PCP Coordinated Care HMO (PCP-HMO) Plans

Based on strong provider-patient partnerships, our PCP Coordinated Care HMO (PCP-HMO) benefit plans offer supported healthcare and reduced costs to both individuals/families and employer groups. PCP Coordinated Care HMO plans are different from open-access HMO plans. Here's what makes them unique:

1. Each member has an assigned primary care provider (PCP). The designated PCP helps coordinate care needed to address the member's health concerns and goals.
2. BCBSAZ-approved PCP referrals are required for most specialist office visits. The referral process ensures in-network care and avoids surprise charges. For services that require a referral, members have no benefit coverage without a BCBSAZ-approved referral from their designated PCP.
3. The pharmacy network excludes CVS.
4. Urgent care outside of Arizona is covered only when rendered by providers in the BlueCard Traditional Network.

Benefit plan names, networks, and prefixes

Here are the benefit plan names, networks, and prefixes associated with PCP-HMO plans:

PCP-HMO BENEFIT PLANS	NETWORKS AVAILABLE FOR THE PLANS	PREFIXES
Options for individuals/families (non-group)		
EverydayHealth Portfolio AdvanceHealth TrueHealth Standardized	MaricopaFocus Network (Maricopa County)	FLH
	PimaFocus Network (Pima County)	FQL
	Neighborhood Network (All counties except Maricopa and Pima)	NNG and NNJ
Options for small employer groups		
EverydayHealth Portfolio Cultivate	Alliance Network (Maricopa and Pinal counties)	XAH
	PimaConnect Network (Pima County)	PMK
	Statewide HMO Network (Statewide)	XHK
Options for large employer groups		
Ascend HMO Plus Ascend HSA HMO	Alliance Network (Maricopa and Pinal counties)	XAH
	PimaConnect Network (Pima County)	PMK
	Statewide HMO Network (Statewide)	XHK

How the "Ascend" benefit plans are different

Ascend PCP-HMO plans are available *only* to large employer groups and may not include all of the qualified health plan (QHP) benefits. Below are some examples of how Ascend plans are different from those available to small groups and individuals/families. Be sure to check eligibility and benefits for plan-specific information.

- Ascend plans use an open formulary.
- Ascend plans do not include dental/vision benefits for members under age 19.

How PCPs are selected and changed

The member's designated PCP must be a medical professional (M.D., D.O., or N.P.), actively practicing as a PCP, and contracted with BCBSAZ to participate in the network associated with the member's benefit plan. Specialties include internal medicine, family medicine, general practice, and pediatrics (for members up to age 19).

PCP Coordinated Care HMO (PCP-HMO) Plans

Requests from members to select an OB-GYN or pediatric sub-specialist provider to be their designated PCP are approved on a case-by-case basis. The OB-GYN or pediatrics sub-specialist must submit a PCP Consent form available in the secure provider portal at "Provider Resources > Forms > PCP Coordinated Care HMO Plans."

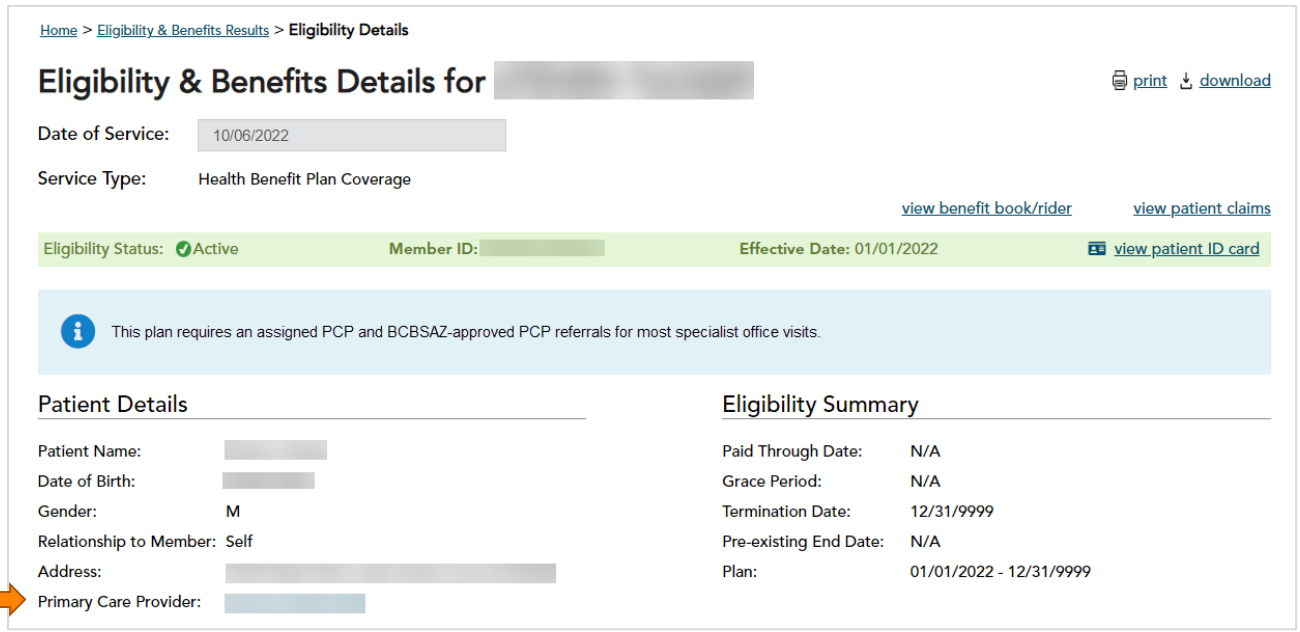
Members are covered for visits to PCPs other than their current designated PCP (or a qualified covering PCP) if there is a BCBSAZ-approved referral from the designated PCP.

PCP changes

After the initial selection by BCBSAZ, members may request a different designated PCP up to six times a year. To check the status of a member's PCP change, do an online eligibility and benefits inquiry – the updated PCP selection is displayed on the member's detailed results page as soon as it becomes effective.

Where to find the member's PCP information

The designated PCP is displayed on the member's "Eligibility and Benefits Detailed Results" page. If a change in PCP is made, it will be displayed here upon approval:



Covering PCPs

Providers who have been selected as a designated PCP must have covering PCPs for when they are not available. A covering PCP must be an M.D., D.O., or N.P., actively practicing as a PCP, and contracted for participation in the network associated with the member's benefit plan. PCPs and PAs within the designated PCP's practice (same tax ID) will automatically be considered covering PCPs–no notification to BCBSAZ is necessary.

Designated PCPs who do ***not*** have covering PCPs or PAs within their practice (same tax ID) must advise BCBSAZ of their external covering PCPs (and any changes). Up to three covering PCPs can be kept on file with BCBSAZ at any time. Use the Covering PCP form to notify BCBSAZ of other covering PCPs (different tax IDs). You can find the form in the secure provider portal at "Provider Resources > Forms > PCP Coordinated Care HMO Plans."

PCP Coordinated Care HMO (PCP-HMO) Plans

PCP panel rosters

Designated PCPs can download a list of currently attributed members by accessing the panel roster tool in the secure portal at "Practice Management > PCP Coordinated Care HMO Plans > PCP Panel Roster."

BCBSAZ-approved referrals to specialists

To help support in-network, coordinated care, designated PCPs must obtain an approved referral from BCBSAZ for office visits to most in-network specialists. The following provider types do *not* need a BCBSAZ-approved referral as long as the provider is participating in the network associated with the member's benefit plan:

- **OFFICE-BASED SERVICES** THAT DO *NOT* REQUIRE BCBSAZ-APPROVED REFERRALS
  - OB-GYN professionals (referrals are required for maternal fetal medicine physicians and midwives)
  - Behavioral/mental health professionals
  - Outpatient therapy – PT/OT/ST (prior authorization is required after meeting the allowed limit of 60 visits combined for habilitative and rehabilitative visits)
  - Chiropractors
  - Dental and vision services for eligible members (age 18 or younger, until the end of the policy year in which the member turns age 19)
- **NON-OFFICE-BASED SERVICES** THAT DO *NOT* REQUIRE BCBSAZ-APPROVED REFERRALS
  - BlueCare Anywhere telehealth services
  - Urgent care centers and retail health clinics (CVS MinuteClinics are *not* in-network for PCP Coordinated Care HMO plans)
  - Facilities (e.g., hospitals, radiology centers, labs, PT/OT/ST, SNFs, mental health facilities)

For all other specialist office visits (including other PCPs)**,** members will have no coverage (claim will be denied) and will have to pay out-of-pocket for office visits without a BCBSAZ-approved referral from their designated PCP (or a qualified covering PCP) on file with BCBSAZ. Referrals to out-of-network providers must be authorized. Failing to obtain prior authorization for out-of-network services will result in a claim denial, except for emergency services.

How long does a referral last?

- **For services that *don't* require prior authorization,** a BCBSAZ-approved specialist referral covers all office services rendered by that specialist (or another provider with the same tax ID and in the same specialty, for the same type of specialty services) for ***up to one year*.**
- **For services that *do* require prior authorization,** the referral is specific to that particular service and the service will not be authorized unless the BCBSAZ-approved referral is in place. The timeline of the referral will correspond with the ***time frame of the prior authorization.***

PCP Coordinated Care HMO (PCP-HMO) Plans

Servicing providers covered by an approved referral or prior authorization

When a member is referred to a specialist, the requested services can be rendered by other providers with the same tax ID and in the same specialty, who are in-network for the member's benefit plan. The same is true for a service that requires prior authorization. The authorized service may be rendered by providers other than the one named in the prior authorization request, as long as the provider has the same tax ID and is in the same specialty and network. For multispecialty provider groups (e.g., OB/GYN practice that includes maternal fetal medicine physicians or midwives), additional referrals and prior authorizations are required for services related to different specialties.

Process for referral approvals

The BCBSAZ referral approval process helps support coordinated, in-network care.

1. The designated PCP (or covering PCP) submits a referral request to BCBSAZ using the PCP-HMO referral request tool.
2. BCBSAZ validates that:
    a. The referral request was submitted by the designated PCP (or qualified covering PCP) in advance of the service.
    b. The referral is to an in-network specialist.
3. If both of the above conditions are validated, BCBSAZ approves the request immediately.

Note: Approval of a referral request is not a decision about coverage or medical necessity.

Referrals for out-of-network services

Referrals to providers not contracted for participation in the network associated with the member's benefit plan must be authorized. Failing to obtain prior authorization for out-of-network services will result in a claim denial, except for emergency services.

Note for Neighborhood Network: In Maricopa County, the only health systems in the Neighborhood Network are Banner Health and Dignity Health, to provide services not available in other counties.

Prior authorization requirements

PCP-HMO plans use the BCBSAZ "standard" list of prior authorization requirements. You can download the requirements on the secure provider portal at "Provider Management > Prior Authorization > BCBSAZ Members-Prior Auth Code Lists." For service dates starting January 1, 2023, members with PCP-HMO plans will be included in our eviCore program for certain specialty services.

How to request or check the status of referrals and prior authorizations

You can make referral and prior auth requests 24/7 by using the PCP-HMO online request tool in the secure provider portal. The tool also displays request status.

This online tool works only for members with PCP Coordinated Care HMO plans. You can't use it for members with any other type of benefit plan. You can find the online tool at "Practice Management > PCP Coordinated Care HMO Plans > Prior Auth Requests (Non-Standard Online Option)." A link to the tool is also available through the Prior Authorization-All Plans menu.

Although this online tool is different from the Arizona standardized request forms, ***BCBSAZ will accept PCP-HMO requests made through this tool as valid.*** For detailed instructions on how to use the tool, see the PCP Coordinated Care HMO e-learning module in the secure provider portal at "Education & Training > Provider Webinars & E-learning > Provider E-learning."

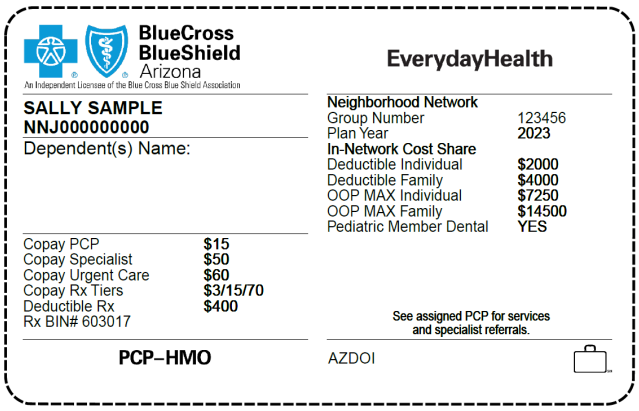
PCP Coordinated Care HMO (PCP-HMO) Plans

We also offer a fax form option for PCP-HMO plans. For phone requests, including urgent requests after normal business hours, call 1-844-807-5106.

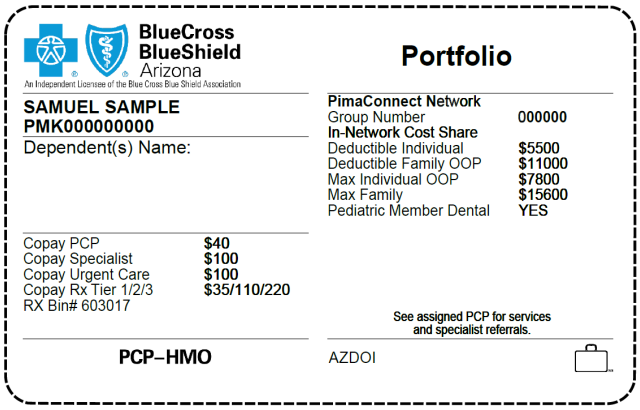
Sample ID cards for PCP-HMO Plans

Please note that the 2023 ID cards no longer display the member's assigned PCP. To find the PCP's name and contact information, do an eligibility and benefits inquiry (270/271).

Individual plan sample:



Small group plan sample:



Large group plan sample: