SECTION III: Provider Roles & Responsibilities

CENTERS FOR MEDICARE & MEDICAID SERVICES REQUIREMENTS

The Centers for Medicare & Medicaid Services (CMS) require that ONECare provide compliance related training materials to health plans' contracted First tier, down stream and related entities (FDRs) and their employees who are involved in the administration or delivery of Medicare benefits. The training is performed as part of initial contracting and must be completed September 30th annually. As a contracted provider you and your staff are considered to be an FDR. There are two attestations ONECare providers must submit to meet this requirement.

PCP GATEKEEPER ROLE

The Primary Care Physician (PCP) serves as the gatekeeper for the health care services of his/her assigned members. Care1st contracts with PCPs for the specialties of Internal Medicine, Family Practice, General Practice, Pediatrics and sometimes OB/GYNs. The PCP is responsible for coordinating, supervising, and delivering care rendered to assigned members. PCPs are responsible for providing Medicare covered services that are included in their contracts and are within the scope of the physician's practice. If a referral to a specialist or ancillary medical service is necessary, the PCP is to follow the established process for obtaining such services (described in Section X). Only contracted providers should be used for referrals, except in extenuating circumstances, given prior approval by ONECare.

Additional responsibilities include:

- Coordinating care when provided without a PCP referral.
- Ensuring behavioral health information is included in the member's medical record.
- Providing clinical information regarding member's health and medications to the treating provider (including behavioral health providers) within 10 business days of a request from the provider.

ONECare has no policies which prevent the PCP from advocating on behalf of the member.

PCP ASSIGNMENTAND PANEL RESTRICTIONS

All members are provided with the opportunity to choose their PCP. If the member does not select a PCP on their ONECare application, Member Services contacts the member to ensure a PCP is chosen to provide care.

A PCP may limit the size of their panel by making a request to voluntarily close their panel. When a provider closes his/her panel, the provider is no longer open for the auto-assignment default process or member choice selection. Exceptions may be made for immediate family of members already on the PCP's panel or other reasons requested by the PCP. PCPs may also request a maximum number of members to be assigned at the time of contracting.

Conversely, ONECare may elect to close or limit a provider's panel if the provider has difficulty meeting appointment or wait time standards, or if there are concerns regarding quality, utilization, or related issues. The provider's panel may be re-opened upon ONECare's approval of a corrective action plan.

SPECIALIST RESPONSIBILITY

Specialists are qualified and licensed to provide Medicare covered services within the scope of their specialty. Contracted Specialists will accept referrals from PCPs when referred for medically necessary services covered by ONECare. After providing the requested services, Specialists who would like to refer the member to additional or different Specialists are to follow the procedure outlined in Section X. Specialists are expected to provide appropriate visit documentation to the PCP.

Care1st has no policies which prevent providers from advocating on behalf of the member.

SERVICE DELIVERY RESPONSIBILITIES

Providers are responsible for member coverage 24 hours a day, 7 days a week. This may be accomplished through an answering service that contacts the physician or on-call physician. The provider may also use an answering machine that directs the patient to the on-call physician. An answering machine on which the member is expected to leave a message is not acceptable. It is likewise unacceptable to use a hospital emergency department as a means of providing 24 hour coverage

APPOINTMENT AND WAIT TIME STANDARDS

ONECare has established appointment availability and office wait time standards to which the provider is expected to adhere. These standards are monitored on an ongoing basis to ensure compliance. Appointment availability standards are measured for both "Established" and "New" patients for Primary Care, Specialist and Dental providers.

An "Established" Patient is defined as a member that has received professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

A "New" Patient is defined as a member that has not received any professional services from the physician or any other physician of the same specialty who belongs to the same group or practice, within the past three years.

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APPOINTMENT AVAILABILITY STANDARDS

PCP	SPECIALTY / DENTAL	MATERNITY	BEHAVIORAL HEALTH
Immediate Need Same day or within 24 hours of the member's phone call or other notification ***Urgent** Within 2 days of request **Routine** Within 21 days of request	**Immediate Need** Within 24 hours of referral ***Urgent** Within 3 days of referral **Routine** Within 45 days of referral	**First Trimester** Within 14 days of request **Second Trimester** Within 7 days of request **Third Trimester** Within 3 days of request **High Risk Pregnancies** Within 3 days of identification of high risk by health plan or maternity care provider, or immediately if an emergency exists	**Immediate Need** Within 24 hours of identification of need **Routine Care Appointments** Assessment Within 7 days of referral **Referrals for Psychotropic Medications** Assess urgency of need immediately, then schedule a follow up based on need but no greater than 30 days.

*Urgent is defined as an acute, but not necessarily life or limb threatening disorder, which, if not attended to, could endanger the patient's health.

APPOINTMENT WAIT TIME STANDARDS:

A member should wait no more than 45 minutes for a scheduled appointment with a PCP or specialist, except when the provider is unavailable due to an emergency.

PROVIDER NETWORK CHANGES

All provider changes must be submitted in writing to your ONECare Provider Network Representative in advance. The provider changes affected by this policy include terminations, office relocations, leaves of absence, or extended vacation.

PCP TERMINATIONS/MEMBER REASSIGNMENT

a. If the terminating PCP practices under a group vendor contract, the members may remain with the group if ONECare determines that to be the appropriate course of action.

b. If the terminating PCP practices under a solo vendor contract, the members will be reassigned to another contracted PCP.

PROVIDER LEAVE OF ABSENCE OR VACATION

PCPs must provide adequate coverage when on leave of absence or on vacation. PCPs must submit a coverage plan to their ONECare Provider Network Representative for any absences longer than four (4) weeks. Absences over ninety (90) days may require transfer of members to another PCP.

REMOVAL OF MEMBER FROM PANEL

There are infrequent occasions when a provider believes that he/she cannot continue to care for a particular member. Providers should make every effort to work with the member to resolve any issues. Providers with difficult or non-compliant members are encouraged to call the Member Services Department for assistance with these members. As a last resort, providers may request that the member be removed from his/her panel. To request a member be removed from a panel, follow the procedure outlined in Section V, Eligibility and Enrollment.

PROVIDER INQUIRIES, COMPLAINTS/GRIEVANCES AND REQUESTS FOR INFORMATION

Providers are instructed to contact Provider Network Operations regarding an inquiry, complaint/grievance and requests for information. Acknowledgement of provider inquiries, complaints/grievances and requests for information occurs within three business days of receipt.

The Provider Network Representative (PNR) works with internal departments, the provider and other applicable parties to facilitate the resolution of inquiries, complaints/grievance and requests for information. Every effort is made to resolve the provider's concern within five working days. Resolution and communication of resolution does not exceed 30 business days unless a different time frame is agreed upon by the PNR and the provider.

MEMBER APPEALS

See Section IX, Provider and Member Appeals.

PROVIDER DIRECTORY

The ONECare Provider Search is updated on a regular basis. All providers are encouraged to review their information in the directory and are responsible for submitting any changes to their assigned PNR. The Provider Search is available on our website - www.care1st.com/az, or you may contact Provider Network Operations for a printed version.

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ELIGIBILITY VERIFICATION

Providers are responsible for verifying member eligibility prior to rendering medical services. To verify eligibility providers can use the Interactive Voice Response system, visit our website www.care1st.com/az or contact Member Services.

Specialists should always verify member eligibility on the day of the appointment. PCPs must verify both eligibility and member assignment on the date of service. ONECare will not reimburse providers for services rendered to members who are not eligible on the date of service. Providers should not rely solely on member identification cards to verify eligibility.

CANCELLED AND MISSED APPOINTMENTS

Providers are expected to develop a system for documenting and following up on cancelled or missed appointments. Providers should contact the Quality Management Department for assistance with members who are chronic "no shows".

COPAYMENTS

Copays applicable to pharmacy only.

Service	Copay
Generic Prescriptions	$1.00
Brand Name Prescriptions when Generic is available	$3.10

PROVISION OF COVERED SERVICES

Physicians are responsible for providing all covered services described in Section VI as medically necessary and appropriate.

REFERRALS AND PRIOR AUTHORIZATION

PCPs are responsible for initiating and coordinating referrals for their assigned members when medically appropriate. Providers are responsible for receiving prior authorization, as required. Refer to the Prior Authorization Guidelines available on our website and the Prior Authorization process outlined in Section X, Medical Operations.

SUBMITTING CLAIMS AND ENCOUNTERS

All services, including capitated services, provided to ONECare members must be documented and submitted to the health plan on the appropriate claim form. Providers must adhere to claim submission and encounter reporting requirements pursuant to their contracts. Refer to Section XII, Billing, Claims and Encounters for additional information.

INAPPROPRIATE USE OF THE EMERGENCY ROOM

PCPs are expected to discourage the inappropriate use of the emergency room by members. Members should be instructed to call 911 any time they believe they have a life-threatening emergency. In non-emergent situations, PCPs should not refer members to the Emergency Department as a means of resolving appointment availability issues.

A more detailed description of covered emergency services is found in Section VI, Covered Services.

DOCUMENTATION

Please refer to Section X for Medical Record requirements. Providers are required to keep a medical record on each patient that is consistent with accepted medical standards. Records should include the patient's advance directives and notations of any recommendations or discussions regarding patient education, family planning, or preventive services.

The PCP must also establish a medical record for those members for whom information is received by another provider even if the PCP has not yet seen the assigned member. In lieu of an actual medical record, the information may be kept in an appropriately labeled file until the member's medical record is established.

ADVANCE DIRECTIVES

PCPs are required to notify their adult members about advance directives and to document such discussion and member preferences in the medical record. Advance directives include living wills and health care/medical powers of attorney. A living will clarifies what life-saving or life-sustaining measures an individual chooses in the event that they become critically ill. A health care or medical power of attorney names a responsible party to make decisions in the event that the patient/member becomes unable to make decisions him/her self. For more information on health care directives refer to Section IV, Member Rights and Responsibilities.

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NON-DISCRIMINATION POLICY

ONECare members have the right to receive courteous, considerate care regardless of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, physical or mental handicap, or source of payment or coverage under a health benefit program. Providers must be compliant with the Americans with Disabilities Act (ADA) requirements and Title VI which prohibits discrimination on the basis of disability.

CULTURALLY COMPETENT CARE

Members have the right to have services provided in a culturally competent manner with consideration for members with limited knowledge of English, limited reading skills, vision, hearing, and those with diverse cultural and ethnic backgrounds. Services shall be offered that are sensitive to the differences in race, ethnic background, linguistic group age, gender, lifestyle, education, literacy level, disability, religion, social group or geographic location. Cultural competency in health refers to being aware of cultural differences among diverse racial, ethnic, and other minority groups, respecting those differences and taking steps to apply that knowledge to professional practice. Better communication with patients, families and groups from diverse cultures, improves health outcomes and patient satisfaction.

Refer to our website for additional resources:
https://www.care1st.com/az/providers/resources.asp, then click on "Cultural Competency"

LANGUAGE SERVICES

ONECare is dedicated to working with its contracted providers to effectively deliver quality health care services to its culturally and linguistically diverse membership. Moreover, ONECare members have a right to interpretation services. To assist in meeting this challenge, ONECare offers over-the-phone language interpretation services to all contracted providers. Provided by CyraCom International, this language interpretation service offers qualified medical interpreters with knowledge of health care terminology and procedures. Available 24 hours a day, 7 days a week, this service helps providers and their staff access interpretation services, so that you can provide care to even the most diverse communities. All ONECare contracted providers have access to CyraCom's interpretation services. Each practice is assigned a PIN that is required to access CyraCom's interpretation services. All fees for services will be billed directly to ONECare so that you can focus on ensuring effective communication with your ONECare non-English speaking patients. Please call 800.481.3293 to access this service. CyraCom's customer service is also available to provide assistance at 800.481.3289.

American Sign Language Interpretation

Valley Center of the Deaf (Maricopa County) and Community Outreach Program for the Deaf (Pima County) are contracted to provide American Sign Language Interpreters. Services are available and arranged through Member Services at least 7 days in advance at no cost to members or providers.