlier application. Earlier applications are reviewed to see if there is a penalty period that has not yet ended. If there is a penalty period from an earlier application that has not yet ended, the customer must serve the rest of the penalty period.

Definitions

Term	Definition
Look-Back Period	The 60 month period before the month the customer applies for ALTCS

Proof

The customer's statement that the transfer occurred on a date before the look-back period is accepted unless there is information that makes it questionable.

When needed, proof that a transfer occurred before the look-back period includes:

- Sales contracts;
- Receipts;
- Bank statements;
- Deeds;
- Records from the County Assessor or County Recorder showing the date the transfer occurred; and
- Other documents showing the date of the transfer.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

B Transfers Made by Certain Other People

Revised 03/22/2022

Policy

A transfer does not affect the customer's eligibility for long term care services when made by someone other than:

- The customer;
- The customer's spouse;
- Any other person, with the legal authority to act on behalf of the customer or spouse; or
- A person or agency, including a court or administrative body, that was acting at the request of the customer or spouse.

NOTE A transfer ordered by a court as the result of a judgment against the customer does not affect eligibility for long term care services as the court's authority was not given by the customer and the court is not acting at the customer's request.

Definitions

Term	Definition
Administrative body	A government unit or agency that exercises a legal or regulatory authority.

Proof

When a transfer is made by someone that did not have authority to act for and did not act at the request of the customer or spouse, proof of the following is needed.

Proof of who made the transfer

Proof includes the following documents when signed or authorized by the person who made the transfer:

- Court documents;
- Deeds; and
- Canceled checks and bank transactions.

Proof of the person's relationship to the customer

Relationships include family relationships, Powers of Attorney (POA), guardians or conservators. Proof of relationships includes:

- POA documents;
- Court orders awarding guardianship or conservatorship.

Proof that the transfers were made by someone without legal authority

Proof that a person made the transfer without the legal authority to do so includes:

- Police reports about the transfer;
- Adult Protective Services (APS) reports of financial exploitation; or
- Other documents that show a person's authority to act on behalf of the customer. For example, a limited Medical Power of Attorney that does not give the representative the right to make financial decisions.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

C Transfers That Do Not Include the Customer's Resources

Revised 08/07/2020

Policy

Transfers that did not include resources of the customer or the customer's spouse do not affect the customer's eligibility for long term care services. See Transfers that Do Not Affect Eligibility Examples.

Proof

When a transfer was made that did not include the customer's resources, proof of who owned the resource at the time of the transfer is needed. Proof includes:

- Deeds;
- Purchase agreements;
- County Assessor or County Recorder records; and
- Bank statements.

NOTE A customer may have held legal title to a resource without having equity interest in the resource (MA704C.1). In this case, bank statements and canceled checks showing that someone else's funds were used to purchase the resource may be used as proof that the customer did not have any equity interest.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

D Adding a Person's Name to a Financial Account

Revised 08/07/2020

Policy

Adding another person's name to a customer's financial account as a joint owner is usually not considered a transfer. The funds in the financial account still belong to and can be accessed by the customer (MA705I).

Exception:

If adding the other person's name to the account changes the customer's access to or right to use the money in the account, it is reviewed as a transfer (see MA902B and MA902C).

NOTE The customer is assumed to retain full access to the assets in the account unless there is evidence to the contrary.

Proof

When information or evidence indicates the customer's access to the account has been changed, proof of the customer's access to the account is needed. Examples of proof include bank records or court documents that show any changes to the customer's ability to access funds.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

E Purchases and Payment of Debts

Revised 08/07/2020

Policy

A transfer does not affect the customer's eligibility for long term care services when the resource is used:

- To make a purchase at current market value (CMV) for the customer; or
- To pay the customer's valid debt.

NOTE Repayment of the customer's debt from a Special Treatment Trust is not allowed (MA803E.1).

Proof

Proof that funds were spent for the benefit of the customer includes:

- Receipts for purchases; or
- Bill payment records.

Proof of CMV is only needed when the purchased goods or services appear to be worth less than the customer paid. For proof of a resource's CMV, see the specific policy for that type of resource in MA705.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

F Transfers of Excluded Resources or Income

Revised 08/07/2020

Policy

In general, the transfer of an excluded resource or income does not affect the customer's eligibility for long term care services. However, there are exceptions to the general rule. Transferring the following excluded resources may affect the customer's eligibility, unless the transfer meets the requirements in MA903G or MA903H:

- Home property (MA705K);
- Proceeds from the sale of home property (MA705K); or
- Refunds from HCBS or nursing facilities for services the customer self-paid before being approved for ALTCS (MA705J).

Proof

Proof that a resource is excluded depends on the resource type. See MA705 for examples of proof by resource type.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

G Transfer of Home Property to Specific People

Revised 08/07/2020

Policy

The transfer of home property to any of the people listed below does not affect eligibility for long term care services:

- The customer's spouse;
- The customer's child or stepchild, when the child is under 21 years of age;
- The customer's child or stepchild, of any age, who lived in the customer's home for at least two years immediately before the date the customer became institutionalized, AND provided care to the customer that allowed the customer to live at home rather than in a medical institution;
- The customer's sibling who has an equity interest (MA704C) in the home and who lived in the home with the customer for at least one year immediately before the date the customer became institutionalized; or
- The customer's child or stepchild, of any age, who has been determined to have a qualifying disability, including blindness (see MA504 and MA509).

NOTE For the transfer policy in this section, a qualifying disability does NOT include a determination of severe impairment.

Definitions

Term	Definition
Actuarially sound	For transfer policy, means that the full value of the transfer should be received by the person within his or her expected life span
Institutionalized	For purposes of the transfer of a home, a customer is considered institutionalized when the customer: • Is living in a nursing facility; • Is in a medical treatment facility and Medicaid payments are made based on a level of care provided in a nursing facility; or • Is eligible for home or community based services through the Arizona Long Term Care System (ALTCS) program.
Severe impairment	A medical condition that significantly limits a person's physical or mental abilities to do basic work activities. (see MA509)

Proof

Use the following table to determine what kind of proof is needed to prove that the home property was transferred to a specific individual and will not affect eligibility:

When the home property was transferred to…	Then proof is needed of….
The customer's spouse	The customer's legal marriage to the spouse. See MA520 for a more detailed list of proof.

The customer's child or step child with a qualifying disability OR To a trust for the sole benefit of the customer's child with a qualifying disability	The child's relationship to the customer. Proof includes birth certificates, court documents and church records. When the child is a step-child, proof is needed of: • The child's relationship to the customer's spouse; AND • The customer's marriage to the child's parent NOTE The death of the child's parent does not terminate the step-parent's relationship
	The child's qualifying disability. Proof includes: • Electronic confirmation from Social Security; • Award letters showing the child receives Social Security Disability benefits or SSI-Cash based on disability; • PAS approval; or • SMI determination
	• In addition to the items above, when the transfer was made to a trust, a copy of the trust document, showing that:The trust is for the sole benefit of the customer's child; • The trust clearly sets out the conditions of the transfer and who can benefit from it; AND NOTE Unless it is a Special Treatment Trust, the trust includes a spending plan for the benefit of the child that is actuarially sound.
A son or daughter who lived with and provided care to the customer that allowed the customer to live at home rather than in a medical institution	The person's relationship to the customer. Proof includes birth certificates, court documents and church records.
	The period of time the person lived with the customer, before the customer was institutionalized.
	The type and amount of care provided by the person that allowed the customer to live at home instead of in an institution. NOTE Proof must include the customer's medical condition and need for care during the period of time that the care was provided.
A sibling who lived in the home and has equity interest in the home	The sibling's relationship to the customer. Proof includes birth certificates, court documents and church records.
	The period of time the sibling lived with the customer, before the customer was institutionalized

	When and how the sibling acquired equity interest in the property. Proof of equity interest in the property includes any the following: • Receipts • Cancelled checks; and • Other documents showing the siblings investment in the property.

Legal Authority

Programs	Legal Authority
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

H Transfer of Resources to or for the Benefit of Specific Individuals

Revised 08/07/2020

Policy

A transfer of income or a countable resource other than home property does not affect the customer's eligibility for long term care services when the transfer is:

- To the customer's spouse, or to another person for the sole benefit of the customer's spouse;
- To the customer's child or stepchild, of any age, who has been determined to have a qualifying disability, including blindness (see MA504 and MA509);
- To a trust established solely for the benefit of the customer's child or stepchild, regardless of age, who has been determined to have a qualifying disability, including blindness (see MA504 and MA509); or
- To a trust established solely for the benefit of a person with a qualifying disability (MA509), who was under 65 years of age at the time of the trust's creation

NOTE For the transfer policy in this section, a qualifying disability does NOT include a determination of severe impairment.

Definitions

Term	Definition
Determination of severe impairment	A medical condition that significantly limits a person's physical or mental abilities to do basic work activities. (see MA509)

Proof

Use the table below to determine what proof is needed:

If the resource was transferred to…	Then proof is needed for…
Another person for the sole benefit of the customer's spouse	The customer's legal marriage to the spouse. See MA520 for proof needed.

	The transfer was for the sole benefit of the spouse. This proof must be in the form of a written document that legally binds the parties to a specific course of action, like trust documents and quit-claim deeds. The document must meet both of the following: • The document must clearly set out the conditions of the transfer and who can benefit from it; AND • Unless the trust is a Special Treatment Trust, the document must include a spending plan for the benefit of the spouse. The spending plan must provide that the full value of the transfer will be received by the spouse within his or her expected life span. NOTE Without such a document, a transfer cannot be considered as made for the sole benefit of the spouse.
To the customer's child or step child with a qualifying disability OR To a trust for the sole benefit of the customer's child or step child with a qualifying disability	The child's relationship to the customer. Proof includes birth certificates, court documents and church records. When the child is a step-child proof is needed of: • The child's relationship to the customer's spouse; AND • The customer's marriage to the child's parent NOTE The death of the child's parent does not terminate the step-parent's relationship
	The child's qualifying disability. Proof includes: • Electronic confirmation from Social Security; • Award letters showing the child receives Social Security Disability benefits or SSI-Cash based on disability; • PAS approval; or • SMI determination
	In addition to the items above, if the transfer was made to a trust, a copy of the trust document, showing that: • The trust is for the sole benefit of the customer's child; • The trust clearly sets out the conditions of the transfer and who can benefit from it; and NOTE Unless it is a Special Treatment Trust, the trust includes a spending plan for the benefit of the child that is actuarially sound.
A Special Treatment Trust	The person's qualifying disability. Proof includes: • Electronic confirmation from Social Security; • Award letters showing the child receives Social Security Disability benefits or SSI-Cash based on disability; • PAS approval; or • SMI determination

	The date of birth of the person. Proof includes: • Electronic confirmation from Social Security; • Birth records,or • Driver's license or other government-issued ID that lists a date of birth.
	A copy of the trust document that meets the Special Treatment Trust requirements (see MA803 – Special Treatment Trusts).

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(2)(A), (B) and (C) 42 USC 1396p(c)(3) AAC R9-28-401 and 409

904 Compensation Received for Transfers

Revised 08/28/2020

Policy

For transfers that are not exempt under MA903, the value of the compensation received determines whether the transfer affects long term care services. When the compensation received is equal to or more than the resource value, the transfer does not affect long term care services.

However, if less than full value is received for the transferred resource, the difference is the uncompensated value and may result in a transfer penalty period. During a penalty period, the customer cannot get long-term care services.

Compensation may be received in different ways. Each may have different rules and proof needed to show the amount of compensation received. The compensation may be received:

- In cash;
- As real or personal property;
- As the assumption of a legal debt;
- As personal care services; or
- As items or services before the date of the transfer.

The following sections give more details on the ways that compensation is received and counted, and proof needed.

1) Compensation in Cash

Compensation in cash is the total amount paid to the customer in exchange for a resource. The value of the cash compensation is the gross amount paid to the customer. The value is not reduced by valid expenses attributed to the sale (for example, closing costs or commissions for real estate sales).

2) Real or Personal Property as Compensation

When the compensation is real or personal property, the value of compensation is the equity value of the property in the month the customer received it or when a contract for sale was signed and notarized, if earlier.

3) Compensation in the Form of Assuming a Legal Debt

When a person pays or takes over a legal debt owed by the customer, the value of the compensation is the outstanding principal amount at the time it was taken over. Interest payments are not included.

4) Compensation in the Form of Personal Care Services

The value of personal care services provided to the customer can be considered as compensation only when:

- There is a valid personal care contract. The contract may be written or oral; and
- The contract is executed before the services are provided. A contract is not valid when services were provided before the agreement was made.

If the contract is not valid, the personal care services cannot be allowed as compensation. See definition for valid contract below.

5) Compensation Received Before the Transfer

Items or services received before the transfer may be considered as compensation only when Items or services were provided according to the terms of a valid contract.

A contract may be written or oral and must be in place before the items or services are provided. A contract is not valid when the items or services were provided before the agreement was made.

If the contract is not valid, the items or services received before the transfer cannot be allowed as compensation.

Definitions

Term	Definition
Assumption of a legal debt	The act of taking over payments for and being legally assigned for someone else's legal debt.
Compensation	Something given or received in exchange for services, property, debt, or loss.
Equity Value	Means the current market value of a resource less any outstanding loans, mortgages, liens, or legal debts.
Oral Contract	A legally binding agreement made verbally. Oral contracts are only legally binding for one year in Arizona. NOTE To be considered valid, full payment must be received within one year of the date of the oral contract.
Personal Care Services	Also called Attendant Care services. A list of these services is available in section 1240 of the AHCCCS Medical Policy Manual;

Valid Contract	To be considered valid, a contract must meet all of the following: • Specify the items or type of services to be provided, how often they will be provided, and the amount of time to be spent providing each service; • Was executed by the customer or the customer's legal representative; NOTE A representative cannot sign the agreement and also be the one paid for providing services, unless the document that provides the representative's legal authority to act for the customer specifically states that the representative can self-contract to provide services; • Written contracts must be signed and dated by the person providing the items or services, and the customer or the customer's legal representative; • Payments are or were made according to the terms of the contract; Personal care contracts must also meet both of the following: • Is not an agreement for a spouse to provide services to the other spouse, or for a parent to provide services for a minor child; and • Provide for payment at least monthly while services are being provided, unless the amount or form of payment is not available at the time services are provided — for example, if the payment for the contract is a house.

Proof

To determine whether full compensation was received for a transfer proof is needed of the following:

• The date of the transfer;
• The value of the resource on the date it was transferred; and
• Proof of the value of the compensation received.

1) Proof of the transfer date

Proof of the date a transfer was made includes:

• Sales receipts;
• Property deeds;
• Loan agreements;
• Financial account statements showing the transfer;
• Canceled checks;
• Trust documents; and
• Other documents and records showing the date of the change in ownership.

NOTE For real property, the date of transfer is the date the document transferring ownership is signed and notarized, not the date it is recorded.

2) Proof of the resource value on the date transferred

The proof needed to determine the equity value of the resource on the date of transfer depends on the type of resource. See MA705 for examples of proof by resource type.

3) Proof of the value of compensation received

The proof needed to determine the value of compensation received depends on the type of compensation. The following table gives examples of proof by type of compensation:

If the compensation is…	Then proof is needed of…
Cash	The amount received. Documents that can be used for proof include: • Financial account statements showing the deposited amount; • Canceled checks made out to the customer or the customer's spouse; and • Other documents that show the customer received the cash compensation.
Resources other than cash	Who previously owned the resource and that ownership was transferred to the customer. Proof includes: • Sales receipts; • Property deeds; • Other documents and records showing the previous owner and the change in ownership.
	The equity value of the resource when it was received by the customer. See MA705 for proof by resource type.
Assumption of legal debt	The debt being legally assigned to the other person. Proof includes: • Legal documents showing the transfer of the debt and the amount of the outstanding principal still owed at the time of the transfer; • Collateral contact to the lender that confirms the debt has been legally assumed by the other person, and the amount of the outstanding principal at the time the debt was assumed.
Personal care services	A valid personal care contract. Proof is needed that all requirements for a valid contract in policy section 4 above are met. Some of the items that may be needed include: • For written contracts, a copy of the contract; • For oral contracts, signed statements of the terms and date of the oral contract are needed from both parties; • Documents or other evidence that the terms of the contract were or are being followed; • Certification or licenses if compensation is claimed for care that requires a higher level of skill; • Supporting legal documents; • Statements from witnesses to the agreement; and • Dated correspondence about the agreement.

Compensation received before the transfer	A valid contract. Proof is needed that all requirements for a valid contract in policy section 5 above are met. Some of the items that may be needed include: • For written contracts, a copy of the contract; • For oral contracts, signed statements of the terms and date of the oral contract are needed from both parties; • Documents or other evidence that the terms of the contract were or are being followed; • Supporting legal documents; • Statements from witnesses to the agreement; and • Dated correspondence about the agreement.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c) AAC R9-28-401 and 409

905 Transfer Penalty Period

Revised 12/19/2023

Policy

For transfers that are not exempt under MA903 and the compensation received is less than the equity value of the transferred resource, the difference is the "uncompensated value". When a transfer results in uncompensated value, a transfer penalty period is calculated. During a transfer penalty period, the customer cannot get long-term care services.

NOTE There is no limit on the length of a transfer penalty period.

See Example - Length of the Transfer Penalty Period.

1) Transfer Penalty Calculation

The penalty period is calculated by dividing the uncompensated value by the Private Pay Rate (PPR) for the geographic area in which the customer lived as of the month the customer was first approved for ALTCS. Because the PPR varies by year and geographic area, the penalty period assessed for the same amount may vary by customer.

When the division does not result in an even number, the fraction of a month is not dropped. The fraction results in a partial penalty month. However, when calculating the partial penalty month, any fraction of a day is dropped.

The Transfer Penalty Period calculation steps are shown in the following table:

Step	Action
1	Divide the uncompensated value of the transfer by the customer's PPR.
2	Multiply any fraction from Step 1 by 30. NOTE For this calculation, 30 is used as the multiplier no matter how many days there are in the month.
3	When the result from Step 2 ends in a fraction, drop the fraction to get the number of whole days in the partial penalty month.

NOTE When the customer has a partial penalty month, the share of cost for that month prorated based on the number of days in that month the customer is eligible for full ALTCS benefits.

See Examples – Transfer Penalty Period Calculations

2) Transfer Penalty Period Begin Date

As a general rule, a transfer penalty period begins the month the uncompensated transfer occurs, or the first month the customer is approved for ALTCS, whichever is later.

Exceptions:

• When a transfer was made before the application is approved, the penalty period begins the first month the customer

qualifies for full ALTCS services.

- When the customer already has a transfer penalty period that has not ended, the new penalty period does not begin until the current penalty period ends.

NOTE Different transfer penalty periods are not applied to the same months and do not overlap.

See Examples - Transfer Penalty Period Begin Date.

3) Multiple Transfers Made in Different Months

All uncompensated transfers made during a month are added up to determine if they total more than $500. If the total uncompensated value of transfers in a month is not more than $500, they are viewed as not made to qualify for ALTCS, and do not result in a penalty period (MA906). When the uncompensated value is more than $500 in a month, a penalty period must be determined.

The following table describes how to determine penalty periods when there are multiple months with total uncompensated transfers of more than $500:

If the Transfers are made...	**Then...**
Before ALTCS is approved	All transfers for the look-back period are added together, and one penalty period is assigned. See Example Multiple Transfers Made Before ALTCS Approval.
In consecutive months after approval	The transfers are added together, and one penalty period assigned. See Example Multiple Transfers Made in Consecutive Months After ALTCS Approval.
Are made or discovered after approval, but were not made in consecutive months	The earliest month with transfers is determined. The penalty period for the transfers made in that month and any consecutive months is calculated. • If the resulting penalty period extends to or past the next transfer in a non-consecutive month, the later transfer is added to the earlier transfers and one penalty period is calculated. The begin date is the month of the earliest transfer. • If the resulting penalty period ends before the next transfer in a non-consecutive month, the penalty periods are calculated separately. The begin date of the second penalty period is the non-consecutive month in which the later transfer was made. See Example Multiple Transfers Made in Non-Consecutive Months After ALTCS Approval.

4) Division of the Penalty Period Between Spouses

With one exception, when both spouses qualify for ALTCS the penalty period is equally divided between the two spouses as follows:

If...	Then...
Both spouses currently qualify for ALTCS	The penalty period is divided and applied equally between the spouses.
The customer is in a transfer penalty period when the spouse applies and qualifies for ALTCS	The remaining penalty period is divided and applied equally between the spouses.
The transfer penalty period was divided between the spouses, but one spouse dies or becomes ineligible for ALTCS before the end of the penalty period.	The ineligible spouse's remaining penalty period is applied to the spouse who remains on ALTCS; extending that spouse's penalty period.

See Example Dividing the Penalty Period Between Spouses

Exception:

Transfers by the community spouse after ALTCS approval. After the initial rules period, the transfer of resources owned solely by the community spouse does not affect the customer's eligibility (see MA707.7).

5) Duration of the Penalty Period

Once the length of a transfer penalty period is established, it does not change unless the full amount of the transferred income or resources are returned to the customer. The penalty period continues to run even when the customer loses ALTCS eligibility during the penalty period.

See Changes in the Penalty Period Examples.

6) Private Pay Rates

The Private Pay Rates vary according to the county in which the customer resides. Private Pay Rates are updated once per year in October but may be updated more frequently.

Customer's County of Residence	10/01/2022 to 09/30/2023	10/01/2023 to 09/30/2024	01/01/2024 to 09/30/2024
Maricopa, Pima, Pinal	$8,912.70	$7,826.46	$7,867.16
All other counties	$8,138.28	$7,281.17	$7,319.03

See Prior Private Pay Rates for rates from 10/1/1988 to present.

Definitions

Term	Definition

Customer's Private Pay Rate	The Private Pay Rate for the geographic area where the customer lived the first time he or she was approved for ALTCS.
Transfer Penalty Period	A period of time that the customer cannot get long term care services.

Proof

When a countable income or resource has been transferred, documents need to be provided to prove:

- The date of the transfer. For transfers of real property, the date of transfer is the date the transfer document is signed and notarized, not the date the document is recorded;
- The person who owned the item both before and after the transfer;
- The Current Market Value (CMV) of the transferred item or the actual future cash value of income at the time of the transfer; and
- Any and all legal encumbrances such as debts and liens against the transferred item at the time of the transfer.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1) and (2)
FTW-ALTCS	AAC R9-28-401 and 409

906 Rebutting the Transfer Penalty Period

Revised 07/10/2020

Policy

A transfer penalty period may be ended or waived if the customer successfully demonstrates one of the following:

- All of the transferred income or resources have been returned to the customer;
- Full compensation was received for the transferred resource or income;
- The customer intended to sell or trade the resource or income for its current market value (CMV), or for other valuable consideration that would equal the CMV; or
- The income or resources were transferred exclusively for a purpose other than to qualify for ALTCS benefits.

1) Return of Transferred Income or Resource

When convincing proof is received that all of the transferred income or resource has been returned to the customer, the following policies are applied:

- The penalty period is ended the month in which all of the transferred income or resources were returned.
- The returned income or resource is counted as of the month of return.

2) Receipt of Compensation

The value of compensation received by the customer is determined according to the kind of compensation using the policy in MA904.

When convincing proof is received that the customer received full compensation, the following policy is applied:

- The penalty period is ended the month in which full compensation was received.
- The returned income or resource is counted as of the month it was received.

3) Intent to Sell or Trade for Current Market Value

The customer may have intended to get CMV for the income or resource, but was unable to, due to reasons outside of the customer's control. When convincing proof is received that the customer intended to sell or trade the income or resource for CMV, the penalty period is waived.

4) Transfer Not Made to Qualify for ALTCS

Transfers are assumed to be made to qualify for ALTCS. To meet this condition, all of the following must be met:

- The customer must have a specific reason for the transfer that is completely unrelated to qualifying for ALTCS;
- None of the factors in the decision to transfer the item may be related to qualifying for ALTCS; and
- The customer must show that a need for ALTCS services could not have been anticipated at the time the transfer was made.

When convincing proof is received that the transfer was not made to qualify for ALTCS, the penalty period is waived.

The Public Information Brochure on Transfers (DE-818) provides information about transfers and rebuttals.

Definition

Term	Definition
Convincing Evidence	Supporting proof required to establish the customer's claim to the satisfaction of the state.
Full compensation	Compensation that is equal to or more than the market value of the item at the time it was transferred.
Rebuttal	A process to dispute the transfer penalty period.

Proof

When the customer wants to rebut the proposed transfer penalty period, the customer must provide proof that one of the rebuttal conditions was met. The burden of proof that the penalty period should not be applied rests with the customer.

The specific proof needed for each rebuttal reason is described below.

1) Return of Transferred Item

To rebut the penalty period based on the return of the transferred income or resource, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- A list of the income or resources returned; and
- The date that each item was returned to the customer.

NOTE The penalty period will not be reduced or ended when only a part of the transferred items are returned.

Supporting proof

Proof that the income or resources were returned will vary depending on the type of item, but examples include:

- Property deed signed and notarized after the initial transfer showing the customer as owner;
- Bank statement or deposit record showing return of cash to the customer's account; or
- Title document issued after the initial transfer showing the customer as owner.

2) Full Compensation Received

To rebut the penalty period based on full compensation being received, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- The type of compensation received;
- The value of the compensation received; and
- The date that compensation was received.

Supporting proof

Proof that the customer has received full compensation for the transferred item will vary depending on the type of item. Examples include:

- When the compensation was in the form of real property, a deed showing the customer as owner, dated after the initial transfer;
- A bank statement or financial record showing cash compensation deposited to the customer's account;
- Other title documents or legal ownership records dated after the initial transfer showing the customer as the new owner of the item received as compensation; and
- When compensation was received in the form of bills or expenses paid on the customer's behalf, the person making the payments must provide proof that the expenses were paid from his or her own funds.

3) Intent to Dispose of Asset for Current Market Value

To rebut the penalty period based on intent to get CMV for the asset, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- Purpose for transferring the income or resource;
- Attempts made to dispose of resource or income at CMV;
- Reasons for accepting less than the CMV for the resource or income;
- Why the customer believes that adequate compensation was received;
- Customer's relationship, if any, to the person to whom the income or resource was transferred; and
- Customer's means of or plans for self-support after the transfer.

Supporting proof

Proof that the customer intended to get CMV for the transferred item will vary depending on the type of item. Examples include:

- Written offers for purchase;
- Declarations from the realtor contracted to sell the property; or
- Estimates of the value of the resource from professional, knowledgeable sources.

4) Transfer Not Made to Qualify for ALTCS

To rebut the penalty period based on the transfer not made to qualify for ALTCS, the customer must provide a written statement and proof that supports the written statement.

Written Statement

The statement must include all of the following information:

- The specific reason for transferring the asset; and
- Why a need for ALTCS services could not have been anticipated at the time the transfer was made.

NOTE A verbal statement cannot be accepted. The customer must provide a signed, written statement.

Supporting proof

Proof will vary depending on the situation. Examples include:

- Court documents showing the transfer was ordered by a court and none of the following people asked or petitioned the court to order the transfer:
  - The customer;
  - The customer's spouse;
  - A person with legal authority to act on behalf of the customer or the customer's spouse; or
  - A person acting at the direction or request of the customer or the customer's spouse.
- Medical records showing that the customer's current need for ALTCS services is solely due to the diagnosis of a disabling condition or a trauma, like an accident or injury that happened after the transfer;
- Legal and other written documents showing that after the transfer there was an unexpected loss of other income or resources

that would have prevented the customer from qualifying for ALTCS;
- At the time of the transfer the customer could not have anticipated qualifying for ALTCS due to other circumstances that would have prevented ALTCS eligibility; or
- Proof that the customer's total counted income and resources would have been below the ALTCS limits standard at all times from the month of transfer through the present month, even if the transferred income or resource had been kept. This reason does not apply to the transfer of excluded resources or home property.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(1)(A) 42 USC 1396p(c)(2) AAC R9-28-401 and 409

907 Undue Hardship Claims for Transfer Penalties

Revised 07/10/2020

Policy

The transfer penalty period may be waived if denial of eligibility for long term care services creates an undue hardship. To request undue hardship, the customer must qualify for ALTCS except for transfer policy.

Undue hardship decisions are made on a case-by-case basis. The application must be approved for the limited service package due to a transfer penalty before undue hardship is requested. A customer must meet the requirements in section one or section two for undue hardship to be considered.

1) Undue hardship may be met

A request for undue hardship will be considered when the transfer penalty would deprive the customer of:

- Medical care to the point that the customer's life or health would be endangered; or
- Food, clothing, shelter or other necessities of life as shown by the fact that the customer's income is less than or equal to 100% of the Federal Poverty Level (FPL). See MA615.2 for the 100% FPL income standard.

2) Undue hardship is met

A request for undue hardship will be granted when a violation of legal authority has occurred. The customer or representative will need to provide proof of all of the following:

- The customer is incapacitated as established by the Court or by a physician;
- The person who had the legal authority to handle the customer's finances has violated the terms of that legal authority; and
- A person acting on the customer's behalf has exhausted all legal remedies to get the asset back, including filing a police report and seeking recovery through civil court.

3) Undue hardship is not met

The request for undue hardship will not be granted when:

- The customer was mentally competent and would have been aware of the consequences of the transfers at the time the transfers occurred; or
- The customer was mentally competent and gave another person the legal authority to make the transfers, and the person did not violate the limits of that authority in making the transfers..

Definitions

Term	Definition
Financial legal authority	For purposes of transfer policy, the legal right to sell, trade, use, or give away a person's income or resources. This authority can be in the form of: • Power of Attorney (POA); • Conservator; or • Legal Guardian.
Incapacitated	Mentally impaired and lacking sufficient understanding or capacity to make or communicate responsible decisions as determined by a court or physician.

Mentally competent	Having the mental capacity and understanding to responsibly participate in making one's own decisions to which they are accountable for.

Proof

Proof of undue hardship, the customer's mental competence, and of financial legal authority includes:

- Court documents, medical records, and written statements from a physician about the customer's mental competence or incapacity;
- Proof of medical and other expenses to support a claim that the customer would be deprived of medically necessary care or food and shelter without long-term care services;
- Medical records;
- Eviction notice from the customer's current facility; or
- Any other documents supporting the customer's claim.

Proof of exhausting all legal remedies to get an asset back includes:

- Court documents;
- Adult Protective Services (APS) reports;
- Police reports; or
- Claims filed with the Attorney General's office.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396p(c)(2)(D) AAC R9-28-409.H

1000 Introduction

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- What proof is needed;

1001 General Provisions

Revised 01/11/2023

Policy

To qualify for Arizona Long Term Care System (ALTCS) services a person must be medically eligible. This is determined using the pre-admission screening (PAS) assessment.

There are two PAS manuals used in determining medical eligibility. One manual EPD PAS is for applicants or members who are assessed using the elderly or physically disabled (EPD) PAS tool; the other manual DD PAS is for applicants or members who are assessed using one of the developmentally disabled (DD) PAS tools. The tools and related glossaries and definitions of abbreviations are available from the Administration upon request.

The following are examples of the PAS tools used:

- DD and EPD 0-5
- DD and EPD 6-11
- DD 12+
- EPD

Definitions

Term	Definition
Developmentally disabled	Determined by the Department of Economic Security/Division of Developmental Disabilities in accordance with ARS 36-551.
Medically eligible	Immediate risk of institutionalization. The status of an applicant or member under ARS § 36-2934(A)(5) and as specified in ARS § 36-2936 and in the Administration's Section 1115 Waiver with the Centers for Medicare and Medicaid Services (CMS).

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Applicant or member score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities

ALTCS	42 CFR 441.302 ARS 36-2934(A)(5) ARS 36-2936 AAC R9-22-101 AAC R9-28-302

1002 Preadmission Screening (PAS) Process

Revised 08/16/2022

Policy

The PAS Assessor shall use the PAS instrument as described below to determine whether the following customers are at immediate risk of institutionalization:

- The Assessor shall use the appropriate PAS instrument described in MA1003 to assess customers with a physical disability who are at least six years old. After assessing a child with a physical disability who is at least six years but less than 12 years, the Assessor shall refer the child for a physician consultant review as described in MA1006.
- The Assessor shall use the age-specific PAS instrument described in MA1005 to assess a customer who has a physical disability and less than six years old. After assessing the child, the Assessor shall refer the child for physician consultant review.
- The Assessor shall use the PAS instrument described in MA1005 to assess customers who are **not** living in a nursing facility (NF). After assessing a child less than six months of age with a developmental disability, the Assessor shall refer the child for physician consultant review.
- The Assessor shall use the PAS instrument described in MA1003 for customers with a developmental disability living in a Nursing Facility (NF).
- The Assessor shall use the PAS instrument described in MA1003 or MA1005, whichever is applicable, to assess a customer classified as ventilator dependent under Section 1902(e)(9) of the Social Security Act.

The PAS assessment is completed by a PAS Assessor who is a registered nurse or social worker:

PAS assessments are completed face-to-face, by telephone, or virtually with a customer, except when the customer is deceased. The Assessor makes reasonable efforts to obtain the customer's available medical records. The Assessor may also obtain information for the PAS assessment from interviews with the:

- Customer;
- Parent;
- Guardian;
- Caregiver; or
- Any person familiar with the customer's functional or medical condition.

Using the information described above, the Assessor completes the PAS assessment using his or her education, experience, professional judgment, and training.

After the PAS assessment is completed, the PAS score is calculated and compared to the established threshold score in MA1003 and MA1005. Except as determined by physician consultant review, the threshold score is the point at which a customer is considered to be at immediate risk of institutionalization.

Upon request from a person acting on behalf of the customer, the Administration shall conduct a PAS assessment to determine whether a deceased customer would have been eligible to receive ALTCS benefits during the time period covered by the application or in any prior quarter month.

A Private Request PAS assessment may be requested for a customer who is not applying for ALTCS to determine if the customer is at risk of institutionalization and requires care equal to that provided in a NF or Intermediate Care facility (ICF). The PAS is completed without charge. Private Request PAS assessments are processed through Eligibility Review (see MA1006). A face-to-face assessment must be conducted for a Private Request PAS.

An eligible PAS, including a Private Request PAS, may be used for up to 180 days when a customer is denied and later reapplies. An ineligible PAS is never used for a new application.

Definition

Term	Definition
Assessor	Social worker as defined in this section or a licensed registered nurse who: • Is employed by the Administration to conduct PAS assessments; • Completes a minimum of 30 hours of classroom training in both EPD and DD PAS for a total of 60 hours; and • Receives intensive oversight and monitoring by the Administration during the first 30 days of employment and ongoing oversight by the Administration during all periods of employment.
Social worker	An individual with two years of case management-related experience or a baccalaureate or master's degree in social work, rehabilitation, counseling, education, sociology, psychology, or other closely related field.

Proof

Proof of immediate risk of institutionalization demonstrated through:

• A PAS score equal to or higher than the applicable PAS threshold; or
• Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-2936 AAC R9-28-303

1003 Preadmission Screening Criteria for an Applicant or Member who is Elderly or Physically Disabled (EPD)

Revised 02/14/2020

Policy

The PAS instrument for an applicant or member who is EPD includes the following categories:

- Intake information category. The Assessor solicits intake information category information on an applicant's or member's demographic background. The components of the intake information category are not included in the calculated PAS score.
- Functional assessment category. The Assessor solicits functional assessment category information on an applicant's or member's:
  - Need for assistance with activities of daily living in the residential environment or other routine setting, including:
    - Bathing;
    - Dressing;
    - Grooming;
    - Eating;
    - Mobility; and
    - Transferring;
  - Communication and sensory skills, including hearing, expressive communication, and vision; and
  - Continence, including bowel and bladder functioning.
- Emotional and cognitive functioning category. The Assessor solicits emotional and cognitive functioning category information on an applicant's or member's:
  - Orientation to person, place, and time. In soliciting this information, the Assessor shall also take into account the caregiver's judgment; and
  - Behavior, including:
    - Wandering;
    - Self-injurious behavior;
    - Aggression;
    - Resistiveness; or
    - Disruptive behavior.
- Medical assessment category. The Assessor solicits medical assessment category information on a customer's:
  - Medical conditions that have an impact on the customer's functional ability in relation to activities of daily living, continence, and vision;
  - Medical condition that requires medical or nursing service and treatment;
  - Medication, treatment, and allergies;
  - Specific services and treatments that the customer is currently receiving; and
  - Physical measurements, hospitalization history, and ventilator dependency.

The Assessor shall use the PAS instrument to assess a customer who is EPD as specified in this Section. A copy of the PAS instrument is available from the Administration. The Administration uses the Assessor's PAS assessment to calculate three scores: a functional score, a medical score, and a total score.

- Functional score.
  - The Administration calculates the functional score from responses to scored items in the functional assessment and emotional and cognitive functioning categories. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
  - The functional items in the following categories are scored according to the matrix shown below:
    - Activities of daily living;
    - Continence;
    - Sensory;
    - Orientation; and
    - Behavior.
  - The sum of the weighted scores equals the functional score. The weighted score per item can range from 0 to 15. The maximum functional score attainable by a customer is 166.
- Medical score.

- In the medical assessment matrix, all items in the following categories are scored according to:
  - Medical conditions according to the matrix below, and
  - Medical or nursing services or treatments according to the matrix below.
- The Administration calculates the medical score based on the customer's:
  - Diagnosis of Alzheimer's, dementia, or organic brain syndrome (OBS);
  - Diagnosis of paralysis; and
  - Current use of oxygen.
- The maximum medical score attainable by an applicant or member is 31.5.

• Total score.
- The sum of a customer's functional and medical score equals the total score.
- The total score is compared to the established threshold score as calculated under this Section. For a customer who is EPD, the threshold score is 60.
- A customer is determined at immediate risk of institutionalization if the total score is equal to or greater than 60.

The following matrices represent the number of points available and the respective weight for each scored item.

• Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
• Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the customer:
- Does not have the scored medical condition;
- Does not need the scored medical or nursing services; or
- Does not receive the scored medical or nursing services.

• Functional Assessment Category/Item	**• Points Available per Item (P)**	**• Weight (W)**	**• Range of Possible Weighted Score per Item (P) x (W)**
ACTIVITIES OF DAILY LIVING SECTION			
• Mobility	• 0 – 3	• 5	• 0 – 15
• Transfer	• 0 – 3	• 5	• 0 – 15
• Bathing	• 0 – 3	• 5	• 0 – 15
• Dressing	• 0 – 3	• 5	• 0 – 15
• Grooming	• 0 – 3	• 5	• 0 – 15
• Eating	• 0 – 3	• 5	• 0 – 15
• Toileting	• 0 – 3	• 5	• 0 – 15
CONTINENCE SECTION			
• Bowel	• 0 – 3	• 1	• 0 – 3
• Bladder	• 0 – 3	• 1	• 0 – 3
SENSORY SECTION			

• Vision	• 0 – 3	• 2	• 0 - 6
• ORIENTATION SECTION			
• Place	• 0 – 4	• 0.5	• 0 – 2
• Time	• 0 – 4	• 0.5	• 0 – 2
EMOTIONAL OR COGNITIVE BEHAVIOR SECTION			
• Aggression - Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Aggression – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Self-Injurious – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Self-Injurious – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Wandering – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Wandering – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Resistiveness – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Resistiveness – Intervention	• 0 – 3	• 1.5	• 0 – 4.5
• Disruptive – Frequency	• 0 – 3	• 1.5	• 0 – 4.5
• Disruptive - Intervention	• 0 – 3	• 1.5	• 0 – 4.5

• Medical Assessment Category/Item	**• Points Available per Item (P)**	**• Weight (W)**	**• Range of Possible Weighted Score per Item (P) x (W)**
MEDICAL CONDITIONS SECTION			
• Paralysis	• 0 – 1	• 6.5	• 0 - 6.5
• Alzheimer's, OBS, or Dementia	• 0 – 1	• 20	• 0 – 20
SERVICES AND TREATMENTS SECTION			
• Oxygen	• 0 – 1	• 5	• 0 – 5

Definitions

Term	Definition
Aggression	Physically attacking another, including: • Throwing an object; • Punching; • Biting; • Pushing; • Pinching; • Pulling hair; • Scratching; or • Physically threatening behavior.
Bathing	The process of washing, rinsing, and drying all parts of the body, including an applicant's or member's ability to transfer to a tub or shower and to obtain bath water and equipment.
Continence	The customer's ability to control the discharge of body waste from bladder and bowel.
Current or currently	Belonging to the present time.
Dressing	The physical process of choosing, putting on, securing fasteners, and removing clothing and footwear. Dressing includes choosing a weather-appropriate article of clothing but excludes aesthetic concerns. Dressing includes the customer's ability to put on artificial limbs, braces, and other appliances that are needed daily.
Eating	The process of putting food and fluids by any means into the digestive system.
Elderly	A customer who is age 65 or older.
Emotional and cognitive functioning	An customer's orientation and mental state, as evidenced in aggressive, self-injurious, wandering, disruptive, and resistive behaviors.
Functional assessment	An evaluation of information about a customer's ability to perform activities related to: • Developmental milestones; • Activities of daily living; • Communication; and • Behavior.

Grooming	A customer's process of tending to appearance. Grooming includes: • Combing or brushing hair; • Shaving; and • Oral hygiene (including denture care). Grooming does not include aesthetics such as styling, skin care, nail care, and applying cosmetics.
Intervention	Therapeutic treatment, including the use of medication, behavior modification, and physical restraints to control behavior. Intervention may be formal or informal and includes actions taken by friends or family to control the behavior.
Medical assessment	An evaluation of a customer's medical condition and the customer's need for medical services.
Medical or nursing services and treatments, or services and treatments	Specific, ongoing medical, psychiatric, or nursing intervention used actively to resolve or prevent deterioration of a medical condition. Durable medical equipment and activities of daily living assistive devices are not treatment unless the equipment or device is used specifically and actively to resolve the existing medical condition.
Mobility	The extent of a customer's purposeful movement within a residential environment.
Orientation	A customer's awareness of self in relation to person, place, and time.
Physically disabled	A customer who is determined physically impaired by the Administration through the PAS assessment as allowed under the Administration's Section 1115 Waiver with CMS.
Resistiveness	Inappropriately obstinate and uncooperative behaviors, including: • Passive or active obstinate behaviors; • Refusing to participate in self-care; or • Refusing to take necessary medications. Resistiveness does not include difficulties with auditory processing or reasonable expressions of self-advocacy.
Self-injurious behavior	Repeated self-induced, abusive behavior that is directed toward infliction of immediate physical harm to the body. Self-injurious behavior does not include suicide attempts, accidents or risky lifestyle choices.
Sensory	Of or relating to the senses.

Toileting	The process involved in a customer's managing the elimination of urine and feces in an appropriate place.
Transferring	A customer's ability to move horizontally or vertically between two surfaces within a residential environment, excluding transfer for toileting or bathing.
Vision	The ability to perceive objects with the eyes.
Wandering	A customer's moving about with no rational purpose and with a tendency to go beyond the physical parameter of the residential environment.

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Customer score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the customer has this status.

Legal Authority

Program	Legal Authorities
ALTCS	AAC R9-28-304

1004 Developmental Disability Status

Revised 12/20/2022

Policy

Customers may be determined to be eligible for services by the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). Eligible customers include those who have been diagnosed with an intellectual cognitive disorder, cerebral palsy, seizure disorder, autism, or down syndrome, and who have significant impairment of their functional abilities.

For children less than six years of age, a diagnosis of developmental delay or risk for developmental disability may serve as the qualifying diagnosis for DES/DDD. Arizona Revised Statutes require that DES/DDD be the provider of services to people with a developmental disability.

The PAS process is intended to determine whether a customer's current functional abilities and medical stability, resulting from a developmental disability, indicate a need for services at the nursing facility (NF) or intermediate care facility (ICF) level of care.

> NOTE Customers with developmental disabilities who qualify to receive services from DES/DDD but are not at risk of institutionalization at the NF or ICF level of care, do not qualify for ALTCS.

ALTCS assigns a DD status to each customer depending on eligibility for DES/DDD services. This status is indicated on the PAS Intake Notice. The DD status classifications are:

- Potential DD. The customer appears to have a cognitive disability, cerebral palsy, seizure disorder autism, or down syndrome, but eligibility has not been determined by DES/DDD.
- DD. DES/DDD has identified the customer has a qualifying developmental disability.
- DD in NF. DES/DDD has identified the customer has a qualifying developmental disability and is living in a nursing facility.
- Not DD. The customer is not diagnosed as having a qualifying developmental disability or has a DD diagnosis but does not qualify for DES/DDD services.

Children ages six and over who are customers of DES/DDD must have one of the five DD qualifying diagnoses identified above to be considered DD for their ALTCS application or reassessment.

Definitions

N/A

Proof

The following are proof of immediate risk of institutionalization:

- PAS score equal to or higher than the applicable PAS threshold score; or
- A finding by a physician consultant reviewer that the customer meets this requirement.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-551 AAC R9-28-303

1005 Preadmission Screening Criteria for an Applicant or Member who is Developmentally Disabled (DD)

Policy

The Administration shall conduct a PAS assessment of an applicant or member who is DD using one of three PAS instruments specifically designed to assess an applicant or member in the following age groups:

- 12 years of age and older,
- 6 through 11 years of age, and
- 0 through 5 years of age.

The PAS instruments for an applicant or member who is DD include three major categories:

- Intake information category. The Assessor solicits intake information category information on an applicant's or member's demographic background. The components of this category are not included in the calculated PAS score.
- Functional assessment category. The functional assessment category differs by age group as indicated below:
  - For an applicant or member 12 years of age and older, the Assessor solicits the functional assessment category information on an applicant's or member's:
    - Need for assistance with independent living skills, including hand use, ambulation, wheelchair mobility, transfer, eating or drinking, dressing, personal hygiene, bathing or showering, food preparation, community mobility, and toileting;
    - Communication skills and cognitive abilities, including expressive verbal communication, clarity of communication, associating time with an event and action, and remembering an instruction and a demonstration; and
    - Behavior, including aggression, verbal or physical threatening, self-injurious behavior, and resistive or rebellious behavior.
  - For an applicant or member 6 through 11 years of age, the Assessor solicits the functional assessment category information on an applicant's or member's:
    - Need for assistance with independent living skills, including rolling and sitting, crawling and standing, ambulation, climbing stairs or ramps, wheelchair mobility, dressing, personal hygiene, bathing or showering, toileting, level of bladder control, and orientation to familiar settings;
    - Communication, including expressive verbal communication and clarity of communication; and
    - Behavior, including aggression, verbal or physical threatening, self-injurious behavior, running or wandering away, and disruptive behavior.
  - For an applicant or member 6 months through 5 years of age, the Assessor scores items in the developmental milestones section based on the age of the applicant or member.
  - For an applicant or member less than 6 months of age, the Assessor shall not complete a functional assessment. The Assessor shall include a description of the applicant's or member's development in the PAS instrument narrative summary.
- Medical assessment category. The Assessor solicits medical assessment category information on an applicant's or member's:
  - Medical condition;
  - Specific services and treatments the applicant or member receives or needs and the frequency of those services and treatments;
  - Current medication;
  - Medical stability;
  - Sensory functioning;
  - Physical measurements; and
  - Current placement, ventilator dependency, and eligibility for DES Division of Developmental Disabilities program services.

The Assessor shall use the PAS instrument to assess an applicant or member who is DD. A copy of the PAS instrument is available from the Administration. The Administration uses the PAS instrument responses to calculate three scores: a functional score, a medical score, and a total score.

- Functional score.
  - The Administration calculates the functional score from responses to scored items in the functional assessment category. For each response to a scored item, a number of points is assigned, which is multiplied by a weighted numerical value. The result is a weighted score for each response.
  - The functional assessment items in the following categories are scored:
    - For an applicant or member 12 years of age and older, all items in the behavior section are scored. Designated items in the independent living skills, communication skills, and cognitive abilities sections also are scored;
    - For an applicant or member 6 through 11 years of age, all items in the communication section are scored. Designated items in the independent living skills and behavior sections also are scored; and
    - For an applicant or member 6 months through 5 years of age, all age-specific items are scored.
  - The sum of the weighted scores equals the functional score. The range of weighted scores per item is presented below:

Age Group	Range for Weighted Score per Item	Maximum Functional Score A

12 and older	0 – 11.2	124.1
6 through 11	0 – 24	112.5
6 months through 5	0 – 5.0	106.02

- No minimum functional score is required.
- Medical score.
  - The Administration calculates the medical score from responses to scored items in the medical assessment category. For each response to a scored item, a number of points is assigned.
  - The medical assessment items in the following categories are scored:
    - For an applicant or member 12 years of age and older and 6 years of age through 11 years of age, designated items in the medical conditions section are scored; and
    - For an applicant or member 6 months of age through 5 years of age designated items in the medical conditions, services and treatments, and medical stability sections are scored.
  - For an applicant less than 6 months of age, only the medical assessment section of the PAS is completed. There is no weighted or calculated score assigned. The Assessor shall refer the applicant or member for physician consultant review in accordance with Section 1006.
  - The sum of the points equals the medical score. The range of points per item and the maximum medical score attainable by an applicant or member is presented below:

Age Group	**Range for Weighted Score per Item**	**Maximum Functional Score A**
12 and older	0 – 20.6	21.4
6 through 11	0 – 2.5	5
6 months through 5	0 – 10	60

- No minimum medical score is required.
- Total score.
  - The sum of an applicant's or member's functional and medical score equals the total score.
  - The total score is compared to the established threshold score as calculated under this Section. For an applicant or member who is DD, the threshold score is 40.
  - An applicant or member is determined at immediate risk of institutionalization if the total score is equal to or greater than 40.

The following matrices represent the number of points available and the respective weight for each scored item.

- Functional assessment points. The lowest value in the range of points available per item in the functional assessment category, zero, indicates minimal to no impairment. Conversely, the highest value indicates severe impairment.
- Medical assessment points. The lowest value in the range of points available per item in the medical assessment category, zero, indicates that the applicant or member:
  - Does not have the scored medical condition,
  - Does not need the scored medical or nursing services, or
  - Does not receive the scored medical or nursing services.

• **Age Group 12 and Older Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighte Score per Item (P) x (W)**
INDEPENDENT LIVING SKILLS SECTION			
• Hand Use, Food Preparation	• 0 – 3	• 3.5	• 0 – 10.5

• Ambulation, Toileting, Eating, Dressing, Personal Hygiene	• 0 – 4	• 2.8	• 0 – 11.2
COMMUNICATIVE SKILLS AND COGNITIVE ABILITIES SECTION			
• Associating Time, Remembering Instructions	• 0 – 3	• 0.5	• 0 – 1.5
BEHAVIOR SECTION			
• Aggression, Threatening, Self-Injurious	• 0 – 4	• 2.8	• 0 – 11.2
• Resistive	• 0 – 3	• 3.5	• 0 – 10.5

• **Age Group 12 and Older Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighte Score per Item (P) x (W)**
MEDICAL CONDITIONS SECTION			
• Cerebral Palsy, Epilepsy	• 0 – 1	• 0.4	• 0 - 0.4
• Moderate, Severe, or Profound Mental Retardation	• 0 – 1	• 20.6	• 0 - 20.6

• **Age Group 6 through 11 Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighte Score per Item (P) x (W)**
INDEPENDENT LIVING SKILLS SECTION			
• Climbing Stairs, Wheelchair Mobility, Bladder Control	• 0 – 3	• 1.875	• 0 – 5.625
• Ambulation, Dressing, Bathing, Toileting	• 0 – 4	• 1.5	• 0 – 6
• Crawling or Standing	• 0 - 5	• 1.25	• 0 – 6.25
• Rolling or Sitting	• 0 – 8	• 0.833	• 0 – 6.66
COMMUNICATION SECTION			
• Clarity	• 0 – 4	• 1.5	• 0 – 6
• Expressive Communication	• 0 – 5	• 1.25	• 0 – 6.25

BEHAVIOR SECTION			
• Wandering	• 0 – 4	• 6	• 0 – 24
• Disruptive	• 0 – 3	• 7.5	• 0 – 22.5

• **Age Group 6 through 11 Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighte Score per Item (P) x (W)**
MEDICAL CONDITIONS SECTION			
• Cerebral Palsy, Epilepsy	• 0 – 1	• 2.5	• 0 - 2.5

• **Age Group 6 months through 5 Functional Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighte Score per Item (P) x (W)**
DEVELOPMENTAL MILESTONES SECTION (FACTORS MEASURING AN INDIVIDUAL'S DEGREE OF FUNCTIONAL GROWTH			
• 6 – 9 Months	• 0 – 1	• 5.0	• 0 – 5.0
• 9 – 11 Months	• 0 – 1	• 4.1	• 0 – 4.1
• 12 – 17 Months	• 0 – 1	• 2.9	• 0 – 2.9
• 18 – 23 Months	• 0 – 1	• 2.125	• 0 – 2.125
• 24 – 29 Months	• 0 – 1	• 1.75	• 0 – 1.75
• 30 – 35 Months	• 0 – 1	• 1.55	• 0 – 1.55
• 36 – 47 Months	• 0 – 1	• 1.34	• 0 – 1.34
• 48 – 59 Months	• 0 – 1	• 1.14	• 0 – 1.14
• 60 Months+	• 0 – 1	• 1.03	• 0 – 1.03

• **Age Group 6 months through 5 Medical Assessment Category/Item**	• **Points Available per Item (P)**	• **Weight (W)**	• **Range of Possible Weighte Score per Item (P) x (W)**
MEDICAL ASSESSMENT			

• Cerebral Palsy	• 0 – 1	• 5.0	• 0 – 5.0
• Epilepsy	• 0 – 1	• 5.0	• 0 – 5.0
• Moderate, Severe, or Profound Mental Retardation • (36 months and older only)	• 0 – 1	• 15.0	• 0 – 15.0
• Autism + M-CHAT: Fails at least six M-CHAT based questions • (18 months and older only)	• 0 – 1	• 7.0	• 0 – 7.0
• Autism + Behaviors: Exhibits at least 3 of 4 specific behaviors • (36 months and older only)	• 0 – 1	• 5.0	• 0 – 5.0
• Autism + Behaviors: Exhibits at least 6 of 8 specific behaviors • (36 months and older only)	• 0 – 1	• 10.0	• 0 – 10.0
• Drug Regulation + Administration • (6 months to 35 months)	• 0 – 1	• 1.0	• 0 – 1.0
• Drug Regulation + Administration • (36 months and older)	• 0 – 1	• 1.5	• 0 – 1.5
• Non-Bowel/Bladder Ostomy Care • (6 months to 35 months)	• 0 – 1	• 7.0	• 0 – 7.0
• Non-Bowel/Bladder Ostomy Care • (36 months and older)	• 0 – 1	• 5.0	• 0 – 5.0
• Tube Feeding • (6 months to 35 months)	• 0 – 1	• 7.0	• 0 – 7.0
• Tube Feeding • (36 months and older)	• 0 – 1	• 5.0	• 0 – 5.0
• Physical Therapy or Occupational Therapy • (6 months to 35 months)	• 0 – 1	• 1.0	• 0 – 1.0
• Physical Therapy or Occupational Therapy • (36 months and older)	• 0 – 1	• 1.5	• 0 – 1.5
• Acute Hospital Admission: One	• 0 – 1	• 1.0	• 0 – 1.0
• Acute Hospital Admission: Two or More	• 0 – 1	• 2.0	• 0 – 2.0

• Direct Care Staff Trained • (6 months to 35 months)	• 0 – 1	• 0.5	• 0 – 0.5
• Direct Care Staff Trained • (36 months and older)	• 0 – 1	• 1.0	• 0 – 1.0
• Special Diet	• 0 – 1	• 2.0	• 0 – 2.0

Definitions

Term	Definition
Aggression	Physically attacking another, including: • Throwing objects; • Punching; • Biting; • Pushing; • Pinching; • Pulling hair; or • Scratching.
Ambulation	The ability to walk, including quality of the walking and the degree of independence in walking.
Associating time with an event and an action	An applicant's or member's ability to associate a regular event with a specific time-frame.
Bathing or showering	An applicant's or member's ability to complete the bathing process, including: • Drawing the bath water; • Washing; • Rinsing; • Drying all parts of the body; and • Washing the hair.
Clarity of communication	An ability to speak in recognizable language or use a formal symbolic substitution, such as American Sign Language.
Climbing stairs or a ramp	An applicant's or member's ability to move up and down stairs or a ramp.
Community mobility	An applicant's or member's ability to move about a neighborhood or community independently, by any mode of transportation.
Current or currently	As defined in Section 1003.
Crawling and standing	An applicant's or member's ability to crawl and stand with or without support.

Developmental milestone	A measure of an applicant's or member's functional abilities, including: • Fine and gross motor skills; • Expressive and receptive language; • Social skills; • Self-help skills; and • Emotional or affective development.
Disruptive behavior	Inappropriate behavior by an applicant or member, including: • Urinating or defecating in inappropriate places; • Sexual behavior inappropriate to time, place or person; or • Excessive whining, crying or screaming that interferes with an applicant's or member's normal activities or the activities of others and requires intervention to stop or interrupt the behavior.
Dressing	An applicant's or member's ability to put on and remove an article of clothing. Dressing does not include the ability to put on or remove braces, nor does it reflect an applicant's or member's ability to match colors or choose clothing appropriate for the weather.
Eating or drinking	The process of putting food and fluid by any means into the digestive system.
Expressive verbal communication	An applicant's or member's ability to communicate thoughts with words or sounds.
Food preparation	An applicant's or member's ability to prepare a simple meal, including a sandwich, cereal, or a frozen meal.
Frequency	Number of times a specific behavior occurs within a specified interval.
Functional assessment	As defined in Section 1003.
Hand use	An applicant's or member's ability to use both hands, or one hand if the applicant or member has only one hand or has the use of only one hand.
Intervention	As defined in Section 1003.
M-CHAT™	Modified Checklist for Autism in Toddlers
Medical assessment	As defined in Section 1003.

Personal hygiene	The process of tending to one's appearance. Personal hygiene may include: • Combing or brushing hair; • Washing face and hands; • Shaving; • Performing routine nail care; • Oral hygiene (including denture care); and • Menstrual care. Personal hygiene does not include aesthetics such as styling hair, skin care, and applying cosmetics.
Remembering an instruction and demonstration	An applicant's or member's ability to recall an instruction or demonstration on how to complete a specific task.
Resistiveness or rebelliousness	An applicant's or member's inappropriate, stubborn, or uncooperative behavior. Resistiveness or rebelliousness does not include an applicant's or member's difficulty with processing information or reasonable expression of self-advocacy that includes an applicant's or member's expression of wants and needs.
Rolling and sitting	An applicant's or member's ability to roll and sit independently or with the physical support of another person or with a device such as a pillow or specially-designed chair.
Running or wandering away	An applicant or member leaving a physical environment without notifying or receiving permission from the appropriate individuals.
Self-injurious behavior	An applicant's or member's repeated behavior that causes injury to the applicant or member.
Special diet	A diet planned by a dietitian, nutritionist, or nurse that includes high fiber, low sodium, or pureed food.
Toileting	As defined in Section 1003.
Verbal or physical threatening	Any behavior in which an applicant or member uses words, sounds, or action to threaten harm to self, others, or an object.
Vision	As defined in Section 1003.
Wheelchair mobility	An applicant's or member's mobility using a wheelchair. Wheelchair mobility does not include the ability to transfer to the wheelchair.

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

• Applicant or member score equal to or higher than the applicable PAS threshold score; or
• Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	AAC 9-28-305

1006 Eligibility Review

Revised 08/03/2021

Policy

Eligibility review is an important part of the Pre-Admission Screening (PAS) assessment process. An eligibility review is conducted when the final PAS score may not be an accurate reflection of the customer's need for Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) level of care.

Eligibility reviews are mainly used for PAS assessments that score below the eligibility threshold but are also used in certain situations when the score is above the eligibility threshold.

There are two types of Eligibility Reviews:

- PAS Analyst Review Consultant (PARC) reviews, and
- Physician Review.

1) PAS Analyst Review Consultant (PARC) Review

A PAS Analyst Review Consultant (PARC), reviews PAS assessments that have been reviewed and referred by a Benefits and Eligibility Manager (BEM) in the following situations:

- PAS Reassessments scoring below the eligibility threshold but that appear eligible. If the PARC review does not confirm that the customer remains medically eligible, the PAS is then referred to a physician consultant for review.
- Initial elderly or physically disabled (EPD) PAS assessments for customers whose PAS score meets the eligibility threshold and have a both a medical condition and a psychiatric condition that may be contributing to the customer's need for care. If the PARC review is unable to determine if the customer's psychiatric condition is a contributing factor in meeting the eligibility threshold, the case will be referred to a physician consultant.

2) Physician Review

A physician consultant reviews the PAS assessment and available medical records, and uses professional judgment to determine whether or not a customer has a developmental disability or a non-psychiatric medical condition that by itself, or in combination with other medical conditions, places the customer at immediate risk of institutionalization.

The physician consultant reviews initial PAS assessments referred after review by a Benefits and Eligibility Manager or PARC, as well as all PAS reassessments that are no longer scoring eligible. After reviewing the PAS for accuracy and completeness, the Benefits and Eligibility Manager will request a physician review in the following circumstances:

- The EPD PAS score is less than the threshold of 60 but is at least 56;
- The DD PAS score is less than threshold of 40 but is at least 38;
- A customer scores below the threshold (60 for EPD and 40 for DD) but the PAS assessor and Benefits and Eligibility Manager have reasonable cause to believe that the customer's functional abilities or medical conditions may place the customer at immediate risk of institutionalization;
- The EPD PAS score is less than the threshold and the customer has a documented diagnosis of autism or autistic-like behavior;
- The EPD PAS score is at or above the threshold, but the customer has a serious mental illness, as defined in ARS § 36-550, that may be contributing to the need for care at a level provided in a nursing facility or intermediate care facility;
- The EPD PAS score is at or above the threshold for a customer on AHCCCS in an acute care program, but the Benefits and Eligibility Manager has reasonable cause to believe that the applicant's condition is improving and needs less than 90 days of institutional care;
- The customer has a physical disability and is less than 12 years of age;
- The customer is under six months of age;
- An ALTCS customer is living in a SNF or ICF and at reassessment, no longer meets the eligibility threshold score for ALTCS

or ALTCS Transitional, as defined in MA1010; and
- An ALTCS DD customer is determined to no longer be DD-eligible by the DES Department of Developmental Disabilities and does not meet the EPD scoring threshold.

The physician consultant reviews and considers the following when determining medical eligibility:

- Dependence on others for help with activities of daily living;
- Delay in development;
- Continence;
- Orientation;
- Behavior;
- Medical conditions, including stability and prognosis of the condition;
- Any medical nursing treatment provided to the customer including skilled monitoring, medication, and therapeutic procedures;
- The degree to which the customer must be supervised;
- The skill and training required of the customer's caregiver; and
- Any other significant factors that impact the individual case.

If the physician consultant cannot make the determination from the PAS assessment and the available medical records, the physician consultant may conduct a face-to-face review with the customer or contact others familiar with the customer's needs, including a primary care physician or other caregiver, to make the determination.

The physician consultant must document the reasons for the determination in the physician review comment section of the PAS assessment.

Definitions

Term	Definition
Physician consultant	A physician who contracts with the Administration to complete eligibility reviews of PAS assessments.
Immediate risk of institutionalization	A need for the level of care typically provided in an institution, like a skilled nursing facility or Intermediate Care Facility.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-550 ARS 36-2936(I) AAC R9-28-303

1007 PAS Reassessments

Revised 01/15/2020

Policy

PAS reassessments must be completed on some ALTCS members to determine continued medical eligibility. The criteria for continued qualification for ALTCS services are the same as for the initial PAS.

EPD Members who were made eligible by physician consultant review on their last assessment and are under age 65 require an annual assessment.

A reassessment may be completed at any time for the following reasons:

- A routine audit of the PAS assessment reveals a question regarding the eligibility determination;
- A review by Administration or an ALTCS physician consultant determines the member may not have a continuing need for long term care services; or
- A Program Contractor, case manager, nursing facility, or other party requests a review that reveals a question regarding continuing eligibility.

NOTE A reassessment may be scheduled at six months when it appears that a customer may not have a continued need for long term care services in the judgment of the physician consultant or PAS Assessor, in consultation with his or her supervisor.

Definitions

Term	Definition
Reassessment	Means the process of redetermining PAS eligibility for ALTCS services.

Proof

Proof of immediate risk of institutionalization shall be demonstrated through:

- Applicant or member score equal to or higher than the applicable PAS threshold score; or
- Finding by a physician consultant reviewer that the applicant or member has this status.

Legal Authority

Program	Legal Authorities
ALTCS	AAC R9-28-306

1008 Applicant/Member Issue Referrals

Policy

When a PAS Assessor witnesses a situation with an applicant or member that calls for immediate intervention, the Assessor shall do one of the following:

- For life-threatening situations, call 911.
- For other situations, notify Adult Protective Services (APS) or Child Protective Services (CPS) of the presence of serious physical or medical neglect.

When it appears that a referral to APS or CPS may be appropriate, the Assessor shall discuss the issue with his or her supervisor. In some cases, depending on the severity of the issue, the discussion may occur after the referral has been made. In less urgent situations, the supervisor may contact the AHCCCS Division of Health Care Management/Clinical Quality Management (DHCM/CQM) for guidance regarding contacting APS or CPS.

In addition, the Assessor shall notify DHCM/CQM using the online form on the AHCCCS website at https://www.azahcccs.gov/ACMS/default.aspx whenever one of the following is suspected:

- A problem with the quality of the care being provided to the member;
- The member is being abused or neglected;
- The member has unmet medical or dental needs;
- Provider fraud has been committed; or
- The member is residing in an unlicensed or uncertified room and board home and is receiving direct, personal, or supervisory care services on other than a temporary basis pending ALTCS approval.

When completing the online Quality of Care Received form the Assessor shall indicate the severity status level as follows:

- Severity Level 1. Potential quality of care issue with **minimal** adverse effects (issue **may** impact the member if not resolved).
- Severity Level 2. Potential quality of care issue with **moderate** adverse effects (issue **will** impact the member if not resolved).
- Severity Level 3. Potential quality of care issue that **immediately** impacts the member and is life-threatening or dangerous.

Definitions

N/A

Proof

A Customer Issue Referral (CIR) form completed by the Assessor or Benefits and Eligibility Specialist.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 483.430

1009 Preadmission Screening and Resident Review (PASRR)

Revised 01/15/2020

Policy

Under the federally-mandated Preadmission Screening and Resident Review (PASRR) program, all customers entering a Medicaid-certified nursing facility after January 1, 1989 must be screened for intellectual cognitive disability and serious mental illness (ICD/MI), to avoid inappropriate placement.

The PASRR is a two-level screening process. Hospital discharge planners and nursing facility staff complete the PASRR prior to admission to a nursing facility (NF). The Level I screening determines whether the customer has any diagnosis or other presenting evidence that suggests the presence of ICD/MI. If there is an indication of ICD/MI, the case must be referred for a Level II determination.

The Level II screening determines whether the customer is ICD/MI and whether he or she can be appropriately treated in a NF setting. If a Level II determination is indicated in Section E of the PASRR Screening Document, the customer or the customer's representative must sign in Section F. Admission to a NF cannot occur until the Level II is completed and indicates that NF admission is appropriate.

Referrals for Level II evaluations for potential mental illness are sent to the PASRR Coordinator at the Arizona Department of Health Services, Division of Behavioral Health Services. Referrals for Level II evaluations for potential intellectual cognitive disability are sent to the Arizona Department of Economic Security, Division of Developmental Disabilities.

Nursing facilities must do all of the following for PASRR:

- Ensure that the Level I screening and, if applicable, Level II determinations have been completed and are kept in the customer's current medical chart;
- Perform a new Level I screening and, if applicable, a Level II, when a customer enters a NF for convalescent or respite care and is later found to require more than 30 days of NF care; and
- Perform a new Level I screening and, if applicable, a Level II, when a customer's mental health condition changes or new medical records information becomes available that indicates the possible need for a Level II referral.

PAS Assessors shall report any nursing facilities that are not in compliance with this regulation to the PASRR Coordinator in DHCM.

Definitions

Term	Definition
Intellectual cognitive disability	Is defined as a chronic disability that impairs general intellectual functioning or adaptive behavior and requires treatment or services. The impairment must be demonstrated before age 22. The impairment must be likely to continue indefinitely and substantially limit the customer's ability to function in major life activities.

Serious mental illness	Is defined as a condition that impairs emotional or behavioral functioning to the point that it interferes with the person's ability to remain in the community without supportive treatment. The mental impairment is severe and persistent and may limit the customer's ability to: • Function in primary activities of daily living, interpersonal relationships, homemaking, self-care, employment or recreation; or • Seek or receive local, state or federal assistance such as housing, medical and dental care, rehabilitation services, income assistance and food stamps, or protective services. NOTE Although people with a primary diagnosis of intellectual cognitive disability frequently have similar problems or limitations, they are not included in this definition.

Proof

Completed PASRR Level I screening and Level II determination, if applicable, in customer's case file maintained by nursing facility.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396b 42 CFR 483.112 42 CFR 483.130 ARS 36-2903.03 AAC 9-28-404

1010 The ALTCS Transitional Program

Revised 01/15/2020

Policy

The ALTCS Transitional program is a program for customers who have improved medically, functionally or both to the point that they no longer need the level of care that is provided in a nursing facility (NF) or intermediate care facility institutionalization for individuals with intellectual disabilities (ICF-IID). These customers are determined through the PAS reassessment process to still need long-term care services, but at a lower level of care.

1) Who qualifies for ALTCS Transitional?

The ALTCS Transitional program is only available to customers who have been approved for ALTCS. It is not available to customer who fail the initial PAS and are not at risk of institutionalization.

The medical eligibility criteria for ALTCS Transitional are as follows:

- DD customers - Receive a score of 30 or higher during the PAS reassessment, or must have a diagnosis of moderate, severe, or profound cognitive disability.
- EPD customers, under age 12 - Must be found eligible for ALTCS Transitional through physician consultant review.
- EPD customers, ages 12 and older - Receive a score of 40 or higher during the PAS reassessment.

The ALTCS Transitional effective date is the first of the month following the PAS decision date, allowing for advance notice of the change.

2) ALTCS Transitional - Covered Services

The ALTCS Transitional program allows customers who meet the lower level of care, to continue to receive all other medically necessary ALTCS covered services. Customers living in a NF or ICF-IID when determined eligible for the ALTCS Transitional Program may get continued NF or ICF-IID services for up to 90 days while being moved to an HCBS placement by the Program Contractor.

An ALTCS Transitional customer's condition may worsen to the point that NF services are again medically necessary. The Program Contractor can place the customer in an NF temporarily, provided the stay is not more than 90 continuous days per admission.

NOTE When an ALTCS Transitional customer may need NF care longer than 90 days, the Program Contractor must request a PAS reassessment. When the customer is determined to be at risk of institutionalization, the customer will be moved back to Full ALTCS effective the first day of the month following the PAS reassessment.

Definitions

Term	Definition
Intermediate Care Facility for Individuals with Intellectual Disabilities.	An institution that: • Is primarily for the diagnosis, treatment, or rehabilitation of people with intellectual disabilities or related conditions; and • Provides ongoing evaluation, planning, 24-hour supervision, coordination, and health or rehabilitative services to help each person function at his or her greatest ability.

Proof

The following information is used as proof of eligibility for ALTCS Transitional:

- Current eligibility approved in the eligibility determination system, HEAplus; AND
- PAS reassessment records showing a PAS score below the threshold for ALTCS but equal to or higher than the threshold score for ALTCS Transitional; or
- Records of a Physician Review determination that the applicant or member meets the criteria for ALTCS Transitional.

Legal Authority

Program	Legal Authorities
ALTCS	AAC 9-28-307

1011 Quality Assurance

Revised 06/14/2022

Policy

The PAS Quality Assurance (QA) Unit consists of nurses and social workers who monitor and evaluate the EPD and DD PAS process. The goal of the unit is to provide feedback on the accuracy and consistency of PAS implementation statewide.

PAS QA staff review completed PAS assessments. The review includes;

- Health-e-Arizona plus (HEAplus) data entry
- Case notes;
- DocuWare; and
- Any other proof in the case file.

Findings from the reviews are collected and used to identify trends that show a need for training, changes to PAS assessment tools, PAS manuals, or the new hire orientation process.

PAS Assessors are responsible for monitoring and improving the quality of the assessments they conduct. Supervisors support quality improvement by:

- Reviewing completed assessments for accuracy and completeness;
- Observing PAS interviews;
- Providing technical assistance;
- Coaching; and
- Identifying training opportunities on an ongoing basis.

Proof

Documentation of quality control activities as maintained by the Quality Assurance Unit and eligibility office supervisors.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-2903.01B3(d)

1100 Introduction

For each enrollment topic in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply to the topic.

1101 Enrollment Overview

Revised 10/01/2018

Policy

Customers who qualify for AHCCCS Medical Assistance are enrolled with an AHCCCS Complete Care (ACC) plan, an ALTCS Program Contractor or a fee-for-service plan.

Enrollment Rights

The customer may file a grievance for an adverse action related to enrollment or provision of services taken by a health plan, a program contractor or AHCCCS. See MA1710 - Grievances for more information.

Enrollment Rosters

Each contractor receives enrollment files from AHCCCS. Daily and monthly enrollment files are produced. The availability of enrollment files to the contractor is considered legal notification of the contractor's responsibility for providing care to customers.

Daily enrollment files include:

- New members for whom the contractor is responsible;
- Persons for whom the contractor is no longer responsible, including persons who are:
  - Newly disenrolled; or
  - Deceased;
- Changes to customers' demographic data, like name, address or date of birth;
- Rate codes; and
- Share of cost information.

Monthly enrollment files are produced three days prior to the end of the month for each contractor. They identify the total active population for each contractor as of the first of the next month.

Definitions

Term	Definition
AHCCCS Complete Care (ACC) plan	An entity with a prepaid capitated contract with AHCCCS to provide acute care medical services to AHCCCS customers.
Arizona Long Term Care System (ALTCS) Program Contractor	A contracted managed care organization that provides long term care, acute care, behavioral health, and case management services to eligible customers who are determined to need an institutional level of care.
Fee-For-Service (FFS)	Means AHCCCS pays providers directly for covered services provided to the customer, instead of the payment being made through a contracted health plan.

Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
ALTCS and FTW-ALTCS	AAC R9-28-412 through R9-28-418
All programs except ALTCS and FTW-ALTCS	AAC R9-22-1701 through R9-22-1705

1102 Enrollment with a Health Plan

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 10/04/2022

Policy

AHCCCS health plans provide physical and behavioral health services to customers. The health plan contracts with primary care physicians, specialists, dentists, hospitals, and other providers to form a network of service providers. Most health plans serve specific Geographic Service Areas (GSAs), which are made up of specific Arizona counties.

This section covers:

• The Arizona counties assigned to each GSA, and

• Health plans that serve specific customer groups

1) Health plans available by county

The following table lists the counties assigned to each GSA:

Geographic Service Areas	Counties
Central	• Gila • Maricopa • Pinal
North	• Apache • Coconino • Mohave • Navajo • Yavapai
South	• Cochise • Graham • Greenlee • La Paz • Pima • Santa Cruz • Yuma

When a Zip code crosses two different counties, the Zip code is assigned to a specific GSA. The health plan is responsible for

providing services to members residing in the entire ZIP code that is assigned to the GSA.

The split ZIP codes GSA assignments are as follows:

ZIP CODE	SPLIT BETWEEN THESE COUNTIES	ASSIGNED GSA
85342	Yavapai and Maricopa	Central
85390	Yavapai and Maricopa	Central
85358	Yavapai and Maricopa	Central
85542	Gila and Graham	South
85550	Gila and Graham	South
85645	Pima and Santa Cruz	South
85192	Gila and Pinal	South

To review a list of the health plans available by county see AHCCCS Health Plan Links.

2) Health plans that serve specific customer groups

- Mercy Care Department of Child Safety Comprehensive Health Plan (DCS CHP) provides services to children in Arizona foster care statewide.
- American Indian Health Program (AIHP) is available to American Indians statewide who choose not to enroll in one of the health plans available by county.
- Mercy Care provides services to customers who have a serious mental illness (SMI) living in the counties of Maricopa, Gila, and Pinal (excluding ZIP codes 85542, 85192, and 85550).
- Care 1st Health Plan provides services to customers who have a SMI living in Northern Arizona. This includes the counties of Apache, Coconino, Mohave, Navajo, and Yavapai.
- Arizona Complete Health provides services to customers who have a SMI living in Southern Arizona. This includes the counties of Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma (including ZIP codes 85542, 85192, and 85550).

Definitions

Term	Definition
Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP)	A health plan administered by the Arizona Department of Child Safety (DCS) that provide services to children in the custody of the State of Arizona's foster care system.

Integrated Health Plan	A plan that joins physical and behavioral health services to treat all aspects of healthcare needs for members under a chosen health plan.
Managed Care Organization	Contracts with primary care physicians (PCP), specialists, dentists, hospitals and other ancillary providers to form a network of service providers.
Primary Care Physician (PCP)	The health care provider chosen by or assigned to a patient to provide medical care, maintain the patient's medical records and make referrals for medically necessary specialty care.

Legal Authority

Program	Legal Authorities
All programs except ALTCS and Medicare Savings Program (MSP)	42 CFR 438.71 AAC R9-22-1702

B Initial Health Plan Enrollment

Revised 04/26/2022

Policy

Within 10 days of enrollment, the health plan provides the customer with:

- Printed information about the health plan's services and service locations;
- The name, address, and telephone number of the customer's primary care provider (PCP); and
- Information on how the customer may change PCPs

Customers receive an AHCCCS Medical Assistance ID card in the mail that includes the health plan's contact information. Customers must present this ID card whenever medical services are requested or provided (ex., doctor's office, hospital, lab, or pharmacy). Customers who do not receive an ID card should call their health plan.

Most customers who do not currently have AHCCCS coverage have a choice of health plans that serve their Geographic Service Area (GSA).

When a customer does not choose a health plan before the application is approved, AHCCCS automatically assigns a health plan and enrolls the customer. The customer is sent a Freedom of Choice letter informing them of the health plan they were assigned and giving them a 90-day period to choose a different health plan. When the customer does not contact AHCCCS to choose a different health plan, the customer remains enrolled with the auto-assigned health plan.

NOTE American Indians customers living within the bounds of the tribal nation that do not choose a plan will be automatically enrolled in AIHP.

Exceptions:

The following customers do not have a health plan choice:

- Customers diagnosed with a Serious Mental Illness (SMI);
- Children in State of Arizona foster care; and
- Customers who were enrolled with a health plan within 90 days before the new approval, AND that health plan remains available in the customer's GSA.

Customers that need help selecting a health plan may:

- Visit www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html; or
- Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800) 334-5283 from area codes (520) and (928).

Definitions

Term	Definition
Freedom of Choice	Customers may select the health plan of their choice within 90 days of auto assignment.
Geographic Service Area (GSA)	AHCCCS awards health plan contracts by GSA. AHCCCS Complete Care (ACC) health plans are responsible for providing services to customers residing in the GSA.

Legal Authority

Program	Legal Authorities
All programs except ALTCS and Medicare Savings Program (MSP)	42 CFR 438.71 AAC R9-22-1702

C Effective Date of Health Plan Enrollment

Revised 09/24/2015

Policy

The effective date of initial enrollment in a health plan depends on the program and other circumstances:

Scenario	Effective Date
Customer's eligibility is changing from ALTCS to AHCCCS Medical Services	Enrollment with the health plan begins the day after the last day of ALTCS eligibility.
All other initial enrollment	Enrollment with the health plan begins on the effective date of eligibility for AHCCCS Medical Assistance, but no earlier than the first day of the month of application.

Definitions

Term	Definition
Effective date of enrollment	The date that the AHCCCS Complete Care (ACC) plan becomes responsible for providing AHCCCS covered services.

Legal Authorities

Program	Legal Authorities
All programs except ALTCS and Medicare Savings Program (MSP)	AAC R9-22-1702

D Newborn Enrollment

Revised 09/14/2021

Policy

The newborn's enrollment is determined by both the:

• Mother's enrollment; and

• Newborn's date of birth.

1) Health Plan Assignment for Newborns

When the newborn's mother is eligible and enrolled with an AHCCCS Complete Care (ACC) plan or AIHP, the newborn is enrolled in the same plan as the mother.

The newborn is auto-assigned to a health plan when the mother:

• Is not enrolled with a health plan or American Indian Health Program (AIHP);

• Has a Children's Rehabilitative Services (CRS) designation;

• Is enrolled with Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP); or

• Is enrolled with a program contractor or tribal ALTCS contractor.

Health plans and hospitals notify AHCCCS of the birth of a newborn so that the newborn can be enrolled with a health plan.

2) ID Card

The newborn's AHCCCS ID card is not sent until the first name is received from the eligibility source.

3) Enrollment Choice

A Freedom of Choice letter is sent to the mother notifying her of the right to choose a different health plan for the child within 90 days from the date of the enrollment notice.

When customers need help selecting a health plan they may:

• Visit https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html; or

Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800)-334-5283 from area codes (520) and (928).

Definitions

Term	Definition

Freedom of Choice	Customers may select the health plan of their choice within 90 days of auto assignment.

Legal Authority

Program	Legal Authorities
Deemed Newborns	42 CFR 438.71 AAC R9-22-1704 AAC R9-31-309

E Guaranteed Enrollment Periods

Revised 11/28/2023

Policy

The guarantee period is calculated at the time the discontinuance is received by PMMIS. Eligibility for the guaranteed enrollment period is based on the reason the customer became ineligible for the AHCCCS program.

NOTE Customers receiving Medicare Savings Program (MSP) only, do not have guaranteed enrollment periods.

Guaranteed enrollment periods apply as follows:

If...	The guaranteed enrollment period is...	Unless the customer...
It is the first time the customer has ever been enrolled with an AHCCCS Complete Care (ACC) plan	Six months	• Moves out of state; • Cannot be located and mail is returned to the agency as undeliverable; • Is incarcerated; • Is adopted; • Was ineligible at the time of initial enrollment; or • Voluntarily withdraws from the program.
The customer is under age 19 when approved or renewed.	12 months	• Reaches age 19; • Moves out of state; • Was approved or renewed in error, or • Voluntarily withdraws from the program.

Definitions

Term	Definition
Guaranteed Enrollment Period	A period of enrollment that continues even when the customer no longer qualifies for AHCCCS or KidsCare for certain reasons.

Legal Authority

Program	Legal Authorities
All Programs (except MSP and KidsCare)	42 USC 1396a(e)(12) AAC R9-22-1705
KidsCare	42 USC 1397gg(e)(1) AAC R9-31-307

F Health Plan Enrollment Changes

Revised 09/14/2021

Policy

In general, customers enrolled in a health plan may change their enrollment once a year during their enrollment choice month.

The enrollment choice month is the month in which the customer was first enrolled with an AHCCCS Complete Care (ACC) plan. During the enrollment choice month, a customer can change their health plan by:

• Electronically submitting requests using https://www.healthearizonaplus.gov; or

• Calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800)-334-5283 from area codes (520) and (928).

Customers who do not want to change their health plan do not have to do anything to remain enrolled with the current health plan.

When a customer does change health plans, the month after the enrollment choice month is the transitional month. During this time AHCCCS notifies both the current health plan and the new health plan of the enrollment change. This allows the health plans time to transfer records and welcome new members.

When more than one person in a household receives AHCCCS Medical Assistance, an enrollment choice month is assigned to the household using the enrollment choice month of the customer that has been on AHCCCS for the longest time. All customers in the household who want to change health plans may do so at that time.

Exceptions:

The annual enrollment process does not apply to any of the following customers:

• Foster care children enrolled with Mercy Care Department of Child Safety Comprehensive Health Plan (DCS/CHP); and

• Customers diagnosed with a Serious Mental Illness.

When customers need help selecting a health plan they may:

• Visit https://www.azahcccs.gov/Members/ProgramsAndCoveredServices/availablehealthplans.html; or

• Speak to a Beneficiary Support Specialist by calling (602) 417-7100 from area codes (480), (602), and (623) or 1-(800) 334-5283 from area codes (520) and (928).

There are situations when the customer's enrollment may be changed outside the annual enrollment period. Listed below are the reasons enrollment may be changed:

Situation/Status	Description
Auto Assignment	When a customer has been auto assigned to a health plan, they may change health plans within 90 days. This is known as Freedom of Choice.
Change to Full Services	When a customer is eligible to move from FES to full services, the customer is sent a letter giving the opportunity to select a health plan and notifying them of the change in services.

Continuity of Care	Health plan changes may be approved on a case-by-case basis to ensure the customer's access to care. Approval requires an agreement from both health plan's Medical Directors. The health plans determine the effective date of the enrollment change. NOTE When the health plans cannot reach an agreement, the AHCCCS Chief Medical Officer makes the decision and the Division of Health Care Management notifies the health plans and the customer.
Family continuity	A customer auto assigned to a different health plan than other currently enrolled family members can change to the health plan in which the other family members are enrolled. NOTE Other family members are not permitted to change to the health plan to which the customer was auto assigned.
Foster Care	When a child is no longer in the custody of Arizona foster care, the customer can choose a health plan.
Grievance	A change in enrollment is allowed when the change is a result of the final outcome of a grievance.
Incorrect Enrollment	If a customer made a pre-enrollment choice but was assigned to the wrong health plan in error, a change may be made.
American Indians	An American Indian customer may change from an available health plan to American Indian Health Program (AIHP) or from AIHP to an available health plan at any time.
Newborn	Newborns are automatically assigned to the mother's health plan. The mother is given 90 days to select another health plan for the newborn. Newborns of Federal Emergency Services (FES) mothers are auto assigned and the mother is given 90 days to select a health plan.
Same Day Plan Change	A member can change their health plan choice within the same day of the original request.
Customer Moves to a New GSA	If the customer moves and his or her current health plan is not available in the new GSA, the customer has 90 days to choose a health plan in the new GSA.

Customers can contact the Agency directly to report an enrollment error or request an enrollment change. The customer may:

• Call (602) 417-7100 or 1-800-962-6690; or

• Send written requests to 801 E. Jefferson St., MD 3400, Phoenix, AZ 85034.

Definitions

Term	Definition
Enrollment Choice Month	The first month after the material is mailed is the enrollment choice month.
Transitional Month	The second month is the transitional month. During this time AHCCCS notifies both the current health plan and the new health plan of the enrollment change. This allows the health plans adequate time to transfer records and welcome new members.

Legal Authority

Program	Legal Authorities
All Programs	AAC R9-22-1702 42 CFR 438.71

1103 Fee-For-Service

Revised 04/26/2022

Policy

Services are provided on a fee-for-service basis in the following situations:

Service Package	When the customer...
AHCCCS Medical Services	• Is eligible to have medical bills paid during the three months prior to application (Prior Quarter) • Is eligible for Federal Emergency Services (FES); • Enrolls with American Indian Health Program (AIHP); • Is eligible for Hospital Presumptive Eligibility (HPE); • Has less than 30 days of prospective eligibility; or • Is eligible only for a retroactive period of eligibility.
ALTCS Services	• The customer is eligible for ALTCS services only during the prior period. Example: The customer dies before ALTCS is approved but is eligible for ALTCS services in the prior period. ALTCS services are paid on a fee-for-service basis. • The customer is enrolled with a tribal contractor, or there is no tribal or EPD program contractor serving the customer's geographical service area. • The Assistant Director of the Division of Member Services approves (on a case-by-case basis) fee-for-service payment for long term care services during the prior period for a customer who: ◦ Was enrolled with an AHCCCS Complete Care (ACC) plan when ALTCS was approved; and ◦ The AHCCCS Complete Care (ACC) plan's responsibility for paying for nursing facility services for a 90-day period per contract year ended prior to the date the ALTCS approval was processed.

Definitions

Term	Definition
AHCCCS American Indian Health Program (AIHP)	AIHP is responsible for paying fee-for-service claims submitted for American Indians who have chosen not to enroll in an acute capitated health plan. If the American Indian customer does not choose a plan and lives within the bounds of the tribal nation, the customer will be automatically enrolled in AIHP.
Federal Emergency Services (FES)	Emergency services provided to immigrants who are eligible for Medicaid except for their immigration status
Hospital Presumptive Eligibility (HPE)	Temporary coverage for people who are likely to qualify for AHCCCS Medical Assistance. See MA417 for details. NOTE Eligibility for HPE is determined by qualified hospitals

Legal Authority

Program	Legal Authorities
All programs	AAC R9-22-1702 AAC R9-28-416 AAC R9-22-1601

1104 Enrollment with a Program Contractor

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 09/21/2017

There are three types of organizations that serve as ALTCS program contractors:

• Program contractors for individuals who are age 65 or older (elderly) or have a physical disability (EPD).

NOTE Program contractors for EPD customers are determined by the customer's county of fiscal responsibility (see MA1104B).

• The Department of Economic Security (DES/DDD); and
• American Indian contractors.

Policy

1) When Does Enrollment Occur?

The effective date of enrollment is determined by the customer's AHCCCS status on the date of approval.

If the customer is...	Then ALTCS enrollment and capitation...
Enrolled with an AHCCCS Complete Care (ACC) plan at the time of approval	Begins on the date ALTCS approval is posted in PMMIS. The customer is disenrolled from the AHCCCS Complete Care (ACC) plan the day before. Exception: If the effective date of ALTCS eligibility is before the date the customer was enrolled with a health plan, the prior period begins on the first day of the ALTCS application (or the first eligible month) and ends on the day before the health plan enrollment began. Enrolled with an AHCCCS Complete Care (ACC) plan at Time of Approval Example
Not enrolled with an AHCCCS health plan	Is retroactive to the effective date of eligibility (prior period coverage). Not Enrolled with an AHCCCS Complete Care (ACC) plan Example The customer may also have unpaid medical bills from services received in the three months prior to the month of application (Prior Quarter) on a Fee-For-Service basis if determined to be eligible for ALTCS during the months in which the medical services were received.

2) What happens after enrollment?

After enrollment occurs:

- The program contractor gives the customer written information about their organization.
- The customer chooses the doctor he or she prefers as a primary care physician (PCP) from the program contractor's list of participating physicians. If the customer does not choose a PCP, one is assigned. The primary care physician coordinates care and acts as a gatekeeper. If the customer's current doctor is a member of the program contractor's network, the customer does not need to change doctors.
- A case manager assigned by the program contractor contacts the customer and the customer's representative soon after enrollment to establish a service plan that best meets the customer's needs. Input from the customer and the customer's family is encouraged.
- The customer receives an ID card in the mail from the program contractor that includes the name and phone number of the program contractor. The customer presents this ID card whenever medical services are requested or provided (ex., doctor's offices, hospitals, labs and pharmacies).

NOTE DDD members receive their ID cards from DDD. American Indian Health Plan (AIHP) members receive their ID cards from AHCCCS.

Definitions

Term	Definition
Program Contractor	Program contractors are responsible for: • Providing services through a managed care plan (health maintenance organization); • Contracting with providers to form a network of service providers; and • Assigning a case manager who works with the customer's primary care physician (PCP) to develop a service plan. The case manager authorizes all long term care services provided through ALTCS.
County of Fiscal Responsibility	The Arizona county that is responsible for paying the State's funding match for the customer's ALTCS Service Package. NOTE The county of physical presence (where customer physically resides) and the county of fiscal responsibility may be the same or different counties.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities

ALTCS	ARS 36-2933 AAC R9-28-412 through R9-28-417

B EPD Program and Contractor Enrollment Process

Revised 04/26/2022

Policy

Only customers who are age 65 or older (elderly) or have a physical disability (EPD) whose county of fiscal responsibility (MA1104E) is Maricopa County, Gila County, Pinal County or Pima County may choose their program contractor. Other fiscal counties do not have multiple program contractors.

Enrollment in a program contractor is determined according to the following policy:

- All ALTCS customers who have a developmental disability are enrolled with the Division of Developmental Disabilities (MA1104C).
- EPD American Indians that are within the bounds of a tribal nation status are enrolled with the tribe or Native American Community Health (NACH) if the tribe is not a program contractor (MA1104D).
- EPD customers whose county of fiscal responsibility is Maricopa County, Gila County, Pinal County or Pima County may choose their program contractor (MA1104E).
- All other EPD customers are enrolled with the program contractor that serves their county of fiscal responsibility.

Program Contractors for EPD Customers Not Enrolled with a Tribal Contractor

When a customer does not choose a program contractor before the application is approved, AHCCCS automatically assigns a program contractor and enrolls the customer. A Freedom of Choice letter is mailed to customers informing them of the program contractor they were enrolled in and giving them a 90-day period to choose a different program contractor if they wish to change. If the customer does not contact AHCCCS to choose a different program contractor, the customer will remain enrolled with the auto-assigned program contractor.

AHCCCS currently contracts with the following program contractors to provide ALTCS services to EPD customers who are not enrolled with a tribal contractor:

ALTCS-EPD Program Contractor	**Counties Served**
Banner – University Family Care https://www.bannerufc.com/acc 2701 E. Elvira Road Tucson, AZ 85756 Toll free (800) 582-8686	Maricopa, Gila, Pinal, Cochise, Graham, Greenlee, La Paz, Pima, Santa Cruz, and Yuma

Mercy Care Plan http://www.mercycareplan.com/ 4350 E. Cotton Center Blvd., Bldg. D Phoenix, AZ 85040 (602) 263-3000 Toll free 1-800-624-3879	Maricopa, Pinal, and Pima
UnitedHealthcare http://www.uhccommunityplan.com/ 1 E. Washington Street Phoenix, AZ 85004 Toll free 1-800-293-3740	Apache, Coconino, Gila, Maricopa, Mohave, Navajo, Pinal, and Yavapai

When customers need assistance selecting a program contractor, they may

• visit www.azahcccs.gov/altcschoice; or
• contact the AHCCCS Benefits and Eligibility Specialist for choice counseling.

Definitions

Term	Definition
Choice Counseling	Providing information and services to help customers make enrollment decisions. It includes answering questions and identifying factors to consider when choosing a program contractor. Choice counseling **does not** include making recommendations for or against enrollment into a specific program contractor.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Elderly or Physically Disabled (EPD)	42 CFR 438.71 ARS 36-2933 AAC R9-28-413

C DDD Enrollment

Revised 11/26/2019

Policy

The Department of Economic Security (DES), Division of Developmental Disabilities (DDD) is the statewide ALTCS program contractor for persons with developmental disablities.

An ALTCS customer is enrolled with DDD when DES/DDD has determined that the customer is eligible for services from their agency.

Customers have a choice of DDD health plans that provide physical and behavioral health services, Children's Rehabilitative Services (CRS) and limited long term services and supports. All other long-term care services and support coordination are provided by DES/DDD. The DDD Health Plans are:

• United Healthcare Complete Plan; and
• Mercy Care Plan

Exception:

American Indian and Alaska Native customers have other enrollment options, See MA1104D for more information.

Definitions

Term	Definition
Department of Economic Services, Division of Developmental Disability (DES/DDD)	The state agency responsible for: • Providing services to customers who have specific disabilities; and • Screening, referring, and making eligibility determinations for DDD services. NOTE DES/DDD also administers a 100% state-funded program for customers with developmental disabilities who are not eligible for ALTCS.

Legal Authority

Program	Legal Authorities
ALTCS – DES/DDD	ARS 36-2933 AAC R9-28-414

D American Indian Enrollment

Revised 04/26/2022

Policy

American Indian and Alaska Native customers that qualify for ALTCS are enrolled based on the following policies:

If the customer...	Then the customer is enrolled in...
Has a developmentally disability	One of the following DDD health plan choices • United Healthcare Complete Plan; • Mercy Care Plan; or • DDD American Indian Health Plan (DDD/AIHP) NOTE When enrolling with DDD/AIHP, the customer can also choose to have behavioral health services provided by the Tribal Regional Behavioral Health Authority (TRBHA).
Currently resides or resided within the bounds of a tribal nation prior to placement in an off-reservation nursing facility (on-reservation status)	The tribe that serves that reservation. The customer does not have to be a member of the contracting tribe. Example: A Hopi customer living within the bounds of the Navajo Tribal Nation is enrolled with the Navajo Nation. NOTE If the tribal nation is not served by one of the seven tribes identified as an American Indian program contractor, the person is enrolled in Native American Community Health (NACH). Exception: Persons who reside within the bounds of a tribal nation, but lack any tribal membership are enrolled with an elderly and/or physically disabled (EPD) program contractor.
Lives in a home and community-based services (HCBS) setting that is not within the bounds of a tribal nation	An EPD program contractor based on the customer's county of fiscal responsibility.

Definitions

Term	Definition

American Indian Program Contractors	Seven American Indian tribes deliver case management services and provide directly or arrange for services to American Indians who are elderly and/or physically disabled and reside on-reservation. These tribes are: • Gila River Indian Community; • Hopi Tribe; • Navajo Nation; • Pascua Yaqui Tribe; • San Carlos Apache Tribe; • Tohono O'Odham Nation; and • White Mountain Apache Tribe.
Native American Community Health Center (NACHC)	NACHC provides case management services to elderly and/or physically disabled American Indian ALTCS customers who live on-reservation and do not receive ALTCS case management from a tribe.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS –American Indian Customers	ARS 36-2932 and 2933 AAC R9-28-415

E County of Fiscal Responsibility

Policy

The county of fiscal responsibility must be determined for all ALTCS customers. However, this determination only affects customers who are age 65 or older (elderly) or have a physical disability (EPD) who are not American Indians with on-reservation status or who are not developmentally disabled.

Not all counties have the same program contractors. The fiscal county is determined in order to enroll the customer with the correct program contractor for that fiscal county.

The Benefits and Eligibility Specialist determines the customer's county of fiscal responsibility. The following criteria are used to establish the county of fiscal responsibility:

If the applicant is...	And...	Then the county of fiscal responsibility is...
An adult	• Resides in his or her own home; or • Moved from another state directly into a nursing facility or alternative HCBS setting in Arizona	The county where the applicant currently resides.
	• Resides in a nursing facility; or • Alternative HCBS setting	The county where the applicant last resided in his or her own home.
	• Moved from the Arizona State Hospital to a nursing facility or alternative HCBS; or • Moved from a penal institution to a nursing facility or alternative HCBS	The county where the applicant resided in his or her own home prior to admission to Arizona State Hospital or the public institution.
A child (under age 18)	Parental rights have not been legally severed	The county where the parent(s) live at the time of ALTCS approval.
	Parental rights have been legally severed	The county where the child resides.
	Parents are legally separated	The county where the parent the child resides with.

County of Fiscal Responsibility Examples

How Is Enrollment Affected?

Although the county of fiscal responsibility must be determined for all ALTCS customers, this determination only affects customers who are age 65 and older (elderly) and/or have a physical disability who are not American Indians with on-reservation status.

Not all counties have the same program contractors. The fiscal county is determined in order to enroll the customer with the correct program contractor for that fiscal county.

If the customer is...	Then the county of fiscal responsibility...
• An American Indian with on-reservation status; or • Developmentally disabled.	Does not affect enrollment.
Elderly and/or physically disabled (including an American Indian who does not have on-reservation status)	Affects enrollment with a program contractor.

Definitions

Term	Definition
County of Fiscal Responsibility	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the customer's ALTCS Service Package. The county of physical presence (the county in which the customer physically resides) and the county of fiscal responsibility may be the same county or different counties.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2913 AAC R9-28-712

F Fiscal County Changes

Policy

After ALTCS is approved, the county of fiscal responsibility is changed only when:

- An adult customer moves to his or her own home in a different county;
- The adult customer's program contractors for the county of fiscal responsibility and residing county both agree to change the enrollment to the program contractor for the county where the customer resides; or
- The parent(s) of a child customer under age 18 move to another county.

When the county of fiscal responsibility is changed, the county change and any related enrollment change is effective the day the change is made.

Fiscal County Changes Examples

1) When A Fiscal County Change May Occur

After ALTCS approval, the county of fiscal responsibility is changed when one of the following happens:

If the applicant is...	And...	Then the county of fiscal responsibility is...
An adult	The customer moves to his or her own home in a different county	Changed when the customer's move is reported by: • The customer; • The customer's representative; or • An Electronic Member Change Report is sent to the ALTCS local office by the program contractor.
	The customer moves to a nursing facility or alternative residential setting in another county	Changed when a DMPS Eligibility System Support (ESS) representative requests a fiscal county change. NOTE This occurs when Eligibility System Support (ESS) receives a Program Contractor Change Request form (DE-621) confirming that the program contractors for both counties have agreed to an enrollment change.
	The customer moves from a nursing facility or alternative HCBS setting into the Arizona State Hospital from a county other than Maricopa county	
	The customer moves from the Arizona State Hospital or a nursing facility to another nursing facility or alternative HCBS setting from a county other than Maricopa county	
A child (under age 18) Child Examples	The customer's parents move to another county	Changed when the customer's move is reported.

	The customer's parents and the customer live in different counties	Changed to the county in which the customer resides only when an Eligibility System Support (ESS) representative requests a fiscal county change. NOTE This occurs when Eligibility System Support (ESS) receives a Program Contractor Change Request form (DE-621) confirming that the program contractors for both counties have agreed to an enrollment change.

2) Effect on Enrollment

When the county of fiscal responsibility changes, the customer's enrollment with a program contractor also changes if the customer's current program contractor does not serve the new county.

Effect on Enrollment Examples

Definitions

Term	Definition
County of Fiscal Responsibility	The county of fiscal responsibility is the Arizona county that is responsible for paying the state's funding match for the customer's ALTCS Service Package. The county of physical presence (the county in which the customer physically resides) and the county of fiscal responsibility may be the same county or different counties.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2913 AAC R9-28-712

1105 ALTCS Enrollment in a Choice County

Revised 04/26/2022

Policy

ALTCS customers who are age 65 or older (elderly) or who have a physically disability (EPD) whose county of fiscal responsibility is Maricopa County, Gila County, Pinal County, or Pima County have a choice of program contractors.

Exception:

See MA1104D for American Indian customers with on-reservation status.

When the customer or representative is unable or unwilling to make a choice, the applicant will automatically be assigned to a program contractor.

If a customer does not choose a program contractor before the application is approved, AHCCCS automatically assigns a program contractor and enrolls the customer. A Freedom of Choice letter is mailed to customers informing them of the program contractor they were enrolled in and giving them a 90-day period to choose a different program contractor if they wish to change. If the customer does not contact AHCCCS to choose a different program contractor, the customer will remain enrolled with the auto-assigned program contractor.

Exception:

A customer who is reapplying for ALTCS is reenrolled with the former program contractor when the application is approved within 90 days of disenrollment.

1) Who May Make an Enrollment Choice

The following policy is used to determine who has the authority to make an enrollment choice:

If...	**Then...**
The customer has a legal representative	Only the legal representative may choose a program contractor for the customer.
The customer does not have a legal representative	The customer, an authorized representative, a family member, a friend, a neighbor, or any other interested party who does not have a conflict of interest may make the enrollment choice
More than one person indicates a choice	All parties are contacted to attempt to determine a mutually acceptable choice. If everyone still disagrees, use the following hierarchy to determine which person is given priority in choosing: • Legal representative • Applicant • Spouse • Parent • Authorized representative

If the customer or representative has not selected a program contractor despite reasonable efforts, and has not requested additional time, the Benefits and Eligibility Specialist will see if a choice can be made for the customer. If the customer's primary healthcare provider(s) contract with only one of the available program contractors, the worker will choose that program contractor for the customer. Otherwise, the customer will be automatically assigned to a program contractor.

2) Conflicts of Interest

A person with a conflict of interest is not allowed to make an enrollment choice for the applicant.

If the customer is unable to make the enrollment choice and there is no one without a conflict of interest who can make the choice, AHCCCS chooses the program contractor.

A social worker employed by a nursing facility, or a case manager employed by a program contractor (even if acting as an authorized representative) has a conflict of interest because the selection may have a financial impact on the person's employer.

3) ALTCS Office Responsibilities

The ALTCS office is responsible for:

- Providing enrollment choice information;
- Helping the customer make an informed choice; and
- Documenting enrollment choice, unless a choice cannot be made, and the customer is auto-assigned to a program contractor.

4) Notice of Enrollment Choice

The customer will receive an AHCCCS ID card with confirmation of enrollment. The name and telephone number of the program contractor are printed on the customer's ID card.

The ID card is mailed to the customer after enrollment is processed. The customer should receive the card a few days after application is approved.

Definitions

Term	Definition
Choice County	A county that has more than one program contractor available to ALTCS customers who are age 65 or older (elderly) or have a physical disability (EPD). Currently, Maricopa, Gila, Pinal, and Pima are choice counties.
Conflict of Interest	When a person is employed by or somehow related to a business or entity with a financial interest in the customer's enrollment or placement.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2932 and 2933 AAC R9-28-413

1106 ALTCS Enrollment Changes

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Policies About ALTCS Enrollment Changes

Policy

The following general policies apply to changes in the customer's enrollment after initial approval:

- The customer must be enrolled with a program contractor that serves the customer's county of fiscal responsibility.
- A fiscal county change may also result in an enrollment change when the customer's current program contractor does not serve the customer's new county of fiscal responsibility.
- Because some program contractors serve multiple counties, a fiscal county change does not always result in an enrollment change. If the former and new counties of fiscal responsibility are both served by the same program contractor, enrollment remains unchanged when the county of fiscal responsibility changes.
- An agreement between two program contractors to transfer responsibility for the customer's care will result in a fiscal county change, unless the change is between program contractors within Maricopa County or Pima County.

Some changes require approval (or agreement) by the customer's Program Contractor(s).

See the following sections for situations when approval or agreement is required or not:

- Changes that do not require program contractor agreement (MA1106.B); and
- Changes requiring program contractor agreement (MA1106.C).

NOTE The enrollment change policy in this section applies only to customers who are elderly and/or physically disabled (EPD) and not to customers who receive services through the DES Division of Developmental Disabilities.

Placements by a Program Contractor

When a program contractor places a customer in a nursing facility or alternative residential setting in a different county, the county of fiscal responsibility and enrollment do not automatically change. This may be done to allow a customer to receive specialized treatment or because of lack of beds in the contractor's county.

Definitions

Term	Definition
Program Contractor	Program contractors are responsible for: • Providing services through a managed care plan (health maintenance organization); • Contracting with providers to form a network of service providers; and • Assigning a case manager who works with the customer's primary care physician (PCP) to develop a service plan. The case manager authorizes all long term care services provided through ALTCS.
Elderly and/or Physically Disabled (EPD)	Elderly and physically disabled refers to customers who are not developmentally disabled but: • Are age 65 or older; or • Have been determined disabled by SSA for SSI MAO, or medically eligible for ALTCS based on physical disabilities.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS – EPD Program	ARS 36-2932 and 2933 AAC R9-28-413

B Changes That Do Not Require Program Contractor Agreement

Revised 04/26/2022

Policy

The ALTCS local office may initiate some enrollment and fiscal county changes when information is received from the:

• Customer;

• Customer's representative; or

• Current program contractor.

The ALTCS local office may change the customer's enrollment when:

• A customer who is enrolled with DES/DDD loses developmentally disabled status;

• A tribal contractor requests an enrollment change; or

• The fiscal county changes.

1) Loss of DD Status

Enrollment must be changed when a customer who is enrolled with DES/DDD loses developmentally disabled (DD) status:

• If the customer is an American Indian, the enrollment is changed based on the policy in MA1104.D.

• All other eligible customers are enrolled with an EPD program contractor based on the customer's county of fiscal responsibility.

2) Tribal Contractor Requests Enrollment Change

When an American Indian customer living within the bounds of the tribal nation, either in a medical institution or HCBS facility, moves to an HCBS facility outside the bounds of the tribal nation, the tribal contractor must determine if the customer should be enrolled with the program contractor in the new location.

To request an enrollment change, the tribal contractor must call or write the Division of Health Care Management (DHCM). If the DHCM agrees with the recommendation, the tribal contractor sends an Electronic Member Change Report to the ALTCS local office instructing the Benefits and Eligibility Specialist to change the program contractor to the county where the customer now resides. Agreement by the new program contractor is not required.

3) Fiscal County Changes

If the fiscal county changes to a county that is not served by the current program contractor, enrollment is changed to a program contractor serving the county in which the customer's home is located.

C Changes Requiring Program Contractor Agreement

Revised 02/03/2020

Policy

When agreement of the program contractors is required, both the enrollment change and the effective date must be approved by both the current and requested ALTCS program contractors. Officials representing both program contractors must complete and sign portions of the Program Contractor Change Request (Exhibit 1620-8 in the AHCCCS Medical Policy Manual).

If the requested program contractor does not agree to the change, the current program contractor can ask the Division of Health Care Management (DHCM) to review the case situation. If the Division of Health Care Management (DHCM) determines a change in enrollment would be in the best interest of the customer, DHCM may authorize the enrollment change. If the DHCM determines that a change in enrollment would not be in the best interest of the customer or does not support the choice of the customer, the Division of Health Care Management (DHCM) may deny the enrollment change. The customer may file an appeal with AHCCCS.

Approval of both program contractors is required when:

Who initiated the enrollment change...	**Reason for change...**
Customer or customer's representative	• Customer has moved to a medical facility or alternative HCBS living arrangement in a county not served by the current program contractor. • Parent(s) and child customer live in different counties.
Program Contractor	• Program contractor is responsible for a customer residing outside of their service area and wishes to enroll customer with program contractor who serves the area. • Customer residing in an institution wishes to move to another institution outside of the area served by the customer's program contractor. • Customer initiates move to medical facility or alternative residential facility in another county and requests an enrollment change through the current program contractor.

1107 ALTCS Enrollment Change Within a Choice County

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 09/21/2017

Each year effective on the customer's anniversary date, an ALTCS customer whose fiscal county is Maricopa County, Gila County, Pinal County, or Pima County has the opportunity to change enrollment to one of the other program contractors that serves their fiscal county.

Policy

1) Enrollment Changes Prior to the Anniversary Date

Generally, once enrollment occurs a customer cannot change enrollment until their anniversary date. However, an ALTCS customer whose county of fiscal responsibility is Maricopa County, Gila County, Pinal County, or Pima County may ask to change to a different program contractor serving that county. In certain circumstances, the customer's request may be approved to allow an enrollment change prior to the anniversary date.

The ALTCS local offices have the authority to approve the change request when any of the following conditions exist:

- Erroneous information or agency error;
- Lack of initial enrollment choice;
- Lack of annual enrollment choice;
- Family continuity of care;
- Continuity of institutional or residential setting; and
- Failure to correctly apply the 90-day re-enrollment policy.

An enrollment change may also be made based on medical continuity of care, but requires the involvement of both the current and receiving program contractors.

If an enrollment change is requested for another reason, the customer is referred to his or her current program contractor.

2) Who May Request an Enrollment Change?

The customer or the customer's representative may contact the ALTCS local office and request an enrollment change.

The current program contractor sends an Electronic Member Change Report to the ALTCS local office when the customer or representative requests an enrollment change through their current program contractor and claims one of the situations in MA1107C.

3) Effective Date

An enrollment change is effective the first day of the month following the month in which the change is made.

NOTE When the county of fiscal responsibility is changed, the county change and any related enrollment change is effective the day the change is made.

4) Denial of Enrollment Change Requests

The customer will receive a denial letter informing them of their hearing rights. The customer may file a grievance with AHCCCS if an enrollment change request is denied.

5) Evaluating the Request

Definitions

Term	Definition

Anniversary Date	The date that coverage first goes into effect becomes its anniversary date each year.
90 Day Re-enrollment Rule	If the customer was enrolled with an AHCCCS program contractor within the 90 days prior to the current approval date, the customer is automatically re-enrolled with the same program contractor.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2932 and 2933 AAC R9-28-413

B Annual Enrollment Choice

Policy

Annual enrollment choice is a two-month process. An Annual Enrollment Notice is mailed to the customer or representative approximately two months prior to the customer's anniversary date.

The first month is the customer's choice month. During this month the customer has the option to change to a different program contractor. The customer is instructed to call the Communications Center or return the form to the Communications Center in Central Office by the end of the month to change to a different program contractor. The customer does not need to do anything to remain with the same program contractor. At the end of the month the program contractors are notified of the upcoming enrollment changes.

The second month is the program contractors' transition month. This period allows program contractors to arrange for the transition in case management and providers. The program contractors must be allowed a minimum of one full calendar month to arrange for the transition in case management and providers so there is no interruption in the customer's medical care and services.

1) Requests Received During the Transition Month

AHCCCS accepts an annual enrollment change request through the last day of the transition month. However, the enrollment change will be delayed by one month to provide the required transition period.

2) Requests Received Outside the Annual Enrollment Period

Definitions

Term	Definition
Choice Month	The first month of annual enrollment choice is the customer's choice month. During this month the customer has the option to change to a different program contractor.
Transition Month	The second month of annual enrollment choice is the program contractors' transition month. This period allows program contractors to arrange for the transition in case management and providers.
Anniversary Month	The month that coverage first goes into effect becomes its anniversary month each year.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities

ALTCS	ARS 36-2933 AAC R9-28-413

C Enrollment Changes Authorized by ALTCS Offices

Revised 09/21/2017

Policy

ALTCS local offices have authority to approve a request to change enrollment to another program contractor when:

- Incorrect information was provided to the customer or representative or the agency made an error when the customer was enrolled.
- Customer enrolled or was automatically enrolled with a program contractor that does not contract with that customer's medical providers or facility;
- Lack of initial enrollment choice for a customer living in either Maricopa or Pima Counties;
- Lack of annual enrollment choice because the customer did not receive notice of annual enrollment;
- Customer requests to be enrolled with the same program contractor as other family members;
- Continuity of institutional or residential setting when the customer's program contractor terminates their contract with the long term care medical institution or HCBS community facility; and
- Failure by AHCCCS staff to correctly apply the 90-Day re-enrollment policy.

1) Receipt of Enrollment Change Requests

An ALTCS office may receive an enrollment change request from:

- The customer or the customer's representative; or
- The current program contractor. The current program contractor contacts the ALTCS local office when the customer or representative requests an enrollment change through the current program contractor and claims one of the situations described in this Subsection.

2) Incorrect Information or Agency Error

This situation exists when the customer or representative made an enrollment choice based on incorrect information regarding facility, residential setting, primary care physician or other provider contracting with the chosen program contractor based on information provided at the program contractors website, marketing materials or agency error.

Incorrect information includes omissions or failure to divulge network limitations and restrictions in the program contractor's marketing material or database submissions.

3) Customer Enrolled with Program Contractor that Does Not Contract with the Customer's Provider

This situation exists when the customer enrolled or was automatically enrolled with a program contractor that does not contract with that customer's medical providers or facility but another program contractor does.

4) Lack of Initial Enrollment Choice

Lack of initial enrollment choice exists when an ALTCS applicant whose fiscal county was Maricopa County, Gila County, Pinal County, or Pima County was entitled to enrollment choice and was, for any reason, not given a choice of program contractors during the application process.

5) Lack of Annual Enrollment Choice

Lack of enrollment choice means the customer was entitled to participate in an Annual Enrollment Choice, but

- Was not sent an Annual Enrollment Choice notice; or
- Was sent an Annual Enrollment Choice notice but the notice was not received; or
- Was sent an Annual Enrollment Choice notice but was unable to participate in the annual enrollment choice due to circumstances beyond the customer's control (i.e., the customer or representative was hospitalized, the anniversary date fell within a 90-day disenroll/enroll period).

6) Family Continuity of Care

A family continuity of care issue exists when the customer, either through auto-assignment or the choice process is not

enrolled with the same program contractor as other family members. Family members, especially married couples, may request, for continuity of care, to be enrolled with the same program contractor.

7) Continuity of Institutional or Residential Setting

An enrollment change may be approved when the customer's program contractor terminates their contract with the institutional or alternative residential setting in which the customer lives, and the customer or the customer's representative requests to change to a program contractor who does contract with the customer's institutional or alternative residential setting. The customer must be enrolled and living in the facility at the time of the contract termination.

If the provider (nursing facility or alternative residential setting) terminates the contract, instruction from the Program Support Administration is required before the Benefits and Eligibility Specialist makes any enrollment change.

8) Failure to Correctly Apply the 90-Day Re-Enrollment Policy

This situation exists when the customer:

• Lost ALTCS eligibility and was disenrolled;
• Was subsequently reapproved for ALTCS within 90-days of the disenrollment date; and
• Was enrolled with a different program contractor.

To correct this situation, the customer is re-enrolled with the program contractor he or she was enrolled with prior to the disenrollment.

9) Evaluating the Request

Definitions

Term	Definition
Family Continuity of Care	The customer requests to be enrolled with the same program contractor as other family members.
90 Day Re-enrollment Rule	If the customer was enrolled with an AHCCCS Complete Care (ACC) plan within the 90 days prior to the current approval date, the customer is automatically re-enrolled with the same health plan.
Annual Enrollment Choice	Annual enrollment choice is a two-month process that allows a customer to select a new AHCCCS Complete Care (ACC) plan: • Choice month; and • Transition month.
Choice Month	The first month of annual enrollment choice is the customer’s choice month. During this month the customer has the option to change to a different program contractor.
Transition Month	The second month of annual enrollment choice is the program contractors’ transition month. This period allows program contractors to arrange for the transition in case management and providers.
Anniversary Month	The month that coverage first goes into effect becomes its anniversary month each year.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2933 AAC R9-28-413

D Medical Continuity of Care

Policy

Special program contractor changes may be approved on a case-by-case basis to ensure the customer's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.

Approval requires consent of the Medical Directors of both program contractors or approval by the AHCCCS Chief Medical Officer.

The program contractors determine the effective date of the enrollment change.

Definitions

Term	Definition
Medical Continuity of Care	Special program contractor changes to ensure the customer's access to care. This is made on a case-by-case basis.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
ALTCS	ARS 36-2932 and 2933 AAC R9-28-413

1108 Disenrollment

Revised 09/14/2018

Policy

Disenrollment due to loss of eligibility is effective with the end of the month prior to the effective date of discontinuance with the following exceptions:

- Death;
- Voluntary discontinuance;
- Discontinuance due to a hearing decision; and
- Incarceration.

1) Death

Disenrollment due to death is effective on the date of death.

2) Voluntary Discontinuance

Disenrollment based on a request for voluntary discontinuance by the customer or the customer's representative is effective on the last day of the month prior to the effective date of discontinuance.

Exception: If the customer or representative requests an immediate voluntary discontinuance, disenrollment is effective the day after the date the discontinuance is received by PMMIS.

3) Discontinuance Due to a Hearing

When benefits have been continued pending an eligibility appeal decision and the discontinuance is upheld, disenrollment is effective the date the discontinuance (based on the hearing decision) is received by PMMIS.

4) Incarceration

When a customer is detained and incarcerated, the customer's enrollment is changed to a no pay status. If jailed in a county that sends daily notifications to AHCCCS, the customer's enrollment is reinstated when released. If incarcerated in the AZ Department of Corrections or an AZ county that does not send daily notification to AHCCCS, the customer's eligibility is stopped.

Definitions

Term	Definition
Voluntary Withdrawal	Disenrollment based on a request for voluntary discontinuance by the customer or the customer's representative.
Eligibility Hearing	The eligibility hearing is an administrative process. It is designed to ensure a fair and impartial review of an adverse action that is appealed.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
All Programs	AAC R9-22-1705(C) AAC R9-28-418 (ALTCS)

1109 Children's Rehabilitative Services

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 10/01/2018

Policy

Children's Rehabilitative Services (CRS) is a designation that provides medical treatment, rehabilitation, and related support services for customers with special health care needs.

To get a CRS designation, the customer must meet the following requirements:

- Be under the age of 21 at the time of initial determination of the CRS designation
- Have a CRS-qualifying condition requiring active treatment; and
- Receiving full acute AHCCCS Medical Assistance or ALTCS/DDD services.

Definitions

Term	Definition
Active Treatment	There is a current need for medical, surgical, or therapeutic treatment of the CRS qualifying condition, or it is anticipated that treatment or evaluation for continuing treatment of the CRS qualifying condition will be needed within 18 months of the date of the most recent CRS service.
CRS-qualifying condition	One of the physical conditions listed in the Arizona Administrative Code at R9-22-1303. These include conditions affecting the following: • Cardiovascular system; • Endocrine system; • Genitourinary system; • Ear, nose, or throat; • Musculoskeletal system; • Gastrointestinal system; • Nervous system; • Ophthalmology; • Respiratory system; • Dermatologic system; • Metabolic system; and • Hemoglobinopathies.

Legal Authority

Program	Legal Authorities

Children's Rehabilitative Services (CRS)	ARS 36-2912 9 AAC 22, Article 13

B CRS Application and Designation

Revised 11/26/2019

Policy

1) Children's Rehabilitative Services (CRS) Application and Designation

A CRS application must be filled out and submitted with medical records from the specialist who is treating the CRS condition. The medical records need to include information about the person's medical condition and the need for treatment within 18 months.

Anyone can complete a CRS application for the customer, including a family member, doctor, or health plan representative. The completed application along with the medical records can be mailed, faxed or dropped off in person to the CRS Unit.

A copy of the CRS application with instructions and contact information for the CRS Unit are available on the AHCCCS website at: https://azahcccs.gov/PlansProviders/CurrentProviders/CRSreferrals.html

2) Processing Timeframes

The CRS designation decision must be completed within 60 days of the date that a complete CRS application is submitted to the CRS Unit. The customer and the AHCCCS Complete Care (ACC) plan are sent a letter with the CRS decision. The CRS designation starts the date the decision is made.

An AHCCCS provider or health plan may ask for a rush on the CRS decision when the customer has an urgent need for treatment. The CRS Unit reviews these requests and works with the health plan to coordinate the process as needed.

3) Responsibility for covering CRS Services

Customers with a CRS designation get CRS services through their AHCCCS Complete Care plan. DDD customers get their CRS services through their DDD Health Plan.

If the customer opts out of their CRS designation, the customer will get the same services through their AHCCCS Complete Care (ACC) plan.

Definitions

Term	Definition
Department of Economic Security Division of Developmental Disability (DES/DDD)	The ALTCS program contractor for all developmentally disabled persons statewide. DDD is responsible for: • Providing a variety of services to persons who have specific disabilities; • Screening and referring developmentally disabled participants to AHCCCS for an ALTCS eligibility determination. NOTE DDD also administers a 100% state-funded program for persons with a developmental disability who are not eligible for ALTCS.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 9 AAC 22, Article 13

C CRS Designation Changes

Revised 11/26/2019

Policy

1) Removal of Designation

CRS designation ends when the customer:

- Is disenrolled from AHCCCS;
- Transitions to ALTCS/EPD and is enrolled with a program contractor;
- Asks to remove the CRS designation; or
- No longer meets the medical eligibility requirements for the CRS program.

NOTE If a medical condition is removed from the list of CRS qualifying conditions in R9-22-1303, it does not impact a customer's CRS designation for customers who are already in active treatment for that condition.

2) Re-designation

CRS customers under age 21 that lose AHCCCS eligibility but regain it within 12 months will get a CRS designation without a new application.

Customers may also get a CRS designation without a new application when they have opted out of CRS, but change their minds within 12 months.

The AHCCCS CRS Unit may use the information already in the system to determine if the customer is eligible for CRS , or may need updated documentation.

Legal Authority

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 9 AAC 22, Article 13

D CRS Designation Reviews

Revised 10/01/2018

Policy

Continued designation for CRS is reviewed when the customer is no longer in active treatment for a CRS qualifying condition. The health plan notifies AHCCCS that the CRS customer is no longer in active treatment.

The AHCCCS CRS Unit reviews the customer's continued need for services. If needed, additional medical documentation is requested from the health plan.

If the customer no longer needs treatment for a CRS qualifying condition, a letter is sent to the customer that the CRS designation is ending and the customer's right to appeal the decision. The health plan is also notified of the decision.

If it is determined that the customer is still eligible for a CRS designation, the health plan is notified of the decision.

Definitions

Term	Definition
CRS qualifying condition	One of the physical conditions listed in the Arizona Administrative Code at R9-22-1303. These include conditions affecting the following: • Cardiovascular system; • Endocrine system; • Genitourinary system; • Ear, nose, or throat; • Musculoskeletal system; • Gastrointestinal system; • Nervous system; • Vision; • Respiratory system; • Dermatologic system; • Metabolic system; and • Hemoglobinopathies.

Legal Authority

Program	Legal Authorities
Children's Rehabilitative Services (CRS)	ARS 36-2912 AAC R9-22, Article 13

1200 Introduction

In this chapter you will find:

- The policies for premiums, co-payments, the Transplant Program share of cost and the ALTCS share of cost;
- Any definitions needed to explain the policy; and
- A list of the federal and state laws that apply.

1201 ALTCS Share of Cost (SOC)

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Overview

Revised 03/28/2023

Policy

The Share of Cost (SOC) is a monthly amount a customer must pay toward the cost of long term care services. Customers who qualify for ALTCS or FTW – ALTCS may have a SOC. However, the maximum SOC is limited to the monthly capitation rate for the customer.

Customers who get ALTCS Acute Care only, and FTW – ALTCS customers who live in an HCBS setting do not have a SOC.

The SOC amount is based on the customer's:

- Counted income;
- Living arrangement; and
- Allowed SOC deductions.

The SOC is recalculated each time there is a change in the customer's income or amount of the SOC deductions.

The ALTCS program contractor is usually responsible for collecting the SOC from the customer. However, there are exceptions as described in the table below:

If the customer...	**Then...**
Is eligible, but not enrolled during a month	The program contractor is not responsible for collecting the customer's SOC for that month.
Changes program contractors during the month	Each program contractor is entitled to a portion of the monthly SOC based on the number of days the customer is enrolled with that program contractor. The program contractor with whom the customer is first enrolled during the month is responsible for collecting the SOC, figuring each program contractor's share, and transferring the prorated SOC amount to the receiving program contractor.

Definitions

Term	**Definition**
ALTCS Acute Care only	The customer qualifies for the ALTCS program but cannot receive long-term services.
Capitation rate	A fixed rate paid to the health plan or program contractor for the delivery of services to each customer enrolled with that health plan or program contractor, regardless of the amount of medical services the customer receives.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) 42 CFR 435.725 and 435.726 ARS 36-2932(L) AAC R9-28-408, 410, 411
FTW-ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) ARS 36-2950 AAC R9-28-1321

B Income Used to Calculate the SOC

Revised 12/27/2022

Policy

The income used for the Share of Cost (SOC) calculation is generally the same as the income used for income eligibility, but some income types are counted differently when calculating SOC.

The following table describes how to count these incomes for SOC:

If the customer...	Then…
• Receives SSI Cash; • Lives in a certified Long Term Care (LTC) medical facility; and • Has more than 50% of their cost-of-care paid for by ALTCS	When the customer has no additional income, the counted SSI Cash amount is $30.00. When the customer's additional income is equal to or more than $50.00, the counted SSI Cash amount is $0.00. When the customer's additional income is less than $50.00, the counted SSI Cash amount is the difference between $50.00 and the additional income. Countable SSI Cash cannot exceed $30.00.
• Is a veteran or the surviving spouse of a veteran; • Has no spouse or dependents; and • Is a resident of an Arizona State Veteran Home	Count all Veteran's Assistance (VA) benefit amounts including: • Aid and Attendance (A&A); and • Unusual Medical Expenses (UME). See MA606RRR for more information about VA benefits.
Has income assigned to a Special Treatment Trust	See MA803E.2 for instructions.
Is eligible for FTW - ALTCS	Gross earned and unearned income is counted.
Was determined eligible using Community Spouse policy	Only the customer's income is counted.

Definitions

Term	Definition
Gross income	Income amount before any deductions like taxes or insurance.

Legal Authority

Program	Legal Authorities
ALTCS FTW - ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) 42 CFR 435.725 and 726 ARS 36-2932(L) and 36-2934.01 AAC R9-28-408, 410, 411 AAC R9-28-1321 (FTW – ALTCS)

C Share of Cost (SOC) Deductions

Revised 12/19/2023

Policy

Certain deductions are subtracted from the customer's total counted income when determining the Share of Cost (SOC). The table below lists the deductions that apply.

When ALTCS eligibility was determined using…	Then the customer may qualify for…
Community spouse or non-community spouse rules (All customers)	• Personal Needs Allowance (PNA); • Medicare and other Third-Party Liability (TPL) health insurance premiums; and • Non-covered medical expenses.
Community spouse policy	• Community Spouse Monthly Income Allowance (CSMIA). The income of the institutionalized spouse must actually be given to the community spouse to allow this deduction; and • A family allowance, for each dependent family member. Proof of the family's income must be provided to allow this deduction.
Non-community spouse policy	• Any one of the following maintenance needs allowances: ◦ Spousal Needs Allowance; ◦ Family Needs Allowance; or ◦ Home Maintenance Needs Allowance; and • A special deduction for some residents of the Arizona State Veteran Home.

1) Personal Needs Allowance (PNA)

The amount of the Personal Needs Allowance (PNA) is determined on a month-by-month basis. The PNA amount depends on the customer's living arrangement during the calendar month. For more information about living arrangements, see MA521.

The amount of the PNA is calculated as follows:

If the customer...	Then the PNA for that month is...

Lives in a long-term care medical facility for the entire calendar month	• 15% of the Federal Benefit Rate (FBR) for ALTCS customers; or • 15% of the FBR plus 50% of the customer's gross earned income for the month for FTW – ALTCS customers
During any part of the calendar month, lives in: • His or her own home; • An HCBS setting; or • A jail, prison, or other detention facility	300% of the FBR.
Has garnished court-ordered child support or spousal support	Increased by the amount of the garnished court-ordered child support or spousal support including administrative fees. See Example PNA for Garnishment

The Table below lists the FBR Standards used to determine the PNA:

	Effective 01/01/2022 to 12/31/2022	**Effective 01/01/2023 to 12/31/2023**	**Effective 01/01/2024 to 12/31/2024**
15% of the FBR	$126.15	$137.10	$141.45
300% of the FBR	$2,523.00	$2,742.00	$2,829.00

2) Spousal Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, a customer with a spouse but no dependent children living at home gets a deduction for the maintenance needs of the spouse. The customer may be living either in a medical facility or in the community.

The spousal allowance is calculated by subtracting the spouse's counted income from the amount of the individual FBR.

3) Family Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, a customer with dependent children living at home gets a deduction for the maintenance needs of the family. The customer may be living either in a medical facility or in the community.

The customer's family includes any of the following living in the home:

• The customer's spouse; and

• The customer's dependent children, including stepchildren.

The Family Allowance is determined by subtracting the combined counted income of the spouse and children from the AFDC A-1 Need Standard shown in the table below for the number of family members (not counting the customer).

Number of people	**Need Standard**

1	$567
2	$765
3	$964
4	$1,162
5	$1,360
6	$1,559
7	$1,757
8	$1,955
9	$2,153
10	$2,351
11	$2,549
12	$2,747
13	$2,945

NOTE For families larger than 13, add $198 to the Need Standard for each additional person.

See Family Allowance (Non-CS) SOC Examples

4) Home Maintenance Needs Allowance (Non-Community Spouse)

When eligibility was determined using non-community spouse rules, the customer may qualify for a Home Maintenance Needs Allowance for up to six months when the customer:

• Lives in a medical institution for the entire calendar month;

• Does not have a spouse or child living at home;

• Is responsible for paying shelter expenses to maintain his or her home; and

• Is likely to return to the home within six months of the date the customer entered the medical institution.

The Home Maintenance Needs Allowance is based on a federal standard and changes infrequently:

Effective 01/01/1989 to 06/30/1993	**Effective 07/01/1993 to Present**

$138.00	$210.00

The Home Maintenance Needs Allowance is deducted beginning the first month following the month the customer entered the medical institution.

In the case of institutionalized couples, only one Home Maintenance Needs Allowance is allowed. If both spouses are expected to return home within the six-month period, the Home Maintenance Needs Allowance is deducted from the SOC of the spouse for whom it would be most beneficial.

The home maintenance allowance can be applied to separate periods of institutionalization for the same customer. However, a temporary absence from an institution is not a basis for beginning a new six-month period for the deduction. The customer must be discharged from the institution before another six-month period is allowed.

See Home Maintenance Needs Allowance SOC Examples

5) Community Spouse Monthly Income Allowance (CSMIA)

When eligibility is determined using community spouse policy, a customer may qualify for a Community Spouse Monthly Income Allowance (CSMIA) deduction when the customer actually gives the monthly CSMIA amount to the community spouse.

If a court has ordered the customer to pay monthly financial support for the community spouse, the CSMIA is the higher of:

• The amount of the monthly support ordered by the court; or

• The calculated CSMIA.

NOTE An Administrative Law Judge may increase the amount of the MMMNA when the customer or spouse appeals the amount and there is proof that the community spouse has a greater need due to circumstances resulting in significant financial hardship.

Steps used to calculate the CSMIA

The following steps are used to calculate the CSMIA. Detailed information about the amounts used in the steps is included below the table:

Step	Action
1	Add the Utility Allowance to the Community Spouse's verified shelter costs.
2	Take the total from Step 1 and subtract 30% of the Monthly Spousal Need Standard. Any remaining amount is the Excess Shelter Allowance.
3	Add the Excess Shelter Allowance and the Monthly Spousal Need Standard. The result is the Minimum Monthly Maintenance Needs Allowance (MMMNA).
4	Compare the MMMNA from Step 3 to the Maximum Monthly Maintenance Needs Standard.
5	Take the lower of the amounts from Step 4 and subtract the counted monthly income of the community spouse. The result is the CSMIA.

Standards used to calculate the CSMIA

The following standards are used in calculating the Community Spouse Monthly Income Allowance (CSMIA) for a community spouse. These are federal standards that change annually:

	Effective 07/01/2020 to 06/30/2021	**Effective 07/01/2021 to 06/30/2022**	**Effective 07/01/2022 to 06/30/2023**	**Effective 07/01/2023 to 06/30/2024**
Monthly Spousal Need Standard	$2,155.00	$2,178.00	$2,289.00	$2,465.00
30% of the Monthly Spousal Need Standard	$647.00	$654.00	$687.00	$740.00

	Effective 01/01/2021 to 12/31/2021	**Effective 01/01/2022 to 12/31/2022**	**Effective 01/01/2023 to 12/31/2023**	**Effective 01/01/2024 to 12/31/2024**
Maximum Monthly Spousal Need Standard	$3,259.50	$3,435.00	$3,715.50	$3,853.50

Standard Utility Allowance (SUA)

Effective 10/01/2020	**Effective 10/01/2021**	**Effective 10/01/2022**	**Effective 10/01/2023**
$295.00	$288.00	$325.00	$318.00

Utility Allowance

When calculating the CSMIA, the customer qualifies for a Utility Allowance when:

• The customer or community spouse pays for heating or cooling the home where the community spouse resides; and

• The costs are billed separately from their rent or mortgage on a regular basis.

The household does not need to be billed by a utility company to get this allowance. If the utility bill is in another person's name but the customer or spouse pays the bill, the customer gets the Utility Allowance.

The customer can get the Utility Allowance even when the household has heating or cooling costs for only part of the year. This includes those who have heating but not cooling costs, or cooling costs but not heating costs.

A Utility Allowance is allowed when household receives Low Income Home Energy Assistance (LIHEA) payments directly or through a vendor.

When the household qualifies for a Utility Allowance, the amount allowed is either:

• The Standard Utility Allowance (SUA); or

• A portion of the SUA.

When the household shares utility expenses with another household, or does not have a separate utility meter:

• The SUA is divided equally by the number of households which share the expense, if each pays an equal share; or

• The SUA is prorated among the households based on the portion paid by each.

When the household pays a required condominium or cooperative maintenance charge that includes a utility expense, that utility expense amount is subtracted from the SUA to get the Utility Allowance.

The following expenses do not qualify the household for the Utility Allowance:

• Costs of operating fans for cooling, portable space heaters, electric blankets, and heat lamps;

• Costs for cooking stoves, unless the stove is the primary heating source;

• The costs of cutting wood for heating;

• Costs for water for evaporative coolers; and

• Costs only for excess heating or cooling expenses. For example, when a customer's utilities are included in the rent up to a certain usage level or dollar amount, the excess amount does not qualify.

When both spouses live in the community, each spouse gets the full Utility Allowance calculated.

Excess Shelter Allowance

A customer may get an Excess Shelter Allowance only for verified shelter expenses.

Shelter expenses that are paid annually, semi-annually, or quarterly, such as taxes, and homeowner's insurance, are divided by the number of months they cover to determine a monthly amount.

When both spouses are receiving or intending to receive HCBS, share the same residence, and are eligible for ALTCS benefits, each is entitled to half of the verified shelter expenses for the Excess Shelter Allowance.

See Community Spouse SOC Examples

6) Community Spouse Family Allowance

When eligibility is determined using community spouse policy, a customer may qualify for a Community Spouse Family Allowance when the customer has a dependent family member living at home with the community spouse.

A family member must meet all of the following to be considered a dependent:

• Income low enough to be claimed as a tax dependent;

• At least 50% of the cost of the family member's support was paid by the customer and the community spouse; and

• Citizenship or residency requirements.

When both spouses are eligible for ALTCS benefits and living in the community, each spouse gets one-half of the Family Allowance.

Income low enough to be claimed as a tax dependent

The family member must not receive enough income during the year to have to file a tax return. For current information about who must file a tax return, go to the IRS webpage listed below and select Publication (Publ.) 501.

http://apps.irs.gov/app/picklist/list/formsPublications.html

Exception:

A child whose income is high enough to have to pay taxes can still be considered a dependent when he or she meets any of the following criteria:

• Was under 19 years of age at the end of the calendar year; or

• Was under 24 years of age at the end of the calendar year and was enrolled as a full-time student at a school during any 5 months of the calendar year.

NOTE The school must have a regular teaching staff, course of study, and enrolled body of students in attendance. On-the-job training courses or correspondence schools do not qualify.

A married family member who is required to file a tax return and files a joint return cannot be a dependent. When the married family member is not required to file and only filed to get a refund, the person can be a dependent.

Support Requirement

To be considered a dependent, the institutionalized or community spouse must have paid over half of the family member's support in the calendar year, including such items as:

• Basic needs like food, clothing and housing;

• Medical and dental care;

• Recreation; and

• Education.

In general, when both parents together paid more than half of the child's support, the child is considered the dependent of the custodial parent if the parents are divorced or separated.

The child is only the dependent of a non-custodial parent when:

• The custodial parent signs IRS Form 8332, or similar written statement, agreeing not to claim the child as a dependent, or

• A divorce decree or other court order states that the non-custodial parent can take an income tax exemption for the child, and the non-custodial parent provided at least $600 for the child's support in the calendar year.

Citizenship or Residency Requirements

To be considered a dependent, the family member must meet one of the following:

• A citizen or national of the U.S.;

• A noncitizen who is a resident of the U.S., Canada, or Mexico; or

• A noncitizen child adopted by and living the entire calendar year with a U.S. citizen parent in a foreign country.

Calculation

The Family Allowance is calculated for each dependent as follows:

Step	Action
1	Start with the Monthly Spousal Need Standard and subtract the dependent's counted monthly income.
2	Divide the remainder from Step 1 by three. The result is the Community Spouse Family Needs Allowance for that family member.

See Community Spouse SOC Examples

7) Health Insurance Premiums

A SOC deduction is allowed for health insurance premiums the customer pays for his or her own coverage. A deduction is not allowed for premiums paid by anyone else or for any part of the premium that covers anyone else. When the premium covers people in addition to the customer, only the customer's share of the premium is allowed as a SOC deduction. Health insurance includes any of the following:

• Medicare;

• Group health insurance;

• Dental insurance;

• Hearing aid insurance;

• Vision care insurance; and

• Prescription drug plans.

Exception:

Premiums for insurance policies that pay a flat rate benefit or a set amount to the person regardless of the actual charges or expenses are not allowed as SOC deductions.

Prorating Health Insurance Premiums

When the premium is billed less often than monthly (for example, quarterly or annually), the customer can choose to have the health insurance premium payment either:

• Deducted from the SOC for the month in which the payment is due; or

• Divided by the number of months it is meant to cover to get a monthly SOC deduction.

See Example Prorating Health Insurance Premiums

Pension Supplements for Health Insurance Premiums

When the customer's pension benefit includes an amount to pay for all or part of the cost of health insurance premiums, a SOC deduction is only allowed for the amount of the health insurance premium that exceeds the amount reimbursed. When the customer also pays health insurance premiums for a spouse, the customer's share of the insurance premium is compared to the total reimbursement received. A SOC deduction is allowed only for the amount of the customer's share of the insurance premium that exceeds the total reimbursement.

See Example Pension Supplement for Health Insurance Premiums

Extra Help for Medicare Part D Coverage

When a customer's Medicare Part D premium is all or partly paid by the Extra Help program, a SOC deduction is only allowed for the amount of the Medicare Part D premium the customer actually pays.

See Example Extra Help for Medicare Part D Coverage

8) Non-Covered Medical Expenses

A SOC deduction is allowed for medical expenses that are not covered by the program contractor or any other health

insurance.

NOTE When the customer is not eligible for the ALTCS full benefit package due to a transfer penalty period, non-covered medical expenses during that period will not be allowed as a SOC deduction.

To qualify for the SOC deduction, the expense must:

- Be medically necessary;
- Be ordered by a licensed healthcare professional (i.e., doctor, dentist, or other provider);
- Not be covered by a third-party (including percentages of unpaid expenses);
- Be the customer's responsibility to pay;
- Be either:
  - A type of care not normally covered by AHCCCS benefits, or
  - A type of care normally covered by AHCCCS, but that AHCCCS cannot pay because the customer was not eligible during the time of service; and
- Has been provided within a specific time period, as described in the table below.

When the customer has non-covered medical expenses and the…	Then…
Application is pending	The deduction for unpaid expenses applies to services received up to 3 months prior to the month the application is submitted. See Example Expenses Incurred While an Application is Pending
ALTCS eligibility is ongoing	• Proof of current payments must be received by the last day of the month after the payment is made. • There is no time limit on reporting unpaid non-covered medical expenses.

Paid Expenses

The amount of the deduction is the actual amount paid for the non-covered medical expense.

When the actual amount paid is more than the SOC for that month, the SOC is zero. Any remaining amount is not deducted in a future month.

See Example Current Payments for Services

Unpaid Expenses

The unpaid balance is the total charge for the medical expense minus the amount covered by a third-party payor minus any payments made.

When an unpaid balance is more than the SOC for the month, the remaining unpaid balance is deducted in the next month. The deduction continues until the full balance is applied.

NOTE A non-covered medical expense paid by a friend, relative, or other party is treated as the customer's unpaid expense when the customer has an agreement to repay that person.

See Example Unpaid Expenses

The allowable amount of the deduction is determined as follows:

When the non-covered medical expense is...	The amount of the deduction is...
A type of service that is covered under the AHCCCS Medical Benefits Package	Limited to the amount Medicaid would normally pay.
A type of medical expense that is not covered under the AHCCCS Medical Benefits Package.	The fair market value for the medical expense.
A long-term care service not covered due to a transfer penalty period.	Zero.
The customer's responsibility such as: • Co-payments; • Co-insurance; and • Deductibles	The amount the customer is responsible to pay.

See Example Calculating the SOC Deduction for Non-Covered Medical Expenses

9) Special Deduction for Some Residents of an Arizona State Veteran Home

A customer who is a resident of an Arizona State Veteran Home gets a special SOC deduction when:

• The customer is a veteran or the surviving spouse of a veteran; and

• The customer has no spouse or dependent children.

Up to $90.00 of the VA pension benefits, including increases for aid and attendance and unusual medical expenses, is allowed as a deduction from the SOC.

The deduction may not exceed the total VA payment. When the customer receives less than $90.00 in VA benefits, the deduction is equal to the VA payment.

Definitions

Term	Definition
Arizona State Veteran Homes (ASVHs)	Medicare certified skilled nursing facilities owned and operated by the State of Arizona. ASVHs serve the long-term care and rehabilitative needs of the veterans of Arizona.
Heating and cooling costs	Heating costs include expenses of electricity, gas, wood, and other heating fuels. Cooling costs include costs for room air conditioners, central air conditioning or evaporative coolers.
Child	Natural, adopted or stepchild of the customer or the community spouse.

Medically necessary	A covered service provided by a physician or other licensed practitioner of the healing arts within the scope of practice under state law to prevent disease, disability or other adverse conditions or their progression, or to prolong life.
Non-covered medical services	Non-covered medical services are medically necessary medical or remedial services that are not covered by the ALTCS program contractor.
Shelter expenses	Shelter costs include rent, mortgage, real property taxes, homeowner's association fees, and homeowner's insurance.
Third-party liability (TPL)	Responsibility of a person, entity, or program to pay for any of a person's medical costs. Third-party liability includes: • Health and dental insurance; • Payments from insurance; • Payments from lawsuits; • Other medical settlements, claims, or benefits; and • Medical support for a child from an absent parent.

Proof

The proof needed varies depending on the SOC deduction as described below:

1) Proof for the Home Maintenance Needs Allowance

Proof of Shelter Expenses

The customer must provide proof that he or she has shelter expenses that need to be paid to maintain the home. Items that may be used as proof include:

• Mortgage statements;

• Tax statements or bills;

• Utility bills;

• Homeowner's insurance or association fee bills; and

• Telephone call to any of the above companies confirming the customer's responsibility for and the amount of the expense.

Likely to Return Home

Proof is limited to a written statement from a physician that states the customer is likely to return to the home within six months from the date the customer entered the institution. The physician's statement must be provided before the date the customer is expected to return home and must show the potential discharge date.

2) Proof for the CSMIA

Excess Shelter Allowance

Items that may be used as proof include:

• Mortgage statements;

• Tax statements or bills;

• Utility bills;

• Homeowner's insurance or association fee bills; and

• Telephone call to any of the above companies confirming the customer's responsibility for and the amount of the expense.

3) Proof of Health Insurance Premiums

Proof of the amount of the premium and who is responsible to pay the premium must be provided before the premium amount can be deducted from the SOC. When proof of a future premium amount is received, the premium amount is deducted from the future SOC.

NOTE If someone other than the customer is paying the premium, it is not necessary to prove the amount of the premium since it is not an allowable deduction from the SOC.

4) Proof of Non-Covered Medical Expenses

To allow a SOC deduction for a non-covered medical expense, the following must be verified:

• The expense is medically necessary;

• The services were provided by a licensed health care professional;

• The expense is not covered by the customer's insurance or a third-party liability;

• The expense will not be covered by the AHCCCS Medical Benefits package;

• The customer is responsible for payment; and

• The amount and date the expense was incurred or paid.

Proof that Services Were Medically Necessary

Proof that the service was medically necessary includes:

• A written statement by a licensed health care professional; or
• Billing statements for preventive services

5) Proof of Garnished Court-Ordered Child Support or Spousal Support

To allow an increase in the Personal Needs Allowance (PNA) for garnished court-ordered child support or spousal support, the following proof must be provided:

• Court documents; and

• Proof the income is garnished. Proof includes:

◦ Letter from payor;

◦ Pay stubs; or

◦ Collateral contact with the source of the payment.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1396a(q) 42 USC 1396r-5(d) 42 CFR 435.725 and 726 ARS 36-2932(L) AAC R9-28-408 and 410

D ALTCS Cost Effectiveness Study Share of Cost (CES SOC)

Revised 03/30/2018

Policy

Program contractors cannot by law pay more for a person's HCBS than they would pay for that same person in a nursing facility, except for a very short amount of time.

The Cost Effectiveness Study Share of Cost (CES SOC) gives the program contractor a figure to use in determining if providing HCBS to a customer is cost effective.

The program contractor may advise the person to consider other alternatives or options if the cost of the HCBS needed is more than the program contractor would be allowed to pay if the customer were in a nursing facility.

1202 Co-Payments

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Mandatory and Optional Co-Payment Groups

Revised 03/03/2014

Policy

Customers who receive AHCCCS Medical Assistance under the following programs are responsible for either optional or mandatory co-payments, unless they meet any one of the exemption criteria in MA1205:

Optional	Mandatory
• SSI Cash • SSI MAO • Caretaker relative • Child • FTW • YATI	• Transitional Medical Assistance (TMA)

1) Exemptions

A customer who meets any of the following is exempt from co-payments:

• Under age 19;
• Children eligible to receive services from the Children's Rehabilitative Services (CRS) program;
• Diagnosed as Seriously Mentally Ill (SMI) by the Arizona Department of Health Services (ADHS);
• Receiving acute care benefits and temporarily living in a nursing home or residential facility, but only when the customer's medical condition would otherwise require hospitalization. This exemption is limited to 90 days in a contract year;
• Receiving hospice care;
• Enrolled with American Indian Health Program (AIHP);
• Eligible for AHCCCS Medical Assistance on a fee-for-service (FFS) basis; or
• Pregnant.

2) Exempt Coverage Groups

Customers who qualify for AHCCCS Medical Assistance under any of the following coverage groups are exempt from co-payment requirements:

• ALTCS, including Freedom to Work-ALTCS;
• Medicare Savings Programs (QMB, SLMB or QI-1);
• KidsCare.
• Adult Group (temporarily)
• Breast & Cervical Cancer Treatment Program

3) Co-Payment Amounts for the Optional Group

Co-payments apply only to specific services and to people who are not exempt.

Co-payments for the optional group described in MA1205 are as follows:

Service	Amount
Prescriptions	$2.30
Doctor or other Provider outpatient office visits for evaluation and management of care (Well Person) or non-emergency surgical procedures	$3.40
Physical, Occupational or Speech Therapies	$2.30

NOTE Providers are required to provide these services even if the member is unable to afford the co-payment.

4) Co-Payment Amounts for TMA Customers

Co-payments for TMA customers who are not exempt (MA1205 and MA1205) are as follows:

Service	Amount
Prescriptions	$2.30
Doctor or other Provider outpatient office visits for evaluation and management of care (Well Person)	$4.00
Physical, Occupational or Speech Therapies	$3.00
Non-emergency surgical procedures in an outpatient setting.	$3.00

NOTE These co-payments are mandatory and the pharmacist or medical service provider can deny a TMA customer services if the customer does not make the co-pays.

A family receiving TMA will not be required to make the co-pays if the total amount of the co-pays the family made is more than 5% of the family's gross income (before taxes and deductions) during a calendar quarter.

AHCCCS will inform customers when family co-pays exceed 5%. However, if a customer thinks that he or she has paid co-pays that equal 5% of the customer's family total quarterly income and AHCCCS has not told the customer that this has happened, the customer should send copies of receipts or other proof of how much the customer has paid to AHCCCS, 801 East Jefferson, Mail Drop 3600, Phoenix, Arizona 85034.

Definitions

Term	Definition

Co-Payment	A co-payment is the amount that the customer pays to a medical provider when a medical service is received. Customers who are eligible in some AHCCCS coverage groups have optional co-payments, while others have mandatory co-payments.
Optional co-payments	When a customer has optional co-payments, the provider must provide the service even when the customer does not pay the co-payment.
Mandatory co-payments	When a customer has mandatory co-payments, the provider may refuse to provide the service when the customer does not pay the co-payment.

Legal Authority

Program	Legal Authorities
All Programs	42 USC 1302 42 CFR 435.Part 447 ARS 36-2903.01(D)(4) AAC R9-22-711

1203 AHCCCS Freedom to Work (FTW) Premiums

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information About FTW Premiums

Revised 07/12/2022

Policy

A FTW premium is calculated for all customers who qualify for:

• AHCCCS Medical Services under an AHCCCS FTW coverage group; or
• FTW-ALTCS services and do not have a Share of Cost (SOC).

The FTW premium amount is based on the customer's net countable monthly earned income:

From	To	Premium
$0.00	$500.00	$0
$500.01	$750.00	$10
$750.01	$1,000.00	$15
$1,000.01	$1,250.00	$20
$1,250.01	$1,500.00	$25
$1,500.01	$1,750.00	$30
$1,750.01	The FTW income limit (250% FPL)	$35

Exception:

American Indian and Alaska Native customers, as well as the children and grandchildren of tribal members, are not charged a premium when they prove their tribal enrollment (or that of their parent/grandparent).

1) Proof of Tribal Enrollment

American Indians and Alaska Natives who qualify for FTW must provide proof of tribal enrollment to be exempt from monthly premium charges. Proof of enrollment or tribal membership includes:

• Certificate of Degree of Indian Blood;
• Tribal ID;
• Tribal Census Record; and
• Other document provided by the tribe stating that the person is an enrolled member of the tribe.

Children and grandchildren of tribal members must submit documentation that proves they are descendants of a tribal member. Proof includes:

• An official letter on tribal letterhead from the tribe stating that the applicant is a child or grandchild of a tribal member; or
• A document verifying the tribal member's enrollment in the tribe and a document verifying that the applicant is a child or grandchild of the tribal member.

When a person claiming to be a American Indian, Alaska Native, or the child/grandchild of a tribal member does not provide proof of tribal enrollment, the premium exemption does not apply and a premium may be charged.

NOTE Do not deny eligibility because there is no proof of tribal enrollment.

When a person is approved with a premium and later provides proof of tribal enrollment, the person is exempt from paying the premium beginning the month after the proof is provided.

2) When Do Premiums Begin?

Premiums begin with the month following the month in which the approval is dispositioned.

Premium Examples

3) Informing Customers of the Premium Amount

An approval notice or change notice is used to:

• Show the customer how countable earned income was calculated;
• Inform the customer of the premium amount;
• Inform the customer of his or her right to appeal the amount of the premium; and
• Advise the customer to report changes in income or work expenses that could cause a change in the premium amount.

Definitions

Term	Definition
Freedom to Work (FTW) Program	The FTW program is for people with disabilities who are working. There are two FTW coverage groups: • The Basic Coverage Group; and • The Medically Improved Group.
Freedom to Work (FTW) Premium	An AHCCCS FTW premium is calculated for all customers who qualify for: • AHCCCS Medical Services under an AHCCCS FTW coverage group; or • AHCCCS FTW – ALTCS HCBS services.

Legal Authority

Program	Legal Authorities

AHCCCS FTW FTW-ALTCS HCBS	42 USC 1396a(a)(10)(A)(ii)(XV) and 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 and ARS 36-2950 AAC R9-22-1909

B Premium Billing and Payment

Revised 11/06/2020

Policy

The AHCCCS Division of Business and Finance (DBF) sends a bill for the premium to the customer on the first day of each month. If the first day of the month is a weekend or holiday, the bills are mailed on the first workday of the month.

The billing statement notifies the customer of:

• The current amount due; and
• Past due amounts.

1) When Are Premium Payments Due?

Premiums are prospective. This means:

• The premium is due on the 15th of the month following the month the person is approved for AHCCCS FTW.
• The premium for each following month is due by the 15th of that month.

If a payment is not received by the 15th of the month, it is considered late.

2) How Can Payments be Made?

The customer or anyone else may pay the premium by:

• Cashier's check or personal check;
• Money order; or
• Credit or debit card.

Payments can be made online using AHCCCS' Online Premium Payment service or can be mailed to the following address:

STATE OF ARIZONA AHCCCS

File 749228

Los Angeles, CA 90074-9228

Important! When mailing a payment, it may take five to seven days to be processed and credited.

Payments may be made in advance. For example, the customer may pay quarterly, bi-annually or annually.

3) Premium Payment During an Appeal Process

When an AHCCCS FTW customer with a premium wants to have AHCCCS Medical Assistance continued during the appeal process, the customer must:

• Request a hearing prior to the effective date of discontinuance; and
• Pay the premium for the first month of the appeal period in advance.

Premium Payment During an Appeal Process Example

4) Appeal of the Premium Amount

If the customer appeals the amount of the premium for an FTW approval, the customer must pay the assessed premium throughout the hearing process.

If a customer appeals an increase in the AHCCCS FTW premium and the appeal request is received prior to the effective date of the premium increase, the premium amount is decreased to the lower amount until a hearing decision is made.

5) When Are Changes in the Premium Amount Effective?

A decrease in a customer's premium is effective the month after proof of the income or Impairment Related Work Expenses (IRWE) change is provided.

An increase in a customer's premium is effective the first month after a 10-day advance notice is sent to the customer. When there are less than 10 days before the first day of the next month, the premium is increased the first day of the month after that.

Definitions

Term	Definition
Impairment Related Work Expenses (IRWE)	The cost of services and items that a person needs in order to work because of a physical or mental impairment.

Legal Authority

Program	Legal Authorities
AHCCCS FTW FTW-ALTCS HCBS	42 USC 1396a(a)(10)(A)(ii)(XV) and 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 and ARS 36-2950 AAC R9-22-1909

C Non-Payment of Premiums

Revised 08/03/2018

Policy

When payments fall more than one month behind, AHCCCS FTW eligibility is stopped the first day of the following month.

Unpaid AHCCCS FTW premiums do not affect the customer's eligibility for any other AHCCCS Medical Assistance programs.

When the customer pays the entire outstanding balance before the date the AHCCCS FTW ends, eligibility is continued.

When the customer does not pay the entire outstanding balance before the date the AHCCCS FTW ends, the customer cannot qualify for AHCCCS FTW again until the full amount is paid, even when the premium amount under a later application is zero.

Legal Authority

Program	Legal Authorities
AHCCCS FTW FTW-ALTCS	42 USC 1396a(a)(10)(A)(ii)(XV) and 42 USC 1396a(a)(10)(A)(ii)(XVI) ARS 36-2929 and ARS 36-2950 AAC R9-22-1909

1204 KidsCare Premiums

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information About KidsCare Premiums

Revised 01/25/2023

Policy

Children enrolled in KidsCare are charged a monthly premium based on the Income Group's total income and the number of children enrolled in KidsCare.

NOTE American Indians and Alaska Natives, as well as the children and grandchildren of tribal members, are not charged a premium when they prove their tribal enrollment (or that of their parent/grandparent).

1) Proof of Tribal Enrollment

American Indians and Alaska Natives who qualify for KidsCare must provide proof of tribal enrollment to be exempt from monthly premium charges. Proof of enrollment or tribal membership includes:

Certificate of Degree of Indian Blood;

- Tribal ID;
- Tribal Census Record; and
- Other document provided by the tribe stating that the person is an enrolled member of the tribe.

Children and grandchildren of tribal members must submit documentation that proves they are descendants of a tribal member. Proof includes:

- An official letter on tribal letterhead from the tribe stating that the applicant is a child or grandchild of a tribal member; or
- A document verifying the tribal member's enrollment in the tribe, and a document verifying that the applicant is a child or grandchild of the tribal member.

When a person claiming to be an American Indian, Alaska Native, or the child/grandchild of a tribal member does not provide proof of tribal enrollment, the premium exemption does not apply and a premium may be charged.

NOTE Eligibility is not denied because there is no proof of tribal enrollment.

When a person is approved with a premium and later provides proof of tribal enrollment, the person is exempt from paying the premium beginning the month after the proof is provided.

2) KidsCare Premiums

Listed below are the monthly premium amounts for children:

Household Size	Income Less Than or Equal to 150% FPL	Income Greater Than 150% But Less Than or Equal to 175%	Income Greater Than 175% But Less Than or Equal to 200%
1	$0.00 - $1,823.00	$1,823.01- $2,127.00	$2,127.01- $2,430.00
2	$0.00 - $2,465.00	$2,465.01- $2,876.00	$2,876.01- $3,287.00
3	$0.00 - $3,108.00	$3,108.01- $3,626.00	$3,626.01- $4,144.00

4	$0.00 - $3,750.00	$3,750.01- $4,375.00	$4,375.01- $5,000.00
5	$0.00 - $4,393.00	$4,393.01- $5,125.00	$5,125.01- $5,857.00
6	$0.00 - $5,035.00	$5,035.01- $5,875.00	$5,875.01- $6,714.00
7	$0.00 - $5,678.00	$5,678.01- $6,624.00	$6,624.01- $7,570.00
8	$0.00 - $6,320.00	$6,320.01- $7,374.00	$7,374.01- $8,427.00
9	$0.00 - $6,963.00	$6,963.01- $8,123.00	$8,123.01- $9,284.00
10	$0.00 - $7,605.00	$7,605.01- $8,873.00	$8,873.01- $10,140.00
Each Additional Customer*	Add $643.00	Add $750.00	Add $857.00
Premium Amount for Children	One Child $10.00/More Than One Child $15.00	One Child $40.00/ More Than One Child $60.00	One Child $50.00/ More Than One Child $70.00

*"Each additional" is an approximate amount only.

3) Premium for Cases with Multiple Income Groups

A case may consist of multiple income groups. The monthly premium amount for a child is based on the income group with the highest income level and the number of eligible children in income groups. This means that instead of having a separate premium for each income group, the case will only be charged one premium that covers everyone in that case.

See Example - Premium for Cases with Multiple Income Groups

Definitions

Term	Definition
KidsCare	KidsCare is for uninsured children under age 19 who are not eligible for Medicaid.

Legal Authority

Program	Legal Authorities

KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4)\ and 36-2982 AAC R9-31-303

B Premium Billing and Payment

Revised 11/06/2020

Policy

The AHCCCS Division of Business and Finance (DBF) receives premium information and mails a bill for the premium to the customer on the 1st day of each month. When the 1st day of the month is a weekend or holiday, the bills are mailed on the first working day.

The monthly billing statement notifies the customer of:

- The children enrolled in KidsCare;
- The date covered;
- The total amount due; and
- Premium due date.

1) When Are Premium Payments Due?

Premiums are due by the 15th of the month for the current month's eligibility.

When the balance is not paid before the first of the following month, the next premium billing statement includes the:

- Current month's premium(s);
- Past due amount; and

Information about the premium hardship waiver (MA1204D) if there is a past due amount for the child's premium.

See MA1204C for additional information about non-payment of premiums.

2) How Can Payments be Made?

The customer or anyone else may pay the premium by:

- Cashier's check;
- Personal check;
- Money order; or
- Credit or debit card.

NOTE The AHCCCS website (azahcccs.gov) allows customers to pay their premiums on-line using either a debit card, credit card, or a bank account.

Premiums may be made in advance. For example, the customer may pay quarterly, bi-annually or annually.

3) Premium Changes

A change in income, number of members in the household, or the number of children who are KidsCare eligible may affect the premium amount.

When there is a decrease in premium and the change is verified by the 25th day of the month, the change is effective the month following the month the change is verified. When there is a decrease in premium and the change is verified on or after the 26th day of the month, the change is effective the second month following the month the change is verified. However, when the premium amount increases, a letter must be issued to inform the household of the increase at least 10 days before the first

day of the following month. When the letter is issued less than 10 days before the first of the following month, the increase does not take effect until the first day of the month after that.

Definitions

Term	Definition
Division of Business and Finance (DBF)	DBF is responsible for the billing, collection, and tracking of premium payments

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4) and 36-2982 AAC R9-31-303 AAC R9-31-1417

C Non-Payment of Premiums

Revised 07/13/2016

Policy

When payments for children in the household are received in full, the children remain eligible for KidsCare. When one month total payment is received, the children remain eligible.

When less than one month total premium payment is received, the Division of Business and Finance (DBF) applies the amount of debt to the children.

The children remain eligible when the remaining balance due is not more than one month behind.

When payments for children in the household fall more than one month behind, the children's eligibility will end.

A discontinuance letter is sent with the past due premium amount and an explanation that when the entire outstanding balance is paid before the effective date, coverage will continue.

1) Payment Received Before Discontinuance Date

At the end of the month, when the balance is paid or waived, eligibility is continued.

2) Reapplication with Past Due Premiums

There is a two month lock-out period for unpaid past due premiums. Children are permitted to re-enroll in KidsCare as soon as their premiums are paid or at the end of the lock-out period, whichever comes first.

Definitions

Term	Definition
KidsCare	KidsCare is for uninsured children under age 19 who are not eligible for Medicaid.
KidsCare Premium	A premium is calculated for all customers who qualify for KidsCare.
Discontinuance Letter	A written letter sent to customers. This letter tells the customer that their coverage is ending.
Lock-Out Period	Under federal law, children who have their KidsCare eligibility discontinued for unpaid premiums are permitted to re-enroll in KidsCare as soon as their premiums are paid or at the end of the State-specified period of time not to exceed 90 days. Arizona has established a two month lock out period.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4)\ and 36-2982 AAC R9-31-303

D Premium Hardship Waiver for KidsCare

Revised 11/06/2020

Policy

A person may request to waive a child's premium for the prior or current month due to a hardship in the month. When the premium is waived for the current month, the premium for the prior month is also waived even when there are no expenses in that month.

The main contact must have paid or be required to pay the expense during the month the premium is waived. When the premium is waived and the customer does not pay the expense, the premium cannot be waived again using the same expense. When a person has ongoing expenses, the premium may be waived for future months as well. When the premium is waived for future months, it must be reevaluated at renewal.

A hardship exists when a member of the budget group died or the budget group has one or more of the following expenses which exceed 10% of the countable gross income of the budget group:

- Medically necessary expenses for any member of the budget group that insurance did not pay for. Medically necessary means a covered service provided by a physician or other licensed practitioner to prevent disease, disability, or other adverse health conditions or their progression or prolong life;
- Health insurance premiums for any member of the budget group;
- Unexpected expenses for repairs to the home. Repairs include items such as fixing a leaky roof, replacing a non-working air conditioner, repairing plumbing, etc. Repairs do not include remodeling or redecorating; or
- Expenses for repairs to a budget group member's transportation so the individual can get to work. This does not include routine maintenance such as tune-ups, oil changes, etc.

1) Proof

The Main Contact's statement on the written request as proof of income and death of a budget group member is accepted.

The Main Contact must provide proof of the expense(s). Proof of the expense(s) includes a copy of the bill or receipt that shows the type, date, and amount of the expense. An estimate is not considered proof.

2) Re-Evaluate Waiver at Renewal

When the premium is currently waived on an ongoing basis, the hardship waiver will be reviewed again at time of renewal even when benefits are being discontinued. When the children remain eligible for the hardship waiver and appeal the discontinuance, the premium is waived during the appeal process.

Definitions

Term	Definition
Hardship Waiver	A request to waive the KidsCare premium for customers with a financial hardship.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4) and 36-2982 AAC R9-31-303

E Premiums During 12-Month Guarantee and Appeals Process

Revised 02/01/2018

Policy

A child who is eligible solely due to the 12-month guarantee period is counted in the premium calculation.

1) 12-Month Guarantee Premium Amount

When a child is eligible due to the guarantee period, the premium amount is recalculated based on the number of children who remain either KidsCare eligible or who are eligible under the guarantee period. One premium amount is calculated for all children in the case. When the income budgeted exceeds the limit, the maximum premium amount is used.

2) 12-Month Guarantee Letter

A KidsCare Guarantee Letter is sent indicating that benefits are continuing under the guarantee period and the revised premium amount.

3) Non-Payment

For non-payment of premiums during the 12-month guarantee period see MA1204C.

4) Premiums During Appeal

When a customer wants to have KidsCare continued during the appeal process, the customer must:

- Request a hearing prior to the effective date of discontinuance;
- Pay the full monthly premium amount prior to the date of the discontinuance; and
- Continue to pay the full monthly premium amount each month during the hearing process.

When the payment is not received by the end of the month, coverage is stopped for the remainder of the fair hearing period.

5) Appeal Due to Premium Increase

When a customer appeals an increase in the KidsCare premium and the hearing request is received prior to the effective date of the premium increase, restore the premium amount to the lower amount until a hearing decision is made. The customer must pay the premium throughout the hearing process.

Definitions

Term	Definition
Guaranteed Enrollment Period	Available to customers of certain AHCCCS Medical Assistance programs who are enrolled with a health plan for the first time and become ineligible prior to enrollment.

Legal Authority

Program	Legal Authorities

KidsCare	42 USC 1397bb(b) 42 CFR 457.Subpart E ARS 36-2903.01(D)(4) and 36-2982 AAC R9-31-303

1205 Transplant Extended Eligibility Program - Share of Cost

Revised 06/20/2023

Policy

Customers that qualify for the Transplant Extended Eligibility Program must pay a “share of cost” to the medical facility performing the transplant.

The following determine the share of cost amount:

- The number of family members in the customer’s household;
- The customer’s family income for a three-month period; and
- The customer’s family medical expenses for a three-month period.

1) Family members

When they live with the customer, the following family members’ income and expenses are used in the Transplant Share of Cost determination:

- Customer;
- Customer’s spouse;
- The customer’s or spouse’s children under age 19; and
- When the customer is under age 19 and unmarried, the customer’s parents.

2) Family Income

The family‘s countable income is determined for a three-month period. The Three-Month Income Period is:

- The month the customer was determined ineligible.
- The month following the month of the customer was determined ineligible.
- The second month following the month the customer was determined ineligible.

3) Medical Expenses

The family's allowable medical expenses over a three month period are deducted from countable income in the Transplant Share of Cost determination. The Three Month Expense Period consists of:

- The month prior to the month the customer was determined ineligible.
- The month the customer was determined ineligible.
- The month after the month the customer was determined ineligible.

Expenses incurred during the Three Month Expense Period by family members who have died or moved out of the home can be used in determining the Transplant Share of Cost when both of the following are met:

- The family member who died or moved out was living in the home when the medical expenses were incurred; AND
- A family member who still lives in the home is financially responsible for paying the medical expenses.

4) 40% of FPL Amounts

The TSOC is based on income in excess of 40% of the FPL for the customer’s family size. The following table provides the

40% FPL monthly amounts:

Family Size	40%
1	$486.00
2	$658.00
3	$829.00
4	$1,000.00
5	$1,172.00
6	$1,343.00
7	$1,514.00
8	$1,686.00
Each Additional*	$172.00

*"Each Additional" is an approximate amount only.

5) Transplant Share of Cost (TSOC) Calculation

Follow the steps below to calculate the TSOC.

Step	Action
1	Total the countable family income for the Three-Month Income Period.
2	Find the 40% of the FPL amount for the number of family members and multiply by three to get the Three-Month Income Standard.
3	Subtract the Three-Month Income Standard from the total income from Step 1.
4	Subtract the allowable expenses incurred in the Three Month Expense Period from the remaining income from Step 3.
5	Divide the remaining amount from Step 4 by the budget group size to get the customer's Transplant Share of Cost amount.

Definitions

Term	Definition
Transplant Share of Cost	The amount a Transplant Extended Eligibility Program customer must pay toward the cost of the transplant procedure.
Countable income	For the Transplant Extended Eligibility Program, is gross income from any source that is not excluded by law from being counted in the determining eligibility for AHCCCS Medical Assistance.
Allowable Medical Expenses	To be allowed as a deduction from income, medical expenses must be the financial responsibility of the family, and must be incurred in the United States. Examples of allowable medical expenses include: • Assistive devices and durable medical equipment, and maintenance and repair costs; • Audiology and optometry services, including eyeglasses and hearing aids; • Chiropractic services; • Dental services; • Family planning services; • Homeopathic and naturopathic services provided by a licensed practitioner; • Inpatient and outpatient services; • Laboratory and X-ray services; • Long-term care services • Health insurance premiums, co-payments, and deductibles; • Occupational and physical therapy services; • Doctor's visits; • Prescription drugs and medical supplies; and • The cost of purchasing and maintaining service animals. Examples of medical expenses that are NOT allowable include: • Custodial or room and board services; • Expenses covered by insurance or paid by someone other than a family member listed in section 1; • Expenses that have been written off by the provider; • Over-the-counter medication, vitamins and food supplements, unless prescribed by a physician; and • Non-emergency transportation costs.

Legal Authority

Program	Legal Authorities
Transplant Extended Eligibility Program	ARS 36-2907.10 and 36-2907.11

1300 Introduction

This chapter contains information for processing AHCCCS Medical Assistance applications.

For each eligibility requirement in this chapter, you will find:

- The policy for the requirement;
- Any definitions needed to explain the policy;
- The timeframe for the requirement; and
- A list of the federal and state laws that apply to the requirement by program.

1301 General Information for All Applicants

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A Application Forms, Assistance, Cooperation and Voter Registration

Revised 10/24/2023

Policy

To qualify for AHCCCS Medical Assistance (MA), the customer or someone acting responsibly for the customer must submit a signed application. The application must be on a form accepted by AHCCCS.

See MA533 for other requirements for a valid application.

1) Application Forms

The Agency accepts the following application forms:

- Health-e-Arizona Plus (HEAplus) Online Application;
- The Department of Economic Security (DES)/Family Assistance Administration (FAA) – Arizona Health Care Cost Containment System (AHCCCS) Joint Application for Benefits;
- Application for Help with Health Coverage Costs;
- Application for AHCCCS Health Insurance and Medicare Savings Programs;
- The Centers for Medicare and Medicaid Services (CMS) Paper Application;
- Breast and Cervical Cancer Treatment Program (BCCTP) Referral Form (BC-100).

2) Who May Sign the Application?

Any of the following people may sign the application for a customer:

- The customer;
- The customer's legal or authorized representative;
- An adult who is in the customer's MAGI Budget Group or Premium Tax Credit Budget Group (MA602D)
- When the customer is a minor child or is incapacitated, someone acting responsibly for the customer.

The application may be signed in writing, by electronic signature, or by a recorded voice signature.

> NOTE When the person signs with a mark, a third party must witness the signature and sign the application attesting to witnessing the signature.

3) Authorized Representatives

The customer may choose a person or an organization as their Authorized Representative. The representative must agree to comply with federal and state conflict of interest and confidentiality requirements.

When an organization is authorized to act on the customer's behalf, each person that interacts with AHCCCS for that organization must sign an Authorized Representative (DE-112) form. The form may be signed in writing, by electronic signature, or by a recorded voice signature when applicable.

> NOTE When a new authorized representative is from the same organization an updated DE-112 only needs the new representative's signature. To choose an authorized representative, the customer and representative must provide:

- An Authorized Representative Form (DE-112);
- The Authorized Representative section of the Application for Benefits (FAA-0001A);
- The Authorized Representative section of the Application for AHCCCS Medical Assistance and Medicare Savings Programs (DE-103); or
- A legal document giving the representative the authority to represent the customer. Acceptable documents include:
  - A Financial or General Power of Attorney;

  ◦ Letters of Acceptance of legal guardianship or conservatorship (a petition is not acceptable); or
  ◦ Court orders.
• United HealthCare Authorization of Assistance form

NOTE An Authorized Representative form is also needed for the person to agree to confidentiality of information provided when:

• a legal document gives the person authority to the represent the customer; or
• a representing organization selects a different person to act on the customer's behalf.

The customer may authorize the representative to do any or all of the following:

• Complete, sign and submit applications, renewal forms, and other documents for the customer;
• Receive copies of the notices and other communications about the customer's MA; or
• Act on behalf of the customer in all other matters related to MA.

The Authorized Representative Form expires when:

• The customer reapplies after a discontinuance, and the new application date is more than 90 days after the prior application date;
• The customer designates a new Authorized Representative;
• The customer or Authorized Representative revokes the authorization; or
• The customer is no longer receiving MA.

NOTE The Authorized Representative Form expires 90 days after MA coverage ends.

4) Customer Assistance

When needed, Benefits and Eligibility Specialists and other staff will help the customer with the application process.

Customers may also have someone of their choice help them with the application process. This includes:

• Going with the customer to the local office;
• Helping the customer fill out the application; and
• Representing the customer.

5) Customer Cooperation

Customers and their representatives must cooperate in the application process. This includes:

• Providing information and any proof needed;

NOTE Proof is only requested from the customer when it is not available from previous records and electronic sources, or the proof found conflicts with the customer's statement.

• Reporting changes; and
• Taking any action needed to qualify for the MA program.

6) Opportunity to Register to Vote

The National Voter Registration Act (NVRA) of 1993 and Arizona Revised Statutes (ARS) require that public assistance offices provide customers with an opportunity to register to vote at the time of application.

Definitions

Term	Definition
Authorized Representative	A person or an organization appointed by the customer to act on their behalf for the application process, renewing eligibility or other communications.
Electronic Signature	An electronic or digital method of identification executed or adopted by a person with the intent to be bound by or to authenticate a record and has the same force and effect as a written signature. The signature must be unique to the person using it and linked to a record in a manner so that if the record is changed the electronic signature is invalidated.
Legal representative	A person authorized by law to represent the customer. This includes: • A person appointed by a Court of Law to represent an individual; • The natural or adoptive custodial parent of a minor child; or • An agency appointed by a Court of Law as guardian of the customer; for example, a tribal social services (foster care) agency.
Organization	An organized body of people with a particular purpose, especially a business, society, or association.

Timeframes

Application processing periods vary by program and are initiated by application date. See MA1301.B for program-specific timeframes.

Legal Authority

Program	Legal Authorities
All Programs	52 USC 20506 42 CFR 435.907 42 CFR 435.908 42 CFR 435.923 42 CFR 457.340 (KidsCare)

B Application Processing

Revised 04/26/2022

Policy

The customer, or someone acting on the customer's behalf, may start the application in a variety of ways as described in the following table:

When the application is made for...	Then the application may be started by...
Arizona Long Term Care System	The customer or representative by: • Mail; • Telephone; • E-mail; • Fax; • Walk-in to a local ALTCS or AHCCCS office; or • Home visit.
Breast and Cervical Cancer Treatment Program	One of the Arizona National Breast and Cervical Cancer Early Detection Programs (AZ-NBCCEDP) programs by: • Mail; • Email; or • Fax.
Any other AHCCCS Medical Assistance program	The customer or representative by: • Online through Health-e-Arizona Plus (HEAplus); • Telephone; • E-mail; • Fax; • Walk-in to a local AHCCCS or DES-FAA office; or • Walk-in to a participating assistor office.

See the following links to find the customer's local office:

• DES-FAA: https://des.az.gov/find-your-local-office

• ALTCS: https://azahcccs.gov/Members/ALTCSlocations.html

• AHCCCS: https://www.azahcccs.gov/shared/AHCCCScontacts.html

1) Application Date

The application date is determined as follows:

When the application is for...	And the signed application is received...	Then the application date is...
Any program	By Health-e-Arizona Plus (HEAplus)	The date the application is submitted in HEAplus.
	By mail	The date the application is received by any of the following: • AHCCCS local office; • ALTCS local office; • DES-FAA local office; or • Outreach site designated to accept AHCCCS Medical Assistance applications.
	By phone	The date the application is received over the phone.
	By e-mail	The date the application is received by any of the offices listed above, even when received after-hours, on a weekend, or a holiday.
	By fax	The date the application is received by any of the offices listed above, even when received after-hours, on a weekend, or a holiday.
	By walk-in	The date the person delivers the application to a local office.
	By a Community Assistor	• The date the application is signed and dated; or • The date the application is received when the application is not dated.
	From a hospital for a hospitalized customer	• The date the application is signed and dated; or • The date on the admittance or cover sheet when the application is not dated.

BCCTP	From an Arizona National Breast and Cervical Cancer Early Detection Program (AZ-NBCCEDP)	The date the diagnostic procedure was performed that confirmed a diagnosis of breast cancer, cervical cancer, or a pre-cancerous cervical lesion. NOTE This date will be earlier than the date the application is received.
ALTCS	During a home visit	Date of the home visit.

NOTE An application may be accepted without a signature. However, the application must be signed by an authorized person before it can be approved.

2) Processing Period

The processing period begins the day of the application date and ends on the date that the decision has been made and the customer is notified.

The decision letter is available electronically as soon as the decision is processed. The processing period and the system record updates may be expedited when the customer:

- Has an emergent medical need; and
- Does not have medical assistance coverage.

3) Decision Letters

Each person that applies for MA must receive a letter explaining the decision on their application.

Letters must be sent to the following persons:

- The customer;
- The customer's legal representative; and
- The customer's authorized representative when the customer and representative do not live together.

4) Requests for Information

A letter is sent to the customer when more information is needed to make a decision. Customers are given at least 15 days from the date of the letter to provide the requested information.

5) Processing Period Extensions

The application processing period may be extended beyond the processing time frame for any of the following reasons:

- The customer appears to be eligible, but documentation from a third-party is needed to make the eligibility determination and the third party has not responded. The customer and Benefits and Eligibility Specialist must continue to take all actions needed to get the information;
- A Policy Clarification Request (PCR) is needed that will affect the eligibility decision;
- A Disability Determinations Services Administration (DDSA) decision is pending; or
- The customer requests more time to get documentation or proof needed for the eligibility decision.

NOTE Failure to process an application within the appropriate timeframe is not a valid reason to deny the application.

Definitions

Term	Definition
Calendar Day	Any day in the month. This includes weekends and holidays.
Emergent Medical Need	A medical condition that, in the absence of immediate medical attention or medication, is reasonably likely to result in at least one of the following: • Placing the customer's health in serious jeopardy • Serious impairment to bodily functions • Serious dysfunction of any bodily organ or part • Serious physical harm to another person
Working Day	Any day Monday through Friday, excluding federal and state holidays.

Timeframes

When the customer is applying for:	Then the processing period is...
SSI-MAO or FTW based on disability	90 calendar days from the application date
KidsCare	30 calendar days from the application date
BCCTP	7 calendar days from the date a complete application is received by AHCCCS.
All other programs	45 calendar days from the application date Exceptions: • 20 calendar days from the application date when the customer is pregnant • 7 calendar days from the application date ONLY when the customer is hospitalized AND no proof or other information is needed for the determination

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.907 42 CFR 435.912 42 CFR 457.340 (KidsCare) AAC R9-22-1413(A) AAC R9-22-2006(A)

C Voluntary Withdrawal of Applications

Revised 09/13/2022

Policy

A person or the person's representative may ask for an application to be withdrawn.

NOTE When a legal representative turned in the application, only the legal representative (or their authorized representative) can ask to withdraw the application.

An application may be withdrawn in writing or verbally.

1) Written Request to Withdraw

A written, signed request for withdrawal may be accepted in one of the following formats:

- Voluntary Withdrawal of Application or Benefits (DE-130) form;
- Voluntary withdrawal option in Health-e-Arizona Plus (HEAplus); or
- A signed, written request to withdraw the application.

2) Verbal Requests to Withdraw

When a verbal request to voluntarily withdraw is made, the application is denied based on the verbal request. A denial letter is sent to notify the person that the application has been denied.

When a person or the person's representative contacts the office to take back the voluntary withdrawal request within 35 days of the denial letter, the case is reopened. When more than 35 days have passed, a new application is required.

Definitions

Term	Definition
Legal representative	A person authorized by law to represent the customer. This includes: • A person appointed by a Court of Law to represent an individual; • The natural or adoptive custodial parent of a minor child; or • An agency appointed by a Court of Law as guardian of the customer, such as a tribal social services (foster care) agency.
Authorized Representative	A person, or an organization, appointed by the customer to act on their behalf for the application process, renewing eligibility, or other communications.

Timeframes

A person may voluntarily withdraw an application at any time prior to the date an eligibility decision is made.

Legal Authority

Program	Legal Authorities
All Programs	CFR 42 431.213 AAC R9-22-313, R9-28-401

D Financial Quality Assurance

Revised 06/14/2022

Policy

The Financial Quality Assurance (QA) Unit has experienced Benefits and Eligibility Specialists (BESs) who monitor and evaluate the financial eligibility process. The goal of the unit is to provide feedback on the accuracy and consistency of financial eligibility statewide.

Financial QA staff review completed applications. The review includes:

- Health-e-Arizona plus (HEAplus) data entry;
- Case notes;
- Data returned by the HUBS;
- DocuWare; and
- Any other proof in the case file

Findings from the reviews are collected and used to identify trends that show a need for training, manual revisions, or changes to the new hire orientation process. Benefits and Eligibility Specialists are responsible for monitoring and improving the quality of the work they complete. Supervisors support quality improvement by:

- Reviewing completed applications for accuracy and completeness;
- Observing financial interviews;
- Providing technical assistance;
- Coaching; and
- Identifying training opportunities on an ongoing basis.

Proof

Proof consists of documentation of quality control activities that are maintained by the Quality Assurance Unit and eligibility office supervisors.

Legal Authority

Program	Legal Authorities
All Programs	CFR 42 431.213 AAC R9-22-313, R9-28-401

1302 Special Procedures for Certain Applicants

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A Children in Tribal Foster Care

Revised 02/20/2019

Policy

AHCCCS Medical Assistance eligibility for children in Tribal foster care is determined by the Department of Economic Security, Family Assistance Administration (FAA) or by AHCCCS, depending on the AHCCCS program. These cases are not referred to the Department of Child Safety (DCS).

When an application is received for a child in Tribal foster care:

- The Tribe is considered the legal guardian and the Tribal Social Services worker can apply for the child without an Authorized Representative form.
- Arizona residency is already established for the child unless the child is placed outside of Arizona.
- Income and other information for members of the foster family is not needed to determine eligibility for the child.

NOTE The only time income information may be needed is when a sibling is in the same foster care placement.

Definitions

Term	Definition
Tribal Foster Care	A foster care program run and maintained by an Arizona Tribe.

Legal Authority

Program	Legal Authorities
All programs	42 CFR 435.907 and 908 42 CFR 435.923 42 CFR 457.340 (KidsCare)

B Deceased Customers

Revised 11/16/2018

Policy

The fact that a person died before the application was filed or an eligibility decision was made does not stop the person from qualifying for a period before the date of death.

Legal Authority

Program	Legal Authorities
All programs except QMB and KidsCare	42 CFR 435.914 R9-22-1407 R9-22-1501(D) R9-28-401.01

C Customer Who Are Homeless, Incapacitated or Have an Impairment

Revised 08/31/2021

Policy

Customers identified in this section may not be able to gather proof needed for the eligibility process and may need extra help.

The state worker will make reasonable efforts to obtain proof on behalf of the customer when the customer is unable to cooperate with the application process because the customer:

• Is Homeless,

• Has a physical or mental impairment, or

• Is Incapacitated.

When a customer is incapacitated, a Physician's Statement of Incapacity (DE-217) may be needed to help get information to approve eligibility. For example, it may be needed to authorize release of financial or medical information to the Agency.

Customers may be referred to a Public Fiduciary when there is no one with the authority to manage the customer's affairs or willing to help in the application process.

See Public Fiduciary Referral Examples

Definitions

Term	Definition
Homeless	A person who does not have a fixed residence. For example: • A public or private place not meant for human habitation; • A supervised shelter designed to provide temporary shelter to homeless persons. • A half-way house or similar place that provides temporary residence. • A room provided rent free in another person's home for 90 days or less. • A place not designed, or ordinarily used, for sleeping. This includes places like a car, bus station, hallway, park, or sidewalk.

Incapacitated	A person who is physically and/or mentally unable to apply for Medical Assistance for him or herself and is unable to authorize someone in writing to act as a representative. • Incapacity is not an issue if the person is represented by: • Court appointed legal guardian or conservator; • Someone previously appointed by customer as a durable general power of attorney (POA) and the POA is still valid; • Someone previously appointed by the person as an Authorized Representative and the Authorized Representative form is still valid; • For customer's under age 18, a natural or adoptive parent; • Spouse, unless divorced or legally separated; or • An adult who is in the customer's MAGI Budget Group (MA602D).

Legal Authority

Program	Legal Authorities
All programs except QMB and KidsCare	42 CFR 435.914 R9-22-1407 R9-22-1501(D) R9-28-401.01

D Customers in Jail, Prison or Other Detention Facilities

Revised 11/16/2018

Policy

A person in a detention facility like jail, prison or juvenile detention may apply for MA before being released. However, the application cannot be approved and benefits cannot start until the person is no longer an inmate.

Definitions

Term	Definition
Inmate	A person who is: • An inmate in a prison within the Arizona Department of Corrections; • An inmate of a county, city, or tribal jail; • An inmate of a prison or jail, prior to arraignment, conviction, or sentencing; • Incarcerated but can leave prison on work release or work furlough, and must return at specific intervals; • Released from prison or jail due to a medical emergency, with no court probation order, who would otherwise be incarcerated except for the medical emergency; • Ordered by the court to reside in the Arizona State Hospital; • A child in a juvenile detention center prior to disposition (judgment), due to criminal activity; • A child in a juvenile detention center prior to disposition, due to care, protection, or in the best interest of the child (ex., Child Protective Services), if there is no specific plan for the child that makes the stay at the detention center temporary; or a • A child placed in a secure treatment facility if the facility is part of the criminal justice system. NOTE For more details about when a person may be considered an inmate, see MA525.

Legal Authority

Program	Legal Authorities
All programs except KidsCare	42 CFR 435.1009; 42 CFR 435.1010

KidsCare	42 CFR 457.310

E Customers in the Address Confidentiality Program

Revised 11/16/2018

Policy

The Address Confidentiality Program (ACP) provides survivors and victims of domestic violence, sexual offenses, and/or stalking with a means to prevent abusers from locating them through public records. The ACP was signed into law April 19, 2011 and is administered by the Secretary of State's Office.

The ACP provides two critical services:

1. A legal substitute address, which may be used as a residential, school, or work address. This address has no reflection of their actual address. When presented with a current and valid authorization card, accept the substitute address as the lawful address of record.

2. A mail forwarding service. The ACP receives first class mail for ACP participants and forwards the mail to the participant's actual confidential mailing address. The ACP also accepts registered, certified, and legal mail on behalf of the participants. ACP does not forward magazines, junk mail, or packages.

NOTE Participation in The Address Confidentiality Program is not confidential, only the participant's actual address is confidential.

Definitions

Term	Definition
Actual address	Participant's residential, work, or school address, including the county and voting precinct number.

Legal Authority

Program	Legal Authorities
All programs	ARS 41-162

F Customers Requesting Letters in an Alternative Format

Policy

Customers, representatives, and legal guardians who receive letters from AHCCCS may ask to receive letters in an alternative format, such as large print. See MA1603 for additional information regarding alternative format requests.

Programs and Legal Authorities

Program	Legal Authorities
All programs	42 CFR 435.905(b) 42 CFR 435.917

G Customers Sent by the Social Security Administration

Policy

Applications sent to AHCCCS electronically by the Social Security Administration (SSA) may not have the customer's contact information or all the information needed to determine eligibility. These applications meet the conditions in MA533 and are considered signed when they are sent to AHCCCS.

When an application is sent electronically by SSA but does not have the customer's citizenship status, the customer's attestation is not needed. AHCCCS will request proof when the customer's citizen or qualified noncitizen status cannot be verified electronically.

Programs and Legal Authorities

Program	Legal Authorities
All programs	42 CFR 435.907 42 CFR 435.406 and 407 42 CFR 435.949 and 956(a)(1)(i) 42 CFR 457.320(b)(6) 42 USC 1396b 8 USC 1611, 1612, 1613, and 1641 ARS 36-2903.03 AAC R9-22-305.4,5,6 AAC R9-28-401.01(B)1 AAC R9-29-204.3 AAC R9-31-302(A)

1303 ALTCS Application Process

Revised 7/16/2021

Policy

ALTCS applications are different from other AHCCCS Medical Assistance applications in the following ways:

• A financial interview with the customer or customer's representative is required;

• A Pre-Admission Screening (PAS) assessment is required;

• A Share of Cost (SOC) is estimated and determined; and

• Customers may still qualify for other AHCCCS Medicaid Assistance categories, when they fail to meet requirements that only apply to ALTCS.

General information about the application process can be found in MA1301 and MA1302. This section provides information specific to the ALTCS application process.

1) ALTCS Interview

A financial interview is required for all ALTCS applications. The interview may be in person or by telephone.

The interview may be with the customer or with a person acting on behalf of the customer such as a representative (MA1301A.3).

2) PAS Assessment

To qualify for ALTCS a customer must be determined to need the level of care provided in a hospital, skilled nursing facility or intermediate care facility. This determination is made through the PAS process.

Chapter 1000 contains a complete description of the PAS process.

3) Estimating the Share of Cost

Most nursing facilities require full payment of all facility expenses prior to ALTCS approval. However, some nursing facilities will allow a patient who has applied for ALTCS to pay the estimated share of cost during the application process.

A Share of Cost Estimate is completed for customers who:

• Live in a nursing facility; or

• Expect placement in a nursing facility during the ALTCS application process.

The most accurate information available is used during the application process to calculate the customer's estimated SOC. This estimate may change once proof of income and deductions is received. The SOC amount can change from month to month based on changes in income, deductions and living arrangements;

The fact that an estimated SOC has been provided is no guarantee that the ALTCS application will be approved. Approval is subject to the customer meeting all financial and medical eligibility requirements. If the application is approved, the approval notice will show the actual SOC amount(s);

The nursing facility may require payment in full pending approval of the ALTCS application. However, if the nursing facility

agrees to accept estimated SOC payments pending ALTCS approval, the customer should begin paying the estimated SOC amount to the nursing facility while the ALTCS application is being processed;

If the customer paid the estimated SOC and the actual SOC is lower, the nursing facility will refund the difference for each approved month (MA705J).

4) Customers Not Eligible for ALTCS

A customer may qualify for other AHCCCS MA categories when the customer does not qualify for ALTCS for one of the following reasons:

• Failed the PAS;

• Missed Appointment;

• Failed to verify resources; or

• Has excess resources.

Definitions

Term	Definition
Financial Interview	An interview to collect financial information for ALTCS eligibility. Either the customer or the customer's representative may attend the interview.
Pre-Admission Screening (PAS)	The screening tool and method used to determine whether a customer is medically eligible for the ALTCS program.
Share of Cost Estimate	An estimate of the amount that the customer will be responsible to pay for his or her care under the ALTCS program if approved.

Programs and Legal Authorities

Program	Legal Authorities
ALTCS	42 CFR 435.725 42 CFR 435.907 ARS 36-2933 ARS 36-2934 ARS R9-28-303 AAC R9-28-401.01

1304 SSI-MAO Application Process

Revised 11/29/2018

Overview

This section describes application requirements that are specific to the Supplemental Security Income - Medical Assistance Only (SSI-MAO) program.

- Screening for one of the three specialty groups within SSI-MAO; and
- Disability determinations.

General information about the application process can be found in MA1301 and MA1302.

A SSI-MAO Specialty Groups

Revised 03/22/2022

Policy

There are three SSI-MAO specialty groups:

- Disabled Adult Child (DAC);
- Disabled Widow Widower (DWW); or
- Pickle.

Everyone in these groups previously received SSI Cash benefits from the Social Security Administration.

All persons who apply for SSI-MAO must be screened to see if they qualify for one of the specialty groups.

Persons in the SSI MAO specialty groups must meet all of the SSI MAO requirements as well as the special conditions in MA413. The income limit for all of the SSI-MAO Specialty Groups is 100% of the Federal Benefit Rate (FBR), but special income disregards may apply. If the customer's income is over 100% of the FBR, see the following manual sections for information about income disregards:

- Disabled Adult Child (see MA611C);
- Disabled Widow Widower (see MA611D);
- Pickle (see MA611B)

Definitions

Term	Definition
Federal Benefit Rate (FBR)	The maximum dollar amount paid to an aged, blind, or disabled person under the Supplemental Security Income (SSI) program. It is also known as the Federal Payment Standard or the SSI Standard Benefit Amount.

Legal Authority

Program	Legal Authorities
Disabled Adult Child (DAC)	42 USC 1383c R9-22-1505
Disabled Widow/Widower (DWW)	42 USC 1383c 42 CFR 435.137, 42 CFR 435.138 R9-22-1505

Pickle	42 CFR 435.135 R9-22-1505

B Disability Determination

Revised 03/22/2022

Policy

A referral to the Disability Determination Services Administration (DDSA) is required when the customer:

- Is under age 65;
- Is applying for Medical Assistance and is not eligible for any other category; and
- Does not have proof of disability (MA509) or blindness (MA504).

1) Customers with Serious Mental Illness (SMI)

Depending on the functional criteria reported on the following forms, the customer may be considered disabled or presumed disabled:

- A SMI Determination Report Summary; or
- SMI Eligibility Outcome supplemental form completed and signed by a physician or psychiatrist; and
- Medical evidence supporting the SMI diagnosis.

If the customer is...	Then...
Considered disabled (SMI A)	Medical Assistance benefits may be approved if the customer is otherwise eligible. However, a DDSA referral is required for a random sample of these customers to confirm the disability.
Presumed disabled (SMI B)	Medical Assistance benefits may be approved if the customer is otherwise eligible. However, a DDSA referral is required to confirm disability.

2) Presumptive Eligibility for SSI-Cash

Under certain circumstances, Social Security will approve SSI-Cash for a six-month presumptive eligibility period while determining whether a person meets the criteria of disability. When a person has been approved for presumptive SSI disability benefits, a DDSA referral is not required because the customer is considered to have met the definition of disabled during the presumptive eligibility period.

Definitions

Term	Definition
Serious Mental Illness (SMI)	A diagnosable mental, behavioralm or emotional disorder that results in functional impairment which substantially interferes with or limits one or more major life activities.

Legal Authority

Program	Legal Authorities
SSI-MAO	42 CFR 435.540; 42 CFR 435.541 AAC R9-22-1501

1305 Medicare Savings Program (MSP) Application Process

Revised 11/29/2018

Policy

This section describes application requirements that are specific to the Medicare Savings Program (MSP) program.

• Dual Eligibility

• Receiving SSI-Cash

• Conditional QMB

• Medicare buy-in

General information about the application process can be found in MA1301 and MA1302.

1) Dual Eligibility

People who qualify for QMB or SLMB may also qualify for AHCCCS Medical Assistance. This is known as “dual eligibility”, because the person is eligible for both programs at the same time.

No dual eligibility is possible for people who qualify for QI-1 because the program requires that the customer cannot be eligible for any other Medicaid program.

2) SSI-Cash Recipients

SSI Cash recipients are automatically eligible for QMB benefits if receiving free Medicare Part A. These customers do not need to apply for QMB.

SSI Cash recipients who are required to pay a premium for Medicare Part A must apply for QMB.

3) Conditional QMB

Most customers who are eligible for Medicare Part A receive free Part A coverage. However, some customers are required to pay a monthly premium.

Customers who are unable or unwilling to pay the Part A premium must apply for Medicare Part A on the condition that their Part A enrollment will only be effective if QMB is later approved. After filing a conditional Part A application with SSA, these customers must apply for QMB.

4) Buy-In Process

When a customer is approved for MSP, the request for Medicare Part A and Part B buy-in is sent to the Centers for Medicare and Medicaid Services (CMS). Requests are sent in once a month. CMS processes the request for buy-in and either accepts or rejects the request. It may take two or three months for payment of the Medicare premiums to begin through the buy-in process.

5) No Medicare Part B but Eligible for SLMB or QI-1

When a customer has Medicare Part A and meets all other requirements, the customer can qualify for SLMB or QI-1 even if they do not have Medicare Part B. The customer can choose to enroll in Medicare Part B and the Part B premium will be paid for through the SLMB or QI-1 eligibility. Customers do not have to enroll in Medicare Part B through this option, and some may not want to enroll. When a customer obtains Medicare part B and later loses eligibility for SLMB or QI-1, they will be responsible to pay the Medicare part B premium. It may take a few months for the buy-in records to update, and the Part B premiums for all months between losing MSP and Social Security records being updated may be deducted at one time from the customer's Social Security benefit.

Definitions

Term	Definition
Medicare Savings Program (MSP)	Provides help with Medicare expenses for customers who are entitled to Medicare Part A.
Dual Eligibility	A customer is eligible for a Medicare Savings Program as well as another AHCCCS program.

Timeframes

See MA1301.B for the processing timeframes.

1306 Freedom to Work (FTW) Application Process

Policy

This section describes application requirements that are specific to the FTW program.

• Meets the FTW disability requirements (see MA509);

• FTW and MSP dual eligibility;

• Does not qualify for AHCCCS Medical Assistance under another program.

A customer who qualifies for AHCCCS FTW coverage may receive either ALTCS services or AHCCCS Medical Assistance:

General information about the application process can be found in MA1301 and MA1302. This section provides information specific to the MSP application process.

1) FTW Disability Determination

If the customer was not previously determined disabled by the Disability Determination Services Administration (DDSA), the AHCCCS FTW Unit requests a special AHCCCS FTW disability determination. DDSA disregards the customer's employment activity that is part of the usual disability determination.

2) FTW and Medicare Savings Program (MSP)

There is no automatic Medicare buy-in for persons who are approved for FTW. However, FTW customers may also qualify for QMB or SLMB.

3) Screening for Other Medicaid Eligibility

• Immediately after the FTW eligibility is approved;

• When the customer becomes ineligible for FTW (e.g., due to age, change in disability, employment, income, or premium non-payment; and

• Annually, during each renewal process.

Timeframes

See MA 1301(B) for processing timeframes.

Legal Authority

Program	Legal Authorities
AHCCCS FTW	42 USC § 1320b-19 ARS § 36-2950

1307 Breast and Cervical Cancer Treatment Program (BCCTP) Application Process

Policy

This section describes application requirements that are specific to the BCCTP program.

• Application referral by an AZ-NBCCEDP provider
• Does not qualify for AHCCCS Medical Assistance under another program that covers full services.

General information about the application process can be found in MA1301 and MA1302.

1) Application referral by an AZ-NBCCEDP provider

The three programs of the AZ-NBCCEDP are:

• Well Woman Healthcheck Program (WWHP);

• The Hopi Women's Health Program; and

• The Navajo Nation Breast and Cervical Cancer Prevention Program.

The AZ-NBCCEDP staff:

• Help women complete an MA application;

• Explain the BCCTP to applicants;

• Provide results of the screening and diagnosis to AHCCCS;

• Refer women who need treatment and appear to be eligible for BCCTP to AHCCCS;

• Provide supporting documentation of eligibility to AHCCCS; and

> NOTE This includes supporting documentation of citizenship status (naturalized citizen or legal non-citizen) and health insurance coverage.

2) Screening for Other MA Eligibility

A woman must be ineligible for all other Medicaid (Title XIX) coverage groups to qualify for the BCCTP coverage group (MA522)

If the woman is eligible for AHCCCS Medical Assistance under any other Medicaid coverage group, she must be approved for the other coverage group.

Review for other MA eligibility when:

• Completing the initial application;

• The customer reports a change in income or household members;

• The customer becomes ineligible for BCCTP (for example, due to the end of cancer treatment, age, health insurance coverage); and

• During the annual renewal.

Definition

Term	Definition
Arizona National Breast and Cervical Cancer Early Detection Program (AZ-NBCCEDP)	Programs funded by the Centers for Disease Control (CDC) to provide breast and cervical cancer screening and diagnosis under the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).
Well Woman Healthcheck Program (WWHP)	Administered by ADHS, the WWHP contracts with health departments, community health centers, or non-profit health agencies in each of Arizona's counties to provide state-wide services

Timeframes

When the AZ-NBCCEDP considers an application for BCCTP to be complete, they send it to AHCCCS within 24 hours.

See MA1301B for the overall processing timeframe.

Legal Authority

Program	Legal Authorities
BCCTP	42 USC 1396a(a)(10)(A)(ii)(XVIII) ARS § 36-2901.05 R9-22-2003

1308 KidsCare Application Process

Revised 01/15/2020

Policy

This section describes application requirements that are specific to the KidsCare program.

• No creditable coverage in the last three months

• Past unpaid premiums

General information about the application process can be found in MA1301 and MA1302.

1) No creditable coverage in the last three months

At application, if the customer has insurance coverage or has had coverage in the last three months the coverage must be reviewed to see if it is creditable. If coverage has ended, the end-date must be verified.

2) Past unpaid premiums

When a customer's KidsCare benefits end because premiums were not paid, the customer cannot get KidsCare for two months or the premiums are paid in full, whichever comes first.

Definitions

Term	Definition
Creditable Coverage	Health insurance coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). NOTE Eligibility for services through Indian Health Service (IHS) or a tribal organization is not considered creditable coverage for KidsCare. Examples of creditable coverage include: • Medicare; • Group health plans including Qualified Health Plans; • Health insurance coverage through a hospital or medical service policy, certificate or plan contract; or • Armed forces insurance (i.e., Tricare).

Non-Creditable Coverage	The following types of policies are considered non-creditable coverage: • Coverage only for accidents (including accidental death and dismemberment); • Liability insurance, including general liability and automobile liability insurance; • Free medical clinics at a work site; • Benefits with limited scope such as dental benefits, vision benefits or long term care benefits; • Coverage for a specific disease or illness (including cancer policies); • Insurance that pays a set amount a day when the person is hospitalized or unable to work.

Timeframes

See MA1301B for the overall processing timeframe.

Legal Authority

Program	Legal Authorities
KidsCare	42 USC 1397jj(b)(1)(C) 42 CFR 457.310(b)(2)(ii); 42 CFR 457.805 ARS 36-2983(G)(2)

1309 Approval of Applications

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information on Approval of Applications

Revised 10/29/2015

Policy

In general, eligibility for AHCCCS Medical Assistance is determined on a month-by-month basis. A customer may be eligible or ineligible for any specific month. See MA1311 for more information.

Definitions

Term	Definition
Approval	An approval is a determination that a person is eligible for Medical Assistance benefits.
Decision Letter	A decision letter notifies a customer of approval or denial of AHCCCS Medical Assistance program eligibility.
Eligibility Begin Date	Effective date a person is eligible for AHCCCS Medical Services.

B Approval Letters

Revised 03/29/2022

Policy

Every person that applies for AHCCCS Medical Assistance must receive a letter explaining the decision on their application. See MA1604 for information regarding written letters.

Generally, approval letters are automatically sent out by:

- Hospital staff from subscriber organizations for HPE; and
- Health-e-Arizona Plus (HEAplus) for all other programs.

Definitions

Term	Definition
Approval Letter	A decision letter that notifies a customer of approval of AHCCCS Medical Assistance program eligibility.
Subscriber Organizations	An organization that has signed a HEAplus subscription agreement that sets forth the terms under which the organization may have access to HEAplus.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare and HPE	42 CFR 435.917
KidsCare	42 CFR 457.340
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

C General Information on Eligibility Begin Dates

Revised 10/29/2015

Policy

Rules that affect all programs:

- For a person that moves to Arizona from out-of-state, MA eligibility cannot start any earlier than the date of the move to Arizona.
- For a person that has been in jail, prison or another detention facility, MA eligibility cannot start any earlier than the date the person no longer meets the definition of an inmate (see MA525 – Definitions).
- For a newborn child, MA eligibility cannot start any earlier than the newborn's date of birth.

Otherwise, the date eligibility starts varies by program. See the table below:

Program	**Eligibility Begin Date**
Medicare Savings Program (MSP) – QMB	QMB eligibility begins with the month following the month that QMB eligibility is determined. QMB Begin Date Example
Breast and Cervical Cancer Treatment Program (BCCTP)	BCCTP eligibility begins on the later of: • First day of the application month (the application month for BCCTP is the month of the BCCTP diagnosis); or • First day of the first month in which the customer meets all the BCCTP eligibility requirements. BCCTP Begin Date Examples
KidsCare	• If eligibility is determined by the 25th day of the month, eligibility begins with the first day of the following month. • If eligibility is determined after the 25th day of the month eligibility begins the first day of the second month following the determination. KidsCare Begin Date Examples
Hospital Presumptive Eligibility (HPE)	HPE eligibility begins no earlier than the date the HPE application is approved.
All other programs	First day of a month, if the customer is eligible at any time during that month.

Legal Authority

Program	**Legal Authorities**

All programs (except BCCTP, QMB, KidsCare and HPE)	42 CFR 435.914
Breast and Cervical Cancer Treatment Program (BCCTP)	R9-22-2007
Medicare Savings Program – QMB	42 USC 1396a(e)(8)
KidsCare	42 CFR 457.340(f)
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

1310 Denial of Applications

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A General Information on Denial of Applications

Policy

An application is denied when any of the conditions below apply:

- The customer does not meet one or more of the conditions of eligibility for an AHCCCS Medical Assistance (MA) program;
- There is insufficient information to make an eligibility determination after all reasonable attempts have been made to obtain the information;
- Mail is returned by the post office, the person cannot be located and residency cannot be determined (MA1502Q);
- An ALTCS application will be denied when the 45-day processing period has ended and all efforts to conduct an ALTCS interview have failed; or
- The customer is an inmate and will not be released during the timely processing period.

NOTE Children in juvenile detention can have a change of status where they are no longer considered an “inmate” even though they have not been physically released from custody (see MA525 for inmate definitions).

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 435.914
KidsCare	42 CFR 457.340(e)

B Denial Letters

Revised 03/29/2022

Policy

Each person that applies for AHCCCS Medical Assistance must receive a letter explaining the decision on their application. See MA1604 for information regarding written letters.

Generally, denial letters are automatically sent out by:

- Hospital staff from subscriber organizations for HPE; and
- Health-e-Arizona Plus (HEAplus) for all other programs.

Definitions

Term	Definition
Denial	A determination that a person is not eligible for Medical Assistance benefits.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare and HPE	42 CFR 435.917
KidsCare	42 CFR 457.340(e)
Hospital Presumptive Eligibility	AAC R9-22-1601

1311 Processing Applications for Multiple Months

Revised 06/14/2018

Policy

When determining eligibility for an application, more than one month may need a determination. Determine each month up through the current calendar month separately, using the actual household situation and monthly income or monthly equivalent for each month.

A customer's situation may change from month to month. Since eligibility is determined on a monthly basis, a customer may qualify for one month but not another.

When a customer does not qualify for MA in a past month, but qualifies in the current month, a new application is not needed.

Each month the customer qualifies for MA is approved. Any months the customer does not qualify for MA are denied.

Definitions

Term	Definition
Denial	A denial is a determination that a person is not eligible for Medical Assistance benefits.
Monthly equivalent	The MA programs that use MAGI income rules may prorate some income over more than one month: • Income received less often than monthly (see MA604D) • Regular seasonal or contract income that is not received during the entire year (see MA604F)

Legal Authority

Program	Legal Authorities
All programs except KidsCare and QMB	42 USC 1396a(a)(34) 42 CFR 435.915

1312 Applications for Hospitalized Inmates

Revised 03/30/2018

Policy

A person in jail, prison or other detention facility who is admitted to a hospital as an inpatient is not considered an inmate during the inpatient hospital stay. AHCCCS has agreements with several Arizona counties and the Arizona Department of Corrections (ADOC) to determine eligibility for inmates who are admitted for an inpatient stay.

1) Eligibility Requirements

The inmate must meet all of the conditions of eligibility for Medicaid to receive medical coverage for their inpatient hospitalization. However, there are some differences in how to treat the following conditions of eligibility:

• Residency; and

• Potential benefits.

Residency

The inmate must be an Arizona resident at the time of incarceration and not placed by another state's department of corrections. Being an inmate in an Arizona detention facility does not make the person an Arizona resident.

Potential Benefits

Inmates are not required to apply for the following benefits as they are not potentially eligible while incarcerated:

• SSI-Cash or Social Security Administration (SSA) benefits;

• Veteran's Administration (VA) pension payments while in prison due to a felony; and

• Unemployment Insurance.

2) Eligibility Period

If the person qualifies, the eligibility may cover an entire month or more, but AHCCCS can only pay for covered services received during the inpatient stay.

3) Processing Inmate Referrals

The DES/FAA Research and Analysis Unit processes all inmate applications received from ADOC.

Legal Authority

Program	Legal Authorities

All Programs except KidsCare and MSP	42 CFR 435.1009 and 1010

1313 Prior Quarter Coverage

Revised 12/19/2023

Policy

This section describes application requirements that are specific to Prior Quarter Coverage.

1) AHCCCS Medical Assistance (MA)

To qualify for Prior Quarter Coverage of MA, the person must:

• Be pregnant, in the 60-day postpartum period, or under age 19;

• Have a medical expense in a Prior Quarter month. The medical expense can be paid or unpaid; and

• Meet all eligibility requirements in the month the medical service occurred.

2) SLMB and QI-1

To qualify for Prior Quarter Coverage of SLMB or QI-1, the person must:

• Be pregnant, in the 60-day postpartum period, or under age 19;

• Have received Medicare Part B in a Prior Quarter month; and

• Meet all eligibility requirements in the month in which Medicare Part B was received.

NOTE Prior quarter coverage for QI-1 cannot begin any earlier than January of the current calendar year.

3) Effective Date of Prior Quarter Coverage:

The prior quarter period depends on when the Prior Quarter Coverage is requested. See the following table for details:

If the request for Prior Quarter Coverage…	**Then…**
Is submitted at the same time as the application for Medical Assistance (MA).	The Prior Quarter Coverage is the three months before the application month.
Is NOT submitted at the same time as an application for MA AND The MA application is still pending.	The prior quarter period is the three months before the application month.
Is NOT submitted at the same time as an application for MA and MSP AND The MA application has already been completed.	The prior quarter period is the three months before the month the customer's request is submitted.

Information about enrollment in AHCCCS fee-for-service for the Prior Quarter Coverage months can be found in MA1103.

Definitions

Term	Definition
Pregnant	A woman expecting the birth of one or more children.
60-day Postpartum Period	A 60-day period starting the day the pregnancy ends. This period applies to a customer who was not enrolled in AHCCCS while pregnant. A customer who is applying for AHCCCS and was pregnant or in their 60-day postpartum period in any of the 3 months before their application month, may be eligible for Prior Quarter Coverage.
Postpartum period	A 12-month period starting the day the pregnancy ends. This period ends on the last day of the 12th month. Customer must be enrolled in AHCCCS while pregnant to be in the 12-month postpartum period as it applies to this group. See Pregnancy and Postpartum for examples.

Timeframes

The standard MA application timeframes apply to Prior Quarter Coverage. Prior Quarter eligibility is determined on a month-by-month basis.

See MA1311 for policy about processing multiple months.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 435.915
BCCTP	R9-22-101 & 303
SSI-MAO	
Freedom to Work	
Child	
Adult	
SLMB	
QI-1	
Caretaker Relative	
Pregnant Women	

1314 Hospital Presumptive Eligibility (HPE) Application Process

Policy

This section describes application requirements that are specific to the **HPE** program.

General information about the application process can be found in MA1301 and MA1302.

1) HPE applications:

A HPE application is a shorter streamlined version of a full AHCCCS Medical Assistance application containing questions only about the following:

• Contact Information;

• Authorized Representative; (if applicable)

• Personal Information; (for all members of the household)

• Citizenship/Residency;

• Pregnancy Information;

• Foster Care Information;

• Employment Information;

• Other Income Information;

• Medicare Information;

• Parent or Caretaker Relative Information

• Application signature.

Unlike other programs, the customer does not need to provide proof of any these factors to qualify for HPE. However, the customer can only qualify for HPE once every 24 months;

> NOTE HPE applications may ONLY be completed by hospital employees or vendors contracted with a hospital that have signed an agreement with AHCCCS to process HPE applications.

2) Who can be approved for HPE?

Only a person who is not currently receiving Medicaid, has not had HPE eligibility in the past 24 months, and qualifies for one of the following categories may be approved for HPE:

• Pregnant Woman (MA410)

• Child (MA406)

• Caretaker Relative (MA405)

• Adult (MA401)

• Young Adult Transitional Insurance (MA416)

3) What is the HPE Period?

The HPE period is a temporary approval period that begins on the date the HPE is approved and continues until the earlier of the following:

• The last day of the month after the month the HPE is approved, if a full Medicaid application is not submitted by this date.

• The date a decision is made on a full Medicaid application when the application is submitted by the last day of the HPE period.

HPE Period examples can be found at MAE1314.

In order for the customer to have eligibility continued beyond the HPE period the customer must complete and submit a full Medicaid application before the end of the HPE period and be found eligible for Medicaid.

4) Who decides HPE eligibility and notifies the customer?

Only qualified hospital staff from Subscriber Organizations determine HPE. This is done by using a shorter streamlined version of the full application in HEAplus and issuing a HPE decision notice.

AHCCCS and DES staff do not make decisions for the HPE program or send decision letters to customers.

Definitions

Term	Definition
Hospital Presumptive Eligibility (HPE)	Temporary coverage for people who are likely to qualify for AHCCCS Medical Assistance. See MA417 for details. NOTE Eligibility for HPE is determined by qualified hospitals
Qualified hospital	A hospital that has agreed to follow the state's HPE policies and procedures.

Legal Authority

Program	Legal Authorities
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

1400 Introduction

This chapter contains information for processing AHCCCS Medical Assistance renewals.

For each eligibility requirement in this chapter, you will find:

• The policy for the requirement;

• Any definitions needed to explain the policy;

• The timeframe for the requirement, if applicable; and

• A list of the federal and state laws that apply to the requirement by program.

1401 General Information about Renewals

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Renewal Processes

Revised 07/12/2022

Policy

1) Renewal Processes — No Response Required

When renewing AHCCCS eligibility, information from the prior application and Federal and State electronic data sources are reviewed to see if there is enough information to determine if the customer still qualifies. When there is enough information available to determine that the customer still qualifies for AHCCCS Medical Assistance, even in another category, eligibility is renewed. A renewal approval letter is sent.

The letter shows the information that was used to renew eligibility. It tells the customer to check the information and report anything that has changed or is not correct. If the information used is current and accurate, the customer does not need to take any further action.

2) Renewal Processes — Response Required

In some cases, eligibility cannot be determined using available information, or the information indicates that the customer no longer qualifies. When this happens, the customer must provide information needed to complete the renewal process.

A renewal letter is sent to the customer. The letter contains the following:

- A pre-populated renewal form with the most current information available from the last application and any electronic data sources; and
- A Request for Information describing any proof needed.

The customer must take the following actions:

- Review the pre-populated renewal form;
- Identify any incorrect information on the form and enter the corrected information on the form;
- Provide proof for any information that was corrected;
- Provide any proof listed in the Request for Information that was sent with the form; and
- Sign the form and submit the signed renewal form with any proof needed.

The customer has 30 days to complete the renewal and provide any information requested. The renewal may be completed by mail, by fax, by phone, or in person. Except for ALTCS customers, renewals can also be completed online in the Health-e-Arizona Plus system.

The following options are available to complete the renewal by phone:

- A voice signature can be provided.
- The customer can confirm the information listed on the prepopulated renewal form is correct.
- The customer may need to provide proof for changes and unverified eligibility factors separately from the call when eligibility staff are unable to get the proof through electronic sources or prior applications.

Customers who do not provide the requested information by the due date will have their eligibility stopped.

When eligibility is stopped for failure to complete the renewal, the customer does not have to submit a new application when:

- The customer submits the completed renewal form before the date the MA eligibility ends, or
- The customer submits the completed renewal form within 90 days of the discontinuance date.

3) Customer Assistance

When needed, Benefits and Eligibility Specialists and other staff will help the customer with the renewal process. Customers may also have someone of their choice help them with the renewal process. This includes:

• Going with the customer to the local office;

• Helping the customer fill out the application; and

• Representing the customer.

4) Customer Cooperation

Customers and their representatives must cooperate in the renewal process. This includes:

• Providing information;

• Reporting changes; and

• Taking any action needed to qualify for the MA program.

5) Opportunity to Register to Vote

The National Voter Registration Act (NVRA) of 1993 and Arizona Revised Statutes (ARS) require that public assistance offices provide applicants and customers with an opportunity to register to vote at the time of renewal. To meet this requirement, Voter Registration forms are sent to customers with renewal letters.

Definitions

Term	Definition
Health-e-Arizona Plus (HEAplus)	Arizona's online application and determination system for AHCCCS Medical Assistance eligibility.
Renewal	A review of financial and non-financial eligibility factors.
Representative	A person appointed by the applicant to act on his or her behalf in the application process

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.908 and 916 42 CFR 457.340 (KidsCare)

B Decision Letters

Policy

All customers must receive a letter explaining the decision on their renewal. See MA1604 for information regarding written letters.

Definitions

Term	Definition
Decision Letter	A letter that notifies a customer of the action taken for their AHCCCS Medical Assistance program eligibility including: • Approval; • Denial; • Discontinuance; • Change in share of cost, premium amount or co-payments; • Change in eligible medical services; and • Enrollment with a health plan or program contractor.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.916 42 CFR 435.919

C Timeframes

Revised 11/29/2018

Policy

AHCCCS Medical Assistance (MA) eligibility must be reviewed and renewed periodically. This section describes how often renewals must be completed.

1) Programs That Must Be Renewed Once Every 12 Months

A renewal of eligibility must be completed once every 12 months for customers enrolled in one of the following MA coverage groups:

• Adult;

• Caretaker Relative;

• Pregnant Woman;

• Child;

• Young Adult Transitional Insurance (YATI);

• KidsCare; and

• Deemed Newborns.

2) Programs That Must Be Renewed At Least Once Every 12 Months

Renewal of eligibility for the following programs must be completed at least once every 12 months:

• ALTCS;

• SSI-MAO;

• Medicare Savings Program (MSP);

• AHCCCS Freedom to Work (FTW); and

• Breast and Cervical Cancer Treatment Program (BCCTP).

3) Programs with Automatic Eligibility

Some customers do not have to complete an AHCCCS renewal because they automatically receive MA by qualifying for one of the following programs:

• SSI-Cash;

• Title IV-E Foster Care; and

• Title IV-E Adoption Assistance.

4) Programs with special Renewal Periods

Transitional Medical Assistance (TMA) and Continued Coverage (CC)

The TMA and CC programs are time-limited extensions of coverage for families when a Caretaker Relative's earnings or spousal support puts them over the income limit. The renewals for these programs are as follows:

• For TMA, at six months and 12 months

• For CC, at four months from the CC start date.

Qualified Individual-1 (QI-1)

Customers are approved for QI-1 until the end of the calendar year. The Federal government funds the QI-1 program on a year to year basis. Renewals for QI-1 are completed annually at the end of the calendar year.

Definitions

Term	Definition
Renewal	A review of financial and non-financial eligibility factors.

Programs and Legal Authorities

Program	Legal Authorities
All Programs	42 CFR 435.916

1402 Proof Needed at Renewal

Revised 09/14/2023

Policy

Some requirements are not verified again at renewal as they do not generally change. Any eligibility requirement that could have changed may need to be reviewed and current proof provided. See the table below for more details:

Requirement	Instructions	Programs
Age (MA501)	Does not need to be verified again at renewal. NOTE If the customer is in a program that has an age limit, age must be reviewed to see if the customer still meets the age requirement for the program.	Adult BCCTP Child Deemed Newborns FTW KidsCare SSI-MAO YATI
Blindness (MA504)	Does not need to be verified again at renewal, unless Social Security has determined that the person is no longer blind.	SSI-MAO
Disability (MA509)	Does not need to be verified again at renewal, unless Social Security has determined that the person is no longer disabled.	ALTCS SSI-MAO FTW
U.S. Citizenship (MA507)	Does not need to be verified again at renewal.	All programs
Residency (MA531)	Does not need to be verified again at renewal unless it is questionable.	All programs
Valid Social Security Number (MA532)	Does not need to be verified again at renewal unless the customer: • Provided proof of application for an SSN, but has not yet provided the SSN; or • Is exempt from providing a valid SSN.	All programs

Non-Citizen Status (MA524)	Does not need to be verified again at renewal unless there has been a change in the customer's immigration status. NOTE For qualified non-citizen who only gets emergency services due to the 5-year bar, the status date must be reviewed to see if the bar period has ended.	All programs
Not an Inmate (MA525)	Does not need to be verified again at renewal unless there is a discrepancy with hub data. NOTE See MA1502V for specific instructions if the person is an inmate.	All programs
Not in an IMD (MA514)	Only verify if it is reported that the child is residing in an IMD.	KidsCare
Medicare Entitlement (MA523)	Does not need to be verified again at renewal unless there is a discrepancy with hub data source information.	MSP Adult SSI-MAO (DWW)
No Creditable Coverage (MA515)	Does not need to be verified again at renewal unless the customer reports a new source of insurance coverage.	BCCTP KidsCare
Ineligible for other MA programs (MA522)	Must be verified at each renewal.	FTW BCCTP KidsCare
Good Cause for not cooperating with DCSS (MA503)	The requirement to cooperate with DCSS in establishing the identity of a child's parents and in obtaining medical support is suspended under a temporary waiver from 09/01/2023 through 05/31/2024. If the customer claims good cause for not cooperating, it must be verified at each renewal.	All programs except KidsCare
Insurance Coverage for Dependent Children (MA518)	Must be verified at each renewal. NOTE Verification should be available from the hub data sources. If the child is receiving MA, this requirement is verified.	Adult
Not eligible for State employee health benefits (MA517)	Does not need to be verified again at renewal unless the customer reports employment with a State Agency.	KidsCare

Potential Benefits (MA526)	The requirement to cooperate with Applying for Potential Benefits is suspended under a temporary waiver from 10/01/2023 through 05/31/2024. Only verify when: • The customer previously applied for potential benefits and the outcome of that application is not known; • There is a new source of potential benefits. For example, the customer was recently laid off and may qualify for Unemployment Insurance; or • There was a change in circumstances in which the customer may need to reapply for that potential benefit. Circumstances could include added or removed household members, deceased parent or spouse, income, age, disability, work history, or living arrangement.	All programs except KidsCare
Income (Chapter 600)	Must be verified at each renewal.	All programs except BCCTP and YATI
Resources (Chapter 700)	All countable resources that can be expected to change and could affect eligibility must be verified at each renewal. Resources are not expected to change when the customer: • Has no resources and no income in the most recent approved application and no income is found by the hubs. • Receives SSI Cash or IVE payments and is verified. • Is under age 18 and has less than $1000.00 in resources. • Has less than $1000.00 in resources and only income is Social Security in the most recent approved application, and no other income is found by the hubs. • Is in a Nursing facility and their only resource is a Patient Trust Account. When AVS returns an account value that does not put the customer over the resource limit, it is reasonably compatible and verified. Otherwise, request proof.	ALTCS

Trusts (Chapter 800)	How trusts are reviewed at renewal depends on whether the trust is a: • Non-Special Treatment Trust; or • Special Treatment Trust.	ALTCS
Cancer Treatment Status (MA505)	Must be verified at each renewal.	BCCTP
Employed (MA510)	Must be verified at each renewal.	FTW
Caretaker Relative of a Dependent Child (MA506)	Does not need to be verified again at renewal unless questionable.	Caretaker Relative Transitional Medical Assistance (TMA) Continued Coverage (CC)
Pregnancy (MA527)	Must be verified at each renewal. However, the woman's statement that she is pregnant is accepted unless there is strong reason to question it.	Pregnant Woman
Living Arrangement (MA521)	Does not need to be verified again at renewal unless questionable.	ALTCS
Student Status	Only verify if the only child living with the caretaker relative is 18 years old (MA506).	Caretaker Relative
	Must be verified at each renewal.	ALTCS SSI-MAO MSP FTW

Definitions

Term	Definition
Renewal	A periodic review of financial and non-financial eligibility factors.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.916 42 CFR 435.940 to 435.956

1403 Persons Losing SSI Cash Eligibility

Revised 12/31/2019

Policy

A customer who receives SSI Cash in Arizona is also eligible for AHCCCS Medical Assistance (MA). If the customer loses SSI Cash, the customer loses automatic eligibility for MA, but may be eligible for another MA program. A two month period is allowed to determine ongoing eligibility. The renewal must be completed or eligibility stopped before the end of the two month period.

Before stopping the customer's MA, a renewal is completed to see if the customer meets the eligibility requirements for any other MA program. The renewal is first done automatically as described in MA1401.A.1.

NOTE ALTCS eligibility does not stop due to the customer losing SSI Cash. When SSI Cash stops, the customer is no longer categorically eligible for ALTCS, and eligibility must be reviewed to see if the customer still qualifies.

If more information is needed to determine eligibility, the customer is sent a Request for Information letter. Eligibility is stopped if the information is not received by the due date. If the information is returned and the customer is not eligible for another program, his or her MA is stopped, and a discontinuation letter is sent.

Legal Authority

This requirement applies to the following program:

Program	Legal Authorities
All programs	42 CFR 435.930

1500 Introduction

This chapter explains policy for changes that occur after the initial approval of AHCCCS Medical Assistance eligibility.

NOTE Enrollment change policy is in Chapter 1100.

In this chapter you will find:

• The policy for changes;

• Any definitions needed to explain the policy;

• Any proof needed;

• Timeframes, where applicable; and

• A list of the federal and state laws that apply to the requirement by program.

1501 General Information about Changes

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A How a Change May Affect a Customer

Policy

Changes in the customer's circumstances could affect the customer's:

• Ability to get letters from AHCCCS, DES, health plan or program contractor;

• Eligibility for AHCCCS Medical Assistance (MA) programs;

• Share of cost, premium amount or co-payments;

• AHCCCS Medical Assistance service package; or

• Enrollment with health plan or program contractor.

Definitions

Term	Definition
Change in circumstance	Something that happens to a person, which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.

Proof

The type of proof needed depends on the type of change. See MA1502 for types of changes and proof needed.

Timeframes

There are different timeframes for each type of change. See MA1502 for types of changes and timeframe requirements.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.916(c) - (f)

B Change Reporting

Revised 04/27/2021

Policy

Customers or their representatives are required to report any changes that may affect their MA eligibility, premium amount or share of cost. The types of changes that must be reported are described in MA1502. However, anyone who knows about a change in the customer's circumstances may report the change. Changes are most commonly reported by:

• Customer;

• Customer's representative;

• Customer's spouse;

• Customer's relatives, friends or neighbors;

• AHCCCS Complete Care (ACC) plan or program contractors;

• Medical facilities and providers;

• Attorneys; and

• Trustees.

NOTE Information reported by someone other than the customer or the customer's spouse or representative must be confirmed before any action can be taken. The customer or customer's representative must confirm the change report is correct, or other proof must be received, even if the change would not normally need proof. For example, a neighbor reports that the customer moved out of state. This must be confirmed before taking any action as the neighbor may not have accurate information.

1) How Can Changes be Reported?

Changes can be reported:

• Online through Health-e-Arizona Plus (HEAplus);

• By phone;

• By fax;

• In writing; or

• In person.

2) How is the Customer Informed?

The customer is informed about their responsibility to report changes in a variety of ways, including:

• On each approval letter or change letter;

• On the AHCCCS Medical Assistance program application;

• For ALTCS only, verbally during an interview and in writing with the Rights and Responsibilities of Customers (DE-113); or

• Verbally during assistance with an in-person application.

Definitions

Term	Definition
Change in Circumstance	Something that happens to a person which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.
Report	A person notifies the Agency of a change in circumstance.

Proof

The type of proof needed depends on the type of change. See MA1502 for types of changes and proof needed.

Timeframes

In general, changes must be reported as soon as the future event becomes known. However, there are different timeframes for some changes. See MA1502 for types of changes and timeframe requirements.

NOTE Special reporting requirements apply to trustees of Special Treatment Trusts. Trustee reporting requirements are described in MA803.A.

Legal Authority

Program	Legal Authorities
All programs, except KidsCare	42 CFR 435.916(c)
ALTCS	AAC R9-28-411(A)
SSI MAO	AAC R9-22-1501(H)
MSP	AAC R9-29-224
FTW	AAC R9-22-1905 and R9-28-1305
BCCTP	AAC R9-22-2005(D)
KidsCare	42 CFR 457.343 AAC R9-31-308

C Change Letters

Revised 03/29/2022

Policy

A written notice is required if a change in circumstance causes:

- A customer to lose eligibility;
- A decrease in services;
- An increase in the customer's share of cost; or
- An increase in the customer's premium amount.

See MA1604 for information regarding written letters.

Definitions

Term	Definition
Change in Circumstance	Something that happens to a person which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 431.210, 211 and 213 42 CFR 435.917 42 CFR 435.919
KidsCare	42 CFR 457.343

1502 Types of Changes

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Address Change

Revised 08/17/2021

Policy

A change in the address of a customer, a customer's spouse, a parent of a minor customer, or a customer's representative must be reported.

1) Customer's Address Changes

A change in the customer's address may affect a variety of factors depending on the program for which the customer is currently eligible. These factors must be reviewed and verified using the proper policy before the address change can be processed.

When the address change is to...	Then the change may affect the customer's...
Outside Arizona	• Eligibility, when the customer is no longer an Arizona resident. • AHCCCS Medical Assistance (MA) services when the person is temporarily out of the state. See MA531 for details on Arizona residency.
A different county	• Eligibility, when there is a change in household members that affects the customer's budget group. See MA1502N for more information. • Enrollment with an AHCCCS Complete Care (ACC) plan or program contractor. Different health plans and program contractors serve different counties. See MA1104 for more information about program contractors.
A jail, prison or other detention facility	Eligibility or enrollment. See MA1502V for specific policy on when a customer is incarcerated.
A long term care living arrangement	Eligibility, enrollment or share of cost. See MA1502P for specific policy on when a customer's living arrangement changes.

2) Spouse's Address Changes

A change in a spouse's address may affect the customer depending on the program for which the customer is currently eligible. The change must be reviewed and verified according to the proper policy before the address change can be processed.

If...	And the customer is eligible for...	Then the change may affect the customer's...

The customer's spouse moves into or out of the home.	All programs	Eligibility or customer costs. See MA 1502N for specific policy on changes to household members.
The spouse moved to a nursing facility	ALTCS	Community spouse policy, which can no longer apply. The change could affect eligibility and share of cost (SOC).

NOTE A change in the spouse's mailing address without a change in the physical address has no effect on the customer.

3) Parent's Address Changes

A change in a parent's address may affect a customer child's eligibility or enrollment depending on the program for which the customer is currently eligible. The impact must be reviewed and verified according to the proper policy before the address change is processed.

NOTE A change in the parent's physical address may affect a customer child's enrollment even when the customer does not move.

When the address change is to...	And the customer is eligible for...	Then the change may affect the customer's...
Another state (permanently)	All programs	Eligibility, when the child is no longer an Arizona resident (MA531).
Another county	ALTCS Elderly and Physically Disabled (EPD)	Enrollment, as enrollment is based on the parent's county of fiscal responsibility (MA1104E).
	DES Division of Developmental Disabilities (DDD) services	No effect on the customer's enrollment.

NOTE A change in the parent's mailing address without a change in the physical address has no effect on the customer child.

4) Other Household Member Address Changes

An address change for other household members may affect the customer's eligibility, share of cost or premium amount:

When the representative is...	Then...
An adult child under age 22 or a tax dependent	Eligibility or customer costs. See 1502N for specific policy on changes to household members.

5) Representative's Address Changes

When the customer's representative is NOT one of the family or household members listed in sections 2 through 4 above, an address change for the representative does not affect the customer's eligibility, share of cost or premium amount.

6) Offering Customers the Opportunity to Register to Vote

The National Voter Registration Act (NRVA) of 1993 (42 USC § 1973gg) and Arizona Revised Statute 16-140 require that public assistance offices provide customers with an opportunity to register to vote when a person reports a change of address.

Definitions

Term	Definition
Tax dependent	A person who qualifies to be claimed as the customer's dependent for tax purposes.

Proof

The proof required to process an address change depends on who provides the information:

When address change information is provided by the...	Then...
• Customer; • Customer's spouse; or • Customer's representative, including a customer child's parent	The person's statement is accepted.
Anyone else	The customer or customer's representative must be contacted to confirm the reported change.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 435.403 42 CFR 435.916
KidsCare	42 CFR 457.320(d) 42 CFR 457.343

B Age

Revised 05/30/2018

Policy

A change in age can affect a customer's eligibility or premium amount depending on the age and the AHCCCS Medical Assistance (MA) program. See the following table for important age changes:

Turns…	Program	Change
Age 1	Deemed Newborn	Deemed Newborn coverage stops after the month the child turns age 1. Eligibility is reviewed to see if the child qualifies for any other MA program.
	Child	The Child program covers children under age 19, but there are different income limits based on the child's age. At age 1, eligibility is reviewed to see if the child still qualifies using the Child program's income limit for children age 1 through 5 (MA615.11), or for any other MA program.
Age 6	Child	The Child program covers children under age 19, but there are different income limits based on the child's age. At age 6, eligibility is reviewed to see if the child still qualifies using the Child program's income limit for children age 6 through 18 (MA615.12), or for any other MA program.
Age 19	Child KidsCare	Coverage under the Child program and KidsCare program stops after the month the customer turns age 19. Eligibility is reviewed to see if the customer qualifies for any other MA program.

Age 22	ALTCS SSI-MAO MSP FTW	The Student Earned Income exclusion stops the month after the student turns age 22. The exclusion is removed and eligibility is reviewed to determine the effect. Stopping the Student Earned Income exclusion increases the customer's counted income when: • The customer is the student, and more earnings are counted; • The customer's child is the student, gets a lower Child Allocation; or • The customer's parent is the student, and more income is deemed to the customer from the parent. The increased income may cause a higher premium or Share of Cost, or the customer may no longer qualify for the current MA program. When the customer is no longer eligible for the current MA program, eligibility is reviewed to see if the customer can qualify for any other MA program.
Age 26	YATI	Coverage under the Young Adult Transitional Insurance (YATI) program stops the month after the customer turns age 26. Eligibility is reviewed to see if the customer qualifies for any other MA program.
Age 65	Adult Disabled Widow/ Widower (DWW) FTW BCCTP	Coverage under these programs stops the month after the customer turns age 65. Eligibility is reviewed to see if the customer qualifies for any other MA program.

Definitions

Term	Definition
Student Earned Income exclusion	A deduction from the earned income of qualifying students under age 22. See MA609B.2 for more information.

Timeframes

Age changes are known in advance. Action is taken to process the change for the month after the person's birth month.

Legal Authority

Program	Legal Authorities
Adult	42 CFR 435.119
Child	42 CFR 435.118
Breast & Cervical Cancer Treatment Program (BCCTP)	ARS 36-2901.05(A)(4) AAC R9-22-2003(a)(2)
Freedom to Work (FTW)	ARS 36-2901(6)(g) AAC R9-22-1901 AAC R9-28-1316(2)
Disabled Widow Widower (DWW)	42 USC 1383c(b) AAC R9-22-1505(A)(4)
YATI	42 USC 1396a(a)(10)(A)(i)(IX)
KidsCare	ARS 36-2981(6) AAC R9-31-303(1)

C ALTCS Customer Refusing Services

Revised 05/30/2018

Policy

A customer who refuses home and community based services (HCBS) may be eligible for ALTCS acute care when the customer's income is less than or equal to 100% of the Federal Benefit Rate (FBR). This change to acute care only does not require a 10- calendar day advance notice because long term care services may be reinstated at the customer's request.

When a customer's income exceeds 100% of the FBR, the customer is ineligible for both long term care and acute care services. The change requires a 10-calendar day advance notice to discontinue eligibility because income exceeds the limit.

All program contractors must identify ALTCS customers who refuse services because customers who are living in the community must be receiving or intend to receive HCBS services. The program contractor must notify the ALTCS office that the customer has refused HCBS services.

Definitions

Term	Definition
Refusing Services	Customers enrolled with an ALTCS program contractor, but are refusing HCBS services; sometimes referred to as ALTCS non-users. Refusing HCBS services includes refusing to move from a non-contracted HCBS facility to a contracted facility.

Proof

The ALTCS program contractor may notify the Agency that the customer is refusing ALTCS HCBS long term care services. They must tell the Agency in writing or electronically.

Programs Affected

This applies to the following programs:

• ALTCS

• FTW - ALTCS

Timeframes

The program contractor reports the change after all attempts to work with the customer have failed.

Legal Authority

Program	Legal Authorities
ALTCS FTW - ALTCS	AAC R9-28-406(B)

D Cancer Treatment Ends

Revised 06/01/2021

Policy

When a Breast and Cervical Cancer Treatment Program (BCCTP) customer's treatment end date is reported, the BCCTP eligibility end date is determined using the following table:

When the treatment was for...	Then BCCTP eligibility ends...
A pre-cancerous cervical lesion	4 months after the cancer treatment ends.
Cervical cancer	12 months after the cancer treatment ends.
Breast cancer	12 months after the last provider visit for a treatment other than hormonal therapy; or at the end of hormonal therapy for breast cancer, whichever is later. Because hormonal therapy is usually prescribed for up to 5 years, there is no extended BCCTP eligibility following hormonal therapy.
Metastasized cancer	As determined on a case-by-case basis by the AHCCCS Chief Medical Officer.

When a woman is no longer eligible for BCCTP, her eligibility is reviewed to see if she qualifies for any other AHCCCS Medical Assistance (MA) program.

Definitions

Term	Definition
Treatment End Date	• Date of the last provider visit for a specific therapy for cervical cancer or a pre-cancerous cervical lesion; or • Date of the last provider visit for a specific therapy for breast cancer or the end of hormonal therapy, whichever is later.

Proof

A Treatment Status Update (BC-241) with a treatment end date as determined by the AHCCCS Complete Care (ACC) plan doctor. The BC-241 is sent at least every six months until the treatment end date is confirmed.

Programs Affected

This policy applies to the Breast and Cervical Cancer Treatment Program (BCCTP).

Timeframes

AHCCCS uses the treatment end date to determine when BCCTP eligibility ends. Action must be taken early enough to allow time to:

• Determine eligibility for other MA programs, and

• When not eligible for any other MA programs, send a letter in advance telling the customer her eligibility is ending. See MA1501C for requirements.

See Examples - BCCTP timeframes when treatment ends

Legal Authority

Program	Legal Authorities
Breast and Cervical Cancer Treatment Program (BCCTP)	ARS 36-2901.05(A)(2) AAC R9-2003(A)(1)

E Citizen or NonCitizen Status Change

Revised 05/30/2018

Policy

A change in U.S. citizen or noncitizen status may occur when:

- A customer becomes a U.S. citizen through the naturalization process;
- AHCCCS receives evidence that a customer who previously claimed to be a U.S. citizen is actually a noncitizen;
- The 5-year waiting period for a Lawful Permanent Resident, parolee or battered alien to get full AHCCCS benefits ends; or
- A customer's noncitizen status changes.

A change in status may allow a customer to get full AHCCCS Medical Assistance services, or it may cause the customer to lose eligibility for full services.

When a customer's U.S. citizenship or noncitizen status changes, eligibility is reviewed and redetermined.

Definitions

Term	Definition
U.S. Citizen	A person may be a U.S. citizen based on where they were born, having a U.S. citizen parent, by marriage or by naturalization as described in MA507.
Non-Citizen	A noncitizen is a person who is not a U.S. citizen or national. See MA524 for details.

Proof

The proof required depends on the change reported:

When the change reported is...	Then proof includes...
Customer has become a naturalized citizen	• A copy of the customer's naturalization certificate • Electronic record of U.S. citizenship from the federal hub.
Change in customer's noncitizen status	USCIS document showing the noncitizen status and SAVE verification.

End of the 5-year waiting period for a Lawful Permanent Resident, Parolee or Battered Noncitizen	The entry date in a qualified status is listed on the proof of qualified status provided at application. No further proof is needed. NOTE Full AHCCCS coverage starts on the first of the month in which the 5-year waiting period ends.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 435.406 ARS 36-2903.03 42 CFR 435.916
ALTCS	AAC R9-28-411(A)(1)(l)
SSI-MAO	AAC R9-22-1501(H)(2)(b) and 1502(C)
Medicare Savings Program (MSP)	AAC R9-29-210
Freedom to Work (FTW)	AAC R9-22-1911 AAC R9-28-1311
Breast and Cervical Cancer Treatment Program (BCCTP)	AAC 9-22-2005(D)(2)
KidsCare	42 CFR 457.343 ARS 36-2983(E) AAC R9-31-303(2)

F CSMIA Amount Made Available to the Community Spouse

Revised 05/30/2018

Policy

The Community Spouse Monthly Income Allowance (CSMIA) is only allowed as a Share of Cost (SOC) deduction for the customer when it is available to the community spouse.

When the full CSMIA is not made available to the community spouse, the CSMIA amount must be adjusted and the customer's SOC recalculated.

When the community spouse also receives AHCCCS Medical Assistance (MA), the amount of the CSMIA made available may affect the amount of his or her counted income depending on the MA program. See MA1502O, for more information about income changes.

Definitions

Term	Definition
Community Spouse Monthly Income Allowance (CSMIA)	A calculated amount to help the community spouse pay his or her living expenses. See MA1201C.5 for details.
Share of Cost (SOC)	The amount a customer is required to pay toward the cost of long term care services.

Proof

Proof that the CSMIA is not available to the community spouse includes:

• Customer's written or verbal statement that he or she will not make the CSMIA available to the community spouse;

• Financial records showing that the CSMIA is not paid to or available to the spouse.

NOTE When the customer's income is deposited to an account that is titled solely or jointly to the community spouse, assume that the community spouse has access to the CSMIA.

Programs Affected

This applies to the following programs:

• ALTCS

• Freedom to Work – ALTCS

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 435.916
Freedom to Work – ALTCS	AAC R9-28-410(C) and R9-28-411(A)(1)(r)

G Death

Revised 03/28/2023

Policy

1) Death of a Customer

When a customer dies his or her eligibility is stopped. When there are other people in the budget group receiving AHCCCS Medical Assistance (MA), the eligibility of these customers must be reviewed as a change in household size (MA1502N).

An ALTCS customer may receive a Share of Cost (SOC) adjustment for the month he or she died. To determine if a SOC adjustment is needed, the prorated capitation rate is compared to the SOC for the month. The SOC for the month the customer died is the prorated capitation rate or the customer's monthly SOC, whichever is lower.

NOTE ALTCS customers who receive Fee-For-Service coverage (MA1103) do not receive a Share of Cost adjustment.

See Prorating Share of Cost When a Customer Dies Examples

2) Death of a Spouse

The death of a customer's spouse results in a change in the customer's marital status and may affect the customer's:

• Income eligibility;

• ALTCS SOC;

• ALTCS resource eligibility; or

• ALTCS transfer penalty, if any.

When the customer is eligible for ALTCS, use of community spouse policy stops the month after the month the customer's spouse died.

The customer's counted income may be less when the deceased spouse was part of the customer's budget group and had income. However, the customer may get more income or resources due to the spouse's death as described below:

• The customer may get increased Social Security (SSA) benefits, all or a portion of the spouse's pension, or Veteran's Administration (VA) benefits.

• The customer may be the beneficiary of death benefits or entitled to assets from the deceased person.

3) Death of a Parent or Other Household Member

The death of a parent or other household member may affect the customer's:

• Income eligibility;

• ALTCS SOC; or

• Resource eligibility (for ALTCS).

The customer's counted income may be less when the deceased person was part of the customer's budget group and had income. However, the customer's income could increase due to qualifying for a survivor's benefit or inheriting income or resources due to the death.

Definitions

Term	Definition
Capitation	A fixed rate paid to the health plan or program contractor for the delivery of services to each customer enrolled with that health plan or program contractor, regardless of the amount of medical services the customer receives.
Death Benefits	Death benefits include, but are not limited to, the following: • Lump sum death benefits from SSA or USOPM; • Railroad Retirement burial benefits; • VA burial benefits; • Life insurance proceeds; • Inheritances in cash or in-kind; or • Cash or in-kind gifts given by relatives, friends, or a community group to assist with expenses related to the death.
Inheritance	Inheritance is cash, a right, or a non-cash item given to a person because of someone's death.
Life Insurance Proceeds	Life insurance proceeds include: • Payments from a life insurance company to the beneficiary of a policy upon the death of the insured; • Payments to the owner of the policy when the policy is surrendered; or • Accelerated life insurance payments.

Proof

The following forms of verification are accepted as proof of date of death:

- Collateral contact with knowledgeable sources such as relatives, case managers, hospital or nursing facility where the customer died, or the funeral home that handled the burial arrangements;
- Social Security record showing date of death;
- Obituary in a newspaper; or
- Death records from Vital Records including:
  - Electronic reporting from the agency; or
  - An official death certificate.

NOTE When records are available from Vital Records they are used over all other forms of proof. Any discrepancies must be reported to Vital Records by a family member. Only a family member can request a change to the death record.

Timeframes

The change must be reported within 10 calendar days of the date of death.

Legal Authority

Program	Legal Authorities
All Programs	42.CFR 431.213(a) 42 CFR 435.916(c)
ALTCS	AAC R9-28-411(A)(1)(g)
SSI-MAO	AAC R9-22-1501(H)(1)(d)
Medicare Savings Program (MSP)	AAC R9-29-213(6)
Freedom to Work (FTW)	AAC R9-22-1905
Breast and Cervical Cancer Treatment Program (BCCTP)	AAC R9-22-2008
KidsCare	42 CFR 457.343 R9-31-310(B)(1)

H DDD Status Change

Revised 06/18/2021

Policy

A change in the customer's eligibility status with the Department of Economic Security's (DES) Division of Developmental Disabilities (DDD) affects the:

• Preadmission Screening (PAS) tool that is used to determine ALTCS medical eligibility;

• Program contractor with whom the customer is enrolled; and

• Types of long term care services available to the customer.

See DD Status Changes for instructions on processing a change in DD status.

Definitions

Term	Definition
Division of Developmental Disabilities (DDD)	The division within DES responsible for providing services to eligible Arizona residents with developmental disabilities, as defined in ARS Title 36, Chapter 5.1.
Preadmission Screening (PAS)	The method of determining whether the customer is medically eligible for the ALTCS program.

Proof

DDD provides information and proof about changes in the customer's DDD status.

Programs Affected

This applies to the following programs:

• ALTCS

• FTW – ALTCS

Legal Authority

Program	Legal Authorities

ALTCS FTW-ALTCS	42 CFR 435.540 42 CFR 435.541 AAC R9-28-402(A)(2) and (3) AAC R9-28-305 and 306

I DDSA Redetermination of Disability or Blindness

Revised 05/30/2018

Policy

SSI-MAO and Freedom to Work (FTW) customers must provide updated information about their disabling conditions in certain circumstances.

The Disability Determination Service Administration (DDSA) usually determines a person to have a disability or blindness for a limited period of time. When this is the case, the person's disability or blindness must be reviewed and determined again at the end of the limited period.

The DDSA decision on the most recent Disability Determination and Transmittal (DE-120) lists the date when next determination is due. This date is also known as the medical diary end date.

Before the medical diary end date, DDSA redetermination forms are sent to SSI-MAO and FTW customers that are under age 65 and do not receive SSI-Cash or Social Security Disability payments. The customer must complete and return these forms to see if they still qualify for SSI-MAO or FTW.

NOTE AHCCCS does not send DDSA redetermination forms when the customer is receiving Social Security Disability or SSI-Cash payments because this is already done as part of the redetermination process for the payments.

See DDSA Redetermination of Disability or Blindness Referrals for instructions.

Definitions

Term	Definition
Disability Determinations Services Administration (DDSA)	The division of the Arizona Department of Economic Security (DES) Arizona authorized to make disability determinations for the Social Security Administration and for the AHCCCS Administration.
Disability Determination	The disability determination for SSI-MAO is the same as is used for the Social Security Administration.

Proof

The Disability Determination and Transmittal (DE-120) from DDSA with the results of the redetermination.

Programs Affected

This applies to the following programs:

- SSI MAO; and
- FTW.

Timeframes

Processing begins 90 calendar days before the end of the diary date.

Legal Authority

Program	Legal Authorities
SSI-MAO	42 CFR 435.540 42 CFR 435.541 42 CFR 435.916 AAC R9-22-1501(B)
Freedom to Work (FTW)	42 CFR 435.540 42 CFR 435.541 42 CFR 435.916 AAC R9-22-1922(B) AAC R9-28-1324(B)

J Demographic Information

Revised 08/15/2023

Policy

The customer may request a correction of the following demographic information:

• Name;

• Date of birth;

• Social Security number;

• Date of marriage;

• Address; or

• Sex (including gender change)

These changes do not usually cause a change to a customer's eligibility or costs but must be reviewed for possible impact.

Proof

The type of proof depends on the type of change:

When the change is a...	Then the proof required includes...
Name change or correction	• Social Security (SSA) records. • Marriage certificate; • Divorce decree; or • Other court records.
When a customer has a Mononymous name	• Birth Certificate; • Legal documents showing the name change when the customer previously had two names; • Social Security (SSA) Records; and • All other needed information to verify pending eligibility factors.
Date of birth correction	See Proof in MA501.
Social Security Number correction	See Proof in MA532.
Date of marriage correction	See Proof in MA1502R
Address change	See Proof in MA1502A

Sex correction, including gender change	Accept the customer's statement. NOTE Warn customers who are eligible for Medicaid and Medicare that this type of change may prevent AHCCCS from paying the Medicare Part B premium when SSA records do not match.

Programs Affected

This applies to all programs.

Legal Authority

Program	Legal Authorities
All Programs (except KidsCare)	42 CFR 435.916
KidsCare	42 CFR 457.343

K Employment with a State Agency

Revised 05/30/2018

Policy

A child does not qualify for KidsCare when the child can get state employee health insurance. See MA517 for details. KidsCare coverage is ended and eligibility is reviewed to determine if the child can qualify for any other MA program.

Definitions

Term	Definition
State employees who do not qualify for State Employee health insurance.	• Employees who work less than 20 hours per week; • Seasonal, temporary, emergency, and clerical pool employees; • Patients or inmates employed in state institutions; • Employees in positions created for rehabilitation only; and • Employees of a state college or university who are hired to work for less than six months, or are not part of a state retirement plan.

Proof

When the person lists coverage through state employee health insurance on the application or verbally, accept the statement as proof.

When the person is a state employee but does not list coverage on the application, proof of coverage includes:

- Pay stubs showing any deduction for health coverage. Dental and vision plans are deductions for health coverage.
- Work Number records showing the person has medical, dental or vision insurance.
- Phone call to the personnel office at the agency, department or university where the person works to confirm whether the employee qualifies for state employee health coverage.

Programs Affected

This applies to the following program:

- KidsCare.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10

calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
KidsCare	42 CFR 457.310(c)(1) ARS 36-2983(G)(3)

L Expenses

Revised 07/12/2019

Policy

The customer may report changes to the following types of expenses:

• Share of cost (SOC) related expenses;

• Work-related expenses; or

• Adjusted gross income deductions.

When the customer reports a change in...	Then the change may affect...
SOC-related expenses	The customer's SOC when the customer receives: • ALTCS; or • FTW-ALTCS and lives in a long term care medical facility.
Work-related expenses: • Blind Work Expenses; or • Impairment Related Work Expenses	The customer's income eligibility or premium amount when the customer receives: • SSI-MAO; • MSP; or • FTW.

Adjustments to Gross Income: • Educator expenses; • Certain business expenses of reservists, performing artists and fee-basis government officials; • Health savings account deduction; • Moving expenses for members of the Armed Forces who move as a result of military orders; • Deductible part of self-employment tax; • Self-employed SEP, SIMPLE and qualified plans; • Self-employed health insurance deductions; • Penalty on early withdrawal of savings; • Alimony paid; when the spousal support agreement was created before 12/31/2018 and has not been modified since that date to add the provisions of the Tax Cuts and Jobs Act of 2017; • IRA deduction; • Student loan interest deduction.	The customer's KidsCare premium amount or income eligibility when the customer qualifies for any of the following MA programs: • Adult; • Caretaker Relative; • Pregnant Woman; • Child; or • KidsCare.

Definitions

Term	Definition
Blind Work Expenses (BWE)	The reasonable cost of services and items that a person with a DDSA determination of blindness needs in order to work and are necessarily incurred by that person because of the visual impairment. (See MA609B.7)
Impairment Related Work Expenses (IRWE)	The reasonable cost of services and items that a person with a disability needs in order to work and are necessarily incurred by that person because of a physical or mental impairment. (See MA609B.5)
Share of Cost Related Expenses	Certain expenses subtracted from the customer's total counted income to figure the share of cost (SOC) amount. See MA1201C for additional information. These expenses include: • Medicare premium amounts; • Third Party Liability insurance (TPL) premiums; • Non-covered medical expenses; or • Shelter expenses

Adjustments to Gross Income	Expenses and income deferrals allowed to determine Adjusted Gross Income (AGI) for tax purposes are also allowed when determining income eligibility using MAGI rules. See MA609C for additional information. See also IRS Publication 17 for full list of the requirements for each adjustment at http://www.irs.gov/publications/p17/index.html).

Proof

Changes to expenses are verified as follows:

When the expense is...	Then the policy used is located at...
Medicare and TPL premium amounts	MA1201C.7
Non-covered medical expenses	MA1201C.8
Shelter expenses	MA1201C.4
Blind Work Expenses	MA609B.7
Impairment Related Work Expenses	MA609B.5
Adjustments to Gross Income	MA609C

Programs Affected

This applies to the following programs:

• ALTCS;

• SSI MAO;

• Medicare Savings Program (MSP);

• Freedom to Work (FTW);

• Adult;

• Caretaker Relative;

• Pregnant Woman;

• Child; and

• KidsCare.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396a(q) and 42 USC 1396r-5(d) 42 CFR 435.725 and 726 AAC R9-28-411
SSI MAO Medicare Savings Program (MSP) Freedom to Work (FTW)	20 CFR 416.1112(c) 42 CFR 435.916
Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.603 42 CFR 435.916 AAC R9-22-306(B)(3)(c)
KidsCare	42 CFR 457.315

M Failure to Cooperate with Division of Child Support Services (DCSS)

Revised 09/14/2023

Policy

The requirement to cooperate with DCSS in establishing the identity of a child's parents and in obtaining medical support is suspended under a temporary waiver from 09/01/2023 through 05/31/2024.

To qualify for or to keep getting AHCCCS Medical Assistance (MA), a person must cooperate with the Division of Child Support Services (DCSS) unless the person has good cause or is exempt. Cooperation includes:

- Providing information needed to determine the paternity of a child in the home who is receiving MA, and
- Taking any actions needed to get medical support from an absent parent, unless the person has good cause not to cooperate.

NOTE There are some situations when a person does not have to cooperate with DCSS.

- A woman while she is pregnant.
- Parents whose children are on KidsCare.

NOTE Parents must cooperate for any other children they have on Medicaid.

Customers who do not comply with this requirement have their MA stopped. The requirement only applies to the customer parent or caretaker relative. The children in the home do not lose their MA when a parent or relative fails to cooperate with DCSS.

Customers who have lost MA for failure to cooperate can qualify again if they meet any of the following:

- Cooperate with DCSS,
- Establish good cause for not cooperating, or
- Become pregnant and are exempt from cooperating.

Definitions

Term	Definition
Division of Child Support Services (DCSS)	The Division of the Department of Economic Security responsible for getting medical support orders in place and enforcing those orders.

Good cause not to cooperate with DCSS	Good cause includes: • Cooperation in determining paternity or getting a support order is reasonably expected to result in physical or emotional harm to the child or the person with whom the child is living; • Legal proceedings for the child's adoption are pending before a court; • The parent is working with a public or licensed private agency to give the child up for adoption, and discussions have not gone on for more than three months; or • The child was conceived as a result of incest or rape.

Proof

Good cause for not cooperating with DCSS

Proof of good cause includes:

• Birth certificate that shows the child was conceived through incest;

• Medical or law enforcement records that show the mother was raped;

• Court or other legal documents showing that adoption proceedings are pending before a court;

• Written statement from the adoption agency that they have been working with the customer on giving up the child for adoption and for how long;

• Court, medical, criminal, child protective services, psychological, social services or law enforcement records showing that the absent parent might physically or emotionally harm the child or caretaker relative; or

• Sworn statements from friends, neighbors, clergy or other people who know the about the situation and can support the good cause claim.

When none of the above is available, the person is asked to provide any information that would support further investigation.

Good cause must be reviewed at renewal and any time there is a change that shows good cause no longer exists.

Cooperation with DCSS

Proof that a person has cooperated with DCSS and can qualify again for MA includes:

• Verification of Cooperation with the Division of Child Support Services form (FAA-1221A), completed by DCSS;

• Other written notice of compliance from DCSS; or

• Phone call to the DCSS to confirm compliance.

Programs Affected

This applies to all programs except KidsCare.

Legal Authority

Program	Legal Authorities
All Programs (except KidsCare)	42 CFR 433.147 42 CFR 435.610
ALTCS	AAC R9-28-401.01(B)(11)
SSI-MAO	AAC R9-22-1501
Medicare Savings Program (MSP)	AAC R9-29-208
Freedom to Work (FTW)	AAC R9-22-1909

N Household and Budget Group Member Changes

Policy

Who is included in the budget group may change due to:

• Birth;

• Death;

• Marriage;

• Separation;

• Divorce;

• People moving into or out of the household; or

• Taxpayer or tax dependent status.

A change in the budget group may affect the customer's eligibility or the customer cost.

See Processing Budget Group Changes for instructions.

Definitions

Term	Definition
Budget Group	Persons included when determining income eligibility.
Tax Dependent	A person claimed as a dependent on someone else's tax return. This can include a person who chooses to or must file a tax return of their own.
Taxpayer	A person who: • Expects to file a tax return for the current year, and • Will not be claimed as a tax dependent by someone else. NOTE Spouses who file a joint return and are not claimed as tax dependents by someone else are both considered tax payers.

Proof

The customer's verbal or written statement about the change is accepted unless questionable.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5 for Community Spouse 20 CFR 416.415, 432, 435, 1163, 1165 and 1202 42 CFR 435.916 AAC R9-28-410
SSI MAO Medicare Savings Program (MSP)	20 CFR 416.415, 432, 435. 1132, 1163 and 1165 42 CFR 435.916 AAC R9-22-1501(H)
Adult Children Caretaker Relative Pregnant Women	42 CFR 435 603 42 CFR 435.916 AAC R9-22-1420(B)
KidsCare	42 CFR 457.301 and 315 42 CFR 457.343

O Income Changes

Revised 08/03/2021

Policy

Customers must report all changes in income for themselves and anyone else included in their budget group. See MA602 for the people included in the budget group for each AHCCCS Medical Assistance (MA) program. Changes in income may also be found through electronic data matches. A change in income includes any of the following:

• How often the income is received;

• The amount of income received; and

• The source of the income.

Impact of Change in Income

Increases or decreases in income may affect the customer in different ways depending on the program under which the customer is receiving benefits:

When the customer receives...	And the income change is for the...	Then the income change may affect the customer's…
ALTCS	• Customer; • Customer's spouse • Customer or spouse's dependent children	• Income eligibility; or • Share of Cost (SOC).
Freedom to Work (FTW) – ALTCS	• Customer; • Customer's spouse • Customer or spouse's dependent children	• Income eligibility; • SOC; or • Monthly premium.
SSI-MAO Medicare Savings Program (MSP)	• Customer; • Customer's spouse; • Customer or spouse's dependent children; or • Customer's parent (when customer is a minor)	• Income eligibility; or • MA program.
Freedom to Work (FTW)	• Customer; • Customer's spouse; • Customer or spouse's dependent children; or • Customer's parent (when customer is a minor)	• Income eligibility; • MA program; or • Monthly premium.

Adult; Caretaker Relative Child	Anyone in the customer's MAGI budget group (See MA602D)	Income eligibility.
Pregnant Woman	Anyone in the customer's MAGI budget group (See MA602D)	MA program. NOTE Increases in income that happen after the customer is approved as a Pregnant Woman do not affect eligibility.
KidsCare	Anyone in the customer's MAGI budget group (See MA602D)	• Income eligibility; • MA program; or • Monthly premium.
Transitional Medical Assistance/Continuous Coverage (TMA/CC)	Anyone in the customer's MAGI budget group (See MA602D)	MA program. NOTE When income increases after a TMA period or CC is approved, no action is taken until the next renewal.
Young Adult Transitional Insurance (YATI)	Anyone in the customer's MAGI budget group (See MA602D)	MA program. NOTE There is no income limit for YATI.

NOTE A change in income only affects Breast and Cervical Cancer Treatment Program (BCCTP) or YATI when the customer's income decreases enough that he or she qualifies for another MA program.

Definitions

Term	Definition
Income	Income is either earned or unearned. There are many types of income within each category of income. Different policies apply to each type of income as described in MA606.

Proof

Changes to income are verified by following the policy related to the specific income type in MA606.

Programs Affected

This applies to all programs except for BCCTP and YATI.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10

calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs, except KidsCare	42 CFR 435.916
ALTCS	AAC R9-28-411
SSI-MAO	AAC R9-22-1501(H) AAC R9-22-1503, 1504 and 1505
Medicare Savings Program (MSP)	AAC R9-29-213
Freedom to Work (FTW)	AAC R9-22-1905
KidsCare	42 CFR 457.315 and 343 R9-31-304 and 308

P Long Term Care Living Arrangement

Revised 12/27/2022

Policy

Changes in a customer's long term care living arrangement, including admission to or discharge from a nursing facility or public institution must be reported.

For a customer who receives services under ALTCS or Freedom to Work (FTW) – ALTCS programs, living arrangement changes may affect the customer's services, Share of Cost (SOC), or premium. See MA521 for detailed policy on living arrangements.

For a Veteran customer, a change in living arrangement may affect:

• Eligibility for VA potential benefits for the customer or applying spouse or dependent; or

• The maximum potential VA income benefit.

See Living Arrangement Changes Examples.

Use the following manual sections for policy related to other living arrangement changes:

When the customer...	Then the following policy is followed...
Moves out of state permanently	MA1502A
Is temporarily out of state	MA1502A
Enters a detention facility	MA1502V

Proof

When the customer reports a new living arrangement the following information is needed:

• Date the customer entered the new living arrangement;

• Type of facility, when customer is residing in a medical or home and community-based setting (HCBS) facility; and

• Date the customer left the previous living arrangement.

Programs Affected

This applies to the following programs:

• ALTCS

• FTW-ALTCS

Timeframes

When the customer moves from a setting in which only limited ALTCS services can be provided to a setting where full long term care services can be provided, the customer is eligible for full long term care services beginning on the date that they moved to a setting where long term care services can be provided, rather than the first of the month.

Legal Authority

Program	Legal Authorities
ALTCS	42 CFR 435.916 42 CFR 435.1005 AAC R9-28-406 AAC R9-28-411(A)(1)(b)
FTW- ALTCS	42 CFR 435.916 ARS §36-2950 AAC R9-28-406 and R9-28-1315

Q Loss of Contact Due to Returned Mail

Revised 09/19/2023

Policy

When mail sent to a customer has been returned as undeliverable with a forwarding address, attempts to contact the customer to confirm the new address provided by USPS must be made. When no forwarding address is provided, the customer has not reported a change of address and cannot be located; AHCCCS Medical Assistance (MA) benefits are stopped for the following month.

When the customer contacts the Benefits and Eligibility Specialist before the date the MA benefits stop, the customer's benefits are reinstated with no loss of coverage. Reinstate eligibility without requiring a new application for MAGI-based customers whose coverage is terminated for failure to return their renewal forms or necessary information if the individual's renewal form or information is returned within 90 days after coverage is terminated.

Definitions

Term	Definition
Loss of Contact	When a person cannot be located. Mail sent to that person is returned as undeliverable.
Returned Mail	Mail that is returned by the post office as undeliverable with no forwarding address.

Proof

Mail that is returned as undeliverable with no forwarding address.

Programs Affected

This applies to all programs.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 431.213(d) 42 CFR 435.403 42 CFR 435.916
KidsCare	42 CFR 457.343

R Marital Status

Revised 07/10/2020

Policy

When a customer marries or divorces, it may affect the customer's eligibility or the amount the customer must pay for a Share of Cost (SOC), premium or copayments.

When the customer divorces, the change in status is effective the month following the month the divorce is final.

When a customer marries, the change in status is effective the month the marriage took place.

For policy on a change in marital status due to the death of a spouse, see MA1502G.

For policy on physical separation of spouses, see MA1502Z.

The following table describes how changes in marital status may affect different programs:

When the program is...	Then...
ALTCS	The change may affect whether or not: • Community Spouse policy applies; • The spouse's income is included in the income determination; • The spouse's resources are included in the resource determination; and • The spouse's income and expenses are included in the SOC determination.
Freedom to Work (FTW)-ALTCS	The change may affect whether or not Community Spouse policy applies when determining the customer's SOC.
FTW Breast and Cervical Cancer Treatment Program (BCCTP)	The customer may qualify for another Medicaid program because of the different income budgeting for married couples.
SSI-MAO Medicare Savings Program (MSP)	The change may affect whether or not: • The spouse's income is included in the income determination; and • The couple income standard may be used instead of the individual standard.
Adult Caretaker Relative Pregnant Woman; Child; or KidsCare	The change may affect who is included in the customer's income group. See MA602D.

See Processing Changes in Marital Status for instructions.

Definitions

Term	Definition
Change in marital status	A customer marries or divorces, or is widowed.

Proof

For all programs except ALTCS and Freedom to Work (FTW), a person's statement of marriage is accepted as proof unless there is evidence to the contrary. A customer's marital status is not needed for FTW eligibility. For ALTCS, see the chart below. The proof needed is based on the marital relationship claimed.

Type	Proof
Legal Marriage	• An official marriage license; • Court or church records; • Marital Status and Family Profile Document issued by the Navajo Nation; • Tribal Family Census Card issued by the Bureau of Indian Affairs; • Marriage license issued by the Navajo Office of Vital Records; or • Phone contacts with an official Agency or Court. NOTE Social Security (SSA) or SSI benefit records cannot be used for proof of legal marriage.
Common Law Marriage established outside Arizona	A completed Customer Statement – Common Law Marriage (DE-119) form.
Divorced	Accept the person's statement unless it is questionable. For example, when a customer previously claimed to be married but later claims to be divorced or widowed, ask for proof of the divorce or death.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5 for Community Spouse 42 CFR 435.916 AAC R9-28-411(A)(1)(h)

SSI-MAO	20 CFR 416.432, 435, 1132, and 1163 42 CFR 435.602 42 CFR 435.916 AC R9-22-1501(H)(1)(e) AAC R9-22-1503, 1504 and 1505
Medicare Savings Program (MSP)	20 CFR 416.432, 435, 1132, and 1163 42 CFR 435.602 42 CFR 435.916 AAC R9-29-213
Freedom to Work (FTW)	42 CFR 435.916 AAC R9-22-1901
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 AAC R9-22-2008
Adult Caretaker Relative Pregnant Woman Child	42 CFR 435.603 42 CFR 435.916
KidsCare	42 CFR 457.343

S Medical Improvement

Revised 02/03/2020

Policy

A change in medical or functional condition must be reported. An improvement in the customer's medical condition may affect the outcome of a Preadmission Screening (PAS) reassessment for ALTCS.

For a medical improvement that affects the Disability Determinations Services Administration (DDSA) disability determination for SSI-MAO or Freedom to Work (FTW) see MA1502I.

When the PAS reassessment determines the customer ...	Then...
Is medically ineligible	The customer's ALTCS eligibility is discontinued and the customer is screened for other Medicaid eligibility.
Has improved medically or functionally and is no longer at risk of institutionalization at a nursing facility (NF) or intermediate care facility (ICF), but requires a lower level of long term care	The customer is transferred to the ALTCS Transitional program.

Definitions

Term	Definition
Preadmission Screening (PAS)	PAS is ALTCS' method of determining whether a customer is medically eligible for the ALTCS program. The PAS process also is used to determine disability for customers under age 65 who have not been determined to have a disability or blindness by DDSA.

Proof

ALTCS Medical Eligibility staff enter the PAS reassessment results in HEAplus.

Programs Affected

This applies to the ALTCS and FTW-ALTCS programs.

Timeframes

Changes must be reported as soon as the event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS FTW - ALTCS	42 USC 1396(a)(10)(A)(ii)(V) and (XVI) 42 CFR 435.916 AAC R9-28-306 and 307

T Medical Insurance Coverage and Premiums

Revised 06/04/2021

Policy

Medicaid is the payer of last resort. The customer must provide current information about any medical insurance coverage or premium amounts. This information allows the appropriate carrier to be billed.

In some cases, changes in medical coverage or premium amounts may affect a customer's eligibility or Share of Cost (SOC):

When the program is...	Then...
ALTCS ALTCS - Freedom to Work	Changes in the customer's medical insurance premium amounts may affect the customer's SOC for ALTCS services (MA1201C).
Adult	When a parent or other relative is living with a child and is the child's main caretaker, the child must have minimum essential coverage for the person to qualify for the Adult group (MA518).
Breast and Cervical Cancer Treatment Program (BCCTP)	A customer is no longer eligible for BCCTP when she has creditable health insurance coverage, unless she qualifies for an exception (MA515).
KidsCare	A customer is no longer eligible for KidsCare when he or she has creditable health insurance coverage (MA515). NOTE When a person chooses to end a child's creditable health insurance coverage, the child cannot qualify for KidsCare for 90 days. The 90 days begins the day after the creditable coverage ends unless the customer meets an exception (MA516).

See Processing Changes in Medical Insurance Coverage or Premiums for details.

Definitions

Term	Definition

Creditable Coverage	Health insurance coverage as defined under the Health Insurance Portability and Accountability Act (HIPAA). Examples of creditable coverage include: • Medicare; • Group health plans including Qualified Health Plans; • Health insurance coverage through a hospital or medical service policy, certificate or plan contract; or • Armed forces insurance (i.e., TriCare).
Non-Creditable Coverage	The following types of policies are considered non-creditable coverage: • Coverage only for accidents (including accidental death and dismemberment); • Liability insurance, including general liability and automobile liability insurance; • Free medical clinics at a work site; • Benefits with limited scope such as dental benefits, vision benefits or long term care benefits; • Coverage for a specific disease or illness (including cancer policies); • Insurance that pays a set amount a day when the person is hospitalized or unable to work.

Minimum Essential Coverage	Means any of the following kinds of health insurance coverage: • Full AHCCCS Medical Assistance benefits; • Medicare Part A; • TriCare for Life; • Veterans health program; • Government health plan for Peace Corps volunteers; • Group and Individual health plans, including Qualified Health Plans purchased on the Federally Facilitated Marketplace; • Employer-sponsored coverage; or • Other health benefits coverage, such as a State health benefits risk pool. Minimum Essential Coverage does NOT include: • Coverage only for accident or disability income insurance; • Liability insurance, including general liability insurance and automobile liability insurance; • Workers' compensation or similar insurance; • Automobile medical payment insurance; • Coverage for on-site medical clinics; • Dental- or vision-only benefits; • Coverage only for long-term care services; • Coverage only for a specified disease or illness; or • Hospital indemnity or other fixed indemnity insurance.

Proof

Proof of new insurance coverage includes:

• Insurance contract;

• Copy of both sides of the insurance card;

• Telephone contact to the insurer to confirm the details of the coverage.

Proof that insurance coverage has ended includes:

• Letter or written statement from the insurer confirming the coverage end date;

• Telephone contact to the insurer confirming the coverage end date;

• Telephone contact to the previous employer to confirm the coverage end date for employer-sponsored insurance.

Proof of a change in premium amount includes:

• Letter or written statement from the insurer with the new premium amount and effective date;

• Telephone call to the insurer confirming the new premium amount and effective date;

• When the customer is no longer paying the premium or someone else is paying the premium, the customer's statement is accepted. No further proof is needed.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Use the following table to determine the effective date for the change.

If the change results in...	Then the effective date of the change is...
A decrease in the ALTCS Share of Cost	The later of the first day of the month in which the change: • Took place; or • Was reported to AHCCCS.
• An increase in the ALTCS Share of Cost; or • Loss of eligibility	The first day of the month after the change that allows for adverse action rules.

Legal Authority

Program	Legal Authorities
ALTCS FTW-ALTCS	42 CFR 435.725(c)(4)(i) 42 CFR 435.726(c)(4)(i) 42 CFR 435.916 AAC R9-28-410(C) AAC R9-28-411(A)(1)
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 ARS 36-2901.05 AAC R9-22-2003(A)(5) AAC R9-22-2005(D)(1)
Adult	42 CFR 435.916 42 CFR 435.119(c)

KidsCare	42 CFR 457.310(b)(2)(ii) ARS 36-2983(G)(2) AAC R9-31-303

U Medicare Eligibility Begins

Revised 05/30/2018

Policy

When a person becomes eligible for or starts receiving Medicare it may affect the following:

• Eligibility;

• Services;

• ALTCS Share of Cost (SOC)

Most people begin receiving Medicare coverage at age 65. People who are under age 65 may qualify for Medicare when they meet one of the following:

• Receive Social Security Disability and have Amyotrophic lateral sclerosis (ALS), which is also known as Lou Gehrig's disease;

• Are diagnosed with End Stage Renal Disease (ESRD) and receive maintenance dialysis or a kidney transplant (eligible for Medicare Part A); or

• Received Social Security Disability benefits for 24 months.

To qualify for certain AHCCCS Medical Assistance (MA) groups, a person cannot have Medicare. See the following table for details:

When the MA program is…	Then…
Adult	The customer is no longer eligible for the Adult group when he or she qualifies for Medicare (MA523).
Breast and Cervical Cancer Treatent Program (BCCTP)	The customer is no longer eligible for BCCTP when she has creditable health insurance coverage, which includes Medicare (MA515).
KidsCare	The customer is no longer eligible for KidsCare when he or she has creditable health insurance coverage, which includes Medicare (MA515).

When Medicare begins the following changes may occur:

• Medicare Part A and Part B premiums may be paid by the State because of the customer's MA category or through a Medicare Savings Program (QMB, SLMB or QI-1);

• The customer will no longer be able to receive most prescription medications through AHCCCS, and will need to enroll in a Medicare Part D drug plan;

• Eligibility for MA in the Adult, BCCTP or KidsCare program stops.

Definitions

Term	Definition
Medicare	Medicare is a health insurance program administered by the Social Security Administration (SSA). For additional information about Medicare go to http://medicare.gov/.

Proof

Social Security records are used to see if the customer is entitled to or receiving Medicare Part A and Medicare Part B.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
Medicare Savings Program (MSP)	42 USC 1396d(p) 42 CFR 435.916 AAC R9-29-218
Adult	42 CFR 435.119(a)(3) 42 CFR 435.916
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 ARS 36-2901.05(A)(5) AAC R9-22-2003(A)(5)
KidsCare	42 CFR 457-310 AAC R9-31-303

V Incarcerated

Revised 11/21/2023

Policy

In general, AHCCCS cannot pay for any services while a person is incarcerated. When a change is reported that a customer is incarcerated, eligibility will continue and enrollment will be suspended.

Definitions

Term	Definition
Inmate of a Penal Institution	A person who is: • An inmate in a federal or state prison; • An inmate of a county, city, or tribal jail; • An inmate of a prison or jail, prior to arraignment, conviction, or sentencing; • Incarcerated but can leave prison on work release or work furlough, and must return at specific intervals; • A child in a juvenile detention center due to criminal activity or held as a material witness; • A person involuntarily placed in a secure treatment facility that is part of the criminal justice system.
Not an Inmate of a Public Institution	A person who is: • After arrest, but before booking, escorted by police to a hospital for medical treatment and held under guard; • Voluntarily living in a public institution; • Released on probation, parole, or a release order with the condition of home arrest, work release, community service, or medical treatment; or • Admitted as an inpatient to a medical institution; • A child held in a juvenile detention center for the care, protection, or in the best interest of the child, if there is a specific plan for that person that makes the stay at the detention center temporary; • A child on intensive probation with the condition of home arrest, treatment in a psychiatric hospital, or a residential treatment center, or outpatient treatment; • A child in a juvenile detention center after disposition when there is a plan to release the child to the community, and the release is only pending arrangements suitable to the child's needs.

Public Institution	An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term “public institution” does NOT include: • Medical institutions; • Intermediate care facilities; • Publicly operated community residence that serves no more than 16 residents; or • State-licensed child care institutions for foster children that house no more than 25 children.
Voluntarily living in a public institution	Means living in a public institution by choice, not as an extension of incarceration. The person is free to leave the institution if he or she chooses.

Proof

Proof of incarceration includes:

- The customer’s statement;
- Electronic records of incarceration from the Arizona Department of Corrections Rehabilitation and Reentry (ADCRR) or a county jail;

NOTE When the customer’s statement conflicts with other information or proof, the detention facility is contacted to confirm the person’s status.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Programs and Legal Authorities

Program	Legal Authorities

All Programs (except KidsCare)	42 CFR 435.1009 and 1010 42 CFR 435.916 AAC R9-22-310 AAC R9-28-406 AAC R9-22-1915 AAC R9-22-2003
KidsCare	42 CFR 457.310 (c)(2)(i) 42 CFR 457.343 ARS 36-2983(G)(4) AAC R9-31-303(9)

W Pregnancy and Postpartum

Revised 12/19/2023

Policy

When a woman becomes pregnant, or is no longer pregnant, the change can affect eligibility and copayments.

When a woman reports that she is pregnant, she may qualify for the Pregnant Woman program. If she qualifies, Pregnant Woman coverage continues through her postpartum period even if her income later increases. Pregnant women do not have to pay copayments.

During the postpartum period, eligibility is reviewed to see if the woman qualifies for any other AHCCCS Medical Assistance (MA) program.

Definition

Term	Definition
Pregnant	Pregnant means that a woman is expecting the birth of one or more children.
60-day Postpartum Period	A 60-day period starting the day the pregnancy ends. This period applies to a customer who was not enrolled in AHCCCS while pregnant. A customer who is applying for AHCCCS and was pregnant or in their 60-day postpartum period in any of the 3 months before their application month, may be eligible for Prior Quarter Coverage.
12-month Postpartum Period	A 12-month period starting the day the pregnancy ends. This period ends on the last day of the 12th month. Customer must be enrolled in AHCCCS while pregnant to be in the 12-month postpartum period as it applies to this group. See Pregnancy and Postpartum for examples.

Proof

The woman's statement that she is pregnant is accepted unless there is strong reason to question the statement.

Programs Affected

This policy applies only to the Pregnant Woman program.

Timeframes

Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
Pregnant Woman	42 CFR 435.116 42 CFR 435.916

X Resource Changes

Revised 03/01/2022

Policy

The customer must report and verify receipt or transfer of all real and personal property.

A change in resources may impact eligibility as follows:

- Uncompensated transfers may result in a period of ineligibility for long term care services, but the customer may continue to qualify for ALTCS Acute Care.
- When the customer's resources exceed the resource standard for the entire calendar month, the customer is ineligible for that month.

NOTE When an ALTCS customer's resources have increased significantly and the customer is under age 65, see MA803 for information about Special Treatment Trusts.

Definitions

Term	Definition
Resource	Resources are items of real or personal property, including cash, which may be used to meet the customer's needs for food or shelter.

Proof

Resource changes are verified as follows:

When the reported change is...	Then...
Transfer of resources	The transfer is verified using policy in MA900.
Increase or decrease in the value of one or more resources	The counted value of a resource is verified using the policy for the specific resource type listed in MA705. Exception: When the change results in the customer's resources being over the resource limit, accept the customer's statement as proof.

Programs Affected

This policy applies only to the ALTCS program.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5(c)for Community Spouse 20 CFR 416.1205 42 CFR 435.916 AAC R9-28-407, R9-28-410 and R9-28-411

Y School Attendance Change

Revised 05/30/2018

Policy

A change in school attendance may affect eligibility and countable income for some AHCCCS Medical Assistance (MA) groups. See the table below for how this change affects different programs:

When the MA group is...	And…	Then...
Caretaker Relative	The only child in the home is age 18 and was a student, but is no longer in school	The customer no longer qualifies for the Caretaker Relative group. See MA506 for more policy.
SSI-MAO Medicare Savings Program (MSP) Freedom to Work (FTW) ALTCS-Acute	The customer is the student and is under age 22	A change in student status may affect whether the customer qualifies for the Student Earned Income Exclusion. See MA609B.2 for more policy.
	The customer's child is the student and is age 18 to 21	A change in student status may affect the customer's child allocation amount. See MA609B.8 for more policy.
ALTCS FTW-ALTCS	The customer's child is age 19 to 23	A change in student status may affect whether or not they can be included as dependents when calculating the Community Spouse Family Allowance. See MA1201C.6 for more policy.

Proof

Proof is required as follows:

When the reported change is…	Then…
School attendance has decreased or ended	The customer's statement is accepted.
School attendance began or increased to a level that would allow the customer to qualify for: • Student Earned Income Exclusion; • An additional child allocation; or • MA as a Caretaker Relative.	Proof includes • Written statement from the school; • Telephone contact with the school; • Completed "Verification of School Attendance" form; or • Other documents that provide student status information.

Programs Affected

This policy applies to the following programs:

• ALTCS;

• SSI MAO;

• Medicare Savings Program (MSP);

• Freedom to Work (FTW); and

• Caretaker Relative.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS SSI MAO Freedom to Work (FTW) Medicare Savings Program (MSP)	42 USC 1382a(b)(1) 20 CFR 416.1112(c)(3) 42 CFR 435.916 AAC R9-28-408(B) and R9-28-411(A) - ALTCS AAC R9-22-1503(A) - SSI-MAO AAC R9-11-1901(5) – FTW AAC R9-29-212 - MSP
Caretaker Relative	42 U.S.C 1396u-1 42 CFR 435.110 42 CFR 435.916

Z Separation

Revised 05/30/2018

Policy

Separation refers to a change in relationship. There are two forms of separation:

• Physical separation; and

• Legal separation.

The effect of separation depends on:

When the spouses are...	And the customer receives...	Then...
Physically separated and no longer living together	SSI MAO Medicare Savings Program (MSP)	Individual budgeting applies beginning the first full month the spouses do not live together.
	ALTCS (Non-Community Spouse)	The separation does not affect the customer's income budgeting but could affect Share of Cost (SOC). Family or spousal maintenance is redetermined.
	ALTCS (Community Spouse) Freedom to Work (FTW) - ALTCS	Community Spouse policy continues to apply unless the spouse moves to a medical facility and is no longer living in the community.
	Breast and Cervical Cancer Treatment Program (BCCTP)	The customer may now qualify for another MA program. When the customer qualifies for another AHCCCS Medical Assistance (MA) program, that eligibility is approved and BCCTP coverage is ended.
	Adult Caretaker Relative Pregnant Woman Child KidsCare	Changes to who lives in the home may impact who is included in the budget group. See MA602D
Legally separated	Any program	Legal separation alone does not affect income or resource budgeting.

Definitions

Term	Definition

Physical Separation	Physical separation means the spouses are not living in the same residence.
Legal Separation	Legal separation involves a court order. The court order may: • Allocate parental rights; • Order the payment of child support or spousal support; and • Provide for the division of marital property and the distribution of assets. Legal separation often is a step toward divorce, but also is used by people who choose not to end their marriage. This may be done for religious reasons or in order to protect assets.

Proof

The customer or representative's statement of the separation and location of the spouse is accepted, unless it is questionable or the customer's ALTCS eligibility is determined using Community Spouse policy.

When the customer's ALTCS eligibility was determined using Community Spouse rules, the living arrangement of the Community Spouse must be verified to determine whether or not to continue using Community Spouse rules. See MA521.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
ALTCS	42 USC 1396r-5 for Community Spouse 42 CFR 435.916 AAC R9-28-401, R9-28-410 and R9-28-411(A)(1)(h)
SSI-MAO	20 CFR 416.1132 and 1163 42 CFR 435.602 42 CFR 435.916 AAC R9-22-1501(H)(1)(e) AAC R9-22-1503

Medicare Savings Program (MSP)	20 CFR 416.1132 and 1163 42 CFR 435.602 42 CFR 435.916 AAC R9-29-213
Freedom to Work (FTW)	42 CFR 435.916 AAC R9-22-1901
Breast and Cervical Cancer Treatment Program (BCCTP)	42 CFR 435.916 AAC R9-22-2008
MAGI	42 CFR 435.603 42 CFR 435.916 AAC R9-22-1420(B)

AA SSI Cash Eligibility Ends

Revised 12/31/2019

Policy

The Social Security Administration determines eligibility for Supplemental Security Income (SSI) Cash. Customers who are approved for SSI-Cash are automatically eligible for AHCCCS Medical Assistance (MA) and do not have to apply for it separately.

Except for customer's receiving ALTCS, the customer's eligibility for other MA programs is ended once they start receiving SSI-Cash because they get MA automatically.

When a customer loses SSI-Cash eligibility, the customer must be evaluated for eligibility in another MA program (see MA1403).

The following table describes how the loss of SSI Cash affects eligibility:

If the Customer was receiving....	Then...
Medical Assistance automatically due to SSI Cash eligibility	The customer is given a two-month extension of coverage while determining eligibility for any other MA category.
SSI-Cash and ALTCS	The customer is no longer categorically eligible once the SSI-Cash ends. ALTCS eligibility must be redetermined to see if the customer still qualifies for ALTCS.

Definition

Term	Definition
SSI-Cash	Payments from the Social Security Administration (SSA) under Title XVI of the Social Security Act to low-income people who are at least age 65, or have been determined by SSA to have a disability or blindness. NOTE Some people do not receive a cash payment because their work income is too high, but are still considered to be receiving SSI-Cash.

Proof

Proof that a person is receiving any of these payments includes:

• AHCCCS records that show the person is currently receiving MA related to SSI-Cash;

• Copies of check stubs for an SSI-Cash payment;

• Social Security award letter;

• Contact by telephone with the agency providing the payment, or

• An electronic record from SSA.

Programs Affected

This applies to all programs.

Timeframes

Changes must be reported as soon as the future event becomes known. Unanticipated changes must be reported within 10 calendar days of the date the change occurred.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 USC 1383c(a) 42 CFR 435.120 42 CFR 435.916
KidsCare	42 CFR 457.310(b)(2)(ii) AAC R9-31-303

BB Voluntary Requests to Stop Medical Assistance

Revised 05/30/2018

Policy

A customer or representative may ask for benefits to be stopped for any AHCCCS Medical Assistance (MA) program at any time. The customer or representative can send this request by:

• Mail;

• Fax;

• Verbal request by telephone; or

• Electronically through HEAplus.

When a customer or main contact asks to stop MA, document the following:

• The date of the request;

• Names of all the customers covered by the request;

• The specific date the customer wants the MA to stop; and

• The reason the customer is asking to stop MA.

1) Written Request to Withdraw

A written, signed request for withdrawal may be accepted in one of the following formats:

• Voluntary Withdrawal of Application or Benefits form (DE-130);

• Withdrawal or Stop Benefits/Appeals Request form (FAA-0574A);

• Voluntary withdrawal option in Health-e-Arizona Plus (HEAplus); or

• A signed, written request to discontinue benefits.

2) Verbal Requests to Withdraw

When a verbal request to voluntarily withdraw is made, the application is discontinued based on the verbal request. A discontinuance letter is sent to notify the person that the benefits have been withdrawn.

Eligibility will be reinstated when the customer contacts AHCCCS/DES to withdraw the request to stop benefits (or to report the request was in error) before the end of the month the action was taken.

Definition

Term	Definition
Voluntary Request to Stop MA	When a customer or representative asks that MA benefits be stopped.

Proof

Proof includes:

• Signed statement asking for benefits to be stopped;

• Documented telephone request; or

• Electronic record in HEAplus.

Programs Affected

This applies to all programs.

Timeframes

When the customer or representative asks that MA benefits be stopped immediately, benefits stop effective the date the action is taken.

Otherwise, benefits stop effective the first day of the following month.

Legal Authority

Program	Legal Authorities
All Programs	42 CFR 431.213 42 CFR 435.914 42 CFR 435.916 AAC R9-22-308; R9-22-313; R9-28-401

1503 Discontinuance

Revised 10/12/2021

Policy

When a customer is no longer eligible for a Medical Assistance (MA) program, benefits must be stopped.

Eligibility is stopped when:

- The customer or representative does not provide proof needed to determine eligibility, does not cooperate in resolving discrepancies, or provides inconsistent or unclear information;
- The customer no longer meets a requirement for the current MA program;
- The customer dies (MA1502G);
- The customer asks for MA benefits to be stopped (MA1502BB); or
- Agency mail is returned by the post office as undeliverable, and the customer cannot be located to determine residency (MA1502Q).

Information may be provided before the date that MA benefits stop that could change the decision to stop benefits. In this case, the customer's eligibility is re-evaluated. See the following table for examples:

MA is stopping because…	And before the MA benefit end date…
Proof was not provided	The proof requested is received.
The customer did not meet an MA requirement	A change is reported showing that the customer meets the requirement.
The customer asked that MA benefits be stopped	The customer contacts the Benefits and Eligibility Specialist and asks for MA benefits to continue.
Returned mail was received from the Post Office	The customer contacts the Benefits and Eligibility Specialist and provides current address information.

Definition

Term	Definition
Discontinuance	A customer's MA benefits are stopped.

Legal Authority

Program	Legal Authorities
All Programs except KidsCare	42 CFR 435.916(c), (d) and (f)
KidsCare	42 CFR 457.343

1600 Introduction

In this Chapter you will find information about customer rights. For each section in this chapter, you will find:

• The policy for the topic;

• Any definitions needed to explain the policy;

• A list of the federal and state laws that apply to the policy by program.

1601 Language Interpretation and Translation

Revised 11/29/2018

Policy

When a customer does not speak or understand English, the customer may provide his or her own interpreter or have AHCCCS provide an interpreter. A customer is not required to accept use of an interpreter provided by the agency.

AHCCCS offers:

• Oral language or sign language interpretation services.

• Translation of written material, as needed.

Even if the customer initially provides his or her own interpreter, the customer may later choose to have the agency provide an interpreter.

Most action notices and agency forms are readily available in English and Spanish. A customer may request a notice or form in a different language by calling 1-855-432-7587.

Legal Authority

Programs	Legal Authorities
All programs	42 CFR 438.10

1602 Confidentiality

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Safeguarding Confidential Information

Revised 06/14/2022

Policy

Confidential information must be protected and can only be released as allowed by Federal and State laws, regulations, and administrative policy. The following policies apply to AHCCCS customers as well as people who are not applying for benefits, but their information is gathered by AHCCCS for any reason.

There are two main legal authorities for AHCCCS Medical Assistance confidentiality policy:

- Title XIX of the Social Security Act restricts the release of confidential information about Medicaid customers for purposes of administering the Medicaid program.
- The Health Insurance Portability and Accountability Act (HIPAA) sets privacy and security standards that apply to health care facilities, providers and insurers, including AHCCCS.

NOTE Both Title XIX and HIPAA may apply to a situation. When this happens, the stricter of the two is applied.

The following information is considered confidential:

- Names, addresses, ZIP Codes, phone numbers, dates of birth, and Social Security numbers;
- Social and economic circumstances;
- Agency evaluations of personal information;
- Protected health information (PHI), including diagnosis and history of disease or disability and Pre-Admission Screening (PAS);
- Information received from electronic data matches, including reports from Federal and State systems;
- Information received from other sources, such as the Arizona Department of Economic Security, Social Security Administration, or private-sector employers;
- Information received when identifying legally liable third-party sources;
- Information related to alcohol or drug abuse, communicable disease, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), mental health, developmental disability, or genetic testing; and

Confidential information may be released only as allowed by federal and state law. See MA1602C for detailed policy.

Non-confidential information does not need to be safeguarded. When information cannot be used to identify a specific person, it is not confidential.

Definitions

Term	Definition
Communicable Disease	A contagious, epidemic or infectious disease that must be reported to the local board of health or health department.

Developmental Disability	A severe, chronic condition caused by cognitive disability, cerebral palsy, epilepsy, or autism that is manifested before the age of eighteen.
Pre-Admission Screening (PAS)	A screening tool used to assess a customer's medical need for long-term care services and is at immediate risk of institutionalization in a nursing facility.
Protected Health Information (PHI)	Health and demographic information about a person created or received by a health plan, health care provider, employer, or health care clearinghouse. Any information that relates to a person's health, health care services received, or payment for health care. This includes PAS information.

Legal Authority

Programs	Legal Authority
All Programs	42 U.S.C. 1396a(a)(7) 42 CFR 431.300 through 307 45 CFR, Part 160 and Part 164 AAC R9-22-512

B **Obtaining Confidential Information**

Revised 09/13/2022

Policy

The customer or the customer's legal representative may authorize someone else to act on behalf of the customer for the eligibility determination process. However, that person may not be able to authorize release of the customer's confidential information. In this situation, the customer or legal representative can give permission to release information to AHCCCS by completing and signing any of the forms listed below:

Form	Description
Release of Information Authorization (DE-200) form	Allows AHCCCS to ask for a broad range of information in order to determine eligibility.
Permission to Release Information (DE-201) form	Used to request specific eligibility information from a third party.
Authorization for the Disclosure of Protected Health Information (DE-202) form	Used to obtain a customer's medical information.
Authorization for the Disclosure of Psychotherapy Notes to the AHCCCS Administration (DE-222) form	Used when a customer's medical records contain psychotherapy notes that could affect the Pre-Admission Screening determination.

Definitions

Term	Definition
Legal Representative	A legal representative is: • A person appointed by a court of law to represent someone else; or • The custodial parent of a minor child.
Authorized Representative	A person, or an organization, authorized by the customer, legal representative, or responsible relative of the customer to act on the customer's behalf in the AHCCCS eligibility process.

Legal Authority

Programs	Legal Authority

All Programs	42 CFR 431.300 through 307 45 CFR, Part 160 and Part 164 (subparts A and E) AAC R9-22-512

C Release of Confidential Information

Revised 10/04/2022

Policy

The policy in this section focuses on the release of confidential information and covers three main areas:

• Releasing confidential information for official purposes;

• Authorization to release confidential information; and

• Additional protections for certain medical information.

1) Releasing confidential information for official purposes

Certain medical records have specific protection under Federal or State law and may only be released under specific conditions as described in section 3. Other confidential information may be released to any of the following without specific written authorization, but only when the information will be used for official purposes:

• Other areas of the AHCCCS Administration;

• Arizona Department of Economic Security (DES);

• Arizona Department of Health Services (DHS);

• The State of Arizona Attorney General's Office;

• Federal agencies, such as the U.S. Department of Health and Human Services and the Social Security Administration, related to the administration of AHCCCS programs;

• AHCCCS program contractors and subcontractors, including case managers;

• Health care professionals;

• Law enforcement officials, when related to the administration of AHCCCS programs; and

• Health Management Systems (HMS), the agency's contractor for third-party recoveries, including special treatment trusts and estate recovery.

Requests for information from the media, public interest groups, advocate groups, and requests from the legal community in the form of subpoenas and bankruptcy documents are handled by the Office of the General Counsel. These documents are time sensitive and are treated differently from customer requests.

2) Authorization to release confidential information

In general, the following people may review and request copies of information in the customer's case file without written permission:

• The customer, when a competent adult or emancipated minor;

• The customer's legal guardian; and

• The custodial parent or legal guardian of a minor customer.

Unless the release of information is for official purposes, all others require written authorization to receive information from the customer's case. When written authorization is needed, one of the people listed above may authorize AHCCCS to release information. The written authorization must be signed, separate from any other document, and must specify all of the following:

• The information that AHCCCS is authorized to release from the case file;

• To whom the release can be made; and

• The period of time the authorization is valid. If no time is stated, the authorization is valid for one year from the date it is signed.

The following guidelines are used to determine who needs written authorization for each type of information:

Information Type	No written authorization needed for…	Written authorization needed for…
Non-Medical Records	• An adult customer, when competent • An emancipated minor child, when competent • The customer's legal guardian • The custodial parent of a minor child customer • The customer's authorized representative • A person with appropriate power of attorney (financial for non-medical information) • The Well Woman HealthCheck program (WWHP) through the Arizona Department of Health when the customer has signed a BCCTP Patient Contact and Consent form (BC-102).	• A minor child (from a custodial parent or guardian) • The customer's spouse • The non-custodial parent of a minor child customer • A stepparent • A customer that has been determined incompetent • The customer's attorney • The customer's conservator • Any other third party • A foster parent (only needed when the foster parent does not have legal guardianship)
PAS Information	Same as non-medical information, except that the customer's authorized representative must have written authorization.	Same as non-medical information above
Medical Records	Same as PAS information, except that the information may only be released when a request for a hearing based on medical eligibility or disability has been filed.	Same as PAS Information, except that the information may only be released when a request for a hearing based on medical eligibility or disability has been filed.

Generally, there is no charge to the customer or the customer's representative for copying material from the case file. However, there may be a charge for costs when copying a large volume of documents.

An AHCCCS employee must be present any time a case file is viewed by an authorized person, to answer any questions and ensure that the case file is not altered.

3) Additional protections for certain medical information

Certain types of medical information may only be released under specific circumstances, as follows:

Type of Information	Policy
Alcohol or drug abuse information	Cannot be released without specific written consent from the person named in the information.

Communicable disease information	Cannot be released without specific written consent from the person named in the information.
Developmental disability (DD) information, including all records created in the course of providing services to DD customers	Cannot be released without written permission from the parent or guardian of a minor with a developmental disability, or the guardian of an adult with developmental disability. NOTE When no guardian has been appointed, a developmentally disabled adult may authorize the release of his or her own information.
Genetic testing information	Cannot be released without specific written consent from the person named in the information.
Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) information	Cannot be released without specific written consent from the person named in the information.
Mental health information	Cannot be released unless a mental health professional has interviewed the person undergoing treatment. The mental health professional must provide a written statement that releasing the information is in the patient's best interest.

Definitions

Term	Definition
Authorized Representative	A person who may act on the customer's behalf in the AHCCCS eligibility process. This person must be authorized by the customer, the customer's legal representative, or a responsible relative of the customer.
Case File	The record of a customer's applications for AHCCCS Medical Assistance and changes reported, and the resulting eligibility decisions. The case file includes all of the following related to the customer's AHCCCS eligibility: • Proof and information provided for an eligibility decision; • Proof from electronic data sources recorded in the eligibility system; • Information from other electronic data sources when used to determine eligibility; • Supporting documents and information stored in a document imaging system; • Notes created by eligibility staff to support decisions made and actions taken. Some electronic sources may generate information for the customer that is not used to determine eligibility. When the information is not used to determine eligibility and is stored in the customer's record, it is not considered part of the case file.
Competent	Means capable of handling one's own affairs. A person is considered competent unless a court has declared that the person is incompetent.

Conservator	A person appointed by a court to manage another person's finances. A conservator is required by law to act in the best financial interest of the person whose finances he or she manages.
Custodial Parent	The parent or parents to whom the court has awarded legal custody of a minor child.
Emancipated Minor	A minor who meets at least one of these conditions: • Has married or divorced; • Has enlisted in military service; or • Has been declared emancipated by court order.
Foster Parent	Any person licensed by the Department of Economic Security (DES) or an Arizona tribe to provide out-of-home care for a foster child
Incompetent	Means legally declared incapable of pursuing one's own interests and for whom a legal guardian has been appointed.
Legal Guardian	A person who has been appointed by a court to act as a representative for an incompetent person, as well as to manage their property and rights. NOTE This does not include a conservator.
Non-Medical Information	All confidential information in the customer's case file other than medical records.
Official Purposes	Means directly related to administering an AHCCCS program, including the following actions: • Determining eligibility; • Determining the amount of medical assistance; • Providing services; • Conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the AHCCCS program; • Evaluating and analyzing AHCCCS operations; and • Recovering AHCCCS costs.
Power of Attorney	A written authorization to act on behalf of another person. The authority given can be as broad or as narrow as the person chooses.

Legal Authority

Programs	Legal Authority

All programs	42 CFR 431.300 through 307 45 CFR, Part 160, and Part 164 (subparts A and E) AAC R9-22-512

1603 Non-Discrimination

Revised 02/20/2019

Policy

An AHCCCS customer must be treated fairly and equally regardless of race, color, religion, national origin, sex, age, political beliefs, or disability.

AHCCCS does not discriminate on the basis of disability in admission to, access to, or operation of its programs, activities, services, or in its employment practices. AHCCCS complies with the Americans with Disabilities Act of 1990.

If the customer is visually or hearing impaired and needs an accommodation or a different format to complete an application, the customer may submit a request by speaking to the Benefits and Eligibility Specialist assigned to their case, or by calling 1-855-432-7587.

Legal Authority

Programs	Legal Authorities
All Programs	42 USC 12112 42 CFR 438.12 AAC R9-22-1403

1604 Written Letters

Revised 03/29/2022

Policy

The customer must get a written letter on an agency form when any of the following actions occur:

• An application for AHCCCS Health Insurance is approved or denied;

• Eligibility is discontinued or changed; or

• The amount the customer must pay (premiums or share of cost) is changed.

Letters must be sent to the following persons:

• The customer, unless the customer:

◦ Is a dependent child living with a parent, in which case a letter only goes to the parent; or

◦ Has a legal representative, in which case a letter only goes to the legal representative;

• The customer's legal representative;

• The customer's authorized representative, responsible relative, or responsible party unless the customer and representative reside together.

1) Approval Letters

An approval letter must contain the following information:

• Type of benefit approved;

• Date eligibility begins;

• Amount the customer must pay in share of cost or premiums, if applicable; and

• Date by which a fair hearing must be requested.

NOTE Hospital Presumptive Eligibility (HPE) approval letters do not include a deadline for filing a fair hearing since people applying only for HPE do not get fair hearing rights.

2) Renewal Letters

A renewal letter must include the following information:

• The type of benefit approved for renewal;

• The amount the customer must pay, if applicable;

• When customer costs or services are changing, the date the change is effective; and

• The date by which an appeal must be requested.

3) Denial Letters

A denial letter must include the following information:

Type of benefit denied;

Effective date of the denial;

Reason for the denial. When the denial is because the person's income or resources are over the limits, the notice must show how the income or resources were calculated;

- Legal references that support the denial;
- Date by which a fair hearing must be requested; and
- If the application was referred to the Federally Facilitated Marketplace for a decision on other insurance affordability programs, an explanation of the referral.

NOTE Denial letters for Hospital Presumptive Eligibility (HPE) are not required to include the above denial letter information.

4) Discontinuance Letters

A discontinuance letter must include the following information:

- The type of benefit(s) discontinued;
- The effective date of the discontinuance;
- The reasons benefits are being stopped;
- How income or resources were calculated when benefits are stopped because income or resources are over the limit;
- The legal references that support the discontinuance;
- The date by which an appeal must be requested; and
- When the application was referred to the Federally Facilitated Marketplace for a decision on other insurance affordability programs, an explanation of the referral.

5) Change Letters

A change letter must include the following information:

- The type or level of benefit that is changing or ending, if applicable;
- The change in the amount of the customer's share of cost or premium, if applicable;
- The effective date of the change;
- The reasons for the change. When the change is caused by the person's income or resources, the notice must also show how the income or resources were calculated;
- The legal references that support the change;
- The date by which a fair hearing must be requested; and
- If the customer was referred to the Federally Facilitated Marketplace for a decision on other insurance affordability programs, an explanation of the referral.

Definitions

Term	Definition
Approval	A determination that a person is eligible for Medical Assistance benefits.

Change	Something that happens to a person which may impact his or her Medicaid eligibility, enrollment, share of cost or premium amount, or ability to be contacted or receive mail.
Decision Letter	A letter that notifies a customer of the action taken for their AHCCCS Medical Assistance program eligibility including: • Approval; • Denial; • Discontinuance; • Change in share of cost, premium amount, or co-payments; • Change in eligible medical services; and • Enrollment with a health plan or program contractor.
Denial	A determination that a person is not eligible for Medical Assistance benefits.
Discontinuance	A determination that a person is no longer eligible for Medical Assistance benefits.
Renewal	A review of financial and non-financial eligibility factors.

Timeframes

A change that does not decrease or stop benefits or increase the customer's costs does not require advance notice.

In most cases, a change to decrease or stop benefits or to increase the customer's costs is effective on the first day of a future month. There must be at least 10 days before the first day of the future month to allow for the change letter to be sent in advance.

Exceptions:

A 10-day period before the effective date of the change is not required in the following situations:

When...	Then the effective date of the chance is...
The customer dies and the death is verified	The date of death.
Mail sent to the customer has been returned to AHCCCS, and the Benefits and Eligibility Specialist has no way of contacting the customer	The first day of the following month.
The customer is confirmed as having been approved for medical services in another state	
The customer is incarcerated in a jail or penal institution	The date the customer is incarcerated.

Legal Authority

Programs	Legal Authorities
All programs except KidsCare and HPE	42 CFR 431.210, 431.211, 431.213 42 CFR 435.912, 435.916, 435.917, 435.919 AAC R9-22-312
KidsCare	42 CFR 457.340, 457.343
Hospital Presumptive Eligibility (HPE)	AAC R9-22-1601

1605 AHCCCS Rules and Regulations

Policy

Descriptions of the federal and state authorities governing the operation of the AHCCCS programs are provided in MA105 of this manual. Internet links to many of the authorities listed are also provided. Copies of these authorities may also be found in public libraries and law libraries.

Upon request, AHCCCS will provide copies of sections of the authorities that are cited on AHCCCS letters and sections this eligibility policy manual to the customer or the customer's representative.

1700 Introduction

For each topic in this chapter, you will find:

• The policy for each requirement;

• Any definitions needed to explain the policy;

• Agency responsibilities, if applicable;

• Customer rights or responsibilities, if applicable;

• The timeframes, if applicable; and

• A list of the federal and state laws that apply.

1701 Eligibility Appeals

Revised 07/10/2020

Policy

A customer has the right to ask for an appeal when an adverse action is taken on the customer's Medical Assistance (MA) application or benefits. This request must be made within 35 calendar days of the date the letter is sent (see MA1702). The customer may also ask for an appeal when a decision is not made about the customer's MA application within the required timeframe (see MA1301B – Timeframes).

A customer has the right to ask for an expedited appeal. A request for an expedited appeal will be approved only when the request is supported by a statement from a medical provider who is recommending a procedure or treatment for the individual. The medical provider statement must say that:

The customer has a procedure or treatment scheduled, or the individual is unable to schedule a procedure or treatment due to the lack of coverage;

The customer does not currently have health insurance that will cover most of the cost of a treatment; and

The customer's life, physical or mental health, or ability to reach, keep, or regain full functionality will be put at serious risk if the customer has to delay a procedure or treatment for 90 days or less from the date of the appeal request.

Expedited appeals must be resolved as soon as possible and no later than seven working days after receipt.

Exceptions:

Customers are not entitled to an appeal when the adverse action is due to a change in Federal or State law. Actions that do not affect the customer's services, benefits or costs are not entitled to an appeal. The customer may file a grievance for such actions (see MA1710).

There are two state agencies in Arizona that determine eligibility for AHCCCS MA programs: AHCCCS and the Department of Economic Security (DES). Generally the agency that makes the eligibility decision processes any appeal request on that decision. However, both agencies work together to coordinate the appeal process when a person asks for an appeal and decisions were made by both agencies. Representatives from both agencies may need to attend the hearing depending on the program decision being appealed.

See the following table for more details on which agency determines each MA program:

If the program is…	Then eligibility is determined by…
• SSI-MAO • Medicare Savings Program	Mainly AHCCCS, but could be either agency
• Adult • Caretaker Relative (including Transitional Medical Assistance and Continuous Coverage) • Pregnant Woman • Child • KidsCare • Young Adult Transitional Insurance	Mainly DES, but could be either agency

• ALTCS • Freedom to Work • Breast and Cervical Cancer Treatment Program	AHCCCS only

NOTE People who are eligible for SSI-Cash, Title IV-E Foster Care or Adoption Subsidy are automatically eligible for MA. A separate MA determination is not done except when the customer is applying for ALTCS.

Definitions

Term	Definition
Adverse Action	In general, an adverse action is any action to: • Deny, suspend or stop MA; • Increase the customer's share of cost or premium amount; or • Reduce services or benefits. NOTE This includes actions to approve emergency services only instead of full MA coverage, and changes from full MA coverage to emergency services only.
Appeal	A fair and impartial review of an adverse action or delayed determination.
Department of Economic Security (DES)	The Arizona State agency that determines eligibility for Nutrition Assistance, Cash Assistance, and certain Medical Assistance programs on AHCCCS' behalf.
Fair Hearing Coordinator	Agency staff member that coordinates the hearing process and represents the agency at the fair hearing.
Office of Administrative Hearing (OAH)	The OAH handles coordinating the hearings on behalf of AHCCCS Administration.
Office of Appeals (OOA)	The OOA handles coordinating the hearings on behalf of the Department of Economic Security (DES).

Agency Responsibilities

The agencies' general responsibilities include:

• Taking requests for appeals;

• Contacting the customer if a request for an appeal is made by someone other than a customer or representative;

• Sending any necessary authorization and notification forms to the customer;

• Determining whether a hearing may be granted;

• Coordinating the pre-hearing discussion (see MA1703);

• Scheduling the hearing and notifying the customer; and

• Preparing a hearing packet.

The Office of Administrative Hearings (OAH) or Office of Appeals (OOA) is responsible for the following:

• Setting the hearing date and notifying the customer and the agency Fair Hearing Coordinator;

• Appointing an Administrative Law Judge (ALJ) to conduct the hearing; and

• Providing an interpreter and reasonable accommodations, upon request.

The ALJ is responsible for the following:

• Presiding over the eligibility hearing;

• Basing a decision solely on evidence presented at the hearing; and

• Issuing a written decision.

Customer Rights and Responsibilities

The customer has the right to:

• Review and get a copy of any part of the case file needed to present the case that is not protected by law from being released;

• Review all documents the State agency will use at the hearing;

• Bring legal counsel, a relative, friend, other spokesperson or witness to the hearing;

NOTE Except for legal counsel, anyone representing the customer or serving as a spokesperson or witness for the customer cannot be a paid representative or anyone else being paid to attend the hearing.

• Present all related facts and circumstances;

• Present an argument without unnecessary interference;

• Question or contradict any testimony or evidence. This includes an opportunity to confront or cross-examine witnesses;

• Ask the agency to furnish an interpreter; and

• Ask the agency to make an accommodation for special needs.

Legal Authority

This requirement applies to the following programs:

Programs	Legal Authorities
All programs	42 USC 1396a(3) 42 CFR 431, Subpart E ARS-41-Article 10 9 AAC 34, Article 1

1702 Eligibility Appeal Requests

Revised 09/21/2017

Policy

Any person may ask for an appeal. However, when someone other than the customer or the customer's representative asks for an appeal, AHCCCS must contact the customer to confirm the request.

When a person who is not authorized to represent an incapacitated customer but is acting responsibly on the customer's behalf, the person requesting the appeal must sign and return an Authorized Representative form (DE-112). A Physician Statement of Incapacity form (DE-217) must also be in the customer's case file.

The request for an appeal may be submitted:

• By mail;

• In-person;

• By telephone;

• By fax;

• By e-mail; or

• Through Health-e-Arizona Plus (HEAplus).

NOTE At this time, ALTCS customers are not able to request an appeal through HEAplus.

Each decision letter includes a pre-printed "Appeal Request Form"; or "I Am Asking For A Hearing" section. The customer is not required to use the form or letter to request an appeal.

A written appeal request must contain the following information:

• The customer's name;

• The action or decision the customer is appealing; and

• The reason for the appeal request.

Definitions

Term	Definition
Appeal Request	A request for a hearing regarding an adverse action or delay in the application process.
Decision Letter	A written notice that explains the action that has been taken on a customer's case.

Good Cause	A valid reason for not submitting the appeal request within the 35-day timeframe. Good cause includes: • Illness; • Failure to receive the decision letter; or • Any other reasonable explanation (as determined by the agency).

Timeframes

Appeal requests must be received by the 35th calendar day after the date on the decision letter. When the 35th calendar day is on a weekend or state holiday, the due date is extended to the end of the next business day. Appeal requests received after the 35th calendar day will be denied.

All appeal requests are date-stamped when they are received. The table below lists the date the request is considered received based on how it is sent to the agency:

When the request for hearing is...	Then the date of request is...
Sent by mail	The date the letter is received.
Faxed	The date the fax transmission was received.
Sent by email	The date the email was received.
Completed through HEAplus	The date the appeal request is submitted.
Made in person or by telephone	The date the request is made.

Agency Responsibilities

The agency determines if the appeal request was filed within the 35 calendar day timeframe and notifies the customer when the request is denied because it was received late.

Customer Rights and Responsibilities

When the agency denies the customer's appeal request because it was received late, the customer may ask for a good cause hearing.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities

All Programs	42 CFR 431.220 and 221 9 AAC 34, Article 1

1703 Pre-Hearing Discussion

Revised 11/29/2018

Policy

The pre-hearing discussion is an opportunity for the customer to meet informally with the agency to review and possibly resolve the concerns with the agency's action before the hearing. The pre-hearing discussion may be completed by telephone or in person. The pre-hearing discussion is not mandatory for the customer and cannot delay the formal hearing process. If the pre-hearing discussion does not resolve the issue, the hearing process is continued.

If the pre-hearing discussion results in an informal resolution, the customer is offered the opportunity to voluntarily withdraw the appeal request. See MA1705 for more information on voluntary withdrawals of appeal requests.

NOTE The customer may ask for a review before filing a formal request for appeal.

Definitions

Term	Definition
Pre-Hearing Discussion	An informal meeting between the customer and the agency to see if the issue can be explained or resolved before the hearing.

Agency Responsibilities

The agency contacts the customer and offers to schedule a pre-hearing discussion. During the pre-hearing discussion, the agency:

- Explains why the action was taken;
- Reviews the information used to make the decision with the customer;
- Gives the customer an opportunity to explain why the action should not have been taken, submit more information and clarify any factors involved;
- Explains the appeal and hearing process;
- Explains the customer's potential financial responsibilities.

Customer Rights and Responsibilities

The customer can choose not to have a pre-hearing discussion.

Timeframes

The agency generally schedules and holds the pre-hearing discussion within one to two weeks of receiving the appeal request. However, if the appeal request is made by telephone or in person, the agency may be able to conduct the pre-hearing discussion at the time the appeal request is made.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	N/A

1704 Continue Eligibility or Restore Prior Level of Service or Cost

Revised 09/21/2017

Policy

When the appeal request is received before the effective date of the adverse action, or the adverse action was taken without allowing for advance notice, the customer is entitled to have the action reversed until the hearing decision is made.

Between the time an appeal request is filed and the hearing decision is made, the customer may be entitled to:

• Continued benefits;

• Pay the prior share of cost (SOC) or premium amount; or

• Receive the prior level of covered services.

See When to Adjust Benefits and SOC and Premium Amounts for more information.

Definitions

Term	Definition
Share of Cost	The amount an ALTCS customer is required to pay toward the cost of long term care services. The share of cost is determined on a month-by-month basis (see MA1201).
Premium	Customers enrolled in Freedom to Work or KidsCare are charged a monthly premium. The premium amount is based on income and household size.
Level of Covered Services	The amount and kinds of services covered by the medical assistance program or service package. Examples of a decrease in covered services include: • Losing coverage for long-term care services under ALTCS; • Losing full services coverage and only qualifying for Medicare Savings Program (MSP); • Losing full services coverage and only qualifying for emergency services; and • Qualified Medicare Beneficiary (QMB) being reduced to Specified Low-income Medicare Beneficiary (SLMB) or Qualified Individual – 1 (QI-1).

Agency Responsibilities

When the appeal request meets the requirements listed in the Policy section above, the agency restores eligibility, prior SOC and premium amounts, or the prior level of covered services unless the customer specifically asks the agency not to do so.

Customer Rights and Responsibilities

Customers who had an existing premium or SOC amount and asked for an appeal because the premium or SOC increased must continue to pay the prior amount during the hearing process.

The customer may choose not to have eligibility, level of services, SOC or premium restored during the appeal process.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.230 42 CFR 431.231 AAC R9-34-114

1705 Voluntary Withdrawal of Appeal Request

Revised 09/21/2017

Policy

The customer or representative may choose to withdraw the appeal request at any time during the appeal process.

The request may be made:

• In writing, including on a Voluntary Withdrawal (DE-171) form;

• Verbally, if the hearing is not yet scheduled, or

NOTE If benefits were continued or the share of cost or premium has been restored back to the prior amount and the customer has voluntarily asked for a withdrawal of the hearing request, the continued benefits are stopped and the share of cost and premium readjusted.

Definitions

Term	Definition
Voluntary Withdrawal	The customer decides to not pursue the appeal.

Agency Responsibilities

The agency must process the voluntary request to withdrawal at any time during the appeal process.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.223 AAC R9-34-112

1706 Changes Received During the Appeal Process

Revised 07/10/2020

Policy

During the appeal process, a new change may occur before the hearing decision is made that affects the customer's eligibility, level of services, premium, or share of cost amount.

The table below explains how changes are processed when they are received during the appeal process.

If...	Then...
• The customer is approved for continued benefits during the appeal process; AND • The reported change will result in an adverse action.	The change is not processed until the hearing process ends.
• The customer is approved for continued benefits during the appeal process; AND • The change results in a non-adverse action	The change is processed and the customer is sent a new decision letter.
The customer does not have continued benefits.	The change is processed and the customer is sent a new decision letter no matter what the eligibility result is.

Definitions

Term	Definition
Adverse Action	In general, an adverse action is any action to: • Deny, suspend or stop MA; • Increase the customer's share of cost or premium amount; or • Reduce services or benefits. NOTE This includes actions to approve emergency services only instead of full MA coverage and changes from full MA coverage to emergency services.
Notice of Action	A notice that explains the action that has been taken on a customer's case.

Agency Responsibilities

Advance notice is given whenever an adverse action is taken before the decision on the original issue.

Customer Rights and Responsibilities

The customer may ask for a fair hearing on the new adverse action and has 35 days from the new notice to file the request.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.231 AAC R9-34-114

1707 The Eligibility Hearing

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Scheduling and Notice of Hearing

Revised 12/14/2018

Policy

When an appeal request is filed on time for an action that can be appealed, a hearing is scheduled and a notice sent to the customer that filed the appeal.

The notice includes the:

• Hearing date;

• Issue to be addressed;

• Legal authorities; and

• Hearing rights.

The customer or the agency may ask for a continuance. The request must be made in writing to the Office of Administrative Hearings (OAH) or the Office of Appeals (OOA). The other may accept or reject the request for a continuance, but when a party rejects a request for continuance the ALJ makes the final decision.

The ALJ may grant a continuance request when:

• There is good cause for the postponement; or

• The reason for the request is beyond the control of either party.

Definitions

Term	Definition
Office of Administrative Hearings (OAH)	The office that conducts eligibility hearings on behalf of the AHCCCS Administration.
Office of Appeals (OOA)	The office that conducts eligibility hearings on behalf of the Department of Economic Security Family Assistance Administration (DES/FAA).
Request for a continuance	A request that the appeal be rescheduled until a later date.

Agency Responsibilities

The responsibilities of the agency processing the hearing and the appeals office include

• Scheduling the hearing and notifying the customer;

NOTE The notice of hearing is sent 20 to 30 days before the scheduled hearing date to give the customer time to prepare for the hearing unless the customer has been approved for an expedited appeal.

• Providing an interpreter and reasonable accommodations, upon request; and

• Preparing a hearing packet.

Customer Rights

The customer has the right to:

• Review and get a copy of any part of the case file needed to present the case that is not protected by law from being released;

• Review all documents the State agency will use at the hearing;

• Bring legal counsel, a relative, friend, other spokesperson or witness to the hearing;

NOTE Except for legal counsel, anyone representing the customer or serving as a spokesperson or witness for the customer cannot be a paid representative or anyone else being paid to attend the hearing.

• Present all related facts and circumstances;

• Present an argument without unnecessary interference;

• Question or contradict any testimony or evidence. This includes an opportunity to confront or cross-examine witnesses;

• Ask the agency to furnish an interpreter; and

• Ask the agency to make an accommodation for special needs.

Timeframes

The timeframe for scheduling and holding the hearing must allow for a hearing decision to be made within 90 days from the date of the hearing request unless:

The customer requests and is granted an expedited appeal; or

A continuance is requested and granted.

When an expedited appeal request is granted, the hearing must be scheduled and held so that an appeal decision can be made within 7 days from the date of the expedited appeal request.

When a continuance is granted, a decision must be made within 120 days from the date of the appeal request**.**

The following table shows the usual timeframes for scheduling and holding the hearing by agency.

If the agency is...	**Then the hearing is scheduled to be held...**
AHCCCS	• Within 30 days from the date the request is filed, if related to the ALTCS CSRD or CSMIA. • Within 60 days from the date the request is filed for all other requests.
DES	Between 20 and 45 calendar days from the date the request is filed. NOTE The customer may ask that the hearing be held within less than 20 days.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.210 AAC R9-34-109

B Hearing Attendance and Proceedings

Revised 12/14/2018

Policy

1) Hearing Attendees

The following persons must attend the hearing:

• Administrative Law Judge (ALJ);

• Customer that requested the hearing;

• Agency representative; and

These other persons may attend:

• Any witnesses invited to the hearing by the customer;

• An attorney representing the customer;

• An attorney representing the agency;

• An interpreter provided by the agency;

• Eligibility office staff;

• Agency representative from another agency responsible for the decision (i.e., DDSA).

2) Penalty for Not Attending the Hearing

If an agency representative fails to attend the hearing, the ALJ may move forward with the hearing and issue a decision based on the complainant's testimony.

If the customer or customer's representative fails to attend the hearing without good cause or without receiving a postponement, the ALJ may:

• Proceed with the hearing;

• Reschedule the hearing;

• Issue a recommendation based on the evidence in the hearing record; or

• Deny the appeal.

3) Proceedings

The following chart summarizes the roles of the people involved in the hearing:

If the person is the...	Then the person...

Administrative Law Judge (ALJ)	• Introduces the people attending the hearing; • Explains that the hearing is recorded when available; • Makes a brief opening statement about the hearing procedures or shows a DVD; • Swears everyone in; • May ask for brief opening statements; and • Makes closing statement.
Agency Representative	• Makes a brief opening statement • Gives legal references to support the action(s) taken; • Cross examines agency witnesses; • Cross examines the customer and their witnesses; • Objects to testimony when needed; • Answers questions from the ALJ; and • Makes a closing statement.
Agency Witness(es)	• Answers questions posed by the Agency representative; • Explains how the SOC or premium amount was figured or why eligibility was denied or stopped, the requirements, and why those requirements were not met; and • Answers questions posed by the ALJ, the complainant, or the complainant's representative.
Customer	• Testifies and calls witnesses to testify; and • Asks questions of the ALJ, Agency representative or the Agency witnesses; and • Makes a final statement.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.240 AAC R9-34-104 and 105

C Hearing Decision

Revised 12/14/2018

Policy

How the hearing decision is made and issued varies slightly depending on the agency processing the hearing.

AHCCCS:

The ALJ makes a written, recommended decision. The AHCCCS Director reviews the ALJ's recommendation and may amend it. The AHCCCS Director issues the final written decision to the customer.

DES

For DES-administered programs, the ALJ makes a written decision. The Office of Appeals issues the ALJ's written decision to the customer.

Definitions

Term	Definition
Director's Decision	The Director's Decision notifies the complainant of the: • Hearing decision; and • Right to petition for a rehearing.

Timeframes

AHCCCS

The ALJ makes a written recommended decision within 20 days from the day of the hearing. The AHCCCS Director reviews the ALJ's recommendation.

The written decision is issued within 30 days from the date of the ALJ's recommended decision and within 90 days after the date the appeal request was filed, or 120 days if a continuance was requested or granted.

If the appeal request is expedited, the written decision is issued within 7 days after the date the appeal request was filed.

DES

A final decision is issued within 90 days from the appeal request date.

If the appeal request is expedited, the written decision is issued within 7 days after the date the appeal request was filed.

Customer Rights

The customer is notified of the:

• Decision; and

• Right to appeal the decision (see MA1708).

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.244 and 245 AAC R9-34-111

1708 Appeal or Petition for Rehearing of Hearing Decision

Policy

If the agency or the customer disagrees with the fair hearing decision, they can appeal the decision. The process varies depending on the agency:

1) Appeals of an AHCCCS Hearing Decision

When the customer or the agency Fair Hearing Coordinator disagrees with the Director's Decision, he or she may ask for a rehearing from the AHCCCS Director. The customer also has the option to appeal the decision with the Superior Court.

NOTE The customer may petition for a rehearing before filing an appeal with the Superior Court, but does not have to do so.

A rehearing or review may be requested for any of the following reasons:

• An irregularity in the hearing or appeal proceedings and the party was deprived of a fair hearing;

• Misconduct on the part of an involved party, the eligibility office or the agency;

• Newly discovered material evidence that could not have been discovered and produced at the hearing;

• The decision was prejudiced;

• The decision was not justified by the evidence or is contrary to the law; or

• One of the parties had good cause for not appearing at the hearing.

The rehearing process involves a review of the hearing file and other written documents submitted by the customer or the agency. Either party may object to the petition, and on rare occasions, more testimony may be requested. After reviewing the information, the Director issues a Final Decision.

2) Appeals of a DES Hearing Decision

When the customer disagrees with the fair hearing decision, he or she may ask for a review of the decision from the Office of Appeals (OOA) Appeals Board.

NOTE The Appeals Board may accept or decline a rehearing or review of a case.

The Appeals Board conducts the review and notifies the customer and the FAA Policy Support Team (PST) of the review results.

If the OOA Appeals Board decision is unfavorable to the appellant, he or she may submit a request for review to the Appeals Board again.

If the Family Assistance Administration (FAA) disagrees with the OOA Appeals Board decision, FAA must submit a request to the Attorney General's Office. When the Attorney General's Office is in agreement with FAA, the Attorney General's Office submits the request for review to the OOA Appeals Board.

Definitions

Term	Definition

Office of Administrative Hearings (OAH)	The office that conducts fair hearings on behalf of the AHCCCS Administration.
Office of Appeals (OOA)	The office that conducts fair hearings on behalf of the Department of Economic Security (DES).
Superior Court	The Superior Court hears appeals of administration decisions.

Timeframes

In general a request for rehearing or an appeal of the hearing decision must be filed in writing within 35 days of the date of the hearing decision letter.

Exceptions:

- When appealing a DES Fair Hearing decision, the request must be filed in writing to the OOA within 15 calendar days of the mailing date of the decision.
- When the agency is appealing an OOA Appeals Board decision, the request must be sent to the Attorney General's Office within 10 calendar days from the date of the OOA Appeals Board decision.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	42 CFR 431.232 and 233 42 CFR 431.244 and 245 ARS 41-1092.08 ARS 41-1092.09 AAC R9-34-113

1709 Disability Reconsideration Requests

Revised 12/14/2018

Policy

A customer may request an appeal when:

• A disability determination was made by the Disability Determinations Services Administration (DDSA);

• The DDSA determined that the customer does not have a disability that meets Social Security criteria; and

• The customer is not eligible for another AHCCCS coverage group.

NOTE When the Social Security Administration denies or stops a customer's SSI-Cash or Social Security disability for not meeting disability criteria, the customer must file the appeal with the Social Security Administration

Definitions

Term	Definition
Disability Determinations Services Administration (DDSA)	The DDSA is a division of the Arizona Department of Economic Security (DES). The DDSA is the only agency in Arizona authorized to make disability determinations for the Social Security Administration and for the AHCCCS Administration.
Disability Reconsideration Request	A request for a hearing to reassess DDSA's determination that a customer is no longer disabled.

Agency Responsibilities

Eligibility Office Responsibility

The eligibility office notifies the Office of Eligibility Appeals (OEA) when:

• An appeal request is received on this issue; and

• The reconsideration paper work has been received and sent to DDSA.

Office of Eligibility Appeals (OEA) Responsibility

OEA monitors the hearing date and if necessary, asks to postpone the hearing until a decision has been received from DDSA about the customer's status.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
SSI-MAO FTW	42 CFR 431.220 AAC R9-34-106

1710 Grievances

Revised 07/12/2022

Policy

A customer also has the right to file a grievance if unsatisfied with a matter other than an adverse action. Adverse actions are actions that can be appealed (see MA1701).

A grievance may be filed by:

• A customer;

• A representative; or

• A provider acting on behalf of the customer.

A grievance may be filed either verbally or in writing with the Agency.

Definitions

Term	Definition
Grievance	An expression of dissatisfaction about any matter other than an adverse action. This includes the quality of care received, the services provided or personal treatment (for example, rudeness or conduct of a provider, health plan or agency staff).
Office of Administrative Hearing (OAH)	The OAH handles coordinating the hearings on behalf of AHCCCS Administration.
Office of the General Counsel (OGC)	Helps OAH with the coordination of the appeals process on behalf of AHCCCS program customers.

Timeframes

Grievances must be filed with the Office of the General Counsel (OGC) within 60 days of the date the action happened, or notice was sent:

• The filing date for a verbal grievance is the date of the verbal communication.

• The filing date of a written grievance is the date it is received by the agency.

The agency issues a decision within 30 days of the filing date unless the customer agrees to an extension.

Legal Authority

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	AAC R9-34-202, 208, 209 and 210 AAC R9-34-301, 302, 308, 309 and 310

1800 Introduction

This chapter contains information about handling complaints of fraud and abuse, as well as steps to take when fraud or abuse is suspected.

For each section in this chapter, you will find:

• The policy for handling complaints of potential fraud and abuse;

• Any definitions needed to explain the policy; and

• A list of the federal and state laws that apply to the policy by program.

1801 Fraud and Abuse

Revised 12/07/2018

Policy

The AHCCCS Administration is responsible for ensuring that program resources are not misused or wasted, and that customers receive appropriate care and services. This responsibility is carried out in several ways.

• Educating the customer or representative of his or her responsibility to report changes and the penalties for perjury and fraud;

• Resolving inconsistent or questionable information received during the eligibility process;

• Identifying, investigating and resolving fraud and abuse cases; and

• Referring concerns to the appropriate area or agency when there is suspected abuse of a customer; and

1) Customer Education

Customers and representatives must be given information about their responsibility to report changes that could affect eligibility, premiums or Share of Cost and the penalties for fraud and perjury. This information is provided on application forms and eligibility letters, and is also explained during eligibility interviews.

For detailed information about reporting changes see Chapter 1500.

The penalties for fraud and perjury may include civil penalties, repayment of benefits received, and criminal prosecution.

2) Resolving Inconsistencies

To prevent fraud and abuse, Benefits and Eligibility Specialists are responsible for resolving inconsistencies when questionable information is received during the eligibility determination process. Information provided by the customer or representative may be questionable when it is inconsistent with:

• Other statements made during the current application;

• Information previously listed on another application; or

• Information received from other sources.

The customer's individual circumstances are considered in determining if information is questionable.

More information or proof may be needed from the customer to resolve the inconsistency. When the customer does not provide the information or proof needed eligibility may be denied or stopped.

3) Identifying and Addressing Potential Fraud

Indications of possible fraud include, but are not limited to, the following:

• Altered documents;

• Contradictory statements made by the same individual;

• Conflicting statements about the same issue made by different people;

• Information about the customer's actual income or resources is not provided or is misrepresented;

• Statements do not agree with information from other proof, documents or applications; and

• Complaints of fraud or abuse received from a third party.

Cases with potential fraud indicators are referred to the AHCCCS or DES Office of Inspector General (OIG) for investigation.

Upon receiving a report of potential fraud the AHCCCS or DES OIG staff review evidence received with the report, conduct an investigation, and determine whether the evidence indicates fraud.

When evidence of fraud is found, OIG pursue repayment for the benefits received due to the fraud, or may refer the case the Attorney General for prosecution.

4) Abuse of a Customer

When there is suspected abuse, neglect or quality of care issues, eligibility staff may need to refer the issue to AHCCCS Division of Health Care Management (DHCM), Adult Protective Services (APS) or the Department of Child Safety (DCS) for follow-up.

A referral to one of these areas may be needed when any of the following are suspected:

• A problem with the quality of care being provided to the customer;

• The customer is being abused, neglected or exploited;

• Provider fraud;

• The customer has unmet healthcare needs;

• A customer living in an unlicensed or uncertified room and board home is receiving direct, personal care services on other than a temporary basis pending ALTCS approval;

• There appears to be a problem with the ALTCS case manager regarding the customer.

Definitions

Term	Definition
Abuse of a Customer	Any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.
Exploitation	Illegal or improper use of a vulnerable adult or his resources for another's profit or advantage

Fraud	Any act of knowing deception or misrepresentation. Fraud includes: • Intentionally providing incorrect information or misrepresenting facts with the purpose of obtaining benefits to which the customer would not otherwise be entitled. • Lying, misrepresenting, or omitting certain information with the intent to obtain a service, payment, or other gain (e.g. AHCCCS Medical Assistance) to which the individual would not otherwise be entitled. • Using another person's AHCCCS ID card to obtain medical services. • Intentionally not reporting changes in income, household composition, living arrangements or other factors that affect AHCCCS eligibility.

Legal Authority

Program	Legal Authorities
All programs	42 CFR, Part 455 ARS 36-2905.04

1900 Introduction

Congress passed the Omnibus Budget Reconciliation Act of 1993 (OBRA ’93) on August 10, 1993. It became effective as Federal law under 42 U.S.C. 1396(p) on October 1, 1993. The passage of this Federal law mandated the states to implement an Estate Recovery Program to recover the costs of certain benefit programs. Arizona implemented its Estate Recovery Program effective January 1, 1994. Under this program, AHCCCS is required to file a claim against an ALTCS customer’s estate to recover its costs for providing Medicaid benefits. This chapter explains the Estate Recovery Program requirements.

For each section in this chapter, you will find:

• The policy for the requirement;

• Any definitions needed to explain the policy;

• What proof is needed; and

• A list of the federal and state laws that apply to the requirement by program.

1901 Estate Recovery Claims

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Click on the next > (arrow) button in the top navigation pane to go to the Chapter subsections.

A Estate Recovery Program Overview

Revised 12/06/2022

Policy

1) To Whom Does Estate Recovery Apply?

Estate recovery applies to any person who meets all of the following:

• Received ALTCS nursing home or HCBS benefits;

• Was 55 years or older when benefits were received;

• Received benefits on or after January 1, 1994, and

• Is deceased.

2) Payments for Which AHCCCS Seeks Recovery

The amount of the AHCCCS claim is the total of all ALTCS payments made by AHCCCS for a customer aged 55 or older. Costs for ALTCS benefits provided before the customer turns 55 are not included. AHCCCS recovers for the following types of payments:

• Capitation payments.

• Medicare coinsurance and deductibles for services provided on or before December 31, 2009. No recovery is made for services provided on or after, January 1, 2010.

• Medicare Part A and Part B premiums paid for months on or before December 31, 2009. No recovery is made for premiums paid for January 2010 or later.

• Reinsurance.

• Fee-for-Service Payments.

3) Assets Subject to Estate Recovery

The AHCCCS estate claim is filed at the time of the customer's death against all property subject to either Small Estate Affidavit or probate. A home that was solely owned by an ALTCS customer, owned jointly without right of survivorship, or owned jointly with right of survivorship (and the joint owner is deceased) is subject to an AHCCCS claim.

4) Long Term Care Partnership Program Claim Exclusion

If a person has a qualifying long-term care partnership insurance policy and was given a resource exclusion (see MA703F), the AHCCCS estate claim is reduced by the amount of resources deducted as a result of the qualified long term care partnership policy.

5) The AHCCCS Recovery Agent

Health Management Systems, (HMS) is a private firm that handles recoveries on behalf of the AHCCCS, including:

• Claims against a customer's estate;

• TEFRA liens;

• Estate Recovery from Special Treatment Trusts (MA803); and

• Achieving a Better Life Experience (ABLE) accounts (MA705I)

NOTE Recovery from ABLE accounts is only for services provided by AHCCCS from the time the ABLE account was established.

Definitions

Term	Definition
Claim	A claim is a legal demand against the estate of an ALTCS customer to recover payment for AHCCCS expenditures issued on the customer's behalf.
Capitation	A payment arrangement for health care service providers. It pays a group of providers in advance for the delivery of health care services. They are paid a set amount for each enrolled person on a monthly basis.
Coinsurance	The percentage of the costs a patient is responsible for toward his health care bill. It is a percentage, not a set amount.
Deductibles	The set amount of expenses that must be paid out of pocket by the insured before an insurer pays any expenses.
Fee-for-Service Payments	AHCCCS directly pays ALTCS customers' medical bills in limited situations described in MA1103. These payments are called 'fee-for-service' payments.
Reinsurance	Additional insurance that is purchased by an insurance company from one or more other insurance companies.
Small Estate Affidavit	An informal procedure for settling estates with less than $50,000 of assets. It is less structured than ordinary probate, and the services of an attorney may not be required. Claims are settled with creditors without probate procedures.

Legal Authority

Program	Legal Authorities

ALTCS	42 USC 1396(p) ARS 36-2935 AAC R9-22-1006 AAC R9-28-901 and R9-28-912

B Estate Recovery Process

Revised 04/30/2018

Policy

There are three main pieces to the Estate Recovery process:

• Informing Customers About Estate Recovery

• Estate Recovery Claims Process

• Notice to Creditor Letters

1) Informing Customers about Estate Recovery

All customers and representatives are given information about the estate recovery program during the initial application interview.

The Estate Recovery Program Brochure (DE-810) is given to all ALTCS customers following the initial application screening process. This brochure explains how the AHCCCS Estate Recovery Program works.

The customer acknowledges the receipt of the Estate Recovery Program brochure and receiving information on the estate recovery program by signing the application.

2)Estate Recovery Claims Process

When notice is received that a customer who is subject to estate recovery has died, HMS proceeds with estate recovery actions as follows:

Step	Action
1	HMS files a “Demand for Notice” with the probate division of the Arizona Superior Court. The “Demand for Notice” requires that AHCCCS be notified of all legal activity concerning the estate.
2	HMS sends the customer’s representative the following documents: • A “Notice of Intent to File a Claim Against the Estate” • An “Estate Questionnaire” • A copy of the “Demand for Notice” NOTE If the estate has already entered probate, HMS bypasses the Demand for Notice and Notice of Intent process. A claim is immediately placed against the estate.
3	HMS reviews the information returned by the representative. If an exemption applies, HMS goes over this with the representative.
4	When the estate contains property that may be subject to a Small Estate Affidavit or probate, and no response is received to the Estate Questionnaire or the estate does not qualify for an exemption, HMS files a “Superior Court Claim Against the Estate”.

5	HMS informs the representative in writing where to send payment, how to file a grievance or request a hearing and how to contact HMS.

3) Notice to Creditor Letters

When probate is filed in court, the executor of the will is legally required to notify creditors to submit claims against the estate by a specific date. If AHCCCS is a creditor because it provided ALTCS benefits to the deceased customer, the executor is required to send AHCCCS a letter advising the Agency to submit its claim. This letter is called a "notice to creditor" letter.

Definitions

Term	Definition
Demand for Notice	A notice that gets filed with the probate division of the Arizona Superior Court. This notice requires that the person or entity filing the notice be notified of all legal activity concerning the estate.
Notice of Intent	Notification sent to the customer's representative indicating that AHCCCS plans to file a claim against the estate.

Legal Authority

Program	Legal Authorities
ALTCS	ARS 36-2935 AAC R9-28-911 through R9-28-913

C Estate Claim Exemptions

Revised 04/26/2022

Policy

Some property and resources in the customer's estate may be exempt from estate recovery. There are two groups of estate claim exemptions:

- Estate Claim Exemption for Resources of American Indians and Alaska Natives
- Estate Claim Statutory Exemptions

1) Estate Claim Exemption for Resources of American Indians and Alaska Natives

The following resources belonging to American Indians (AI) and Alaska Natives (AN) are not subject to estate recovery:

- Tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission and the U.S. Claims Court;
- Property, including real property and improvements, located within or near the bounds of a tribal nation or located within the most recent boundaries of a prior federal reservation as designated by the Bureau of Indian Affairs of the U.S. Department of the Interior;
- Rents, leases, royalties, or usage rights related to natural resources, including extraction of natural resources, or harvesting of timber, other plants and plant products, animals, fish, and shellfish, resulting from the exercise of federally protected rights.
- Ownership interests in, or usage rights to, items that have unique religious, spiritual, traditional, and/or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

2) Estate Claim Statutory Exemptions

In certain circumstances, an AHCCCS estate claim may be deferred. These situations are referred to as Estate Claim Statutory Exemptions. Exemptions may exist when the deceased ALTCS customer is survived by any of the following:

- A spouse;
- A child under age 21; or
- A child of any age who meets SSA or SSI disability criteria and is blind or disabled.

Legal Authorities

Program	Legal Authorities
ALTCS	42 US 1396(p) AAC R9-28-911 through R9-28-913

D Deferment and Reductions of Claims

Revised 07/12/2022

Policy

There are certain situations when AHCCCS may defer estate recovery or reduce its claim and recover a lower amount. The estate recovery process also allows an opportunity for the estate's representative to file grievance and request for a hearing on estate recovery decisions.

These policies are covered in the following three sections:

• Undue Hardship Deferment

• Partial Recovery or Reduction

• Grievance Procedure

1) Undue Hardship Deferment

AHCCCS may defer its claim when an heir or devisee to the estate meets all of the AHCCCS' Undue Hardship described in the following table:

If	And	Then
The estate contains real property, and the heir owns a business located on the property	• The business has been in operation at the property for at least 12 months before the customer's death; • The business provides more than 50% of the heir's livelihood; and • Recovery would result in the heir's loss of livelihood	AHCCCS defers its recovery claim
The estate contains residential property, and the heir currently lives in the residence	• The heir lived in the residence at the time of the ALTCS customer's death; • The property was the heir's primary residence for the 12 months immediately before the customer's death; and • The heir does not own another residence	AHCCCS defers its recovery claim
The estate contains personal property only	• The heir's annual gross income, counting the members of the heir's immediate family as appropriate, is less than the Federal Poverty Level (FPL); and • The heir does not own a home, land, or other real property	AHCCCS defers its recovery claim

The estate contains both real and personal property	• The heir qualifies for an undue hardship	AHCCCS does not grant an undue hardship deferment, but adjusts its claim to the value of the personal property

2) Partial Recovery or Reduction

When there is no Estate Claim Exemption and undue hardship policy is not met, AHCCCS considers a partial recovery or a reduction of its claim against the estate claim.

When HMS notifies an estate of a claim, it also provides information indicating what factors are considered when deciding whether a partial recovery can be approved. These include:

• A financial or medical hardship;

• Whether the heir's household income is less than Federal Poverty Level (FPL);

• The value and type of resources held by the estate (real and personal);

• The amount of the claim;

• The claims of other creditor's and whether any property in the estate has been foreclosed on; and

• Any other factors that may relate to a fair determination.

When an heir wishes to apply for an Undue Hardship deferment of estate claim or reduction of an AHCCCS estate claim, the heir must submit a written statement and provide all supporting documents to HMS no later than 30 days from the date on the "Notification of the AHCCCS Claim Against the Estate." AHCCCS makes a decision within 60 days of receiving the completed application for a deferment or reduction.

3) Grievance Procedure

Information about how to file an estate recovery grievance and request a fair hearing is included in notices sent to the estate's personal representative. A grievance must be received by the Office of the General Counsel (OGC) no later than 60 days from the date shown on the "Notification of the AHCCCS Claim Against the Estate" or the "Decision Notice Regarding the AHCCCS Estate Claim." Grievances must be submitted in writing to:

AHCCCS Administration

Office of the General Counsel

Mail Drop 6200

P.O. Box 25520

Phoenix, Arizona 85002

Definitions

Term	Definition
Heir	A person who is legally entitled to inherit some or all of the estate of another person who has died.
Devisee	A person who inherits or receives a gift of real property by a will.

Real property	Any property that is attached directly to land, as well as the land itself.
Residential real property	Any property used as a residence that is attached directly to land, as well as the land itself.
Personal property	Any resource other than real estate or real property.

Legal Authorities

Program	Legal Authorities
ALTCS	42 US 1396(p) AAC R9-28-911 through R9-28-913

1902 TEFRA Liens

Revised 04/26/2022

Policy

AHCCCS may file a lien against the customer's real property, including the customer's home, after the customer becomes permanently institutionalized at a nursing home, mental health hospital, or other long term care medical facility.

The purpose of the lien is to recover the cost of benefits provided upon the customer's death or upon a sale or transfer of an interest in the property.

The policy in this section covers the following topics:

- Customers subject to a TEFRA Lien
- Exemptions to filing a TEFRA lien
- Notice and filing of a TEFRA lien
- Changes after a TEFRA Lien has been filed
- Sale or transfer of property that has a TEFRA lien
- Non-enforcement of TEFRA liens

1) Customers Subject to a TEFRA Lien

ALTCS customers who are permanently institutionalized will have a lien filed against their home or other real property unless an exemption exists.

NOTE If a customer is discharged from a facility and returns to his or her own home on a permanent basis, the lien will be removed.

2) Exemptions to Filing a Lien

A lien will not be filed against the following real property belonging to members of federally recognized American Indian tribes:

- Tribal land and other resources currently held in trust and judgment funds from the Indian Claims Commission and the U.S. Claims Court;
- Property, including real property and improvements, located within or near the bounds of a tribal nation or located within the most recent boundaries of a prior federal reservation as designated by the Bureau of Indian Affairs of the U.S. Department of the Interior;

A lien will not be filed if one of the following individuals is lawfully living in the customer's home:

- The customer's spouse;
- The customer's child who is under age 21;
- The customer's child who is blind or permanently and totally disabled; or
- The customer's sibling who has an equity interest in the home and who was living in the member's home for at least one year immediately before the date the customer was permanently institutionalized.

3) Notice and Filing of a TEFRA Lien

Following notification that a customer has lived in an institution for 90 days or more, Health Management Systems (HMS) sends a Notice of Intent to File a Lien and a Questionnaire to the customer or the customer's authorized representative.

If there is no response or HMS determines that the proper criteria have been met, HMS files a TEFRA Lien against the customer's home on behalf of AHCCCS.

Should a customer wish to contest the lien, he or she may file a request for a fair hearing within 30 days of receiving the Notice of Intent.

4) Changes after a TEFRA Lien has been Filed

No further action is taken by AHCCCS after the lien has been filed until either:

- The customer dies;
- The property ownership is sold or transferred; or
- The customer returns home and the lien is removed.

5) Sale or Transfer of Property that has a TEFRA Lien

When property with a TEFRA lien is sold, the customer must repay AHCCCS for payments made by AHCCCS on the customer's behalf. The repayment amount is equal to the amount that AHCCCS has paid. AHCCCS cannot collect more than the amount that it has paid at the time the property is sold.

6) Non-Enforcement of Liens

A lien will not be enforced against any real property when the customer is survived by his or her:

- Spouse,
- Child under the age of 21, or
- Child who is blind or permanently and totally disabled.
- Sibling who lives in the deceased customer's home and who was living there for a least one year immediately before the date the customer was institutionalized, or
- Child who lives in the deceased customer's home and who was living there for at least two years immediately before the date the customer was institutionalized.

Definitions

Term	Definition
TEFRA Lien	A lien under 42 USC 1396p of the Tax Equity and Fiscal Responsibility Act of 1982.
Permanently Institutionalized	Permanently institutionalized means the customer has lived in a long-term care nursing facility for at least 90 consecutive days and continues to live there and cannot reasonably be expected to be discharged and return to his or her own home.

Legal Authority

Program	Legal Authority
ALTCS	42 USC 1396p AAC R9-28-801 through R9-28-807

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Glossary