The CHC Provider Network - Provider Enrollment, Search and Network Monitoring

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CHC Provider Network: Contracting / Enrollment Process

Before Starting the Contracting / Enrollment Process:

- Providers can contact us via Phone/Email/Provider Portal to express interest
- They are instructed to complete a Contract Information Form (CIF)
- We perform an initial review of basic information (Processing and Management Information System (PROMISe) ID, Sanctions, etc.), specialties and locations
- Provider is given an application to complete

Submitting an Application:

- Provider submits application along with supporting credentialing documents which are determined by provider type
- Items validated during this process include:
  - Active PROMISe ID
  - Malpractice/Liability Insurance
  - Drug Enforcement Administration (DEA) Certificate
  - Appropriate License/Certification as required by PA law

CHC Provider Network: Contracting / Enrollment Process

After Submitting an Application:

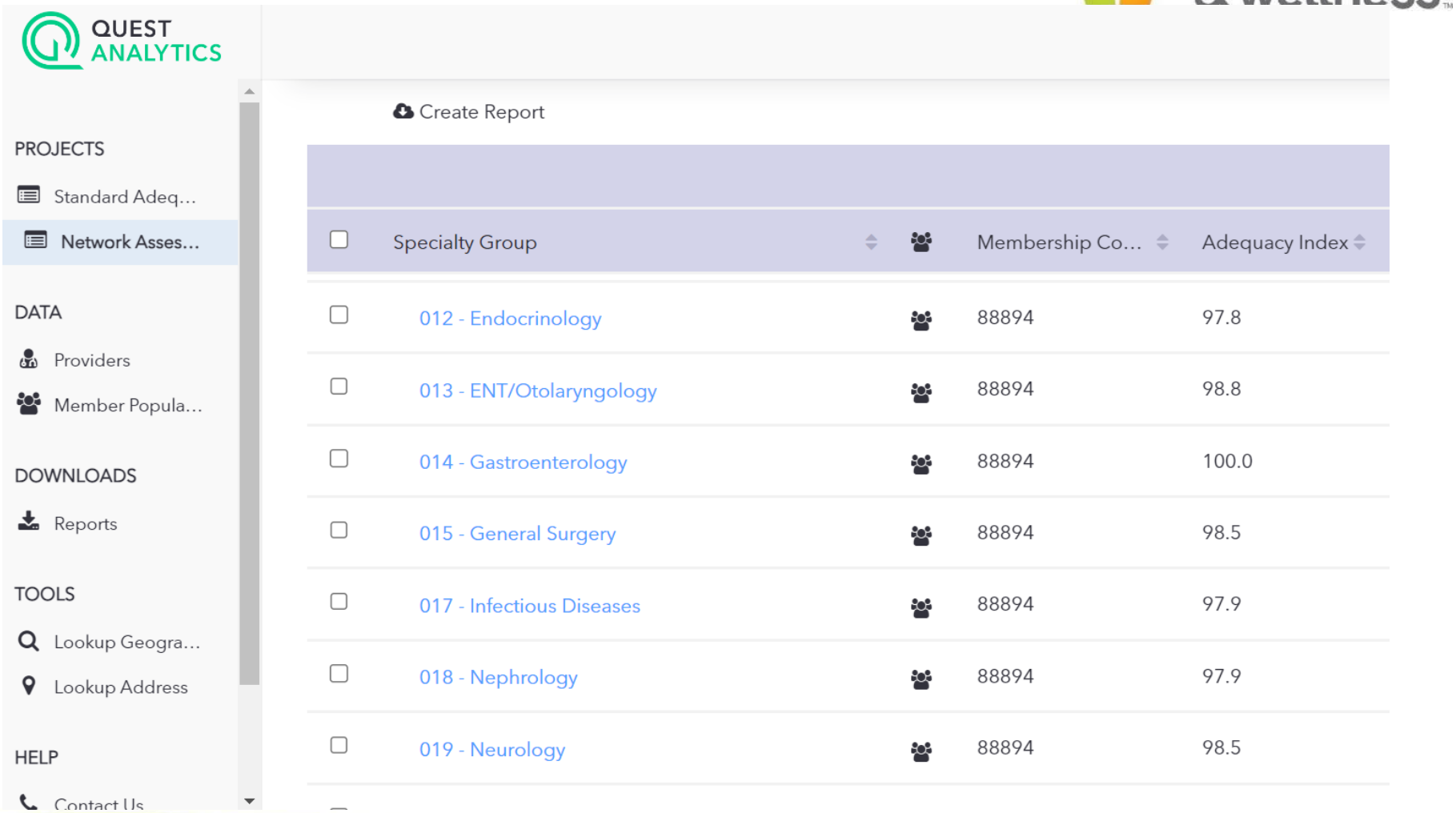
- If all appears in order, a contract is created and sent to the provider
- A provider profile is created on our system
- Upon receipt of the signed contract, the contract and credentialing information is submitted for processing
- Upon completion of the enrollment process, a notification letter is sent to the provider and they are made active in our systems. This process typically requires 30 – 60 days assuming all necessary data is submitted.

CHC Provider Network: Network Adequacy

- PA Health & Wellness (PHW) ensures that its network has a sufficient number and type of practitioners who provide primary care, behavioral health care and specialty care to meet the needs and preferences of its membership.

- This is accomplished by:
  - Conducting performance assessments against adequacy standards
  - For Primary Care Physician (PCP), Specialists, and facility providers utilizing the Quest geographic access tool which is generated and reviewed on a weekly basis.

CHC Provider Network: Network Adequacy



CHC Provider Network:
Primary Drivers of Network Recruitment

- Meet Federal and State regulatory requirements for network adequacy for specialties, locations, number of provider to meet participant needs within time and distance requirements
- Service offerings providing essential or unique services or supplies
- Focus on providers with demonstrated quality performance
- Practitioners or facilities rendering care at locations affiliated with in-network providers
- Meeting the cultural needs and preferences of participants
- Out of network utilization demonstrating participant desire
- Single case agreements indicating network need
- Member request via Brokers/Sales for Medicare products
- Internal input/tracking on placement needs by Service Coordination, Nursing Home Transition, (reviewed monthly)

CHC Provider Network:
Additional Network Adequacy Activities

- To evaluate member experience with network adequacy, perform annual monitoring of:
  - Consumer Assessment of Healthcare Providers & Systems (CAHPS) survey data related to appointment availability (quarterly)
  - Complaints and Appeals regarding network adequacy
  - Requests for and utilization of Out-of-Network services
  - Cultural and linguistic network availability

- Annual assessment of network adequacy is presented to and approved by PHW Quality Management Committee

- SharePoint site established to track progress on all contracting initiatives
  - Reason for contracting engagement
  - Provider specialties and services
  - Status of progress
  - Contracting outcomes

pa health & wellness™

Questions?

The Community HealthChoices (CHC) Provider Network – Provider Enrollment, Search and Network Monitoring

Meghan Stroud, Director of Provider Network Management

AmeriHealth Caritas

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CHC Provider Network

Once a provider has received all their licensing, Medical Assistance (MA) Identification (ID), and related documentation/enrollment to practice in Pennsylvania Medicaid, the provider:

- Submits a contract application for review and consideration.
- If the provider's contract application is approved, the provider is assigned to an Account Executive for outreach to the provider.
- Once contracted and credentialed, the provider is set up in our system as a participating provider and their assigned Account Executive reaches out to schedule the provider orientation.

When a provider submits a contract application, the following is taken into consideration.

- Network adequacy – is there a need?
- Participant request – has a Participant contacted the Health Plan regarding the provider's network status?
- Participant care – Are Participants seeking care and obtaining a single case agreement?

CHC Provider Network, continued

Network adequacy is monitored in the following ways:

Geographical (GEO) access – Quest Analytics

- Reviewed annually
- Reviewed if there is a significant change in provider participation (e.g., hospital closure)
- Monthly review of provider terminations

Should a potential adequacy issue arise:

- Provider-targeted recruitment is initiated.
- Continued contracting of new providers, where this is a known potential gap, occurs throughout the year (e.g., Dermatology providers).

Demonstration

Thank You

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UPMC Community HealthChoices

The CHC Provider Network:

Provider Enrollment, Search and Network Monitoring

October 4, 2022

How does a DHS Approved provider apply as a participating provider for UPMCHP?

- Providers interested in applying for participation with UPMC CHC can visit the UPMCHP Provider Webpage to submit an electronic Pre-Application.

For Health Care Providers | UPMC Health Plan

This page is dedicated to UPMCHP participating providers and includes information for review and reference for any provider that is currently participating with UPMCHP or wishes to apply for participation.

Information such as:

- Dedicated provider pages for Medical, Dental, Vision and Home and Community-Based Services (HCBS) providers
- Announcements and updates and the Provider Partner Update Newsletter
- UPMCHP Provider Manual
- Policies and Procedures, Forms, Guidelines
- Access to UPMC HP Secure Participating Provider OnLine Portal (POL)
- Pre-application to Join Out Network

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How does a DHS Approved provider apply as a participating provider for UPMCHP?

https://www.upmchealthplan.com/providers/

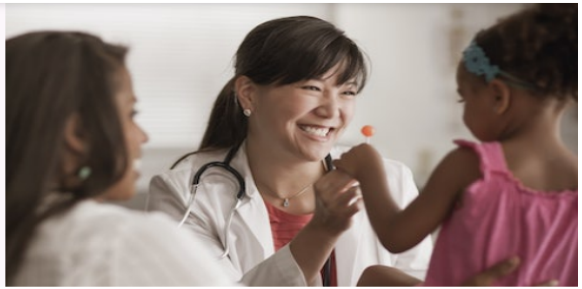
UPMC HEALTH PLAN

Find Care | Sign in/Register | For Providers | About | Contact

PROVIDERS | Medical | Dental | Vision | HCBS

Providers

Get the latest resources, news, and announcements from UPMC Health Plan for participating providers.



Medical Providers

As the only provider-led health insurer in western Pennsylvania, we recognize the importance of partnership with network physicians and sensitivity to doctor-patient relationships. View resources for medical providers, log into Provider OnLine, and get access to downloadable forms.

Resources for Medical Providers

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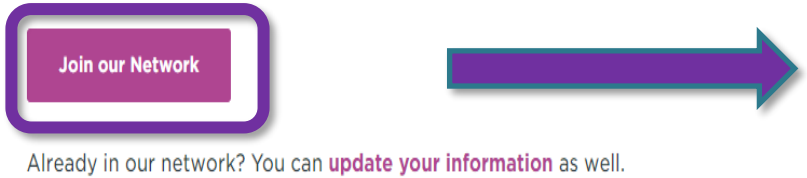
How does a DHS Approved provider apply as a participating provider for UPMCHP?



- Each Provider Type has a unique Pre-Application requesting information specific to the Provider Type/Service.
- Once required information is submitted, the Pre-Application is forwarded directly to the specific department.
- Pre-Applications are reviewed for determination of network needs.
- If determined a network need, an electronic application is forwarded to the provider to complete and return with supporting documentation.

Ancillary Providers

Apply to Join our Provider Network

Chiropractic Providers

Apply to Join our Provider Network

Physicians and Extenders (CRNP, CNM, CRNA, PA)

Apply to Join our Provider Network

Home and Community Based Service Providers (HCBS, LTSS)

Apply to Join our Provider Network

Dental and Vision Providers

Apply to Join our Dental Network

Apply to Join our Vision Network

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I submitted my electronic Application - What next?

- Each department reviews the provider type application to ensure a complete, clean application was submitted.
  - Submitting a non-complete application will result in delay in review and decision.
- On average, Medical and Ancillary Provider receive a response within 48-72 hours of submission.
  - Can be a request for additional information (non-complete application)
  - Can be approval and if applicable sent for credentialing, and a contract sent for review
  - Can be a denial letter
- If necessary, rate negotiations will occur between provider, network and reimbursement team. Rate negotiations are reviewed via a cost analysis, comparison of rates as it relates to the service area. Rate negotiations often consist of counter offers or denial of rate increase; however, only after a thorough review.
- Rate and contract negotiations are deemed confidential as it relates to the provider and UPMCHP and should not be discussed or shared with others outside of the provider organization.
- Rate and contract negotiations will delay the completion of the contracting process based on the complexity.
- All applicants for participation go through an extensive debarment review process by the UPMCHP Fraud Waste and Abuse (FWA) team.
- All applicants must submit a Disclosure of Ownership document prior to moving to contracting.

I submitted my electronic Application - What next?

Medical:

- Time Frame
- Approval:
  - Credentialing can take up to 2 months for completion, but usually less
  - Once credentialed, contract is forwarded to the provider
  - Contract review/finalization depends on provider redlines, need for fee negotiation and timing return of the electronic signed agreement
- Medical providers are rarely denied for participation for CHC product
  - Denials can be a result of inability to settle on rate negotiation, contract redlines, etc.

Ancillary (anything other than hospital or physician/specialist or HCBS):

- Time Frame between receipt of application and decision is ~10 days
- Timeframe between decision and final participation status is 30-45 days for non-credentialed provider
- Approval:
  - Some Ancillary require credentialing - can take up to 2 months for completion
  - Contract is forwarded to the provider upon approval of the application
    - Redlines are returned to Network to review/approve/deny
  - Contract review/finalization depends on provider redlines, need for fee negotiation, credentialing needs and timing return of the electronic signed agreement
- Denial:
  - Ancillary network team reviews the request for application as it relates to gap in service in area by provider type, adequacy standards (to be reviewed later in presentation).
  - In general, Ancillary does not deny a request for CHC participation in most areas.
  - Denials can be a result of inability to settle on rate negotiation, contract redlines, etc.

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I submitted my electronic Application - What next?

Dental:

- Turnaround time from receipt of completed application to decision of participation is ~25 days
- Turnaround time from receipt of completed application to provider contracting is ~35 days

HCBS:

- Timeframe from receipt of a completed application with all required documentation, typical turn around is one week
  - Applications are reviewed for new and pending every Monday and Friday and in between as needed.
- Approval:
  - Once a completed application is received, a Documentation of Ownership (DOO) is sent to provider and received bi-weekly
  - All providers go through a debarment and issue review by FWA team
  - If DOO is received and FWA is clear, contract is forwarded to the provider
  - Contract review/finalization depends on provider redlines, need for fee negotiation and timing return of the electronic signed agreement
- Denial:
  - Adequacy if reviewed for HCBS provider (per later slide) to determine the need for additional provider in the service area
  - Specialized care and services are taken into consideration when reviewing
  - Rate and contract negotiations can result in a denial of the application

I submitted my electronic Application - What next?

Nursing Facility (NF):

- Depends on the request and receipt of the application
- Approval:
  - NF if not participating with other products, requires credentialing - can take up to 2 months for completion
  - Contract is forwarded to the provider upon approval of the application
    - Amendment is sent if only adding the CHC product
  - Contract/Amendment review/finalization depends on provider redlines, need for fee negotiation, credentialing needs and timing return of the electronic signed agreement
- Denial:
  - Long-Term Services and Supports (LTSS) network team reviews the request for application as it relates to gap in service in area by provider type, adequacy standards (to be reviewed later in presentation).
  - In general, LTSS network does not deny a request for CHC participation for a NF in most areas.
  - Denials can be a result of inability to settle on rate negotiation, contract redlines, etc.

How is Network Adequacy determined?

UPMCHP uses Department of Human Services (DOH) standards to monitor adequacy for the UPMCCHC Network

Standards: 1 provider type within 20 miles/30 minutes urban, 40 miles/60 minutes rural. PCPs are measured with the standard of 2 within a county. HCBS provider standards is a minimum 2 providers within a county when available.

Frequency of review: Quest (UPMCHP network platform used for network adequacy) cloud product is refreshed weekly to monitor our current network. The review is based on DOH standards outlined above.

OPS5 Report: UPMCHP submits the OPS5 report to PA Department of Human Services (DHS) annually based on participating CHC providers measured against CHC membership.

UPMCHP maintains internal policy to ensure adequacy guidelines are followed for both CHC Physical Health and HCBS providers. This policy is audited yearly.

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How and how often is adequacy monitored/reviewed?

- UPMCHP submits adequacy reports to DHS and DOH yearly
- Adequacy is specifically analyzed for the Medical/Ancillary/Dental when:
  - A provider terms the network
  - UPMCHP expands a product to other areas
  - Provider expansion of locations
  - Provider request for participation indicates a gap in service
  - Requested by others (UPMCHP Product Teams, DHS, Centers for Medicare & Medicaid Services (CMS), DOH, etc.)

HCBS Specifically:

- A provider terms
- Service Coordination indicates a difficulty in finding service in a specific area
- Provider Miss Shift reports indicate an increase in unserviced shifts

Adequacy Reporting Tools:

- QUEST is used to determine adequacy by member population using the specific DHS standard for Medicaid products and CMS Standard for Medicare Products. UPMCHP also uses DOH standard as an additional reference point for adequacy.

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UPMCHP Provider Directory Overview

Quality Health Insurance | UPMC Health Plan

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