

## **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, the Department of Economic Security (DES) 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 or DES/DDD in the case of DDD members. 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.

### **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.

### **DES/DDD**

Persons with developmental disabilities are eligible for certain services provided through the Department of Economic Security, Division of Developmental Disabilities (DES/DDD). DDD members choose or are assigned to a health plan by DES/DDD.

Services for DDD members are similar to those provided to AHCCCS members. In addition to AHCCCS covered benefits, DDD members are also covered for additional services. Please see Section VI, Covered Services, for details.

### **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:

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- **MED** - **M**edical **E**xpense **D**eduction, part of the Title XIX Waiver Group
- **NON-MED** - **N**on-**M**edical **E**xpense **D**eduction, part of the Title XIX Waiver Group
- **QMB** - **Q**ualified **M**edicare **B**eneficiary
- **SFPS** - **S**OBRA **F**amily **P**lanning **S**ervices: For further details see Section VI, Covered Services.
- **SOBRA** - **S**ixth **O**mnibus **B**udget **R**econciliation **A**ct (pregnant women and young children above the federal poverty level)
- **SSI** - **S**ocial **S**ecurity **I**ncome (for Blind, Aged and Disabled)
- **TANF** - **T**emporary **A**ssistance to **N**eedy **F**amilies (Previously know as “AFDC”)
- **KIDSCARE** - KidsCare (Children’s Health Insurance Program)
- **BCCTP** - **B**reast and **C**ervical **C**ancer **T**reatment **P**rogram

### MEMBER IDENTIFICATION CARDS

AHCCCS members are provided an AHCCCS identification card that includes the member name, ID number, health plan name and phone number. DDD members are issued a member identification card by Care1st. **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 use the Integrate Voice Response system, visit our website [www.care1st.com/az](http://www.care1st.com/az) or contact Member Services as outlined below.

### PCP ASSIGNMENT

A listing of contracted PCPs is included with the Member Packet so members may choose their PCP. Members that do not choose a PCP will be assigned a PCP based on geographic location, provider availability, the member’s age, and any special medical needs of the member.

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### ***PCP ASSIGNMENT CHANGES***

#### ***MEMBER INITIATED***

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

Most change requests received by the Member Services Department will be effective on the first of the following month. Members who request frequent PCP changes will be contacted by the Member Services 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 Member Services 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 Member Services 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 Member Services will contact and reassign the member considering member choice as well as geographic, linguistic, medical needs, and other member variables. The transferring provider is responsible for forwarding the member record to the new provider within ten (10) days of the re-assignment.

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.

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### 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 any of the verification methods defined below.

#### **WEBSITE - [www.care1st.com/az](http://www.care1st.com/az)**

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

#### **INTERACTIVE VOICE RESPONSE (IVR)**

The IVR system is available to verify member eligibility or to check claims status. The IVR system can be accessed by:

1. Call 602.778.1800; enter option 5 then option 2
2. IVR prompts the caller to enter the provider’s login number (the provider’s 6-digit AHCCCS provider number)
3. IVR then prompts the caller to enter their PIN (set as 654321 for all providers as a default)
4. Continue to listen and follow prompts

#### **MEMBER SERVICES**

To speak with a representative from our Member Services 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

#### **EXEMPT MEMBERS**

The following populations are exempt from co-payments for ALL services regardless of the assigned eligibility Rate Code:

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1. Members under age 19, including KidsCare members
2. Pregnant women
3. ALTCS enrolled members
4. Members with Serious Mental Illness who are receiving services from Magellan
5. Members who are enrolled with Children's Rehabilitative Services (CRS)
6. Members enrolled in SOBRA Family Planning Services Only
7. DDD members with no additional coverage

**NOTE: Co-payments are not applicable for family planning services or supplies.**

### ***STANDARD CO-PAYMENTS***

**NOTE: Services to this population may not be denied for failure to pay co-payment.**

The following are the standard co-payments for all members except for HIFA (Health Insurance Flexibility Act) members (parents of KidsCare and SOBRA Children):

<b>Service</b>	<b>Co-payment</b>
Generic Prescriptions	\$ 0
Brand Name Prescriptions when Generic is available	\$ 0
Non Emergency Use of ER	\$ 1
Physician Visits	\$ 1