REVISION DATES: 07/08/2024; 1/30/2023; 10/1/2018; 12/29/2017; 12/22/2017

GENERAL INFORMATION

All Arizona residents can apply for AHCCCS services or the Arizona Long Term Care System (ALTCS) program. There are many programs that individuals may qualify for in order to receive AHCCCS medical or behavioral health services or ALTCS coverage.

The programs have a number of different financial and non-financial requirements that applicants must meet, including, but not limited to:

1. Proof of Arizona residency at the time of application.
2. Proof of U.S. citizenship and identity or proof of qualified alien status.
   - If a non-citizen does not meet the qualified alien status requirements for full services, but meets all other requirements for the Caretaker Relative, SOBRA Child, SOBRA Pregnant Woman, Young Adult Transitional Insurance (YATI), Adult, or SSI-MAO category, the individual is eligible to receive Federal Emergency Services (FES) only.
3. An income test that requires applicants to identify all individual and/or family earned and unearned income and to provide documentation if needed.
4. A resource test that requires applicants to identify resources (e.g., homes, other property, liquid assets, vehicles, and any other item of value) and provide documentation of their value.

   NOTE: A resource test is only required for the ALTCS program.
5. Other requirements
   - Each program has certain non-financial and/or financial requirements that are unique to the program and are aimed at servicing specific groups of people.

For additional information please refer to https://azahcccs.gov/Members/GetCovered.

ELIGIBILITY

Eligibility determination is not performed under one roof, but by various agencies, depending on the eligibility category.

For example:

- Pregnant women, caretaker relatives, children, and single individuals enter AHCCCS by way of the Department of Economic Security.
- The blind, aged or disabled, who receive Supplemental Security Income, enter through the Social Security Administration.
- Eligibility for categories such as ALTCS, SSI – Medical Assistance Only (Aged, Blind and Disabled, who do not qualify for Supplemental Security Income cash payment), KidsCare, Freedom to Work, Breast and Cervical Cancer Treatment Program and

Medicare Cost Sharing programs are handled directly by the AHCCCS Administration.

Each eligibility category has its own eligibility criteria. This information is also available on the AHCCCS website at:

https://azahcccs.gov/AHCCCS/AboutUs/programdescription.html

1. Coverage for parents and caretaker relatives is provided under Caretaker Relatives.
2. Coverage for children is provided under the following eligibility categories:
    a. ALTCS
    b. KidsCare
        i. KidsCare is Arizona's version of the Title XXI State Children's Health Insurance Program.
        ii. It covers low-income children under age 19, if the family income is less than 200 percent of the Federal Poverty Level (FPL).
    c. Child Group
    d. SSI Cash (Title XVI) or SSI MAO
    e. Young Adult Transitional Insurance (YATI) for former Foster Care Children aged 18 to 26
    f. Foster Care Children
    g. Adoption Subsidy Children
    h. Newborns
    All babies born to AHCCCS-eligible mothers are also deemed to be AHCCCS eligible and may remain eligible for up to one year, as long as the newborn continues to reside in Arizona.
        i. Newborns born to mothers receiving Federal Emergency Services (FES) also are eligible up to one year of age. While the mother will be covered on a Fee-For-Service basis under FESP, the newborn will be enrolled with a health plan.
        ii. Newborns born to mothers enrolled in KidsCare will be approved for KidsCare beginning with the newborn's date of birth, unless the child is Medicaid eligible.
        iii. 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.
3. Coverage for single individuals and couples is provided under the following eligibility categories:
    a. ALTCS
    b. Breast and Cervical Cancer Treatment Program
    c. Family Planning Services (FPS) provides family planning services for up to 24 months to SOBRA pregnant women after a 60-day post partum period.
    d. SOBRA Pregnant Women
    e. SSI Cash (Title XVI) or SSI MAO
    f. Adults
    g. Freedom to Work

h. Transplants
i. Medicare Cost Sharing
j. Hospital Presumptive Eligibility (HPE)

Various Medicare Savings Programs help members pay Medicare Part A & B premiums, deductibles, and coinsurance.

1. Qualified Medicare Beneficiary (QMB)
2. Qualified Individual 1 (QI-1)
3. Specified Low Income Medicare Beneficiary (SLMB)

COVERAGE OUT OF STATE

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

1. Medical services are required because of a medical emergency. Documentation of the emergency must be submitted with the claim to AHCCCS.
2. The member requires a particular treatment that can only be obtained in another state.
3. The member has a chronic illness necessitating treatment during a temporary absence from the state or the member's condition must be stabilized before returning to the state.

Services furnished to AHCCCS members outside of the United States are not covered.

ELIGIBILITY EFFECTIVE DATES

The following general guidelines apply to eligibility effective dates:

1. For most members, eligibility is effective from the first day of the month of application, the first day of the month in which the member meets the qualifications for the program, or their date of birth, whichever is later.

2. For KidsCare members, if the eligibility determination is completed by the 25th day of the month, eligibility begins on the first day of the following month. For eligibility determinations completed after the 25th day of the month, eligibility begins on the first day of the second month following the determination of eligibility.

3. For Medicare Savings Program (MSP) – QMB members, eligibility begins with the month following the month that QMB eligibility is determined.

4. For Breast and Cervical Cancer Treatment Program (BCCTP) members, eligibility begins on the later of the first date of the month (the application month for BCCTP is the month of the BCCTP diagnosis), or the first day of the month in which the customer meets all the BCCCTP eligibility requirements.

5. For a move into state or release from prison, the begin date is no sooner than that date.

ENROLLMENT

AHCCCS *pre-enrolls* most acute care members with contractors of their choice when they apply for eligibility through DES and the Social Security Administration. Each member who applies at a DES or SSA office receives information about the contractors available to him or her.

ALTCS applicants in Maricopa County and all SSI-MAO applicants also have the opportunity to select a contractor during the application process.

KidsCare applicants may choose a contractor prior to approval of their application.

Because the member can select a contractor while the eligibility decision is pending, he or she is enrolled on the same day that he or she is determined eligible. A member who does not choose a contractor is auto-assigned to a contractor on the same day that his or her eligibility is posted in the AHCCCS system. The person then has 30 days to enroll with a different contractor, if they wish.

A person who is in the Address Confidentiality Program (ACP) has a pre-assigned address in Maricopa County, regardless of where the individual lives. If the person is not currently enrolled with an AHCCCS contractor, AHCCCS enrolls the person in Fee-For-Service until a choice is obtained. If the person is currently enrolled with an AHCCCS contractor they will remain with that contractor, unless the person is in another county and qualifies for a plan change.

Contractors are responsible for reimbursing providers for covered services rendered to members during the Prior Period Coverage (PPC) time frame. The PPC time frame is the period between the member's starting date of AHCCCS eligibility and their date of enrollment with a contractor.

Example

05/12	Member applies at DES and indicates their choice of health plan, which is sent to AHCCCS.
06/18	DES approves the application and sends the transaction to AHCCCS.
06/19	Eligibility is approved by AHCCCS with an effective date of 05/01 and enrollment is posted and back-dated to 5/01.

The member is enrolled in his or her pre-selected plan. If the member did not make a pre-enrollment choice, then AHCCCS follows re-enrollment rules and family continuity rules before auto-assigning the member to a plan.

The health plan is responsible for the Prior Period Coverage (PPC) time frame from 05/01 (the start of eligibility) through 06/18 (the day before the enrollment was processed). The plan is capitated at the appropriate PPC rate for this time frame. Starting on 06/19, the plan is then capitated under the appropriate on-going rate.

The eligibility begin date may be different than the Program Contractor enrollment date, if the member is acute care eligible. The member will remain enrolled in the acute care health plan until the day of ALTCS approval.

AHCCCS Complete Care (ACC) members, who maintain eligibility, may change plans once a year during their enrollment anniversary month. The enrollment anniversary is the month in which a member was first enrolled with an AHCCCS contractor. American Indian/Alaskan Native (AI/AN) members may choose to switch their enrollment between an AHCCCS Complete Care (ACC) health plan or the American Indian Health Program (AIHP) at any time. However, they may only change between different ACC plans once per year during annual enrollment.

If more than one person in a household/case is on AHCCCS, that household's anniversary is the month in which enrollment occurred for the member who has been an AHCCCS member continuously for the longest period of time. Any member of the household who wants to change plans may do so at the same time.

Two months prior to their anniversary date, members are reminded of their opportunity to change plans. Those who wish to change contractors have two months to notify AHCCCS of their decision.

The month following the choice is the transitional month, during which time AHCCCS notifies both the former plan and new plan of the enrollment changes. This allows the plans adequate time to transfer records and welcome new members.

Members who do not want to change plans will remain enrolled with their current plan as long as the eligibility remains open.

This same process applies to ALTCS members in Maricopa and Pima Counties, where a choice of contractors is available. Only one ALTCS contractor is available in other counties.

INCENTIVES

Contractors may not offer members incentive items (e.g. gift cards, discounts for merchandise or services, manufacturer or store coupons for savings on products) to

influence their enrollment or continued enrollment with a particular contractor, as specified in A.A.C R9-22-504.

Contractors *may* offer incentive items to members to participate in health-related promotions, but the total value of the items at each event or program may not exceed $50.00 per member annually.

PRIOR QUARTER COVERAGE ELIGIBILITY

Coverage for most newly eligible members is retroactive to the first day of the month in which the Medicaid application is received.

Pregnant women and children up to age 19 are exempt from this requirement.

If an exempt individual is determined to qualify for AHCCCS during any one or more of the three months prior to the month of application, then the individual will be determined to have "Prior Quarter Coverage" eligibility during those months.

The AHCCCS Administration will determine whether or not an applicant meets prior quarter coverage criteria. If so, the providers will be required to bill AHCCCS for services provided during a prior quarter eligibility period upon verification of eligibility or upon notification from the member of prior quarter coverage eligibility.

For further information regarding the submission of prior quarter coverage claims, please refer to Chapter 4, General Billing Rules, of the IHS/638 Tribal Provider Billing Manual.

HOSPITAL PRESUMPTIVE ELIGIBILITY (HPE)

In accordance with the Affordable Care Act, qualified hospitals may elect to participate in the Hospital Presumptive Eligibility (HPE) Program. Qualified hospitals may determine persons, who have not submitted a full application to AHCCCS, to be presumptively eligible for AHCCCS Medicaid covered services. Persons determined presumptively eligible will qualify for Medicaid services from the date the hospital determines the individual to be presumptively eligible through the last day of the month following the month in which the determination of presumptive eligibility was made.

- If a person is determined to be presumptively eligible on March 3rd then that person would qualify for Medicaid services, under HPE, from March 3rd through April 30th.
- Claims for persons determined to be presumptively eligible for AHCCCS should be submitted to the AHCCCS Administration until a full application is completed by the member and they have been enrolled with a Contractor.

For persons who apply for presumptive eligibility and who also submit a full application to AHCCCS, coverage of Medicaid services will begin on the date that the hospital determines the individual to be presumptively eligible and will continue through the date that AHCCCS

issues a determination on that application. All persons determined presumptively eligible for AHCCCS will be enrolled with AHCCCS Fee-For-Service for the duration of the HPE period.

- Claims for persons determined to be presumptively eligible for AHCCCS should be submitted to the AHCCCS Administration until a determination is made on the application's status.

If a member, made eligible via HPE, is subsequently determined eligible for AHCCCS via the full application process, then Prior Period Coverage for the member will also be covered by AHCCCS Fee-For-Service. The member will be enrolled with the Contractor only on a prospective basis.

INCARCERATED INDIVIDUALS

States are prohibited from receiving federal Medicaid payments for treatment of health care costs during incarceration, except for allowable inpatient expenses.

Examples of non-reimbursable services:

- A physician coming into the detention center to provide treatment would **not** be reimbursable via Medicaid.
- An incarcerated individual who has been removed from prison for an M.D. appointment for the day (outpatient) would **not** be reimbursable via Medicaid.

Telehealth services do not allow this prohibition to be waived.
This prohibition applies to both medical and behavioral health services, including prescription coverage.

Medicaid Federal Financial Participation (FFP) is not available to individuals residing in state or federal prisons, local jails, or detention facilities; Federal Residential Re-entry Centers; or residential mental health and substance use disorder treatment facilities for inmates.

Section 1902(a)(34) of the Social Security Act establishes Medicaid eligibility provisions that allow FFP to be available for Medicaid-covered inpatient services provided in a medical institution, to an inmate, under certain circumstances: the inpatient stay shall be a hospitalization 24 hours or greater, and the inmate would otherwise be eligible for Medicaid.

Medicaid Federal Financial Participation (FFP) is available for individuals who are on parole, probation, or released into the community pending a trial; living in a halfway house (unless the individual does not have "freedom of movement association"); living in a public institution *voluntarily*; or on home confinement.

For additional information regarding covered Medicaid services for Incarcerated Individuals refer to:

- SHO #16-007 - To Facilitate Successful Re-entry for Individuals Transitioning from

Incarceration to their Communities
- Arizona Department of Corrections (ADOC) web page on the AHCCCS Fee-for-Service website

VERIFYING AHCCCS ELIGIBILITY AND ENROLLMENT

Even if a member presents an AHCCCS ID card or a decision letter from an eligibility agency, the provider must always verify the member's eligibility and enrollment status.

Effective dates of eligibility can only be verified through the AHCCCS system and may change as information is updated in the system. Eligibility categories also may change or be overridden by other eligibility categories. Members also may change their choice of contractors.

Although there are no Prior Authorization (PA) requirements during the PPC time frame, once prospective enrollment begins the contractors may impose PA requirements. These requirements may differ from those established by AHCCCS for Fee-For-Service members.

Providers may use any one of several verification processes to obtain eligibility, enrollment, and Medicare/TPL information (if available).

1. AHCCCS encourages verifications through a batch process (270/271), in which the provider sends a file of individuals to AHCCCS, which AHCCCS returns with information the following day. Information on that process can be obtained by calling the AHCCCS Help Desk at (602) 417-4451.

2. AHCCCS has developed a Web application that allows providers to verify eligibility and enrollment using the Internet. Providers also can obtain Medicare/TPL information for a member.
    a. To create an account and begin using the application, providers must go to https://azweb.statemedicaid.us.
    b. For technical support when creating an account, providers should call (602) 417-4451.

3. The Medical Electronic Verification System (MEVS) uses a variety of applications to provide member information to providers. For information on MEVS, please contact EMDEON at https://www.changehealthcare.com/contact-us.

4. The Interactive Voice Response system (IVR) allows an unlimited number of verifications by entering information on a touch-tone telephone.

    Providers may call IVR at:
    Phoenix: (602) 417-7200
    All others: 1-800-331-5090

5. In Maricopa County only, providers can request faxed documentation.

Medifax EDI: 1-800-444-4336

6. If a provider cannot use the AHCCCS batch or web processes, IVR or EMDEON, for verification of eligibility or enrollment, the provider may call the *AHCCCS Verification Unit.*

The unit is staffed from 8:00 a.m. to 5:00 p.m., Monday through Friday.

Providers should be prepared to give the operator the following information:

a. *Provider* NPI (if applicable) or the AHCCCS Provider Registration number; and
b. *Member's* name, date of birth, and AHCCCS ID number or Social Security number; and
c. Date(s) of *se*rvice.

NOTE: Rate Codes can be referenced on the AHCCCS website.

Revision History

Date	Description of changes	Page(s)
7/8/2024	Updated Prior Quarter Coverage section	6
1/30/2023	Incarcerated Individuals Sections added	7
10/1/2018	The Enrollment section was updated to include information about AHCCCS Complete Care and the fact that American Indian/Alaskan Native (AI/AN) members may choose to switch their enrollment between an AHCCCS Complete Care (ACC) health plan or the American Indian Health Program (AIHP) at any time. However, they may only change between different ACC plans once per year during annual enrollment.	5
12/29/2017	Hospital Presumptive Eligibility (HPE) section added	7
12/22/2017	Incentives information added Formatting	5 All