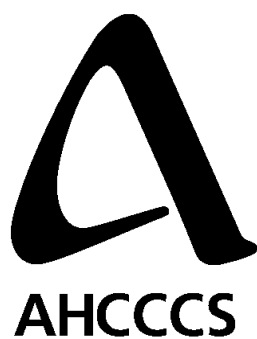


Chapter 2

Eligibility



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A. OVERVIEW

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 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 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 serving specific groups of people.

Refer to <http://www.azahcccs.gov/applicants/default.aspx> for additional information.

B. 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 in a booklet on the AHCCCS website:

http://www.ahcccs.gov/community/Downloads/resources/Description_of_AHCCCS_Programs.pdf

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 per cent of 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 if the newborn continues to reside in Arizona.

 - i. Newborns born to mothers receiving Federal Emergency Services 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 only 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

Various Medicare Savings Programs help recipients 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)

C. COVERAGE OUT OF STATE

A recipient 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 recipient requires a particular treatment that can only be obtained in another state.
3. 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.

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



D. ELIGIBILITY EFFECTIVE DATES

The following general guidelines apply to eligibility effective dates:

1. For most recipients, eligibility is effective from the first day of the month of application or the first day of the month in which the recipient meets the qualifications for the program or the date of birth whichever is later.
2. For KidsCare recipients, 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 a move into state or release from prison, the begin date is no sooner than that date.

E. ENROLLMENT

AHCCCS *pre-enrolls* most acute care recipients with contractors of their choice when they apply for eligibility through DES and the Social Security Administration. Each recipient 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 recipient can select a contractor while the eligibility decision is pending, he or she is enrolled on the same day he or she is determined eligible. A recipient 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 in an AHCCCS contractor, AHCCCS enrolls the person in Fee-for-Service until a choice is obtained. If the person is currently enrolled in 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 recipients during the Prior Period Coverage (PPC) time frame. The PPC is the period between the recipient's starting date of AHCCCS eligibility and the date of enrollment with a contractor.

Example

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

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

The health plan is responsible for prior period coverage from 05/01 (start of eligibility) through 06/18 (day before the enrollment is being processed). The plan is capitated at the appropriate PPC rate for this period. Starting 06/19, the plan is 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 acute care recipients who maintain eligibility may change plans once a year during their enrollment anniversary month. The enrollment anniversary is the month in which a recipient was first enrolled with an AHCCCS contractor. Native Americans may change between American Indian Health Plan (AIHP) and an AHCCCS contractor at any time.

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 recipient who has been an AHCCCS recipient 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, recipients 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.

Recipients 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 recipients in Maricopa and Pima Counties, where a choice of contractors is available. Only one ALTCS contractor is available in other counties

F. EFFECTIVE 1/1/2014 PRIOR QUARTER COVERAGE ELIGIBILITY

Beginning January 1, 2014, AHCCCS will be required to expand the time period AHCCCS pays for covered services for an eligible individual, to include the three months prior to the month the individual applied for AHCCCS, if the individual met AHCCCS eligibility requirements during the month in which the Medicaid covered service was provided.

Federal requirements provide that an applicant may be eligible for covered services during any of the three months prior to the Medicaid application date if the applicant:

1. received one or more AHCCCS covered services during the month and
2. would have qualified for AHCCCS at the time services were received if the person had applied for AHCCCS.

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

As stated above, Prior Quarter Coverage eligibility will begin January 1, 2014 which means that individuals applying for AHCCCS in February 2014 may be determined to qualify for prior quarter coverage during the month of January 2014. Persons applying in March 2014 may qualify for prior quarter coverage in January and February. Persons who apply on or after April 1, 2014 may qualify for prior quarter coverage for up to the full 3 months prior to the month of the Medicaid application.

AHCCCS will not institute prior quarter coverage eligibility before January 1, 2014.

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 recipient of prior quarter coverage eligibility.



Refer to Chapter 4 General Billing Rules for submitting prior quarter claims.

G. VERIFYING AHCCCS ELIGIBILITY AND ENROLLMENT

Even if a recipient presents an AHCCCS ID card or a decision letter from an eligibility agency, the provider must always verify the recipient'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. Recipients 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 recipients.

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 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 recipient.
 - 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, contact EMDEON at <http://www.emdeon.com/contactus/>
4. The Interactive Voice Response system (IVR) allows an unlimited number of verifications by entering information on a touch-tone telephone.
5. Providers may call IVR at:
Phoenix: (602) 417-7200
All others: 1-800-331-5090



6. In Maricopa County only, providers can request faxed documentation.
Medifax EDI 1-800-444-4336
7. 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
- b. *Recipient's* name, date of birth, and AHCCCS ID number or Social Security number
- c. Date(s) of service

NOTE: Rate Codes can be referenced on the AHCCCS website