

510 – PRIMARY CARE PROVIDERS

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I. PURPOSE

This Policy applies to ACC, ALTCS E/PD, DCS/Comprehensive Health Plan (CHP), DES/DDD (DDD), RBHA Contractors, and Fee-For-Service (FFS) Programs including: American Indian Health Program (AIHP), Tribal ALTCS, TRBHAs, and all FFS populations, excluding Federal Emergency Services (FES). (For FES, refer to AMPM Chapter 1100). This Policy establishes requirements regarding Primary Care Providers participating in AHCCCS programs.

II. DEFINITIONS

IN-NETWORK PROVIDER An individual or entity which has signed a provider agreement as specified in A.R.S. § 36-2904 and is authorized through a subcontract with an AHCCCS Contractor to provide services as specified in A.R.S. § 36-2901 et seq. for members enrolled with the Contractor.

NON-CONTRACTING PROVIDER An individual or entity that provides services as prescribed in A.R.S. § 36-2901 who does not have a subcontract with an AHCCCS Contractor.

PRIMARY CARE PROVIDER (PCP) An individual who meets the requirements of A.R.S. § 36-2901, and who is responsible for the management of the member's health care. A PCP may be a physician defined as an individual licensed as an allopathic or osteopathic physician according to A.R.S. Title 32, Chapter 13 or Chapter 17, or a practitioner defined as a physician assistant licensed under A.R.S. Title 32, Chapter 25, or a certified nurse practitioner licensed under A.R.S. Title 32, Chapter 15. The PCP must be an individual, not a group or association of individuals, such as a clinic.

III. POLICY**A. PRIMARY CARE PROVIDER ROLE AND RESPONSIBILITIES**

The principal role and responsibilities of Primary Care Providers (PCP)s participating in AHCCCS programs include, but are not limited to:

1. Providing initial and primary care services to members.
2. Initiating, supervising, and coordinating referrals for specialty care and inpatient services and maintaining continuity of member care.
3. Maintaining the member's medical record.

B. PROVISION OF INITIAL AND PRIMARY CARE SERVICES

The PCP is responsible for rendering, or ensuring the provision of, covered preventive and primary care services to members. These services include, at a minimum, the treatment of health screenings, routine illness, maternity services if applicable, immunizations, Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. All members under the age of 21 are eligible for EPSDT services and shall receive health screening and services, to “correct or ameliorate” defects or physical and behavioral illnesses or conditions identified in an EPSDT screening, as specified in AMPM Policy 430. Members 21 years of age and over shall receive health screening and medically necessary treatments as specified in AMPM Chapter 300.

C. BEHAVIORAL HEALTH SERVICES PROVIDED BY THE PRIMARY CARE PROVIDER

The Contractor and FFS Programs shall provide coverage for medically necessary, cost-effective, federal, and state reimbursable behavioral health services provided by a PCP within their scope of practice. For the antipsychotic class of medications, Prior Authorization (PA) may be required. This includes the monitoring and adjustments of behavioral health medications.

D. PRIMARY CARE PROVIDER CARE COORDINATION RESPONSIBILITIES

PCPs in their care coordination role serve as a referral agent for specialty and referral treatments and services provided to members and ensure coordinated quality care that is efficient and cost effective. Coordination responsibilities include, but are not limited to:

1. Referring members to providers or hospitals within the Contractor network, as appropriate, and if necessary, referring members to non-contracting specialty providers.
2. Coordinating services with the Contractor or the appropriate entity for FFS members. Appropriate entities for coordination of services for FFS members include:

- a. DFSM – Care coordination resources for FFS members not enrolled in a Tribal ALTCS program or with a TRBHA,
 - b. Tribal ALTCS – For coordination of physical and behavioral health services for FFS members enrolled in a Tribal ALTCS program, and
 - c. TRBHA – For coordination of behavioral health services for TRBHA enrolled FFS members.
3. Coordination with a member’s Contractor care manager, provider case manager or ALTCS case manager.
 4. Conducting follow-up (including maintaining records of services provided) for referral services that are rendered to members by other providers, specialty providers, and/or hospitals.
 5. Coordinating the medical care of members, including at a minimum:
 - a. Oversight of drug regimens to prevent negative interactive effects,
 - b. Follow-up for all emergency services,
 - c. Coordination of inpatient care,
 - d. Coordination of services provided on a referral basis, and
 - e. Assurance that care rendered by specialty providers is appropriate and consistent with each member's health care needs.
 6. Coordinating care for Behavioral Health Medication Management

When a PCP has initiated medication management services for a member to treat a behavioral health disorder, and it is subsequently determined by the PCP that the member should be referred to a behavioral health provider for evaluation and/or continued medication management services, the Contractor and FFS providers shall require and ensure coordination of referral to the behavioral health provider.

The Contractor and FFS Providers’ policies and procedures shall address, at a minimum, the following:

- a. Guidelines for PCP referral to a behavioral health provider for medication management,
- b. Guidelines for transfer of a member with a Serious Mental Illness (SMI) designation for ongoing treatment coordination, as applicable,
- c. Protocols for notifying entities of the member’s transfer, including reason for transfer, diagnostic information, and medication history,
- d. Protocols and guidelines for the transfer or sharing of medical records information and protocols for responding to requests for additional medical record information,
- e. Protocols for transition of prescription services, including but not limited to notification to the appropriate entities of the member’s current medications and timeframes for dispensing and refilling medications during the transition period. The PCP shall ensure, at a minimum, that the member does not run out of prescribed medications prior to the first appointment with the behavioral health

provider prescriber and that all relevant member medical information, including the reason for transfer, is forwarded to the behavioral health provider prior to the member's first scheduled appointment, and

- f. Contractor monitoring activities to ensure that members are appropriately transitioned for care.

E. MAINTENANCE OF THE MEMBER'S MEDICAL RECORD

Refer to AMPM Policy 940 for information regarding the maintenance of the member's medical record.

F. PRIMARY CARE PROVIDER ASSIGNMENT AND APPOINTMENT STANDARDS

The Contractor shall make provisions to ensure that newly enrolled members are assigned to a PCP and notified of the assignment within 12 business days of the enrollment notification. The Contractor shall ensure that PCPs under contract register with AHCCCS as an approved service provider and receive an AHCCCS provider ID number. AHCCCS allows licensed providers from several medical disciplines to qualify as PCPs.

Refer to AMPM Chapter 600 for information regarding specific AHCCCS requirements for participating providers.

The Contractor shall maintain a current file of member PCP assignments. It is critical that the Contractor maintains accurate tracking of PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data. The Contractor shall make PCP assignment rosters available to providers within 10 business days of a provider's request, as specified in ACOM Policy 416.

The Contractor shall allow the member freedom of choice of the PCPs available within their network. If the member does not select a PCP, the member shall automatically be assigned to a PCP by the Contractor. The Contractor shall ensure that their network of PCPs is sufficient to provide members with available and accessible service within the time frames specified in ACOM Policy 417. The Contractor shall provide information to the member on how to contact the member's assigned PCP as specified in 42 CFR 457.1230(c), 42 CFR 438.208(b)(1).

The Contractor shall develop procedures to ensure that newly enrolled pregnant members are assigned to a PCP who provides obstetrical care or are referred to an obstetrician as specified in AMPM Policy 410. Women may elect to use a specialist in obstetrics and/or gynecology for well woman services.

The Contractor shall assign members with complex medical conditions, who are age 12 and younger, to board certified pediatricians.

The Contractor shall develop a methodology to assign members to those providers participating in value-based purchasing initiatives who have demonstrated high value services or improved outcomes.

G. REFERRALS AND APPOINTMENT STANDARDS FOR SPECIALTY CARE

The Contractor shall have adequate referral procedures in place for PCP's to ensure appropriate availability and monitoring of health care services. Referral procedures shall include the following:

1. Utilization of a Contractor specific referral process.
2. Definition of who is responsible for initiating referrals, authorizing referrals, and adjudicating disputes regarding approval of a referral (referral to either an In-Network Provider or Non-Contracting Provider).
3. Specifications addressing the timely availability of specialty referral appointments as specified in ACOM Policy 417.
4. Specifications and procedures for linking specialty and other referrals to the financial management system, such as through the PA process.

Refer to AMPM Policy 420 for family planning services information.

H. PHYSICIAN ASSISTANT AND NURSE PRACTITIONER VISITS IN A NURSING FACILITY

Both initial and any or all subsequent visits to a member in a nursing facility made by a Physician Assistant or Nurse Practitioner (NP), are covered services when the following criteria are met:

1. The Physician Assistant or NP is not an employee of the facility.
2. The source of payment for the nursing facility stay is Medicaid.

I. MEDICAL RESIDENT VISITS UNDER SPECIFIC CIRCUMSTANCES

Residents providing service without the presence of a teaching physician shall have completed more than six months (postgraduate) of an approved residency program. Medical residents may provide low level evaluation and management services to members in designated settings without the presence of the teaching physician.