# PROVIDER Q&A

## CONSUMER RELATED // OMBUDSMAN/BENEFICIARY SUPPORT SYSTEM

**Why does the Department of Human Services (Department) Quality Strategy not include a Community HealthChoices (CHC) ombudsman?**

The Medicaid Managed Care Rule requires the Department to have a Beneficiary Support System in all of its managed care organization (CHC-MCO) programs. The Department is still considering how best to meet the requirement. More information will be shared in the future on the Beneficiary Support System.

## CONSUMER RELATED // LIMITED ENGLISH PROFICIENCY/DIGITAL ACCESS

**How is the Department reaching consumers who are not online or with Limited English Proficiency (LEP)?**

The Civil Rights Act of 1964: The Department's goal is to provide meaningful access for individuals with LEP. Tag lines in the top (15) prevalent languages in Pennsylvania are made available to participants, in addition to an English tag line in large print, for all significant publications and communications. CHC-MCOs are required to provide oral interpretation in all languages. CHC-MCOs must revise and update their policies, procedures, and materials to integrate templates and taglines in accordance with the requirements.

## CONSUMER RELATED // PROVIDER RESOURCES TO HELP CONSUMERS

**Will providers be given talking points so they can respond to consumer CHC questions?**

The Department is disseminating information to providers every two weeks and will inform providers when consumer notices are issued. There is also specific training targeted for service coordination entities and nursing facilities to assist in educating their participants.

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## DIRECT CARE WORKFORCE

**What will the CHC-MCOs do to ensure an adequate supply of direct care workers (DCW)?**

CHC-MCOs must meet network adequacy standards as part of the readiness review. The Department has been working with stakeholders to develop long-term services and supports (LTSS) specific network adequacy standards. Recognizing the importance and the challenges with ensuring a sufficient supply of workers, CHC includes a goal of innovation on workforce issues. The Department is proposing annual measures of DCW availability and retention as part of the quality strategy. CHC-MCOs are responsible to implement innovations that can improve these measures over time.

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## OTHER VENDORS // SERVICE COORDINATION ENTITY (SCE)

### What happens to service coordination entities (SCEs) after the continuity-of-care period?

All existing SCEs on the date of implementation for each CHC zone are covered by the continuity-of-care period. After the continuity-of-are period ends, the CHC-MCO can decide to continue contracting with the SCE, conduct service coordination themselves, or execute a mixture of contracting and direct service coordination. CHC-MCOs are responsible for service coordination under the CHC agreement and are given the flexibility to decide how it is administered.

## OTHER VENDORS // ELECTRONIC VISIT VERIFICATION

### Will Electronic Visit Verification (EVV) be required in CHC?

The 21st Century Cures Act requires states to implement EVV for personal care services by Jan. 1, 2019, and home health care services by Jan. 1, 2023. EVV will be required for these services for CHC.

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## PROVIDER BILLING

### Will providers have to use three different CHC-MCO billing systems?

Each CHC-MCO will have their own billing system. The CHC-MCOs are required to demonstrate to the Department that their system works. CHC-MCOs will be testing their billing systems and will seek provider volunteers to participate in the testing.

### Will CHC-MCOs train providers on their systems?

The CHC-MCOs are required to train providers on claims submission. As per the CHC agreement, each CHC-MCO must have a Provider Claims Educator who is located in Pennsylvania and facilitates the exchange of information between grievances, claims processing, and provide relations systems. This includes educating contracted and non-contracted providers regarding appropriate claims submission requirements, coding updates, electronic claims transaction and electronic fund transfer and available CHC-MCO resources such as provider manuals, websites, fee schedules, etc.

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## PROVIDER CREDENTIALING

### Will CHC-MCOs all have their own credentialing?

CHC-MCOs are required to have a credentialing process and must establish and maintain minimum credentialing and re-credentialing criteria for all provider types that satisfies the Department's requirements outlined in the CHC agreement.

# PROVIDER Q&A

### Why do providers need to go through credentialing if they are already approved through the Medicaid enrollment process?

The Medicaid enrollment process verifies that a provider meets Medicaid enrollment requirements. Federal Medicaid regulations require that all network providers, including managed care providers, be enrolled in Medicaid. To meet necessary accreditation standards, CHC-MCOs must go through a similar process including additional requirements related to the approval process, time limits for how long information can be used in verifying providers, and direct verification requirements. As a result, to meet Medicaid and accreditation requirements, providers must currently provide information to the Department and the CHC-MCOs.

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## PROVIDER DISPUTES

### What can a provider do if they disagree with a CHC-MCO's decision, especially if the CHC-MCO decides to discontinue them from the network?

The CHC-MCO must develop, implement, and maintain a provider dispute resolution process, which provides for informal resolution of provider disputes at the lowest level and a formal process for provider appeals. The CHC-MCO and the provider must handle the resolution of all issues regarding the interpretation of provider agreements and shall not involve the Department; therefore, provider disputes and appeals are not within the jurisdiction of the Department's Bureau of Hearings and Appeals.

### Can the provider appeal an CHC-MCO decision?

The provider can appeal the decision of a provider dispute. The provider appeal is heard by a Provider Appeal Committee, which includes at least 25% of the membership of the committee be composed of providers/peers.

### What role will the Department play for provider disputes and appeals?

The Department shall review and approve the CHC-MCOs policies and procedures for resolution of provider disputes and appeals. The Department will also review reports from the CHC-MCOs on provider appeal decisions. The CHC-MCO and the provider must handle the resolution of all issues regarding the interpretation of provider agreements. This process does not involve the Department and provider appeals are not within the jurisdiction of the Department's Bureau of Hearings and Appeals.

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## PROVIDER // CHC-MCO EVENTS

### Will there be an event where providers can interact directly with the CHC-MCOs?

Yes, provider/CHC-MCO events are scheduled in the Southwest for July 24-27, 2017. Similar events will be held in early 2018 for the Southeast.

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## PROVIDER PARTICIPATION POST-CONTINUITY OF CARE PERIOD

**If the providers get through both processes (provider enrollment and credentialing), shouldn't they be guaranteed a contract from the CHC-MCO beyond the 180 days? Doesn't that indicate that the provider has met the quality standards?**

Enrollment and credentialing establish that a provider meets minimum qualifications to participate in the program. Contracting generally involves rate negotiation and review-of-quality measures. The continuity-of-care period is a provider's opportunity to demonstrate their ability to deliver high-quality services.

**What criteria will CHC-MCOs use to reduce their networks after the continuity-of-care period? Won't CHC-MCOs just want to contract with large providers?**

The CHC-MCOs will have their own criteria for measuring provider performance. Providers may want to request this information from the CHC-MCO. CHC-MCOs must maintain an adequate provider network.

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## PROVIDER RATES

**Will providers all be paid the same rate by all CHC-MCOs or is the rate up to the CHC-MCO?**

CHC-MCOs determine their rates. The Department is requiring an extended continuity-of-care provision for personal assistance and nursing facility services to promote their quality of care and quality of life. To meet this requirement the Department expects CHC-MCOs to pay for these services at the fee-for-service (FFS) level unless the parties agree to another payment arrangement.

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## SELF-DIRECTED WORKERS

**Will self-directed workers continue providing services?**

Participant directed services will continue and CHC-MCOs must offer this option to all participants.

**How will self-directed workers be paid?**

Self-directed workers will be paid through the Fiscal/Employer Agent (F/EA). CHC-MCOs are required to establish agreements and cooperate with the commonwealth-procured F/EA in order that the necessary Financial Management Services (FMS) services are provided on behalf of the participants.