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TO: **Arkansas Medicaid Health Care Providers**

DATE: **July 1, 2005**

SUBJECT: **Provider Manual Update Transmittal**

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REMOVE		**INSERT**	
Section	**Date**	**Section**	**Date**
170.000 – 183.000	10-13-03	170.000 – 173.630	7-1-05

Explanation of Updates

Section 170.100: This introductory has been renamed, renumbered and reformatted.

Section 171.000: This is the former section 178.000.

Section 171.110: This is the former section 178.100, renamed, renumbered and reformatted.

Section 171.120: Former section 178.200 has been divided into 9 sections. This is the first of them, formerly part C of 178.200.

Section 171.130: This section was formerly part of part A of 178.200.

Section 171.140: This section was formerly part of part A of 178.200.

Section 171.150: This section was formerly part of part A of 178.200.

Section 171.160: This section was formerly part B of 178.200

Section 171.200: This is a new section number.

Section 171.210: This section was formerly section 179.000.

Section 171.220: This section was formerly part E of 178.200.

Section 171.230: This section was formerly section 183.000.

Section 171.300: This is a new section heading.

Section 171.310: This section was formerly part G of section 178.200.

Section 171.320: This section was formerly part I of section 178.200.

Section 171.321: This section was formerly part H of section 178.200.

Section 171.400: This section was formerly section 182.000.

Section 171.410: This section was formerly section 182.100.

Section 171.500: This section was formerly section 180.000.

Section 171.510: This section was formerly section 181.000.

Section 171.600: This section was formerly section 182.200.

Section 171.601: This section was formerly section 182.210.

Section 171.610: This section was formerly section 182.220.

Section 171.620: This section was formerly section 182.230.

Section 171.630: This section was formerly section 182.240.

Section 172.000: This is a new section heading.

Section 172.100: This section was formerly section 176.000.

Section 172.110: This section was formerly section 177.000.

Section 172.200: This section was formerly section 171.000.

Section 172.300: This section was formerly section 174.000.

Section 173.000: This section has been renamed.

Section 173.100: This section has been reformatted and the name has been amended.

Section 173.200: This section has been reformatted and the name has been amended.

Section 173.300: This section has been reformatted.

Section 173.400: This section has been reformatted.

Section 173.500: This section has been reformatted.

Section 173.600: This heading was formerly numbered 175.000.

Section 173.610: This is the former section 175.100.

Section 173.620: This was formerly section 175.200.

Section 173.630: This was formerly section 175.300.

Paper versions of this update transmittal have updated pages attached to file in your provider manual. See Section I for instructions on updating the paper version of the manual. For electronic versions, these changes have already been incorporated.

Thank you for your participation in the Arkansas Medicaid Program.

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Roy Jeffus, Director

If you need this material in an alternative format, such as large print, please contact our Americans with Disabilities Act Coordinator at (501) 682-6789 or 1-877-708-8191. Both telephone numbers are voice and TDD.

If you have questions regarding this transmittal, please contact the EDS Provider Assistance Center at 1-800-457-4454 (Toll-Free) within Arkansas or locally and Out-of-State at (501) 376-2211.

Arkansas Medicaid provider manuals (including update transmittals), official notices and remittance advice (RA) messages are available for downloading from the Arkansas Medicaid website: www.medicaid.state.ar.us.

SECTION I - GENERAL POLICY
CONTENTS

170.000 THE ARKANSAS MEDICAID PRIMARY CARE CASE MANAGEMENT PROGRAM 7-1-05

170.100 Introduction 7-1-05

Arkansas Medicaid's Primary Care Case Management (PCCM) Program, *ConnectCare*, operates statewide under the waiver authority of Section 1915(b) of the Social Security Act.

A. Most Medicaid beneficiaries and all ARKids First-B participants must enroll with a primary care physician (PCP), also known as a primary care case manager (PCCM).

1. PCPs provide primary care services and health education.
2. PCPs make referrals for medically necessary specialty physician's services, hospital care and other services.
3. PCPs assist their enrollees with locating medical services.
4. PCPs coordinate and monitor their enrollees' prescribed medical and rehabilitation services.

B. *ConnectCare* enrollees may receive services only from their PCP unless their PCP refers them to another provider, or unless they access a service that does not require a PCP referral.

171.000 Primary Care Physician Participation 7-1-05

171.100 PCP-Qualified Physicians and Single-Entity Providers 7-1-05

A. Obstetricians and gynecologists may choose whether or not to be PCPs.

B. All other PCP-qualified physicians and clinics must enroll as PCPs, except for physicians who certify in writing that their practice is solely in hospitals (i.e., they are "hospitalists").

C. PCP-qualified physicians are those whose sole or primary specialty is

1. Family Practice
2. General Practice
3. Internal Medicine
4. Obstetrics and gynecology
5. Pediatrics and Adolescent Medicine

D. Physicians with multiple specialties may elect to enroll as PCPs if a secondary or tertiary specialty in their Medicaid provider file is listed in part C above.

E. PCP-qualified clinics and health centers (single-entity PCPs) are

1. Area Health Education Centers (AHECs)
2. Federally Qualified Health Centers (FQHCs)
3. The family practice and internal medicine clinics at the University of Arkansas for Medical Sciences

171.110 Exclusions 7-1-05

A. Physicians whose only specialty is emergency care or who practice exclusively in hospital emergency departments may not enroll as PCPs.

B. Physician group practices (except the family practice and internal medicine clinics at UAMS) may not be PCPs.

C. Rural Health Clinics (RHCs) may not be PCPs but PCP-qualified physicians affiliated with RHCs may be PCPs.

171.120 Hospital Admitting Privileges Requirement 7-1-05

A. Only physicians with hospital admitting privileges may be PCPs.

B. The state may waive this requirement to help ensure adequate access to services.

1. On the primary care case manager (PCCM) contract, a physician may name another physician who has hospital admitting privileges and with whom he or she has an agreement by which they handle hospital admissions.
2. A copy of the physicians' agreement must be submitted with the PCCM contract.

171.130 EPSDT Agreement Requirement 7-1-05

A. A PCP applicant must sign an agreement to participate as a screening provider in the Child Health Services (EPSDT) Program.

B. Internists, obstetricians and gynecologists are not required to furnish EPSDT screens.

1. Their participation in the Child Health Services (EPSDT) Program is optional.
2. They must, however, sign Child Health Services (EPSDT agreements if they elect to be screening providers.

C. PCP-qualified single-entity providers must execute Child Health Services (EPSDT) agreements.

171.140 Primary Care Case Manager Agreement 7-1-05

A. Every PCP applicant must sign a primary care case manager (PCCM) contract.

B. PCP-qualified single-entity providers must execute Child Health Services (EPSDT) agreements.

171.150 Physician Group Single-Entity PCCMs 7-1-05

The family practice and internal medicine groups at the University of Arkansas for Medical Sciences are the only physician group providers that may enroll as single-entity PCPs.

171.160 PCP Instate and Trade Area Restriction 7-1-05

With the following exceptions, PCPs must practice in Arkansas.

A. PCP-qualified physicians in the trade-area cities (Monroe and Shreveport, Louisiana; Clarksdale and Greenville, Mississippi; Poplar Bluff, Missouri; Poteau and Sallisaw, Oklahoma; Memphis, Tennessee and Texarkana, Texas), may be PCPs.

B. To ensure adequate access to services, the state may waive the trade-area city rule for border-state physicians who are not in trade-area cities.

171.200 PCCM Enrollee/Caseload Management 7-1-05

171.210 Caseload Maximum and PCP Caseload Limits 7-1-05

A. Each PCP may establish an upper limit to his or her Medicaid caseload, up to the default maximum of 1000.

1. The state may permit higher maximum caseloads in areas the federal government has designated as medically underserved.
2. The state may permit higher maximum caseloads for PCPs who state in writing that a caseload limit of 1000 will create a hardship for them, their patients and/or the community they serve.

B. The state will not require any PCP to accept a caseload greater than the PCP's requested caseload maximum.

C. A PCP may increase or decrease his or her maximum desired caseload by any amount, at any time, by submitting a signed request to the Medicaid Provider Enrollment Unit.

171.220 Illegal Discrimination 7-1-05

A. A PCP may not reject a potential enrollee, and may not discriminate against a beneficiary because of the individual's age, sex, race, national origin or type of illness or condition.

B. Rejecting a potential enrollee based on the individual's age or sex does not constitute unlawful discrimination if the physician customarily sees only patients of one sex and/or a particular age range. For instance:

1. An obstetrician/gynecologist doesn't treat males, so he or she is not expected to enroll males.
2. A pediatrician specializing in adolescent medicine may only see patients in a particular age range, such as 12 through 18.

C. PCPs may specify the minimum and maximum ages of Medicaid and ARKids First-B enrollees they will accept.

171.230 Primary Care Case Management Fee 7-1-05

A. In addition to reimbursing PCPs on a fee for service basis for physician services, Arkansas Medicaid pays them a monthly case management fee for each enrollee on their caseloads.

B. The amount due for each month is determined by multiplying the established case management fee by the number of enrollees on the PCP's caseload on the last day of the month.

1. Medicaid pays case management fees quarterly—in October, January, April and July.
2. The accompanying Medicaid Remittance and Status Report (RA) itemizes the payments and lists the number of enrollees and each enrollment month.
3. Enrollees are listed alphabetically by name, with their Medicaid identification numbers and addresses also displayed.

171.300 Required Case Management Activities and Services 7-1-05

171.310 Investigating Abuse and Neglect 7-1-05

A PCP must perform an examination and/or make necessary referrals within 24 hours of contact by government officials in alleged or substantiated cases of abuse, neglect or maltreatment of a Medicaid-eligible individual and when the state has custody of a Medicaid-eligible individual.

171.320 Child Health Services (EPSDT) Requirements 7-1-05

A. A PCP must monitor and maintain the Child Health Services (EPSDT) screening periodicity of each of his or her enrollees under the age of 21, regardless of who screens those enrollees.

B. A PCP may refer his or her enrollees to other providers for EPSDT screens and related lab work.

1. Screening providers must report the results to the referring PCP.
2. The PCP must coordinate and monitor subsequent referrals, treatment or testing.

171.321 Childhood Immunizations 7-1-05

A PCP must monitor and coordinate the immunization status of his or her enrollees under the age of 21. **View or print the Arkansas Department of Health Immunizations Data Entry Office contact information.**

171.400 PCP Referrals 7-1-05

A. Referrals may be only for medically necessary services, supplies or equipment.

B. In order for a PCP to refer an enrollee to a specific provider by name, he or she must allow the enrollee free choice by naming two or more providers of the same type or specialty.

C. PCPs are not required to make retroactive referrals.

D. Since PCPs are responsible for coordinating and monitoring all medical and rehabilitative services received by their enrollees, they must accept co-responsibility for the ongoing care of patients they refer to other providers.

E. PCP referrals expire on the date specified by the PCP, upon receipt of the number or amount of services specified by the PCP or in six months, whichever occurs first. (This requirement varies somewhat in some programs; applicable regulations are clearly set forth in the appropriate Arkansas Medicaid Provider Manuals.)

F. There is no limit on the number of times a referral may be renewed, but renewals must be medically necessary and at least every six months (with exceptions as noted in part E, above).

G. An enrollee's PCP determines whether it is necessary to see the enrollee before making or renewing a referral.

H. Medicaid beneficiaries and ARKids First-B participants are responsible for any charges they incur for services obtained without PCP referrals except for the services listed in section 172.000.

171.410 PCCM Referrals and Documentation 7-1-05

A. Medicaid provides an optional referral form, form DMS-2610, to facilitate referrals. **View or print form DMS-2610.**

1. Additionally, PCP referrals may be oral, by note or by letter.
2. Referrals may be faxed.

B. Regardless of the means by which the PCP makes the referral, Medicaid requires documentation of the referral in the enrollee's medical record.

1. Medicaid also requires documentation in the patient's chart by the provider to whom the referral is made.
2. Providers of referred services must correspond with the PCP to the extent necessary to coordinate patient care and as requested by the PCP.

171.500 Primary Care Case Management Activities and Services 7-1-05

A *ConnectCare* PCP is also known as a primary care case manager (PCCM). He or she provides primary care physician services as well as these additional services:

A. Health education

B. Assessing each enrollee's medical condition, initiating and recommending treatment or therapy when needed

C. Initiating referrals to specialty physicians and for hospital care and other medically necessary services

D. Assisting with locating needed medical services

E. Coordinating, with other professionals, prescribed medical and rehabilitation services

F. Monitoring enrollees' prescribed medical and rehabilitation services

171.510 Access Requirements for PCPs 7-1-05

A. A PCP must have hours of operation that are reasonable and adequate to serve all of his or her patients.

1. The PCP's office must be open to Medicaid enrollees during the same hours and for the same number of hours as it is for self-pay and insured patients.
2. *ConnectCare* enrollees must have the same access as private pay and insured persons to emergency and non-emergency medical services.

B. A PCP must make available 24-hour, 7 days per week telephone access to a live voice (an employee of the primary care physician or an answering service) or to an answering machine that will immediately page an on-call medical professional. The on-call professional will

1. Provide information and instructions for treating emergency and non-emergency conditions,
2. Make appropriate referrals for non-emergency services and
3. Provide information regarding accessing other services and handling medical problems during hours the PCP's office is closed.

C. Response to after-hours calls regarding non-emergencies must be within 30 minutes.

1. PCPs must make the after hours telephone number as widely available as possible to their patients.
2. When employing an answering machine with recorded instructions for after-hours callers, PCPs should regularly check to ensure that the machine functions correctly and that the instructions are up to date.

D. PCPs in underserved and sparsely populated areas may refer their patients to the nearest facility available, but enrollees must be able to obtain the necessary instructions by telephone.

E. As regards access to services, PCPs are required to provide the same level of service for their *ConnectCare* enrollees as they provide for their insured and private-pay patients.

F. Physicians and facilities treating a PCP's enrollees after hours must report diagnosis, treatment, significant findings, recommendations and any other pertinent information to the PCP for inclusion in the patient's medical record.

G. A PCP may not refer *ConnectCare* enrollees to an emergency department for non-emergency conditions during the PCP's regular office hours.

171.600 PCP Substitutes 7-1-05

171.601 PCP Substitutes; General Requirements 7-1-05

A. Physicians substituting for PCPs are not required to be PCPs themselves.

B. In addition to the rules that apply to physician substitutes (found in the Arkansas Medicaid Physician/Independent Lab/CRNA/Radiation Therapy Center Provider Manual), physicians substituting for PCPs are subject to the following regulations.

1. The PCP and the substitute must document the substitution in each enrollee's record(s) as a referral and include the reason for the substitution.
2. The substitute physician must furnish the PCP's name and provider number to any other provider to whom he or she refers the patient.

171.610 PCP Substitutes; Rural Health Clinics and Physician Group Practices 7-1-05

When a PCP is affiliated with a rural health clinic (RHC) or is a member of a physician group, other physicians affiliated with the RHC or other members of the physician group may substitute for the PCP when he or she is unavailable.

A. Acceptable reasons for a PCP not to be available include (but are not limited to):

1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
2. The PCP is in surgery or attending a delivery.
3. An unusual number of patients need services outside the PCP's normal working hours.
4. The PCP is ill or on vacation or other leave of absence.

B. Habitual over scheduling of patients or having too great a caseload are not acceptable reasons for a PCP's use of a substitute.

171.620 PCP Substitutes; Individual Practitioners 7-1-05

A PCP that is an individual practitioner must designate a substitute physician to take call, see patients and make appropriate referrals when the PCP is unavailable.

A. Acceptable reasons for a PCP not to be available are:

1. The PCP's schedule is full because of an unusual number of urgent or time-consuming cases.
2. The PCP is in surgery or attending a delivery.
3. An unusual number of patients need services outside the PCP's normal working hours.
4. The PCP is ill or on vacation or other leave of absence.

B. Habitual over scheduling or having too great a caseload are not acceptable reasons for a PCPs use of a substitute.

171.630 Nurse Practitioners and Physician Assistants in Rural Health Clinics (RHCs) 7-1-05

Licensed nurse practitioners or licensed physician assistants employed by a Medicaid-enrolled RHC provider may not function as PCP substitutes, but they may provide primary care for a PCP's enrollees, with certain restrictions.

A. The PCP affiliated with the RHC must issue a standing referral, authorizing primary care services to be furnished

1. To the PCP's enrollees,
2. By nurse practitioners and physician assistants
3. In and/or on behalf of the RHC.

B. Nurse practitioners and physician assistants may not make referrals for medical services except for pharmacy services per established protocol.

C. The PCP must maintain a supervisory relationship with the nurse practitioners and physician assistants.

172.000 Exemptions and Special Instructions 7-1-05

172.100 Services not Requiring a PCP Referral 7-1-05

The services listed in this section do not require a PCP referral.

A. Alternatives for Adults with Physical Disabilities (Alternatives Program) waiver services

B. Anesthesia services, excluding outpatient pain management

C. Assessment (including the physician's assessment) in the emergency department of an acute care hospital to determine whether an emergency condition exists The physician and facility assessment services do not require a PCP referral if the Medicaid beneficiary or ARKids First-B participant is enrolled with a PCP.

D. Dental services

E. DDS Alternative Community Services (ACS) Waiver services

F. Developmental Day Treatment Clinic Services (DDTCS) core services

G. Disease control services for communicable diseases, including testing for and treating sexually transmitted diseases such as HIV/AIDS.

H. Domiciliary Care

I. ElderChoices waiver services

J. Emergency services in an acute care hospital emergency department, including emergency physician services

K. Family Planning services

L. Gynecological care

M. Inpatient hospital admissions on the effective date of PCP enrollment or on the day after the effective date of PCP enrollment

N. Mental health services, as follows:

1. Psychiatry
2. Rehabilitative services for persons with mental illness (RSPMI Program) who are aged 21 and older
3. Rehabilitative Services for Youth and Children (RSYC) Program

O. Obstetric (antepartum, delivery and postpartum) services.

1. Only obstetric-gynecologic services are exempt from the PCP referral requirement.
2. The obstetrician or the PCP may order home health care for antepartum or postpartum complications
3. The PCP must perform non-obstetric, non-gynecologic medical services for a pregnant woman or refer her to an appropriate provider.

P. Nursing facility services and intermediate care facility for mentally retarded (ICF/MR) services.

Q. Ophthalmology services, including eye examinations, eyeglasses, and the treatment of diseases and conditions of the eye

R. Optometry services

S. Pharmacy services.

T. Physician services for inpatients in an acute care hospital. This includes

1. Direct patient care (initial and subsequent evaluation and management services, surgery, etc.) and
2. Indirect care (pathology, interpretation of X-rays etc.).

U. Physician visits (except consultations) in the outpatient departments of acute care hospitals

1. Medicaid will cover these services without a PCP referral only if the Medicaid beneficiary is enrolled with a PCP and the services are within applicable benefit limitations.
2. Consultations require PCP referral.

V. Professional components of diagnostic laboratory, radiology and machine tests in the outpatient departments of acute care hospitals. Medicaid covers these services without a PCP referral only

1. If the Medicaid beneficiary is enrolled with a PCP and
2. The services are within applicable benefit limitations.

W. Targeted Case Management services provided by the Division of Youth Services or the Division of Children and Family Services under an inter-agency agreement with the Division of Medical Services

X. Transportation (emergency and non-emergency) to Medicaid-covered services

Y. Other services, such as sexual abuse examinations, when the Medicaid Program determines that restricting access to care would be detrimental to the patient's welfare or to program integrity, or would create unnecessary hardship.

172.110 PCP Enrollment/Referral Guidelines for Medicaid Waiver Program Participants 7-1-05

Some individuals become Medicaid eligible under the guidelines of a home and community based waiver program.

A. Participants in home and community based waiver programs do not need PCP referrals for services covered under the waiver program in which they participate.

B. When accessing any other Medicaid services, participants in waiver programs are subject to all applicable *ConnectCare* regulations.

172.200 Medicaid-Eligible Individuals that may not Enroll with a PCP 7-1-05

All Medicaid-eligible individuals and ARKids First-B participants must enroll with a PCP unless they:

A. Have Medicare as their primary insurance.

B. Are in a long term care aid category and a resident of a nursing facility.

C. Reside in an intermediate care facility for the mentally retarded (ICF/MR).

D. Are in a Medically Needy-Spend Down eligibility category.

E. Have a retroactive eligibility period.

1. Medicaid does not require PCP enrollment for the period between the beginning of the retroactive eligibility segment and the fourth day (inclusive) following the eligibility authorization date.
2. If eligibility extends beyond the fourth day following the authorization date, Medicaid requires PCP enrollment unless the beneficiary is otherwise exempt from PCCM requirements.

172.300 Automated PCP Enrollment Verification 7-1-05

A. An electronic Medicaid eligibility verification response includes PCP name and telephone number and the beginning date of the current enrollment period.

1. If no current PCP is displayed on the eligibility response, the individual is not enrolled with a PCP.

2. Beneficiaries with no PCP should be referred to the *ConnectCare Helpline* for information and assistance. **View or print the *ConnectCare Helpline* contact information.**

B. Medicaid beneficiaries and ARKids First-B participants—whether or not they are enrolled with a PCP—are responsible for all charges for services they receive without obtaining required referrals

173.000 PCCM Selection, Enrollment and Transfer 7-1-05

A. A Medicaid beneficiary or ARKids First-B participant must be enrolled with a PCP in order to obtain a PCP referral for medical services.

1. All newly eligible individuals are given opportunities to enroll.
2. Medicaid beneficiaries and ARKids First-B participants receive regular reminders from *ConnectCare* of the advantages of PCP enrollment.

B. An individual must select a PCP that is located near his or her residence.

1. A PCP may be in the beneficiary's county of residence, a county adjacent to the county of residence or a county that adjoins a county adjacent to the county of residence.
2. When the county of residence is an Arkansas county bordering another state, the individual may select a PCP in the state bordering the county of residence.

173.100 PCP Selection and Enrollment at Local County DHS Offices 7-1-05

A. Medicaid applicants receive from DHS county office staff, a description and explanation of *ConnectCare*.

1. By means of form DCO-2609, "Primary Care Physician Selection and Change Form", an applicant indicates the first, second and third choice for PCPs of each family member included in the Medicaid case.
2. Individuals applying for ARKids First A and B indicate their PCP preferences on the mail-in application, form DCO-995.
3. Family members may choose the same PCP whenever there is a PCP available that can serve all eligible family members.

B. When eligibility is determined, a DHS worker uses a Web-based program or a telephonic voice response system to complete the PCP enrollment, beginning with each beneficiary/participant's first choice.

1. If the first choice has a full caseload, the worker tries the second choice and so on.
2. The county office forwards confirmation of PCP enrollment to each new enrollee.

173.200 PCP Selection and Enrollment at PCP Offices and Clinics 7-1-05

Physician and single-entity PCPs may enroll Medicaid beneficiaries and ARKids First-B participants by means of the telephonic voice response system (VRS).

A. Enrollees must document their PCP choice on a "Primary Care Physician Selection/Change" form (form DMS 2609 or form DCO-2609).

1. The form must be completed, dated and signed by the enrollee.
2. The enrollee may request and receive a copy of the form.
3. The PCP office must retain a copy of the form in the enrollee's file.

B. Enrolling the patient is performed by accessing the VRS and following the instructions. **View or print Voice Response System (VRS) contact information.**

C. When a PCP wants to add a new enrollee but the PCP's Medicaid caseload is full; or when a PCP wants to increase or decrease his or her caseload limit, the PCP must write the

Medicaid Provider Enrollment Unit, specifying the number of slots to add or subtract. **View or print Medicaid Provider Unit contact information**.

173.300 PCP Selection and Enrollment Through the *ConnectCare HelpLine* 7-1-05

A. PCP enrollment through the *ConnectCare HelpLine* is recommended.

B. ConnectCare *HelpLine* is operated by Medicaid Outreach and Education for *ConnectCare.*

1. *ConnectCare HelpLine* staff is available for PCP enrollments and transfers 24 hours a day, Monday through Thursday, and Friday until Midnight.
2. *The HelpLine* number (1-800-275-1131) is prominently displayed in *ConnectCare* publications, frequently in more than one place. **View or print *ConnectCare* contact information.**
3. *HelpLine* staff members help Medicaid beneficiaries and ARKids First-B participants locate PCPs in their area.
4. *HelpLine* staff can help non-English-speaking individuals locate PCP offices or clinics where they can communicate in their native language.

173.400 PCP Selection and Enrollment at Participating Hospitals 7-1-05

Arkansas Medicaid pays acute care hospitals for helping Medicaid beneficiaries enroll with PCPs.

A. Enrollment is by means of a Primary Care Physician Selection/Change form, (form DMS-2609 or form DCO-2609) and the voice response system (VRS).

1. Hospital personnel enter the PCP selection via the VRS.
2. The enrollment is effective immediately upon its acceptance by the online transaction processor (OLTP) that interfaces with the VRS.
3. The OLTP automatically updates the Medicaid Management Information System (MMIS) within 24 hours, but in the meantime, the enrollment information is part of the Medicaid eligibility file in the system.

B. The effective date of the PCP enrollment is the date the enrollment is electronically accepted.

C. The enrollee may request and receive a copy of the completed selection form.

D. Hospital staff must forward a copy of the selection form to the PCP accepted by the VRS.

173.500 PCP Selection for Supplemental Security Income (SSI) Beneficiaries 7-1-05

Individuals that are eligible for Medicaid because they are Supplemental Security Income (SSI) beneficiaries do not have an opportunity to select a PCP when they apply for SSI, because SSI application is made in a federal government office.

A. When an SSI beneficiary's Medicaid eligibility determination is made, EDS generates a letter describing *ConnectCare*.

1. It includes instructions for selecting and enrolling with a PCP.
2. A Primary Care Physician Selection/Change form, form DCO-2609, is enclosed in the mailing.

B. SSI beneficiaries may enroll with PCPs by any of the methods used by other Medicaid beneficiaries.

173.600 Transferring PCP Enrollment 7-1-05

173.610 PCP Transfers by Enrollee Request 7-1-05

ConnectCare enrollees may transfer their PCP enrollment at any time, for any stated reason.

A. Enrollees are encouraged to use the *ConnectCare HelpLine* when transferring their enrollment from one PCP to another, unless the enrollee is a child in foster care, in which case the PCP enrollment transfer must be done by the local DHS county office in the child's county of residence.

B. PCP transfer for any reason may be done at the local DHS county office in the enrollee's county of residence, but the enrollee or the enrollee's parent or guardian must request the transfer in person and in writing by means of form DCO-2609.

173.620 PCP Transfers by PCP Request 7-1-05

A PCP may request that an individual transfer his or her PCP enrollment to another PCP because the arrangement with that individual is not acceptable to the PCP.

A. Examples of unacceptable arrangements include, but are not limited to the following.

1. The enrollee fails to appear for 2 or more appointments without contacting the PCP before the scheduled appointment time.
2. The enrollee is abusive to the PCP.
3. The enrollee does not comply with the PCP's medical instruction.

B. At least 30 days in advance of the effective date of the termination, the PCP must give the enrollee written notice to transfer his or her enrollment to another PCP.

1. The notice must state that the enrollee has 30 days in which to enroll with a different PCP.
2. The PCP must forward a copy to the enrollee and to the local DHS office in the enrollee's county of residence.

C. The PCP continues as the enrollee's primary care physician during the 30 days or until the individual transfers to another PCP, whichever comes first.

173.630 PCP Enrollment Transfers Initiated by the State 7-1-05

The state may initiate PCP enrollment transfers whenever they are necessary. State-initiated enrollment transfers come about because DMS, in exercising its regulatory function, sometimes must sanction, suspend or terminate a provider.

A. For instance, a provider may lose his or her PCP or Medicaid contract for

1. Failure to meet PCP or Medicaid contractual obligations
2. Proven and consistent excessive utilization
3. Unnecessarily limited utilization of medically necessary services

B. When the State terminates a PCP's contract, DMS contacts the PCP's enrollees with instructions for transferring their PCP enrollment.