

Arizona Health Care Cost Containment System

Manual: Office of Managed Care Policy and Procedures	Effective Date: August 1, 1994 Revision Date: February 1, 2003
Subject: 402 Change of Plan Policy	
Authorized Signature:	Page 1 of 7

I. Purpose

This policy establishes guidelines, criteria and timeframes for how, when and by whom plan change requests will be processed for Title XIX and Title XXI members. This policy delineates the rights, obligations and responsibilities of 1) the member, 2) the member's current health plan, 3) the requested health plan and 4) the AHCCCS Administration in facilitating continuity of care, quality of care and efficient and effective program operations and in responding to administrative issues regarding member notification and errors in assignment.

II. Definitions

Day: Means a calendar day unless otherwise specified.

III. Policy

A. Criteria for Change of Plan Approval

Plan change requests will be granted for members if certain conditions are met. These conditions are:

1. Administrative Actions Resulting in a Request for a Health Plan Change

- a. A member was entitled to freedom of choice, but was not given a Pre-enrollment Notice or sent an Auto-Assignment/Freedom of Choice Notice. Title XXI members must choose a health plan prior to eligibility being effective. If a Title XXI member is transferred from Title XIX to Title XXI, and the Title XXI member has not made a health plan choice, the Title XXI member will continue to be enrolled in the health plan they were enrolled in at the time of transfer. They

will then be sent an enrollment choice notice giving them all Title XXI enrollment choices and an opportunity to select a health plan.

b. A member was entitled to participate in an Annual Enrollment Choice but (a) was not sent an Annual Enrollment Choice or (b) was sent an Annual Enrollment Choice notice but was unable to participate in the Annual Enrollment Choice due to circumstances beyond the member's control.

c. Family members were inadvertently enrolled in different health plans (this paragraph does not apply to Title XXI members). A member 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 member who was inadvertently enrolled will be 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. Other family members will not be permitted to change to the health plan to which the new member was auto-assigned. However, the condition set forth in this paragraph shall not apply if a member was afforded an enrollment choice during their Annual Enrollment Choice period.

d. A member of a special group is not enrolled in the same health plan as the group, in accordance with the AHCCCS Administration's list of special group agreements (this paragraph does not apply to Title XXI members). If a member who is part of such a special group is inadvertently enrolled in the wrong health plan, AHCCCS, upon notification will disenroll the member from the health plan and enroll the member in the special group health plan.

e. A member who was enrolled in a health plan, lost eligibility and was disenrolled, then was subsequently redetermined eligible and reenrolled in a different health plan within 90 days from the date of disenrollment. In this case the member should be reenrolled in the health plan that the member was enrolled in prior to the loss of eligibility. If this does not occur, AHCCCS, upon notification, will enroll the member in the correct health plan. Title XXI members who lose eligibility and subsequently re-apply must choose a health plan prior to being made eligible regardless of the length of time between eligibility periods.

f. A Title XIX applicant who made a pre-enrollment choice and was denied Title XIX, but determined Title XXI eligible will be granted their Title XIX pre-enrollment choice. The person will be advised of their approval for Title XXI. The member will have 16 days to make a Title XXI choice. If the member does not change their choice within this timeframe the member will remain with their Title XIX choice. If the Title XIX applicant did not pre-enroll and was subsequently approved for Title XXI, the member will be contacted to obtain a Title XXI choice.

g. Newborns will automatically be assigned to the mother's health plan. If the mother is Title XIX or Title XXI eligible she will be given 16 days from notification to select another health plan for the newborn. Newborns of Federal

Emergency Service (FES) mothers will be auto-assigned and the mother will be given 16 days from notification to select another health plan.

h. Adoption subsidy children will be auto-assigned and the guardian will be given 16 days from the child's enrollment to select another health plan.

i. A Title XIX eligible member who is entitled to freedom of choice but becomes eligible and is auto-assigned prior to having the full choice period of 16 days. The member will be given an opportunity to request a plan change following auto-assignment, however, the member must request a plan change within 16 days from the interview date (application record receipt date) or receipt of the choice letter. A member who does not make a selection within 16 days will remain with the auto-assigned health plan.

j. A member whose eligibility category changes from SOBRA to the SOBRA Family Planning Extension Program may change their health plan if their current PCP will not be providing Family Planning Extension Program services.

2. Medical Continuity of Prenatal Care

a. A pregnant member who is enrolled in a health plan through auto-assignment or freedom of choice, but who is receiving or has received prenatal care from a provider who is affiliated with another health plan may be granted a medical continuity plan change if the medical directors of both health plans concur.

b. If there are other individuals in the pregnant member's family who are also AHCCCS eligible and enrolled, they have the option to remain with the current plan or go to the new plan if the medical continuity plan change is granted. The member may not return to the original health plan or change to another health plan after the medical continuity plan change has been granted except during the Annual Enrollment Choice period.

c. The member must be transitioned within the requirements and protocols in the *AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* and in the *AHCCCS Medical Policy Manual*, Chapter 500.

3. Medical Continuity of Care

a. AHCCCS has standards for network composition that result in uniform availability and accessibility of services from all health plans serving a specific geographic area. It is impossible for standards to cover and respond to the array of circumstances that may occur in the actual delivery of medical/health care services. In unique situations, special plan changes may be approved on a case-by-case basis if necessary to ensure the member access to medical/health care.

b. A plan change for medical continuity is not an automatic process. The member's PCP, or other medical provider, must provide documentation to both health plans that supports the need for a health plan change. The health plan(s) must be reasonable in the request for documentation. However, the burden of proof that a plan change is necessary rests with the member's medical provider. The Plan change must be approved by both health plan Medical Directors.

c. The member must be transitioned within the requirements and protocols in the *AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* and in the *AHCCCS Medical Policy Manual*, Chapter 500.

B. Responsibility for Processing, Evaluation and Approval

1. Current Health Plan Responsibilities When a Plan Change is Not Warranted

a. The current health plan has the responsibility to promptly address the member's concerns regarding availability and accessibility of service and quality of medical care delivery issues that may have caused a plan change request. These issues include, but are not limited to:

Quality of medical care delivery

Transportation convenience

Transportation service availability

Physician or provider preference

Physician or provider recommendation

Physician or provider office hours

Timing of appointments and services

Office waiting time

b. Additionally, the health plan must explore all options available to the member, such as resolving transportation problems, provider availability issues, allowing the member to choose another PCP, or to see another medical provider, if appropriate.

c. Quality of care and delivery of medical service issues raised by the member must be referred to the current health plan's Quality Management Staff and/or the health plan's Medical Director for review within one day of the health plan's receipt/notification of the problem.

d. The delivery of covered services remains the responsibility of the current health plan if a plan change for medical continuity of prenatal or other medical care is not approved.

e. The current health plan must notify the member, in writing, that a plan change is not warranted. If the plan change request was the result of a member concern, as defined in section B(1)(a) of this policy, the notice must include the health plan's resolution of this concern. The notice must also advise the member of the AHCCCS/Health Plan Grievance Policy and include timeframes for filing a grievance.

f. Health plans may reach an agreement with an out-of-network provider, to care for the member on a temporary basis, for the members' period of illness and/or pregnancy in order to provide continuity of care.

2. Current (Sending) Health Plan Responsibilities when a Plan Change is Warranted

a. If a member contacts the current health plan, verbally or in writing, and states that the reason for the plan change request is due to situations defined in Section A (1) of this policy, the sending/current health plan shall advise the member to telephone the AHCCCS Verification Unit at 417-7000 or 1-800-962-6690 in order for AHCCCS to process the change.

b. If the member contacts the sending/current health plan, verbally or in writing, to request a plan change for medical continuity of care as defined in A (2) or A (3) of this policy, the following steps must be taken:

i. The sending/current health plan will contact the receiving health plan to discuss the request. If a plan change is indicated for medical continuity of care, the AHCCCS Plan Change Request form must be completed. All the members to be affected are added to the form and the form signed by the medical directors or physician designees of both health plans. When the AHCCCS Plan Change Request form is signed it is to be submitted to the AHCCCS Division of Member Services (DMS) Enrollment Unit.

ii. To facilitate continuity of prenatal care for the member, health plans shall sign off and forward the AHCCCS Plan Change Request form to the AHCCCS DMS Enrollment Unit Manager within 2 working days of the member's plan change request. The timeframe for other continuity of care issues is 10 working days.

iii. The Enrollment Unit Manager will review the plan change documentation and forward to the Enrollment Unit for processing.

iv. The Enrollment Unit will consider these plan changes as an administrative plan change.

c. The member must be transitioned within the requirements and protocols in the *AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* and in the *AHCCCS Medical Policy Manual*, Chapter 500.

3. Notification Requirements

The health plans will provide notification to its physicians and members of this policy. Information regarding this policy must be included in the provider manual and in the member handbook.

4. Receiving Health Plan Responsibilities

The member must be transitioned within the requirements and protocols in the *AHCCCS Member Transition for Annual Enrollment Choice, Open Enrollment and Other Plan Changes Policy* and in the *AHCCCS Medical Policy Manual*, Chapter 500.

5. Member Responsibilities

a. The member shall request a change of plan directly from AHCCCS only for situations defined in Section A (1) of this policy. The member shall direct all other plan change requests to the member's current health plan.

b. A member who has questions or concerns about the Plan Change Policy should be first advised about the options available to the member and the steps the health plan is required to take to accommodate medically necessary services. If the member continues to present questions or concerns, the member should be advised of the AHCCCS/Health Plan Grievance Policy, including timeframes for filing a grievance.

C. AHCCCS Administration Responsibilities

1. The AHCCCS Administration shall process change of plan requests that are listed in Section A (1) and shall send notification of the change via the daily recipient roster to the sending and receiving health plan. It is the health plan's responsibility to identify members from the daily recipient roster who are leaving the health plan.

Additionally, AHCCCSA will send the relinquishing health plan's Transition Coordinator a Prior Plan letter. The Prior Plan letter is system generated and mailed on a daily basis. The letter includes the transitioning member's name, AHCCCS ID, date of birth, and the name of the receiving health plan.

If the AHCCCS Administration denies a Section A(1) change of plan request, AHCCCS will send the member a denial letter. The member will be given 60 days to file a grievance.

2. If AHCCCS Administration receives a letter or verbal request from a member wanting a plan change, for reasons defined in Section A (1) of this policy, that also references other problems (i.e., transportation, accessibility or availability of services), that information will be sent to the current health plan.

3. If AHCCCS Administration receives a letter or verbal request from a member wanting a plan change for reasons listed in Section A (2) or A (3) the information will be forwarded to the current health plan.

IV. References

- 1) Arizona Administrative Code R9-22-509, R9-31-306, R9-31-309, and R9-31-509.
- 2) Acute Care Contract, Sec. D.
- 3) AHCCCS Medical Policy Manual, Chapter 500.