Helping you care for your patients is our top priority

PROVIDING QUALITY CARE

As our valued provider, your ability to serve our members is important. Care1st Health Plan Arizona is here with information to help you provide the very best care. This information is part of our Quality Improvement (QI) program designed to address both the quality and safety of services provided to your patients and our members.

ANNUAL CAHPS SURVEY

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is a chance for your patients to report their satisfaction with their healthcare, including their experience with their providers and health plan. The CAHPS survey scores are made available to the public and can determine whether patients and members stay with their provider or health plan or look elsewhere for their care. Surveys are sent to our member from February through June.

ANNUAL PROVIDER SATISFACTION SURVEY

You are essential to providing the highest-quality healthcare possible for our members, and your satisfaction is important to us, too. We assess your experience with the health plan through an annual Provider Satisfaction Survey. These survey results will be reviewed by Care1st and will be key to helping us improve the provider experience, so please be sure to complete the survey if you receive one in the 4th quarter.

PROVIDER CREDENTIALING RIGHTS

During the credentialing process, Care1st obtains information from various sources to evaluate your application. Ensuring the accuracy of this information is key, so please review and provide any corrected information as soon as possible. You also have the right to review the status of your credentialing or re-credentialing application at any time by calling your health plan Provider Engagement Representative.

PROVIDER DIRECTORY & CONTINUED ACCESS TO CARE

If your address or telephone number changes, or if you can no longer accept new patients or are leaving the network, please notify Care1st as soon as possible so we can update our Provider Directory. Having access to accurate provider information is vitally important to our members, and we want to work together to ensure continuity of care can be maintained for Care1st members.

UTILIZATION MANAGEMENT

Utilization Management (UM) decisions are based only on the appropriateness of care and service and the existence of coverage.

Care1st does not reward providers, practitioners, or other individuals for issuing denials of coverage or care and does not have financial incentives in place that encourage decisions resulting in underutilization. Denials are based on lack of medical necessity or lack of covered benefit. National recognized criteria (such as InterQual or MCG) are used if available for the specific service request, without additional criteria (e.g., clinical/medical policies) developed internally through a process that includes a review of scientific evidence and input from relevant specialists.

Submitting complete clinical information with the initial request for a service or treatment will help us make appropriate and timely UM decisions. You may discuss any UM denial decisions with a physician or another appropriate reviewer at the time of notification of an adverse determination. You may also request UM criteria pertinent to a specific authorization request or for any other UM-related request or issue by contacting the UM department at the health plan.

TRANSITION TO OTHER CARE

Providing quality care to our members includes helping adolescents transition to an adult care provider. If you or one of your patients need assistance in finding an adult primary care provider or specialist, contact Care1st or reference the information in the Provider Manual. We can assist in locating an in-network adult care provider or arranging care if needed.

PHARMACY

The health plan formulary/Preferred Drug List (PDL) is based on the plan benefits and is updated on a regular basis. If you believe a medication merits an addition to the PDL, a request may be submitted using the Formulary Change Request form. The current PDL, which includes information regarding covered drugs, restrictions, prior authorization requirements, limitations, etc., is located on the health plan website.

ACCESS TO CASE MANAGEMENT

Our Care Management team is available for members who may benefit from increased coordination of services. The team is available to assist and support providers with member issues including non-adherence to medications/medical advice, multiple complex co-morbidities, or to offer guidance with a new diagnosis.

The care management team helps members:

- Achieve optimum health, functional capability, and quality of life through improved management of their disease or condition.
- Determine and access available benefits and resources.
- Develop goals and coordinate with family, providers, and community organizations to achieve these goals.
- Facilitate timely receipt of appropriate services in the right setting.

Early intervention is essential to maximizing treatment options and minimizing potential complications associated with illnesses, injury, or chronic conditions. Members can receive services through face-to-face visits, over the phone or in a provider's office. You can directly refer members to the Care Management program at any time by calling the health plan or initiating a referral on the Provider Portal.

APPOINTMENT ACCESS STANDARDS

Every Year Care1st assesses appointment availability for PCPs, specialists, and behavioral health practitioners. There are established standards for each type of appointment (routine care, urgent/sick visits, etc.) and type of practitioner. Please review the Provider Manual for the expectations of how quickly our members should be able to get an appointment.

MEMBER RIGHTS AND RESPONSIBILITIES

Providers are expected to follow member rights. Members are informed of their rights and responsibilities in their member handbook.

Member rights include, but are not limited to:

- Receiving all services the health plan provides.
- Being treated with dignity and respect.
- Knowing their medical records will be kept private, consistent with state and federal laws and health plan policies.
- Being able to see their medical records.
- Being able to receive information in a different format in compliance with the Americans with Disabilities Act.

Member responsibilities include:

- Understanding their health problems and telling their healthcare providers if they do not understand their treatment plan or what is expected of them.
- Keeping scheduled appointments and calling the physician's office whenever possible if there is a delay or cancellation.
- Showing their member ID card at appointments.
- Following the treatment plans and instructions for care that they have agreed on with their healthcare.

We encourage you to view the Provider Manual to review the full list of rights and responsibilities.