

MEMBER ELIGIBILITY & ENROLLMENT OVERVIEW

A. AHCCCS ELIGIBILITY & HEALTH PLAN ASSIGNMENT:

Eligibility for members is determined by the Arizona Health Care Cost Containment System (AHCCCS). PHS staff are not involved in the process and cannot make any decisions regarding eligibility. Eligibility is determined by three agencies for the various coverage groups:

- Social Security Administration (SSA) - determines eligibility for the Supplemental Security Income (SSI) cash program whose recipients are automatically eligible for AHCCCS coverage.
- Department of Economic Security (DES) determines eligibility for the families with children under section 1931 of the Social Security Act, pregnant women and children under SOBRA, the Adoption Subsidy Program, Title IV-E foster care children, Young Adult Transitional Insurance Program, the Federal Emergency Services program (FES), HIFA parents of SOBRA eligible children, and the Title 19 Waiver Members.
- * Children receiving foster care or adoption subsidy payments under Title IV-E of the Social Security Act are considered categorically eligible.
- AHCCCA determines eligibility for SSI/Medical Assistance Only groups, including FES program for this population (aged, disabled, blind), the Arizona Long Term Care System (ALTCS), the Qualified Medicare Beneficiary program and other Medicare cost sharing programs, BCCTP, the Freedom to Work program, the Title XXI KidsCare program, and the HIFA parents of KidsCare children.
- State AHCCCSA Program “KidsCare” - program under Title XXI that determines medical eligibility for children under the age of 19 who do not meet the income requirements for other state and federally funded programs. KidsCare members have the same benefit package as AHCCCS members.

Each member is assigned a rate code which indicates the eligibility type and Medicare eligibility. The capitation for each member is determined according to the rate code. All members have a choice of available contractors. Members who do not make a plan choice at the time of their eligibility determination are automatically assigned to a contractor using AHCCCSA's auto-assignment algorithm.

B. KIDSCARE SPECIAL CONDITIONS/LIMITATIONS:

Effective 10/1/01, KidsCare members are eligible for the same benefits as members under AHCCCS.

For more information on the benefits, limitations and conditions of the KidsCare program refer to the KidsCare section of this manual.

C. ALTCS ELIGIBILITY:

Eligibility for long-term care members is determined by the Arizona Long Term Care System (ALTCS), the long term care program that is administered by AHCCCS. ALTCS eligibility is based on both financial and medical eligibility as determined by the State Eligibility Office. PHS staff are not involved in the process and cannot make any decisions regarding eligibility. Once an applicant's financial eligibility is established a pre-admission screening (PAS) is conducted by ALTCS staff. The PAS is used to determine whether the applicant should be placed, or is at risk of being placed, in a nursing facility or intermediate care facility. ALTCS members are generally reevaluated by AHCCCS on an annual basis.

When a member in Pima or Santa Cruz County is determined eligible for ALTCS services they are assigned to PHS Long Term Care and will receive an initial assessment and interview, conducted by a PHS case manager. Members who require nursing facility services will be informed by the case manager that each nursing facility has an assigned Long Term Care Primary Care Provider (PCP), and they will be assigned to that PCP.

D. SHARE OF COST (SOC):

ALTCS regulations require members to contribute toward the cost of their care based on their income. Some members, either because of their limited income or the methodology used to determine the SOC, do not have to pay a SOC. The ALTCS Eligibility Office determines the amount of the share of cost. Pima Health System delegates the responsibility for collecting the share of cost to the provider and compensates these providers net of the share of cost.

E. MEMBER TRANSITIONS AND PROGRAM CONTRACTOR CHANGES:

PHS is responsible to identify and manage the needs of ALTCS members during transitions between health plans or program contractors, and when they change service areas, subcontractors and / or health care providers. PHS will facilitate enrollment transfers between program contractors when a member leaves Pima County and ensure that services are not interrupted. PHS LTC will coordinate the transition of members from AHCCCS health plans to the ALTCS program by following applicable protocols to ensure that continuity and quality of care is maintained during and after the transition. Members with special circumstances may require additional or distinctive assistance during a period of transition. Refer to the PHS Medical/Administrative Standard and Procedure Manual and the AHCCCS Contractor Operations Manual (ACOM) Chapter 400, which can be found on the AHCCCS website at www.azahcccs.gov for further information regarding member transitions between programs and plans.

F. ASSIGNMENT TO A PRIMARY CARE PROVIDER (PCP):

When new members are assigned to PHS they are provided with information about PHS and informed about their right to select an appropriate PCP in the PHS network. PHS will initially assign each member to a PCP and notify the member in writing of that assignment, and the process to change the PCP if necessary (*see member assignment policy included in the PHS' Policy and Procedures section*). PHS will monitor member assignments and provide each contracted PCP with a printed roster or tape/electronic transmission monthly upon request. Members are assigned on a daily basis, and there may be members assigned to a PCP who will not appear on the roster. Each PCP should check with PHS Member Services if there is a question on a member's eligibility. If a member requests a change of PCP, the change will become effective the first of the following month, unless the circumstances require differently.

G. IDENTIFICATION ENROLLMENT VERIFICATION:

AHCCCS issues an identification card to each member that contains the member's name and AHCCCS ID number. Members should present this card each time they arrive for services. The PCP/clinic staff should verify the member's eligibility from on-line eligibility data, the PHS roster, or call PHS Member Services if there is any question as to the member's enrollment or eligibility. Services cannot be denied if the member fails to produce the AHCCCS ID card, but the provider should ask for other types of identification to verify the identity of the member.

H. MEMBER CO-PAYMENTS:

AHCCCS allows providers to charge co-payments for some services. Effective October 1, 2003, AHCCCS regulations regarding co-payments have changed. The co-payment a member pays will depend on their AHCCCS enrollment. When verifying PHS eligibility you will find out if the member has a standard co-payment. If the member has a standard co-payment, they cannot be denied services if they are unable to pay the co-payment.

The following AHCCCS members do not have to pay any co-payments:

- All AHCCCS members under the age of 19, including KidsCare members.
- All AHCCCS pregnant women.
- All members receiving “Serious Mental Illness (SMI)” services from the RHBA/CPSA.
- All members who are receiving CRS services.
- All SOBRA Family Planning Services Only members.
- All AHCCCS members when receiving family planning services or supplies.
- All ALTCS enrolled members.

Each patient is assigned a rate code. The codes indicate various demographic information concerning the member. Of most importance to a provider is the third position of the rate code. If the third digit is either a zero (0) or a two (2), the member has Medicare coverage.

I. MEMBER RIGHTS AND RESPONSIBILITIES:

PHS requires that all providers observe the rights of members in the delivery of health care services, and to assist members in understanding their responsibilities in participating in their health care. These rights and responsibilities are communicated to members in the member handbook. The PHS Standards and Procedures relating to member rights and responsibilities are also included in this section of the Manual for your use.

PHS has an advance directive brochure which will be provided to each new member or their representative along with their copy of the member handbook. The brochure includes agencies which the member may contact for more information and assistance in drafting advance directives. Members receive the PHS Privacy Notice at time of enrollment.

The enclosed Pima Health System Member Booklet outlines the following:

Acute Care

- Member Responsibilities
- Member Rights

ALTCS (Arizona Long Term Care System)

- Member Responsibilities
- Member Rights

Living Will and other Health Care Directives

This booklet is provided to Pima Health System members upon initial enrollment and annually.

See the PHS Standard and Procedure Section for more information regarding:

-Member Assignment to a Primary Care Provider

-Member Appeal of Action

-Member Grievance