



Tribal ALTCS Fee-For-Service Member Handbook

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IMPORTANT TELEPHONE NUMBERS

CASE MANAGER: _____ PHONE: _____

CASE MANAGEMENT
AGENCY/SUPERVISOR: _____ PHONE: _____

DOCTOR: _____ PHONE: _____

NURSING HOME: _____ PHONE: _____

EMERGENCY CARE: Call **911** or if this is not available, call: _____

AMBULANCE: _____

FIRE DEPARTMENT: _____

OMBUDSMAN: _____

TRIBAL SOCIAL SERVICE OFFICE: _____

ALTCS ELIGIBILITY OFFICE: _____

If you have trouble reading and/or understanding the information in this handbook, please ask your case manager for assistance.

WELCOME

Welcome to the Arizona Long Term Care System (ALTCS).

This is your Member Handbook. Please read this book very carefully. It should give you all the information you will need to get help with your health care. You may want to look at this book from time to time, so keep it in a place where you can find it.

As a member of ALTCS, you have been assigned to a Tribal ALTCS program and case manager. This case manager will mark the Tribal ALTCS Program you have been assigned.

Tribal ALTCS Program Name	Tribal ALTCS Websites	Phone Number	Tribal ALTCS Program
Gila River Indian Community	http://www.gilariver.org/index.php/departments--programs/tribal-development-services	602-528-1200	
Hopi Tribe	https://www.hopi-nsn.gov/tribal-services/department-of-community-health-services/office-of-aging-adult-services/	928-734-3551	
Navajo Nation/Chinle	https://www.nndss.navajo-nsn.gov/DSSPrograms/DepartmentofFamilyServices.aspx	928-674-2236	
Navajo Nation/Fort Defiance		928-871-7988	
Navajo Nation/Tuba City		928-283-3250	
Dilkon ALTCS		928-657-8036	
Pascua Yaqui Tribe	https://www.pascuayaqui-nsn.gov/index.php/altc-tucson-and-guadalupe	520-879-6020	
San Carlos Apache Tribe		928-475-2138	
Tohono O'Odham Nation	http://www.tonation-nsn.gov/health-human-services/senior-services/	520-383-6075	
White Mountain Apache Tribe	www.wmat.nsn.us	928-338-1242	
Native Health	https://www.nativehealthphoenix.org/services/community-health-and-wellness/altcs/	602-279-5262	

American Indian ALTCS members residing on reservations, other than the seven tribes, receive case management services through [Native Health](#) (phone: 602-279-5262).

- Ak-Chin Indian Community
- Cocopah Indian Tribe
- Colorado River Indian Tribes
- Fort McDowell Yavapai Nation
- Fort Mohave Indian Tribe
- Havasupai Tribe
- Hualapai Tribe
- Kaibab Band of Paiute Indians
- Quechan Indian Tribe
- Salt River Pima-Maricopa Indian Community
- San Juan Southern Paiute Tribe
- Tonto Apache Tribe
- Yavapai - Apache Nation
- Yavapai - Prescott Indian Tribe

YOUR CASE MANAGER

Your ALTCS Case Manager is the person who gave you this book. As an ALTCS member, you now have a case manager that will help you get the health services you need. Examples of what your case manager can do for you are:

- Your case manager may set up services in your home that will help you stay there as long as possible, such as: Attendant Care, Personal Care, Homemaker, Home-Delivered Meals and/or Home Health Nursing.
- If you need more help than you and your family can manage at home, your case manager can help with other types of placements, like an assisted living facility or nursing home.
- Your case manager will help you find a doctor or specialist if you need one.
- Your case manager will work with your doctor to make sure you get the physical and behavioral health services you need.
- Your case manager will visit or contact you on a regular basis (at least every 3 months if you live in the community or in an Assisted Living Facility (ALF), or every 6 months if you live in a nursing facility) to check on you.

Your case manager must approve and authorize your services before they start, or AHCCCS will not pay for those services.

Your case manager will visit you to talk about what services you need. Your case manager will see if there are any problems with the services you are getting or if you need different services. If you would like to have other people with you when the case manager visits to talk about these things, you should tell your case manager.

If you have any questions about physical health, behavioral health and/or long term care services between visits with your case manager, or if you need to talk about changes in your services, call your case manager whose phone number is listed on page 3 of this handbook.

AHCCCS MEMBER ID CARD

It is very important that you take your AHCCCS ID card *and* your Arizona Driver's License or State Issued ID with you and show it when you go to the doctor's office, emergency room, hospital, clinic or pharmacy. The card shows that you are an AHCCCS/ALTCS member and helps your provider know what steps to follow for approval and payment to AHCCCS/Medicaid/Fee-for-Service.

If you have Medicare or other insurance, you also need to take those health cards with you and show them before you get services.

Do not loan, sell or give your AHCCCS ID card to anyone else to use. This could result in loss of your eligibility or legal action against you. Do not discard your ID card.

If you lose your AHCCCS card, call either (602) 417-7000 (from 602, 480 or 623 area codes) or toll-free 1-800-962-6690 (for all other area codes), Press Option 1 for English, Press Option 2 for all other calls, then Press Option 1 to Verify Eligibility or to request a new card.

YOUR RIGHTS

As a member of the ALTCS program, you have rights. These rights include, but are not limited, to the following:

You have the right to:

- Be treated with respect by Tribal ALTCS Program staff, AHCCCS, and all providers of care;
- Be treated fairly, regardless of your race, ethnicity, national origin, religion, gender, age, behavioral health condition (intellectual) or physical disability, sexual preference, genetic information, or ability to pay;

- Have your privacy protected, including your medical or health records and information;
- Receive decisions about your or your doctor’s request for services in a timely manner;
- Be told in writing if your request for services is being denied or if your current services will be decreased or stopped for a period of time;
- Have a replacement Direct Care Worker sent to provide care within 2 hours of notice to the case manager or provider agency if your regular Direct Care Worker is unable to come as scheduled (applies to members who receive “Critical Services” in their home as defined in this handbook);
- Request a copy of and/or inspect your own health records from your treating provider(s), at no cost to you;
- Have the right to amend or correct your medical records;
- Be provided an explanation of what your physical and/or behavioral health conditions are from your treating provider;
- Receive information on treatment choices for your condition that are presented in a way that you and/or your authorized representative understand, in your language of choice;
- Choose a registered AHCCCS provider(s) to provide your services;
- Participate in decisions regarding your health care, including the right to refuse any services or treatments;
- Get a second opinion from another qualified health care professional on your health and treatment choices, at no cost to you;
- Participate in decision-making regarding your health care. This includes the opportunity to discuss with your provider what the risks of your health condition(s) may be and the treatment options, including the risks and/or complications of not receiving care or treatment;
- Choose someone to make your health care decisions for you if/when you are unable to make them for yourself;
- Be free from chemical or physical restraints and seclusion used as a means of coercion, discipline, convenience or retaliation;
- Have an interpreter present to explain things if you do not speak English;
- Have a person proficient in sign language available for the hearing impaired;
- Have written materials available in Braille for the blind or in different formats;
- Have services provided in a culturally competent manner;
- Be provided with resources on how to file a grievance or appeal and how to request a hearing when you do not agree with a decision about your care or services;
- Handle your own money or pick someone you trust to do this for you;

- Choose a nursing facility or Assisted Living Facility as your place of residence when it is medically necessary and cost effective; and/or
- Be free to exercise your rights with the knowledge that it will not affect your treatment by providers.

For members living in their home, please also see page 33 of this Handbook for an important notice about additional rights related to services you are authorized to receive.

YOUR RESPONSIBILITIES

As a member of the ALTCS program, your responsibilities include, but are not limited to, the following:

You have a responsibility to:

- Treat others with respect, including Tribal ALTCS Program staff, AHCCCS, providers and, if applicable, other people living in your facility;
- Tell your doctor, Direct Care Worker and/or case manager about all your health care needs;
- Tell your doctor, Direct Care Worker and/or case manager when there are changes in your health condition and/or needs;
- Do what your doctor tells you to do, including taking your medicines and following their advice about diet and exercise;
- Ask your doctor, Direct Care Worker, case manager and/or other providers about your care and treatments if you do not understand them;
- Take care of any equipment or supplies you are given and only use them as they are intended to be used;
- Make your appointments ahead of time and be on time for them;
- Cancel medical appointments and transportation when you are not able to keep these;
- Call your Direct Care Agency and call your case manager when you are admitted to the hospital or other medical facility and will not be receiving services in your home, even if only temporarily;

- Keep your AHCCCS ID and Medicare cards in a safe place. Take and show your cards when you go to the doctor’s office, emergency room, hospital, clinic or pharmacy;
- Let your case manager or ALTCS eligibility worker know if you have medical insurance other than ALTCS;
- Go to or call the ALTCS office when you get a letter telling you to do so (or you may not be eligible to get services any longer);
- Tell your case manager or ALTCS eligibility worker about any changes in your income, address, phone number or other things that could affect your eligibility. Notify and provide your contact information to your Tribal ALTCS Program staff and AHCCCS; and
- Talk to your case manager before you move.

PRIOR AUTHORIZATION

Certain covered services may require Prior Authorization (prior approval) by your case manager or the AHCCCS Administration. AHCCCS registered providers should know how and when to get approval. Some of the services you get will need to be:

- Ordered by your doctor, and/or
- Approved by your case manager or the AHCCCS Administration **before** you get the service.

Note: You will need to show your AHCCCS card before you get medical services. If you have any questions, call your case manager.

COVERED SERVICES

The services listed below are some of the services you may be able to receive under ALTCS. If you have any questions about what these services are or if they are right for you, call your case manager.

ALTCS MEMBERS MAY RECEIVE HEALTH ASSESSMENTS, SCREENING TESTS, IMUNIZATIONS, AND HEALTH EDUCATION LIKE:

- WELL EXAMS AND PHYSICAL EXAMS
- LABORATORY TESTS
- CANCER SCREENINGS

- ◆ Breast (Mammogram)
- ◆ Cervical (Pap tests)
- ◆ Colon (Colonoscopy)
- ◆ Prostate (PSA test)

- HEART DISEASE SCREENINGS
 - ◆ High blood pressure screening
 - ◆ Cholesterol screening

- OTHER DISEASE SCREENINGS
 - ◆ HIV screening
 - ◆ Sexually transmitted disease screening
 - ◆ Tuberculosis screening

- SPECIALIST CARE
 - ◆ Specialist care requires a referral from the member's Doctor/Primary Care Physician (PCP).

- X-RAYS AND LABORATORY TESTS

BEHAVIORAL HEALTH SERVICES

- ◆ Laboratory and x-ray services for medication regulation and diagnosis
- ◆ Inpatient psychiatric facilities (residential treatment centers sub-acute facilities)
- ◆ Evaluation and screening
- ◆ Emergency and crisis intervention services**

CRISIS SITUATIONS

If you are in a crisis situation and think you might hurt yourself or someone else, please call **911 right away!**

If **911** is NOT available in your area, seek immediate medical care at the nearest hospital or other emergency care setting.

Crisis Phone Hotlines:

If you are experiencing a behavioral health crisis call one of the phone numbers below that matches the county you live in.

Crisis Phone Hotlines by County:

Maricopa County: **602-222-9444** or **1-800-631-1314**

Cochise, Graham, Greenlee, La Paz, Pima, Pinal, Santa Cruz and Yuma Counties: **1-866-495-6735**

Apache, Coconino, Gila, Mohave, Navajo and Yavapai Counties: **1-877-756-4090**

Gila River and Ak-Chin Indian Communities: **1-800-259-3449**

Especially for Teens:

Teen Lifeline phone or text **602-248-TEEN (8336)**

National 24-Hour Crisis Phone Hotlines:

National Suicide Prevention Lifeline **1-800-273-TALK (8255)**

Online: <https://suicidepreventionlifeline.org>

National Substance Use and Disorder Issues

Referral and Treatment Phone Hotline **1-800-662-HELP (4357)**

Text: Text the word **“HOME”** to **741741**

Veterans Crisis Line/Be Connected Line:

Veterans Crisis (and those who support them) **1-866-4AZ-VETS** or **1-866-429-8387**

PRESCRIPTIONS (Medicine)

- AHCCCS covers drugs which are medically necessary, cost effective, and allowed by federal and state law.
If you have Medicare Part D and ALTCS, AHCCCS does NOT pay for any drugs paid for by Medicare, or for the cost-sharing (coinsurance, deductibles, and copayments) for these drugs.
- AHCCCS and Tribal ALTCS Programs are prohibited from paying for these medications or the cost-sharing (coinsurance, deductibles, and copayments) for drugs available through Medicare Part D, even if the member chooses not to enroll in the Part D plan.
Medications and Medication Adjustment: Medicare (not AHCCCS) may cover most, if not all, of your medications.
- Some medications may require PA if obtained at a non-IHS/638 pharmacy from OptumRx.

INPATIENT HOSPITAL SERVICES

For members 21 years of age or older, coverage of in-state and out-of-state inpatient hospital services is limited to 25 days per benefit year. The benefit year is a one year time period of October 1st through September 30th. Some exclusion will apply such as days in a governmentally operated burn unit, days that are part of a transplant stay, or days in the hospital for behavioral health reasons. Covered services include, but are not limited to:

- Routine (regular) hospital care;
- Intensive care;
- Intensive care for newborns;
- Maternity care, including labor and delivery, recovery rooms, and birthing centers;
- Nursery for newborns and infants;
- Surgery, including anesthesiology; and
- Emergency services.

ROUTINE IMMUNIZATIONS

Covered immunizations include, but are not limited to:

- Diphtheria-Tetanus-Pertussis (DTP);
- Influenza;
- Pneumococcus;
- Rubella;
- Measles;
- Hepatitis B;
- Pertussis, as currently recommended by the Centers for Disease Control and Prevention (CDC) or ACIP;
- Zoster vaccine, for members 60 and older;
- HPV vaccine, for females and males up to age 26 years; and
- All child and adolescent immunizations, as recommended by the CDC childhood immunization schedules.

DENTAL

Tribal Members under the age of 21 may receive dental benefits, as outlined in AMPM 430, EPSDT Services. Communicate with your case manager when you receive dental services.

Tribal ALTCS members age 21 or older may receive medically necessary dental benefits up to \$1,000 per member per contract year (October 1st to September 30th) for:

- Diagnostic,
- Therapeutic,
- Preventative care, and
- Dentures.

EMERGENCY DENTAL

Members age 21 or older may receive emergency dental care and extractions up to \$1000 per member per contract year (October 1st to September 30th). A dental emergency is an acute disorder of oral health resulting in severe pain and/or infection as a result of pathology or trauma.

VISION SERVICES

Medically necessary vision services are covered:

- Following cataract removal; and
- Emergency care (including eye exams and lenses/glasses).

Note: Routine eye exams, for the sole purpose of obtaining prescription lenses, are not covered.

MEDICAL TRANSPORTATION (Physical & Behavioral Health Services)

Medically Necessary Emergency or Non-Emergency Medical Transportation (NEMT) is a covered service.

- Emergency Medical Transportation **Does Not** require prior approval.
- Medically Necessary Non-Emergency Medical Transportation (NEMT)
 - Covered to and from the nearest and appropriate AHCCCS registered physical and/or behavioral health provider.
 - Covered when transportation service is the same day as the covered medical service provided by an AHCCCS registered provider. This includes trips to any AHCCCS covered service (Example: Walk-in, doctor's office, clinic, hospital, dialysis or therapy, etc.).
 - NEMT trips greater than 100 miles (one-way or round trip) requires PA from your case manager.

EMERGENCY CARE

- 24 hour emergency physical and behavioral health care,
- Emergency transportation, and
- Emergency room services.

MEDICALLY NECESSARY ORGAN AND TISSUE TRANSPLANTS

NUTRITIONAL ASSESSMENTS

MATERNITY AND FAMILY PLANNING SERVICES

Maternity and family planning services, including medically necessary preconception counseling, identification of pregnancy, prenatal care, labor and delivery services and postpartum care are covered. Prenatal HIV testing and counseling are also covered.

It is very important that female members who are pregnant make and keep all maternity appointments, before, during and after pregnancy.

TOBACCO CESSATION

The Arizona Department of Health Services' Tobacco Education and Prevention Program offers help to members who are thinking about quitting tobacco use. For more information, please call the Arizona Smokers' Helpline at 1-800-556-6222, visit their website at www.ashline.org, or talk to your doctor.

FOR MEMBERS UNDER THE AGE OF 21

EARLY PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT)

Early Periodic Screening, Diagnostic and Treatment (EPSDT) is a comprehensive child health program of prevention and treatment, correction, and improvement (amelioration) of physical

and mental health problems for AHCCCS members under the age of 21. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist Medicaid members in effectively utilizing these resources.

EPSDT services provide comprehensive health care through primary prevention, early intervention, diagnosis, medically necessary treatment, and follow-up care of physical and behavioral health problems for AHCCCS members less than 21 years of age. EPSDT services include screening services, vision services, dental services, hearing services and all other medically necessary mandatory and optional services listed in federal law 42 USC 1396(d)(a) to correct or ameliorate defects and physical and mental illnesses and conditions identified in an EPSDT screening, whether or not the services are covered under the AHCCCS State Plan. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

A well child visit is synonymous with an EPSDT visit and includes all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules.

Amount, Duration and Scope

The Medicaid Act defines EPSDT services to include screening services, vision services, dental services, hearing services and “such other necessary health care, diagnostic services, treatment and other measures described in federal law subsection 42 USC 1396(d)(a) to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the (AHCCCS) State Plan.”

This means that EPSDT covered services include services that correct or ameliorate physical and mental defects, conditions, and illnesses discovered by the screening process when those services fall within one of the 28 optional and mandatory categories of “medical assistance” as defined in the Medicaid Act. Services covered under EPSDT include all 28 categories of services in the federal law even when they are not listed as covered services in the AHCCCS State Plan, AHCCCS statutes, rules, or policies as long as the services are medically necessary and cost effective.

EPSDT includes, but is not limited to, coverage of: inpatient and outpatient hospital services, laboratory and x-ray services, physician services, nurse practitioner services, medications, dental services, therapy services, behavioral health services, medical supplies, prosthetic devices, eyeglasses, transportation, and family planning services. EPSDT also includes diagnostic, screening, preventive and rehabilitative services. However, EPSDT services do not include services that are solely for cosmetic purposes, or that are not cost effective when compared to other interventions.

CHILDREN’S REHABILITATIVE SERVICES (CRS)

Arizona’s Children’s Rehabilitative Services (CRS) program, authorized by ARS 36-261 et seq., was originally created in 1929 to serve children with complex health care needs who required specialized services coordinated by a multidisciplinary team. Your Tribal ALTCS Case Manager

works in coordination with the multidisciplinary team to provide the medically necessary and cost-effective physical and behavioral health services.

Children with a Children’s Rehabilitative Services (CRS) designation will have their physical and behavioral health services covered under Tribal ALTCS.

LONG TERM CARE SERVICES

All Long Term Care services listed below REQUIRE PRIOR APPROVAL from your case manager before the service can begin.

NURSING FACILITY CARE

Services provided in licensed nursing homes for members who need regular medical and/or skilled nursing care. Members in a nursing facility may have a monthly Share of Cost (SOC) that they must pay towards the cost of their care. SOC is determined by the AHCCCS Division of Member Services (DMS). Members receive written notice of their SOC amount and any changes to the amount.

ADULT DAY HEALTH

A day care program that provides personal care, health monitoring, group meals and activities in a licensed health care setting.

ATTENDANT CARE (also known as Direct Care Services)

Services that help with dressing, bathing and other personal care, housekeeping, meal preparation and supervision for those who are not safe to be left alone. A member’s spouse can be the paid Direct Care Worker (with limits). Talk to your case manager about conditions that apply to this service. Attendant care can be provided through the following options:

- “Traditional” Attendant Care – a model of service delivery in which a provider agency of the member’s choice is authorized by the case manager to provide care. The Direct Care Worker is an employee of the agency. The Direct Care Worker may have been specifically chosen by the member to be the Direct Care Worker and/or may be a relative of the member, including the spouse.
- Agency with Choice – beginning January 1, 2013, this new member-directed option is available to home-based ALTCS members. Under the Agency with Choice option, the member or individual representative and a provider agency share employer-based responsibilities for the paid Direct Care Worker. Other services (Personal Care, Homemaker and Habilitation services) may also be provided through the Agency with Choice option.
- Self-Directed Attendant Care – members who live at home can manage their own care by hiring, training and supervising their own Direct Care Workers. Talk to your case

manager about how this option works. Spouses may NOT be the paid Direct Care Worker under this option.

COMMUNITY TRANSITION SERVICE

Provides certain goods and services in order to help members living in a nursing facility to establish or return to their own home in the community. Assistance is limited to no more than \$2000 per 5 year period.

EMERGENCY ALERT SYSTEM

Monitoring devices for members who are unable to access emergency assistance and/or who live alone.

HOME-DELIVERED MEALS

A healthy meal delivered once a day to the member's home when the member is not able to prepare their own meals and/or does not have someone to prepare a meal for them.

HOME HEALTH SERVICES

Visits from a nurse, home health aide, and/or therapist are ordered by the doctor to treat a specific condition and/or monitor the member's health.

HOMEMAKER

Help with household jobs like cleaning, shopping or cooking for the member only.

HOME MODIFICATIONS

Changes to a member's house, such as a wheelchair ramp or roll-in shower, that help the member to be able to do more care for themselves in the home. This service does not include repairs to a member's home or building additions and adding amenities that are not already in place. If you want to dis-enroll from the ALTCS program during the home modification process, please contact your case manager prior to calling the AHCCCS Division of Member Services.

HOSPICE

Service for members, and their families, who are at end of life.

MEDICAL EQUIPMENT AND SUPPLIES

- PROSTHETICS
 - ◆ Prosthetics are items that replace a part of the body that is missing, deformed, or not working, like artificial limbs.

- ORTHOTICS
 - ◆ Orthotics are items that support a part of the body that is weak or deformed, like leg braces, wrist splints and neck braces.
 - ◆ Maintenance (care of existing orthotics) and repair of parts will still be paid for.

PERSONAL CARE

Help with things like dressing, bathing and eating.

RESPITE CARE

Respite care service provided in the member's home or in a nursing home is a covered long term care and behavioral health service. This service allows the person who usually takes care of the member a break. Respite hours are limited to 600 hours per contract year (October 1 - September 30).

THERAPIES

Therapies covered for Members who are 21 Years of age and older:

- Occupational Therapy inpatient/outpatient: Covered when medically necessary.
 - ◆ Occupational Therapy (OT) is a medically ordered treatment to improve or restore functions which have been impaired by illness or injury, or which have been permanently lost or reduced by illness or injury. OT may also be ordered to help a member attain or acquire a particular skill or function never learned or acquired and to maintain that function once acquired. OT is intended to improve the member's ability to perform those tasks required for independent functioning.
- Physical Therapy inpatient/outpatient: Covered when medically necessary.
 - ◆ Physical Therapy (PT) is a medically ordered treatment to restore, maintain, or improve muscle tone, joint mobility, or physical function; and it helps a member to attain or acquire a particular skill or function never learned or acquired and to maintain that function once acquired.
- Speech therapy inpatient/outpatient: Covered when medically necessary.
 - ◆ Speech Therapy (ST) is a service that evaluates, diagnoses, and treats/trains members in receptive and expressive language, voice, articulation, fluency, rehabilitation and medical issues dealing with swallowing.

ALTERNATIVE RESIDENTIAL SETTINGS

Community based settings that are licensed or certified to provide personal or directed care services to residents in a home-like environment.

Federal regulations prevent AHCCCS from paying Room and Board in these settings; therefore, **members and/or representative payee must pay Room and Board when placed in these types of settings.** The amount a member must pay is based on monthly income or the minimum amount set by AHCCCS. The case manager will tell the member what the monthly amount is.

The following types of settings are available:

- Adult Foster Care – provides services for up to four (4) adults in a family-like setting.

- Assisted Living Home – provides services for ten (10) or fewer people in a home setting.
- Assisted Living Centers - provides services to 11 or more people in rooms or units which are apartment-type settings that include living and sleeping space, a bathroom and storage space.
- Behavioral Health Homes – provides a structured setting to members who need behavioral health treatment and supervision on a 24-hour basis.

MEDICAL TRANSPORTATION (Physical & Behavioral Health Services)

Medically Necessary Non-Emergency Medical Transportation (NEMT) is a covered transportation service. Transportation greater than 100 miles (one-way or round trip) requires prior approval from your case manager.

- Covered to and from the nearest and appropriate AHCCCS registered physical and/or behavioral health provider.
- Covered when transportation service is the same day as the covered medical service provided by an AHCCCS registered provider. This includes trips to any AHCCCS covered service (Example: walk-in, doctor’s office, clinic, hospital, dialysis or therapy, etc.).

BEHAVIORAL HEALTH SERVICES

ALTCS members, regardless of age, are eligible for behavioral health services (sometimes called Mental Health services) through the ALTCS program. Your case manager or doctor can help you decide what services you need and help set up your behavioral health care.

Behavioral health and crisis services are covered services when provided at an Indian Health Service (IHS) facility, at a tribally owned and/or operated 638 facility, or at an AHCCCS registered provider who accepts fee-for-service.

If you have a serious mental illness (SMI) determination and you’re 18 years or older with a mental, behavioral, or emotional disorder that severely and negatively affects your daily life:

- You may not be able to remain in the community without treatment and/or services.
- You are eligible to receive SMI services.
- Your ALTCS case manager may coordinate and provide prior approval for SMI services

Prior Approval by the Case Manager **IS NEEDED** for:

THERAPY AND COUNSELING (Individual, Group, or Family)

PSYCHOSOCIAL REHABILITATION (living skills training, health promotion, supported employment services)

BEHAVIOR MANAGEMENT (personal assistance, family support, home care training and peer support)

BEHAVIORAL HEALTH DAY PROGRAMS (supervised, therapeutic and medical day programs)

SUBSTANCE ABUSE SERVICES

THERAPEUTIC HOME CARE

BEHAVIORAL HEALTH RESIDENTIAL SETTINGS (Members must pay Room and Board charges in these settings.)

HOUSING (Members would need to work with Case Manager regarding this benefit)

If you have any questions about these covered services, call your case manager. Some of these services may not be available in your area, but your case manager will help you get the services you need.

AHCCCS SERVICES THAT ARE NOT COVERED

The services listed below are **NOT COVERED** by AHCCCS:

ANY SERVICES THAT WERE NOT PRIOR APPROVED BY THE CASE MANAGER OR AHCCCS WHEN PRIOR APPROVAL IS REQUIRED

SERVICES RECEIVED FROM PROVIDERS THAT ARE NOT REGISTERED AHCCCS PROVIDERS

ANY CARE OR SERVICE THAT IS NOT MEDICALLY NECESSARY

HEARING AIDS for adults

EYE EXAMS and EYE GLASSES for adults, except following cataract surgery and/or when medically necessary

PERSONAL COMFORT OR COSMETIC SERVICES AND ITEMS

NON-PRESCRIPTION OR EXPERIMENTAL DRUGS AND SUPPLIES

EXPERIMENTAL SERVICES

ROOM AND BOARD CHARGES IN ASSISTED LIVING FACILITIES AND BEHAVIORAL HEALTH RESIDENTIAL SETTINGS

If you have any questions about non-covered services, ask your case manager.

WHAT IF I GET BILLED FOR COVERED SERVICES?

If you get a bill for a service that you think is covered by AHCCCS, call the provider and be sure they have your insurance information, like AHCCCS and/or Medicare Identification numbers.

If you continue to get billed for covered services even after you have told the provider that you are an AHCCCS member, you should tell the AHCCCS Office of Inspector General by calling 602-417-4000. They will look into this for you.

AHCCCS providers are not allowed to bill members for services except under the following circumstances:

- To collect an authorized co-payment.
- To recover payments made to the member from other insurance sources when the payment duplicates benefits paid by AHCCCS.
- When the member intentionally withheld information or intentionally provided inaccurate information about AHCCCS eligibility that caused the provider to not be paid correctly.
- When the member has signed a document from the provider, before receiving the service, accepting responsibility for payment of services that are not covered, that were not authorized, or that were provided in excess of the limit for the service.
- When the provider has verified that the individual was not an eligible member on the date of service.

CHOOSING YOUR DOCTOR

The choice of your doctor is important. The doctor you choose is called your “Primary Care Provider” or PCP. Your PCP will order the health care and medicine that you may need. Your case manager will work closely with your PCP to get the services you need.

You can choose to see any AHCCCS registered doctor who is willing to bill AHCCCS for his or her services. You may also choose to see a doctor at the IHS hospital or clinic if you would like. If you live in the community, you should see your PCP on a regular basis, when the PCP tells you to come to the office or clinic, or when you have a change in your health. If you are in a nursing home, your PCP will come to visit you on a regular basis.

If you have a doctor when you become a member of ALTCS and he or she already works with AHCCCS, you won’t have to change doctors.

SCHEDULING A DOCTOR’S APPOINTMENT

To see your PCP, you need to call the doctor’s office to make an appointment. Even if you feel you need to see the doctor right away you should call the office first. When you call the

doctor's office tell them why you need to see the doctor. This will help them set up the right amount of time with the doctor.

If your doctor is an IHS doctor, please call or see the appointment clerk at the hospital or clinic to make the appointment.

If you live in a nursing home or assisted living facility, ask the staff to make an appointment with your doctor for you.

If you need help making an appointment with your doctor or transportation to an appointment, call your case manager for help.

CANCELING AN APPOINTMENT

If you can't keep your appointment, please call the doctor's office or clinic as soon as possible to let them know and to set up another appointment. If transportation was arranged for your appointment, tell your case manager so this can be canceled and re-scheduled if needed.

APPOINTMENT WITH A SPECIALIST

Your PCP may feel that you need to see a different doctor for a special health problem. This type of doctor is called a specialist and this type of appointment should not be missed. You should not make appointments with anyone other than your PCP without talking to your PCP or case manager first. AHCCCS may not be able to pay for appointments with the specialist if permission has not been given.

The following applies to female members, 21 years of age and over:

- They may have direct access to an AHCCCS registered Obstetrician/Gynecologist without a referral from the PCP.
- Preventative services such as a cervical cancer screening or referral for a mammogram are covered.
- Well woman exams are not a covered benefit.

The following applies to female members under the age of 21 years:

- They may have direct access to preventive and well care services from an AHCCCS registered Obstetrician/Gynecologist, without a referral from the PCP.

EMERGENCY CARE

Prior approval from AHCCCS or your case manager is not required for emergency services. In an emergency, you have the right to go to any hospital or other setting for emergency care.

WHAT IS AN EMERGENCY?

- A medical emergency is something that happens suddenly and could result in your health being in danger or in serious injury to your body. Examples of emergencies are:
 - ◆ Severe chest or other pain,
 - ◆ Bleeding that does not stop,
 - ◆ Fainting,
 - ◆ Being unable to breathe,
 - ◆ Severe burns,
 - ◆ Overdose of medication,
 - ◆ Poisoning,
 - ◆ Sudden loss of feeling in part of your body, and/or
 - ◆ Broken bones.
- The emergency room is not the place to treat minor problems such as the flu or a cold. Do not use it in place of your doctor's office or clinic. If the situation is not life threatening, but you still feel you need help right away, call your doctor.

IF YOU LIVE AT HOME AND NEED EMERGENCY CARE:

- **Call 911 immediately.**
- And if 911 is not available in your area, please call _____.
- If you do not have a phone, ask someone to take you to the closest medical center. An ambulance should only be called if the problem is so bad that you need to get to the hospital right away.

IF YOU LIVE IN A NURSING HOME OR ASSISTED LIVING FACILITY:

- The staff at the facility is trained on what to do for you in an emergency. If it is a life threatening emergency, they will call for medical help (such as an ambulance) right away. At other times, they will just call your doctor for instructions.

AFTER HOURS/URGENT CARE

Except in an emergency, call your PCP first whenever you need medical care. If the office is closed, the doctor's answering service will make sure your doctor gets your message. Your PCP will call you back and tell you what to do. Be sure your phone accepts blocked calls. Otherwise, the doctor may not be able to reach you.

If you have an urgent problem and your doctor cannot see you, he or she might recommend you go to an Urgent Care Center, if there is one available in your area.

HOW WILL ALTCS WORK WITH MEDICARE & OTHER INSURANCE?

- Service providers must always try to get paid by Medicare and any other insurance you have first before they bill AHCCCS.
- ALTCS pays Medicare Part A and B co-payments and deductibles for eligible members. AHCCCS does NOT pay your Medicare Part D copays (for medicines).
- When you have a doctor's appointment, please present all medical insurance cards. The doctor's office will take care of the billing.
- For more information about your Medicare benefits, please contact your local Social Security office for a copy of "Other Things You Should Know About Medicare" or visit the Medicare website at www.medicare.gov.

"CRITICAL" SERVICES & CONTINGENCY PLANNING

The term "critical services" includes tasks such as bathing, toileting, dressing, feeding, and transferring to or from bed or a wheelchair, and help with similar daily activities. AHCCCS defines the following Home and Community Based Services as "critical services":

- Attendant Care, including Spouse Attendant Care;
- Personal Care;
- Homemaker; and/or
- In-Home Respite.

ALTCS members who receive "critical services" in their home will have their case manager help them to come up with a back-up or Contingency Plan. This Plan will have information about what you or your family should do if your Direct Care Worker does not show up as scheduled and what other choices you have for care, including agency or other providers and your informal support system (family and friends).

You will be asked to say how quickly you want to have a service gap filled if the scheduled Direct Care Worker of critical service is not available. This is called the "Member Service Preference Level" and it will be recorded on your Contingency Plan as one of the following:

- 1) Needs service within two hours,
- 2) Needs service today,

- 3) Needs service within 48 hours, or
- 4) Can wait until the next scheduled service date.

Your case manager will go over the Contingency Plan with you every time he or she visits you to see if you have any changes to the information, including your Member Service Preference Level. You can change Member Service Preference Level and your choices for how service gaps will be filled at any time.

FILING A COMPLAINT OR GRIEVANCE

You have the right to make a complaint if you have concerns about or problems with your care and services. A complaint is also called a “grievance.” You or your representative can file a grievance at:

<https://www.azahcccs.gov/Members/GetCovered/RightsAndResponsibilities/grievanceandappeals.html>

If you have a complaint or grievance you can also send a written complaint to your case manager, who may be able to help you resolve the problem right away. If the case manager is not able to help you right away, he or she can take up to 30 days to resolve the problem.

If the complaint is about the case manager, you should contact the case manager’s supervisor, who should be able to help you with the problem. If talking to the supervisor does not resolve the problem, you may file a complaint or grievance with AHCCCS. A written complaint can be sent to:

AHCCCS Administration/Office of Administrative Legal Services
701 E. Jefferson
Mail Drop 6200
Phoenix, AZ 85034
Phone: 1-602-417-4000

WHAT IF MY SERVICES ARE DENIED OR CHANGED? *

In general, AHCCCS or the case manager must make a decision about your or your provider’s request for services within 14 calendar days of that request. If AHCCCS or the case manager needs more information in order to make a decision about the request, an additional 14 days may be taken to make the decision. AHCCCS or the case manager will provide you with written notice telling you that more time will be taken and the reason.

If you or your doctor think that taking 14 days to make a decision would put your life or health in danger, you can ask AHCCCS to make a decision faster. If AHCCCS agrees that your life or health could be in danger, they will make a decision within 3 working days of the request.

When a service you, your doctor or other provider has requested is denied, your case manager will send you a written **Notice of Adverse Benefit/Notice of Action (NOA)**. This Notice will tell you that the requested service has been denied and the reason for the decision.

If AHCCCS or the case manager makes a decision to reduce or stop services that you are already receiving and you do not agree with that decision, a written Notice of Adverse Benefit/Notice of Action (NOA) will be sent to you at least 10 days before those services are changed. That Notice of Adverse Benefit/Notice of Action (NOA) will tell you the decision that was made, the reason for the decision, and the date the change will take place.

If you receive a Notice of Adverse Benefit/Notice of Action (NOA) and do not agree with it or if it is not written in a way that you can understand it, you can tell AHCCCS that you want to file an **appeal**. Information about how to file an appeal will be included in the Notice of Adverse Benefit/Notice of Action (NOA). You must tell AHCCCS, in writing or by telephone that you want to file an appeal within 60 days of getting the Notice of Adverse Benefit/Notice of Action (NOA) letter. A health care provider can also help you file an appeal.

If the Notice of Action is about changes to services you already have, it will also include information about how to request that your services continue unchanged until the appeal is over. The continuation of services only applies when the service had been authorized and was being received prior to the Notice.

If you file an appeal, AHCCCS will schedule you for a hearing with the Office of Administrative Hearings, a separate State governmental agency. You will be sent a Notice of Hearing, giving you the time and date of your hearing, within 30 days. Your case will be heard by an Administrative Law Judge.

AHCCCS will send you a **Director's Decision** within 30 days after the Administrative Law Judge makes a recommendation to AHCCCS. This will generally be completed within 90 days after the appeal was first filed with AHCCCS.

If your doctor says or if AHCCCS thinks taking 30 days to make a decision on your appeal could put your life or health in danger, AHCCCS will schedule you for an **"Expedited"** State Fair Hearing instead. When an Expedited State Fair Hearing occurs, a written **Director's Decision** will be sent to you within 3 working days after the hearing is over.

Please note that if you request that your services continue unchanged until the appeal or hearing is over and you "lose" the appeal and/or hearing, you could be charged for those services.

* Reference: Arizona Administrative Code, Title 9, Chapter 34, Article 3.

MEMBER COSTS

If you have a monthly income (such as from Social Security), you may have to pay part of the cost of the services you get from ALTCS. This is called your “Share of Cost.” The AHCCCS ALTCS eligibility worker will figure out how much you must pay. You will be given or sent a letter telling you the amount of your Share of Cost. You must pay the Share of Cost each month.

If you are living in a nursing home, you or your representative payee must pay your Share of Cost directly to the nursing home. Call your AHCCCS ALTCS eligibility worker if you have any questions about your Share of Cost.

If you live at home or in another community based setting, you will likely not have a Share of Cost. However, it is possible that you could have a Share of Cost; the Division of Member and Provider Services/ALTCS unit will notify you if you have a Share of Cost that must be paid in a Home Community Base Services (HCBS) setting. Your case manager will tell you how much and how to pay your Share of Cost.

If you live in an Assisted Living Facility, you must pay Room and Board charges to the facility. This amount will be based on your monthly income but you must pay at least the AHCCCS minimum Room and Board amount. Your case manager will tell you how much and how to pay Room and Board.

ALTCS TRANSITIONAL PROGRAM

The ALTCS Transitional Program is a program for currently eligible ALTCS members whose health has gotten better so that they, do not need a nursing facility level of care anymore, but who still need some long term care services.

- Transitional members continue to get all medically necessary home and community based services.
- Nursing facility services are not included for Transitional members, unless the stay is **less than 90 consecutive days**.

If you are a Transitional Program member and your medical needs change, including the need for care in a long-term nursing facility, your case manager will assist you to get the services you need.

MOVING OR VISITING OUT OF YOUR AREA OR THE STATE

If you plan to move, even temporarily, call your case manager before you move. You may have to change doctors and who provides your in-home care. Which Health Plan you are enrolled with may also change if you move off the reservation where you lived when you became eligible. It is important to talk to your case manager about the move so he or she can help you make the changes for your medical care and other services.

You must also let the ALTCS eligibility office know that you plan to move or if you are going for a visit out of the State of Arizona for more than 30 days.

If you have to go out of State, you may only be able to get emergency services. AHCCCS does not cover any services provided outside the United States.

If you are moving out of Arizona, the ALTCS office can give you the phone number of an agency where you are moving that may be able to help you with your medical care and services.

FRAUD AND ABUSE

Fraud is defined by Federal law (42 CFR 455.2) as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person.

There are 2 kinds of Abuse:

Abuse of the Program is defined by Federal law (42 CFR 455.2) as "provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes member practices that result in unnecessary cost to the Medicaid program."

Abuse of a member, as defined by Arizona law (A.R.S. 46-451 & 13-3623), includes any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

Your case manager must report incidents of possible fraud and abuse. You can help by telling your case manager or AHCCCS about the following:

- If you or another AHCCCS member are the possible victim of physical or verbal abuse, neglect or exploitation, especially by an AHCCCS provider, such as nursing facility, hospital, doctor, Assisted Living Facility or Attendant/Personal Care provider.

- If a medical provider does not give you the medical care that you need, including not scheduling an appointment when you need one, or not sending you for tests or to a specialist when needed.
- If a provider continues to bill you for covered services even after the provider has been told that you are an AHCCCS member.
- If a provider borrows or steals anything from you. It is not appropriate for a provider to borrow money or other things from you for their personal use. This could include things like your car, TV, VCR, or any other items. If someone goes shopping for you, please make sure they give you a receipt. Also make sure you count your change if you use cash.
- If a provider or case manager accepts gifts. Case managers and providers are not allowed to accept gifts from members.
- If a Direct Care Worker asks you to sign an attendance sheet before they have completed your care or when the care has not been performed at all. Members should make sure the hours worked are correct before they sign an attendance sheet.

Members should also be aware of the following things that are not appropriate activities:

- It is not appropriate to sell, give-away or misuse any medical equipment or supplies that are given to you. You are responsible for proper care and use of all equipment and supplies.
- It is not appropriate for you to loan, sell or give your AHCCCS ID card to others to use. This could result in loss of your eligibility or legal action against you.

To report any of these things if they happen to you or others, please call your case manager. You can also contact the AHCCCS Office of Inspector General (OIG) at the numbers below:

Provider Fraud

If you want to report suspected fraud by a medical provider, please call the number below:

- In Maricopa County: 602-417-4045
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

Member Fraud

If you want to report suspected fraud by an AHCCCS member, please call the number below:

- In Maricopa County: 602-417-4193
- Outside of Maricopa County: 888-ITS-NOT-OK or 888-487-6686

Online Reporting

You can file a report of suspected fraud or abuse online at:

<https://www.azahcccs.gov/Fraud/ReportFraud/onlineform.aspx>

Questions

If you have questions about AHCCCS fraud, abuse of the program, or abuse of a member, please email the AHCCCS Office of Inspector General (OIG) at AHCCCSFraud@azahcccs.gov

HEALTH CARE DIRECTIVES

Question: What is a “Health Care Directive”?

Answer: A “Health Care Directive” is a written statement about how you want decisions about your health care made when you are unable to speak for yourself. Under Arizona law, there are 4 common types of Health Care Directives. They are:

- ◆ A Health Care Power of Attorney is a written statement in which you name an adult to make health care decisions for you. That person will make health care decisions for you **only** when you cannot make or communicate those decisions.
- ◆ A Mental Health Care Power of Attorney is a written statement in which you name an adult to make mental health care decisions for you. That person will make mental health care decisions for you **only** when you cannot make or communicate those decisions.
- ◆ A Living Will is a written statement about health care you want or do not want that is to be followed if you cannot make your own health care decisions at the time. For example, a living will could say whether you want to be fed through a tube if you were unconscious and unlikely to recover.
- ◆ A Pre-Hospital Medical Care Directive is a directive refusing cardiopulmonary resuscitation (CPR), a type of lifesaving emergency care, if you have a heart attack or cannot breathe outside a hospital or in a hospital emergency room.

These directives used separately or together can help you say “Yes” to treatment you want and “No” to treatment you do not want, when you are not able to say those things for yourself at the time treatment decisions are needed.

Question: Who makes my health care decisions?

Answer: You do, if you can make and tell others about them. Your doctor should tell you about the treatments he or she recommends, other options and important medical risks and benefits of those treatments and other options. You have the right to decide what health care, if any, you will accept. Information about whether or not you have a Health Care Directive should be included in your medical records.

Question: What happens if I become unable to make or tell anyone about my health care decisions?

Answer: If you plan ahead, you will still be able to make your health care decisions. One way is by making a Health Care Directive, which names someone to make these decisions for you or gives specific instructions about your choices on medical care even after you are unable to say what you want.

Question: Who can legally make health care decisions for me if I am unable to make my own decisions and I have not made a Health Care Power of Attorney?

Answer: A court may appoint a “guardian” to make health care decisions for you. Otherwise, your health care provider must go down the following list to find a “surrogate” to make health care decisions for you:

1. Your spouse, unless you are legally separated;
2. Your adult child. If you have more than one adult child, a majority of those who are available;
3. Your mother or father;
4. Your domestic partner, unless someone else has financial responsibility for you;
5. Your brother or sister; or
6. A close friend of yours (someone who shows special concern for you and is familiar with your health care choices).

If your health care provider cannot find an available and willing surrogate to make health care decisions for you, then your doctor can decide, with the advice of an ethics committee or, if this is not possible, with the approval of another doctor.

You can keep anyone from becoming your surrogate by saying, preferably in writing, that you do not want that person to make health care decisions for you.

A surrogate will not have the right to decide to have tubes taken out that are used to give you food or fluids unless:

- ◆ You have appointed that surrogate to make health care decisions for you in a health care power of attorney, or
- ◆ A court has appointed that surrogate as your guardian to make health care decisions for you, or
- ◆ You have stated in a Health Care Directive that you do not want this specific treatment.

Question: Who can legally make health care decisions for me if I am unable to make my own decisions and I have not made a Mental Health Care Power of Attorney?

Answer: The surrogates listed above or a person you appoint in a regular Health Care Power of Attorney can make decisions about your mental health care treatment, except he or she cannot make a decision to admit you to a psychiatric hospital. A person given a Mental Health Power of Attorney, or a guardian specifically appointed by the court to make mental health decisions, can admit you to a psychiatric hospital. If there is no such person, then only a court can order you to go to a psychiatric hospital.

Question: Do I need a lawyer to make a Health Care Directive?

Answer: No. Just be sure that your directive is valid under Arizona law. It is suggested that you get help writing your Living Will and Medical Power of Attorney. Ask your case manager or doctor for help if you are not sure whom to call.

Question: What does the law require for Health Care Directives?

Answer: Below is a summary of the requirements for Health Care Directives. Members should be sure that their Directives contain all the information required by Arizona Law.

A Health Care Power of Attorney must:

- ◆ Name a person to make health care decisions for you if you become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old.
- ◆ Be signed or marked by you. If you are unable to sign, the witness and notary, at your direction, can state in writing that the Power of Attorney states your wishes and that you want to enact the Power of Attorney.
- ◆ Be signed by a notary or by an adult witness or witnesses who saw you sign or mark the document and who say you appear to be of sound mind and free from pressure to make a specific decision. A notary or witness cannot be the person you name to make your decisions and cannot be providing health care to you. If you only have one witness, that witness cannot be related to you or someone who will get any of your property from your estate if you die.

A Mental Health Care Power of Attorney must:

- ◆ Name a person to make mental health care decisions for you if you become unable to make your own decisions. You may also name an additional person or persons to make decisions for you if your first choice cannot serve. The person or persons must be at least 18 years old.
- ◆ Be signed or marked by you. If you are unable to sign, the witness and notary, at your direction, can state in writing that the Power of Attorney states your wishes and that you want to enact the Power of Attorney.
- ◆ Be notarized or witnessed in the same way described above for a Health Care Power of Attorney.
- ◆ Have separately initialed by you any paragraphs which give the following powers to the person appointed:
 1. The power to admit you to an inpatient psychiatric hospital, and/or
 2. The power to consent to mental health treatment against your wishes.

A Living Will must:

- ◆ State how you want your health care decisions to be made in the future,
- ◆ Be signed or marked by you and dated, and
- ◆ Be notarized or witnessed in the same way described above for a Health Care Power of Attorney.

A Medical Care Directive must:

- ◆ Be in the exact form required by law,
- ◆ Be printed on an orange background,
- ◆ Be signed or marked by you and dated, and
- ◆ Be signed by a licensed health care provider and a witness.

If you have signed an orange pre-hospital Medical Care Directive, you may also wear an orange bracelet. It must state your name, your doctor's name and the words "Do Not Resuscitate". This bracelet will call to the attention of emergency medical personnel that you have signed the form and that you do not want CPR outside a hospital or in a hospital emergency room.

Question: Must my Health Care Directives be followed?

Answer: Yes. Both health care providers and surrogates must follow valid Health Care Directives.

Question: Can I be required to make a Health Care Directive?

Answer: No. Whether or not you make a Health Care Directive is completely up to you. A health care provider cannot refuse care based on whether or not you have a Health Care Directive.

Question: Who should have a copy of my Health Care Directive?

Answer: Give a copy of your Health Care Directive to your doctor and to any medical center when you are admitted. If you have a Health Care or Mental Health Care Power of Attorney, you should also give a copy to the person you have named on it. You should also keep copies for yourself.

Question: Can I change or cancel my Advance Health Care Directive?

Answer: Yes. If you change or cancel your directive, be sure to tell anyone who has a copy.

Question: Where do I get the forms to make a Health Care Directive?

Answer: The following organizations provide Health Care Directive forms and/or information:

- ✓ Health Care Decisions at www.hcdecisions.org or (602) 222-2229
- ✓ Arizona Center for Disability Law at www.acdl.com or (602) 274-6287
- ✓ Department of Economic Security/Aging and Adult Administration at <https://des.az.gov/services/older-adults/legal-services-assistance> or (602) 542-4446
- ✓ Arizona Attorney General's Office <https://www.azag.gov/seniors/life-care-planning> at or (602) 542-5025

You can have your Health Care Directive registered with the Arizona Registry at <https://azsos.gov/services/advance-directives> or by calling 1-800-458-5842.

IMPORTANT MEMBER RIGHTS NOTICE

(For members who receive or will receive Home and Community Based Services)

As a result of the lawsuit *Ball v. Biedess*, the AHCCCS Administration is giving you this notice about your rights to receive “critical” long term care services at home when you are enrolled in the Tribal ALTCS Program.

You have the right to receive all the services in your care plan to help you with bathing, toileting, dressing, feeding, transferring to or from your bed and wheelchair and other similar daily activities. These services are called “critical services.” Your Tribal ALTCS Program must make sure that you receive these critical services without delays. If there is a delay and you do not receive these services on time, your Tribal ALTCS Program must provide them within 2 hours of the time they are notified of the gap. (A gap in critical services is defined as the difference between the number of hours of critical service scheduled in each individual’s care plan and the hours of the scheduled type of critical service that are actually delivered to the individual.) Your other long term care services cannot be reduced to make up for the critical services that you did not receive on time.

If you do not receive your critical services on time, call your Direct Care Agency to report the issue. In addition, you may also call your Tribal ALTCS Program at the telephone numbers listed below to report the problem. Your case manager will also provide you with phone numbers to call if there are delays in getting your critical services. You can also call your case manager or speak to a Tribal ALTCS supervisor during normal business hours. You will get an answer by phone or in writing. You will be told the reason for the delay and how it will be fixed now and in the future if it happens again.

We will give you another notice if a court makes changes to this information. If you have any questions about this notice, please call your Tribal ALTCS Program, your case manager, or AHCCCS.

DEFINITIONS

A.A.C (Arizona Administrative Code): State regulations established pursuant to relevant statutes.

Action: An action by AHCCCS/Tribal ALTCS Program means:

- The denial or limited authorization of a service you or your doctor have asked for;
- The reduction, suspension or ending of an existing service;
- The denial of payment for a service, either all or part;
- Failure to provide services in a timely manner; and/or

- Failure to act within certain timeframes for grievances and appeals.

Advance Directive: A written statement telling your wishes about what types of care you do or do not want.

AHCCCS: The Arizona Health Care Cost Containment System (AHCCCS), the state agency that manages the Medicaid program in Arizona using federal and state funds.

ALTCS: The Arizona Long Term Care System (ALTCS), a program under AHCCCS that delivers long term, acute, behavioral health care and case management services to eligible members.

Appeal: A request from an applicant, member, provider, health plan, or other approved entity to reconsider or change a decision, also known as an action.

An action includes any denial, reduction, suspension, or termination of a service or benefit, or a failure to act in a timely manner.

ARS (Arizona Revised Statutes): The laws of the State of Arizona.

Arizona Long Term Care System (ALTCS) Types

Program Contractor: A contracted managed care organization that provides long term care, acute care, behavioral health and case management services to Title XIX eligible individuals, who are either elderly and/or who have physical or developmental disabilities, who are determined to be at immediate risk of institutionalization. Refer to A.R.S. Title 36, Chapter 29, Article 2.

Tribal ALTCS Program: A Tribal organization or urban American Indian organization contracted with AHCCCS through an Intergovernmental Agreement (IGA) to arrange for case management services through registered providers to American Indians who have on-reservation status and are enrolled in ALTCS.

Authorization: An approval from your case manager and/or doctor before getting health care services including, but not limited to, in-home services, laboratory and radiology tests, and visits to specialists.

Case Manager: Someone who helps you to coordinate your services, ensures your needs are appropriately assessed, and serves as the point of contact for coordination with any persons involved in your care.

CFR (Code of Federal Regulations): The rules published in the Federal Register by the departments and agencies of the Federal Government.

Complaint: The expression of dissatisfaction with any aspect of your care that is not an action that can be appealed.

Covered Services: Health services, including medical and behavioral health services, available to members of ALTCS.

CRS: Children’s Rehabilitative Services as defined under Arizona Administrative Code Title 9, Chapter 7 for children with certain complex health care conditions who require specialized services.

Disenrollment: The end of a member’s ability to receive covered services through AHCCCS.

Durable Medical Equipment (DME): Equipment which:

- May be used over and over,
- Is primarily used to serve a medical purpose,
- Usually is not useful to a person when they are not sick or hurt, AND
- Is easily used in the home.

Some examples are crutches, wheelchairs, walkers, etc.

Emergency: An emergency is a medical condition that could cause serious health problems or even death if not treated immediately.

Enrollment: The process of becoming eligible with AHCCCS Tribal ALTCS to receive health services.

Expedited Appeal: An appeal that is processed sooner than a standard appeal in order to not seriously jeopardize the person’s life, health or ability to attain, maintain or regain maximum functioning.

Family Planning: Education and treatment services for a member who voluntarily chooses to delay or prevent pregnancy.

Grievance: Any written or verbal expression of dissatisfaction over a matter other than an action, as defined in this Handbook, by a member or provider authorized in writing to act on the member's behalf. A grievance may be submitted orally or in writing. Grievances include, but are not limited to, issues regarding:

- Quality of care or services;
- Accessibility or availability of services;
- Interpersonal relationships (e.g. rudeness of a provider or employee, cultural barriers or insensitivity); or
- Failure to respect a member's rights.

Medical Necessity: A service that is needed in order to prevent disease, disability, or other harmful health conditions or keep them from getting work, or is needed in order to help a person live longer.

Medically Necessary Transportation: Transportation that takes you to and from required medical services.

Member: A person enrolled with AHCCCS/ALTCS to get health services.

Notice of Adverse Benefit Determination (NOA): The written notice you get of an intended action or adverse decision made by the Tribal ALTCS Program regarding denial or limited authorization of a service request, or the reduction, suspension or termination of a previously approved service. The letter will tell you what action was taken and the reason for it; your right to file an appeal and how to do it; your right to ask for a fair hearing with AHCCCS and how to do it; your right to ask for an expedited resolution and how to do it; and your right to ask that their benefits be continued during the appeal, how to do it, and when you may have to pay the costs for the services.

Obstetrician/Gynecologist (OB/GYN): A doctor who cares for women during pregnancy, childbirth, postpartum and well-women exams.

PCP is short for Primary Care Provider: An individual who provides or authorizes all your health care. Your PCP refers you to a specialist if you need special health care services. A PCP may be a physician, a physician assistant or a certified nurse practitioner.

Power of Attorney: A written statement naming a person you choose to make health care or mental health decisions for you if you cannot do it.

Practitioner: A provider who is either a certified nurse practitioner in midwifery, a physician's assistant, or other nurse practitioner. Physician's assistants and nurse practitioners are defined in the Arizona Revised Statutes (ARS), Title 32, Chapters 25 and 15.

Prenatal care: The health care provided during pregnancy that includes 3 major parts:

- 1) Early and continuous risk assessment;
- 2) Health promotion; and
- 3) Medical monitoring, intervention and follow-up.

Prescription: An order from your doctor for medicine. The prescription may be called in over the telephone or can be written down.

Qualified Medicare Beneficiaries (QMB): Members who qualify for both AHCCCS and Medicare, who have their Medicare Part A and Part B premiums, coinsurance and deductibles paid for by AHCCCS.

Referral: When your PCP sends you to a specialist for a specific, usually complex, problem.

Specialist: A doctor who treats specific health care needs. For example, a cardiologist is a specialist. You must get a referral from your doctor before seeing a specialist.

Title XIX (Medicaid; may also be called AHCCCS): Medical, dental and behavioral health care insurance for low-income persons, children and families.

NOTICE OF NON-DISCRIMINATION

Arizona Health Care Cost Containment System (AHCCCS) complies with applicable Federal civil rights laws, does not discriminate, and does not treat people differently on the basis of race, color, national origin, age, disability, or sex.

If you believe that AHCCCS, or an AHCCCS-registered contractor or provider, failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the AHCCCS Office of Administrative Legal Services.

You can file a grievance in person or by mail, fax, or email. Your grievance must be in writing and must be submitted within 180 days of the date that the person filing the grievance becomes aware of what is believed to be discrimination. Submit your grievance to:

General Counsel, AHCCCS Administration
Office of Administrative Legal Services, MD 6200
701 E. Jefferson
Phoenix, AZ 85034
Fax: 602 253 9115
Email: EqualAccess@azahcccs.gov.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at:

<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>.

Or by mail at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201

Or by phone at:

1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at: <http://www.hhs.gov/ocr/office/file/index.html>.

Prepared by the Arizona Health Care Cost Containment System (AHCCCS)

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