



Establishing Eligibility for Arizona Health Care Cost Containment System (AHCCCS) Health Insurance

A Self-Advocacy Guide

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

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

This guide is available in alternative formats upon request.

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TABLE OF CONTENTS

A.	Introduction to the Arizona Health Care Cost Containment System (AHCCCS) and this Guide	1
1.	What is the Arizona Health Care Cost Containment System?.....	1
2.	Introduction to this Guide	1
B.	The Arizona Health Care Cost Containment System	2
1.	What are the federal health care programs?.....	2
2.	What are the AHCCCS health insurance programs?	3
3.	How does AHCCCS deliver health care services?	3
4.	What if you are not enrolled in an AHCCCS health plan?	3
5.	What health care services are covered by AHCCCS health insurance?	4
6.	Does AHCCCS charge for services?	4
7.	How does AHCCCS and DES work together?	4
8.	How do Native American tribal members receive AHCCCS services?	5
9.	What is the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services program for children?.....	6
10.	What if you have Medicare or private insurance in addition to AHCCCS health insurance?	6
11.	What is a “dual-eligible” AHCCCS member?.....	7
12.	What is the Medical Expense Deduction (MED) program?	7
C.	Department of Health Services, Division of Behavioral Health Services	8
1.	What is the AHCCCS screen and enroll process for persons who have been determined to have a Serious Mental Illness (SMI)?.....	9
D.	What are the basic eligibility factors for AHCCCS health insurance?	11
1.	What are the non-financial eligibility requirements?.....	11
a.	Residency	11
b.	Social Security Number	11
c.	U.S. Citizenship	12

d.	Immigration Status.....	12
e.	When is a determination of disability required for AHCCCS?	13
2.	What are the financial eligibility requirements?	13
a.	How is income counted?.....	14
b.	How are resources counted?	15
E.	What is the application process for AHCCCS health insurance?	16
1.	Where do you apply for AHCCCS health insurance?	17
2.	How do you apply for AHCCCS health insurance?	17
3.	What happens after you file your application?	18
4.	How long does the agency have to make a decision on your application?.....	18
5.	When does your eligibility for AHCCCS health insurance start?	19
F.	What happens after your AHCCCS application is approved?.....	19
G.	When do you need to reapply?.....	20
H.	What happens if the AHCCCS health insurance application is denied or current AHCCCS benefits are stopped?.....	20
I.	Legal Resources for this Guide.....	21

Appendix A	AHCCCS Health Insurance Programs
Appendix B	AHCCCS and ALTCS Health Plans
Appendix C	AHCCCS and ALTCS Covered Services
Appendix D	EPSDT Covered Services

A. Introduction to the Arizona Health Care Cost Containment System (AHCCCS) and this Guide

1. What is the Arizona Health Care Cost Containment System?

The Arizona Health Care Cost Containment System (AHCCCS) Administration is the state agency that administers health insurance programs for low-income persons in Arizona. There are several AHCCCS health insurance programs for individuals, children and families, which are funded by state and federal funds. AHCCCS is a managed care system where program contractors provide medical, behavioral health and long-term care services to persons eligible for AHCCCS health insurance. AHCCCS has agreements with the Arizona Department of Economic Security to process Medicaid applications and to provide services to persons with developmental disabilities, and with the Arizona Department of Health Services to provide behavioral health services to persons eligible for AHCCCS programs.

2. Introduction to this Guide

This guide focuses on the rights of persons eligible for AHCCCS health insurance including persons who have been determined to have a Serious Mental Illness (SMI). The purpose of this guide is to help you establish your eligibility for AHCCCS health insurance and to get AHCCCS services. This guide provides general information about AHCCCS health insurance programs and explains the basic eligibility requirements for the AHCCCS acute care programs. This is a guide only. For more specific information about applying or qualifying for an AHCCCS health insurance program or obtaining AHCCCS health care services, you should contact the AHCCCS Administration or the Arizona Center for Disability Law. The Arizona Center for Disability Law will not be able to assist you with the application process; however, they will provide you with referrals to agencies that can help you.

This guide is not a substitute for legal advice. The Arizona Center for Disability Law recommends that you seek legal advice if you are unable to resolve a dispute involving eligibility or services under an AHCCCS program. You should ask for legal

advice as soon as the dispute arises, as there are strict time lines to challenge a decision of the AHCCCS Administration or a program contractor.

B. The Arizona Health Care Cost Containment System

1. What are the federal health care programs?

Arizona receives federal funding under the Medicaid program and the Children's Health Insurance Program (CHIP) to provide health insurance to low-income residents.

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

CHIP is a federal health insurance program that provides health care coverage to children under age 19 who are not eligible for Medicaid and who do not have any other health insurance. In Arizona, the CHIP program is called KidsCare. CHIP is Title XXI (Title 21) of the Social Security Act. CHIP funding pays about 76% of the cost to provide health care services to KidsCare-eligible children. Arizona pays the remaining costs. AHCCCS is required to screen applications for Medicaid eligibility before it approves a child for KidsCare. Children who lose Medicaid eligibility are referred to AHCCCS to determine if they are eligible for KidsCare. Unlike Medicaid, you must pay a monthly premium for KidsCare. Services provided to KidsCare-eligible children are similar to those services provided to children covered by Medicaid. AHCCCS health plans and other program contractors provide medical, long-term care, and behavioral health services to persons eligible for Medicaid and KidsCare.

2. What are the AHCCCS health insurance programs?

AHCCCS administers several health insurance programs for low-income individuals, children and families. A list and brief description of the AHCCCS health insurance programs is attached to this guide as Appendix A.

3. How does AHCCCS deliver health care services?

AHCCCS is a statewide “managed care” system. AHCCCS contracts with health plans, Indian Tribes and state agencies, called program contractors, to provide health care services to persons eligible for AHCCCS health insurance. AHCCCS has two groups of health plans: acute care plans and long-term care plans. To deliver services, health plans and other program contractors contract with medical providers such as primary care physicians, specialists, pharmacies, laboratories and hospitals in geographic service areas (GSA). These contractors must make sure there are enough medical providers, provide medically necessary covered services and case management, process and pay service claims, and have a grievance and appeal process for their members. A list of the AHCCCS and ALTCS health plans is attached to this guide as Appendix B.

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

4. What if you are not enrolled in an AHCCCS health plan?

If you are not enrolled in an AHCCCS health plan, you may receive medical services on a “fee-for-service” basis. This means AHCCCS pays the provider, not the health plan, for the services provided to you. Fee-for-service payments are primarily made for emergency services provided to immigrants under the Federal Emergency

Services (FES) program and for Native Americans who receive health care through Indian Health Services.

5. What health care services are covered by AHCCCS health insurance?

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

Children are eligible for a greater range of Medicaid services than adults. Under the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, AHCCCS must cover all Medicaid *mandatory and optional* services for children and youth under age 21, whether or not the services are covered for adults. A similar range of EPSDT services is provided to children and youth eligible for the KidsCare program. A list of EPSDT covered services is attached to this guide as Appendix D.

6. Does AHCCCS charge for services?

You may be required to pay premiums or co-payments to receive medical services under some AHCCCS programs. Generally, the amount of these payments depends on the AHCCCS program and your monthly income. You must pay a monthly premium to get health insurance under the KidsCare and Freedom to Work programs. Under the ALTCS program, you may be required to pay a monthly “share of cost” payment to receive long-term care services. However, some costs are not mandatory. For example, medical providers may ask you to pay a small co-payment to receive certain medical services, such as \$1 for a doctor visit, but they cannot deny the service if you are unable to pay the co-payment.

7. How does AHCCCS and DES work together?

Based on an agreement with AHCCCS, the Arizona Department of Economic Security (DES) determines eligibility for most individuals, families, pregnant women and

children who apply for Medicaid-funded programs. In fact, several divisions of DES participate with AHCCCS to coordinate and deliver a variety of services to AHCCCS members. Below is a brief summary of some of the DES programs:

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

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

8. How do Native American tribal members receive AHCCCS services?

If you are Native American, you may receive AHCCCS health care services through Indian Health Services (IHS) or through an off-reservation AHCCCS health plan. If you choose IHS, then IHS provides all of the medical services. If a covered service is not available through IHS, you may be able to get the service on a fee-for-service basis, if the service is authorized by AHCCCS. You may switch between IHS and an AHCCCS health plan any time. Native American AHCCCS members also receive behavioral health services from a tribal or non-tribal Regional Behavioral Health Authority (RBHA) or at a Tribal “638 Facility.”

For specific information regarding long-term care services for Native Americans, see the Arizona Center for Disability Law’s advocacy guide entitled “Arizona Long Term Care System,” which may be found at www.azdisabilitylaw.org.

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

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

Under EPSDT, children and youth under 21 are eligible for more services than adults. The medical necessity standard for covered services under EPSDT is broader than the adult medical necessity standard. Federal EPSDT law requires health plans and program contractors to cover “all necessary health care, diagnostic services, treatment, and other measures . . . to correct or ameliorate [make better] defects and physical and mental illnesses and conditions” for all Medicaid-eligible children and youth under age 21. If a health plan determines a particular service is needed for a child, then the service must be covered to the extent it is needed and allowed under federal Medicaid law. Thus, health plans and other program contractors may not apply the adult standard for Medicaid services to limit the type or amount of services provided to a child or youth under age 21. This includes all medical, behavioral and long-term care services.

Advocacy tip: If your child is denied a medical service, make sure the health plan has applied the EPSDT standard to the decision. You should request an appeal right away if the adult standard was used, and you should ask the plan to apply the EPSDT standard. For more information about appeals, see the Arizona Center for Disability Law’s advocacy guide entitled “How to Represent Yourself in an AHCCCS Appeal or Administrative Hearing,” at www.azdisabilitylaw.org.

10. What if you have Medicare or private insurance in addition to AHCCCS health insurance?

You are required to tell AHCCCS if you have other insurance. If you have Medicare or private health insurance in addition to AHCCCS health insurance and you are enrolled in an AHCCCS health plan, your health plan determines if the other

insurance should pay for the services provided to you before it pays your medical provider. AHCCCS health plans contact Medicare and other health insurance companies to coordinate these payments. Generally, you are not responsible for the amounts Medicare or the private insurance does not pay.

11. What is a “dual-eligible” AHCCCS member?

If you are eligible for Medicare and AHCCCS health insurance through Medicaid, you are called a “dual-eligible” member. Medicare is a federally funded health insurance program for individuals who are age 65 or older, individuals under age 65 with certain disabilities, and individuals of all ages with End-Stage Renal Disease. The Social Security Administration (SSA) determines eligibility and processes Medicare enrollment. Medicare services include Medicare Part A (Hospital Insurance), Medicare Part B (Medical Insurance) and Medicare Part D (Prescriptions). There are premiums, co-payments and deductibles associated with Medicare services. If you are a dual-eligible member, AHCCCS will pay your Medicare premiums, co-payments and deductibles through its Medicare cost-sharing program.

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

12. What is the Medical Expense Deduction (MED) program?

If you are not eligible for AHCCCS health insurance under any other Medicaid category, you may be eligible for AHCCCS insurance through the Medical Expense Deduction (MED) program. The MED program is especially important for uninsured, hospitalized persons with incomes that are too high to qualify for the traditional AHCCCS health insurance programs. Under the MED program, you can “spend-down” your income to the MED income limit to qualify for AHCCCS health insurance. To spend-down, you must have enough paid or billed medical expenses during a specific three-month period to reduce your total income to 40% of the Federal Poverty Level (FPL). These medical expenses must be your responsibility to pay; they cannot be expenses covered by medical insurance or other third parties. There is a \$100,000 resource limit for the MED program, which includes the equity value of your home, car

and other things of value. Within this \$100,000 limit, liquid assets such as cash on hand or in the bank cannot be more than \$5000. Your resources also may be spent down to the maximum resource limit before DES makes a final decision on the MED application.

You can apply for the MED program at a hospital or a DES office. To calculate MED eligibility, DES compares three months of your medical expenses to three months of your income. The only medical bills that can be used to spend-down your income are bills incurred the months before, during and after the application month. DES subtracts the medical expenses for this three-month period from the income you receive during the month of the MED application and the following two months. If the remaining amount of income is less than 40% of the FPL, and your resources are less than the MED resource limit, you are eligible for AHCCCS health insurance under the MED program, if you meet the other AHCCCS eligibility requirements. Eligibility for the MED program starts on the day your income and resources are spent below the MED income and resource limits. If you applied for AHCCCS health insurance when you were hospitalized, a portion or the entire hospital bill may be paid by AHCCCS once the application is approved.

Advocacy tip: If you go to the emergency room or you are hospitalized and you do not have insurance, you should tell the hospital staff you want to apply for AHCCCS health insurance. You should apply right away because your hospital bill may be covered by AHCCCS if your application is approved. Do not wait to apply for AHCCCS when you get out of the hospital, as the application approval date may not cover the hospital bill.

C. Department of Health Services, Division of Behavioral Health Services

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/DBHS) is the state agency that administers the public behavioral health system in Arizona. The AHCCCS Administration contracts with ADHS/DBHS to provide comprehensive behavioral health benefits to persons eligible for AHCCCS. To deliver behavioral health services, ADHS/DBHS sub-contracts with community-based organizations called Regional Behavioral Health Authorities (RBHAs). Four RBHAs serve the six geographical service areas (GSA) in Arizona. RBHAs function like health plans. They contract with a network of service providers to deliver a full range of behavioral health services to adults and children. This includes prevention and treatment

services for adults with substance abuse, general mental health disorders or serious mental illness and for children with serious emotional disturbance.

ADHS/DBHS has an agreement with DES/DDD to provide behavioral health services to persons with DD through the RBHA system. ADHS/DBHS also has agreements with several Indian Tribes to deliver behavioral health services to persons who live on reservation through the Tribal RBHAs. For those tribes who do not have agreements with ADHS/DBHS, behavioral health services are provided by the RBHA where the reservation is located. ADHS/DBHS does not provide behavioral health services to elderly and disabled members eligible for ALTCS services. Instead, ALTCS health plans contract directly with licensed behavioral health professionals and agencies to provide behavioral health services to their long-term care members.

1. What is the AHCCCS screen and enroll process for persons who have been determined to have a Serious Mental Illness (SMI)?

If you are a person who has been determined to have a Serious Mental Illness (SMI), your RBHA must determine if you are potentially eligible for AHCCCS health insurance. If so, RBHA staff must help you complete an application and send it to the DES, KidsCare or AHCCCS SSI-Medical Assistance Only (SSI-MAO) office to be processed. This is called the AHCCCS “screen and enroll” or “screening and referral” process. The agency staff will inform you and your RBHA if more information is needed to complete the application process and if your application is approved or denied. The RBHA and/or its subcontracted behavioral health providers must help you with the AHCCCS application process by:

- Explaining the AHCCCS application process;
- Helping you complete the AHCCCS application;
- Helping you gather documentation for the eligibility determination;
- Helping you complete a Disability Report, if it is needed to establish disability;
- If appropriate, submitting the application and documentation to the AHCCCS SSI-MAO office, including the SMI Determination Summary Report and medical evidence that supports the SMI diagnosis;
- Helping you apply for other potential benefits, if required by AHCCCS;

- Tracking the status of your AHCCCS application; and
- Once approved, helping you access services from AHCCCS.

In addition to meeting the non-financial and financial requirements for AHCCCS health insurance, you may need to prove eligibility for AHCCCS health insurance on the basis of disability. If you are age 65 or older, blind, receive Social Security Disability Insurance (SSDI) benefits or determined to have a SMI, your application is processed by the AHCCCS SSI-MAO office.

If you are a person determined to have a SMI, your application should include a “SMI Determination Summary Report” signed by a physician or psychologist and medical evidence regarding your SMI diagnosis. The RBHA staff will send your application and the medical documentation to the AHCCCS SSI-MAO office. Depending on the information in the SMI Determination Summary Report, you may be found disabled or you may be presumed disabled. If you are presumed disabled, the SSI-MAO office will send your application and the supporting documents to the Disability Determination Services Administration (DDSA) to confirm your disability. If necessary, RBHA staff must help you fill out forms and gather documentation that DDSA requests. However, the SSI-MAO office will not send your application to DDSA if the SMI Determination Summary Report contains enough information to support a finding that you are disabled. In this case, the SSI-MAO office will approve your application if you are otherwise eligible for AHCCCS health insurance.

If your income is less than 100% of the FPL, the SSI-MAO office will refer your application to DES if DDSA determines you are not disabled or the SSI-MAO office did not receive the medical documentation it requested from you and/or your RBHA. DES will determine if you are eligible for AHCCCS health insurance under a Medicaid category that does not require a disability determination. You should receive a notice from AHCCCS and/or DES explaining that your application was referred to DES. After that, DES should send you a notice either approving or denying your application.

Important Note: If you refuse to participate in the AHCCCS eligibility screening and referral process at your RBHA, you will not be eligible for state funded behavioral health services. However, you do not have to go through the screening and referral

process to get AHCCCS health insurance. You can apply for AHCCCS insurance on your own by filing your own application with AHCCCS or DES anytime.

Advocacy tip: Because different divisions of AHCCCS and DES may be involved in the “screening and referral” process, it is important to stay in frequent contact with your RBHA office regarding the status of your AHCCCS application. You should take any letters, notices or forms you receive from AHCCCS or DES to your RBHA office immediately.

D. What are the basic eligibility factors for AHCCCS health insurance?

You must meet non-financial and financial requirements to qualify for AHCCCS health insurance. The general requirements are listed below.

For specific information on qualifying for long-term care services through the ALTCS program, see the Arizona Center for Disability Law’s advocacy guide, “Arizona Long Term Care System,” which may be found at www.azdisabilitylaw.org.

1. What are the non-financial eligibility requirements?

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

a. Residency

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

b. Social Security Number

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

c. U.S. Citizenship

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

Certain AHCCCS applicants are not required to document citizenship. If you are entitled to or enrolled in Medicare or receiving Social Security Disability Insurance (SSDI) or Supplemental Security Income (SSI) benefits, you do not have to document your citizenship. Also, children who receive Title IV-B or IV-E foster care or subsidized adoption benefits and newborns under age one do not have to document citizenship.

d. Immigration Status

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

If you are a LPR, parolee or battered immigrant, you must meet additional requirements to be eligible for AHCCCS health insurance: you must be a qualified immigrant for at least five years; or you must be able to show you entered the U.S. before August 22, 1996, and you continuously remained in the U.S. until you became a qualified immigrant; or you must have a military connection. To meet the military connection, you

must be an active duty member or an honorably discharged veteran of the U.S. Armed Forces; the spouse or dependent child of an active duty member or veteran; or the surviving spouse or child of a veteran.

Certain immigrants who do not qualify for full service AHCCCS health insurance because of their immigration status may be eligible for emergency services under the Federal Emergency Services (FES) program.

e. When is a determination of disability required for AHCCCS?

Most AHCCCS health insurance programs do not require a person to be disabled to qualify for AHCCCS. However, there are some programs that require you to be elderly or disabled to get AHCCCS health insurance. You may qualify for AHCCCS health insurance through programs processed by the SSI-Medical Assistance Only (SSI-MAO) office if you are age 65 or older, or disabled. You must prove disability to qualify for AHCCCS health insurance through the Freedom to Work program. AHCCCS will refer your disability-related application to DDSA to determine if you meet the disability standard appropriate to the AHCCCS program you are applying for. In addition, to qualify for long-term care services, you must pass a medical assessment called the “PAS” test under the ALTCS program. ALTCS does the PAS assessment.

2. What are the financial eligibility requirements?

Countable income and resources are considered when determining eligibility for most AHCCCS health insurance programs. The maximum amount of income or resources you may have and be eligible for AHCCCS health insurance depends on factors such as age, marital status or family composition. If your countable income is less than the maximum income limit for the appropriate AHCCCS health insurance program, your application will be approved if you are otherwise eligible. Also, if you receive monthly SSI cash benefits, you are automatically eligible for AHCCCS, so you do not have to apply for AHCCCS health insurance to receive AHCCCS benefits. Specific information about income and resource limits for AHCCCS health insurance programs is on AHCCCS’ website at www.azahcccs.gov.

a. How is income counted?

The income that AHCCCS counts depends on the program you are applying for and who you live with. Generally, AHCCCS considers your income, your spouse's income and the income of a parent of an unmarried minor child. If you are an immigrant, AHCCCS determines if your immigration sponsor's income must be counted as your income. Also, if individuals are applying as a family and the family includes a dependent child, the income of a specified relative or a non-parent caretaker, his or her spouse and their unmarried children may be counted to determine which individuals are eligible for AHCCCS health insurance.

All earned and unearned income is considered in determining whether you are financially eligible for AHCCCS health insurance. Income is defined as monies that can be used to obtain food, clothing, or shelter. It is divided into two major categories: earned and unearned income. Within each category, there are numerous types of income, which is either counted or excluded. Earned income includes wages, salaries, commissions or profits earned as an employee or a self-employed person. Unearned income includes monies such as cash welfare payments, retirement funds, pensions, annuities, child and spousal support, unemployment insurance, worker's compensation, and retirement and disability benefits from the Veteran's Administration and Social Security (except SSI). Interest, dividends and certain cash contributions also are counted as unearned income.

Although income may be counted differently based on the AHCCCS program, AHCCCS generally does not count income such as: SSI payments; burial benefits; cash contributions not intended to cover basic living expenses; energy assistance payments; certain federal educational grants and scholarships; Bureau of Indian Affairs (BIA) student assistance payments; earnings from high school on-the-job training programs; earned income of dependent children enrolled in school at least half-time; nutrition assistance (formerly food stamps); governmental housing; rental subsidies; income tax refunds; loans; reimbursements; vendor payments; WIC benefits and other income specifically excluded by federal law. Also, AHCCCS may not count a portion of your earned income. For some AHCCCS programs, AHCCCS subtracts a \$90 cost of employment allowance from the monthly gross earnings of any person whose income is

being counted. In addition, a limited amount of income may be deducted from gross earned income for childcare or adult care expenses.

b. How are resources counted?

Resources are defined as real property, personal property and liquid assets. Most AHCCCS programs do not have limits on the amount of resources you may have and be eligible for AHCCCS health insurance. If the AHCCCS program you are applying for has a resource limit, your countable resources are compared to the resource limit for that program. You are “resource eligible” for AHCCCS health insurance if your total countable resources are less than the AHCCCS program’s resource limit.

There is no resource limit for AHCCCS medical coverage provided under the Medicaid S.O.B.R.A. and Section 1931 categories for families with children and pregnant women, the AHCCCS Care program for persons without children, the KidsCare program for children, the Freedom to Work program for persons with disabilities, and the Medicare cost sharing programs. See Appendix A for a description of the AHCCCS health insurance programs.

There are resource limits for the ALTCS program, the Medical Expense Deduction (MED) program and the SSI-Cash group. The ALTCS program has a resource limit of \$2000 for an individual but this amount is much greater if the applicant has a spouse that lives in the community. ALTCS also has strict rules against transferring resources without consideration prior to and after applying for ALTCS services. The MED program has a resource limit of \$100,000 of which no more than \$5,000 can be in liquid assets such as cash. There is a resource limit of \$2000 for an individual and \$3000 for a couple who qualify for AHCCCS health insurance as a member of one of the Social Security/SSI special groups.

Resources may be available, unavailable, or excluded during a specific month. AHCCCS evaluates each resource to determine if it is actually available to meet your needs. Only available resources are counted. Resources are usually evaluated at equity value unless there is an exception for a particular type of resource. Countable resources include cash; stocks; bonds; certificates of deposits; bank accounts; real property such as a house you do not live in; non-exempt vehicles; and the cash value of some life

insurance policies. Exempt resources do not count against the resource limit. Generally, exempt resources include the home you live in, your personal and household belongings, a vehicle, burial plots, irrevocable burial plans, and up to \$1,500 in a burial fund.

Advocacy tip: If the AHCCCS program you are applying for has a resource limit, you must report all your resources to the agency processing your application. If you think you have a resource that may prevent you from qualifying for AHCCCS health insurance, you should seek legal advice prior to applying for AHCCCS benefits.

E. What is the application process for AHCCCS health insurance?

You have a right to apply for AHCCCS health insurance anytime, without delay. AHCCCS and DES workers may not pre-screen you or require you to come back another day. The agency must accept your application if it has at least the date, legible names and addresses of each applicant, and the signature of the person filing the application.

Application forms are available at AHCCCS or DES offices or can be downloaded from AHCCCS' website at www.azahcccs.gov or DES' website at www.azdes.gov. AHCCCS has a universal application that may be used to apply for several of the AHCCCS health insurance programs. DES' joint application allows you to apply for cash assistance and nutrition assistance (food stamps) in addition to AHCCCS health insurance. The websites and application forms contain specific information about the application process for the different AHCCCS programs.

You also can apply for several of the AHCCCS health insurance programs on-line by using the Health-e application process at www.healthearizona.org. Based on a series of questions, the on-line application process first determines which AHCCCS health insurance program you are potentially eligible for and then asks if you want to complete the on-line application process. Once completed, the on-line program sends your application to the proper AHCCCS or DES office. If more information is needed to complete the application process, that office will contact you. You can track the status of your application on-line.

Advocacy tip: You should keep proof of the mailing or faxing of your application to protect the application filing date in case there is a problem. If the application is filed in person, you should ask for a date-stamped copy or a receipt. Also, a receipt for an on-line application may be printed after it is electronically sent to AHCCCS.

1. Where do you apply for AHCCCS health insurance?

The AHCCCS Administration processes applications for some, but not all, AHCCCS programs. AHCCCS has an agreement with DES to process applications for most of the Medicaid categories for AHCCCS health insurance.

AHCCCS processes applications for the ALTCS, KidsCare, SSI-related groups, Medicare Cost Sharing, Freedom to Work, and Breast and Cervical Cancer Treatment programs. You may apply for long-term care services at any ALTCS office in person, by phone, mail or fax. For other programs processed by AHCCCS, you may send a written application to the central AHCCCS office in Phoenix in person, on-line, by mail or fax.

DES determines AHCCCS eligibility for individuals with incomes at or less than 100% of the FPL, Section 1931 for families, S.O.B.R.A. children and pregnant women, Federal Emergency Services (FES) for immigrants and the MED program. You may apply for AHCCCS health insurance at any DES/FAA office or at an approved location such as the Children's Rehabilitation Services (CRS) clinic, Federally Qualified Health Centers, behavioral health services offices, or if you are pregnant, at a Baby Arizona provider's office. If you go to the emergency room or you become hospitalized, you can apply for AHCCCS health insurance at the hospital. DES must accept and process AHCCCS health insurance applications completed at the hospital. Written applications may be submitted to DES anytime in person, on-line, by mail or fax.

Advocacy tip: The address, phone number and fax number of the office where you send your application may be found on the application form or the agency's website. If the application is sent to the wrong agency or office, they must immediately forward it to the proper office for timely processing.

2. How do you apply for AHCCCS health insurance?

You may apply for AHCCCS health insurance for yourself and your children. With your consent, another person may apply for you and/or act on your behalf during the application process. If you are incapacitated, any interested person may start the application process. An incapacitated applicant is a person who is physically and/or mentally unable to apply for AHCCCS health insurance and is unable to authorize someone to act as his or her representative. You and/or your representative must

cooperate in the application process by providing complete and accurate information, reporting changes, and taking the necessary actions to establish your eligibility.

Advocacy tip: Changes may be reported orally or in writing. We recommend that you or your representative report changes in writing to create a record of the report.

3. What happens after you file your application?

Interviews are required for some, but not all, AHCCCS health insurance programs. AHCCCS or DES will contact you to schedule an interview if required. The interview may be in person or by telephone, and it may be with you and/or your representative. In-person interviews may be scheduled at the AHCCCS or DES office or at your home. The interview appointment may be rescheduled, if necessary.

During the appointment, the interviewer must review the information on your application and have you sign any necessary release forms. The interviewer also must explain certain information to you, such as the agency's time frame to make a decision on your application; eligibility requirements; proof you need to verify your eligibility; your responsibility to provide information, report changes and cooperate with the application process; your appeal rights and the hearing process; how your SSN is used; enrolling with an AHCCCS health plan; fraud and penalties; and the renewal application process.

Certain information such as income, deductions from income, resources, citizenship or immigration status, residency, and household composition must be verified in writing or by a third party. DES or AHCCCS must send you a written request for information or documentation, and they must give you at least 10 days to provide the information to them. You may ask to extend this due date if you need more time to get the information. Also, you may ask the agency to help you get the information. If you do not provide the information, you do not ask for an extension, or you do not ask for help before the 10-day deadline is up, the application may be denied.

4. How long does the agency have to make a decision on your application?

The application-processing period begins the day after the application date and ends on the day the decision notice is mailed to you. The number of days AHCCCS or DES has to make a decision on an application depends on the AHCCCS program.

Generally, AHCCCS must approve or deny an application in writing within 45 days of the date of the application. This period may be extended beyond 45 days under certain circumstances. AHCCCS has 90 days to make a decision on a disability-related application. If you are pregnant, the decision must be made within 20 days of the application date, unless more information is needed to make the decision. If you applied while you were in the hospital, DES must make a decision within seven days of the application date, unless more information is needed. If so, DES has 45 days to make a decision. For the KidsCare program, AHCCCS must make a decision within 30 days of the application date, except in emergencies beyond AHCCCS' control.

5. When does your eligibility for AHCCCS health insurance start?

Eligibility begins for most AHCCCS health insurance programs on the first day of the month the application is filed. Programs with other dates of eligibility are:

- MED: The first day of eligibility for applications approved under the MED program is the date both the income and resource requirements are met, but no earlier than the first day of the month of application.
- KidsCare: Eligibility for the KidsCare program starts the first day of the month following an eligibility decision if AHCCCS makes the decision by the 25th day of the month. If AHCCCS makes the decision after the 25th day of the month, eligibility starts on the first day of the second month after the eligibility decision.
- Medicare Cost Sharing: Eligibility for the Medicare Cost Sharing programs starts on the first day of the month following the month the decision was made.

F. What happens after your AHCCCS application is approved?

Once the application is approved, you are enrolled with an AHCCCS health plan. The health plan sends you written information about the plan, and you choose a primary care physician (PCP) from the list of the health plan's providers. AHCCCS also sends you an AHCCCS ID card with the name and phone number of your health plan. You should present this ID card to your medical providers, such as doctors, hospitals, and

laboratories whenever you request medical services. Also, you contact your health plan directly to obtain, coordinate, or dispute AHCCCS health care services.

G. When do you need to reapply?

DES or AHCCCS reviews your eligibility for AHCCCS health insurance every few months. Depending on the AHCCCS program, you may be required to file a renewal application every 6 months or every 12 months. DES or AHCCCS will send you a letter when it is time to file a renewal application for AHCCCS health insurance.

H. What happens if the AHCCCS health insurance application is denied or current AHCCCS benefits are stopped?

If DES or AHCCCS denies your application or terminates your AHCCCS health insurance, the agency that made the decision must send you a notice of adverse action. The notice must explain the action the agency has taken or intends to take; the reasons for the action; financial calculations and the financial standard, if applicable; the specific law or regulations that support the action; the right to request a hearing; and how to continue AHCCCS health insurance benefits until a decision is made on the appeal.

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

There also is an appeal and hearing process for adverse decisions made by AHCCCS health plans or other program contractors. For more information about the AHCCCS and DES hearing process, see the advocacy guide on the Arizona Center for Disability Law's website entitled "How to Represent Yourself in an AHCCCS Appeal or Administrative Hearing" at www.azdisabilitylaw.org.

I. Legal Resources for this Guide

AHCCCS must provide health insurance to low-income persons consistent with federal and state law and regulations. AHCCCS and DES staff determine eligibility for AHCCCS health insurance by following agency policies developed or approved by AHCCCS, which must be based on the federal and state laws and regulations. You can find links to these laws, regulations and policies under a heading called “Laws and Regulations” on AHCCCS’ website at www.azahcccs.gov. The AHCCCS Eligibility Policy Manual is at <http://azahcccs.gov/Publications/Eligibility/default.asp>. Also, DES’ policies on processing applications for AHCCCS health insurance can be found in the FAA Policy Manual, which is on DES’ website at www.azdes.gov. If you are unable to access these laws and policies on-line, you should call the AHCCCS or DES office to ask for a copy of the law or policy that they relied on to make a decision in your case.

Appendix A
AHCCCS Health Insurance Programs

Medicaid/AHCCCS Coverage Group	Description
AHCCCS Care (AC)	Available to single, individual, or married couples who do not qualify for traditional Medicaid programs because they are not age 65 or older, blind, or disabled and do not have any dependent children.
AHCCCS Freedom to Work (FTW)	Available to working individuals who have a disability. Individuals may be eligible for Long Term Care Services or AHCCCS Medical Services.
Arizona Long Term Care System (ALTCS)	Available to individuals who are elderly, physically or developmentally disabled and who have a medical need for long-term care services.
Breast and Cervical Cancer Treatment Program (BCCTP)	Available to women under age 65 who are screened and diagnosed as needing medical treatment for breast cancer, cervical cancer or a pre-cancerous cervical lesion by one of the programs in the Arizona National Breast and Cervical Cancer Early Detection Program.
Deemed Newborns	Available for up to 1 year of coverage for children born to mothers receiving Medicaid medical services as long as the child continuously lives with the mother in Arizona. Eligibility begins on the child's date of birth and ends with the last day of the month in which the child turns age 1.
Families with Children (AFC)	Available to families that include deprived, dependent children. Coverage under AFC is based on requirements in Section 1931 of the Social Security Act. It is sometimes referred to as "1931". Families whose AFC benefits are terminated due to: (1) employment - may be eligible for an additional six months of AHCCCS health insurance after becoming ineligible for AHCCCS benefits due to excess income; or (2) receipt of or increase in child support payments - may be eligible for an additional four months of AHCCCS health insurance after becoming ineligible for AHCCCS due to excess income.
KidsCare	Available to children under age 19 who are not eligible for Medicaid. Children eligible for KidsCare must pay monthly premiums.

Medical Expense Deduction (MED)	Available to individuals, couples, or families whose income exceeds the Medicaid limits may be eligible for AHCCCS health insurance after deducting their medical expenses from their income.
S.O.B.R.A Pregnant Women	Available to pregnant women beginning with any month of pregnancy through the 60-day postpartum period. Note: Women who lose S.O.B.R.A. eligibility receive Family Planning Services for up to 24 months.
S.O.B.R.A. Child	Available to children up to their 19 th birthday. S.O.B.R.A. is named for the Sixth Omnibus Reconciliation Act, which created this coverage group.
Supplemental Social Security Income (SSI) Cash	Available to individuals receiving SSI cash benefits from the Social Security Administration (SSA) because they are age 65 or older, blind or disabled.
Supplemental Security Income - Medical Assistance Only (SSI-MAO)	Available to individuals age 65 or older, blind, or disabled, who are not eligible for SSI cash benefits, may be eligible for AHCCCS health insurance under the SSI non-cash coverage group.
Title IV-E Foster Care and Adoption Subsidy	Available to persons with an adoption assistance agreement or foster care maintenance payments under the provisions of Title IV-E of the Social Security Act. They are deemed to meet the non-medical conditions of eligibility for ALTCS.
Young Adult Transitional Insurance (YATI)	Available to any person under age 21 who was in DES foster care when turning age 18.
Qualified Medicare Beneficiary	Available to persons entitled to Medicare and eligible for Medicaid. AHCCCS pays the Medicare Part A & B monthly premiums, coinsurance and deductibles.
Specified Low-Income Medicare Beneficiary	Available to persons entitled to Medicare. AHCCCS pays the monthly Medicare Part B premium only.
QI-1	Available to persons entitled to Medicare. AHCCCS pays the monthly Medicare Part B premium only.

Six Month Guarantee	Available to individuals who are enrolled with an AHCCCS health plan for the first time and become ineligible prior to 6 months of enrollment. AHCCCS members in the following coverage groups receive continued AHCCCS coverage under the guarantee enrollment period, providing the member does not voluntarily withdraw, is eligible when enrolled, is not an inmate of a public institution, or is adopted, and remains an Arizona resident: AHCCCS Care; Families with Children; Breast and Cervical Cancer Treatment Program; AHCCCS Freedom to Work; SSI Cash; SSI-Medical Assistance Only; S.O.B.R.A. Child; Pregnant Women; Title IV-E Foster Care and Adoption Subsidy; and YATI. Note: The 6-month guarantee does not apply to customers receiving Long Term Care services.
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Appendix B
AHCCCS and ALTCS Health Plans and Tribal Contractors

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

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

AHCCCS Acute Care Covered Services	ALTCS Covered Services
<ul style="list-style-type: none"> ➤ Physician services ➤ Inpatient and outpatient hospital services ➤ Outpatient clinics, including Rural Health Clinic or Federally Qualified Health Center services ➤ Prescription drugs ➤ Laboratory, X-ray and medical imaging services ➤ Nursing facility services in lieu of hospitalization not to exceed 90 days per contract year ➤ Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services for members under age 21. EPSDT includes all medically necessary Medicaid services ➤ Family planning services, including drugs, supplies, devices and surgical procedures provided to delay or prevent pregnancy ➤ Emergency dental services and medically necessary dentures for members age 21+ ➤ Nurse-midwife and nurse practitioner services ➤ Home health services in lieu of hospitalization ➤ Emergency ambulance and medically necessary non-emergency transportation ➤ Emergency room services ➤ Other licensed practitioner services, including respiratory therapists, physician assistants, certified nurse anesthetists, licensed midwives and non-physician behavior health professionals ➤ Medical supplies, durable medical equipment and prosthetic and orthotic devices ➤ Physical, occupational, audiology and speech therapies. Occupational and speech therapy in outpatient setting only for acute care members under age 21. No limitation for ALTCS members ➤ Podiatry services ➤ Private duty nursing services ➤ Dialysis services ➤ Non-experimental transplants approved for Medicaid reimbursement ➤ Optometrist services ➤ Eyeglasses and contact lenses for members age 21+ as the sole external prosthetic device after cataract extraction ➤ Home health therapy services ➤ Screening, diagnostic, rehabilitation and preventative services for members age 21+ 	<ul style="list-style-type: none"> ➤ All AHCCCS acute care services ➤ Nursing facility services ➤ Case management ➤ Speech, physical and occupational therapies ➤ Respiratory care services for ventilator dependent members ➤ Services provided in Christian Science Sanatoria ➤ Hospice ➤ Adult day health (EPD only) ➤ Intermediate Care Facility for Mentally Retarded (DD only) ➤ Developmentally Disabled day care (DD only) ➤ Home delivered meals (EPD only) ➤ Home health agency services, including nursing services and home health aide ➤ Homemaker ➤ Personal care ➤ Respite care ➤ Habilitation ➤ Group respite services as an alternative to adult day health (EPD only) ➤ Attendant care services ➤ In home private duty nursing services ➤ Environmental modifications ➤ Life line alert ➤ Supported employment ➤ Other services, if approved by CMS and the Director of AHCCCS ➤ Services provided in the following settings: <ul style="list-style-type: none"> ➤ Adult foster care home ➤ Assisted living home ➤ Assisted living center (choice of single occupancy) ➤ Center for Traumatically Brain Injured ➤ DD group home ➤ Adult development home ➤ Child development foster home ➤ Level I behavioral facility ➤ Level II behavioral facility ➤ Level III behavioral facility

EPD—Elderly and Physically Disabled
DD—Developmentally Disabled

Appendix D
Covered Services for the EPSDT Program for Children

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

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

Nursing facility services for persons age 65+ in an institution for mental diseases	1396d(a)(14)	440.140(b); 441.100-.106		X
Intermediate care facility services for the mentally retarded	1396d(a)(15)	440.150; 483.400 <i>et seq.</i>		X
Nursing facility services other than in institutions for mental diseases	1396d(a)(4)(A)	440.155		X
Inpatient psychiatric services for person under age 21	1396d(a)(16); 1396d(h)	440.160; 441.150-.182; 483.350-.376		X
Nurse-midwife services	1396d(a)(17)	440.165; 441.21	X	
Nurse practitioner services	1396d(a)(21)	440.166(a); 441.22	X	
Certified pediatric nurse practitioner services	1396d(a)(21)	440.166(b) 441.22	X	
Certified family nurse practitioner	1396d(a)(21)	440.166(c) 441.22	X	
Personal care services	1396d(a)(24)	440.167		X
Primary care case management services	1396d(a)(25)	440.168		X
Case management services	1396d(a)(19)	440.169; 441.18		X
Targeted case management services	1396d(a)(19); 1396n(g)			X
TB-related services	1396d(a)(19)			X
PACE program services	1396d(a)(26); 1396u-4			X
Treatment and services for persons with Sickle Cell disease	1396d(a)(27)			X

Any other medical care or remedial care recognized under State law & specified by the Secretary of HHS	1396d(a)(28)	440.170		X
Transportation	1396d(a)(28)	440.170(a); 441.62; 483.55(a)(3)(iii) 483.75(k)(2)(iii)		X
Services furnished in a religious nonmedical health care institution	1396d(a)(28)	440.170(b)		X
Skilled nursing facility services for persons under age 21	1396d(a)(28)	440.170(d)		X
Emergency hospital services	1396d(a)(28)	440.170(e)		X
Critical access hospital services	1396d(a)(28)	440.170(g)		X
Home or community based services	1396d(a)(7)	440.180(a), (b)		X
Expanded habilitation services	1396d(a)(7)	440.180(c)		X
Services for the chronically mentally ill	1396d(a)(7)	440.180(d)		X
Home and community care for persons age 65+	1396d(a)(22); 1396t	440.181		X
Respiratory care for ventilator-dependent persons	1396d(a)(20)	440.185		X
Hospice Care	1396a(a)(13)(B); 1396d(a)(18); 1396d(o)			X
Organ transplants	1396b(i)(1)	441.35		X
End-stage renal disease services	<i>See generally,</i> 1396d(a)(6); 1396d(a)(13); 1396d(a)(28)	441.40		X
Community supported living arrangement services	1396d(a)(23); 1396u	441.400 <i>et seq.</i>		X