

SECTION V: Eligibility and Enrollment

ELIGIBILITY DETERMINATION AND ENROLLMENT

Eligibility for AHCCCS is determined by different agencies depending on the program to which the member is applying. These agencies/entities include AHCCCS and the Social Security Administration. Care1st does not play any role in determining eligibility.

All members are given the opportunity to select a health plan serving their geographic area. If they do not select a plan, they are automatically assigned one by AHCCCS. Individuals applying for KidsCare must select a health plan at the time of application. Members are assigned to health plans, and become enrolled on a health plan's roster, every day of the month.

CHANGE OF CONTRACTOR

Members who are outside of their initial enrollment choice or their Annual Enrollment Choice (AEC) period may request a plan change from Care1st if certain conditions are met. Care1st follows the criteria set forth in ACOM Policy 401 Change of Contractor: Acute Care Contractors to determine if the member meets the required criteria for a plan change. Members may submit plan change requests to the Contractor or AHCCCS. Care1st may not request disenrollment because of an adverse change in the member's health status, nor because of the member's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs.

TRANSITION OF MEMBERS

Care1st adheres to the AMPM and the ACOM standards (ACOM Policies 401 and 402 and AMPM Chapter 500) for member transitions between Plans or Geographical Service Areas (GSAs), Children's Rehabilitative Services (CRS), the Comprehensive Medical and Dental Program (CMDP), Department of Economic Security (DES), Regional Behavioral Health Authority (RBHA), or to the Arizona Long Term Care System (ALTCs) plan, and upon termination or expiration of a plan's contract with AHCCCS.

The relinquishing plan is responsible for timely notification to the receiving plan regarding pertinent information related to any special needs of transitioning members. The new plan, when receiving a transitioning member with special needs, is responsible to coordinate care with the relinquishing plan in order that services are not interrupted, and for providing the new member with plan and service information, emergency numbers and instructions on how to obtain services. Transition activities also include transmitting appropriate medical records and case management files of the transitioning member.

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KIDSCARE

KidsCare is a program for children with family incomes above the AHCCCS eligibility limits, but who do not have private insurance. It is administered by AHCCCS, and is financed by a combination of state and federal funds, like AHCCCS.

KidsCare services are similar to those provided to AHCCCS members. All policies and procedures described in this manual apply to KidsCare as well as AHCCCS members.

RATE CODES

Each member falls within a rate code or eligibility category. Rate codes are important to PCPs because capitation rates are determined by rate code. In addition, there is some slight variation in coverage and co-payment requirements based on rate code.

Major rate code categories are as follows:

- **NEAD** – Newly Eligible Adults
- **ACMA (formerly known as AHCCCS CARE)** - Eligible individuals and childless adults whose income is less than or equal to 100% of the FPL
- **QMB** - Qualified Medicare Beneficiary
- **SOBRA** - Sixth Omnibus Budget Reconciliation Act (pregnant women and young children above the federal poverty level)
- **SSI** - Social Security Income (for Blind, Aged and Disabled)
- **TANF** - Temporary Assistance to Needy Families (Previously known as “AFDC”)
- **KIDSCARE** - KidsCare (Children’s Health Insurance Program)
- **BCCTP** - Breast and Cervical Cancer Treatment Program

MEMBER IDENTIFICATION CARDS

Care1st issues identification cards for AHCCCS members. **Members may not be refused service because they do not have their ID card.** The identification card does not guarantee that the member is still eligible for services. To verify eligibility providers can visit our website www.care1staz.com or contact Customer Service as outlined below.

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PCP ASSIGNMENT

Members will be assigned a PCP based on geographic location, provider availability, the member's age, and any special medical needs of the member. Directions on how to view and/or obtain a listing of contracted PCPs is included in the Member Packet so members may change their PCP.

Providers may request a PCP assignment member roster from Care1st. Care1st will provide the roster within 10 business days of receipt of the request. To request a PCP assignment member roster, please contact Network Management at 1-866-560-4042 (5, 7).

PCP ASSIGNMENT CHANGES

MEMBER INITIATED

Members may request a PCP change at any time and for any reason by contacting the Customer Service Department. Each eligible member in a family may select a different PCP.

Most change requests received by the Customer Service Department will be effective the following day. Members who request frequent PCP changes will be contacted by the Customer Service Department to determine why they are unable to establish an ongoing relationship with a PCP.

PROVIDER INITIATED

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Customer Service Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. Providers must notify the member (with a copy to the Customer Service Department) in writing that they can no longer provide services to the member and must:

- Be sent on the provider's letterhead and include the member's name, AHCCCS ID, date of birth, the specific reason for the change request, and the signature of the Provider,
- Request that the member choose a new PCP,
- Indicate that the provider will continue to provide emergency care for 30-day period following their written request, or, until that member is reassigned to another PCP

Upon receipt of a change request, the Customer Service Department will contact and reassign the member considering member choice as well as geographic, linguistic,

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medical needs, and other member variables. The transferring provider must be available for care thirty (30) days after the member is notified and is also responsible for forwarding the member record to the new provider within ten (10) business days from receipt request for transfer of the medical records.

The following are not acceptable grounds for a provider to seek the transfer of a member:

- Member's Medical Condition
- Amount, variety, or cost of covered services required by a member
- Demographic and Cultural characteristics

Care1st does not condone discrimination against its members for any reason and will investigate any allegations or indications of such.

ELIGIBILITY VERIFICATION

Although members do not frequently lose eligibility mid-month, it does occur. Members may also request a PCP change during the month. To ensure payment, **all providers must verify eligibility at the time of service.** Eligibility and PCP assignment can be verified using one of the verification methods defined below.

WEBSITE - www.care1staz.com

Our website offers member eligibility, claims status and online remittance advice viewing and printing. A one-time registration process is required in order to obtain a log on and password. To complete the registration process:

1. Choose "Login" under the Provider menu
2. Complete the Registration On-Line Form
3. You will receive your logon and temporary password via e-mail

CUSTOMER SERVICE

To speak with a representative from our Customer Service Department dial 602.778.1800 or 1.866.560.4042 (options 5, 3)

NEWBORN NOTIFICATION

Hospital providers are required to notify AHCCCS of all newborns in a timely manner to be eligible for reimbursement from Care1st.

AHCCCS COST SHARING & COPAYMENTS

MANDATORY (REQUIRED) COPAYMENTS

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AHCCCS members who have mandatory copayments for certain services are:

- ▲ Transitional Medical Assistance (TMA) members (Copay Level 50)

TMA Copayments (Copay Level 50)

Pharmacy	\$2.30
Office Visits	\$4.00
Outpatient Professional Therapies	\$3.00
Surgeries (In Office; Outpatient non-emergent; ASCs	\$3.00

Mandatory copayments **permit** providers to **deny** services to members who do not pay the copayment. However, certain services (such as emergency services) are exempt from mandatory copayments, and specific members (such as individuals under the age of 19) are also exempt from copayments. Please be aware that payments to providers are reduced by the amount of a member's copayment obligation *regardless of whether or not the provider successfully collects the mandatory copayment*.

These copayments do not apply to:

- People under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services
- An individual designated eligible for Children's Rehabilitative Services (CRS) pursuant to Title 9, Chapter 22, Article 13
- ACC, CMDP, and RBHA members who are residing in nursing facilities or residential facilities such as an Assisted Living Home and only when member's medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year
- People who are enrolled in the Arizona Long Term Care System (ALTCS)
- People who are Qualified Medicare Beneficiaries
- People who receive hospice care
- American Indian members who are active or previous users of the Indian Health Service, tribal health programs operated under P.L. 93-638, or urban Indian health programs
- People in the Breast & Cervical Cancer Treatment Program (BCCTP)
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age
- People who are pregnant and throughout the postpartum period following the pregnancy
- Individuals in the Adult Group (for a limited time*)

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* NOTE: For a limited time persons who are eligible in the Adult Group will not have any copays. Members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. Copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

Services that will not require a copayment include:

- Hospitalizations and services received while in a hospital
- Emergency services
- Services received in the emergency department
- Family Planning services and supplies
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women
- Preventative services, such as well visits, pap smears, colonoscopies, mammograms and immunizations
- Provider preventable services

OPTIONAL (NON-MANDATORY) COPAYMENTS

Optional (also known as non-mandatory) copayments apply to AHCCCS members who are not required to make the mandatory copayments as noted above. When a member has an optional copayment, providers are **prohibited** from denying the service when the member is unable to pay the copayment. As in mandatory copayment situations, there are certain services (such as emergency services) and certain populations (such as individuals under age 19) which are exempt from the optional copayment.

5% LIMIT ON ALL COPAYS

The amount of total copays cannot be more than 5% of the family's total income (before taxes and deductions) during a calendar quarter (January-March, April-June, July-September, and October-December). The 5% limit applies to both optional and required copays.

HOW TO DETERMINE IF A MEMBER HAS A MANDATORY COPAYMENT

Providers can identify whether a member has a mandatory copayment by using a member's specific copay level available through various AHCCCS eligibility verification

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systems *other than IVR*. EVS, the web, and HIPAA transactions 270 and 271 will identify a member's copay level, but IVR will not. A member's copay level in the AHCCCS verification system corresponds to specific copayment amounts for specific services.

AHCCCS Online, <https://azweb.statemedicaid.us/Account/Login.aspx>, has the most current eligibility and copayment information for all AHCCCS members. If you are not registered to use this system, register by choosing the "Register" link under "New Account". The Co-Payment tab at the top of the page of the member's eligibility verification screen indicates the member copay level and provides a link to the AHCCCS Copay Grid, which provides you the detail on the mandatory copay levels and applicable services.

COPAYMENT TRACKING

AHCCCS Administration tracks each member's specific copayment levels by service type, and this information will also identify those members who have reached the 5% copayment limit. AHCCCS will further identify whether the member is subject to a mandatory or a nominal copayment and when copayments cannot be charged, i.e. the service or member is exempt from copayments.

Ongoing updates from AHCCCS regarding copayment requirements can be found at: <https://azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html>