Q1: When will the ACC Plans get the data of their membership and how will providers know which plan their members are assigned?

A: ACC Plans will begin receiving potential new member information from AHCCCS starting in August. This information will be utilized for relinquishing and receiving plans to share member information to coordinate care and work to ensure a smooth transition.

ACC Plans will receive the notification of their new members on the 9/28/18 daily 834 during September month end processes (either late 9/29/18 or early 9/30/18). The changes will be reflected in the normal AHCCCS verification places (AHCCCS Online, 270/271, etc.) for providers.

Q2: How will open service authorizations be transitioned?

A: The receiving ACC Plan will receive information on open prior authorizations from the plan the member is leaving and shall honor previously approved prior authorizations for a minimum period of 30 days.

Q3: Have there been provider forums?

A: AHCCCS has held numerous public and targeted group forums to educate members, providers and interested stakeholders. Presentations can be requested and available forums viewed at: www.azahcccs.gov/AHCCCS/Initiatives/AHCCCSCompleteCare/CommunityResources/

Q4: Will ACC Plans continue to hold provider forums and participation like the RBHAs do?

A: The ACC Plans are required to hold a provider forum no less than semi-annually. The forum must be chaired by the Contractor's Administrator/CEO or designee. The purpose of the forum is to improve communication between the Contractor and its providers. The forum shall be open to all providers and shall not be the only venue available to providers to communicate and participate in issues affecting the provider network.

In addition to the provider forum, the Contractor shall coordinate a meeting with a broad spectrum of behavioral health providers to gather input; discuss issues; identify challenges and barriers; problem-solve; share information and strategize ways to improve or strengthen the health care service delivery. These meetings shall be held no less than quarterly in the first year of the Contract and semi-annually thereafter.

Q5: Will behavioral health providers contract with all ACC Plans?

A: All AHCCCS registered providers are free to contract with any or all of the ACC Plans.

Q6: Will all ACC Plan have to offer the same behavioral health and CRS covered services now offered to members through the RBHAs and UnitedHealthcare Community Plan CRS?

A: Covered services are not changing and ACC Plans will be responsible for providing the same array of medically necessary covered services.

Q7: What will be included in the letters that go out to members?

A: Members in exiting plans will be given a brief explanation of the reason for the letter describing the change and their new plan assignment. Members will be provided with phone numbers for each plan as well as plan website information to review network and other plan information. Finally, members will be provided with information on how to change to a different ACC Plan using a member portal that will be available starting on July 1st or by calling AHCCCS starting on July 2nd.

Members enrolled with a continuing plan that is not affiliated with the RBHA, who are identified by AHCCCS as having received at least $1,000 in RBHA behavioral health services for dates of service in calendar year 2017, will be given will be given a one-time choice of the ACC Plan that is affiliated with the RBHA. These letters will describe this one time choice members are getting prior to October 1st along with information on how to change to a different ACC Plan using a member portal.

All letters will also provide information to American Indian members regarding their options for choice and service delivery. Lastly, the letter provides notice that all ACC Plans (with exception of Magellan Complete Care) will have an affiliated Medicare Special Needs plan that the member can enroll with if they are dual Medicare and Medicaid eligible. Magellan Complete Care was not approved to offer a Medicare plan starting January 1, 2019 and will plan for a January 1, 2020 implementation of this requirement.

Q8: What is being done to share market provider rates versus AHCCCS fee for service rates?

A: This information has been shared with the Managed Care Organizations.

Q9: How will member assignment to ACC Plans work?

A: Members currently in a health plan that will be an ACC Plan in their service area on October 1, 2018 will stay with their current health plan. Members currently in a health plan that will not be an ACC Plan in their service area will be assigned an ACC Plan. Members in the same household will be assigned to the same ACC Plan. Assignment to a plan is based initially on assignment to new and small plans and then on an algorithm with target percentages that are based on RFP scoring.

AHCCCS will send member letters with their assigned ACC Plan by the end of June, 2018. Members will be allowed to choose a different ACC Plan in their service area in July, 2018. ACC Plans will begin service to members on October 1, 2018.

Some members currently in a plan that will also be an ACC Plan (not affiliated with their assigned RBHA) in their service area, who received behavioral health services through the RBHA in 2017, will be given a one-time choice to move to the ACC Plan that is affiliated with the RBHA in their service area. These members will be notified in late June 2018 and will be allowed to make their choice during the month of July, 2018.

For more information on member auto-assignment starting October 1, 2018, see the paragraph on Auto-Assignment Algorithm on page 50 of the RFP
www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH19/ACC_RFP_11022017.pdf

Q10: If I need to contact an ACC Plan in my area to explore contracting, who do I contact?

Available Health Plans	Website	Phone #	GSA
Care1st Health Plan (ID 010254)	www.care1staz.com	1-866-560-4042	Central, North
Steward Health Choice Arizona (ID 010497)	www.StewardHealthChoiceAZ.com	1-800-322-8670	Central, North
Magellan Complete Care (ID 010500)	www.mccofaz.com	1-800-424-5891	Central
Mercy Care (ID 010306)	www.mercycareaz.org	1-800-624-3879	Central
Banner-University Family Care (ID 010314)	www.bannerufc.com/acc	1-800-582-8686	Central, South
UnitedHealthcare Community Plan (ID 010158)	www.uhccommunityplan.com	1-800-348-4058	Central, Pima
Arizona Complete Health Complete Care Plan (ID 010422)	www.azcompletehealth.com/providers.html	1-888-788-4408	Central, South

Q11: For behavioral health providers, what will be done with demographics and how those are reported by behavioral health providers?

A: AHCCCS is in the process of paring down the required data set elements as well as determining what services, providers, and Contractors to which the DUG will apply. Please see more information at www.azahcccs.gov/PlansProviders/Demographics/

Q12: What is happening with grant and housing money?

A: Responsibility for administering grant funds (for non-Title XIX members and/or services) and housing services will remain with the RBHAs. The ACC Plan shall assist members with how to access these services and shall coordinate care for the member as appropriate.

Q13: Will ACC Plans be responsible for continuing Justice System Collaboration that the RBHAs were required to do?

A: Yes. Utilizing existing collaborative protocols as a foundation, AHCCCS will require the ACC plans to work together with other ACC Plans and RBHAs in their area to continue and develop consistent collaborative protocols with each County, District, or Regional Office of: Administrative Office of the Courts, Juvenile Probation and Adult Probation, Arizona Department of Corrections and Arizona Department of Juvenile Corrections, and the Veteran's Administration.

The plans shall develop strategies to communicate timely data for coordination of care, development of treatment plans, safe transition into the community upon release, and to optimize the use of services in connection with Mental Health Courts and Drug Courts.

In addition, in order to facilitate members transitioning out of jails and prisons into communities, ACC Plans are required to participate in criminal justice system "reach-in" care coordination efforts. The ACC Plans shall collaborate with criminal justice partners (e.g. Jails, Sherriff's Office, Correctional Health Services, Arizona Department of Corrections, including Community Supervision, Probation, Courts), to identify justice-involved members in the adult criminal justice system with physical and/or behavioral health chronic and/or complex care needs prior to member's release.

Q14: Who is responsible for payment of Court Ordered Evaluation (COE) and Court Ordered Treatment (COT)?

A: The ACC Plan is required to develop a collaborative process with the counties to ensure coordination of care and information sharing for timely access to pre-petition screening, court ordered evaluation (COE), and court ordered treatment (COT) provided as described in AMPM Policy 320-U.

Under A.R.S. §36-545.06, the cost of pre-petition screening and COE remains a county responsibility unless the county has an agreement with AHCCCS under A.R.S. § 36-545.07 to provide those services for the county. If such an agreement exists, the RBHA contract will include those services within the scope of the RBHA's responsibilities.

The ACC Plan is responsible for medically necessary, covered behavioral health treatment that is court ordered but not including services associated with the pre-petition screening and COE for their enrolled members. Services that are Medicaid covered for a Medicaid enrolled member that

are separate from the COE services and medically necessary physical health services are the responsibility of the ACC Plan during the COE time period.

Q15: What changes may be coming to ACC due to changes with the AHCCCS waiver?

A: Information regarding potential waiver authority changes can be found at: www.azahcccs.gov/shared/FiveYear.html or www.azahcccs.gov/Resources/Federal/PendingWaivers/priorquartercoveragewaiveramendment.html

Q16: How will a provider know that a member is designated to have a Children's Rehabilitative Services designation?

A: After designation by AHCCCS, the member can be identified as having a CRS condition with the specific CRS segment that is a component of the eligibility verification. There will be no change to how it exists today.

Q17: Will there be changes to the AHCCCS Covered Behavioral Health Services Guide?

A: AHCCCS is in the process of transitioning the AHCCCS Covered Behavioral Health Services Guide (CBHSG) into the AHCCCS Medical Policy Manual (AMPM Policies 310-B, Behavioral Health Services and 320-T, Non-Discretionary Federal Grants). No changes are being made to the Medicaid covered behavioral health services benefit. AMPM Policy 320-T will expand to cover more information regarding funding/services related to the Non-Title XIX population. The B2 Matrix, which is now part of the AHCCCS CBHSG, will continue to be maintained by AHCCCS and available for stakeholders to view on the AHCCCS website. These changes are anticipated to be completed by October 1, 2018.

Q18: What happens to my patients after 10/1/18 if I am not contracted with their new health plan?

A: To ensure a smooth transition for members, if non-contracted providers agree to continue to serve an established patient, ACC Plans must reimburse PCPs for services provided before January 1, 2019 or Specialists before April 1, 2019. See a more comprehensive description of member transition requirements affecting non-contracted providers at www.azahcccs.gov/AHCCCS/Downloads/ACC/EXHIBIT_G.pdf