

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> 1102 Enrollment with a Health Plan

1102 Enrollment with a Health Plan

A Overview

B Health Plan Enrollment Process

C Effective Date of Health Plan Enrollment

D Newborn Enrollment

E Guaranteed Enrollment Periods

F After Enrollment

G Health Plan Enrollment Changes

H Annual Enrollment Process



Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> A Overview

A Overview

Policy

1) How Acute Care Health Plans are Assigned

2) AHCCCS Health Plans

Definitions

A health plan provides services as a Managed Care Organization (MCO) to customers. The MCO contracts with primary care physicians (PCP), specialists, dentists, hospitals, and other ancillary providers to form a network of service providers.

Policy

1) How Acute Care Health Plans are Assigned

The following is an overview of how customers are assigned to an acute care health plan:

- AHCCCS contracts with Comprehensive Medical/Dental Program (CMDP/ DES) to provide services to foster care children statewide.
- Native Americans can choose to receive services through fee for service or from one of the acute health plans for the county in which they reside.

NOTE The American Indian Health Program (AIHP) is the entity within AHCCCS that is responsible for paying fee-for-service claims submitted for Native Americans who have chosen not to enroll in an acute capitated health plan. If the Native American member does not choose a plan and lives on the reservation, the member will be automatically enrolled in AIHP.

- AHCCCS awards other health plan contracts by Geographic Service Areas (GSAs) as follows:

GSA #	County
2	Yuma, LaPaz
4	Apache, Coconino, Mohave, Navajo

6	Yavapai
8	Gila, Pinal
10	Pima, Santa Cruz
12	Maricopa
14	Cochise, Graham, Greenlee

NOTE Split zip codes are those which are located in two different counties. Enrollment for members residing in these zip codes is based upon the county and GSA to which the entire zip code has been assigned by AHCCCS. The health plan is responsible for providing services to members residing in the entire zip code that is assigned to the GSA.

NOTE The split zip codes GSA assignments are as follows:

NOTE

ZIP CODE	SPLIT BETWEEN THESE COUNTIES	COUNTY ASSIGNED TO	ASSIGNED GSA
85220	Pinal and Maricopa	Maricopa	12
85242	Pinal and Maricopa	Maricopa	12
85292	Gila and Pinal	Gila	8
85342	Yavapai and Maricopa	Maricopa	12
85358	Yavapai and Maricopa	Maricopa	12
85390	Yavapai and Maricopa	Maricopa	12
85643	Graham and Cochise	Cochise	14
85645	Pima and Santa Cruz	Santa Cruz	10

85943	Apache and Navajo	Navajo	4
86336	Coconino and Yavapai	Yavapai	6
86351	Coconino and Yavapai	Coconino	4
86434	Mohave and Yavapai	Mohave	6
86340	Coconino and Yavapai	Yavapai	6

2) AHCCCS Health Plans

To review a list of AHCCCS Health Plans available by County see <http://www.azahcccs.gov/applicants/healthplans/healthplans.aspx>.

Definitions

Term	Definition
American Indian Health Program (AIHP)	Entity within AHCCCS that is responsible for paying fee-for-service claims submitted for Native American customers who have not chosen to enroll in an acute capitated health plan.
Geographic Service Area (GSA)	AHCCCS awards health plan contracts by GSA. AHCCCS health plans are responsible for providing services to customers residing in the GSA.
Managed Care Organization (MCO)	A MCO contracts with primary care physicians (PCP), specialists, dentists, hospitals and other ancillary providers to form a network of service providers.
Enrollment	Enrollment is the act of signing people up for participation in a specific health plan.

Enrollment date	A customer's date of enrollment is the date enrollment action is taken by the Administration. However, if a plan change occurs for an annual enrollment choice, the effective date is the month of the customer's enrollment anniversary date.
Primary Care Physician (PCP)	Each customer is assigned to a PCP. The PCP is responsible for the overall health care of the customer assigned to him or her, including but not limited to: supervision, coordination, the referral process for medically necessary specialty care and maintenance of the customer's medical records.



Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> B Health Plan Enrollment Process

B Health Plan Enrollment Process

Policy

- 1) Health Plan Selection
- 2) Auto-Assignment to a Health Plan
- 3) AIHP Enrollment

Definitions

Programs and Legal Authorities

[Revised 09/03/2014](#)

Policy

Customers may obtain information on health plans from the following resources:

- Individual health plans - <https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx>;
- Health-e-Arizona Plus - <https://www.healtharizonaplus.gov>; and
- Department of Economic Security - <https://www.azdes.gov/>.

1) Health Plan Selection

Usually the customer can choose a health plan during the application process.

NOTE Customers must enroll with a health plan in their Geographic Service Area (GSA). Customers are auto-assigned into a health plan if a pre-enrollment choice is not made prior to the Eligibility Specialist making an eligibility determination.

The 90 Day Re-enrollment Rule is used prior to the member's pre-enrollment selection.

The 90 day re-enrollment rule takes priority over pre-enrollment choice and initial enrollment choice. When a customer loses and regains eligibility within 90 days or less, AHCCCS re-enrolls the customer into the previous health plan, if it is still available, unless the:

- Customer no longer resides in the health plan Geographic Service Area (GSA).
- Health plan is suspended or terminated.

- Customer was previously enrolled with CMDP but at the time of re-enrollment is no longer a foster care child.
- Customer was previously enrolled with a health plan but at the time of re-enrollment is now a foster care child.

2) **Auto-Assignment to a Health Plan**

If a customer did not choose a health plan prior to approval of the application, AHCCCS automatically enrolls the customer with a health plan in the customer's GSA. Automatic enrollment is a process that enrolls customers evenly between the health plans.

All customers have the opportunity to select a health plan of their choice. A Freedom of Choice letter is mailed to customers informing them of the health plan they were enrolled in. Customers are given 30 days to select a different health plan. . If the customer does not contact AHCCCS with the name of a new health plan, the customer will remain enrolled with the auto-assigned health plan.

3) **AIHP Enrollment**

American Indian Health Program (AIHP) members may receive health care services from Indian Health Facilities and other AHCCCS-registered doctors.

When a medically necessary service is not available through an Indian Health Facility, AIHP may refer the customer to an AHCCCS fee-for-service provider. All referrals made must be for medically necessary services, which are initiated and approved by AIHP.

Definitions

Term	Definition
Auto Assignment	Customers who do not make a health plan selection prior to an eligibility determination are auto-assigned to a health plan.
Freedom of Choice	Customers may select the health plan of their choice within 30 days of auto assignment.
Geographic Service Area (GSA)	AHCCCS awards health plan contracts by GSA. AHCCCS health plans are responsible for providing services to customers residing in the GSA.

90 Day Re-enrollment Rule	If the customer was enrolled with an AHCCCS health plan within the 90 days prior to the current approval date, the customer is automatically re-enrolled with the same health plan.
Comprehensive Medical/Dental Program (CMDP/ DES)	AHCCCS contracts with the CMDP/ DES to provide services to foster care children statewide.
American Indian Health Program (AIHP)	Entity within AHCCCS that is responsible for paying fee-for-service claims submitted for Native American customers who have not chosen to enroll in an acute capitated health plan.
Indian Health Facilities	Includes the Indian Health Service (IHS), tribally-operated "638" health programs and urban Indian health clinics.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
All Programs	AAC R9-22-1702



Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> C Effective Date of Health Plan Enrollment

C Effective Date of Health Plan Enrollment

Policy
Definitions
Programs and Legal Authorities

Policy

The effective date of enrollment depends on the program and other circumstances:

Program	Effective Date
Transition from ALTCS to AHCCCS Medical Services	<p>When an ALTCS customer loses ALTCS eligibility but continues to be eligible for AHCCCS Medical Assistance, enrollment with a health plan begins on the effective date of the ALTCS discontinuance.</p> <p><Transition from ALTCS to AHCCCS Medical Services Example></p> <p>Customers must be given an opportunity to choose a health plan. For additional information, see <How to Provide Assistance with Enrollment Choice When ALTCS Is Discontinued>.</p>
Adult Caretaker Relative Child Pregnant Woman SSI-MAO	<p>Enrollment with a health plan can be a past date or a future date, but can be no earlier than the first day of the month of application.</p> <p>A customer can also qualify to have unpaid medical bills from the three months before the month of application paid by AHCCCS Fee-for-Service if the customer was also eligible during those three months. This is known as prior quarter coverage.</p>

	<Adult, Caretaker Relative, Child, Pregnant Woman and SSI-MAO Example>
KidsCare (Title XXI)	<p>The effective date for initial enrollment is as follows:</p> <ul style="list-style-type: none"> • If a customer's application is approved by the 25th day of the month, enrollment begins on the first day of the next month following the determination of eligibility. <p><KidsCare (Title XXI) Example #1></p> <ul style="list-style-type: none"> • If a customer's application is approved after the 25th day of the month, enrollment begins on the first day of the second month following the determination of eligibility. <p><KidsCare (Title XXI) Example #2></p>

Definitions

Term	Definition
Prior Quarter Coverage	<p>Medicaid is effective no later than the third month before the month of the application if the person:</p> <ul style="list-style-type: none"> • Received Medicaid services at any time during that period; and • Would have been eligible for Medicaid at the time they received the services. • Medical bills for medical services received during the prior quarter are paid Fee-For-Service.

Programs and Legal Authorities

This requirement applies to the following programs:

Program	Legal Authorities
Adult	42 CFR 435.914 (prior quarter coverage)
Caretaker Relative	AAC R9-1702
Child	
Pregnant Woman	
SSI-MAO	



Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> D Newborn Enrollment

D Newborn Enrollment

Policy

1) Deemed Newborn Program

2) Notification

3) Mother's Enrollment and Newborn Health Plan Assignment

4) ID Card

5) Enrollment Choice

Definitions

Programs and Legal Authorities

Policy

The newborn's enrollment is determined by both the:

- Mother's enrollment; and
- Newborn's date of birth.

A newborn's enrollment ends with the last day of the month the child turns age 1.

1) Deemed Newborn Program

Most babies born to AHCCCS eligible mothers are eligible for the first 12 months until they turn age one, at which time eligibility will be determined for continued eligibility under another AHCCCS program. These customers are known as Deemed Newborns.

2) Notification

The health plans and hospitals notify the Agency of the birth of a newborn so that the newborn can be enrolled with a health plan. The plans and providers can report the birth up to one year from the birth. However, if plans do not report the birth within 24 hours, each day between the date of birth and date of notification will be a no pay plan. This means that the plan would need to cover all services from the date of birth but the capitation will not start until the notification date. When the mother is enrolled in an acute capitated plan, the plan will receive a supplemental payment on the mother's record for the labor and delivery. This is known as the "Newborn Payment." The supplemental payment is paid except when the Newborn is reported to the eligibility source and added through that process instead of being communicated to the agency from the plan or provider.

3) **Mother's Enrollment and Newborn Health Plan Assignment**

A child born to a mother who is eligible for AHCCCS Medical Assistance and enrolled in a health plan is enrolled with a health plan or AIHP, based on the mother's enrollment.

A child born to a mother receiving Federal Emergency Services (FES) is entitled to full Medical Assistance coverage and enrollment in a health plan. The child is a US citizen.

If the mother is enrolled in fee-for-service (FFS), FES or the Comprehensive Medical/Dental Program (CMDP), then the newborn's enrollment is based on:

- Family continuity which enrolls the newborn in the same plan as the other family members if they are enrolled in an acute capitated plan; or
- Auto assignment.

The newborn is auto-assigned to a health plan when the mother:

- Is not enrolled with a health plan;
- Receives AHCCCS services on a FFS basis; or
- Is enrolled with a program contractor or tribal ALTCS contractor.

4) **ID Card**

If the baby has not been named, the Agency may receive the first name as "Baby Boy" or "Baby Girl." An ID card is not sent until the first name is received from the eligibility source.

5) **Enrollment Choice**

AHCCCS Administration notifies the newborn's mother of her right to choose a different health plan for her child. A Freedom of Choice letter is sent to the mother notifying her of the right to choose a different health plan for the child within 30 days from the date of the enrollment notice.

Definitions

Term	Definition
Newborn	A child is considered a newborn through the month of the child's 1st birth date.

<p>Deemed Newborn Program</p>	<p>Deemed Newborn coverage is for children through the month of the child’s 1st birth date. The child must be:</p> <ul style="list-style-type: none"> • Born to a mother eligible for ALTCS, SSI Cash, SSI MAO, Adult, Caretaker Relative, Pregnant Women, Children or KidsCare; and • Reside in Arizona.
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Programs and Legal Authorities

This requirement applies to the following program:

Program	Legal Authorities
Deemed Newborns	AAC R9-22-1704 AAC R9-31-309



Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> E Guaranteed Enrollment Periods

E Guaranteed Enrollment Periods

Policy
Definitions
Programs and Legal Authorities

Policy

The guarantee period is calculated at the time the discontinuance is received by PMMIS. Eligibility for the guaranteed enrollment period is based on the reason the customer became ineligible for the AHCCCS program.

Guaranteed enrollment periods apply as follows:

If...	The guaranteed enrollment period is...	Unless the customer...
<p>It is the first time the customer is eligible for any program except KidsCare, and is enrolled with an AHCCCS health plan.</p> <p>NOTE If approved for a retroactive period only was and not enrolled, the guarantee period does not apply.</p>	Six months (one-time)	<ul style="list-style-type: none"> • Moves out of state; • Is incarcerated; • Is adopted; • Was ineligible at the time of initial enrollment; or • Voluntarily withdraws from the program.
Approved for KidsCare	Twelve months	<ul style="list-style-type: none"> • Reaches age 19; • Moves out of state; • Is incarcerated or in an Institution for Mental Disease (IMD); • Is approved for another MA program;

	<ul style="list-style-type: none"> • Gets creditable coverage; • Is adopted; • Has mail returned and the person’s location is unknown; • Does not pay the monthly premium; • Fails to cooperate; • Was ineligible at the time of the initial enrollment; or • Voluntarily withdraws from the program.
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- Persons receiving ALTCS or Medicare Savings Program (MSP) do not have guaranteed enrollment periods.
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Definitions

Term	Definition
Guaranteed Enrollment Period	Available to customers of certain AHCCCS Medical Assistance programs who are enrolled with a health plan for the first time.

Programs and Legal Authorities

This requirement applies to the following program:

Program	Legal Authorities
All Programs (except ALTCS, MSP and KidsCare)	AAC R9-22-1705

KidsCare	AAC R9-31-307
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 back to top

Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> F After Enrollment

F After Enrollment

Policy

[Revised 09/03/2014](#)

Policy

Within 10 days of enrollment, the health plan provides the customer with:

- Printed information about the health plan's services and service locations that has been approved for distribution by the AHCCCS Administration.
- The name, address, and telephone number of the customer's primary care provider (PCP) and information on how the customer may change PCPs, if dissatisfied with the PCP assigned.

ID Card

Customers receive an AHCCCS Medical Assistance ID card in the mail that includes the name and phone number of the health plan.

Customers must present this ID card whenever medical services are requested or provided (ex., doctor's office, hospital, lab or pharmacy.)

Customers who do not receive an ID card should call their health plan.



Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> G Health Plan Enrollment Changes

G Health Plan Enrollment Changes

Policy

Policy

There are situations when the customer's enrollment may be changed outside the annual enrollment period. Listed below are the reasons enrollment may be changed:

Situation/Status	Description
Adoption Subsidy Children	Are auto-assigned and the guardian is given 30 days from notification to select another health plan.
Auto Assignment	Under certain conditions, once a customer has been auto assigned to a health plan, they may change health plans. The customer has a 30 day window in which they may change health plans. (This is known as Freedom of Choice.)
Continuity of Care	<p>In unusual situations, health plan changes may be approved on a case-by-case basis to ensure the customer's access to care. These situations generally involve existing conditions at the time of enrollment as opposed to new conditions that develop after enrollment.</p> <p>Approval requires an agreement from both of the Medical Directors for the health plans, or approval by the AHCCCS Chief Medical Officer.</p> <p>The health plans determine the effective date of the enrollment change.</p> <p>When the Medical Directors for both acute care health plans cannot reach an agreement, the AHCCCS Chief Medical Officer makes the decision, the Division of Health Care</p>

	Management notifies both health plans and sends a written notice to the customer that includes grievance rights
Continuity – Family	A customer who is enrolled in a health plan through the auto-assignment process may inadvertently be enrolled in a different health plan than other family members. In this case, the customer who was inadvertently enrolled is disenrolled from the health plan of assignment and enrolled in the health plan where the other family members are enrolled when AHCCCS is notified of the problem. DMS Communication Center staff research and determine if this is the problem and if a change can be made. Other family members are not permitted to change to the health plan to which the customer was auto-assigned.
Change From FES To Full Acute Care	When a customer is eligible to move from FES to full acute care, the customer is sent a letter giving the opportunity to select a health plan and notifying them of the change in services.
Foster Care	When a customer is no longer classified as a foster care child, the customer may change health plans and is notified in a letter of this opportunity. The effective date of the new enrollment choice is the date AHCCCS processes the enrollment choice.
Grievance	A change in enrollment is approved for any customer if the change is a result of the final outcome of a grievance.
Incorrect Enrollment	If a customer made a pre-enrollment choice but was assigned an incorrect health plan (agency error), a change may be made.
Change of Programs	If a customer is transferred from a Medicaid program to KidsCare, the KidsCare customer continues to be enrolled in the health plan they were enrolled in at the time of transfer.
Native Americans	A Native American customer may change from an available health plan to AIHP or from AIHP to an available health plan at any time.
Newborn	

	Newborns are automatically assigned to the mother's health plan. The mother is given 30 days from notification to select another health plan for the newborn. Newborns of Federal Emergency Services (FES) mothers are auto assigned and the mother is given 30 days from notification to select a health plan.
Same Day Change	A member can change their health plan choice within the same day of the original request. This is called "Same Day Plan Change". For example, if a member enrolls in "Plan A" then discovers their PCP is not in that health plan they may call back that same day and change to "Plan B".
Customer Moves to a New Residential Address	<p>If a customer moves to a geographic service area (GSA) that is served by the same health plan, the customer remains enrolled in the same health plan in the new GSA.</p> <p>If a customer moves to a GSA not served by the same health plan, the customer is notified and has 30 days to choose a health plan in the new GSA. The customer is auto-assigned to a health plan in the new GSA if an enrollment choice is not made within 30 days. The member is disenrolled from the previous plan the day prior to the date of new enrollment. The new health plan is responsible for services from the date of disenrollment from the previous health plan.</p>

Customer Requests

Customers can contact the Agency directly to report an agency error.

For all other change requests, the customer can:

- Call (602) 417-7100 or 1-800-962-6690;
- Send written requests to MD 3400; and
- Electronically submit requests to <https://www.healtharizonaplus.gov> during an annual enrollment change.



Effective Until 06/17/2015

Medical Assistance (MA) [Chapter 1100 Enrollment](#) >> [1102 Enrollment with a Health Plan](#) >> H Annual Enrollment Process

H Annual Enrollment Process

Policy
Definitions
Programs and Legal Authorities

Policy

Customers who are enrolled in a health plan may change enrollment once a year during their anniversary month.

- The enrollment anniversary month is the month in which the customer was first enrolled with an AHCCCS health plan.
- If more than one person in a household receives AHCCCS Medical Services, the household’s anniversary month is the month in which enrollment occurred for the customer that has been an AHCCCS recipient for the longest time. All customers in the household who want to change health plans may do so at the same time.

NOTE The following programs do not participate in annual enrollment:

- Foster Care children enrolled with Comprehensive Medical/Dental Program (CMDP);
- Federal Emergency Services (FES); and
- American Indian Health Program (AIHP) customers. (However, AIHP customers can choose to change to an acute health plan at any time and do receive the annual enrollment notification.)

Definitions

Term	Definition
Information Mailing	Enrollment choice information is mailed to each customer two months prior to his or her anniversary date.
Enrollment Choice Month	

	<p>The first month after the material is mailed is the enrollment choice month.</p> <ul style="list-style-type: none"> • A customer who wishes to change to a different health plan must notify AHCCCS either by mail, by calling the Automated Voice Response Phone System (IVR), or by calling the AHCCCS Communications Center during this month. • A customer who does not wish to change enrollment does not have to do anything to remain enrolled with the current health plan.
Transitional Month	<p>The second month is the transitional month. During this time AHCCCS notifies both the current health plan and the new health plan of the enrollment change. This allows the health plans adequate time to transfer records and welcome new members.</p>
Change Month	<p>The enrollment change is effective the first day of the third month.</p>

Programs and Legal Authorities

This requirement applies to the following program:

Program	Legal Authorities
All Programs	AAC R9-22-1702

