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Vermont Medicaid
Primary Care Provider (PCP) Manual

VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF VERMONT HEALTH ACCESS

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Section 1 Primary Care Plus (PC PLUS)

Primary Care Plus (PC Plus) is a primary care case management program developed by the Department of Vermont Health Access (DVHA) as part of Vermont's Global Commitment. Vermont requires that all Vermont Medicaid and Dr. Dynasaur members enroll in PC Plus. Many services covered under PC Plus need to be authorized by the Primary Care Provider (PCP). Services rendered to a member enrolled in a Primary Care Case Management (PCCM) must follow the guidelines for the PCCM program.

The key goals of PC Plus are to:

- Enhance the continuity of care through the creation of a "medical home"
- Establish a partnership between the Vermont Medicaid administration and community providers
- Maximize dollars spent for medical services

PCPs coordinate their members' health care needs by providing the following services:

- Primary care medical services, covered by Vermont Medicaid
- Referrals for needed specialty and other covered medical services
- Arrange 24-hour-a-day/seven days-a-week coverage

PCPs receive a monthly case management fee for each member enrolled with the PCP. This fee is for coordinating members' health care services. The case management payment structure is based on the number of patients that are attributed to the practice. Vermont Medicaid will attribute members to the PCP who has billed for appropriate services and who has seen the member within the last 24 months.

Membership in PC Plus is mandatory for all Vermont Medicaid and Dr. Dynasaur members who are not otherwise exempt from managed care enrollment under the provisions of the 1115 waiver. Under the waiver, individuals who have third party insurance, in addition to Vermont Medicaid/Dr. Dynasaur, and individuals who are on home and community-based waivers, are exempted from PC Plus enrollment. In addition, individuals enrolled in the Vermont Medicaid High Tech Program and individuals living in long-term care facilities are exempt from PC Plus enrollment.

Once they are found eligible, members who are not exempt are sent an enrollment package from the Green Mountain Care Member Services Unit and are asked to select a primary care provider. A primary care provider is assigned to those members who do not make a selection within 30 days.

Members may change their PCP by contacting the Member Services Unit, 800.250.8427. Members can be verified as members of PC Plus using the VRS and the Vermont Medicaid web site http://www.vtmedicaid.com/#/home.

A PCP enrolled in the PC Plus program must meet all of the following requirements listed in the below sections.

1.1 Allowed Practitioner Types

The PCP must be enrolled and in good standing in the Vermont Medicaid program and be routinely providing services as a:

- Family Practice Physician
- General Practice Physician
- Internal Medicine Physician (general internists)

- Pediatric Physician
- Adult, Pediatric or Family Nurse Practitioner
- Naturopaths

Physician specialists, with one or more sub-specialties, may enroll as PCPs for members with life-threatening, degenerative or disabling conditions or disease. They must agree to meet the obligations of a PCP and have experience in and are willing to provide primary care services.

1.2 Application

Providers who wish to be a PCP in the PC Plus program must be actively enrolled in the Vermont Medicaid program and are required to complete and return the PCP "Agreement For Participation".

Providers who are enrolling with PC Plus as a group, must complete a single "Application for Participation", signed by a representative of the practice group. The PCP Agreement for Participation and the Provider Enrollment Agreement can be accessed at:
http://www.vtmedicaid.com/#/provEnrollDataMaint

1.2.1 Enrollment Minimum/Maximum

PC Plus PCPs can set a limit on the number of PC Plus members to be enrolled in their practice. Maximum enrollment for a PCP is 1500.

Should a PCP desire to increase or decrease the maximum number of members to be managed, the PCP must notify Gainwell in writing at least 60 days prior to the new change. A new Application for Participation will not be required.

1.2.2 Monthly Enrollment List

PCPs will receive a monthly roster of enrolled members. The roster does not assure continuing eligibility; therefore, eligibility should be verified for each date of service prior to rendering the service. It is required that incorrect member information is noted, and a revised roster be returned to the Gainwell Enrollment Unit for updating.

This information may be returned by fax 802.433.4199, Attn: Enrollment or mailed to:

Gainwell Technologies
Attn: Enrollment
PO Box 888
Williston, VT 05495

1.2.3 Provider Enrollment Status Change

PCPs must notify Gainwell in writing should any of the changes listed below occur which will affect participation in the plan. PCPs must send a Vermont Medicaid Provider Information Change Form http://www.vtmedicaid.com/#/provEnrollDataMaint.

This information may be returned by fax to 802.433.4199, Attn: Enrollment or mailed to:

Gainwell Technologies
Attn: Enrollment
PO Box 888
Williston, VT 05495

1.2.3.1 Group Composition

If there is any change in the composition of individual providers in a group that originally agreed to participate in the Primary Care Plus Plan, the moving PCP is required to complete a new Agreement for Participation prior to the effective date of change.

In addition, any provider who has not previously participated in the PC Plus plan will need to complete the Agreement for Participation located at http://www.vtmedicaid.com/#/provEnrollDataMaint.

1.2.3.2 Office Location

PCPs must notify Gainwell in writing should any change occur regarding PCP office address, telephone numbers or name of practice, as soon as possible and prior to the effective date of the change. http://www.vtmedicaid.com/#/provEnrollDataMaint

1.2.4 Notice of Termination of Participation in PCP Plus

All individually participating or group identified PCPs must notify Gainwell of their intention to withdraw from participation, in writing, at least 90 days prior to the termination date. Providers are required to give their patients 30-day notice prior to termination.
http://www.vtmedicaid.com/assets/provEnroll/TerminationNotice.pdf

1.2.5 Hospital Admitting Privileges

A PC Plus PCP must have either local hospital admitting privileges or a formal arrangement with a physician who has local hospital admitting privileges and who agrees to abide by PC Plus requirements.

1.2.6 Referrals

Referral of PC Plus members can be made to any provider currently enrolled in the Vermont Medicaid program.

The goals of the referral process are to:

- Ensure that the PCP is involved in medical decisions affecting members
- Reduce utilization of unnecessary medical services
- Reduce duplication of services
- Promote continuity of care

The PCP will be responsible for coordinating care between the member and any specialty care that the member may need through the referral system. A referral takes place when a participating PCP refers their PC Plus member for medically necessary covered services not normally provided by the PCP. Referrals by the member's PCP will be required for payment of claims submitted by specialty providers. Members seeking specialty care without a referral from their PCP will be responsible for the visit, if they are informed in advance and in writing that because they have no referral, they will have to accept financial responsibility for the visit. See Section 1.5, Notice That Vermont Medicaid Will Not Be Accepted, in the Vermont Medicaid General Billing and Forms Manual.
http://www.vtmedicaid.com/#/manuals

Non-emergency (elective) out-of-state medical visits will require prior authorization from the DVHA Clinical Unit. Out-of-State Network Hospitals and Extended Network Hospitals are excluded from this requirement. In network referring providers must submit requests using the Out-of-State Elective Office Visit Request Form located at:
https://dvha.vermont.gov/forms-manuals/forms. Fax requests to 802.879.5963.

Referrals may be made orally or in writing. Both the PCP and the referral to specialty provider are required to keep documentation of the referral in the patient's medical records. The referral must include the following information:

- Patient identification information

- Date
- Reason for referral
- Requested service (evaluate, evaluate and treat)

Providers who make referrals in writing may do so using their own referral form. Referral forms do not need to be attached when submitting claims. The referral provider will be reimbursed on a fee-for-service basis for Vermont Medicaid covered services.

The following services do not require a referral from the PCP:

- Chiropractic services
- Dental services (Vermont Medicaid/Dr. Dynasaur only)
- Emergency services
- Family planning services, defined as services that prevent or delay pregnancy
- Gynecological services
- Naturopathic services
- Personal care for children
- Prenatal and maternity care
- Routine eye exams for adults/children and eyeglasses for children
- Mental health services
- School-based health services
- Services rendered by the PCP or those providing back-up coverage for the PCP
- Substance abuse services
- Local Transportation services (Vermont Medicaid/Dr. Dynasaur only)

1.3 Coverage Review

The Department of Vermont Health Access (DVHA) conducts code reviews on a quarterly or annual basis depending on the type of services that are being requested for consideration. Coverage reviews are initiated when a written prior authorization (PA) request is received by DVHA from a Vermont Medicaid enrolled provider for any Vermont Medicaid beneficiary.

DVHA does not review requests for coverage by a manufacturer, a manufacturer's representative, a Durable Medical Equipment vendor, or other third parties.

Refer to the Fee Schedule at https://dvha.vermont.gov/providers/codesfee-schedules for information about the code coverage and if the specific code in question, requires a prior authorization. Questions about this policy can be directed to the DVHA Clinical Operations Unit at 802-879-5903.

Section 2 Case Management Responsibilities

In addition to providing primary care services, PCPs must provide a number of case management services. Responsibilities include:

- For referrals, the PCP must use Vermont Medicaid participating providers or providers enrolled to serve members enrolled in the PC Plus program, unless the required service is not otherwise available from a currently enrolled Vermont Medicaid provider. If the PCP wants to use a provider who is not enrolled, Gainwell should be notified to solicit the enrollment of the provider.
- The PCP must have provisions for access to 24-hour/seven days-per-week coverage that will assure practitioner availability in person or by phone.
- The PCP (or PCP's practice) must maintain office-visiting hours at least four days per week for at least twenty-five hours per week for member appointments, unless this provision is waived by the DVHA in order to assure access to services and providers. Participating PCPs who work in a practice on a part-time basis, must inform the DVHA of the times they are available to see patients.
- DVHA may request a corrective action plan from the PCP if timely access responsibilities are not met.
- The PCP must assure that all members have a current medical history and medical record and must maintain medical records for each member.
- The PCP must agree to adhere to the appointment waiting times standards set out in the Medicaid Rule 7101.3 O (1) (b). These appointment standards state that any member should have immediate access to emergency care and for non-emergent care be seen within: 24 hours for urgent care, 2 weeks for non-urgent care with prompt follow-up and 90 days for preventive and routine physical examinations and 30 days for routine, laboratory, x-ray, general optometry, and all other routine services.
- PCPs must provide all covered primary care services consistent with their qualifications.
- The PCP must assure that every child or adolescent enrolled in the practice is screened according to the requirements of the Vermont Department of Health's EPSDT Periodicity Schedule.
- The PCP must follow the provisions of the Generic Drug Act where it permits substitution and will prescribe the lowest cost equivalent available.
- After consultation with specialists, the PCP will review and approve medically necessary specialty services as appropriate, except for services exempted or those approved by the DVHA or the DVHA's designated prior authorization agent.
- The PCP must participate in quality improvement projects agreed to by participants in the PC Plus network and the DVHA.
- The PCP must cooperate with the DVHA's accessibility surveyors. The DVHA will provide each PCP practice site with the results of any accessibility survey conducted.
- The PCP must notify the DVHA of any change in his/her office physical plant that might change physical accessibility to The Department.

2.1 Case Management Fee and Treatment Plan

In addition to fee-for-service reimbursement, PCPs will be paid a monthly case management fee for each member assigned to their practice. The PCP does not need to file a claim for the case management fee. Claims for the monthly fee will be generated by Gainwell based on the number of members enrolled in the practice and payment will appear on the Remittance Advice (RA). Actual services provided to members will be reimbursed on a fee-for-service basis in accordance with Vermont Medicaid fee-for-service payment policies and procedures.

When a PCP develops a treatment plan for a member, the PCP may submit a claim to Gainwell for reimbursement for the development of this plan using procedure code G9001. A PCP may submit no more than one treatment plan claim, per member, per calendar year. A covering practitioner cannot bill for a treatment plan. Payment will be made in accordance with the Vermont Medicaid fee schedule for this service. The treatment plan does not have to be submitted with the claim; however, it must be kept in the member's medical records. Treatment plans must include, at a minimum, the following information:

- Presenting clinical problems
- Expected outcomes
- Services required, including level of intensity
- Provider(s) of services