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# Gateway Policy Explorer: Long-Term Care Series

## Arizona, USA

## Long-Term Care In-Kind Benefit Plan Details

## 1992-2024

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## Preface

This document is intended for researchers who want to understand the evolution of policy or the policy in place at a particular point in time. This document is not intended for financial advice or to aid in decision-making. The authors have made significant effort to identify and collect historical information pertaining to these policies, to accurately represent these policies, and to communicate how policies may interact to determine legal requirements, eligibility for benefits, and/or benefits levels. The policies presented in this document focus on rules applicable to most individuals aged 50 and older from 1992. Many systems include special policies or alternative eligibility rules for specific groups. We encourage all users to complete their own review of literature in this area depending on the research questions they have in mind.

If you have feedback or questions or identify an error, please contact policy@g2aging.org.

## Background — *Gateway Policy Explorer: Long-Term Care Series*

The *Gateway Policy Explorer* (http://g2aging.org/policy-explorer) is part of the Gateway to Global Aging Data (http://g2aging.org) project. The *Long-Term Care Series* captures historical policy that affects the birth cohorts of respondents in the surveys covered by the Gateway. It was motivated by the rapid evolution of policies affecting older people across the world. As the Health and Retirement Study (HRS) began in 1992 and many of the international network of studies (HRS-INS) cover more than a decade, understanding the policies in place at the time of the survey has become more demanding for researchers.

*Why are we tracking past policy*? Individuals make choices based on current policies and the outcomes we see today may reflect responses to past policies. When interpreting the survey responses of individuals, an understanding of the policy environment under which those individuals operate is critical. The collection of contextual information in the *Gateway Policy Explorer* aims to support researchers who want to understand or use policy changes in their research and provide context for longitudinal or cross-country differences. Over the period 2023–2026 the *Gateway Policy Explorer* will be expanded to include information on retirement, long-term care, education, and other policies affecting the life cycle.

The key dimensions to the *Gateway Policy Explorer: Long-Term Care Series* are country and time. In the United States, policy is reported at the state level. We prioritize data collection for each country or state based on its first interview wave and are continuing to expand our data collection back in time to 1992, the earliest survey date in the HRS-INS.

A separate document, like this one, is developed for each country or state and each broad category of policies covered in the *Gateway Policy Explorer: Long-Term Care Series*.

# Arizona, USA

In-Kind Benefits

Plan details 1992-2024 * †

Public long-term care (LTC) benefits in Arizona are primarily provided by Medicaid, a public health insurance program for low-income individuals. Enrollment in Medicaid is voluntary.

In Arizona, LTC services are primarily provided as in-kind benefits. LTC benefits vary by program, however, Arizona has a single program that covers home-based care, semi-residential care, and residential care: the Arizona Long Term Care System (ALTCS).

Since 1992, Arizona's Medicaid LTC system has been subject to two major policy reforms, both in 2001: Arizona implemented new eligibility tracks for individuals with income up to 100% of the Federal Poverty Level (FPL). These tracks included coverage of single and childless adults, and individuals at least 65 years of age, blind, or disabled. An additional eligibility track was added for individuals and families whose income exceeds 100% of the FPL and also have significant medical expenses.

**Key Dates**

First law: 1981

Major changes since 1992: 2001

## Contents



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† Detailed information and definitions are provided in tables, formulas and a glossary at the end of this document. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

# Chapter 1: Policy enacted 1992-2000

## Overview

Long-term care (LTC) benefits in Arizona are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Arizona is administered at the state level by the Arizona Health Care Cost Containment System (AHCCCS), and enrollment is voluntary. Arizona's Medicaid program, including LTC services, is mostly administered through a managed care delivery model.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Arizona are mostly provided through the Medicaid state plan managed care benefit program (Arizona Long Term Care Services - ALTCS).

ALTCS provides Arizona's LTC services including Nursing Facility Care, Home Health Services, and other services. People covered by ALTCS are able to receive a variety of benefits if deemed medically eligible, such as case management, and Adult Day Health Care (ADHC). State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for ALTCS are not immediately guaranteed HCBS care (excluding Home Health Services), as Arizona capped HCBS services during this policy period.

In order to qualify for ALTCS services a person must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

During this policy period, the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 restricted most legal immigrants entering the United States after August 22, 1996 from receiving federally funded Medicaid (and some other public assistance) for at least five years after immigration.

**Statutory basis**

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Arizona Law for Medicaid

- Arizona Administrative Code (A.A.C.), Title 9 - Health Services (AAC, 2024a)

## Financing

**Source of financing**

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Arizona Medicaid spending on beneficiaries in fiscal year 1992 was 62.61%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending, though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

## Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

**Risk covered definition**

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

**Eligible population**

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Arizona Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Arizona.

Eligibility for Medicaid in Arizona for people needing LTC services is primarily attained by satisfying at least one of 2 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 1992, the monthly federal benefit amount was $422 for an individual and $633 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[2]
  - Citizenship/immigration requirements: The applicant must be an Arizona resident and a U.S. citizen or non-citizen who meets additional eligibility requirements.[3] After 1996, the applicant must be an Arizona resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals who entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See SSA (2024b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Income may not exceed 300% of the monthly SSI federal benefit amount (SLSA, 1987). In 1992, this was $1,266. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[5] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[6] See Table 3 for historical monthly spousal disregards.
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving or in need of LTC services through Arizona's LTC program, ALTCS.
    - The applicant must be at least age 65, blind, or disabled.

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. These tracks are omitted because they are more rarely used or do not cover older adults.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

ALTCS

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit Eligibility* section of this policy period).

## Benefit

### Home care benefit

Home care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS

ALTCS provides (CFR, 1992b; SLSA, 1991; AAR, 1997b):

- Home Health Services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, and vital monitoring
- Personal care services
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker Services: Assistance in the performance of activities related to household maintenance within a beneficiary's home

Personal care services can also be provided to residents who live in Assisted Living Facilities (ALFs).

In 1992, the cap on HCBS services (excluding Home Health Services) provided by ALTCS was set at 25% of the Elderly/Physically Disabled (EPD) population. The cap had been steadily increased until April 2000 when the cap was removed retroactively to October 1, 1999 (AHCCCS, 2000).

### Community care

Community care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS

ALTCS provides Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (SLSA, 1991; AAC, 2024a).

### Residential care

Residential care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS

ALTCS covers residential care in a nursing facility (CFR, 1992; AAR, 1997b; AAC, 2024a). Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

### Other benefits

Other care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS provides the following services in addition to those offered under the state plan, unless otherwise noted (AAR, 1997b, Arizona State Medicaid Plan):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services
- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Non-medical transportation: Additional coverage of transportation to community services and activities

- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses) - from 1995 (AAR, 2001)
- Home modifications: physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization - from 1996 (AMPM, 2024a)
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency - from 1996 (AMPM, 2024)

**Provision of care**

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Arizona Department of Health Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Arizona uses a managed care delivery model. The AHCCCS manages the ALTCS program through contractors who are responsible for delivering services to beneficiaries.

ALTCS

Skilled nursing services must be provided by a registered nurse. If services are provided through a Medicare certified home health agency, they may also be provided by a licensed practical nurse (AMPM, 2024d).

Home health aide services may be provided by a Health Aide licensed by the Arizona State Board of Nursing through a Medicare Certified home health agency.

Personal care services may be provided by an attendant care worker with at a minimum, hands-on training in First Aid, CPR, Universal Precautions, and state and federal laws regarding privacy of health information (AAR, 2007).

## Benefit eligibility

**Qualifying period**

Potential users may apply at any time.

**Minimum level of dependence**

The minimum level of dependence varies by health benefit program. The details of the the largest program are summarized below.

ALTCS

Applicants must meet an NFLOC as determined by the Preadmission Screening (PAS) (AAR, 1997). There are 3 ways an applicant can be determined to need an NFLOC:

- Any applicant who scores at least 60 total points on the PAS
- An applicant in Group 1 who has a functional score of at least 30, and a medical score of at least 13.
- An applicant in Group 2 who has a functional score of at least 30, and a total score of at least 5 in the orientation section, or an unscaled score of 2 for any single behavior in the emotional and cognitive behavior subsection.

PAS components:

- Medical assessment (Group 1): Table 4
- Medical assessment (Group 2): Table 5
- Functional assessment: Table 6
- Emotional and cognitive functioning assessment: Table 7

The PAS assessment process is detailed further in the *Care needs assessment* section.

**Duration of benefit**

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the largest program.

Medicaid

Federal law requires states to renew Medicaid eligibility at least every 12 months.

ALTCS

Reassessments using the PAS occur annually. In 1997, Arizona began reassessing beneficiaries meeting certain criteria every other year. See Box 1 for details (SLSA, 1987; AAR, 1997).

**Means testing**

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

**Age requirement**

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

ALTCS

There is no age requirement.

## Care needs assessment

**Definition of dependence**

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the largest program.

ALTCS

An applicant must be medically in need of long-term care services as determined by the PAS (PAS, 1992). The PAS has a functional score, and a medical score. The functional score is based of a functional assessment subsection and an emotional and cognitive functioning assessment subsection. The sum of the functional and medical scores equals the total score. The PAS separates applicants into two groups. An applicant must satisfy one of the following pathways to meet the requirements for an NFLOC:

- Any applicant who scores at least 60 total points on the PAS
- An applicant in Group 1 who has a functional score of at least 30, and a medical score of at least 13.
- An applicant in Group 2 who has a functional score of at least 30, and a total score of at least 5 in the orientation section, or an unscaled score of 2 for any single behavior in the emotional and cognitive functioning subsection.

**Evaluation of dependence**

Evaluations of dependence vary depending on the health benefit program. The details of the largest program are summarized below.

ALTCS

Upon applying for LTC services, a social worker and registered nurse performs an assessment using the PAS tool for the elderly or physically disabled (EPD) person (AAR, 1997). The tool is used to assess the functional, medical, nursing and social needs of the applicant. Meeting or exceeding the threshold score of 60 total points on this screening tool establishes initial eligibility for an NFLOC. A combination of weighted functional and medical factors are evaluated and assigned a numerical value to reach totaled scores. The threshold score, or point at which an individual becomes eligible, is determined by a formula using those scores.

The ALTCS PAS assessment consists of two scored sections:

- A functional score based on the functional assessment and the emotional and cognitive functioning assessment.
- A medical score based on the medical assessment.
- The total score is the sum of the functional and medical scores.

The medical score is dependent upon which Group (1 or 2) an applicant is assigned. This assignment is based on the individual's diagnoses and is designated as follows:

- Group 1 includes an applicant or member diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease, and anyone not in Group 2.
- Group 2 includes an applicant or member diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome.

PAS components:

- Medical assessment (Group 1): Table 4
- Medical assessment (Group 2): Table 5

- Functional assessment: Table 6
- Emotional and cognitive functioning assessment: Table 7

See Box 2 for a narrative example of an assessment for Group 1, and Box 3 for a narrative example of an assessment for Group 2.

**Evaluators**

Evaluators vary by health benefit program. The details of the largest program are summarized below.

ALTCS

The PAS is completed by a registered nurse and a social worker (SLSA, 1987).

## Benefit limitations

**Can you mix LTC benefits?**

All Arizona Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in the ALTCS program. Beneficiaries may not duplicate services across programs.

**Is there free choice between cash and benefits in-kind?**

The LTC system does not offer a cash benefit.

**Can you receive LTC benefits with other public benefits?**

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

## User costs

**User charges**

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the largest program.

Medicaid

As required by federal law, Arizona enforces Estate Recovery. The acceptance of Medicaid in Arizona creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (SLSA, 1987).

ALTCS

Beneficiaries in an institution for more than 30 days are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance of 15% of the SSI federal benefit amount and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. Beneficiaries in an institution for less than 30 days have a personal needs allowance of 300% of the SSI federal benefit rate. See Table 2 for historical monthly benefit amounts (SLSA, 1991; AAR, 1999; AAC, 2024a).

**Taxation of benefits**

In-kind benefits are not subject to taxation.

# Chapter 2: Policy enacted 2001-2024

**Policy change in 2001**
In 2001, Arizona added 3 new Medicaid eligibility tracks (AAR, 2001b, sections R9-22-1504, R9-22-1421, and R9-22-1429).

1. Eligibility Track 2b. (Federal Poverty Level Aged and Disabled) is for aged, blind, or disabled adults. This track allows all adults at least age 65, blind, or disabled to become eligible for Medicaid if their income is at or below 100% of the federal poverty level (FPL).
2. Arizona expanded eligibility to all adults with incomes up to 100% of the FPL who are ineligible under any other Medicaid groups. Most states did not cover this population until the ACA in 2014. We refer to this eligibility track as 2c. Affordable Care Act (ACA) Expansion Adults for this reason and for consistency across documents. In an effort to control costs, Arizona closed new enrollment for this track in 2011. In 2014, Arizona reopened new enrollment for this track under ACA Medicaid expansion with an increased income limit of 133% of the FPL (ABH, 2022).
3. Arizona expanded eligibility to individuals and families whose income exceeds 100% of the FPL and also have significant medical expenses. Applicants must "spend down" their income on qualifying medical expenses to 40% of the FPL. Most states only provide this eligibility track for those that are aged, blind, or disabled. However, this is not a requirement in Arizona. We refer to this eligibility track as 3a. Aged, Blind, or Disabled. In 2011, in an effort to control costs, Arizona closed new eligibility for this track and it was not reopened. Those that qualified for this track prior to 2011 and remained eligible are still covered (AAC, 2024).

Other reforms during this period:
- (2002) Private Duty Nursing Services were added as a benefit to all ALTCS members. This had previously only been a benefit for ventilator dependent members (AAR, 2002).
- (2006) The Preasmission Screening (PAS) was updated, eliminating the separate medical scoring methodologies for Group 1 and Group 2 (PAS, 2006).
- (2007) Arizona added the option for spouses to be paid for providing Personal Care Services under specific conditions[9] (AAR, 2007)
- (2011) Arizona implemented consumer-directed personal care services, meaning the participant can hire and manage the caretaker of their choice. This may include a family member (AAR, 2012).

## Overview

Long-term care (LTC) benefits in Arizona are primarily provided by Medicaid, a public health insurance program for low-income individuals. Medicaid in Arizona is administered at the state level by the Arizona Health Care Cost Containment System (AHCCCS), and enrollment is voluntary. Arizona's Medicaid program, including LTC services, is mostly administered through a managed care delivery model.

Eligibility for Medicaid is determined by eligibility tracks that may have different requirements, such as income and asset limits. LTC benefits in Arizona are mostly provided through the Medicaid state plan managed care benefit program (Arizona Long Term Care Services - ALTCS).

ALTCS provides Arizona's LTC services including Nursing Facility Care, Home Health Services, and other services. People covered by ALTCS are able to receive a variety of benefits if deemed medically eligible, such as case management, and Adult Day Health Care (ADHC). State plan benefits are not mutually exclusive, and a beneficiary may receive multiple benefits if eligible. Once a specific state plan benefit is determined to be medically necessary, the beneficiary may immediately receive care. Those applying for ALTCS are not immediately guaranteed HCBS care (excluding Home Health Services), as Arizona capped HCBS services during this policy period.

In order to qualify for ALTCS services a person must meet a nursing facility level of care (NFLOC) based on a comprehensive assessment prior to admission.

**Statutory basis**

Federal Law for Medicaid: 42 U.S.C. 1396-1 to 1396w-5, Title XIX of the Social Security Act (SSA, 2024c)

Arizona Law for Medicaid

- Arizona Administrative Code (A.A.C.), Title 9 - Health Services (AAC, 2024a)

## Financing

**Source of financing**

Funding for Medicaid is split between federal and state financing. The federal government matches state spending for individuals eligible for services and the matching rate is determined by a formula based on a state's per capita income relative to other states, called the Federal Medical Assistance Percentage (FMAP). The federal share for Arizona Medicaid spending on beneficiaries in fiscal year 2001 was 65.77%. See Table 1 for historical FMAPs. The standard FMAP applies to most Medicaid spending, though there are exceptions for certain administrative functions that may receive a higher federal matching rate.

## Coverage

This section discusses the scope of risks covered and the requirements to be eligible for benefits when the need for care arises. Dependence requirements are discussed in the later section on *Benefit Eligibility*.

**Risk covered definition**

Medicaid LTC serves individuals with limited income and assets who need assistance with physical, functional, and cognitive impairments and/or other limitations of daily living that may prevent them from being fully independent. For example, many individuals pursue LTC for assistance with activities of daily living (ADLs), which are fundamental tasks like eating, dressing, and showering. If the beneficiary meets level of care requirements, Medicaid will also pay for 24-hour care in a nursing facility.

**Eligible population**

There exist several LTC benefits and programs under Medicaid, many of which have age or dependence-related eligibility requirements that must be met before service authorization or program enrollment. However, all benefits and programs first require eligibility for Medicaid. Here we detail eligibility for Arizona Medicaid, followed by additional requirements for specific benefits and programs under Medicaid.

Medicaid

States are federally required to provide Medicaid coverage to certain categorical populations, called the mandatory categorically needy. While there are many groups within this track (e.g., pregnant women, children), we only detail eligibility information for categories that are most likely to require LTC (e.g., aged or disabled individuals). Additionally, states may opt in to cover additional categorical populations, called the optional categorically needy. There is substantial variation in who is covered as optional categorically needy across states. Here we detail the eligibility criteria for the most relevant eligibility tracks and coverage groups in Arizona.

Eligibility for Medicaid in Arizona for people needing LTC services is primarily attained by satisfying at least one of 5 alternative eligibility tracks:

Eligibility Track 1: Mandatory Categorically Needy

- 1a. Supplemental Security Income (SSI) recipients
  - Income requirements: Monthly income may not exceed the maximum SSI benefit amount.[1] In 2001, the monthly federal benefit amount was $531 for an individual and $796 for a couple (SSA, 2024a). See Table 2 for historical monthly benefit amounts.
  - Asset requirements: Resources may not exceed $2,000 for an individual and $3,000 for a couple. This standard has remained the same since 1989.
    - Asset transfer: With some exceptions, applicants who dispose of resources or income for less than fair market value on or after the look back date will be subject to a period of ineligibility for LTC services.[7]
  - Citizenship/immigration requirements: The applicant must be an Arizona resident and a U.S. citizen or a qualified non-citizen, such as a lawfully admitted permanent resident, refugee admitted under Section 207 of the Immigration and Nationality Act (INA), or someone granted asylum under Section 208 of the INA —individuals that entered the United States on or after August 22, 1996, are ineligible for SSI and Medicaid for the first 5 years as a lawfully admitted permanent resident. See (SSA, 2024b) for additional information.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.[4]

Eligibility Track 2: Optional Categorically Needy

- 2a. Institutional rules for people receiving LTC
  - Income requirements: Monthly income may not exceed 300% of the monthly federal SSI amount. In 2001, this was $1,593. Income for this track is evaluated independently from the applicant's spouse or other dependents (CMS, 2021). See Table 2 for historical income limits. Additional income disregards exist when a person is institutionalized and has a spouse residing in the community.[10] See Table 3 for historical monthly spousal disregards.
  - Asset requirements: Resources may not exceed $2,000. Assets for this track are evaluated independently from the applicant's spouse or other dependents (CMS, 2021). Additional asset disregards exist when a person is institutionalized and has a spouse residing in the community.[11] See Table 3 for historical monthly spousal disregards.
    - Asset transfer: Same as eligibility track 1a.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be receiving or in need of LTC services through Arizona's LTC program, ALTCS.
    - The applicant must be at least age 65, blind, or disabled.
- 2b. Federal Poverty Level Aged and Disabled
  - Income requirements: Monthly income may not exceed 100% of the monthly federal poverty level (FPL) amount. In 2001, this was $716 for an individual and $967 for a couple. See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.
  - Other requirements
    - The applicant must be at least age 65, blind, or disabled.
- 2c. Affordable Care Act (ACA) Expansion Adults[8]
  - Income requirements: Monthly income may not exceed 100% of the monthly FPL. In 2001, this was $716 for an individual and $967 for a couple. From 2014, Arizona expanded Medicaid under the ACA, increasing the income limits up to 133% of the FPL. See Table 2 for historical income limits.
  - Asset requirements: There is no asset test for this population.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.

  In an effort to reduce costs, Arizona closed new enrollment for this track in 2011. In 2014, Arizona reopened new enrollment for this track under ACA Medicaid expansion with an increased income limit of 133% of the FPL (ABH, 2022).

Eligibility Track 3: Medically Needy

- 3a. Aged, blind, or disabled
  - Income requirements: In order to be eligible under the medically needy track, individuals must "spend down" their excess income over a three month period to be equal to or less than 40% of the FPL after medical expense deductions. In 2001, this was $286 for an individual and $387 for a couple.
  - Asset requirements: Resources may not exceed $100,000 of which no more than $5,000 shall be liquid assets.
  - Citizenship/immigration requirements: Same citizenship requirements as eligibility track 1a.

Most states only provide this eligibility track for those that are aged, blind, or disabled. However, this is not a requirement in Arizona. In 2011, in an effort to control costs, Arizona closed new eligibility for this track and it was not reopened. Those that qualified for this track prior to 2011 and remained eligible are still covered (AAC, 2024).

Other Eligibility Tracks

There exist alternative eligibility tracks targeted at other populations. Some of these tracks include (AAR, 2001):

- Breast and Cervical Cancer program: Implemented in 2001, uninsured women who have been screened for early detection may be eligible for Medicaid.

Once eligibility for Medicaid has been determined, beneficiaries may have to meet additional eligibility criteria in order to become eligible for specific LTC health benefit programs under Medicaid. Additional program criteria (if applicable) is detailed below.

ALTCS

There are no additional conditions for coverage. Benefit qualification depends on minimum level of dependence (this is detailed in the *Benefit eligibility* section of this policy period).

## Benefit

### Home care benefit

Home care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS

ALTCS provides (CFR, 1992b; AAC, 2024a):

- Home Health Services
  - Skilled nursing services: Intermittent or part-time nursing services, such as colostomy and ileostomy care, tracheotomy aspiration, levin tube care, provided by a registered nurse or licensed practical nurse
  - Home health aide services: Semi-skilled care, such as simple wound care, and vital monitoring
- Personal care services
  - Assistance with activities of daily living (ADLs), such as eating, toileting, bathing, grooming, dressing, ambulation, and transferring
  - Assistance with Instrumental ADLs (IADLs), such as personal laundry, light housekeeping, shopping, meal preparation, and medication administration
- Homemaker Services: Assistance in the performance of activities related to household maintenance within a beneficiary's home
- Private Duty Nursing Services - from 2011: Skilled nursing interventions on an individual and ongoing basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent (AAR, 2002).

Personal care services can also be provided to residents who live in Assisted Living Facilities (ALFs).

### Community care

Community care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS

ALTCS provides Adult Day Health Care (ADHC): Centers provide daytime supervision, personal care assistance, and sometimes meals to recipients in a group setting (SLSA, 1991; AAC, 2024a).

### Residential care

Residential care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS

ALTCS covers residential care in a nursing facility (CFR, 1992; AAR, 1997b; AAC, 2024a). Care is provided 24-hours a day in a nursing facility and includes all services necessary to meet patient needs. Services may include the following:

- Physician services
- Room and board
- All general nursing services, including restorative nursing
- Personal hygiene care, such as help with bathing, dressing, grooming, and using the toilet
- Medical supplies and equipment
- Rehabilitative services, including physical, speech, and occupational therapies

### Other benefits

Other care benefits vary by LTC health benefit program. The details of the largest program are summarized below.

ALTCS provides the following services in addition to those offered under the state plan, unless otherwise noted (AAC, 2024a):

- Case management: Services that assist the participant in developing, authorizing, and monitoring the plan of care
- Durable medical equipment and supplies: Items that assist with an illness or injury may include walkers, wheelchairs, suction pumps, bandages, or similar aids —this is a required benefit under Home Health Services

- Non-emergency medical transportation: Medically necessary transportation for any recipient and personal care attendant or escort, if required, who have no other means of transportation available to any Medicaid-compensable service for the purpose of receiving treatment, medical evaluation, or therapy
- Non-medical transportation: Additional coverage of transportation to community services and activities
- Home-delivered meals: Provision of at least one nutritionally sound meal per day to persons who are dependent, aged, or physically disabled and unable to care for their nutritional needs
- Habilitation services: Services that encompass the provision of training in independent living skills or special developmental skills, sensory-motor development, orientation and mobility and behavior intervention. Physical, occupational or speech therapies may be provided as a part of or in conjunction with other habilitation services
- Respite: Services provided to participants unable to care for themselves that are furnished on a short-term basis because of the absence of or need of relief for those persons normally providing care for the participant
- Personal Emergency Response System (PERS): The installation and monitoring of electronic devices that allow enrollees at high risk of institutionalization to secure help in an emergency
- Community transition services: Non-recurring expenses for people who are in the process of transitioning from a nursing facility to a less institutional setting (e.g., case management, financial support for moving expenses)

**Provision of care**

Medicaid benefits may be provided by non-profit organizations, home health agencies, hospitals, nursing facilities, and for-profit providers, all of which are licensed and overseen by the Arizona Department of Health Services. Providers that accept Medicaid payment rates and meet licensing requirements may participate in Medicaid. Arizona uses a managed care delivery model. The AHCCCS manages the ALTCS program through contractors who are responsible for delivering services to beneficiaries.

ALTCS

Skilled nursing services must be provided by a registered nurse. If services are provided through a Medicare certified home health agency, they may also be provided by a licensed practical nurse (AMPM, 2024d).

Home health aide services may be provided by a Health Aide licensed by the Arizona State Board of Nursing through a Medicare Certified home health agency.

Private Duty Nursing Services must be provided by a registered nurse.

Personal care services may be provided by an attendant care worker with at a minimum, hands-on training in First Aid, CPR, Universal Precautions, and state and federal laws regarding privacy of health information (AAR, 2007).

## Benefit eligibility

**Qualifying period**

Potential users may apply at any time.

**Minimum level of dependence**

The minimum level of dependence varies by health benefit program. The details of the largest program are summarized below.

ALTCS

During this policy period, there were two different assessment processes used to determine eligibility. Prior to 2006, applicants were separated into two groups for the medical assessment. From 2006 to 2024, the separate groups were eliminated and every applicant was assessed in the same manner.

Effective policy 2001 to 2005

Applicants must meet an NFLOC as determined by the Preadmission Screening (PAS) (AAR, 1997). There are 3 ways an applicant can be determined to need an NFLOC:

- Any applicant who scores at least 60 total points on the PAS
- An applicant in Group 1 who has a functional score of at least 30, and a medical score of at least 13.
- An applicant in Group 2 who has a functional score of at least 30, and a total score of at least 5 in the orientation section, or an unscaled score of 2 for any single behavior in the emotional and cognitive behavior subsection.

PAS components:

- Medical assessment (Group 1): Table 4

- Medical assessment (Group 2): Table 5
- Functional assessment: Table 6
- Emotional and cognitive functioning assessment: Table 7

The PAS assessment process is detailed further in the *Care needs assessment* section.

Effective policy 2006 to 2024
Applicants must meet an NFLOC as determined by the PAS. Meeting a minimum total score of 60 determines an applicant to need an NFLOC (AAR, 2006). See Table 8 for the PAS from 2006 to 2024.

**Duration of benefit**

Reassessments of eligibility differ by program and service type. Below we detail reassessments for Medicaid, followed by reassessments for the largest program.

Medicaid
Federal law requires states to renew Medicaid eligibility at least every 12 months.

ALTCS
From 2001 to 2003, reassessments using the PAS occured annually for most beneficiaries with some exceptions. See Box 4 for details of these exceptions. Beginning in 2004, reassessments are only performed annually when a benificiary is part of a population identified by the Director of the AHCCCS in a written report as having an increased likelihood of becoming ineligible. The plan of care must be reviewed by a physician every 60 days (AAR, 2001; AAR, 2004).

**Means testing**

In-kind benefits are means-tested. Depending on the eligibility track used to qualify for Medicaid, the income and asset limits may differ. Means testing does not differ by health benefit program beyond the requirements used to qualify for Medicaid.

**Age requirement**

There is no age requirement for Medicaid. Age would only impact the eligibility track used to qualify for Medicaid.

ALTCS
There is no age requirement.

## Care needs assessment

**Definition of dependence**

Definitions of dependence vary depending on the health benefit program. The details are summarized below for the largest program.

ALTCS
During this policy period, there were two different assessment processes used to determine eligibility. Prior to 2006, applicants were separated into two groups for the medical assessment. From 2006 to 2024, the separate groups were eliminated and every applicant was assessed in the same manner.

An applicant must be medically in need of long-term care services as determined by the PAS (PAS, 1992). The PAS has a functional score, and a medical score. The functional score is based of a functional assessment subsection and an emotional and cognitive functioning assessment subsection. The sum of the functional and medical scores equals the total score. The PAS separates applicants into two groups.

Effective policy 2001 to 2005
An applicant must satisfy one of the following pathways to meet the requirements for an NFLOC:

- Any applicant who scores at least 60 total points on the PAS
- An applicant in Group 1 who has a functional score of at least 30, and a medical score of at least 13.
- An applicant in Group 2 who has a functional score of at least 30, and a total score of at least 5 in the orientation section, or an unscaled score of 2 for any single behavior in the emotional and cognitive functioning subsection.

Effective policy 2006 to 2024
A minimum total score of 60 became the only way to qualify for the program. See Table 8 for the PAS from 2006. (AAR, 2006).

**Evaluation of dependence**

Evaluations of dependence vary depending on the health benefit program. The details of the largest program are summarized below.

ALTCS

Upon applying for LTC services, a social worker or registered nurse performs an assessment using the PAS tool for the elderly or physically disabled (EPD) person (AAR, 1997). The tool is used to assess the functional, medical, nursing and social needs of the applicant. Meeting or exceeding the threshold score of 60 total points on this screening tool establishes initial eligibility for an NFLOC. A combination of weighted functional and medical factors are evaluated and assigned a numerical value to reach totaled scores. The threshold score, or point at which an individual becomes eligible, is determined by a formula using those scores.

The ALTCS PAS assessment consists of two scored sections:

- A functional score based on the functional assessment and the emotional and cognitive functioning assessment.
- A medical score based on the medical assessment.
- The total score is the sum of the functional and medical scores.

Effective policy 2001 to 2005

The medical score was dependent upon which Group (1 or 2) an applicant was assigned. This assignment was based on the individual's diagnoses and was designated as follows:

- Group 1 includes an applicant or member diagnosed with paralysis, head trauma, multiple sclerosis, amyotrophic lateral sclerosis, or Parkinson's disease, and anyone not in Group 2.
- Group 2 includes an applicant or member diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome.

PAS components:

- Medical assessment (Group 1): Table 4
- Medical assessment (Group 2): Table 5
- Functional assessment: Table 6
- Emotional and cognitive functioning assessment: Table 7

See Box 2 for a narrative example of an assessment for Group 1, and Box 3 for a narrative example of an assessment for Group 2.

Effective policy 2006 to 2024

Arizona eliminated the separate scoring methodologies for Groups 1 and 2 and all applicants were assessed using the same PAS tool. Meeting a minimum total score of 60 on the PAS became the only way to qualify for the program. See Table 8 for scoring methodology from 2006 (AAR, 2006).

**Evaluators**

Evaluators vary by health benefit program. The details of the largest program are summarized below.

ALTCS

The PAS is completed by a registered nurse or social worker (AAR, 2001).

## Benefit limitations

**Can you mix LTC benefits?**

All Arizona Medicaid beneficiaries receive the state plan benefit package. Some beneficiaries, if eligible, may also enroll in the ALTCS program. Beneficiaries may not duplicate services across programs.

**Is there free choice between cash and benefits in-kind?**

The LTC system does not offer a cash benefit.

**Can you receive LTC benefits with other public benefits?**

It is possible to receive LTC benefits along with other benefits, such as SSI and Supplemental Nutrition Assistance Program (SNAP).

## User costs

### User charges

User charges vary by LTC health benefit program. Below we detail user charges for Medicaid, followed by user charges for the largest program.

Medicaid

As required by federal law, Arizona enforces Estate Recovery. The acceptance of Medicaid in Arizona creates a debt to the state agency in the total amount paid to or for the benefit of the recipient for medical assistance after the recipient reached 55 years of age or was permanently institutionalized. Upon the death of the recipient, the state agency may recover the debt by filing a statement of claim against the estate of the deceased Medicaid recipient. However, the debt will not be enforced if the recipient is survived by a spouse, child or children under 21 years of age, or a child or children who are blind or disabled (SLSA, 1987).

ALTCS

Beneficiaries in an institution for more than 30 days are expected to contribute all of their income to the cost of care in a nursing home, except for a monthly personal needs allowance of 15% of the SSI federal benefit amount and any funds protected by the spousal impoverishment rules. See Table 3 for historical spousal impoverishment standards. Beneficiaries in an institution for less than 30 days have a personal needs allowance of 300% of the SSI federal benefit rate. See Table 2 for historical monthly benefit amounts (SLSA, 1991; AAR, 1999; AAC, 2024a).

### Taxation of benefits

In-kind benefits are not subject to taxation.

## Tables and Formulas

**Table 1: Arizona Federal Medical Assistance Percentage (FMAP) for Medicaid (1992-2024)**

| Fiscal Year | FMAP |
|---|---|
| 1992 | 62.61% |
| 1993 | 65.89 |
| 1994 | 65.90 |
| 1995 | 66.40 |
| 1996 | 65.85 |
| 1997 | 65.53 |
| 1998 | 65.33 |
| 1999 | 65.50 |
| 2000 | 65.92 |
| 2001 | 65.77 |
| 2002 | 64.98 |
| 2003 | 68.73 |
| 2004 | 69.47 |
| 2005 | 67.45 |
| 2006 | 66.98 |
| 2007 | 66.47 |
| 2008 | 66.20 |
| 2009 | 75.47 |
| 2010 | 75.93 |
| 2011 | 71.50 |
| 2012 | 67.30 |
| 2013 | 65.68 |
| 2014 | 67.23 |
| 2015 | 68.46 |
| 2016 | 68.92 |
| 2017 | 69.24 |
| 2018 | 69.89 |
| 2019 | 69.81 |
| 2020 | 74.67 |
| 2021 | 76.21 |
| 2022 | 76.21 |
| 2023[1] | 74.54 |
| 2024 | 66.67 |

**Source:** U.S. DHHS (2023)

**Notes:** FMAPs displayed here apply to the federal fiscal year indicated unless otherwise noted, which runs from October 1 through September 30. For example, FY 2022 refers to the period from October 1, 2021 through September 30, 2022. FY 2020, FY 2021, FY 2022, and FY 2023 FMAPs reflect higher federal matching funding (6.2 percent increase in FMAP rates for all states) made available through the Families First Coronavirus Response Act for the duration of the public health emergency period. [1] The enhanced FMAP decreased from 6.2 to 5 percentage points from April to June 2023, 2.5 percentage points from June to September 2023, and 1.5 percentage points from October to December 2023.

**Table 2: Arizona Medicaid Income Limits (1992-2024)**

| Year | SSI (Individual) | SSI (Couple) | 300% SSI (Individual) | 300% SSI (Couple) | 138% FPL (Individual) | 138% FPL (Couple) |
|---|---|---|---|---|---|---|
| 1992 | $422.00 | $633.00 | $1266.00 | $1899.00 | | |
| 1993 | 434.00 | 652.00 | 1302.00 | 1956.00 | | |
| 1994 | 446.00 | 669.00 | 1338.00 | 2007.00 | | |
| 1995 | 458.00 | 687.00 | 1374.00 | 2061.00 | | |
| 1996 | 470.00 | 705.00 | 1410.00 | 2115.00 | | |
| 1997 | 484.00 | 726.00 | 1452.00 | 2178.00 | | |
| 1998 | 494.00 | 741.00 | 1482.00 | 2223.00 | | |
| 1999 | 500.00 | 751.00 | 1,500.00 | 2,223.00 | | |
| 2000 | 513.00 | 769.00 | 1,539.00 | 2,307.00 | | |
| 2001 | 531.00 | 796.00 | 1,593.00 | 2,388.00 | | |
| 2002 | 545.00 | 817.00 | 1,635.00 | 2,451.00 | | |
| 2003 | 552.00 | 829.00 | 1,656.00 | 2,487.00 | | |
| 2004 | 564.00 | 846.00 | 1,692.00 | 2,538.00 | | |
| 2005 | 579.00 | 869.00 | 1,737.00 | 2,607.00 | | |
| 2006 | 603.00 | 904.00 | 1,809.00 | 2,712.00 | | |
| 2007 | 623.00 | 934.00 | 1,869.00 | 2,802.00 | | |
| 2008 | 637.00 | 956.00 | 1,911.00 | 2,868.00 | | |
| 2009 | 674.00 | 1,011.00 | 2,022.00 | 3,033.00 | | |
| 2010 | 674.00 | 1,011.00 | 2,022.00 | 3,033.00 | | |
| 2011 | 674.00 | 1,011.00 | 2,022.00 | 3,033.00 | | |
| 2012 | 698.00 | 1,048.00 | 2,094.00 | 3,144.00 | | |
| 2013 | 710.00 | 1,066.00 | 2,130.00 | 3,198.00 | | |
| 2014 | 721.00 | 1,082.00 | 2,163.00 | 3,246.00 | $1,341.00 | $1,809.00 |
| 2015 | 733.00 | 1,100.00 | 2,199.00 | 3,300.00 | 1,354.00 | 1,833.00 |
| 2016 | 733.00 | 1,100.00 | 2,199.00 | 3,300.00 | 1,366.00 | 1,842.00 |
| 2017 | 735.00 | 1,103.00 | 2,205.00 | 3,309.00 | 1,387.00 | 1,867.00 |
| 2018 | 750.00 | 1,125.00 | 2,250.00 | 3,375.00 | 1,397.00 | 1,893.00 |
| 2019 | 771.00 | 1,157.00 | 2,313.00 | 3,471.00 | 1,437.00 | 1,944.00 |
| 2020 | 783.00 | 1,175.00 | 2,349.00 | 3,525.00 | 1,467.00 | 1,983.00 |
| 2021 | 794.00 | 1,191.00 | 2,382.00 | 3,573.00 | 1,481.00 | 2,004.00 |
| 2022 | 841.00 | 1,261.00 | 2,523.00 | 3,783.00 | 1,564.00 | 2,106.00 |
| 2023 | 914.00 | 1,371.00 | 2,742.00 | 4,113.00 | 1,677.00 | 2,267.00 |
| 2024 | 943.00 | 1,415.00 | 2,829.00 | 4,245.00 | 1,732.00 | 2,350.00 |

**Source:** SSA (2023b); CMS (2024)

**Notes:** Income limits for individuals and couples are monthly. Income limits at 138% of the FPL began in 2014 respectively, corresponding to Ohio's implementation of eligibility track 2c. Affordable Care Act (ACA) Expansion Adults.

**Table 3: Federal Spousal Impoverishment Standards (1992-2024)**

| Year | Minimum MMNA | Maximum MMNA | Minimum CSRA | Maximum CSRA |
|---|---|---|---|---|
| 1992 | $984.20 | $1,718.00 | $13,740.00 | $68,700.00 |
| 1993 | 1,148.75 | 1,769.00 | 14,148.00 | 70,740.00 |
| 1994 | 1,178.75 | 1,817.00 | 14,532.00 | 72,660.00 |
| 1995 | 1,230.00 | 1,871.00 | 14,964.00 | 74,820.00 |
| 1996 | 1,253.75 | 1,919.00 | 15,348.00 | 76,740.00 |
| 1997 | 1,295.00 | 1,976.00 | 15,804.00 | 79,020.00 |
| 1998 | 1,326.25 | 2,019.00 | 16,152.00 | 80,760.00 |
| 1999 | 1,356.25 | 2,049.00 | 16,392.00 | 81,960.00 |
| 2000 | 1,382.50 | 2,103.00 | 16,824.00 | 84,120.00 |
| 2001 | 1,406.25 | 2,175.00 | 17,400.00 | 87,000.00 |
| 2002 | 1,451.25 | 2,232.00 | 17,856.00 | 89,280.00 |
| 2003 | 1,492.50 | 2,266.50 | 18,132.00 | 90,660.00 |
| 2004 | 1,515.00 | 2,319.00 | 18,552.00 | 92,760.00 |
| 2005 | 1,561.25 | 2,377.50 | 19,020.00 | 95,100.00 |
| 2006 | 1,603.75 | 2,488.50 | 19,908.00 | 99,540.00 |
| 2007 | 1,650.00 | 2,541.00 | 20,328.00 | 101,640.00 |
| 2008 | 1,711.25 | 2,610.00 | 20,880.00 | 104,400.00 |
| 2009 | 1,750.00 | 2,739.00 | 21,912.00 | 109,560.00 |
| 2010 | 1,821.25 | 2,739.00 | 21,912.00 | 109,560.00 |
| 2011 | 1,821.25 | 2,739.00 | 21,912.00 | 109,560.00 |
| 2012 | 1,838.75 | 2,841.00 | 22,728.00 | 113,640.00 |
| 2013 | 1,891.25 | 2,898.00 | 23,184.00 | 115,920.00 |
| 2014 | 1,938.75 | 2,931.00 | 23,448.00 | 117,240.00 |
| 2015 | 1,966.25 | 2,980.50 | 23,844.00 | 119,220.00 |
| 2016 | 2,002.50 | 2,980.50 | 23,844.00 | 119,220.00 |
| 2017 | 2,002.50 | 3,022.50 | 24,180.00 | 120,900.00 |
| 2018 | 2,030.00 | 3,090.00 | 24,720.00 | 123,600.00 |
| 2019 | 2,057.50 | 3,160.50 | 25,284.00 | 126,420.00 |
| 2020 | 2,113.75 | 3,216.00 | 25,728.00 | 128,640.00 |
| 2021 | 2,155.00 | 3,259.50 | 26,076.00 | 130,380.00 |
| 2022 | 2,177.50 | 3,435.00 | 27,480.00 | 137,400.00 |
| 2023 | 2,288.75 | 3,715.50 | 29,724.00 | 148,620.00 |
| 2024 | 2,465.00 | 3,853.50 | 30,828.00 | 154,140.00 |

**Source:** CMS (2024)

**Notes:** State sources were not found for all years, but they are subject to the federal minimum and maximum standards. Federal law requires states to set the minimum monthly maintenance needs allowance (MMNA) standard at 150% of the federal poverty level (FPL) for a couple, increasing each year with inflation, except for FY 1992, which was set at 133% of the FPL. MMNAs are calculated using FPLs for each year and are validated by state and federal sources. Some states round to the dollar, which may lead to minor variations between the calculated federal amounts and state-specific standards. For Community Spouse Resource Allowances (CSRAs), the minimum was set at $12,000 and the maximum at $60,000 as of September 30, 1989, increasing each year with inflation. CSRAs are calculated using the Consumer Price Index for urban consumers (CPI-U).

**Table 4: Arizona Preadmission Screening (PAS) Medical Assessment Group 1 (1992-2005)**

| Assessment | Number of Points Available per Question | Weight | Range of Possible Weighted Score per Question |
|---|---|---|---|
| Paralysis/Sclerosis | 0-1 | 3.00 | 0-3.0 |
| Alzheimer's/OBS/Dementia | 0-1 | 3.50 | 0-3.5 |
| Physical Therapy | 0-1 | 0.50 | 0-0.5 |
| Occupational Therapy | 0-1 | 0.50 | 0-0.5 |
| Speech Therapy | 0-1 | 0.50 | 0-0.5 |
| Suctioning | 0-1 | 1.50 | 0-1.5 |
| Oxygen | 0-1 | 1.50 | 0-1.5 |
| Small Volume Nebulizer | 0-1 | 1.50 | 0-1.5 |
| Tracheostomy Care | 0-1 | 1.50 | 0-1.5 |
| Postural Drainage | 0-1 | 1.50 | 0-1.5 |
| Respiratory Therapy | 0-1 | 1.50 | 0-1.5 |
| Drug Regulation | 0-1 | 2.00 | 0-2.0 |
| Decubitus Care | 0-1 | 3.00 | 0-3.0 |
| Wound Care | 0-1 | 3.00 | 0-3.0 |
| Ostomy Care | 0-1 | 3.00 | 0-3.0 |
| Feedings-Tube and/or Parenteral | 0-1 | 3.00 | 0-3.0 |
| Catheter Care | 0-1 | 3.00 | 0-3.0 |
| Other Ostomy Care | 0-1 | 3.00 | 0-3.0 |
| Dialysis | 0-1 | 3.00 | 0-3.0 |
| Fluid Intake/Output | 0-1 | 3.00 | 0-3.0 |
| Teaching/Training Program | 0-1 | 4.00 | 0-4.0 |
| Bowel/Bladder Program | 0-1 | 4.00 | 0-4.0 |
| Range of Motion | 0-1 | 4.00 | 0-4.0 |
| Other Rehabilitative Nursing | 0-1 | 4.00 | 0-4.0 |
| Restraints | 0-1 | 4.00 | 0-4.0 |

**Source:** AAR (1997)
**Notes:** An unweighted (raw) score of 0 indicates no diagnosis or medical treatment for that item. An unweighted score of 1 indicates a medical diagnosis or treatment for that item.

**Table 5: Arizona Preadmission Screening (PAS) Medical Assessment Group 2 (1992-2005)**

| Assessment | Number of Points Available per Question | Weight | Range of Possible Weighted Score per Question |
|---|---|---|---|
| Alzheimer's/OBS/Dementia | 0-1 | 3.50 | 0-3.5 |
| Drug Regulation | 0-1 | 2.00 | 0-2.0 |
| Teaching/Training Program | 0-1 | 6.00 | 0-6.0 |
| Bowel/Bladder Program | 0-1 | 6.00 | 0-6.0 |
| Range of Motion | 0-1 | 6.00 | 0-6.0 |
| Other Rehabilitative Nursing | 0-1 | 6.00 | 0-6.0 |
| Restraints (Physical/Chemical) | 0-1 | 16.00 | 0-16.0 |

**Source:** AAR (1997)
**Notes:** An unweighted (raw) score of 0 indicates no diagnosis or medical treatment for that item. An unweighted score of 1 indicates a medical diagnosis or treatment for that item.

**Table 6: Arizona Preadmission Screening (PAS) Functional Assessment subsection (1992-2005)**

| Assessment | Number of Points Available per Question | Weight | Range of Possible Weighted Score per Question |
|---|---|---|---|
| Bathing | 0-5 | 3.00 | 0-15 |
| Dressing | 0-5 | 3.00 | 0-15 |
| Grooming | 0-5 | 3.00 | 0-15 |
| Mobility | 0-5 | 3.00 | 0-15 |
| Toileting | 0-5 | 3.00 | 0-15 |
| Eating | 0-6 | 2.50 | 0-15 |
| Transferring | 0-4 | 3.75 | 0-15 |
| Bowel Continence | 0-2 | 0.00 | 0.00 |
| Bowel Continence | 3 | 0.167 | 0.50 |
| Bladder Continence | 0-4 | 0.50 | 0-2.0 |
| Vision | 0-1 | 0.00 | 0.00 |
| Vision | 2 | 1.75 | 3.5 |
| Vision | 3 | 1.167 | 3.5 |

**Source:** AAR (1997)
**Notes:** The lowest value in the range of points available per question indicates minimal or no impairment, and conversely, the highest value indicates severe impairment.

**Table 7: Arizona Preadmission Screening (PAS) Emotional and Cognitive Functioning subsection (1992-2005)**

| Assessment | Number of Points Available per Question | Weight | Range of Possible Weighted Score per Question |
|---|---|---|---|
| Orientation: Person | 0-3 | 1.00 | 0-3.0 |
| Orientation: Place | 0-3 | 1.00 | 0-3.0 |
| Orientation: Time | 0-3 | 1.00 | 0-3.0 |
| Aggressive Behavior | 0-3 | 1.00 | 0-3.0 |
| Self-Injurious Behavior | 0-3 | 1.00 | 0-3.0 |
| Suicidal Behavior | 0-3 | 1.00 | 0-3.0 |
| Wandering Behavior | 0-3 | 1.00 | 0-3.0 |
| Disruptive Behavior | 0-3 | 3.00 | 0-9.0 |

**Source:** AAR (1997)
**Notes:** The lowest value in the range of points available per question indicates minimal or no impairment, and conversely, the highest value indicates severe impairment.

**Box 1: Reassessment of ALTCS eligibility (1997-2001)**

Reassessments for ALTCS eligibility occurs every other year for the following beneficiaries:

- Individuals 80 years of age and older who have been eligible for two consecutive years
- Individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome who have been eligible for 2 consecutive years
- Individuals who have been eligible for two consecutive years and have had a SNF-2 level of care on their last two PAS assessments. A SNF-2 level of care is met with the following PAS scores:
    1. Group 1 and a total score of at least 140, and a functional score of at least 86, an a medical score greater than 17
    2. Group 1 and a functional score of from 86 to 99.99, and two of the services listed below in 5
    3. Group 1 and a functional score of at least 100 and one service listed below in 5
    4. Group 2 and a functional score from 100 to 119.99 and two services listed below in 5
    5. Group 2 and a functional score of at least 120 and one of the services listed below
        - ◇ IV Therapy
        - ◇ Decubitus care
        - ◇ Wound care
        - ◇ Parenteral feeding
        - ◇ Tube feeding
        - ◇ Ostomy care
        - ◇ Suctioning
        - ◇ Tracheostomy care

**Source:** AAR (1997); EPM (2006)

**Box 2: Preadmission Screening (PAS) assessment. Group 1 example (1992 - 2005)**

In order to be determined eligible for Arizona Long-Term Care Services (ALTCS), applicants must meet a Nursing Facility Level of Care (NFLOC) using the Preadmission Screening (PAS) assessment. AN NFLOC is met if the applicant is one of the following:

1. Any applicant who scores at least 60 total points on the PAS
2. An applicant in Group 1 who has a functional score of at least 30, and a medical score of at least 13.
3. An applicant in Group 2 who has a functional score of at least 30, and a total score of at least 5 in the orientation section, or an unweighted (raw) score of at least 2 for at least one behavior in the emotional/cognitive behavior subsection.

For example, suppose 67-year-old George is assessed in 1998. George is not diagnosed with organic brain syndrome (OBS), Alzheimer's disease, or dementia, which puts him in Group 1 for the medical assessment subsection of the PAS. We can calculate George's unweighted score as follows:

- Functional assessment: needs some hands-on physical assistance in 3 items (2 points x 3 items = 6 points) and needs extensive hands-on physical assistance in 1 item (4 points x 1 item = 4 points)
  - Some hands-on physical assistance: bathing, dressing, and grooming
  - Extensive hands-on physical assistance: mobility
- Emotional and cognitive functioning assessment: no emotional or cognitive problems (0 points)
- Medical assessment: diagnosis/treatment in 5 items (1 point x 5 items = 5 points)
  - Treatments: oxygen, respiratory therapy, wound care, dialysis, and range of motion

He scores 10 points on the functional assessment subsection (10 items), 0 points on the emotional and cognitive functioning subsection (8 items), and 5 points on the medical assessment (25 items).

Bathing, dressing, grooming, and mobility have weights of 3. Oxygen and respiratory therapy have weights of 1.5. Wound care and dialysis have weights of 3. Range of motion has a weight of 4. Using these weights we can convert George's raw score to the following scores:

- Functional assessment: 10 points (raw score) →30 points (weighted score)
- Emotional and cognitive assessment: 0 points
- Medical assessment: 5 points (raw score) →13 points (weighted score)

George's total score is 43 points, which is less than threshold 1 (60 total points). However, because he is in Group 1, the 30 point functional score and 13 point medical score qualifies him for an NFLOC.

**Source:** AAR (1997)
**Notes:** See Table 6 for the functional assessment subsection, Table 7 for the emotional and cognitive functioning subsection, and Table 4 for the Group 1 Medical Assessment

**Box 3: Preadmission Screening (PAS) assessment. Group 2 example (1992 - 2005)**

In order to be determined eligible for Arizona Long-Term Care Services (ALTCS), applicants must meet a Nursing Facility Level of Care (NFLOC) using the Preadmission Screening (PAS) assessment. An NFLOC is met if the applicant is one of the following:

1. Any applicant who scores at least 60 total points on the PAS
2. An applicant in Group 1 who has a functional score of at least 30, and a medical score of at least 13.
3. An applicant in Group 2 who has a functional score of at least 30, and a total score of at least 5 in the orientation section, or an unweighted (raw) score of at least 2 for at least one behavior in the emotional/cognitive behavior subsection.

For example, suppose 65-year-old Lorraine is assessed in 1996. She was diagnosed with Alzheimer's disease, which puts her in Group 2 for the medical assessment subsection of the PAS. We can calculate Lorraine's unweighted score as follows:

- Functional assessment: needs some hands-on physical assistance in 2 items (2 points x 2 items = 4 points) and needs extensive hands-on physical assistance in 1 item (4 points x 1 item = 4 points)
  - Some hands-on physical assistance: grooming, and toileting
  - Extensive hands-on physical assistance: bathing
- Emotional and cognitive functioning assessment: disoriented occasionally in 3 items (1 point x 3 items = 3 points) and occurs frequently and requires intervention in one behavior (2 points x 1 item = 2 points)
  - Disoriented occasionally: person, place, and time
  - Occurs frequently and requires intervention: disruptive behavior
- Medical assessment: Alzheimer's diagnosis (1 point x 1 item = 1 point)

She scores 8 points on the functional assessment subsection (10 items), 5 points on the emotional and cognitive functioning subsection (8 items), and 1 point on the medical assessment (7 items).

Bathing, grooming, and toileting have weights of 3. Each orientation has a weight of 1. Disruptive behavior has a weight of 3. Alzheimers diagnosis has a weight of 3.5. With these weights we can Lorraine's raw scores are converted into the following scores:

- Functional assessment: 8 points (raw score) →24 points (weighted score)
- Emotional and cognitive assessment: 5 points (raw score) →9 points (weighted score)
- Medical assessment: 1 points (raw score) →3.5 points (weighted score)

Lorraine's total score is 36.5 points, which is less than threshold 1 (60 total points). However, because she is in Group 2, the 33 point functional score (functional assessment subsection plus emotional/cognitive assessment subsection) and the unweighted score of 2 on disruptive behavior qualifies her for an NFLOC.

**Source:** AAR (1997)
**Notes:** See Table 6 for the functional assessment subsection, Table 7 for the emotional and cognitive functioning subsection, and Table 5 for the Group 2 Medical Assessment

**Table 8: Arizona Preadmission Screening (PAS) Assessment (2006-2024)**

| Assessment | Number of Points Available per Question | Weight | Range of Possible Weighted Score per Question |
|---|---|---|---|
| Mobility | 0-3 | 5.00 | 0-15.0 |
| Transferring | 0-3 | 5.00 | 0-15.0 |
| Bathing | 0-3 | 5.00 | 0-15.0 |
| Dressing | 0-3 | 5.00 | 0-15.0 |
| Grooming | 0-3 | 5.00 | 0-15.0 |
| Eating | 0-3 | 5.00 | 0-15.0 |
| Toileting | 0-3 | 5.00 | 0-15.0 |
| Bowel Continence | 0-3 | 1.00 | 0-3.0 |
| Bladder Continence | 0-3 | 1.00 | 0-3.0 |
| Vision | 0-3 | 2.00 | 0-6.0 |
| Orientation: Place | 0-4 | 0.50 | 0-2.0 |
| Orientation: Time | 0-4 | 0.50 | 0-2.0 |
| Wandering: Frequency of Behavior | 0-3 | 1.50 | 0-4.5 |
| Wandering: Intensity of Intervention | 0-3 | 1.50 | 0-4.5 |
| Salf Injury: Frequency of Behavior | 0-3 | 1.50 | 0-4.5 |
| Self-Injury: Intensity of Intervention | 0-3 | 1.50 | 0-4.5 |
| Aggression: Frequency of Behavior | 0-3 | 1.50 | 0-4.5 |
| Aggression: Intensity of Intervention | 0-3 | 1.50 | 0-4.5 |
| Resistive: Frequency of Behavior | 0-3 | 1.50 | 0-4.5 |
| Resistive: Intensity of Intervention | 0-3 | 1.50 | 0-4.5 |
| Disruptive: Frequency of Behavior | 0-3 | 1.50 | 0-4.5 |
| Disruptive: Intensity of Intervention | 0-3 | 1.50 | 0-4.5 |
| Alzheimer's/Dimentia Diagnosis | 0-1 | 20.0 | 0-20.0 |
| Paralysis Diagnosis | 0-1 | 6.50 | 0-6.5 |
| Use of Oxygen | 0-1 | 5.00 | 0-5.0 |

**Source:** PAS Manual for the Elderly and Physically Disabled (2006)

**Notes:** The lowest value in the range of points available per question indicates minimal or no impairment, and conversely, the highest value indicates severe impairment.

**Box 4: Reassessment of ALTCS eligibility (2001-2003)**

Reassessments for ALTCS eligibility occurs every four years for the following beneficiaries:

- Individuals at leat 80 years of age who have been eligible for at least two consecutive years
- Individuals diagnosed with Alzheimer's disease, dementia, or an organic brain syndrome who have been eligible for at least 2 consecutive years
- Individuals who have been continuously institutionalized for at least three years, and have been eligible for at least three consecutive years
- Individuals who have been eligible for two consecutive years and have had a SNF-2 level of care on their last two PAS assessments. A SNF-2 level of care is met with the following PAS scores:
    1. Group 1 and a total score of at least 140, and a functional score of at least 86, and a medical score greater than 17
    2. Group 1 and a functional score of from 86 to 99.99, and two of the services listed below in 5
    3. Group 1 and a functional score of at least 100 and one service listed below in 5
    4. Group 2 and a functional score from 100 to 119.99 and two services listed below in 5
    5. Group 2 and a functional score of at least 120 and one of the services listed below
        - IV Therapy
        - Decubitus care
        - Wound care
        - Parenteral feeding
        - Tube feeding
        - Ostomy care
        - Suctioning
        - Tracheostomy care

Reassessments for ALTCS eligibility occurs every other year for individuals who have been eligible for at least two consecutive years, have had at least three assessments, and have scored 20 or more points on the last assessment.

**Source:** AAR (1997); AZEPM (2006)

**Notes:** From 2004, reassessments are only performed annually when a beneficiary is part of a population identified by the Director of the AHCCCS in a written report as having an increased likelihood of becoming ineligible.

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## Glossary of terms

This section summarizes key definitions from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: “Alt” + “←”; In Adobe Acrobat on a MAC: “command” + “←”; In Preview on a MAC: “command” + “[”.

**Activities of Daily Living (ADLs)**: Tasks performed on a daily basis that are considered necessary to live independently, including bathing or showering, dressing, toileting, eating, and transferring (mobility).

**Adult Day Health Care (ADHC)**: A community-based long-term care benefit that provides comprehensive health care services in a congregate day setting. Services include nursing, case management, clinical management, medical, diagnostic, social, rehabilitative, recreational and personal care services on a routine or daily basis. Services are provided according to the assessed needs of the beneficiary.

**Affordable Care Act (ACA)**: The Patient Protection and Affordable Care Act (ACA) made a number of changes to Medicaid, most notably is the expansion of eligibility to adults with incomes up to 133 percent of the federal poverty level (FPL). Originally a requirement, the June 2012 Supreme Court ruling in National Federation of Independent Business v. Sebelius effectively made the Medicaid expansion an option. To date, over three-quarters of states have opted to expand.

**Arizona Health Care Cost Containment System (AHCCCS)**: AHCCCS is Arizona's single state agency that administers the state Medicaid program. AHCCCS was established in 1981 as a division of the Arizona Department of Health Services. In 1984 it became an independent state agency.

**Arizona Long Term Care System (ALTCS)**: Arizona's comprehensive state plan program for individuals who have an age related and/or physical disability and who require nursing facility level of care. Services may be provided in an institution or HCBS setting.

**Assisted Living Facility (ALF)**: A group residence that provides consistent care to older adults (e.g., personal care) that do not require the type of care provided in a nursing facility.

**Community Spouse Resource Allowance (CSRA)**: Amount of countable assets a spouse residing in the community can retain if their spouse is institutionalized or requires home and community-based long-term care.

**Community Transition Service**: Non-recurring expenses for people who are in the process of transiitoning form a nursing facility to a less institutional setting. This includes services such as case management and support for moving expenses. Arizona added this benefit to ALTCS in 1995.

**Consumer-directed personal care services**: Personal care services provided by an aide that is hired and managed by the recipient.

**Eligibility Track 1a. Supplemental Security Income (SSI) Recipients**: Mandatory coverage group under Medicaid that generally automatically results in Medicaid coverage for individuals that receive SSI, a federal cash assistance benefit for aged, blind, and disabled individuals with low income and assets.

**Eligibility Track 2a. Institutional Rules for people receiving LTC**: Optional coverage group under Medicaid that allows for expanded income limits, up to 300 percent of the federal poverty level, for individuals that are in an institution or who medically qualify for placement in an institution and are instead receiving home and community-based services (HCBS). Federal terminology separates the institutional and HCBS populations into two coverage groups: Individuals receiving HCBS under Institutional Rules, and Institutional Individuals Eligible under a Special Income Level. This is because some states do not extend this income limit to both coverage groups. For ease, we have combined the two groups under a single track, as regardless of whether it applies only to institutional care or extends to HCBS, the eligibility track uses institutional standards, e.g., institutional income/asset limits including spousal impoverishment disregards, as well as dependence requirements (NFLOC). It will be clearly noted in policy documents when a state does not extend this income limit to both populations.

**Eligibility Track 2b. Federal Poverty Level Aged and Disabled**: Optional coverage group under Medicaid that allows for expanded income limits, up to 100 percent of the federal poverty level, for individuals that are at least age 65 or disabled.

**Eligibility Track 2c. Affordable Care Act (ACA) Expansion Adults**: Optional coverage group under Medicaid that allows for expanded income and asset limits for individuals ages 19-64 who are ineligible for Medicaid through any other group. States that choose to cover this group may cover adults up to 138 percent of the federal poverty level. There is no asset test for this population. Prior to the ACA, Arizona had an earlier version of this track that expanded the income limit to 100

**Eligibility Track 3a. Medically Needy Aged, Blind, or Disabled**: Optional coverage group under Medicaid for individuals who would qualify for Medicaid under a different track if not for excess income. This track allows these applicants to "spend down" their excess income on medical bills and other related expenses in order to become eligible for coverage. Arizona calls this the Medical Expense Deduction (MED) eligibility track.

**Eligibility Tracks**: Requirements for an individual to qualify for Medicaid and start receiving long-term care benefits. An individual must satisfy only one eligibility track to qualify for Medicaid.

**Estate Recovery**: State Medicaid programs must recover certain Medicaid benefits paid on behalf of a Medicaid enrollee. For individuals age 55 or older, states are required to seek recovery of payments from the individual's estate for nursing facility services, home and community-based services, and related hospital and prescription drug services. States may not recover from the estate of a deceased Medicaid enrollee who is survived by a spouse, child under age 21, or blind or disabled child of any age.

**Federal Medical Assistance Percentage (FMAP)**: The percentage of Medicaid payments that the federal government pays as a share of both federal and state government payments for Medicaid services. The FMAP is computed from a formula that takes into account the average per capita income for each State relative to the national average. The minimum FMAP is 50 percent. The standard FMAP applies to most Medicaid spending on benefits, while the administrative rate nationwide is 50 percent with exceptions for some administrative activities such as training and compensation of skilled professionals (75 percent) and preadmission screening and resident review (75 percent).

**Federal Poverty Level (FPL)**: Poverty threshold established by the Department of Health and Human Services (HHS) for administrative purposes, such as determining financial eligibility for federal programs. The Federal Poverty Level (FPL) is determined annually for different household sizes and financial eligibility for a program is generally a percentage of the FPL (e.g., 100 percent of the FPL), meaning households with annual/monthly income at or below 100 percent of the FPL would qualify based on financial eligibility.

**Group 1**: Individuals in Group 1 of the ALTCS Preadmission screening (PAS) for the Elderly and Physically Disabled consist of applicants with a diagnosis of paralysis, head trauma, multiple sclerosis (MS), amyotrophic lateral sclerosis (ALS) or Parkinson's disease, and anyone not in Group 2. Arizona used two separate groups for the medical assessment portion of the PAS from 1992-2006.

**Group 2**: Individuals in Group 2 of the ALTCS Preadmission screening (PAS) for the Elderly and Physically Disabled consist of applicants with a diagnosis of organic brain syndrome, Alzheimer's disease or dementia. Arizona used ttwo separate groups for the medical assessment portion of the PAS from 1992-2006.

**Home Health Aide Services**: Home health aides assist with personal care as well as some semi-skilled tasks, such as observing vital signs, administering medication under the direction of a nurse, and more.

**Home Health Services**: Medicaid health benefit program that provides services in the patient's home to promote, maintain, or restore health or lessen the effects of illness and disability. Services may include part-time or intermittent nursing care, speech, physical and occupational therapies, and home health aide services (personal care and semi-skilled tasks such as ostomy care). This service also includes medical equipment and supplies if medically necessary.

**Home Modifications**: physical modifications that have a specific adaptive purpose aimed at increasing the member's ability to function with greater independence in his or her own home thus reducing the risk of institutionalization. Arizona added this benefit to ALTCS in 1996.

**Home-and Community-Based Services (HCBS)**: Services designed to assist individuals in a home or community setting, such as an adult day center. HCBS are often designed to enable people to stay in their homes in lieu of nursing home admission.

**Instrumental Activities of Daily Living (IADLs)**: Tasks related to independent living including preparing meals, managing money, shopping for groceries, performing housework, and using a telephone.

**Managed Care Organization (MCO)**: Health plans that administer Medicaid services and contract with providers to deliver services. MCOs receive a capitated per member per month fee from the state and reimburse providers for services enrollees receive.

**Managed Care**: A health care delivery system organized to manage cost, utilization, and quality. Under Medicaid, managed care provides for the delivery of state plan services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept a set per member per month (capitation) payment for these services.

**Mandatory Categorically Needy**: An eligibility track that states are required to cover under Medicaid. This track encompasses several categorical groups, including individuals receiving SSI, pregnant women, and some children.

**Medicaid State Plan**: Every state has a Medicaid State Plan, a comprehensive document that outlines the amount, scope, and duration of all services offered under the State's standard benefit package. All beneficiaries may receive all services in the standard benefit

package (e.g., personal care, home health), however, benefit programs may have varying eligibility criteria (e.g., level of dependence). If eligible, some beneficiaries may enroll in an HCBS program. HCBS program enrollees may receive all state plan benefits as well as additional services under the program. If a beneficiary is enrolled in managed care, they may receive all state plan benefits through their managed care plan and may receive additional benefits as available. Arizona's Medicaid program is mostly administered through a managed care delivery model. Almost all LTC services are provided through this managed care model.

**Medically necessary**: As defined by the U.S. Department of Health and Human Services, medically necessary services are health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. This is usually the dependence threshold that must be met to receive a Medicaid benefit. However, the exact dependence characteristics needed to meet this threshold vary by state, although it usually is met through a physician's order for services.

**Medically Needy Income Limit (MNIL)**: The income standard that a Medicaid applicant must spend-down to meet if they are seeking Medicaid eligibility through eligibility track 3a (Medical Expense Deduction - MED). Typically, this standard is very low.

**Medically Needy**: A group states can elect to insure through Medicaid that would otherwise qualify for Medicaid through a categorically needy pathway if not for their income or assets (i.e., above SSI limits but below state determined limits for income or assets). This pathway for qualifying for Medicaid is an optional pathway.

**Minimum Data Set (MDS)**: A federally mandated tool for implementing standardized assessment and for facilitating care management in nursing homes.

**Monthly Maintenance Needs Allowance (MMNA)**: Amount of countable income for a beneficiary's spouse residing in the community if the beneficiary is institutionalized or requires home and community-based long-term care.

**Nursing facility care**: Residential care that typically provides skilled nursing or medical care and related services, rehabilitation needed due to injury, disability, or illness, and health-related care and services (above the level of room and board) not available in the community, needed regularly due to a mental or physical condition.

**Nursing facility level of care (NFLOC)**: Level of care comparable to what an individual would receive in a nursing facility. This is often the minimum level of dependence required for long-term care programs.

**Optional Categorically Needy**: An eligibility track that states may opt in to cover. This track encompasses several groups, including aged and disabled individuals not receiving SSI, some individuals receiving long-term care, and more.

**Other populations**: The Gateway Policy Explorer Long-Term Care Series is primarily focused on individuals most likely to require long-term care, such as older adults or disabled individuals. There are additional eligibility tracks one may use to qualify for Medicaid that are out-of-scope for this Series. Some of these include pregnant women, children, and families with children.

**Personal Care Services**: Medicaid optional state plan benefit that provides in-home assistance to recipients with housekeeping and personal care needs, such as bathing, dressing, eating, and mobility.

**Personal Needs Allowance**: Income that is exempt from contribution to nursing home cost that may be spent on any personal item by institutionalized beneficiaries.

**Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996**: Federal legislation that restricted most legal immigrants entering the United States after August 22, 1996, from receiving federally funded Medicaid or Supplemental Security Income (SSI) for at least five years after immigration or until they attain citizenship.

**Preadmission Screening (PAS)**: The ALTCS tool used to assess the functional, medical, nursing, and social needs of LTC beneficiaries and applicants. Arizona used one PAS tool from 1992-2006 when it was updated to the current version of the PAS.

**Preadmission Screening and Resident Review (PASRR)**: A federally required assessment for nursing facility applicants to ensure that individuals are not inappropriately placed in nursing homes for long term care. The initial Level I assessment screens for mental illnesses or other related conditions. If the Level I assessment indicates that the applicant has a mental illness or related condition, they will be directed to a Level II assessment and alternative residential care.

**Prior authorization**: An approval that is sometimes required before a service may be provided. Specifically, prior authorization is a determination by a utilization review entity that a covered service has been reviewed and, based on the information provided, satisfies

the utilization review entity's requirements for medical necessity and appropriateness and that payment will be made for that health care service.

**Private Duty Nursing**: Skilled nursing interventions on an individual and ongoing basis (in contrast to intermittent or part-time) and respiratory care for participants who are ventilator dependent.

**PRUCOL**: An immigration status where Immigration and Naturalization Services knows of and permits the individual's presence in the country and does not contemplate enforcing their departure. Oftentimes, this status is for refugees or parolees.

**Restorative Nursing**: Interventions that promote the resident's ability to adapt and adjust to living as independently and safely as possible.

**Skilled Nursing Services**: Skilled nursing care consists of those services that must, under State law, be performed by or under the supervision of a licensed or certified nurse. These services include injections, tube feedings, catheter changes, observation and assessment of a patient's conditions, and more.

**Social Security Administration (SSA)**: United States government agency that administers public assistance programs covering disability, retirement, and survivors' benefits. The SSA administers Supplemental Security Income (SSI) payments.

**Social Security Disability Insurance (SSDI)**: Social Security Disability Insurance is a payroll tax-funded federal insurance program of the United States government. It is managed by the Social Security Administration and designed to provide monthly benefits to people who have a medically determinable disability that restricts their ability to be employed.

**State Supplemental Payment (SSP)**: Small supplement to recipients of federal Supplemental Security Income (SSI) and some non-SSI recipients who are low-income persons with disabilities and older adults with limited resources to pay their living expenses. Arizona is one of six states that does not provide State Supplement Payments.

**Supplemental Nutritional Assistance Program (SNAP)**: Federal nutrition assistance program that provides benefits to eligible low-income individuals and families via an Electronic Benefits Transfer card. This card can be used like a debit card to purchase eligible food in authorized retail food stores.

**Supplemental Security Income (SSI)**: The U.S. cash assistance program for aged, blind, and disabled persons of limited means.

## Notes

This section reports notes from the main text. To facilitate switching back and forth, this document is designed with hyperlinks. Most PDF readers have shortcuts that permit a reader to return to the previous location after selecting a hyperlink. In Adobe Acrobat on a PC: "Alt" + "←"; In Adobe Acrobat on a MAC: "command" + "←"; In Preview on a MAC: "command" + "[".

1. Some SSI recipients in some states may receive a State Supplementary Payment (SSP). SSP amounts vary by living arrangement. Receipt of this payment will marginally increase the income limit under this track. Arizona is one of six states that do not pay State Supplementary Payments. See SSA (2011) for more information.

2. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application.

3. Lawfully permanent residents and PRUCOL (i.e., Immigration and Naturalization Services knows of and permits their presence in the country and does not contemplate enforcing their departure, oftentimes refugees or parolees).

4. Applicants must meet strict requirements established by the Social Security Administration in order to qualify for SSI through a disability or blindness. See SSA (2024d) for more information on these requirements.

5. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the MMNA as the community spouse's income. In 1992, the minimum MMNA in Arizona was $984.20 per month, and the maximum was $1,718. This standard increases annually with inflation. See Table 3 for historical MMNAs.

6. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $13,740 to $68,700 in 1992. In Arizona, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. See Table 3 for historical CSRAs.

7. The look back period is 36 months prior to the date of application, except in the case of a trust treated as a transfer in which case the look back period is 60 months prior to the date of application. From 2014, Arizona increased the look back period for asset transfers from 36 months (60 months for a trust) to 60 months for all assets.

8. In 2001, Arizona expanded eligibility to all adults with incomes up to 100% of the FPL who are ineligible under any other Medicaid groups. Most states did not cover this population until the ACA in 2014. We refer to this eligibility track as 2c. Affordable Care Act (ACA) Expansion Adults for this reason and for consistency across documents. In an effort to reduce costs, Arizona closed new enrollment for this track in 2011. In 2014, Arizona reopened new enrollment for this track under ACA Medicaid expansion with an increased income limit of 133% of the FPL.

9. In order for a spouse to be a paid caregiver they must meet the standard training requirements, be providing care that exceeds the range of activities that a spouse would ordinarily perform in the household, and the ALTCS member must reside in their own home. The paid caregiver must be employed or contracted by a Direct Care Worker Agency that subcontracts with the member's contractor. The spouse will be paid at a rate that does not exceed the rate paid to non-spouse caregivers and will not be paid for more than 40 hours in a seven day period.

10. Spousal considerations for income: If a beneficiary is institutionalized (e.g., resides in a nursing home) and their spouse resides in the community, there are spousal impoverishment laws that allow the community spouse to retain countable income and assets up to a certain amount. The community spouse is allowed to keep a Monthly Maintenance Needs Allowance (MMNA) and can allocate from the institutionalized spouse's income up to the maximum MMNA as the community spouse's income. In 2001, the maximum MMNA in Arizona was $2,175 per month. This standard increases annually with inflation. See Table 3 for historical MMNAs.

11. Spousal considerations for assets: The community spouse is also able to keep countable assets up to the federal Community Spouse Resource Allowance (CSRA), which ranged between $17,400 and $87,000 in 2001. In Arizona, the CSRA is determined by calculating one half of the couple's combined assets; if this amount falls below the range the spouse may retain the minimum, if this amount falls above the range they may retain the maximum. Countable assets/property are real and personal property that are counted to determine eligibility. During the first 12 months of ALTCS eligibility, any resources in excess of $2,000 must be transferred to the community spouse. After this 12 month period, the resources that are only in the community spouse's name are not included in the resource test. See Table 3 for historical CSRAs.

## Version information

*Current Version: 1.0 (December 2024)*

**Version History**

- 1.0 (December 2024): First Version.