

COEs Transition to Managed Care FAQs

These Frequently Asked Questions are issued by the Department of Human Services (DHS) and are intended to guide Opioid Use Disorder COEs (COEs), Managed Care Organizations (MCOs), Single County Authorities and other stakeholders as the COEs transition away from grant funding to billing the MCOs for care management services COEs in 2019.

Topics addressed in this document include:

- Per Member Per Month (PMPM) payment
- Serving members not enrolled in the HealthChoices program
- Consent and confidentiality
- Requirements to receive the PMPM (PMPM) payment
- Members for whom the PMPM payment will be paid
- Remaining grant funds
- Billing logistics
- Contracting
- Level of care
- Value-based payment
- Data
- MCO oversight

PMPM Payment

What is the PMPM rate? Will it fully replace the \$500,000 that COEs currently receive annually through grant funding?

COEs will receive \$277.22 PMPM for each member for whom they provide a face-to-face care management service during a month.

How does the payment a COE receives relate to the previously received grant-funded amount?

If a sufficient number of patients receive care management services from a COE in a given month that qualify for the payment of the PMPM rate, the COE will receive a total amount of funding that is consistent with the amount they previously received through the grant. Because the payment is a PMPM payment, the total amount of funding a COE receives for the year is tied to the volume of patients seen.

Will the PMPM payment be a lump sum payment, or will a COE submit individual claims specifically under the patient's name, therefore generating an Explanation of Benefits and resulting in an individual payment to be applied to a specific patient account?

Payment will be paid for individual patients and should be submitted as a claim under the individual patient's name.

Will the primary contractors, counties, MCOs and oversight agencies be involved in the development of the rates?

No. The rates have already been developed by the Department's actuary and approved by the

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Department.

What data will be used in the development of the PMPM rate for each provider? Will service capacity and/or census be used?

The rates were developed by DHS's actuarial contractor based on the requirements that COEs must fulfill and the staffing level/mix needed to fulfill those requirements. The rate is the same for all COEs.

[Serving Members Not Enrolled in the HealthChoices Program](#)

May a COE bill the Medicaid Fee-For-Service program for providing care management services to individuals who are enrolled in Medicaid but are not yet enrolled in a MCO?

The Medicaid fee-for-service program will not pay the PMPM amount. COEs will have to wait to bill for this type of member until they are enrolled in a MCO and may therefore not receive payment for those individuals for a period of time. There will be no retrospective payment for the time period during which the member was in the fee-for-service program. The COE can document the initial treatment service date while the member was enrolled in fee-for-service but cannot bill the MCO for the PMPM payment until there is a documented face-to-face visit with the care management team that occurs after the member has been enrolled in a MCO.

Will commercial insurance companies pay COEs?

Commercial insurance companies are not required to pay the PMPM payment for care management services. A COE may work with its Single County Authority to seek payment for uninsured or underinsured individuals.

Will Medicare Advantage plans pay the PMPM payment for dually-eligible individuals? What about the Community HealthChoices MCOs?

No. Only Physical Health and Behavioral Health Medicaid MCOs will make this payment.

Will MCOs be paying Single County Authorities for services rendered to uninsured/underinsured individuals, or will the Single County Authorities contract with COEs to reimburse them for these services?

The Medicaid MCOs will only pay for members enrolled in their own organizations. COEs may receive payment for under- or uninsured individuals by contracting with Single County Authorities as they currently do. The only situation in which a Single County Authority would receive a PMPM payment from a MCO is if the Single County Authority is also a COE serving the MCO's members.

[Consent and Confidentiality](#)

How should a COE coordinate confidentiality/consent with the Single County Authority or the MCO?

Consumer must name a specific person or people from the MCO care management team on a consent form, being sure to define the time period during which the consent will remain valid,

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which cannot be more than 12 months.

Requirements to receive the PMPM Payment

On what date will the MCOs be required to begin making the PMPM payment to COEs?

For Physical Health COEs, the transition date is 1/1/19. For Behavioral Health COEs, the transition date is 7/1/19.

How exactly should a COE document care management activities in the electronic medical record?

Staff should document as they would any clinical note, making sure to include the following: date, location of service, identity of the staff person who provided the face-to-face care management service, how much time was spent during the face-to-face care management encounter, and the care management activities that were performed during the encounter using the care management activity codes from the care management report submitted monthly to DHS. Staff should also document the formalized care plan and updates to care plans in clinical notes. This documentation should all be made in the medical record, whether electronic or not. The COE must continue to follow all guidelines of the Medicaid Program and should consult the provider handbook as necessary.

Where can a face-to-face encounter with a member take place?

The face-to-face encounter can take place anywhere, as long as it is documented appropriately in the patient's medical record. Face-to-face encounters do not need to take place inside the COE location to qualify for the PMPM payment.

During a COE member's first two months of engagement, he or she may be seen by multiple COEs to determine the provider that most meets their needs. In this instance, is the MCO still responsible for only one payment per month for the member?

No. In this instance, the MCO may pay a claim for the G9012 procedure code to more than one COE for a single member.

Can the COE bill for the PMPM payment for members who are already engaged if there is no other billable activity during a given month? A corresponding claim with an Evaluation & Management code is required for new members, but what about for existing ones?

During the first month of a new member's engagement, a COE must bill both an Evaluation & Management code and the G9012 procedure code. For subsequent months of engagement, the G9012 procedure code on its own is sufficient to receive the PMPM payment.

How can a COE ensure that it receives payment for a new member if they refer to another provider to provide an Evaluation & Management service during the first month of engagement?

The COE should document the referral in the case note and indicate the identity of that provider, date of OUD treatment service, date of facilitated referral or warm handoff, type of service, location, and

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duration in their medical record.

Is there a month after the first month of a member's engagement where an additional procedure code claim is necessary to continue to qualify for the PMPM payment?

No. There is currently no requirement beyond the first month of engagement because each individual living with OUD is different. Only the G9012 procedure code is required.

What are some examples of procedure codes that would qualify for the purposes of demonstrating a new member's engagement during the first month?

These should be claims that correspond to the treatment of an Opioid Use Disorder-related ICD-10 code. Examples include: Any service included in the American Society of Addiction Medicine Level of Care; Medication-Assisted Treatment; outpatient residential rehabilitation; inpatient residential rehabilitation; inpatient/outpatient detoxification; admission to a halfway house; telehealth consultations for Medication-Assisted Treatment services; Evaluation & Management for Medication-Assisted Treatment; outpatient drug and alcohol counseling; or partial hospitalization.

Does a Level of Care Assessment qualify as a service that would demonstrate a new member's engagement for purposes of receiving the PMPM payment?

Yes. A Level of Care Assessment together with a face-to-face care management service during the first month of engagement will be sufficient to receive the PMPM payment.

Can the Evaluation & Management code of "New Patient" be used to demonstrate a new member's engagement for purposes of receiving the PMPM payment?

Yes, as long as the "New Patient" code is associated with an Opioid Use Disorder-related ICD-10 code.

For new members, are there situations where the monthly face-to-face COE care management service could occur prior to the initial, otherwise billable treatment service related to the treatment of an OUD-related ICD-10 code if they both occur in the same month?

Yes. As long as the face-to-face care management encounter and a service for the treatment of an OUD-related ICD-10 code occur in the same month, it does not matter which service is provided first.

For the existing COE engaged members, how will the MCOs be able to verify that they are an existing COE engaged member vs. a new COE engaged member that needs to have the initial, otherwise billable service document?

The COE can document, in their medical record, that the member has already been enrolled.

How will MCOs know if a service meets the criteria to receive the PMPM payment? How will a MCO know if a face-to-face encounter occurred?

Like any other billable service, the COEs need to document face-to-face care management encounters in the medical record. MCOs have the ability to audit medical records but should do so post-payment

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so as not to delay payment.

Does the COE itself have to provide the underlying billable service during the first month of engagement or will a referral suffice?

The COE does not have to perform the billable service. They may make a referral, but also need to document, in their own medical record, the date and location that the patient actually received the billable service with another provider.

Are Certified Recovery Specialists (CRS) expected to be reimbursed through the MCO or through the Single County Authority?

CRSs should be paid through the MCO when they provide the face-to-face care management service payable by the G9012 procedure code to a member of the MCO. If the individual is not a member of an MCO, the SCA should pay the CRS. However, a claim for CRS services and a claim for the G9012 procedure code will not be paid for the same member during the same calendar month.

Will providers who are not currently designated as COEs be able to receive the PMPM payment for providing care management services?

If a MCO would like to pay the PMPM payment to another provider, they may choose to pay the G9012 code or pay for COE-like services as part of a value-based arrangement. However, MCOs are only required to pay this PMPM payment to all currently designated COEs. If another provider were to provide care management services, the provider would have to negotiate payment for those services.

Will COEs receive payment for serving members who have any substance use diagnosis, or will it be limited to those members who specifically have an opioid use disorder?

COE services are for individuals with Opioid Use Disorder diagnoses.

When may a COE discharge a member?

A COE may discharge a member when a member no longer wishes to receive COE services or when the COE is no longer able to meet the member's treatment or non-treatment needs. For example, if a member is enrolled in a COE that provides buprenorphine, but not methadone, and an updated assessment of the member indicates that the member is better suited for methadone, the COE may transfer the member to another provider that offers methadone.

Members for Whom the PMPM Will Be Paid

What if a member hasn't received any services in 60 days; does the COE have to re-engage them in order to receive the PMPM payment?

Yes. If a member is not seen face-to-face for two consecutive calendar months, they will need to be re-engaged.

How can a COE serve a member in an inpatient setting, like one who is hospitalized, in inpatient rehabilitation, or incarcerated, given that a face-to-face encounter is required?

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The COE should continue to count engagement as they do currently by recording on the spreadsheet submitted monthly to DHS that another provider is providing an inpatient service as of the date of admission. The COE cannot bill for the PMPM payment unless a care management service is being provided face-to-face. A COE cannot bill for incarcerated individuals during their period of incarceration.

Which COE may submit a care management claim for a member if there are two COEs serving the same member?

Each COE must assume the sole care management responsibility for the patient and confirm that no other COE is billing for the care management services. COEs that may be jointly providing direct care for the member must determine which COE will assume the responsibility for and bill for care management. DHS will annually review encounter data to ensure that physical health and behavioral health COEs have not submitted claims for the PMPM payment within the same program month for the same HealthChoices member. DHS will also perform retrospective audits to ensure that claims were not submitted on behalf of the same patient by multiple COEs. Below are two examples that illustrate which COE may submit a claim.

1. A physical health COE engages a member who is clinically appropriate for and interested in methadone treatment. The first COE refers this member to a second COE for methadone dosing. The first COE continues to provide qualifying care management services. The first COE may bill for the PMPM and may count the member as its member.
2. A physical health COE engages a member who is clinically appropriate for and interested in methadone treatment. The first COE refers this member to a second COE for methadone dosing. Once the member is referred to the second COE, the first COE loses contact with the member and provides no face-to-face care management services. The second COE, in addition to providing methadone dosing, begins to provide care management services. The second COE may bill for the PMPM and may count the member as its member.

How can the Behavioral Health MCOs and counties coordinate services to minimize the risk of duplication, such as when a COE and a Single County Authority both provide case management services or CRS services?

All parties involved should communicate to ensure there is no duplication of services. Care management services paid for through the PMPM payment cannot be duplicative of other funded care management services. The provider should not be double billing for Drug and Alcohol targeted case management (a supplemental service) and COE care management for the same individual. It will ultimately be the MCO's responsibility to confirm that multiple duplicative claims are not being submitted on behalf of a single patient.

If a member is also receiving mental health Blended Case Management services at another agency, can the COE still bill for the care management services it provides, or would this be a duplication of services?

Blended Case Management services are related to a distinct mental health-targeted state plan service, while COEs focus on care management services related to treatment of Opioid Use Disorder. Therefore, this is not a duplication of services, and the COE may bill the G9012 procedure code even if the member is already receiving Blended Case Management services from another provider.

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Remaining Grant Funds

How long does a COE have to spend down remaining grant funds? What can it spend those funds on?

COEs may spend down grant funds until June 30, 2019. COEs that were previously funded through their Single County Authorities may use remaining grant funds to serve individuals who are not enrolled in Medicaid. COEs that were not previously funded through their Single County Authorities may spend down the funds on allowable non-care management activities, such as software updates, hardware, mobile devices, administrative expenses, travel-related expenses for staff related to serving Medicaid patients, and Learning Network participation. They may also spend remaining grant funds on trainings, such as Acceptance & Commitment Therapy or similar trainings, Drug and Alcohol Treatment Act of 2000 buprenorphine waiver trainings, or American Society of Addiction Medicine level of care placement trainings.

Will COEs be required to spend down their grant funds before billing the MCOs?

No. A PHMCO must pay the PMPM for dates of service on or after January 1, 2019, and a BH-MCO must pay the PMPM for dates of service on or after July 1, 2019, regardless of whether the COE has expended all of its grant funds.

Billing Logistics

For which members should a Federally Qualified Health Center be billing for the PMPM payment versus their prospective payment system payment?

A Federally Qualified Health Center that is also a COE should bill the MCO for the PMPM payment when providing care management to Medicaid members seeking treatment for Opioid Use Disorder from the COE. This PMPM payment replaces the grant funding that was previously managed directly by DHS.

Since MCOs can only accept a T1015 procedure code from Federally Qualified Health Centers, in what format will a COE bill the G9012 procedure code so there are no denials and the MCOs can differentiate between a claim in which they need to pay the prospective payment system rate and a claim they need to pay the reimbursement rate for this specific G9012 code?

DHS will communicate with the MCOs to identify those Federally Qualified Health Centers that are also COEs. DHS's frequently asked questions document related to the prospective payment system rate will be updated to include a section on payment for COEs care management services versus the payment at the prospective payment system rate for care management services.

Will the prospective payment system rate for Federally Qualified Health Centers be increased to include payment for COEs services, or will they be allowed to bill separately for COE and Federally Qualified Health Center services?

The prospective payment service rate will not be increased. COEs that are Federally Qualified Health Centers will be able to bill separately using T1015 or G9012 depending on the services being provided and to whom they are being provided. Federally Qualified Health Centers should bill the G9012 when

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providing care management services to members seeking Opioid Use Disorder treatment from the Federally Qualified Health Center in its capacity as a COE. MCOs can pay the PMPM payment since the MCO is operating within the Pennsylvania's Section 1915(b) Medicaid waiver. Federally Qualified Health Centers can provide care management services throughout the month for Medicaid members with Opioid Use Disorder, but the Federally Qualified Health Center will only receive the PMPM payment once per month.

Will DHS update both the Behavioral Health Services Reporting Classification Chart as well as the Person Level Event edits to ensure encounters can be accurately reported? Are there specific reporting requirements for Person Level Events?

No. DHS will work directly with the behavioral health MCOs on this coding question.

What will be the available codes to utilize for COEs services?

There is only one code that will be used for all COEs services, and that is G9012.

Is the G9012 procedure code exempt from third party liability procedures?

Federal law requires DHS to perform third party liability identifications for all claims paid using Medicaid dollars. There is no exception for G9012 despite the fact that Medicaid is currently the only payer that is covering this claim. A denial from the primary carrier should be obtained.

Must a MCO perform a pre-payment audit to confirm that payment requirements have been satisfied before rendering payment?

This is not required. However, MCOs **may** audit to verify a claim on a retrospective basis in the case of physical health claim or on a pre-payment basis in the case of behavioral health claim. Claims for COEs services should not be treated any differently than any other claim, and standard operating procedures should apply.

Will the COEs care management service be added to the January 1, 2019 covered services grid for behavioral health?

The G9012 code will be available for COEs usage on July 1, 2019. DHS will work directly with the behavioral health MCOs and COEs to develop systems for code utilization. Due to the limited number of providers able to use the G9012 code it will not be published in the services grid.

What place of service codes will be applicable to G9012 claims?

The face-to-face care management services that trigger the PMPM payment can take place anywhere except when an individual is incarcerated. The encounter can be documented as outpatient. The medical record documentation should list the actual location. A place of service code of 99 (other) is acceptable.

What are the unit duration and limitations? May a COE bill for multiple units in a day or one unit in a day?

One entry of G9012 triggers the requirement to pay the PMPM payment. That one payment is

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intended to pay for all COE care management services provided within the month, not specific units of services. Only one G9012 code claim will be paid per person per calendar month. The G9012 procedure code is billable any day of the calendar month. An MCO may require a COE to use the G9012 procedure code any time a face-to-face care management service is provided, but the PMPM will only be paid once.

Will there be provider type specialty specific to the COE's enrollment in PROMISE?

No.

What provider types may bill for the G9012 procedure code?

The following provider types may submit claims for the G9012 procedure code:

- 01: Inpatient Facility
- 08: Clinic
- 11: Mental Health/Substance Abuse Services Provider
- 21: Case Manager
- 31: Physician/Physician Group

Please note that if a claim is submitted by a provider type 31: Physician/Physician group, then there must be both a billing provider and a rendering provider included on the claim. Both providers must be credentialed by the MCO to whom the claim is being submitted.

When will changes be made to state reference files, such as the procedure code, diagnosis, or provider type specialty?

No changes will be needed. The procedure code already exists, there will be no new provider type created, and existing diagnosis codes should be used.

Since the G9012 code is to be billed separately from the medical encounter, who is the rendering provider for this code and who is to be signing off on the claim documentation? Case Managers are generally not credentialed providers.

Anyone on the care management team can document the face-to-face visit in the medical record. Licensed providers can counter-sign the medical record if needed. The rendering provider can be the COE entity such as a Federally Qualified Health Center (FQHC), outpatient clinic, or the licensed provider who counter signed the Case Manager's note.

What date should the G9012 code be billed? Should a COE wait until the end of the month to determine a list of patients who received a medical encounter in order to bill the once-per-month code?

The G9012 code should be billed the first day services are rendered. There should only be one claim submitted for payment with that code per month per Medicaid member. Additional claims not for payment may be submitted for encounter tracking and reporting purposes.

What kind of staff are eligible to bill for the PMPM payment?

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Any care management staff may submit a claim for care management services. If a particular care management staff member is unable to access or edit the medical record because they are not themselves an enrolled provider (e.g., a CRS), an appropriately enrolled and credentialed staff member may submit the claim on the care manager's behalf and identify the individual who actually provided the service in the case notes. The Group NPI number may also be used as the rendering provider.

If a patient's enrollment in a Medicaid MCO is retroactive, may COEs bill retroactively?

Yes.

Do all COEs need to have electronic health record systems?

Yes.

What qualifies as a month for purposes of billing for the PMPM payment?

A calendar month is the basis for billing for the PMPM payment.

For members that have primary commercial insurance and secondary Medicaid coverage, should a COE submit a G9012 code claim to the Medicaid MCO?

Yes, because primary commercial insurers likely will not pay the G9012 code claim. The Medicaid MCOs may ask for a denial from the primary insurer before paying the claim.

How would a COE bill a MCO if they are working with a Certified Community Behavioral Health Center as well?

If federal funding for Certified Community Behavioral Health Centers is extended by the federal government, a COE and a Certified Community Behavioral Health Center may not both bill a MCO for the same service. The Certified Community Behavioral Health Center and COE should work together to determine whether a shared member is receiving services more related to a mental health diagnosis or an opioid use disorder diagnosis. If the patient is receiving treatment and services primarily related to his or her opioid use disorder diagnosis, then the patient should be considered a COE member and the COE should bill the MCO for the PMPM payment.

Is there a timeframe required for clean claims to be paid by MCOs?

The same rules that apply to the submission and payment of any claims apply in this context as well.

Should the G9012 procedure code be billed by itself?

The G9012 procedure code may be billed by itself if no other billable services were provided at the time the care management services were provided.

May a COE that has an approved supplemental service for CRSs still bill for that supplemental service, or must they bill using the G9012 procedure code?

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All COEs must have a CRS on staff. They may bill for CRS services, but they may not bill using both the G9012 procedure code and for a CRS service for the same member during the same calendar month.

Can another agency, i.e., a non-COE program or a Single County Authority, bill case management or CRS services for a member who is also actively enrolled in the COE?

They may. While this would not result in duplicative payment to a single provider, the MCO may consider whether to pay multiple claims for the same or similar services to multiple providers based on their existing policies.

Must the opioid use disorder diagnosis be included on every claim using the G9012 procedure code as part of the claim edit?

No, but the member must have a current opioid use disorder diagnosis recorded in his or her medical record for the claim to be paid.

Contracting

If a behavioral health MCO operates in every HealthChoices zone but is not contracted with every primary contractor in the zone, are they required to contract with every COE in the zone regardless of which primary contractor they contract through?

No. The behavioral health MCO must only contract with COEs located in the counties in which they have members or counties in which their members could reasonably be expected to seek treatment.

May a behavioral health COE contract with a physical health MCO, or vice versa?

They may, as long as the COE ensures that they do not submit a claim to both a physical health and a behavioral health MCO for a single member.

Must a COE office be in the same space as the parent company? Can they share an MA ID number with the parent company if they are at a different location?

The COE office does not have to be in the same space as the parent company as long as they share an MA ID. The primary contractor or MCO must contract with all COEs as specified in their HealthChoices agreement. A claim with the G9012 procedure code must be paid when face-to-face care management services are provided by a COE staff member within a calendar month, regardless of the physical location in which those care management services are provided.

Are COEs able to turn away a COE referral if the member is not part of their Health System panel?

COEs are not required to accept any individual referral. However, MCOs are required to contract with all COEs that operate in the same HealthChoices zone or county as the MCO operates.

Level of Care

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Will COEs be required to follow level of care-specific regulations or will the State develop COEs- specific regulations?

COEs must follow all existing rules and regulations from the Department of Drug and Alcohol Programs regarding Level of Care Assessments.

Value-Based Payment (VBP)

Will DHS consider opportunities to attach quality and value-based performance metrics to the PMPM payment?

Yes. DHS will consider this, particularly in future years, as long as there are no penalties or down-side withholding.

Can you provide examples of value-based bundled payment arrangements for services aside from those paid for with the PMPM payment? Is this incentive/outcomes-based?

A COE could be awarded additional funds by tracking the following: retention of individuals in treatment for 6 (or 12) months or longer; completion of initial and 6-month recovery surveys; placement of patients into stable housing; receipt by pregnant patients of prenatal care, postpartum care, family planning services, and the newborn's attendance of well child visits within the first 15 months of life; provision of screening for Hepatitis B and C, as well as HIV; continued receipt of Medication Assisted Treatment for 6 (or 12) months or longer; percentage of members with negative urine drug screening results; and percentage of patients who are not prescribed benzodiazepines or opiates.

Will any part of the PMPM payment be linked to performance on key metrics?

Not at this time. COEs and MCOs may develop a value-based payment model in the future and are encouraged to begin thinking about that process now. However, for this year, the PMPM is a directed payment and must be paid. If an MCO and a COE are going to negotiate a VBP model, it must be above and in addition to the PMPM, and the PMPM must be paid separately in accordance with CMS's approval of the directed payment arrangement.

If an MCO and a COE have an existing value-based payment arrangement, must the community- based care management services covered by the G9012 procedure code and payable by the PMPM payment be carved out?

Yes. According to CMS's approval of the directed payment arrangement, the G9012 procedure code must be claimed separately and the specified PMPM amount must be paid. MCOs may pay the remainder of the amount negotiated as part of their VBP arrangement in addition to the PMPM as long as it is paid as a separate claim.

Data

Will COEs be required to collect data on prior overdose experiences for the purpose of assessing risk of individuals?

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This is not a current requirement. Risk assessment for both next overdose event and death are predicted by existing claims data.

Will COEs be required to continue reporting data to the state once the transition in funding mechanism occurs?

Yes; COEs must continue to submit data to DHS. Until an announcement to the contrary is made, COEs should continue to report as they are currently reporting.

Will COEs have to submit data to both DHS and MCOs, or will DHS send the data to the MCOs?

COEs must submit their data to DHS monthly, and DHS will transmit the data quarterly to the MCOs.

Will DHS provide a file layout for the care management report?

DHS will continue to dictate the format of the care management report.

What expectation does DHS have for MCOs regarding use of the data provided in the care management report?

MCOs should use any care management report data that they receive to analyze the effectiveness of care management services being rendered by the COEs. They can tie this data to outcomes measures to determine which services are most effective and lead to the best patient outcomes. They can also use care management report data to confirm that services qualifying for the PMPM payment are being provided. They may supplement DHS's analysis by analyzing their own paid claims.

What, when and how will data collected from the COEs be shared with primary contractors, counties, MCOs and oversight agencies?

DHS anticipates sharing aggregated (i.e., not patient-specific) data with stakeholders on a quarterly basis. This data will likely be provided in a format similar to the data that was shared on November 2, 2018. Stakeholders with claims data may elect to perform their own claims analyses by identifying COEs members as those for whom a G9012 code claim was submitted.

Will DHS be making any changes or updates to the data collected based upon experience?

Yes. DHS has already made some changes and will continue to make more changes as needed. For example, a metric tracking receipt of Medication Assisted Treatment has been added to the newest version of the data collection spreadsheet.

Should COEs list their CRSs and care managers as licensed or unlicensed for reporting purposes?

For reporting purposes, they are to be listed as unlicensed. CRSs must be certified by the PA State Certification Board.

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MCO Oversight

What is the MCO's responsibility to ensure compliance with the COEs program requirements?

MCOs are responsible for monitoring compliance with the terms of their individual contracts with a COE. They may not impose additional requirements beyond what DHS has specified in their agreements with the MCOs. DHS will continue to monitor compliance with its own requirements.

Who will be conducting compliance visits or chart reviews for the purpose of monitoring compliance with program requirements?

MCOs should monitor the terms of their agreements with the COEs in whatever manner they would typically monitor compliance with the terms of a provider agreement.

How should MCOs ensure that they are not paying claims for a single patient to multiple COEs?

MCOs shall check for claims submitted using procedure code G9012 for a single individual by multiple COEs in a single month. DHS will be responsible for ensuring that COEs are not billing both a physical health and a behavioral health MCO for a single member.

May MCOs stipulate an exclusion for COEs providers to disallow them from working separately in cash clinics?

Yes, they may.

Is there a maximum caseload for care managers?

While there is no requirement, DHS has a preference of a maximum caseload for care managers of 30 patients, as this ratio is supported as preferable by the relevant literature.