



DEVELOPMENTAL PROGRAMS BULLETIN

COMMONWEALTH OF PENNSYLVANIA DEPARTMENT OF PUBLIC WELFARE

DATE OF ISSUE
December 27, 2007

EFFECTIVE DATE
January 1, 2008

NUMBER
00-08-01

SUBJECT:

**Process for Qualification and
Disqualification of Waiver Providers**

BY:

A handwritten signature in black ink that reads "Kevin T. Casey".

Kevin T. Casey
Deputy Secretary for Developmental Programs

SCOPE:

Administrative Entity Administrators/Directors
Supports Coordination Entity Directors
Providers of Mental Retardation Medicaid Waiver Services

PURPOSE:

The purpose of this bulletin is to outline the standardized process for qualification and disqualification of provider agencies, individual professionals, and vendors that provide licensed and unlicensed Medicaid Waiver services, with the exception of Supports Coordination Services, to individuals in the Consolidated and Person/Family Directed Support (P/FDS) Waivers.

BACKGROUND:

In the past, County Programs qualified Waiver providers on an annual basis using the qualification criteria listed in the approved Consolidated and P/FDS Waivers. Although County Programs were provided with standard criteria to qualify providers, qualification processes differed across the Commonwealth. This resulted in inconsistencies in provider standards, and the localized qualification of providers.

During the Office of Developmental Programs' (ODP's) Consolidated Waiver renewal process in 2005, the Centers for Medicare and Medicaid Services (CMS) requested that ODP provide evidence that Waiver service providers are qualified to provide services **statewide** using the criteria listed in the approved Waivers, as per federal requirements. In order to comply with federal requirements, ODP assured CMS that a statewide Provider Qualification process would be adopted.

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

The Appropriate Developmental Programs Regional Office

DISCUSSION:

The Commonwealth of Pennsylvania supports the implementation of a statewide provider qualification and disqualification process for a number of reasons. A statewide process:

- Provides consistent qualification and disqualification information so that Waiver participants and family members can make more informed decisions about the selection of qualified providers.
- Affords all interested providers with the opportunity to request qualification, and if they meet the qualification criteria, enroll as Waiver service providers with ODP.
- Promotes statewide availability of qualified organizations and individual professionals for the Commonwealth's Waiver participants.
- Is consistent with federal Medicaid Waiver requirements.

POLICY:

All provider agencies, individual professionals, and vendors that provide Consolidated and P/FDS Waiver services must meet the qualification criteria outlined in the Waiver for the service they currently provide, or for new providers the services they intend to provide¹. As per the Waivers, Administrative Entities (AEs) are responsible to qualify Waiver providers, with the exception of those individuals and vendors pending and services through an Intermediary Service Organization, initially and annually thereafter. In order to comply with the Waivers, AEs must verify that all new providers meet the Waiver qualification criteria prior to the provider delivering Waiver services. The AEs must also verify periodically, at least on an annual basis, that existing Waiver providers continue to meet the provider qualification criteria outlined in the Waivers. For providers that operate in multiple areas of the Commonwealth, the responsible AE is the Entity responsible for the geographic area where the provider's legal address, as indicated in the Home and Community Services Information System (HCSIS), is located.

Process for Qualification of Waiver Providers

The outline below represents a detailed overview of the statewide process that AE's must use in qualifying provider agencies, and individual professional vendors that provide Consolidated and P/FDS Waiver services. Please note that this process does not apply to qualified support service workers and vendors providing Waiver services through an Intermediary Service Organization, nor does it apply to Supports Coordination Services.

- The standardized Provider Qualification process will begin **January 1, 2008** for both new and existing providers.
- All new providers on or after **January 1, 2008** will undergo the new statewide qualification process prior to providing services.
- AE's must conduct the annual verification of provider qualification status for existing providers, using the statewide process and as per a rollout plan that will span **January 1, 2008 through December 31, 2008** (please see below).

¹ Qualification criteria can be found in Appendix C of the Consolidated Waiver and Appendix B-2 of the P/FDS Waiver. Upon approval of the renewal of the P/FDS Waiver, the qualification criteria can be found in Appendix C.

Standardized Rollout Process for Existing Providers Only (January 1, 2008 – December 31, 2008)

The Standardized Rollout Process is detailed below. The Administrative Entities have not been assigned a role in HCSIS to support Provider Qualification. ODP is working with Deloitte and HCSIS to make this functionality available. Until this occurs, providers will be notified by Sue Pasker, ODP via electronic mail. Providers will use the HCSIS screens to input their information and then will provide a hard copy to their respective Administrative Entity. We will implement this process until the Administrative Entity role is available in HCSIS.

When the HCSIS role is available to the Administrative Entities, the rollout process for existing providers will consist of a random scheduling of providers for provider qualification. The scheduling of providers will be made through the HCSIS website, www.hcsis.state.pa.us. This service will be available in February, 2008. As part of the rollout plan, HCSIS will alert the provider thirty (30) calendar days before the randomly assigned deadline. The alert will direct the provider to complete the HCSIS provider qualifications application and submit all qualification materials to the appropriate AE within seven (7) calendar days of receiving the alert. The AE is responsible to verify that the provider meets the qualification criteria, and enter this information into HCSIS (see step 3 below). If the qualification information has not been entered by the AE within fourteen (14) calendar days prior to submittal deadline, the AE and the provider will receive an alert prompting them to complete the entry of information in HCSIS.

Standardized Process for Initial Qualification of Providers

Step One: Waiver Provider Reviews Qualification Process Information

- Provider becomes familiar with all key information regarding the standardized Qualification Process, including:
 - Qualification Criteria included in the Consolidated and P/FDS Waivers.
 - This Bulletin, including timelines for qualification.
 - DPW Website: www.dpw.state.pa.us.
 - HCSIS website for Provider Access functionality and information: www.hcsis.state.pa.us.
 - The current *Provider Agreement for Participation in Pennsylvania's Medical Assistance Program*, which must be signed by all qualified providers and submitted to ODP.
 - Applicable licensure processes and requirements.
 - Contact Information for appropriate ODP Regional and AE offices.
- Provider prepares/gathers appropriate documentation to substantiate qualification criteria.

Step Two: Waiver Provider Submits Qualification Material

- Provider accesses HCSIS website to initiate qualification application for the services they intend to provide.
- Provider responds to questions and submits the qualification application through HCSIS.
- After Provider submits the application, a new status is reflected in HCSIS to denote submission.
 - HCSIS generates an alert prompting the provider to submit the required mailed materials to the AE within seven (7) calendar days.

- Provider submits qualification materials to the appropriate AE, including liability, automobile, and workers' compensation insurance documents.

Step Three: AEs Verify Waiver Providers Meet Qualification Criteria

- The appropriate AE is alerted by HCSIS that the Provider's application has been submitted.
- The AE accesses HCSIS and reviews the qualification responses submitted by the Provider.
 - The AE will receive alerts on a daily basis regarding the provider's submission until the AE accesses HCSIS and begins the review process.
 - Once the AE accesses HCSIS and begins the review process, a new status indicator is reflected in HCSIS to denote review by AE.
 - The AE will prompt HCSIS to alert the provider, through a status indicator, that the submitted materials have been received.
- The AE reviews the qualification criteria using ODP approved methods, including but not limited to:
 - *Onsite Review* – Review of qualification materials at the Provider's site to ensure the qualification criteria are met, including examination of training plans and records, criminal background and child abuse checks, etc. For licensed providers, Administrative Entities do not need to review materials that are reviewed within the scope of licensing inspections.
 - *Review of Submitted Materials* – Review of information submitted by the Provider, including proof of license (for licensed providers and licensed professionals), and proof of liability, automobile, and workers' compensation insurances, without an onsite visit to the Provider's site.
- The AE has twenty-one (21) calendar days from the date that the Provider completes the online application to verify the documentation, enter the verification information into HCSIS, and finalize the Provider's application.

Step Four: Provider Receives Qualification Status

- After the AE finalizes the Provider's application in HCSIS, a status change is reflected to denote that the provider is qualified and the Provider is notified through an alert.
- The Provider logs into HCSIS to review its updated qualification status.
 - If qualified, the Provider's status is updated in the Services and Supports Directory (SSD) by service.
 - Providers who are denied qualification will receive notification of this decision, along with their right to initiate the ODP dispute resolution process as per Bulletin 00-06-14. These Providers may review the AE's qualification decision in HCSIS, and may update their application with current information and resubmit it for another review.

Step Five: ODP Oversight of AE Verification

- ODP will review and oversee AE verification to ensure timeliness, consistency and quality of the Provider Qualification process.
- ODP will also conduct site visits with Providers to ensure proper verification, when deemed appropriate.

Annual Re-Qualification Process

Step One: HCSIS Notification of Renewal Requirement

- HCSIS sends an automated “renewal” alert to the Provider and the AE sixty (60) calendar days prior to qualification expiration date (Note: The qualification “expires” one year from the date of the initial qualification of the Provider).
- HCSIS sends a second alert if the provider has not renewed its application within thirty (30) days prior to the qualification expiration date.

Steps Two through Five (see above under *Standardized Process for Initial Qualification of Providers*)

If the provider fails to access or complete its renewal application before the expiration of their “qualified” status, HCSIS will send an alert to ODP and the appropriate AE that the provider has not renewed their application. ODP will conduct follow-up with the provider and the AE, as necessary, to determine the nature of the issue regarding annual renewal.

Adding a New Service

Provider qualification takes place on an individual service basis. Should a provider agency or individual professional or vendor wish to add service offerings, the qualification status of the provider must be updated to reflect the new service offering(s), as follows:

- The Provider accesses HCSIS to add a new service offering.
- The qualification process for the new service may occur at any time during the year, or the provider may introduce new services at the time of their re-qualification. If requested during the year, HCSIS would send an alert to the AE indicating that a provider is requesting to alter their qualifications. If requested during re-qualification, the provider is responsible to submit qualification materials for the existing and new service.
- The Provider submits qualification material as per Step Two (see above).
- The AE will initiate the verification process to confirm provider qualification for the new service offering, as detailed in Step Three (see above).
- Steps Four through Step Five. (see above).

Please note that the Provider may only begin providing the new service after the AE verifies that they meet the provider qualification criteria included in the Waivers.

Process for Disqualification of Waiver Providers

A Waiver Provider may be restricted through disqualification for a particular Waiver service or agency-wide if it has been determined the Provider has:

- Failed to meet qualification criteria.
- Failed to comply with any of the provisions of the *Provider Agreement for Participation in Pennsylvania’s Medical Assistance Program*; and/or
- In a significant number or proportion of cases:
 - Furnished waiver services at a frequency or amount not consistent with authorized Individual Support Plans, as determined in accordance with utilization guidelines established by ODP; or

- Furnished waiver services of a quality that does not meet professionally recognized standards of health care, as defined in 42 CFR 1001.2.

If an AE determines that a previously qualified Provider meets the criteria for disqualification, the AE must immediately notify the appropriate ODP Regional Office and within seven (7) calendar days provide documentation to support restriction of the Provider. The Regional Office is responsible to review the documentation, as well as additional information, including licensing summaries, HCSIS records and data, and any information submitted by the provider. Based on this review, the Regional Office must make a determination regarding the Provider's qualification status, and submit their determination to the Office of Developmental Programs, Division of Program Management, P.O. Box 2675, Health and Welfare Building, Harrisburg, Pennsylvania 17105. The determination must be submitted within fifteen (15) calendar days of receipt of documentation from the AE. The ODP will make a final determination regarding restriction of the provider based on the Regional Office review. The final ODP determination will be made within fifteen (15) calendar days of receipt of the Regional Office's review.

If the ODP determination would place restrictions on the provider, through disqualification, the provider will receive advance notice of at least thirty (30) calendar days, but no longer than sixty (60) days, of the intended restriction. The notice will include the reason(s) for the restriction, as well as the Provider's right to request Dispute Resolution through ODP.

Before imposing the restriction, ODP must meet the following conditions:²

- Notify CMS and the general public of the restriction and its duration; and
- Ensure that the restrictions do not result in denying waiver participants reasonable access (taking into account geographic location and reasonable travel time) to waiver services of adequate quality, including emergency services.

If the ODP findings reveal fraudulent claims or significant abuse of participants, the findings will be reported to the appropriate State and/or Federal agencies.

RESOURCES:

The Consolidated and P/FDS Waivers, including qualification criteria, can be accessed on the Department of Public Welfare at:
<http://www.dpw.state.pa.us/PubsFormsReports/NewslettersBulletins/003673169.aspx>. Please contact the appropriate ODP Regional Office or the ODP Customer Service Number (1-888-565-9435) if there any difficulties locating or accessing the Waivers.

² Per 42CFR 431.54.