2 Member Eligibility and Member Services

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HEALTH CHOICE ARIZONA MEMBER SERVICES DEPARTMENT

Our members and their medical care are very important to us. To ensure their needs are met, the Health Choice Arizona Member Services Department coordinates all membership activities. The Primary functions of Member Services Department include:

- Verification of member eligibility
- Primary care physician (PCP) assignment and changes
- General Health Plan questions
- Immediate Member issue resolution; referrals of other issues (grievances/complaints to quality management for further investigation and resolution.
- Arranging translation services including hearing impaired and sign language
- Conducting Member Satisfaction Surveys

The Health Choice Arizona Member Services Department is available from 6:00 AM to 6:00 PM, Monday through Friday at (480) 968-6866 or (800) 322-8670. The Member Services Department is closed on the following holidays: New Year's Day, Memorial Day, 4th of July, Labor Day, Thanksgiving Day and Christmas Day.

AHCCCS ELIGIBILITY

The Department of Economic Security, the Social Security Administration, or the AHCCCS Administration determines AHCCCS eligibility. Individuals must meet eligibility requirements set forth by the State of Arizona to become eligible for benefits under AHCCCS.

Health Choice Arizona does not participate in the AHCCCS eligibility determination process.

Health Choice Arizona is a *Health-e-Arizona* Participant. If Health Choice member needs to renew their AHCCCS medical benefits they can come to Health Choice Arizona and we will assist them in completing their online application for Arizona Residents. We can also check the status of their application for them. Renewal is free and easy!

COVERED SERVICES THROUGH HEALTH CHOICE ARIZONA

Members are eligible for covered services under the Title XIX program. A covered service must be medically necessary. Examples of the covered services are listed below; however, please refer to Chapter 1 for a detailed list of covered and non- covered services.

For eligible members with AHCCCS health plans, the covered medically necessary services include:

- Doctor's visits / Well-Child Visits (See Exhibit 3.2, EPSDT Periodicity Schedule)
- Specialist care, if necessary
- Hospital services
- Pregnancy care
- Prescriptions and medical supplies
- Laboratory and x-ray services
- 24-hour emergency medical care
- Family Planning Services, not to include pregnancy termination or pregnancy termination counseling
- Complete physical exams
- Immunizations
- Dental screening and treatment (for children under age 21)
- Eye Exams, prescriptive lenses and repairs or replacements of lenses and frames (for children under age 21)
- Hospice Services
- Hearing tests and hearing aids (for children under age 21)
- Behavioral health services
- Non-emergent and emergent medical transportation

COVERED SERVICES THROUGH INDIAN HEALTH CHOICE SERVICES (IHS)

Members eligible through the Indian Health Services (IHS) will receive all services listed above at an IHS facility

CO-PAYMENTS

AHCCCS Copayments (Copays):
Copays are amounts members pay directly to a provider for each item or service they receive at the time of a service. Copays can be mandatory (also known as required) or optional (also known as nominal) as explained below. Certain services and populations are exempt from any copays which means that no mandatory or optional copays will be charged.

Below is a description of current AHCCCS copays, and the new copays AHCCCS proposes to charge certain members, subject to approval by the Centers for Medicare and Medicaid Services. Members will be notified of any changes in copays before they happen. These proposed copays include the mandatory copays that AHCCCS plans to charge members in the Adult Group with income above 106% FPL.

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.

Mandatory Copays (also known as "required"):
If a member has a mandatory copay, providers CAN deny services if the member does not pay the mandatory copay. There are certain services and populations which are exempt from any copays as described below, which means that no copay can be charged. Members who can be charged mandatory copays are persons in the:

1. Adult Group who have income above 106% FPL *(PROPOSED; SEE CHART BELOW) and
2. Transitional Medical Assistance (TMA) program- individuals who were receiving AHCCCS in the Caretaker Relative category who become ineligible due to the increased earnings.

Optional Copays (also known as "nominal"):
If a member has an optional copay, a provider CANNOT deny the service if the member is unable to pay the optional copay. There are certain services and populations that are exempt from any copays as described below, which means that no copay can be charged. Members who can be charged nominal copays are persons in the:

- AHCCCS for Families with Children (1931)
- Young Adult Transitional Insurance (YATI) for young adults who were in foster care
- State Adoption Assistance for Special Needs Children who are being adopted
- Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled
- SSI Medical Assistance Only (SSI MAO) for individuals who are age 65 or older, blind or disabled
- Freedom to Work (FTW)

Copays are not charged for the following services:
- Family planning services and supplies
- Pregnancy related health care including tobacco cessation treatment for pregnant women
- Emergency services
- Services paid on a fee-for-service basis
- Preventive services, such as well visits, immunizations, pap smears, colonoscopies, and mammograms
- Provider preventable services

Copays are not charged to the following persons:
- Children under age 19
- People determined to be Seriously Mentally Ill (SMI) by the Arizona Department of Health Services

- People enrolled in the Arizona Long Term Care System
- People enrolled in the Children's Rehabilitative Services program
- People eligible as Qualified Medicare Beneficiaries
- People who are acute care members residing in nursing homes, or residential facilities when the acute care member's medical condition would otherwise require hospitalization. The exemption from copayments for acute care members is limited to 90 days in a contract year
- People who receive hospice care
- People enrolled in the Breast and Cervical Cancer program
- People who are pregnant and throughout the postpartum period following the pregnancy
- 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 receiving Title IV-E Adoption Subsidy or Foster Care Assistance
- People receiving Title IV-B Child Welfare Services
- People in the Adult Group (for a limited time*).

* 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 proposed, and will be effective after CMS approval. Members will be told about any changes in copays before they happen.

AHCCCS Copayments

Service	**Population and Copay Amounts**		
	MANDATORY COPAYS		OPTIONAL COPAYS
	Adult Group over 106% FPL (PROPOSED)	**TMA** (current)	**Other** (current)
Prescription Drugs	$4.00 per drug	$2.30	$2.30
*Office Visits	$5.00 or $10.00[1]per visit	$4.00	$3.40
*Outpatient professional therapies	$2.00, $4.00 or $5.00[2] per visit	$3.00	$2.30
*Non-emergency surgery[3]	$30.00 or $50.00[4] per surgery	$3.00	None
Inpatient Hospital Stay	$75 per stay	None	None
Non-emergency use of the Emergency Room	$8.00 per visit	None	None
Taxis for Non-emergency Medical Transportation in Pima and Maricopa Counties	$2.00 per trip	None	None

* = Applies to primary care physician, specialist, or other health care provider visits not in a hospital Emergency Room setting.

5% Limit on All Copays

The amount of total copays cannot be more than 5% of the family's total income during a calendar quarter (January-March, April-June, July-September, and October-December). If this 5% limit is reached, no more copays will be charged for the rest of that quarter. AHCCCS has a process to track cost sharing. If a member thinks that the total copays they have paid are more than 5% of the family's total quarterly income and AHCCCS has not already told them, the member should send copies of receipts or other proof of how much they have paid to:

AHCCCS
801 E. Jefferson
Mail Drop 4600
Phoenix, Arizona 85034

If a member's income or circumstances have changed, it is important to contact the eligibility office right away.

Non-Emergency Use of the Emergency Room

As part of the proposed copay request, all hospitals in Arizona will have their payments reduced by the copay amounts for Non-emergency use of the Emergency Room as described above. As such, it is expected that all hospitals will charge members in the Adult Group for Non-emergency use of the Emergency Room, upon CMS approval.

For additional information regarding copayment requirements, please visit the AHCCCS website at: https://www.azahcccs.gov/PlansProviders/RatesAndBilling/copayments.html

Benefit Changes

Health Choice Arizona, under the direction of the AHCCCS Administration, will no longer pay for certain medical care for anyone who is 21 years old or older. If you are a Qualified Medicare Beneficiary, we will continue to pay your Medicare deductible and coinsurance for these services.

The medical services that are not covered are:

AHCCCS EXCLUDED BENEFITS TABLE (ADULTS AGE 21 AND OLDER)

BENEFIT/ SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Percussive Vests	This vest is placed on a person's chest and shakes to loosen mucous	AHCCCS will not pay for percussive vests. AHCCCS will pay for supplies, care, and repair of the vest.

Bone-Anchored Hearing Aid	A hearing aid put on a person's bone near the ear by surgery to carry sound	AHCCCS will not pay for Bone-Anchored Hearing AID (BAHA). AHCCCS will pay for supplies, care of the hearing aid, and repair of any parts.
Cochlear Implant	A small device put in a person's ear by surgery to help them hear better	AHCCCS will not pay for cochlear implants. AHCCCS will pay for supplies, care of the implant and repair of any parts.
Lower limb Microprocessor controlled joint/ Prosthetic	A device that replaces a missing part of the body and uses a computer to help move the joint	AHCCCS will not pay for a lower limb (leg, knee, or foot) prosthetic that includes a microprocessor (computer chip) that controls the joint.
BENEFIT/ SERVICE	SERVICE DESCRIPTION	SERVICE EXCLUSIONS OR LIMITATIONS
Emergency Dental Service	Emergency services when you need immediate care for a bad infection or severe pain in your mouth. Effective 10/01/2017, AHCCCS will pay for emergency dental services for adults up to $1,000 per membership year (October 1 – September 30). A *Dental Emergency* is defined as "an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma."	AHCCCS will not cover dental services. This includes emergency dental services unless it is a medical or surgical service related to dental (oral) care. Medically necessary emergency dental care is covered for persons age 21 years and older who meet the criteria for a dental emergency. The $1,000 dental emergency benefit does not cover diagnosis and treatment of TMJ, fixed bridgework to replace missing teeth or maxillofacial dental services (except for reduction of trauma). Treatment for tooth loss is limited.
Services by Podiatrist	Any service by a doctor who treats feet and ankle problems	AHCCCS only covers medically necessary podiatry services that are performed by a licensed podiatrist and ordered by a primary care provider or primary care practitioner.
Respite Care	Short-term or continuous services as a temporary break for caregivers	The number of respite hours available to adults and children under ALTCS benefits or behavioral health services is 600 within a 12-month period. The 12 months will run from October 1 to September 30 of the next year.
Physical Therapy	Exercises taught or provided by a physical therapist to make you stronger or help improve movement.	Outpatient physical therapy visits are limited to 15 per contract year (Oct. 1 – Sept. 30). If you have Medicare, call us to find out how the visits will be counted.

Occupational Therapy	Outpatient Occupational therapy visits are limited to 15 outpatient occupational therapy visits when they are needed to **keep** a level of function or help **get** to a level of function, and 15 outpatient occupational therapy visits to **restore** a level of function per contract year (Oct. 1 – Sept. 30).

ELIGIBILITY VERIFICATION

In order to receive payment for covered services, it is critical that member eligibility is verified before providing services. If a patient presents as a Health Choice Arizona member, but has lost eligibility and you do not verify their status before providing services, payment will not be made.

As long as you are a contracted primary care provider with Health Choice Arizona claims will not be denied if the member is not assigned to the provider or group on the date of service. However, members should update their PCP with Member Services.

- Health Choice Arizona has an Eligibility module within the secure provider portal at: https://www.healthchoicearizona.com/ProviderPortal/login/
- This website allows providers to receive member eligibility information.
- AHCCCS Automated Verification System (AVS) – The AHCCCS AVS will provide you with the same eligibility information as their Emdeon (MediFax) AVS system. To contact AHCCCS Telephone Verification (602) 417-7200 within Maricopa County or (800) 331-5090 outside Maricopa County.
- AHCCCS also has an on-line verification system under the "Plans/Providers" link at https://www.azahcccs.gov/
- Health Choice Telephone Verification – You may also contact Health Choice Arizona directly in Member Services by dialing (480) 968-6866 or (800) 322- 8670.

Primary Care Physicians (PCP's) can also refer to their monthly member roster. However, the roster represents your membership for the first day of the month only. Providers can also locate their member roster online through Health Choice Arizona Provider Portal.

AHCCCS ID CARD

Each AHCCCS eligible member is given a Health Choice Arizona identification card that indicates the member's name and the member's AHCCCS identification number.

Providers should request the member's Health Plan identification card at the time of visit. **Services cannot be denied if the member does not have their ID card at the time of the appointment.** Health Choice Arizona recommends you ask for a second form of identification for members not known to you.

If a member has lost their card, please direct them to call Health Choice Member Services to request a new card.

HEALTH PLAN SELECTION

All AHCCCS members have the right to select their AHCCCS health plan. Individuals receive information on how to choose an AHCCCS health plan at the time of eligibility. If they do not select a health plan, they are automatically assigned to a health plan through the AHCCCS algorithm system.

PLAN CHANGES

Members are generally not allowed to change their health plan until their Annual Enrollment Choice (AEC) period, which occurs on the anniversary date of their enrollment. Only in certain circumstances may a member request a change outside of this timeframe. Plan change requests may be granted based on continuity of medical care. Most often these requests involve continuity of prenatal care or care due to a chronic disease. The Medical Director(s) or designee will make the plan change determination based on information provided by the provider.

PRIMARY CARE PHYSICIAN (PCP) SELECTION

Health Choice Arizona contracts with General Practice, Family Practice, Internal Medicine, and Pediatric physicians to provide PCP services to enrolled Health Choice Arizona members. If a member does not choose a PCP, the Health Choice Arizona Member Services Department assigns the member to a PCP based on geographic location.

Health Choice Arizona offers its members the freedom of choice in selecting a PCP within its network. There are instances when Health Choice Arizona may restrict a member's choice of PCP. Examples include, but are not limited to, when a member frequently changes their PCP, for medically necessary reasons or due to location to members' residence.

Each new member enrolled with Health Choice Arizona receives written notification of their PCP by mail. In addition to the letter with the PCP information, a Member Handbook is provided that outlines the Member's Rights and Responsibilities. The Member Handbook is a resource that provides assistance for members on how to obtain health care services through Health Choice Arizona.

PRIMARY CARE OBSTETRICIAN (PCO) SELECTION

Pregnant Members may choose a Primary Care Obstetrician (PCO). If the member does not choose, they are assigned to a PCO. The PCO is the primary source of care for these members. For more information on PCO assignments, please refer to Chapter 16: Women and Children's Services.

NEWBORNS

All babies born to Health Choice Arizona-eligible mothers are also deemed to be Health Choice Arizona eligible and may remain eligible for up to one year if the new born continues to reside with the mother and newborn and mother continue to reside in Arizona.

Newborns receive separate AHCCCS ID numbers, and services for them must be billed separately using the newborn's ID. Services for a newborn that are included on the mother's claim will be denied.

Out of State Coverage

A recipient who is temporarily out of the state but still a resident of Arizona is entitled to receive AHCCCS benefits under one of the following conditions:

- Medical services are required because of medical emergency.
    - Documentation of the emergency must be submitted with the claims to Health Choice Arizona.
- The recipient requires a particular treatment that can only be obtained in another state and prior approval is provided by Health Choice Arizona.
- The recipient has a chronic illness necessitating treatment during a temporary absence from the state or the recipient's condition must be stabilized before returning to the state.
- Providers out of state must be willing to register with AHCCCS and bill Health Choice Arizona for the services.

Services furnished to Health Choice Arizona members outside the United States are not covered.

Member Rosters

Member Rosters list PCP's or PCO's assigned members as of the first day of the month. Provider member rosters are available through the Health Choice Arizona Provider Portal, at https://www.healthchoicearizona.com/ProviderPortal/login/. If a member seeking care is not listed on your roster, please have the member call Health Choice Arizona Member Services at (480) 968-6866 or (800) 322- 8670 to change PCPs.

PCP/PCO Assignment Change*:* Providers may request a member be removed from his/her roster. This must be submitted in writing and signed by the physician, the provider must provide emergency services for a period of thirty (30) days from the notice or until the member is assigned and able to establish with a new PCP, whichever comes first. A copy of the notice needs to be provided to the member and Health Choice Arizona. Rather than remove these members from your roster, we prefer to collaborate with you in managing their health care. Depending on the issue, Health Choice Arizona will either contact the member directly or coordinate with our Case Management Department to attempt to resolve the issue. It is important for your office to continue providing care to the member during this process. If no improvement is achieved after our interventions, it may be agreed that the member needs a new primary care physician. Member removal from your roster should be considered as a last resort.

Member assignment changes are effective the first of the month following notification. You can fax both provider and member letters to (480) 760-4708, Attention Member Services.

MEMBER RIGHTS AND RESPONSIBILITIES

MEMBER RIGHTS

As a Health Choice Arizona Member, you have the right to:

- Privacy and to be treated with respect and dignity.
- Be treated fairly when getting medical care. This means you have equal access to all Health Choice Arizona services. Health Choice does not discriminate against any member based on race, color, national origin, disability, sex, religion or age, physical or mental illness, or ability to pay.
- Have services and materials provided in a way that helps you understand. This may include help with
  - Language Needs: This includes having materials translated into your own language. We can help you find providers who speak your language. If your provider does not speak your language, we can get you an interpreter for your medical appointments.
  - Visual Needs: This may include recorded materials, such as a CD, or materials in Braille. You can also ask for larger print.
  - Hearing Needs: If you are hard of hearing, you can call Arizona Relay Services at **711.** This telephone relay, or TTY/TDD, is a free public service. There is no cost to you. We can also get you a sign language interpreter for your medical appointments.
- Choose a primary care physician (PCP) and other providers from the Health Choice Arizona network list. This also includes the right to refuse care from providers. You also have the right to a second opinion.
- Make decisions about your health care. This includes agreeing to treatment. It can also include the right to refuse treatment.
- Be free from any form of control or isolation used as a means of force, authority, convenience, or retaliation. You cannot be held against your will. You cannot be forced to do something you do not want to do.
- Create a plan that tells health care providers what kind of treatment you do or do not want if you become too sick to make your own health care decisions. These are called “advanced directives”. We can give you information to help you create your own advance directive.

- You have the right to get other information, such as:
  - How to get after-hours and emergency services
  - Available treatment options (including the option of no treatment)
  - Prior authorization, referrals or any special procedures needed to get medical services
  - How to get mental health or substance abuse services
  - How to get services outside the Health Choice Arizona service area
  - How to get covered services that are not offered or available through the health plan
  - The right to family planning services from an appropriate registered provider
  - A description of how the organization evaluates new technology for inclusion as a covered benefit
- You have the right to complain about Health Choice. You cannot be denied services if you file a complaint.
- Information about grievances, appeals and requests for a hearing.
- You have the right to look at your medical records. You have the right to ask for a copy of your medical records at least annually. There is no cost to you.
  - You have the right to a written reply from Health Choice within 30 days of your request.
  - If denied, you have the right to information about why your request was denied.
  - You have the right to seek review of the denial in accordance with 45 CFR Part 164.
  - You have the right to change or correct your records.
- You have the right to request restrictions.
- You have the right to private communications.
- You have the right to accounting of disclosures.
- You have the right to a paper copy of the Notice of Privacy Practices. See the "Your Privacy section of this handbook for more information.
- Ask for information about Health Choice such as:
  - The plan's physician incentive program: This means that you can ask about ways that the health plan pays our providers.
  - If stop-loss insurance is required
  - Member survey results for the health plan
- Receive information on available treatment options and alternatives, presented in a manner appropriate to your condition and in a way you can understand
- Get health care services in accordance with access to care and quality standards
- Health Choice Arizona will not hold it against you if you choose to use any of your rights.

MEMBER RESPONSIBILITIES

As a Health Choice Arizona Member, you have the responsibility to:

- Protect your Member ID card at all times. Show your ID card before you get services. Do not throw your ID card away.
- Know the name of your primary care doctor (PCP). This is your assigned doctor. Tell him or her about your health history. Be sure to include any medical problems or concerns. This will help you get the best possible care.
- Follow your doctor's instructions and treatment plan. This includes:

  o Taking all of your medicines as directed by your doctor

  o Talking with your doctor about your medical care
- Make sure your doctor gets prior approval for services when needed.
- Use the hospital emergency room for true emergencies only. Go to your doctor or urgent care centers for all other care.
- Make your health care appointments during office hours whenever possible. Try to see your doctor for routine care.
- Get to your appointments on time. Call your doctor ahead of time if you cannot make your appointment. Arrive at the office early if you are seeing the doctor for the first time.
- If you need a ride to your appointment, call (800) 322-8760 at least three days before your appointment
- Bring records of your children's shots to every appointment. This includes all members who are 18 years of age or younger.
- Call the office at least one day in advance, if you cannot make your doctor appointment. Remember to cancel your transportation.
- Tell AHCCCS if you have any changes to your personal information, such as address or family size.
- Tell Health Choice or AHCCCS if you suspect fraud or abuse by a provider, member or other person.
- Tell AHCCCS if you get a new health insurance plan (primary insurance) or if you cancel a health insurance plan you were covered under when you enrolled in AHCCCS.

RATE CODES

A complete list of rate codes can be found in the Codes & Values Manual at: https://www.azahcccs.gov/Resources/Contractor/Manuals/TIG/HealthPlans/Codes/