

**403 - ENROLLMENT CHOICE IN A COUNTY WITH CHOICE AND CHANGE OF CONTRACTOR:
ARIZONA LONG TERM CARE SYSTEM CONTRACTORS**

EFFECTIVE DATES: 10/01/00, 01/01/17, 04/01/17, 01/25/19, 10/01/24, 10/01/25, 10/01/26

APPROVAL DATES: 08/01/01, 02/02/17, 01/11/19, 05/07/24, 05/30/25, 04/06/26

I. PURPOSE

This Policy applies to ALTCS E/PD Contractors only. This Policy establishes guidelines, criteria, and timeframes for enrollment choice in a county where the member has a choice of Contractor and how a Contractor change request shall be processed.

II. DEFINITIONS

Refer to the [AHCCCS ACOM and AMPM Dictionary](#) for common terms found in this Policy.

For purposes of this Policy, the following terms are defined as:

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| COUNTY WITH CHOICE | A county with more than one ALTCS E/PD Contractors. |
| CURRENT CONTRACTOR | The Contractor with whom the member is enrolled at the time the change request is generated. |

III. POLICY

A. ENROLLMENT CHOICE IN A COUNTY WITH CHOICE

1. Enrollment choice is available when:
 - a. An applicant's County of Fiscal Responsibility is a County With Choice,
 - b. A member moves from one County to their own home in a different County that is a County With Choice, unless the member's current Contractor is available in that new County,
 - c. A member moves from one County to a Nursing Facility (NF) or alternative residential setting in a different County that is a County With Choice and the member's current Contractor has chosen to negotiate an enrollment change,
 - d. A member is currently enrolled with a Contractor in a County where the Contractor is serving as a County With Choice, but a valid condition exists (see Section B) for the member to request an enrollment change to another Contractor serving that County,
 - e. A former member resides in a County With Choice and the member reestablish eligibility that results in their reenrollment more than 90 days after disenrollment,
 - f. A member reaches their annual anniversary date, or
 - g. If an ALTCS E/PD member is not enrolled in a Medicare Advantage Fully Integrated Dual Special Needs Plan (FIDE SNP), the member may choose from the available ALTCS E/PD plans.

2. Enrollment choice is not available for:
 - a. A member whose county of fiscal responsibility is not a County With Choice (unless the current Contractor chooses to negotiate an enrollment change),
 - b. A member who was disenrolled from a Contractor in a County With Choice, but subsequently re-establishes ALTCS E/PD eligibility that results in reenrollment within 90 days from disenrollment,
 - c. A member who moves to a County With Choice and the member's current Contractor is available in that new County, or
 - d. A member who is enrolled in a Medicare Advantage FIDE SNP, the member will be automatically enrolled with the companion ALTCS E/PD Contractor with the same parent company.

B. REQUESTS FOR CONTRACTOR CHANGES WITHIN A COUNTY OF CHOICE

An enrollment changes from one Contractor to another, in a County With Choice, can be made outside of a member's Annual Enrollment Choice (AEC) for the following reasons:

1. Medical Continuity of Care Request(s)

The Contractor changes may be approved on a case-by-case basis to ensure the member's access to care. In order to provide continuity of care on a temporary basis for the member's period of illness, the member's current Contractor may agree to a reimbursement schedule with the member's provider rather than approve a member's change of Contractor:

- a. If the Medical Directors of both Contractors **approve** the change request:
 - i. The current Contractor sends the completed AMPM Exhibit 1620-8, the Contractor Change Request Form to the Receiving Contractor and AHCCCS at PCCRS@azahcccs.gov as specified in Contract Section F, Attachment F3, Contractor Chart of Deliverables, and
 - ii. The current Contractor notifies the member in writing of the approved change, and in advance of the effective date of the change. The approval of the member request must take effect no later than the first day of the second month after the members' request or the Contractor sent the request to AHCCCS as specified in 42 CFR 438.56.or
- b. If the requested Contractors **denies** the request:
 - i. The Form is returned to the current Contractor,
 - ii. The current Contractor may forward the Form to the AHCCCS Chief Medical Officer (CMO) or designee for a final decision,
 - iii. If the AHCCCS CMO or designee approves the change, the Form is returned to the current Contractor for submission to the AHCCCS central office, and
 - iv. If the change request is denied by the AHCCCS CMO or designee, AHCCCS will provide written notice of the denial including notice of appeal rights to the member and to both the current Contractor and requested Contractor.

2. Erroneous provider network information or agency error - The applicant or representative made an enrollment choice based on erroneous information regarding facility, residential setting, Primary Care Provider (PCP), or other provider contracting with the chosen Contractor based on information supplied by the Contractor's network database, marketing materials, or agency error.

Erroneous information includes omissions or failures to divulge network limitations or restrictions in the Contractor's marketing materials or network database. The member's current Contractor shall submit an Electronic Member Change Report (eMCR) for these requests. Refer to the AHCCCS ALTCS Member Change Report User Guide for MCR instructions.

3. Lack of initial enrollment choice - An ALTCS E/PD applicant residing in a County With Choice is, for any reason, not offered a choice of Contractors during the application process. The member's current Contractor shall submit an eMCR for these requests.
4. Lack of Annual Enrollment Choice - The member was entitled to participate in an AEC but was not sent an AEC notice, the notice was not received, or the member was sent an AEC notice but was unable to participate in the AEC due to circumstances beyond the member's control (i.e., member or representative was hospitalized, Anniversary Date fell within a 90 day disenroll/reenroll period). The current Contractor shall submit an eMCR for these requests.
5. Family continuity of care - The member, either through auto-assignment or the choice process, is not enrolled with the same Contractor as the other family members. The current Contractor shall submit an eMCR for these requests.
6. Continuity of providers - The Contractor's contract with the institutional, residential or employment supports provider from which the member receives services is terminated, and the member or the member's representative requests to change to a Contractor who contracts with their provider (42 CFR 438.56 (d)(2)(iv)). The member shall be receiving services from the provider at the time of the contract termination. The current Contractor shall submit an eMCR for these requests.
7. Failure to correctly apply the 90-day reenrollment policy - A member who lost ALTCS eligibility and was disenrolled, then was subsequently reapproved for ALTCS eligibility within 90 days of the disenrollment date but was enrolled with a different Contractor. The current Contractor shall submit an eMCR for these requests.

C. MEMBER MOVES TO OWN HOME IN ANOTHER COUNTY

1. When a member resides in their own home the following policies apply:
 - a. The County of Fiscal Responsibility is the county where the member's home is located,
 - b. Enrollment is with a Contractor serving the Geographic Service Area (GSA) (or fiscal county) where the home is located, and
 - c. When the member moves to their own home in a County With Choice and is not already enrolled with a Contractor serving that county, the member shall be given an opportunity to choose a Contractor. The member will be enrolled with the Contractor selected through the enrollment choice process.
2. The member is responsible for reporting a move or anticipated move to the current Contractor and to AHCCCS.

3. The current Contractor is responsible for:
 - a. Notifying AHCCCS that the member moved by sending an eMCR,
 - b. Explaining service limitations and exclusions to a member who moves out of the Contractor's service area, and
 - c. Transitioning the member to the new Contractor according to the requirements and protocols in AMPM Policy 520.

D. MEMBER MOVES TO A NURSING FACILITY OR ALTERNATIVE RESIDENTIAL SETTING IN ANOTHER COUNTY

When a Contractor places a member in a NF or alternative residential setting in a different county (either to receive specialized treatment or because of lack of beds in the Contractor's County), the County of Fiscal Responsibility and enrollment do not change.

When the current Contractor chooses to contract with the NF or alternative residential setting in another County, the enrollment and County of Fiscal Responsibility for that member do not change.

When the member moves to a County With Choice, the enrollment choice process shall be completed before the current Contractor can initiate negotiations with the requested Contractor.

1. Current Contractor Responsibilities:
 - a. When the current Contractor is notified that a member has moved to another county or plans to move to another county, and the member resides or plans to reside in a NF or alternative residential setting, and the current Contractor does not serve the other county, the current Contractor has the following options:
 - i. Retain the member and contract with an out-of-county provider,
 - ii. Negotiate an enrollment change for the member, or
 - iii. Negotiate a single case agreement with the facility while plans are being made to move the member to a contracted facility.
 - b. When enrollment change is the preferred option, the current Contractor is responsible for:
 - i. Completing a Contractor Change Request Form and sending it to the Contractor serving the County or the requested Contractor in a County With Choice, and
 - ii. Transitioning the member when a change is approved.
2. Requested Contractor's Responsibilities. When a Contractor Change Request Form is received, the requested Contractor is responsible for:
 - a. Approving or denying the change request by completing the Form, and
 - b. Transitioning the member when the change request is approved or when the AHCCCS CMO or designee directs the change.

E. ADDITIONAL CONTRACTOR RESPONSIBILITIES

1. Contractors are responsible for providing information on the Contractor change policy in:
 - a. The Contractor's Member Handbook, and
 - b. The Contractor's Provider Manual.

2. The current Contractor shall follow the grievance process for making a determination on a plan change request including but not limited to:
 - a. The Contractor shall issue a decision on the plan change request no later than 30 days from the date of the member's request,
 - b. If, as a result of the grievance process, the Contractor approves of the members' request, AHCCCS is not required to make a determination in accordance with 42 CFR 438.56(d)(5)(iii). The approval of the member request must take effect no later than the first day of the second month after the members' request or the Contractor sent the request to AHCCCS as specified in 42 CFR 438.56,
 - c. If, as a result of the grievance process, the Contractor denies the plan change request, the Contractor shall notify the member of the determination and their right to request a State Fair Hearing. The Contractor shall allow the member 90 days to file a State Fair Hearing from the date of the determination notice as specified in 42 CFR 431.221,
 - d. If the Contractor or AHCCCS (whichever is responsible) does not make a determination within the timeframes, the request is considered approved for the effective date that would have been established had the Contractor or AHCCCS complied with the requirements as specified in 42 CFR 438.56.
3. The current Contractor is responsible for promptly addressing a member's concerns including but not limited to:
 - a. Availability and accessibility of services,
 - b. Quality Of Care (QOC),
 - c. Case management responsiveness,
 - d. Transportation service availability,
 - e. Institutional care issues,
 - f. Physician or provider office hours,
 - g. Office waiting time, and
 - h. Provider network limitations and restrictions.
4. When QOC and delivery of medical service issues raised by the member cannot be solved through the normal case management process, the current Contractor shall refer to the issue for review to:
 - a. The current Contractor's Quality Management Department, and/or
 - b. The AHCCCS Quality Management Department.
5. When an enrollment change is approved while a member is hospitalized, the current Contractor shall notify the hospital of the member's disenrollment prior to the enrollment with the receiving Contractor.

If the current Contractor fails to provide such notice to the hospital, the current Contractor will continue to be responsible for payment of hospital services provided to the member until the date notice is provided to the hospital as required in the AMPM Policy 520.

6. When an enrollment change requested by the member is denied at the Contractor level (not by the AHCCCS CMO), the current Contractor is responsible for processing any resulting member grievances or hearing requests.