

AHCCCS COMPLETE CARE ANSWERS FOR MEMBERS WITH CRS CONDITIONS

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Q1: Will my covered services change under AHCCCS Complete Care?

A: Under AHCCCS Complete Care (and other plans as noted), members will have access to the same array of covered services as they do under their current health plan.

Q2: Will CRS members have to change health plans?

A: Currently, most members with CRS conditions are enrolled with UnitedHealth Care Community Plan, a single statewide health plan that covers all or a portion of their services. Effective October 1, 2018, CRS members will be enrolled with, and will have choice of, an AHCCCS Complete Care (ACC) plan for all services (CRS, non-CRS physical health services, and behavioral health services). The ACC Plan will provide all medically necessary covered services for members with CRS qualifying conditions.

See more information for members with CRS conditions who enrolled in other programs at:

www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/CRS/

Q3: What are the geographic service areas (GSA) in AHCCCS Complete Care?

A: More than one ACC Plan will be available in each geographic service area:

- Central GSA – Pinal, Gila, Maricopa
- South GSA – Pima, Santa Cruz, Graham, Yuma, Cochise, Greenlee, LaPaz
- North GSA – Mohave, Yavapai, Coconino, Apache, Navajo

Note: Zip codes 85542, 85192, 85550 are included in the South GSA.

Q4: What are the available ACC Plans in each geographic service area (GSA)?

A: A: See the ACC Plans in each GSA at <http://www.azahcccs.gov/ACC>.

Q5: Will my foster child's Comprehensive Medical Dental Program (CMDP) coverage change?

A: Children in foster care who have CRS conditions will receive all physical health services, including services for their CRS condition, from CMDP. Like all children in foster care, they will transition to the Regional Behavioral Health Authority (RBHA) in their area for behavioral health services. AHCCCS and CMDP are evaluating future integration options for foster children, with a target date of 2020.

Q6: If my child is enrolled in AIHP, how will she/he receive CRS services?

A: The American Indian Health Program (AIHP) will provide physical and behavioral health services, including CRS services, to children enrolled in that program..

Q7: How will members with CRS qualifying conditions who are enrolled in ALTCS DDD (through DES) receive services?

A: Members with developmental disabilities and CRS conditions who are enrolled in Arizona Long Term Care will remain with UnitedHealthcare Community Plan for physical health services related to their CRS conditions and for all behavioral health services. These members will use their assigned DDD health plan for all non-CRS related physical health services. Find more information about plans to integrate ALTCS/DDD services at: <https://des.az.gov/services/disabilities/developmental-disabilities/integrated-health-plan>.

Q8: How will members with CRS conditions who are determined to have a serious mental illness (SMI) receive services?

A: Any member with a CRS condition who is determined to have an SMI (and who is not enrolled with DES/DDD) will move to the RBHA for all physical, behavioral, and CRS services.

Q9: Will I be assigned to an ACC health plan or will I have choice of ACC Plan?

A: Members will initially be assigned to an available ACC plan or a plan with other family members assigned to it. Members will be notified of that assignment by the end of June 2018, and can elect to change plans (within their GSA) during the month of July.

Q10: How will CRS conditions be determined and will members still have a CRS designation?

A: The CRS application and referral process will remain essentially the same. Members will continue to be referred to the AHCCCS Division of Member Services for CRS determination. ACC health plans will be notified when a member has been determined to have a CRS condition, and should ensure first provider visit within 30 days of CRS designation

Q11: How will the health plans ensure that members with CRS Special Health Care Needs get the comprehensive care they need?

A: The ACC and other plans will assign care coordinators who will ensure a first provider visit within 30 days of CRS designation. In addition, an initial service plan and a comprehensive service plan will be coordinated and developed by the plan and the providers.

ACC and other plans will be required to treat all members with CRS qualifying conditions as a child/young adult with special health care needs. The health plan will recognize that in addition to a primary care provider, children/young adults with CRS qualifying conditions may receive services from subspecialists who manage care related to their condition(s) and coordinate with other specialty services.

Services should be provided using an integrated family-centered, culturally competent, multi-specialty, interdisciplinary approach that includes the following elements:

- A process for using a centralized, integrated medical record that is accessible to the health plan and service providers consistent with Federal and State privacy laws to facilitate well-coordinated care,
- A process for developing and implementing a Service Plan accessible to the health plan and service providers that is consistent with Federal and State privacy laws that contains the clinical, medical, and administrative information necessary to monitor coordinated treatment plan implementation, and
- Collaboration with individuals, groups, providers, organizations and agencies charged with the administration, support or delivery of services for persons with special health care needs.

Q12: Can members and families continue to access Multi-Specialty Interdisciplinary Clinics (MSICs)?

A: Yes, families can use MSICs in their area and community based providers in the plan’s network. Health plans will be required to offer current MSICs in their network in the geographic area they are serving. If a plan is not successful with a long-term contract with an MSIC and the MSIC agrees, the ACC Plan shall allow members to use the MSICs for non-emergency conditions while the health plan contracts with a new MSIC.

Q13: Can my child continue to receive services from current providers?

A: Parents and members should review the network of each ACC plan to determine which plan to enroll with to ensure continued access to current providers.

Transition requirements for all ACC plans require that members who are receiving an active course of treatment, identified in the service plan for a serious and chronic physical, developmental or behavioral health condition, be allowed to receive the services from their established provider for the duration of their treatment or six months; whichever occurs first, regardless of whether or not the specialist participates in the health plan’s provider network. However, it should be noted that even with this above requirement, a provider may choose not to see a member enrolled with a plan the provider does not participate with.

Q14: Will anything change at age 21 for a member with a CRS designation?

A: **Members enrolled in ACC:** Starting October 1, 2018, for ACC members, the CRS designation will be discontinued at age 21. However, the ACC Plan will receive information from AHCCCS identifying the adult member as former CRS and the member will be considered an adult with special health care needs.

There will no longer be a choice to remain enrolled or “opt-in” to CRS. This is because after September 30, 2018, CRS members and their families will have choice of ACC plans that will all serve members with CRS conditions.

Current CRS members over the age of 21 who are NOT enrolled with DES/DDD will be assigned to an ACC plan, but will have a choice to pick another ACC plan in their area. Watch for a letter in the mail for this choice.

If a Multi-Specialty Interdisciplinary Clinic (MSIC) has practitioners and specialists whose scope of practice allows them to treat adults, those members age 21 and older wanting to continue services with the MSIC may do so.

Members enrolled with DES/DDD: DES is working with UnitedHealthcare Community Plan to continue providing statewide CRS and behavioral health services for members who:

- are enrolled with DES/DDD; and
- are ALTCS eligible; and
- have a CRS designation.

This is scheduled to begin on October 1, 2018. DES/DDD plans to continue to allow members to “opt in” after 21 years of age. Members will receive a letter from AHCCCS prior to their 21st birthday giving them steps on how to make this choice.

Q15: Will there be any changes to how other insurance coverage is handled?

A: There will not be any changes regarding how other insurance is handled. Families of children with CRS conditions that have commercial insurance will have the choice of utilizing the commercial network for services related to the CRS condition in addition to the ACC Plan network.

- When the member receives services from providers within the ACC Plan network, the ACC Plan is responsible for payment of covered services, although AHCCCS is the payor of last resort.
- Families wishing to obtain services from commercial providers (outside of the ACC Plan network) for treatment of their children’s CRS condition will be required to use their available private insurance coverage or Medicare to cover treatment for CRS covered conditions. In these circumstances, the ACC Plan shall be the secondary payer responsible for payment in accordance with AHCCCS Contractor Operations Manual Policy 201 and 203.
- The ACC Plan shall be responsible for all medically necessary covered CRS services provided through the ACC Plan’s network when the member’s Medicare or private insurance expires, is exhausted, certain annual or lifetime limits are reached, or the member’s private insurance/Medicare does not cover the CRS condition. Unless the ACC Plan refers the member out of network the ACC Plan will have no payment responsibility for services received outside of network when the member’s Medicare or private insurance expires, is exhausted, certain annual or lifetime limits are reached, or the member’s private insurance/Medicare does not cover the CRS condition.