510 – PRIMARY CARE PROVIDERS

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I. PURPOSE

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

II. DEFINITIONS

Refer to the AHCCCS Contract and Policy Dictionary for common terms found in this Policy including:

BEHAVIORAL HEALTH SERVICES	**CASE MANAGER**	**EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)**
IMMUNIZATIONS	**IN-NETWORK PROVIDER**	**MEDICAL RECORD**
MEMBER	**NON-CONTRACTING PROVIDER**	**NURSING FACILITY**
PRIMARY CARE PROVIDER (PCP)	**PRIOR AUTHORIZATION (PA)**	**SERIOUS MENTAL ILLNESS (SMI)**

III. POLICY

A. PRIMARY CARE PROVIDER ROLE AND RESPONSIBILITIES

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

1. Providing initial and primary care services to members.

2. Initiating, supervising, and coordinating referrals for specialty care, inpatient services, behavioral health services, as necessary and maintaining continuity of member care.

3. Maintaining the member's medical record, refer to AMPM Policy 940 for requirements.

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:

1. The treatment of health screenings.

2. Routine illness.

3. Maternity services, if applicable.

4. Immunizations.

5 . 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 screenings 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. Refer to AMPM Policy 310-V for requirements on Prescription Medications/Pharmacy Services. For Fee-For-Service PA, refer to AMPM Policy 820.

The Contractor shall ensure PCPs coordinate and collaborate with behavioral health providers.

D. PRIMARY CARE COORDINATION RESPONSIBILITIES

PCPs in their care coordination role serve as a referral agent for specialty and referral treatments and services for physical and/or behavioral health services as needed, that are provided to members to 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 and non-contracting community benefit organizations.

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 management resources for FFS members not enrolled in a Tribal ALTCS program, American Indian Medical Home (AIMH), or with a TRBHA,
   b. Tribal ALTCS – For coordination of physical and behavioral health services for FFS members enrolled in a Tribal ALTCS program,
   c. AIMH - For coordination of physical and behavioral health services for AIHP members enrolled with an AIMH, to include coordination with TRBHAs when applicable, and
   d. 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. Refer to AMPM Policy 570 for case management responsibilities.

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. Home visits if medically necessary,
   e. Member education,
   f. Preventative health services, (i.e., well-visits, immunizations, and PAP smears),
   g. Screening and referral for health-related social needs (i.e., social determinants of health),
   h. Coordination of services and
   i. 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 (Refer to AMPM Policy 520).

   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. 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 AHCCCS-Registered PCPs 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, maintain accurate tracking of PCP assignments to facilitate continuity of care, control utilization, and obtain encounter data. The Contractor shall make PCP assignment rosters, clinical information regarding member's health and medications, including behavioral health providers, available to the assigned PCP within 10 business days of a provider's request, as specified in ACOM Policy 416.

Refer to ACOM Policy 325 for additional information related to Contractor responsibilities and PCP assignments pertaining to providers participating in Targeted Investments 2.0.

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 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.

FFS members have freedom of choice and are not required to have an assigned PCP. FFS members may receive services from any AHCCCS registered PCP and any IHS/638 facility.

F. REFERRALS AND APPOINTMENT STANDARDS FOR SPECIALTY CARE

The Contractor shall have adequate referral procedures in place for PCPs 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 appointments as specified in ACOM Policy 417.

4. Specifications and procedures for linking specialty and other referrals to the claims management system, such as through the PA process.

Refer to AMPM Policy 420 for family planning services information.

G. 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.

H. 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.