# HealthChoices Physical Health Training

**Video URL: https://youtu.be/fWXgX1xDML4**

Hello, this is Scott Matlock with the Bureau of Managed Care Operations and the Office of Medical Assistance. I'm continuing the training that you may have just listened to regarding enrollment in the fee for service program in medical assistance, but there is also a different step for people who want to enroll in Health Choices or health choices. Physical health, which are health choices, is the name of Pennsylvania's Medical Assistance Program, which is the state Medicaid program.

And, Pennsylvania has been employing the health Choices model for over 25 years. Medicaid, just to explain, is an entitlement program primarily based on income, and it's jointly administered and financed by the state and federal government. The Department of Human Services manages health choices in Pennsylvania. Although each state Medicaid program is different. So through Medicaid managed care organizations or macOS, eligible individuals in Pennsylvania receive access to high quality physical health and behavioral health medical care as well as long term services, and report supports or lights for qualified qualifying individuals.

That's known as community health choices. The Behavioral Health Choices and Community Health Choices programs are administered by a different set of macOS, and that's not what I'm discussing here. Specifically. Are physical health macOS. So those physical health macOS that I'm discussing are Medicaid managed care organizations or macOS. These organizations serve as the glue that binds the provider and community resources with a unified health care strategy, and it looks at all the factors affecting the health of individuals.

So through their reach and their expertise in health care delivery, macOS partnered with the Department of Human Services, health care providers, and community organizations throughout the Commonwealth to bring together disparate parts of the health care system. Strong provider networks ensure that quality providers are available to members, and that they have access to a breadth of services, so identifying the right managed care organization, you need first to identify whether your patients are fee for service or managed care enrollees.

Two different programs, both under medical assistance by reviewing their ID, their identification cards fee for service identification card sample is provided here. As you can see under Pennsylvania Access Card MCO ID cards, a separate ID card have the brand of a specific company, and they're not all displayed here, but each company will have its own logo to display it.

This, you know, underscores the point that people are enrolled in fee for service. Patients are enrolled in eligible for fee for service. Enrolled for can be enrolled in fee for service or managed care. Not both at the same time. They're both covered under medical assistance or Medicaid. The different ways of receiving their services. Most recipients are served through a managed care organization.

Most patients and also, explains how you can use the eligibility verification system for EVs. The link provided here to look up a person's enrollment. If they don't have their identification card, if they have their number, gives you alternate ways to look up the information. And, there's some information in the table below about different ways to get into the eligibility verification system, whether through the web, through an interactive web application, through batches that can be submitted through promise transactions or just by calling a telephone number.

So there are a variety of ways to use the eligibility verification to determine whether someone is eligible for medical assistance, slash Medicaid and which, program they're in, or are they in fee for service, or are they enrolled in managed care with a specific company? Then the second step here is to determine, whether the services you provide are considered physical health services, behavioral health services, or long term services supports.

So the physical health services, that I'm discussing primarily here and that are my bureau's, area of, responsible are covered by physical health managed care organizations and also by Community Health Choice and CHC managed care organizations who provide long term services. So this training specifically relates to physical health services and physical health managed care services only.

There are separate trainings that will be developed for behavioral health managed care organizations and for long term services and supports provided through community health choices. The third step here is to determine which of the MSOs serve the county, counties, or zone in which you and your patients are located. And there's a map on the next slide that you can consult that will tell you which zone the MCO serves it.

Contact information for each of these managed care organizations is also available at the link shown below, in a document that's updated every month, called the Pennsylvania Medicaid Managed Care Directory. At that link shown, that shows you ways to contact each of the companies and the different divisions in those companies. This slide, shows that map referenced in the last slide, and it shows where each of these companies served.

And what it shows is that most of these companies serve in all zones statewide. There are only, two exceptions, that United serves only in the Southeast Zone, and that Highmark Homecare serves in two zones Health Choices Lehigh Capital Zone and Center, and the capital, Lehigh Region of the state. And in the southwest version of the state, the southwest zone of the state.

All the other managed care organizations operate in all five zones throughout the state. So here's a description, step by step, of how you begin to work with these managed care organizations if you want to join them. So first, as described in the presentation, you may have already watched, you have to enroll with the Department of Human Services.

So as a health care provider in Pennsylvania, you have to enroll with the Department of Human Services to ensure that you can provide the necessary medical services to our state Health Choices program. Now, enrolling with DHS means that you can then begin the credentialing and contracting process, a separate process with each of the managed or any of the managed care organizations that you select and on completion of contracting with one or more of those managed care organizations, you can then bill for and receive payment for the services they provide to Medicaid.

Beneficial freeze in the Health Choices program. So two steps you need to become a medical assistance or Medicaid provider in Pennsylvania by enrolling through promise, as described in in the other presentation you may have seen recently. And then there is a separate but concurrent process that you can do at the same time to pick which of the managed care companies you want to credential and sign contracts with.

You don't need the promise ID that you will get from your medical assistance enrollment to start the credentialing and contracting, outreach and process with the MSOs, but you will need it for them to complete the contracting process with you. So we don't want to delay your process to get in touch with the managed care organizations and start that process for them to check your credentials and start the process.

Discussing contracts. You can start the enrollment process first before you get that promise ID, but you will need it before they finish the contracts and credentialing. The macOS. So a little bit more about contracting with managed care organizations. It's required by federal law. Federal law requires each of these companies to have a contract with each of the enrolled providers in order for them to pay you for their services, much the same as with, fee for service medical assistance.

Each MCO will have different payment rates and different conditions set forth in their contracts. There is no universal rate for any service or provider among managed care organizations, and they're not obliged under law to pay the same rate that the fee for that fee for service does. In many cases they might. But each MCO will have different payment rates that are a matter to settle in contracting between every provider and the managed care company.

You are having those, relations with providers have to contract with each individual MCO with which they want to do business, or provide member service separately. Now, enrollment with the Department of Human Services does not guarantee payment by one of these managed care companies. Managed care companies are not required to contract with all interested providers that want to.

Rather, they must maintain adequate networks of providers as defined in sections five S and exhibit triple A of the Health Choices Agreement, which is contained shown at this link. So just to reiterate that, because that's very important that you understand, that the managed care companies, just like you have an option to decide which of the managed care companies you wish to enroll with.

They in turn, have the option to decide whether they want to accept you into their networks, even if you are qualified, even if you are, you know, you can be fully credentialed. They are not obliged under law to accept a contract with you. But it is, of course, the department's hope that all, interested providers and necessary providers and NCOs will work together to make sure that there are adequate networks of providers in all areas of the state.

Another important to think, thing to point out when you're dealing with managed care organizations is, the role of benefit managers, dental benefit managers, pharmacy benefit managers, vision benefit managers. There may be other types, but those are the three primary ones. Benefit managers are external companies, or sometimes in-house subsidiaries or parts of MSOs that subcontract with the MCO to perform a lot of provider network functions, such as, but not limited to, recruiting new providers, contracting them, credentialing the providers prior authorizing services.

Once a provider has been contracted, utilization management, claims processing and payment and provider call lines, call call centers and helplines. So all of our health choices, physical health managed care organizations use some benefit managers to perform at least some or in some cases, all of these functions for dental, pharmacy and vision services. And these benefit managers are often the primary contact or managed care liaison, for those providers for those dental pharmacy and vision providers.

So although you may contact the MCO directly at any time, the MCO is you in many cases uses this benefit manager as their primary liaison. So they may be the people that you have most contact with in day to day operations, whether in contracting or other functions that the companies use them for. Fortunately, several benefit managers serve multiple managed care organizations, and that can allow providers to accomplish these functions with multiple macOS at the same time, which can save you some time and effort and administrative work.

However, you can always contact any managed care organization directly for information and referral, or to discuss any issues or concerns you may have with the performance or the policies of both the Benefit Manager or the managed care organization itself. A really important point to bear in mind is from the state's point of view and from our agreement with these companies, managed care organizations always have the final and primary responsible for the operations of any of these benefit managers or any subcontractor under the terms of their agreements with the Department of Human Services and with Pennsylvania.

So although you may deal primarily with the benefit manager most of the time, if you have any concern or any reason that you want to contact the MCO directly, they are ultimately responsible for the operations of their subcontractors. So the next slide will provide you a list of the benefit managers used by Health Choices. Physical health MCO as a reference, just always have to point out and note when we provide a static list like this that things change.

Manage care organizations, change these kind of subcontractors or get new ones, or get rid of old ones periodically. So this information is accurate as of October 2024 when it was gathered. But new or prospective providers, you should always start by contacting the ministry organization directly. To start this process. To make sure you have the most current information. And this slide as of October 2024, just shows you the various companies that provide either dental benefit manager services, pharmacy Benefit Managers services or Vision Benefit Manager services for each of our companies.

And you see that in most cases, they are provided by some, external company benefit manager or in some cases an in-house service or subsidiary.

Some of the terms you might hear during this process, when you're working to contract with managed care organizations, physical health managed care organizations, that might or might not be familiar to is the fee schedule, the fee schedule or the payment rates. It's a list of charges for the various health care services that you may provide and for which they'll pay.

There is, of course, an Ma fee schedule. But bear in mind that, as we discussed before, the managed care organizations are not required to pay the same fees or use the same fee schedule as MC as fee for service, payment rates are a matter for contractual discussions between every individual provider and, the MCO in question.

Another term you might hear is value based purchasing. So contracts like the contracts that involve value based purchasing linked provider payments to patient outcomes. So they align the incentives, so that providers can improve care and reduce unnecessary costs. Another term that comes up is bundled payments. Bundle payments. This is considered a type of value based purchasing where contracts utilize bundled payments, which include all payments for services rendered to treat a patient for an identified condition, say pregnancy or delivery, during a specified time period.

The Department of Human Services may specify certain services that must be paid through bundled bundle payments, so there are some instances where there are managed care companies are required to do that. This just gives, an example from one of the companies that serves throughout the Commonwealth, UPMC for you, one of our physical health managed care organizations showing their flowchart for how their process works, which I won't go through in detail, but it will give you an idea of the how, specifically that companies process works.

It is similar to the process of almost all the managed care organizations physical health managed care organizations. Not identical, but it should give you a pretty good idea of how the process runs for most or all of the companies. This gives an example from another one of our companies, Keystone First, which operates in the southeast zone. Notice I said that, Keystone First and Mary Health operates statewide.

There are two parts of the same corporation, Vista. So they do operate statewide. But Keystone first is the name of the managed care company or the part of their company that operates just in the Southeast zone, which is Philadelphia and the surrounding five counties. So for Keystone, first, this is a picture of their contract application. Shows the PDF that you have to complete, and there's a link to those and how Keystone first handles it and how they will, you know, reply to you an email with the appropriate instructions and how you would proceed.

Again, it may be somewhat different for other companies, but there's a similar process for all of the CEOs. Or if it's managed by a benefit manager on their behalf, for the benefit manager that manages on the company's behalf. Now, to give you a little bit more detail about the credentialing process used by managed care organizations. Each managed care organization will need the credential you independently for their managed care company.

In order to pay a claim and list you in their directory. I will go back to my note that in some cases, it's fortunate that some companies might share a benefit manager who does credentialing, so it's possible that you might be able to accomplish this with more than one managed care organization at a time. But it's also likely that you may need to do separate credentialing, with other MSOs depending on those that you select and where you provide services.

So once, a completed initial file, the beginning file is sent to the credentialing department of the managed care organization. It's generally assigned to a credentialing specialist who has 30 business days to complete the file. And that is a requirement that that 30 business days, is a requirement that is monitored in force by the state. So that's common to all NCOs.

If the specialist deems the file incomplete, they'll reach out to you for the missing information. But that file will be discontinued if the information is not provided, if they're not able to contact you or not able to provide that information. All complete file information is added to the Managed Care Organizations credentialing database, where verifications will then be performed for all health care professionals to show that they have the proper education, the right training, and the licenses necessary to care for patients for their members.

Now, once all primary source verification has been completed, the file is submitted and will become approved. The day of submission. I have an important point to note here is that claims processing can be backdated to the date of the application submitted. If the provider already has an active promise ID for that date of service. So if you have already been enrolled in Promise, if you have already become a managed care, a medical assistance provider and Ma fee for service provider, and then you are going through the credentialing process, you can the your services that you provide before they complete their credentialing can be paid retroactively, as long as you have an active Promise ID for

those retroactive dates of service. But this just gives you a quick example of a managed care organization credentialing checklist the kind of things that are submitted, which are pretty common among macOS, or the benefit managers that do this service. For NCOs, you're going to have to simply to submit a completed and accurate provider application. You're going to have to register with CoC, where you can add their information and share it with multiple insurance companies.

So fortunately, that is another part of the process. The registration with that, I think all or most of the companies share. So that will be something that you can perform for multiple, macOS at the same time. You will have to have a national provider, identification or NPI number. Now this says be a certified perinatal doula.

This is an example of if a doula who are one of the, relatively new provider types who are recreating this outreach for. So here's an example. You would have to be a certified perinatal doula through the Perinatal Duties Certification Board. There might be and are similar certification board requirements for other provider types not shown here, but this example addresses doulas.

You will have to be enrolled. As discussed with the Department of Human Services. You'll have to have a promise ID number. You will have had to enroll in medical assistance. You will have to provide a copy of your professional liability insurance policy. And much as described in the in the fee for service or Ma enrollment. Presentation, you cannot be listed or found on any excluded or death master file or sanctioned listings.

If there are reasons that you are sanctioned or not to be a medical assistance or managed care provider. This shows an example of a health insurance claim form with which you may be familiar. To give you a little bit more information about the claims and billing process. So claims and billing resources can be found on each individual macOS website.

You can submit your claims, through on paper through the CMS 1500 and form, a link to which is shown here. If you're not familiar with it or and other appropriate claims form through the each macOS provider portal or through a direct fee. So there are a number of ways to deal with billing. Each MCO has its own requirements about which billing codes are payable, what information needs to be submitted to support the claim?

Timelines for claims submission and their own rates that will be paid so providers should consult their contracts with the MCO or that macOS provider manual or handbook for these details, which are typically available on all the provider portal, and provider network websites for each of the companies. This point is important, so I just want to re-emphasize that each MCO, although they are covered by a lot of the same regulations, they are allowed to have their own requirements as to how codes, which billing codes are payable and what information you need to submit to support a claim and that kind of information.

And this slide just provides everyone with the links to that section of each of these, managed care organizations website that deals directly with credentialing, provides information about the form. It's a little different for each one, but it's a similar process for each of these companies. So this slide identifies all those companies. Remember that the previous slide a number back give you a map of where they operate and that,

Five out of seven of them operate statewide. And it gives you the link to where on their website, you can get more information about credentialing or reach out to their benefit manager, if that's how they're contracting is handled. And we've provided a provider hotline similar to the provider assistance hotline that you can use for medical assistance or fee for service.

Each of these companies, each of our physical health and care companies is, of course, also required to have a provider toll free provider hotline number for assistance with any of these procedures, whether they can refer you to their benefit manager or to someone in-house, or just provide general advice. So that's a brief, overview of the process to enroll, credential and be paid by the managed care organizations that run the physical health managed care organizations, managed care process or physical health choices in Pennsylvania.

And once again, thank you for your attention.