

The Contractor shall complete a separate checklist for each line of business (ACC, ACC-RBHA, ALTCS E/PD, CHP, and DDD). The Contractor shall complete column ‘C’ and may comment in column ‘D’ if applicable. The required information shall be incorporated into the Contractor’s member handbook in the order identified on the checklist.

	(A) MEMBER HANDBOOK REQUIREMENTS  CONTRACT SECTION D ACOM POLICY 406	(B) REQUIREMENTS APPLY TO LINES OF BUSINESS AS INDICATED BELOW					(C) FOUND ON PAGE:	CONTRACTOR		FOR AHCCCS USE ONLY			
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1.	Readability scale – The Contractor shall specify the Flesch-Kincaid reading level in the cover letter when submitting the member handbook for approval.	X	X	X	X	X			1				
2.	The cover letter shall include a summary of the distribution method the Contractor will use to ensure members receive written notice of how the member handbook is available, as specified in policy.	X	X			X			1				
3.	The member handbook revision date.	X	X	X	X	X			1				
4.	<b><u>“To be included verbatim in the member handbook”:</u></b> “Covered services are funded under contract with AHCCCS”.	X	X	X	X	X			1				
5.	Table of contents	X	X	X	X	X			1				

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6.	Toll free telephone and TTY/TDY number(s) for each of the following: member services, medical management, and any other unit providing services to members and include a description of each unit's function [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			1				
7.	Contractor's toll-free TTY/TDY nurse triage line telephone number which shall be available 24 hours/7 days a week.	X	X	X	X	X			1				
8.	How to contact the Contractor eCase Manager, including information on why and how to contact the Contractor eCase Manager in between Person-Centered Service Plan (PCSP) meetings.			X	X				4				
9.	How to access after-hours care (urgent care).	X	X	X	X	X			1				

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10.	Information on the availability and accessibility of behavioral health crisis services, including TRBHA crisis lines. This information should include the single statewide crisis hotline telephone number and the national 988 number. Text and chat information options must be included.	X	X	X	X	X			12				
11.	Information on how to access substance use disorder services and specifically addressing opioid treatment services including Medications for Opioid Use Disorder (MOUD).	X	X	X	X	X			7				
12.	Instructions for obtaining culturally competent materials and/or services, including translated member materials.	X	X	X	X	X			1				
13.	The availability of printed materials in alternative formats and how to access such materials at no cost.	X	X	X	X	X			1				
14.	The availability of interpretation services for oral information at no cost to the member and how to obtain these services.	X	X	X	X	X			1				

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15.	A definition of and how to access auxiliary aids and services, at no cost, including additional information in alternative formats or languages [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			1				
16.	The availability of information identifying a network provider’s cultural and linguistic capabilities, including languages offered by the provider or a skilled medical interpreter at the provider’s office, and how to access that information.	X	X	X	X	X			11				
17.	The availability of information identifying network provider offices that offer reasonable accommodations for members such as: physical access, accessible equipment, and culturally competent communications, and how members may access that information.	X	X	X	X	X			11				

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18.	Information on how members with high acuity illnesses or high service utilization can get assistance in navigating the provider network.	X	X	X	X	X			3,11				
19.	Information on what steps should be taken when a member presents to a non-contracted provider.	X	X	X	X	X			1				
20.	How to obtain, at no charge, a directory of providers.	X	X	X	X	X			1				
21.	A description of the <b>g</b> Geographic <b>s</b> Service <b>a</b> Area(s) ( <b>G</b> SAs) served by the Contractor.	X		X		X			1				
22.	A general description about how managed care works, particularly in regard to member responsibilities, appropriate utilization of services and the Primary Care Provider (PCP)'s role as gatekeeper of services.	X	X	X	X	X			1, 3				

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23.	Includes information that if the member has an Arizona driver’s license or State issued Identification (ID), AHCCCS will obtain the member’s picture from the Arizona Department of Transportation Motor Vehicle Division (MVD); and that the AHCCCS eligibility verification screen viewed by providers contains the member’s picture (if available) and coverage details.	X	X	X	X	X			1				
24.	A statement that the member is responsible for protecting their ID card and that misuse of the card, including loaning, selling, or giving it to others could result in loss of the member’s eligibility and/or legal action. A sentence shall be included that stresses the importance of members keeping, not discarding, the ID card.	X	X	X	X	X			1				

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25.	Contributions the member can make towards their own health, member responsibilities, appropriate and inappropriate behavior and any other information deemed essential by the Contractor.	X	X	X	X	X			1				
26.	Information on what to do when family size or other demographic information change.	X	X	X	X	X			1				
27.	Information on out-of-country/out-of-State/out of <del>Geographic Service Area (GSA)</del> moves.	X	X	X	X	X			1				
28.	Explanation of when and how the member may request a change of Contractor.	X		X	X	X			1,3,4				
29.	The ability to change Contractors for continuity of care reasons should be included (this is not applicable if there is only one Contractor in a GSA).	X		X		X			1,3				
30.	Information to facilitate family members as decision-makers in the treatment planning process.	X	X	X	X	X			3				

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31.	Explanation of the ALTCS Transitional Program and what services are available to members enrolled.			X	X			4				
32.	Description of the transition of care policy to ensure continued access to services when a member changes from Fee-For-Service (FFS) to Managed Care Organization (MCO), MCO to MCO, or MCO to FFS.	X	X	X	X	X		3				
33.	Information about what constitutes an emergency medical condition and emergency services [42 CFR 457.1207, 42 CFR 438.10]. Including examples of when it would be appropriate to utilize urgent care instead of the Emergency Department (ED) or be seen by a Primary Care Provider (PCP).	X	X	X	X	X		3				
34.	Description that Prior Authorization (PA) is not required for emergency services [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X		3				

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35.	How to obtain emergency transportation and medically necessary transportation.	X	X	X	X	X			3			
36.	A description of all available covered services and where to access services provided, including any cost sharing. The description should include covered dental [including clarification that the dental limit does not apply for American Indian/Alaska Native (AI/AN) members, when receiving dental services at an IHS/638 facility] and behavioral health services [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			3,6			
37.	A description of what services are covered by the Division of Developmental Disabilities (DDD) and what services are covered by the DDD Subcontracted Health Plans and how members can access those services.				X				3,6			

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38.	The amount, duration, and scope of benefits available in sufficient detail to ensure that members understand the benefits to which they are entitled [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			3				
39.	Information on any service limitations or exclusions from coverage. Refer to AMPM Exhibit 300-1 and other AMPM policies as applicable.	X	X	X	X	X			3				
40.	A description of Non-Title XIX/XXI services available to Title XIX/XXI and Non-Title XIX/XXI members and how to access these services.  The description shall include a reference to copayment coverage in the member handbook where Serious Mental Illness (SMI) services (not funded through Title XIX/XXI) may be referenced.					X			7, 17				
41.	A description of Non-Title XIX/XXI services available to Title XIX/XXI members and how to access these services.	X	X	X	X				7, 17				

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42.	Housing services. This shall include but is not limited to a description of supportive housing services and housing subsidy resources, including: a. Contact information for Housing Specialist/ Coordinator, b. A description of covered services available to the member for supportive housing services, c. Describe where contact information for Housing Specialists within the provider network can be found, d. Local Housing and Urban Development (HUD), e. Continuum of Care (CoC) Coordinated Entry for persons experiencing or at risk of homelessness, f. AHCCCS Housing Programs, and g. Housing and Health Opportunities (H2O) Program.	X		X	X	X			16			<u>No Change – Housing</u>	

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43.	Employment Services. This shall include, but is not limited to, the following: a. A “Did You Know?” about the benefits of working; ability to work while on public benefits; and how Vocational Rehabilitation is an important resource, b. AHCCCS Employment Services, c. How to Connect to Employment Services, and d. Other Employment Resources that include Vocational Rehabilitation, ARIZONA@WORK, -Benefits Planning & Education (DB101 and ABILITY360), and AHCCCS Freedom to Work Program.	X	X	X	X	X		18				
44.	Detailed descriptions of all current alternative Home and Community Based Services (HCBS) placement options. For Attendant Care, the Contractor’s shall also include the types of service delivery models it offers and its descriptions.			X	X			4,10				

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45.	Explanation of End-Of-Life (EOL) care services.	X	X	X	X	X			3				
46.	The process of referral and self-referral to specialists and other providers.	X	X	X	X	X			3,7				
47.	The Contractor’s process for referrals and provision of Augmentative and Alternative Communication related services, including Augmentative and Alternative Communication device evaluations.	X	X	X	X	X			11				
48.	A description of how to access services, including counseling or referral services, not covered due to moral or religious objections (if applicable) [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			3,7				
49.	<b><u>To be included verbatim in the member handbook:</u></b> “American Indian members are able to receive health care services from any Indian Health Service (IHS) facility or tribally owned and/or operated facility at any time.”	X	X	X	X	X			1,3				

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50.	How to obtain a PCP.	X	X	X	X	X			3				
51.	How to change a PCP.	X	X	X	X	X			3				
52.	How to make, change, and cancel appointments with a PCP <u>or other</u> <del>Providers</del> .	X	X	X	X	X			3				
53.	<del>Appointment</del> <u>Clinical and Minimum Network Appointment<sup>1</sup> availability</u> standard timelines as specified in ACOM Policy 417 for all provider types relevant to the Contractor's <del>Line of Business (LOB)</del> .	X	X	X	X	X			11				
54.	<b>To be included verbatim in the member handbook:</b> "Well visits (well exams) are covered for members under the age of 21 through the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Most well visits (also called checkup or physical) include a medical history, physical exam, health screenings, health counseling, and medically necessary immunizations".	X	X	X	X	X			1,6				

<sup>1</sup> Added to reflect the new structure of ACOM 417.

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55.	A complete description of the services enumerated in AMPM Policy 411 for Women’s Preventive Care Services including, but not limited to, a physical exam, a clinical breast exam, a pelvic exam, review and administration of immunizations, screenings and testing, lifestyle counseling, and initiation of necessary referrals.	X	X	X	X	X			6				
56.	<b><u>To be included verbatim in the member handbook:</u></b> EPSDT language (Refer to Attachment A. Section <a href="#">35</a> ).	X	X	X	X	X			1,6				
57.	<b><u>To be included verbatim in the member handbook:</u></b> “Female members, or members assigned female at birth, have direct access to preventive and well care services from a PCP, Obstetrics/ Gynecology (OB/GYN), or other maternity care provider within the Contractor’s network without a referral from a primary care provider.”	X	X	X	X	X			1,6				

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58.	Maternity Care Services. This shall include a description of covered maternity care services as enumerated in AMPM Policy 410, information on the importance of making and keeping appointments, assistance with scheduling appointments, the availability of family planning services and supplies (including immediate postpartum long-acting reversible contraceptives) and other postpartum services, benefits of breastfeeding, including how members can obtain a breast pump from their health plan, and an explanation regarding choosing a Maternity Care Provider as specified in AMPM Policy 410. This explanation must include the fact that members who transition to a new Contractor or become enrolled during their third trimester of pregnancy are allowed to complete maternity care with their current AHCCCS registered provider, regardless of contractual status, to ensure continuity of care.	X	X	X	X	X			6				

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59.	Information regarding prenatal Human Immunodeficiency Virus (HIV) testing, counseling, and treatment services, including benefits of treatment for the pregnant member and infant if a test is positive.	X	X	X	X	X			6				
60.	Information regarding HIV testing, counseling, and treatment for all members.	X	X	X	X	X			3,6				
61.	Provide information regarding family planning services and supplies, including a list of covered services as specified in AMPM Policy 420. The Family Planning Services and Supplies section shall be separate from the Maternity section.	X	X	X	X	X			6				

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62.	Information that members may choose to obtain family planning services and supplies from any appropriate provider regardless of whether or not the family planning services providers are network providers. This includes an explanation that the Contractor cannot require a member to obtain a referral or prior authorization before choosing a family planning provider [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			6				
63.	<b>To be included verbatim in the member handbook:</b> Medically necessary pregnancy terminations (Refer to Attachment A. Section 24).	X	X	X	X	X			1,6				
64.	Information regarding dental homes, including specifications that the member can choose or change an assigned dental provider.	X	X	X	X	X			6				
65.	Description of the process for making, changing, or cancelling dental appointments.	X	X	X	X	X			6				

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66.	A description of how to obtain pharmacy services after hours/-weekends/holidays. In addition, information on what to do if the member is turned away at the Point of Sale (POS).	X	X	X	X	X			3				
67.	Description of the exclusive pharmacy evaluation criteria (AMPM Policy- <del>1024310-FF</del> ). <sup>2</sup>	X	X	X	X	X			3				
68.	How to access covered behavioral health services including information on the referral process for obtaining a Serious Emotional Disturbance (SED) Identification or Serious Mental Illness (SMI) Designation.	X	X	X	X	X			7				

<sup>2</sup> Revised to indicate correct policy.

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69.	<b>To be included verbatim in the member handbook:</b> <a href="#">Children’s System of Care – Vision and Guiding Principles</a> <del>Arizona’s Vision for the Delivery of Behavioral Health Services and The Twelve Principles for the Delivery of Services to Children</del> (Refer to <del>Attachment A. Section 2</del> <a href="#">AMPM Policy 300-3</a> ). <sup>3</sup>	X	X	X	X	X			1,7				
70.	<b>To be included verbatim in the member handbook:</b> Nine Guiding Principles for <a href="#">system development, service delivery, and collaboration</a> <del>Recovery-Oriented Adult Behavioral Health Services and Systems</del> (Refer to <del>Attachment A. Section 3</del> <a href="#">AMPM Policy 300-3</a> ). <sup>4</sup>	X		X	X	X			1,7				

<sup>3</sup> Revised to now reflect reference to [AMPM 300-3. Attachment A. Section 2](#) further below to be removed in its entirety from the checklist.

<sup>4</sup> Revised to now reflect reference to [AMPM 300-3. Attachment A. Section 2](#) further below to be removed in its entirety from the checklist.

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71.	The location and a description of each Multi-Specialty Interdisciplinary Clinic’s (MSICs) specialties.	X	X	X	X	X			3,11			
72.	Information on how to make, change, and cancel appointments with a MSIC.	X	X	X	X	X			3,11			
73.	Information regarding the unique needs of children with Children’s Rehabilitative Services (CRS) Conditions including services provided at a MSIC.	X	X	X	X	X			3			
74.	A description of member council(s) and who to contact if a member is interested in participating.	X	X	X	X	X			9			
75.	Information on any restrictions on freedom of choice among providers [42 CFR 457.1207, 42 CFR 438.10].	X	X	X	X	X			3			
76.	<b>To be included verbatim in the member handbook:</b> List of applicable copayments. (Refer to Attachment A. Section 1.)	X				X			1			

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77.	A statement that the member is exempt from Medicaid copayments, as applicable.		X	X	X	X			1				
78.	Information regarding a member's share of cost.			X	X				4				
79.	Information regarding a member's portion of the cost of care in an Alternative HCBS setting. Refer to AMPM Policy 1620-D.			X	X				4				
80.	What to do if a member is billed, and under what circumstances a member may be billed for non-covered services as specified by AHCCCS.	X	X	X	X	X			1				
81.	Information on the use of other sources of insurance including Medicare. See "coordination of benefits and third-party liability" in the Contract.	X	X	X	X	X			2				

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82.	Dual eligibility (Medicare and Medicaid) services received in and out of the Contractor's network and coinsurance and deductibles. Refer to Contract and ACOM Policy 201.	X	X	X	X	X			2				

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83.	To be included verbatim in the <b>member Handbook</b> <b>for Dual Eligible Members:</b> "Medicaid does not cover medications that are eligible for coverage under Medicare Part D plans. Medicaid does not pay for Medicare copayments, deductibles or cost sharing for Medicare Part D medications except for persons who have an SMI designation. AHCCCS covers medications that are excluded from coverage under Medicare Part D when those covered medications are deemed medically necessary. An excluded drug is a medication that is not eligible for coverage under Medicare Part D. AHCCCS may cover some medications that are Over the Counter (OTC), refer to the (Insert Contractor name) OTC Drug List for a list of products available on our website at (insert link to Contractor's OTC listing from website) or call Member Services to request a printed copy."	X	X	X	X	X			1,2				

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84.	Information on coverage of Medicare Part D copayments, deductible, coverage gap and cost sharing for persons with an SMI designation.					X			2				
85.	An explanation of the Contractor's PA approval and denial process.	X	X	X	X	X			3				
86.	Advise members that the criteria that decisions are based on are available upon request.	X	X	X	X	X			3				
87.	A description of the time frames in which the Contractor will render a decision for service authorizations and medication requests including standard, expedited, and requests in which additional information is required to render a decision.	X	X	X	X	X			3				

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88.	How to file a complaint with the Contractor. This shall include the member's right to file a complaint to the Contractor regarding the adequacy of Contractor's <del>n</del> Notice of <del>a</del> Adverse <del>b</del> Benefit <del>d</del> Determination ( <del>N</del> <u>NABD</u> ) <sup>5</sup> letters. Further, it shall include how to contact AHCCCS medical management at: MedicalManagement@azahcccs.gov if the Contractor does not resolve the member's concern of adequacy with the <del>notice of adverse benefit determination</del> <u>NABD</u> letter.	X	X	X	X	X			3				

<sup>5</sup> Revised to align with the commonly utilized acronym, changes made throughout document.

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89.	All Title XIX/XXI grievance and requests for hearing information as described in the "Grievance System" section of the Contract. This includes but is not limited to: a. The right to file grievances and appeals, b. The requirements and timeframes for filing a grievance or appeal, c. The availability of assistance in the filing process, d. The right to request a state fair hearing after the Contractor has made an adverse determination to the member, e. The continuation of —benefits during the member’s appeal or request for state fair hearing and requirement to pay the cost of services if the decision is adverse to the member.	X	X	X	X	X			3,8,14				

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		ACC	CHP	ALTCS E/PD	DDD	ACC-RBHA		(D) CONTRACTOR COMMENTS	(E) CODE	(F) YES	(G) NO	(H) AHCCCS COMMENTS	
90.	Information on how members/Health Care Decision Makers (HCDMs) can submit concerns that include but is not limited to: a. The inability to receive health care services, b. Concerns about the Quality of Care (QOC) received, c. Issues with health care providers, d. Issues with health plans, or e. Timely access to services.	X	X	X	X	X			13				
91.	<del>Information on how</del> How members may file a grievance, <del>appeal,</del> and request for hearing regarding services provided by the Division of Developmental Disabilities (DDD) Subcontracted Health Plans.				X				8,14				
92.	<del>Information on how</del> How members <u>may</u> file a grievance, <del>appeal,</del> and request for hearing with the ACC-RBHA regarding crisis services provided by the ACC-RBHA.	X	X	X	X				8,14				

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93.	All complaint, grievance, appeal, and request for hearing information for members with an SMI designation.			X	X	X			5,14				
94.	All complaint, grievance, appeal, and request for hearing information for members not determined SMI and not eligible for Title XIX/XXI services.					X			5,14				
95.	<b><u>To be included verbatim in the member handbook:</u></b> Information on the opt-out process. (Refer to Attachment A. Section <a href="#">46</a> ).					X			1,5				

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96.	A statement that the organization complies with all Federal and State laws, including: Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 80, The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, The Rehabilitation Act of 1973, Title IX of the Education Amendments of 1972 (regarding education programs and activities), Titles II and III of the Americans with Disabilities Act; and section 1557 of the Patient Protection and Affordable Care Act.	X	X	X	X	X			1				
97.	The member's right to file a complaint about the Contractor. This complaint can be filed with the Contractor or with AHCCCS verbally or in writing.	X	X	X	X	X			1,5				
98.	The member's right to request information on the structure and operation of the Contractor or its subcontractors.	X	X	X	X	X			1				

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99.	A statement that informs the member of their right to request information on whether or not the Contractor has Physician Incentive Plans that affect the use of referral services, the right to know the types of compensation arrangements the Contractor uses, the right to know whether stop-loss insurance is required and the right to a summary of member survey results, in accordance with Physician Incentive Plan regulation.	X	X	X	X	X			1				
100.	The member’s right to be treated fairly regardless of disability, race, color, ethnicity, national origin, religion, gender, age, sex, gender identity, behavioral health condition (intellectual) or physical disability, sexual orientation, genetic information, or ability to pay.	X	X	X	X	X			1				
101.	Confidentiality and confidentiality limitations.	X	X	X	X	X			13				

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102.	The member’s right to a second opinion from a qualified health care professional within the network, or have a second opinion arranged outside the network, only if there is not adequate in-network coverage, at no cost to the enrollee.	X	X	X	X	X			1			
103.	The member’s right to receive information on available treatment options <b>and including</b> alternatives, <b>presented in a manner appropriate to the member’s condition and ability to understand.</b> <del>and any information the member needs in order to decide in a manner the member is able to understand the information.</del>	X	X	X	X	X			1			
104.	The member’s right to develop a contingency plan with their provider agency to decide their preferences for each service, subject to Electronic Visit Verification (EVV) and provided by the provider when a service visit is short, late, or missed.	X	X	X	X	X			4,10			

<sup>6</sup> Revised to align with 42 CFR 438.100

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		ACC	CHP	ALTCS E/PD	DDD	ACC-RBHA			(E) CODE	(F) YES	(G) NO	(H) AHCCCS COMMENTS
105.	Information about general member rights including rights under the HCBS rules regulation.			X	X				4,10, 14			
106.	The member’s right to be provided information about formulating advance directives.	X		X	X	X			1			
107.	The member’s right to inspect medical records.  The member’s right to annually request and receive a copy of their medical record at no cost.	X	X	X	X	X			1			

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108.	The <a href="#">member's right to request and receive a copy of their medical records within 30 days of the request, including the right to receive a written denial that explains the basis for the denial and how to seek review of the denial in accordance with 45 CFR Part 164<sup>7</sup>.</a> <del>member's right that the Contractor shall reply within 30 days to the member's request for a copy of the medical records. The response may be a copy of the medical record or a written denial that includes the basis for the denial and information about how to seek review of the denial in accordance with 45 CFR Part 164.</del>	X	X	X	X	X			1				
109.	The member's right to request their medical record be amended or corrected. 45 CFR Part 164.	X	X	X	X	X			1				

<sup>7</sup> Revised to better align with 45 CFR 164.524 and 42 CFR 438.100.

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110.	The member's right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.	X	X	X	X	X			13,14				
111.	The member's right to receive information on beneficiary and plan information.	X	X	X	X	X			1				
112.	The member's right to be treated with respect and with due consideration for their dignity and privacy.	X	X	X	X	X			1				
113.	The member's right to participate in decisions regarding their health care, including the right to refuse treatment.	X	X	X	X	X			1				
114.	The member's right to know about providers who speak languages other than English.	X	X	X	X	X			1				
115.	Information regarding the member's right to use any hospital or other setting for emergency care.	X	X	X	X	X			1				
116.	A definition of member Fraud, Waste, and Abuse (FWA) with reference to penalty for fraud and abuse under law.	X	X	X	X	X			15				

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117.	A description of provider FWA, including instructions on how to report providers who may be providing unnecessary or inappropriate services.	X	X	X	X	X			15			
118.	Tobacco Cessation information. This shall include, but is not limited to, information regarding the availability/ accessibility of community support groups, information regarding the Arizona Smokers Helpline, and how members can seek tobacco cessation treatment, care, and services. The following link and phone number shall be provided: <a href="https://www.azdhs.gov/prevention/chronic-disease/tobacco-free-az/index.php">https://www.azdhs.gov/prevention/chronic-disease/tobacco-free-az/index.php</a> , 1-800-556-6222.	X	X	X	X	X			3			
119.	Information on community resources applicable to the Contractor’s population and GSA. Resources shall include but are not limited to: The Special Supplemental Nutrition Program for Women, Infants and Children (WIC), Count the Kicks, Head	X	X	X	X	X			1,6			

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	Start/Early Head Start, Vaccines For Children (VFC), Arizona Early Intervention Program (AzEIP), Power Me A2Z, Arizona Department of Health Services (ADHS) Pregnancy and Breastfeeding Hotline, Fussy Baby/Birth to Five Helpline, Poison Control, <a href="#">Encircle Families</a> <sup>8</sup> <del>Raising Special Kids</del> , Strong Families AZ Website for home visitation programs, Postpartum Support International, Opioid Assistance & Referral, 2-1-1 Arizona, Dump the Drugs AZ: <del>www.healthearizonaplus.gov</del> <a href="#">Health-e-Arizona PLUS</a> <sup>9</sup> , ARIZONA@WORK, <del>and</del> Arizona Disability Benefits 101 (DB101): <a href="#">AZ Links</a> <del>www.azlinks.gov</del> , Area Agency on Aging, the Alzheimer’s Association, AZ Suicide Prevention Coalition, 988 Suicide and Crisis Lifeline, Teen Lifeline.												

<sup>8</sup> [Raising Special Kids became Encircle Families May 2025.](#)

<sup>9</sup> [Removing web address references or URLs and replace/reference the resource agency name throughout this item.](#)

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120.	A description of ways a member may access primary and preventive care at low or no cost should they lose their eligibility.	X	X	X	X	X			3			
121.	Advocacy information, including behavioral health advocates and advocacy systems and how to access those supports. Resources shall include but are not limited to: - Disability Rights Arizona – Mental Health - National Alliance on Mental Illness (NAMI) - Arizona Coalition Against Sexual and Domestic Violence.	X	X	X	X	X			9			
122.	Special Assistance information including, but not limited to, the required assessment for all individuals with an SMI determination. The information will explain Special Assistance criteria and the assessment process, and the required notification to the Office of Human Rights (OHR). Information shall include available resources for members with an SMI determination as well as how to access them.			X	X	X			14			

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123.	Information about ALTCS advocates and advocacy systems and how to access those supports. Resources shall include but <a href="#">isare</a> not limited to: -Centers for Independent Living -Disability Rights Arizona -Long Term Care Ombudsman -Legal Aid -Low-income housing services			X	X			4,10				
124.	Definitions for managed care terminology included in ACOM Policy 406, Attachment B	X	X	X	X	X		1				
125.	Maternity Care Service Definitions: Certified Nurse Midwife (CNM), free standing birthing centers, high-risk pregnancy, Licensed Midwife (LM), maternity care, maternity care coordination, maternity care provider, practitioner, prenatal care, postpartum, postpartum care, preconception counseling. (Refer to AHCCCS <a href="#">Contract and ACOM and AMPM Policy</a> Dictionary. Definitions should be member-facing and not verbatim)	X	X	X	X	X		6				

**ATTACHMENT A. SECTION 1.**

**COPAYMENTS**

Some people who get AHCCCS Medicaid benefits are asked to pay copayments for some of the AHCCCS medical services that they receive.

\*NOTE: Copayments referenced in this section means copayments charged under Medicaid (AHCCCS). It does not mean a person is exempt from Medicare copayments.

**THE FOLLOWING PERSONS ARE NOT ASKED TO PAY COPAYMENTS:**

- Children under age 19,
- People determined to have a Serious Mental Illness (SMI),
- An individual designated eligible for Children’s Rehabilitative Services (CRS) pursuant to as AAC Title 9, Chapter 22, Article 13,
- ACC, ACC-RBHA, and CHP members who are residing in a Nursing Facilities (NFS) or residential facilities such as an Assisted Living Home (ALH) and only when member’s medical condition would otherwise require hospitalization. The exemption from copayments for these members is limited to 90 days in a contract year,
- People who are enrolled in the Arizona Long Term Care System (ALTCS),
- People who are Qualified Medicare Beneficiaries (QMBs),
- People who receive hospice care,
- American Indian members who are active or previous users of the Indian Health Service (IHS), tribal health programs operated under Public Law 93-638, or urban Indian health programs,
- People in the Breast and Cervical Cancer Treatment Program (BCCTP),
- People receiving child welfare services under Title IV-B on the basis of being a child in foster care or receiving adoption or foster care assistance under Title IV-E regardless of age,
- People who are pregnant and throughout postpartum period following the pregnancy, and
- Individuals in the Adult Group (for a limited time\*\*).

\*\*NOTE: For a limited time, persons who are eligible in the Adult Group will not have any copays. The members in the Adult Group include persons who were transitioned from the AHCCCS Care program as well as individuals who are between the ages of 19-64, and who are not entitled to Medicare, and who are not pregnant, and who have income at or below 133% of the Federal Poverty Level (FPL) and who are not AHCCCS eligible under any other category. The copays for persons in the Adult Group with income over 106% FPL are planned for the future. Members will be told about any changes in copays before they happen.

**IN ADDITION, COPAYMENTS ARE NOT CHARGED FOR THE FOLLOWING SERVICES FOR ANYONE:**

- Hospitalizations,
- Emergency services,
- Family Planning services and supplies,
- Pregnancy related health care and health care for any other medical condition that may complicate the pregnancy, including tobacco cessation treatment for pregnant women,

- Preventive services, such as well visits, pap smears, colonoscopies, mammograms, and immunizations,
- Provider preventable services, and
- Services received in the emergency department.

**PEOPLE WITH OPTIONAL (NON-MANDATORY) COPAYMENTS:**

The individuals eligible for AHCCCS through any of the programs below may be charged non-mandatory copays, unless:

1. They are receiving one of the services above that cannot be charged a copay, or
2. They are in one of the groups above that cannot be charged a copay.

Non-mandatory copays are also called optional copays. If a member has a non-mandatory copay, then a provider cannot deny the service if the member states that they are unable to pay the copay. The members in the following programs may be charged non-mandatory copay by their provider:

- AHCCCS for Families with Children (1931),
- Young Adult Transitional Insurance (YATI) for young people in foster care,
- State Adoption Assistance for Special Needs Children who are being adopted,
- Receiving Supplemental Security Income (SSI) through the Social Security Administration for people who are age 65 or older, blind or disabled,
- SSI Medical Assistance Only (SSI MAO) for individual who are age 65 or older, blind or disabled, and
- Freedom to Work (FTW).

Ask your provider to look up your eligibility to find out what copays you may have. You can also find out by calling [HEALTH PLAN NAME] member services representative. You can also check the [HEALTH PLAN NAME] website for more information.

AHCCCS members with non-mandatory copays may be asked to pay the following non-mandatory copayments for medical services:

**OPTIONAL (NON-MANDATORY) COPAYMENT AMOUNTS FOR SOME MEDICAL SERVICES**

SERVICE	COPAYMENT
Prescriptions	\$2.30
Out-patient services for physical, occupational and speech therapy	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	\$3.40

The medical providers will ask you to pay these amounts but will **NOT** refuse you services if you are unable to pay. If you cannot afford your copay, tell your medical provider you are unable to pay these amounts so you will not be refused services.

**PEOPLE WITH REQUIRED (MANDATORY) COPAYMENTS:**

Some AHCCCS members have required (or mandatory) copays unless they are receiving one of the services above that cannot be charged a copay or unless they are in one of the groups above that cannot be charged a copay. The members with required copays will need to pay the copays in order to get the services. The providers can refuse services to these members if they do not pay the mandatory copays. The mandatory copays are charged to persons in families with children that are no longer eligible due to earnings – also known as Transitional Medical Assistance (TMA)

The adults on TMA have to pay required (or mandatory) copays for some medical services. If you are on the TMA Program now or if you become eligible to receive TMA benefits later, the notice from Department of Economic Security (DES) or AHCCCS will tell you so. The copays for TMA members are listed below.

**REQUIRED (MANDATORY) COPAYMENT AMOUNTS FOR PERSONS RECEIVING TMA BENEFITS**

SERVICE	COPAYMENT
Prescriptions	\$2.30
Doctor or other provider outpatient office visits for evaluation and management of your care	\$4.00
Physical, Occupational and Speech Therapies	\$3.00
Outpatient non-emergency or voluntary surgical procedures	\$3.00

Pharmacists and Medical Providers can refuse services if the copayments are not made.

**5% LIMIT ON ALL COPAYMENTS**

The amount of total copays cannot be more than 5% of the family’s total income (before taxes and deductions) during a calendar quarter (January through March, April through June, July through September, and October through December.) The 5% limit applies to both nominal and required copays.

AHCCCS will track each member’s specific copayment levels to identify members who have reached the 5% copayment limit. If you think that the total copays you have paid are more than 5% of your family’s total quarterly income and AHCCCS has not already told you this has happened, you should send copies of receipts or other proof of how much you have paid to AHCCCS, 150 N. 18<sup>th</sup> Avenue, Mail Drop 6500, Phoenix, Arizona 85007.

If you are on this program but your circumstances have changed, contact your local DES office to ask them to review your eligibility. Members can always request a reassessment of their 5% limit if their circumstances have changed.

**ATTACHMENT A, SECTION 2**

**ARIZONA'S VISION FOR THE DELIVERY OF BEHAVIORAL HEALTH SERVICES**

All behavioral health services are delivered according to the following system principles. AHCCCS supports administration of a behavioral health delivery system that is consistent with AHCCCS values, principles, and goals:

1. Timely access to care.
2. Culturally competent and linguistically appropriate.
3. Promotion of evidence-based practices through innovation.
4. Expectation for continuous quality improvement.
5. Engagement of member and family members at all system levels.
6. Collaboration with the greater community.

**THE 12 PRINCIPLES FOR THE DELIVERY OF SERVICES TO CHILDREN:**

1. Collaboration with the child and family:
  - a. Respect for and active collaboration with the child and parents is the cornerstone to achieving positive behavioral health outcomes, and
  - b. Parents and children are treated as partners in the assessment process, and the planning, delivery, and evaluation of behavioral health services, and their preferences are taken seriously.
2. Functional outcomes:
  - a. The Behavioral health services are designed and implemented to aid children to achieve success in school, live with their families, avoid delinquency, and become stable and productive adults, and
  - b. Implementation of the behavioral health services plan stabilizes the child's condition and minimizes safety risks.
3. Collaboration with others:
  - a. When children have multi-agency, multi-system involvement, a joint assessment is developed and a jointly established behavioral health services plan is collaboratively implemented,
  - b. Person-centered teams plan and deliver services,
  - c. Each child's team includes the child and parents and any foster parents, any individual important in the child's life who is invited to participate by the child or parents. The team also includes all other persons needed to develop an effective plan, including, as appropriate, the child's teacher, the child's Division of Child Safety (DCS) and/or Division of Developmental Disabilities (DDD) caseworker, and the child's probation officer, and
  - d. The team:
    - i. Develops a common assessment of the child's and family's strengths and needs,
    - ii. Develops an individualized service plan,

- iii. ~~Monitors implementation of the plan, and~~
- iv. ~~Makes adjustments in the plan, if it is not succeeding.~~

4. ~~Accessible services:~~

- a. ~~Children have access to a comprehensive array of behavioral health services, sufficient to ensure that they receive the treatment they need,~~
- b. ~~Plans identify transportation the parents and child need to access behavioral health services, and how transportation assistance will be provided, and~~
- c. ~~Behavioral health services are adapted or created when they are needed but not available.~~

5. ~~Best practices:~~

- a. ~~Competent individuals who are adequately trained and supervised provide behavioral health services,~~
- b. ~~The Behavioral health services utilize treatment modalities and programs that are evidenced based and supported by Substance Abuse and Mental Health Services Administration (SAMSHA) or other nationally recognized organizations,~~
- c. ~~The Behavioral health service plans identify and appropriately address behavioral symptoms that are reactions to death of a family member, abuse or neglect, learning disorders, and other similar traumatic or frightening circumstances, substance abuse problems, the specialized behavioral health needs of children who are developmentally disabled, maladaptive sexual behavior, including abusive conduct and risky behavior, and the need for stability and the need to promote permanency in member's lives, especially members in foster care, and~~
- d. ~~The Behavioral health services are continuously evaluated and modified if ineffective in achieving desired outcomes.~~

6. ~~Most appropriate setting:~~

- a. ~~Children are provided behavioral health services in their home and community to the extent possible, and~~
- b. ~~The Behavioral health services are provided in the most integrated setting appropriate to the child's needs. When provided in a residential setting, the setting is the most integrated and most home-like setting that is appropriate to the child's needs.~~

7. ~~Timeliness:~~

- a. ~~Children identified as needing behavioral health services are assessed and served promptly.~~

8. ~~Services tailored to the child and family:~~

- a. ~~The unique strengths and needs of children and their families dictate the type, mix, and intensity of behavioral health services provided, and~~
- b. ~~Parents and children are encouraged and assisted to articulate their own strengths and needs, the goals they are seeking, and what services they think are required to meet these goals.~~

9. ~~Stability:~~

- ~~a.—The Behavioral health service plans strive to minimize multiple placements,~~
- ~~b.—The service plans identify whether a member is at risk of experiencing a placement disruption and, if so, identify the steps to be taken to minimize or eliminate the risk,~~
- ~~c.—The Behavioral health service plans anticipate crises that might develop and include specific strategies and services that will be employed if a crisis develops,~~
- ~~d.—In responding to crises, the behavioral health system uses all appropriate behavioral health services to help the child remain at home, minimize placement disruptions, and avoid the inappropriate use of the police and the criminal justice system, and~~
- ~~e.—The Behavioral health service plans anticipate and appropriately plan for transitions in children’s lives, including transitions to new schools and new placements, and transitions to adult services.~~

~~10. Respect for the child and family’s unique cultural heritage:~~

- ~~a.—The Behavioral health services are provided in a manner that respects the cultural tradition and heritage of the child and family, and~~
- ~~b.—The services are provided in the child and family’s primary language.~~

~~11. Independence:~~

- ~~a.—The Behavioral health services include support and training for parents in meeting their child’s behavioral health needs, and support and training for children in self-management, and~~
- ~~b.—The Behavioral health service plans identify parents’ and children’s need for training and support to participate as partners in the assessment process, and in the planning, delivery, and evaluation of services, and provide that such training and support, including transportation assistance, advance discussions, and help with understanding written materials, shall be made available.~~

~~12. Connection to natural supports:~~

- ~~a.—The behavioral health system identifies and appropriately utilizes natural supports available from the child and parents’ own network of associates, including friends and neighbors, and from community organizations, including service and religious organizations.~~

**ATTACHMENT A. SECTION 3**

**~~NINE GUIDING PRINCIPLES FOR RECOVERY-ORIENTED ADULT BEHAVIORAL HEALTH SERVICES AND SYSTEMS:~~**

- ~~1.—Respect – Respect is the cornerstone. Meet the individual where they are without judgment, with great patience and compassion.~~
- ~~2.—The individuals in recovery choose services and are included in program decisions and program development efforts—An individual in recovery has choice and a voice. Their self-determination in driving services, program decisions and program development are made possible, in part, by the ongoing dynamics of education, discussion, and evaluation, thus creating the “informed consumer” and the broadest possible palette from which choice is made. The Persons in recovery should be involved at every level of the system, from administration to service delivery.~~

- ~~3.— Focus on individual as a whole person, while including and/or developing natural supports — An individual in recovery is held as nothing less than a whole being: capable, competent, and respected for their opinions and choices. As such, focus is given to empowering the greatest possible autonomy and the most natural and well-rounded lifestyle. This includes access to and involvement in the natural supports and social systems customary to an individual's social community.~~
- ~~4.— Empower individuals taking steps towards independence and allowing risk taking without fear of failure — An individual in recovery finds independence through exploration, experimentation, evaluation, contemplation, and action. An atmosphere is maintained whereby steps toward independence are encouraged and reinforced in a setting where both security and risk are valued as ingredients promoting growth.~~
- ~~5.— Integration, collaboration, and participation with the community of one's choice — An individual in recovery is a valued, contributing member of society and, as such, is deserving of and beneficial to the community. Such integration and participation underscore one's role as a vital part of the community, the community dynamic being inextricable from the human experience. Community service and volunteerism is valued.~~
- ~~6.— Partnership between individuals, staff and family members/natural supports for shared decision making with a foundation of trust — An individual in recovery, as with any member of a society, finds strength and support through partnerships. Compassion-based alliances with a focus on recovery optimization bolster self-confidence, expand understanding in all participants and lead to the creation of optimum protocols, and outcomes.~~
- ~~7.— The individuals in recovery define their own success — An individual in recovery — by their own declaration — discovers success, in part, by quality-of-life outcomes, which may include an improved sense of well-being, advanced integration into the community, and greater self-determination. Individuals in recovery are the experts on themselves, defining their own goals and desired outcomes.~~
- ~~8.— Strengths based, flexible, responsive services reflective of an individual's cultural preferences — An individual in recovery can expect and deserves flexible, timely, and responsive services that are accessible, available, reliable, accountable, and sensitive to cultural values and morals/mores. An individual in recovery is the source of their own strength and resiliency. Those who serve as supports and facilitators identify, explore, and serve to optimize demonstrated strengths in the individual as tools for generating greater autonomy and effectiveness in life.~~
- ~~9.— Hope is the foundation for the journey towards recovery — An individual in recovery has the capacity for hope and thrives best in associations that foster hope. Through hope, a future of possibility enriches the life experience and creates the environment for uncommon and unexpected positive outcomes to be made real. An individual in recovery is held as boundless in potential and possibility.~~

**ATTACHMENT A. SECTION 42**

**MEDICALLY NECESSARY PREGNANCY TERMINATIONS**

Pregnancy terminations are an AHCCCS covered service only in special situations. AHCCCS covers pregnancy termination if one of the following criteria is present:

1. The pregnant woman suffers from a physical disorder, physical injury, or physical illness including a life-endangering physical condition caused by, or arising from, the pregnancy itself that would, as certified by a physician, place the member in danger of death, unless the pregnancy is terminated.
2. The pregnancy is a result of incest.
3. The pregnancy is a result of rape.
4. The pregnancy termination is medically necessary according to the medical judgment of a licensed physician, who attests that continuation of the pregnancy could reasonably be expected to pose a serious physical or behavioral health problem for the pregnant woman by:
  - a. Creating a serious physical or behavioral health problem for the pregnant woman,
  - b. Seriously impairing a bodily function of the pregnant woman,
  - c. Causing dysfunction of a bodily organ or part of the pregnant woman,
  - d. Exacerbating a health problem of the pregnant woman, or
  - e. Preventing the pregnant woman from obtaining treatment for a health problem.

**ATTACHMENT A. SECTION 53**

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) is the name of the Medicaid benefit that ensures AHCCCS members under the age of 21 receive comprehensive health care through prevention, early intervention, diagnosis, correction, amelioration (improvement), and treatment for –physical and behavioral health conditions. The purpose of EPSDT is to ensure the availability and accessibility of health care resources, as well as to assist EPSDT-aged members and their parents or guardians in effectively utilizing these resources.

Amount, Duration and Scope: The Medicaid Act defines EPSDT services to include screening services, vision services, replacement and repair of eyeglasses, dental services, hearing services and such other necessary health care, diagnostic services, treatment and other measures described in Federal law subsection 42 USC 1396d(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. Limitations and exclusions, other than the requirement for medical necessity and cost effectiveness, do not apply to EPSDT services.

This means that services covered under EPSDT include all 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.

Some additional examples of services covered under EPSDT include, but are not limited to, well-child (preventive) visits, inpatient and outpatient hospital services, laboratory and x-ray services, physician services, naturopathic services, nurse practitioner services, medications, therapy services, behavioral health services, medical equipment, appliances and supplies, orthotics, prosthetic devices, assistance with scheduling appointments, transportation to medical appointments, family planning services and supplies, and maternity services. EPSDT also includes diagnostic, screening, preventive, and rehabilitative services. However, EPSDT does not include services that are experimental, solely for cosmetic purposes, or that are not cost effective when compared to other interventions. Well-child visits for EPSDT-aged members, even when they are healthy, are important because they include all screenings and services described in the AHCCCS EPSDT and dental periodicity schedules and can identify problems early.

#### **ATTACHMENT A. SECTION 6-4**

Members who are determined to have a Serious Mental Illness and who are enrolled in one plan for both physical health and behavioral health services may request a different plan for their physical health services. This is called an opt-out request. An opt-out will only be approved for the member under one of the following conditions:

1. The network does not allow choice from at least two PCPs, and it does not have a needed specialty provider,
2. The current treating physician says there is a need to continue a course of treatment,
3. There is evidence of harm or unfair treatment.

If you would like to ask for an opt-out, contact member services at [xxx-xxx-xxxx].