Provider Training

Provider Responsibilities

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# Welcome

# Provider Training – Provider Responsibilities

Welcome to the Office of Long-Term Living’s Provider online training. This two-part training educates new waiver/program service providers prior to enrolling as a provider and attending the required one-day classroom course.

## Course Overview

This training contains two modules.

* Module 1: Introduction to Long-term Care and
* Module 2: Provider Responsibilities

This course only relates to OLTL publicly funded programs. It does not apply to programs through other offices.

## Module Overview

Module 2: Provider Responsibilities includes OLTL provider responsibilities, prohibited practices, quality management, and systems information.

Module 2 contains five lessons.

* Lesson 1: Ongoing Enrollment Requirements,
* Lesson 2: Responsibilities to Participants,
* Lesson 3: Business Practices,
* Lesson 4: Quality Management, and
* Lesson 5: OLTL’s Systems.

## Objectives

After completing this module, you will be able to:

* Meet ongoing enrollment requirements
* Protect participants from abuse, neglect, exploitation, and abandonment
* Manage critical incidents
* Develop quality management plans
* Ensure that participants are eligible to receive services
* Ensure the accessibility of services

During emergency situations when the Governor issues a disaster emergency declaration, the Office of Long-Term Living (OLTL) may need to make temporary changes to the Community HealthChoices (CHC) and/or OBRA waivers through an Appendix K amendment of each waiver, to allow flexibilities in responding to the emergency. OLTL may also decide to allow similar flexibilities in the Act 150 Program. If OLTL elects to allow temporary flexibilities to a waiver or the Act 150 Program, OLTL will inform providers of the approved changes through a ListServ email or through the CHC-MCOs.

## Additional Objectives

After completing this module, you will be able to:

* Maintain a sound financial, billing, and reporting structure
* Recruit, hire, train, and orient employees
* Conduct background checks and exclusion screenings
* Maintain records
* Avoid prohibited practices
* Work with quality monitoring teams and develop corrective action plans
* Identify systems used in providing home and community-based services

## Resources

Many resources are mentioned in this module. To ensure that the links remain accurate and active, we have placed them in a separate document on this website.

Whenever a link is available in the Resources Document, a bar will be displayed in the training module, usually at the bottom of your screen.

# Lesson 1: Ongoing Enrollment Requirements

In Module 1, you learned how to enroll as a provider. Let’s start this module with how providers meet their ongoing enrollment requirements.

## Changes Requiring OLTL Notification

Providers must enroll all service locations and note the services provided. This information must be kept up-to-date. When there is a change in service locations, licenses, or services provided, you must notify OLTL’s Enrollment section 30 days prior to the change.

## Revalidation

As part of the Provider Enrollment and Screening Provisions of the Affordable Care Act, all providers are required to revalidate all service locations every five years. 60 days prior to revalidation, you should log into PROMISe to verify your revalidation date and submit a revalidation application. When revalidating, you need to complete a new enrollment application for your provider type for each service location.

## Changes in Ownership & Management

Ownership and management records must be kept up-to-date with OLTL. Providers must report all changes in ownership of 5% or more at least 30 days prior to taking effect. In addition, you must complete and submit an Ownership and Control Interest Disclosure form to include social security numbers, dates of birth, and residential addresses for all board members, managing employees, and owners with 5% or more controlling interest. A copy of all owners’ social security cards must supplement the form. The Department is required to conduct exclusion screenings on these individuals.

## Changes through ePEAP

If you are only changing your contact information which includes your phone number, email, mail to or pay to address, you can use the ePEAP application on the PROMISe Provider Portal Main Page.

## Summary

In summary, OLTL must be notified 30 days in advance when there are changes to:

* Ownership of 5% or more,
* Counties served,
* Waivers supported,
* Services offered in each waiver,
* Service locations,
* Licensure, or
* Contact information.

The Department requires notifications because it ensures that exclusion and background checks are performed and that licensures are active prior to updating a provider’s profile. Depending on the scope of changes, a new provider base application may be required. Enrollment’s contact information can be found in the Resources Document.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 1 Knowledge Check

1. All providers must revalidate all service locations every 7 years.

True

False

Please pause.

The correct answer is False. All providers must revalidate all service locations every 5 years.

2. Providers must notify OLTL and change their documented provider status 30 days in advance when: (Select all that apply.)

Counties, services, or waivers are added and/or changed

Service locations are changed or added

Emails or phone numbers are added or changed

Licensure status changes

Please pause.

The correct answer is that providers must notify OLTL and change their documented provider status 30 days in advance when counties, services, or waivers are added and/or changed; service locations are changed or expanded; and licensure status changes

# Lesson 2: Responsibilities to Participants

Now, let’s talk about provider responsibilities to participants.

## Protect Participants from Abuse

All waiver providers are required to ensure that participants are protected from abuse, neglect, exploitation, and abandonment. Providers do this through prevention, identification, and remediation policies, procedures, and practices.

Providers are mandatory reporters under both the Adult Protective Services Act and the Older Adult Protective Services Act. Providers are required to train all of their employees upon hire and annually on prevention, identification, remediation, and reporting.

To find out more information about provider responsibilities related to participant abuse, neglect, exploitation, and abandonment, take the Incident Management and Protective Services online training courses. The link to these trainings can be found in the Resources Document.

## Manage Critical Incidents

In addition to protecting participants from abuse, neglect, exploitation, and abandonment, providers must develop and implement written policies and procedures relating to critical incident management. The policies and procedures must cover:

* Prevention and trend tracking
* Risk management
* Investigations
* Reporting
* Notifications
* Staff training (upon hire and annually)

To find out more information about provider responsibilities related to critical incident management, take the Incident Management and Protective Services online training courses. The link to these trainings can be found in the Resources Document.

## Address Participant Complaints

Some participant concerns do not rise to the level of a critical incident report but are still very important. All providers are required to have a plan and system in place to record, respond to, and resolve participant complaints. The complaint system must document both resolution strategies and participants’ satisfaction with the resolution. Information must be stored in a way that allows providers to track and trend data.

Providers must review this information quarterly to:

* Analyze the number of complaints resolved to the participant’s satisfaction,
* Analyze the number of complaints not resolved to the participant’s satisfaction, and
* Measure the number of complaints referred to the Department for resolution.

Complaint resolution statistics are part of the provider’s overall quality management plan. The complaint resolution process will be reviewed by OLTL’s Quality Management Efficiency Teams, known as the QMETs, during their visits. For more information, please refer to 55 Pa Code Chapter 52.18.

If you are providing services through CHC-MCOs, please refer to their complaint resolution procedures.

## Ensure Participant Eligibility

Let’s move to providing services starting with participant eligibility. Providers are responsible for ensuring that participants are eligible to receive services before rendering services. You can use the Eligibility Verification System (EVS) application to determine this. EVS is an application on the PROMISe Provider Portal. If a participant is no longer eligible in EVS, contact the service coordinator and the participant to investigate the situation.

## Provide Services Appropriately

So, the participant is eligible and your employee is ready to deliver services. What’s next? All services must be delivered appropriately. Providers must ensure that their care workers are trained to perform specific services in accordance with waiver requirements and State regulations.

## Provide Services

### Service Authorization

After determining that a person is eligible, providers must deliver services in the type, scope, amount, duration, and frequency described in the service authorization documentation from the service coordinator.

Providers are reimbursed only for services rendered. Providers may be reimbursed only for services rendered that are specifically defined on the service plan. Providers will not be reimbursed for units or services that exceed what is on the service authorization from the service coordinator.

### Timeframes

Providers are expected to follow the timeframes noted in the service authorization. The timeframes matter. Service coordinators develop them to ensure that direct care worker activities do not conflict with other activities such as nursing, physical therapy, or other services.

### Changes

If a participant requests a change in timeframe, you may accommodate the request. Notify the service coordinator so that all scheduling can be updated.

Please note that any failure of a provider to deliver services that result in a risk to the participant’s health, welfare, or safety is a reportable critical incident. Providers must report it.

### Participant Preferences

Providers must also honor the participant’s preferences that are noted in the service authorization from the service coordinator. A common preference is to have a care worker of the same gender.

If there are challenges complying with the participant’s preferences, work with the service coordinator to remedy the situation.

### Interpreter Services

Providers must provide language services at no cost to the participant, in accordance with federal and state regulations.

This includes interpretation and translation services for participants with Limited English Proficiency (LEP), and sign language interpretation services for participants who are deaf or hard of hearing. Additionally, communication in materials such as Braille or large print must be provided to participants who are blind or have low vision.

The Office of Medical Assistance Programs Bulletin 99-17-11, “Limited English Proficiency Requirements,” contains further information on language services.

Using family members as interpreters may present issues of bias in interpretation. Professional interpreters are the best way to ensure that communication is accurate and complete.

To find interpreters in your area, contact an interpreter’s trade association or a local non-profit organization assisting people with LEP. If you are providing services through CHC, contact the CHC-MCO. Contact information can be found in the Resources Document.

### Without Discrimination

Providers must also ensure that all services are delivered without discrimination based on age, race, creed, color, national origin, ancestry, marital status, sexual orientation, gender identity, or disability.

All employees must be trained on these concepts and how they apply to delivering home and community-based services.

### Electronic Visit Verification (EVV)

What is EVV?

EVV is a system that electronically verifies personal care and home health care services were delivered. EVV must be implemented for personal care services (PCS) by January 1, 2021 and for home health care services by January 1, 2023.

The Department of Human Services (DHS) has implemented an EVV system for PCS and all providers are required to collect EVV data when PCS are provided.

Beginning January 1, 2021, all claims submitted for PCS must have matching EVV visit data in order for the claim to be paid.

What services are considered PCS?

In Office of Long-Term Living programs, Personal Assistance Services, Respite provided in unlicensed settings, and Participant-Directed Community Supports are considered PCS.

What do providers need to do?

Providers Enrolling in Community HealthChoices (CHC)

If providers elect to use the HHAeXchange EVV system offered by the Managed Care Organizations (MCOs), providers must work with the MCOs to complete training and other onboarding requirements.

Providers who elect to use a third party or alternate EVV system in CHC must work with the MCOs to send their EVV data to the appropriate MCO.

Providers should contact HHAeXchange at EDIsupport@hhaexchange.com <mailto:EDIsupport@hhaexchange.com> to complete third party system integration activities for CHC.

Providers Enrolling in Fee-For-Service (OBRA Waiver and Act 150 Program)

The DHS Sandata EVV system is being offered to Fee-For-Service providers at no cost to the provider.

Providers using the DHS Sandata EVV system must complete training in order to begin setting up their agency accounts and security permissions. This training can be accessed at: https://sandatalearn.com/#/signup-form <https://sandatalearn.com/>

If providers elect to use a third party or alternate EVV system, the DHS Aggregator will receive information from the alternate EVV systems being used by providers in fee-for-service programs.

Providers must contact Sandata at 1-855-705-2407 or PAAltEVV@sandata.com <mailto:PAAltEVV@sandata.com> to complete Alternate EVV system integration activities to send data to the DHS Aggregator for fee-for-service programs.

Resources

More information can be found on the DHS EVV website.

## Accessibility to Services

Providers are required to remove barriers that affect the accessibility of waiver services. A common barrier is transportation. Participants are eligible for the Medical Assistance Transportation Program (MATP) for their non-emergency medical transportation needs, such as dialysis, health clinics, and outpatient services. Service coordinators and providers should be familiar with the MATP providers in their counties. Non-medical transportation needs covered by programs are included in the participant’s service plan. Transportation brokers manage the process in CHC. In addition, some service definitions include transportation.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 2 Knowledge Check

1. Before rendering services, providers must ensure that participants are eligible to receive services.

True

False

Please pause.

The correct answer is True. Providers must ensure that participants are eligible to receive services before rendering services. Participant eligibility can be checked using the Eligibility Verification System (EVS).

2. If a participant requests a change in timeframe, providers may accommodate the request.

True

False

Please pause.

The correct answer is True. If a participant requests a change in timeframe, you may accommodate the request. Notify the service coordinator so that all scheduling can be updated.

3. Providers must develop and implement written policies and procedures relating to critical incident management. The policies and procedures must cover: (Select all that apply.)

Prevention and trend tracking

Risk management

Investigations

Reporting

Notifications

Staff training

Please pause.

The correct answer is that the critical incident management policies and procedures must cover prevention and trend tracking, risk management, investigations, reporting, notifications, and staff training (upon hire and annually).

4. After determining that a person is eligible, providers must deliver services described in the service authorization according to which of the following? (Select all that apply.)

Type

Scope

Amount

Duration

Frequency

Please pause.

The correct answer is that the services must be delivered in the type, scope, amount, duration, and frequency listed in the service authorization.

# Lesson 3: Business Practices

Now, let’s shift to required provider business practices.

## Maintain Sound Business Practices

Providers must maintain a sound financial, billing, and reporting structure. This includes policies, procedures, and training to:

* Submit complete and accurate billings to OLTL through the PROMISe system, or to the CHC-MCOs through their billing systems,
* Avoid exceeding established rates,
* Maintain evidence of expenditures for at least five years, and
* Use generally accepted accounting principles (or GAAP).

OLTL and CHC-MCOs review these procedures during their quality reviews.

## Recruit, Hire, & Orient Employees

Providers are required to recruit and retain quality employees to deliver services without discrimination based on age, race, creed, color, national origin, ancestry, marital status, sexual orientation, gender identity, or disability. Providers must have an orientation program for all new employees that covers required training relevant to the specific waiver services definitions and State requirements.

## Provisional Hiring

### Pa Code

Providers have the option to hire individuals on a provisional basis as outlined in 55 Pa Code § 52.20.

Provisional hiring is an option. It is not required.

### Background Checks

A provider can use provisional hiring to bring in a worker while waiting for the results of his or her background checks.

Workers must swear or affirm in writing that they will pass the background check.

### Monitoring

Providers must monitor provisionally hired individuals through direct observation.

### Length of Time

The provisional period cannot be longer than:

* 30 days for a worker who has been a PA resident of more than two years
* 90 days for a worker who has been a PA resident for fewer than two years

### Summary

For more information on the specifics of provisional hiring, review the Pa Code. A link to the Pa Code can be found in the Resource Document.

## Employee Training

Employee training is essential to ensure the quality of services rendered, the safety of participants, and the safety of direct care workers. Providers have multiple sets of training responsibilities. They must:

* Develop and use an orientation package and training for all new hires
* Adhere to 55 Pa Code Chapter 52.21 training requirements
* Meet the training requirements necessary to maintain licensures and certifications

## Prior to Delivery

Prior to providing an individual service to a participant, employees must be trained on how to provide that service in accordance with the participant’s service plan and in accordance with waiver service definition requirements.

## Annually

The Pa Code requires providers to implement standard annual training for employees providing services. At a minimum, the training should include:

* Prevention of abuse and exploitation of participants
* Critical incident reporting
* Participant complaint resolution
* Department-issued policies and procedures
* Provider’s quality management plan
* Prevention of fraud and financial abuse

## Documentation

Providers must maintain documentation for both employee attendance at trainings and the content of trainings. If you have questions on maintaining training documentation, contact your QMET or CHC-MCO representative for guidance.

## Background Checks

Providers must perform both background checks and exclusions on all employees. We’ll start with background checks.

## Criminal History

Providers must conduct a Pennsylvania State Police criminal history for the provider and all employees upon hire. A federal criminal history is required if the employee has been a resident of Pennsylvania for less than two years.

## Child Abuse History

A child abuse history certification is required for all prospective and current adults working in a paid or unpaid capacity who have direct contact or routine interaction with children under 18 years of age. If a care worker provides services in a home where children live or visit routinely, a child abuse history certification is required.

Child abuse history certifications are required every five years. Providers must present written results of the background checks to OLTL. Please refer to all applicable child abuse regulations and waiver language to ensure your agency is in compliance.

## Exclusion Screenings

### What?

Exclusions are different, separate, and in addition to background checks.

Exclusions refer to individuals or organizations that have been barred from doing business with Pennsylvania or the federal government.

### Who?

The exclusion screenings must be conducted for all employees, contractors, board members, and businesses or individuals with a financial relationship to the provider.

### When?

The exclusion screenings must be conducted upon hire and every month after hire.

### Required Screenings

There are three required monthly exclusion screenings:

* Pennsylvania Medicheck List
* List of Excluded Individuals/Entities (LEIE)
* Excluded Parties List System (EPLS)

“Every employee/every board member/every contractor/ every month/three exclusions.”

### Documentation

Providers have flexibility in documenting the performed screenings. Many providers use a spreadsheet listing all required persons, the three exclusions, and a place to date and initial that the screenings were performed for each person.

Contact your local QMET, or CHC-MCO representative, or OLTL for questions about documenting exclusion screenings.

### Summary

For more information on exclusion screenings, please refer to Medical Assistance Bulletin 99-11-05.

A link to the bulletin can be found in the Resources Document.

## Retain Records

Record keeping is essential to ensure the quality of services provided. Record keeping is also essential to Pennsylvania being able to prove or assure that it has met its requirement to continue to receive federal funding. OLTL requires records to be maintained for a minimum of five years after creation. Please note that some regulations, including licensure and HIPAA, may have a longer retention rate. A provider must maintain their records for the greater timeframe. Maintaining accurate records helps to:

* ensure accurate service delivery;
* make it easier to address continuity of care issues; and
* clear potential billing issues that may arise later.

## Records

### Organizational Records

* Enrollment documents, such as the MA Provider Agreement and PROMISe™
* Provider Enrollment Base application
* Provider mission statement
* Long-range plan
* Organizational chart
* Annual report, results of an annual self-assessment, or minutes of advisory committee meeting
* National Provider Identifier (NPI) and Master Provider Index (MPI) provider identification numbers (The provider’s MPI number is the same as its PROMISe™ number.)

### Employee Files

* Employee job descriptions
* Orientation package for employees
* Resumes and appropriate individual licensure
* Employee files that include employee training records and plans, such as required training on:
	+ Prevention of abuse and exploitation of participants
	+ Reporting critical incidents
	+ Participant complaint resolution
	+ Department-issued policies and procedures
	+ Provider’s quality management plan
	+ Fraud and financial abuse prevention
	+ Written outcomes of criminal history and child abuse clearances
	+ Policies and Procedures

### Fiscal Records

* Payroll ledgers, canceled checks, bank deposit slips, and any other accounting records prepared by or for the provider
* Contracts for services or supplies relating to the provider’s costs and billings for participant health services
* Evidence of provider charges to OLTL participants and non-participants
* Evidence of claims for reimbursement, payments, settlements, or denials resulting from claims submitted to third party payers or programs
* Billing transmittal forms
* Records showing all persons, corporations, partnerships, and entities with an ownership or controlling interest in the provider
* Documentation of rates

### Quality

* Detection, investigation, and reporting of suspected abuse and copies of the incident reports and their resolution
* Provider-specific quality management strategy

### Participant Files

* Participant records must be maintained by providers for at least five (5) years, unless the participant’s case is involved in an unresolved audit or litigation.
* Each participant file must be legible throughout and identify the participant’s name on each page.
* Alterations of the participant’s record must be signed and dated. If changes are required, providers must use strikethrough with initialing (never whiteout or delete changes or entries.)
* Copy of and all revisions to the service authorization
* Evidence of service delivery noting time in/time out – timesheets, case notes, logs, telephony reports
* Billing invoices

### Additional SC Files

* Participant’s individual spending plan for Services My Way and all spending plan changes
* A copy of the physician’s prescription (not needed for Act 150 Program)
* A copy of the recertification of the need for HCBS
* A record of participant’s MA eligibility, including a copy of the Enrollment Application
* A complete medical history of the participant
* A copy of the participant’s advance directive, if executed
* Updated progress and service notes
* A copy of the participant’s signed service plan
* A copy of the updated assessment
* A copy of the signed Participant Choice Form

### Electronic Records

Providers may maintain electronic records as long as the provider meets the following requirements:

* The electronic format conforms to federal and State requirements.
* The electronic record is the original record and has not been altered or if altered shows the original and altered versions, dates of creation, and the creator.
* The electronic record is readily accessible to the Department, the Department’s designee, and State and Federal agencies.
* The provider creates and implements an electronic record retention policy.
* Electronic imaging of paper documentation must result in an exact reproduction of the original record and conform to the provider’s electronic record retention policy.

The commonwealth may obtain and review all records related to providing services at any time with or without prior notice.

### HIPAA Compliance

The provider shall ensure records are compliant with the Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act (HIPAA) was enacted by the U.S. Congress in 1996.

HIPAA requires all health care providers and payers nationwide to use a universal set of standards for paper and electronic billing and administrative transactions to safeguard against inappropriate access or distribution of protected health information, PHI.

Compliance with HIPAA is an important condition of being a provider in Pennsylvania. Providers are responsible for ensuring these standards are met. Providers must:

* Submit claims that meet HIPAA requirements.
* Take appropriate administrative, physical, and technical safeguards to protect against inappropriate access to protected data. For example, establish policies that clearly identify employees that will have access to PHI, lock participant files, and create password-protected files.
* Obtain a participant’s or their legal representative’s permission prior to sharing personal health information.
* Train all care workers on HIPAA requirements.

### Summary

For more information on the specifics of record keeping, please refer to the link to the 55 Pa Code § 52.25 found in the Resources Document.

## Prohibited Practices

OLTL, CHC-MCOs, and DHS will take action if a provider is participating in any of the following practices:

* Abuse of a participant in any form
* Acting as participant’s legal guardian or life insurance beneficiary
* Having sexual contact with the participant
* Using chemical or physical restraints
* Committing fraud and/or abuse, including:
	+ Submitting claims that are duplicative, have missing or incorrect information, have procedure codes that overstate level or amount of service provided, or are for non-reimbursable, non-compliant, or non-medically necessary health services
	+ Failing to develop and maintain health service records
	+ Failing to use generally accepted accounting principles or methods
	+ Failing to disclose or make available to OLTL the participant’s record
	+ Failing to keep, disclose, or make available financial records
	+ Failing to report duplicate third party payments (Medicare or others) for covered services provided to MA recipients and billed to DHS
	+ Failing to obtain information and assignment of benefits
	+ Knowingly and willfully submitting a fraudulent enrollment application
	+ Soliciting
	+ Payment of program funds by a provider to another provider
	+ Failing to comply with Provider Agreement requirements
	+ Influencing, soliciting, or coercing individuals to receive from a particular provider or supplier any item or service for which payment may be made

## Avoid Prohibited Practices

OLTL may initiate remedial actions against the provider at any time for non-compliance including sanctions and/or termination of the Provider Agreement.

Now check your understanding of what’s been covered so far by answering these review questions.

## Lesson 3 Knowledge Check

1. OLTL requires records to be maintained for a minimum of five years after creation.

True

False

Please pause.

Some regulations have a longer retention rate. A provider must maintain their records for the greatest timeframe.

2. Once a year, the following exclusions are required for every employee, board member, and contractor:

Pennsylvania Medicheck List

List of Excluded Individuals/Entities

Excluded Parties List System.

True

False

Please pause.

The correct answer is False. The three exclusions are required on a monthly basis.

“Every employee/every board member/every contractor/every month/three exclusions.”

3. A child abuse history certification is required only when a care worker has direct contact with a child.

True

False

Please pause.

The correct answer is False. A child abuse history certification is required when a care worker provides services in a home where children live or visit routinely.

4. Which of the following are considered prohibited practices? (Select all that apply.)

Abusing a participant in any form

Failing to develop and maintain health service records

Hiring a relative of the participant

Recommending a supplier for medical items

Soliciting a participant

Please pause.

The correct answer is that the following are prohibited practices: abusing a participant in any form, failing to develop and maintain health service records, recommending a supplier for medical items, and soliciting a participant.

# Lesson 4: Quality Management

Quality is more than responding to and resolving complaints. Quality management is an approach to doing business.

## Quality Management

Quality management includes three functions – discovery, remediation, and continuous improvement.

During discovery we ask, “How do we measure what we’ve done?” Discovery is the collection of data that reflects the ongoing implementation of the program. It identifies both strengths and opportunities for improvement.

During remediation we ask, “What do we do when things haven’t worked well?” Remediation is taking action to remedy specific problems or concerns that arise in data collection.

During continuous improvement, we ask, “How do we do things better?” Continuous improvement uses collected data on actions and remediation to change processes and improve outcomes.

## Develop QMP

Every provider is required to develop and implement a Quality Management Plan, known as a QMP, in accordance with 55 Pa Code Chapters 52 and 1101. The plan must include three items:

* Measurable goals (What you want to achieve);
* Data-driven outcomes (How close you came to achieving it); and
* Department-approved Corrective Action Plans (If they are needed).

The QMP should also address other areas of quality improvement identified by the provider. If you have questions on elements of your QMP, contact your QMET or CHC-MCO representative for support. Let’s focus on goals and outcomes.

## Goals

The key task of providers in the QMP is to identify a set of goals that can be measured. The goals must relate to the quality of their services, the quality of their organization and employees, and the satisfaction of participants.

A goal is a statement of what should happen or what you intend to achieve. For example, a provider goal might be to “ensure that the company meets or exceeds the needs and expectations of participants.”

## Outcomes

Data-driven outcomes are what actually happened. To create a data-driven outcome related to the “expectations” goal, the organization needs to find a way to measure satisfaction. A survey can be created for participants to rate their expectations of service as “unmet,” “met,” or “exceeded.” The data-driven outcome documents how many participants rate the organization as “meeting” or “exceeding” expectations.

Participant surveys, complaints, and commendations support how well your organization, its processes, and its individual employees are rated by participants.

## Work with QMETs

So, how do we know that providers are complying with all of the rules, regulations, policies, and procedures? For Act 150 and fee-for-service waivers and programs, providers work with QMETs. For managed care, CHC-MCOs have their own quality management procedures.

QMETs are OLTL’s monitoring agents for Act 150 and the OBRA waiver. QMETs are also a great resource for providers. QMETs help Act 150 and OBRA waiver providers to be better at compliance.

## QMET Monitoring

At a minimum of every two years, QMETs conduct comprehensive on-site fee-for-service provider monitoring. QMET monitoring visits identify areas of improvement. Monitoring visits are typically announced but OLTL reserves the right to monitor at any time without notice.

## QMET Monitoring Process

The QMET monitoring process has three stages: Preparation, On-site Monitoring, and Follow-up.

## Preparation Phase

In the preparation phase, a notification of monitoring letter is sent to the provider prior to the on-site monitoring visit. The letter outlines the information and data that the QMET will review and requests documents and files to be sent prior to the on-site monitoring visit.

## On-site Monitoring Phase

On-site monitoring is when QMETs come to your site. The on-site coordinator conducts an entrance conference that outlines the process and what to expect. QMETs conduct a status update with the provider for each day. In the update meeting, QMETs may request additional documentation and answer questions. At the end of the on-site monitoring, the QMETs conduct an exit conference that summarizes findings and next steps.

## Follow-up Phase

Within fifteen business days after the end of the on-site monitoring visit, if necessary, a Statement of Findings (SoF) with corresponding Corrective Action Plan (CAP) template will be emailed to the provider.

## Corrective Action Plans

The Corrective Action Plan (CAP) is a document to ensure that all items in the statement of findings are resolved.

### OLTL Template

Providers must submit their CAPs using the OLTL template.

### Pa Code

The CAP must be in accordance with 55 Pa Code § 52.23.

### Action Steps

The CAP must include the specific action steps that the provider commits to taking to address a specific finding.

Each action step must have a completion date and an explanation of how the action step will remediate the finding.

### Review

OLTL reviews and monitors all CAPs to ensure that each finding is corrected.

If you discover that you cannot meet a deadline on the CAP, contact your QMET to update the CAP.

### Monitoring

A follow-up monitoring will occur to ensure the success of the CAP. Follow-up for CAPs is between 30 and 90 days.

The CAP is only closed when all action steps are completed. QMETs will provide technical assistance to providers as needed.

## Sanctions

OLTL places a large focus on quality. OLTL may require a CAP or initiate remedial action against the provider at any time for non-compliance with federal or State statutes, regulations, or requirements. Please note, depending on the QMET finding, they may also make a referral to an outside agency in cases of potential fraud and abuse.

## Criteria for Remedial Action

* Failure to submit a CAP to OLTL.
* Continued submission of an incomplete CAP to OLTL.
* Non-compliance with federal or State record-keeping requirements, including non-maintenance of adequate documentation of actual service delivery to support bills submitted.
* Suspension or termination from the Medicare program because of fraud and/or abuse.

“Fraud and/or abuse” refers to intentional and/or ongoing intent to deceive. This can include falsifying service provision records or billings.
* Violation of any terms and conditions of participation in the MA Provider Agreement.
* No longer meeting MA provider standards applicable for the service. For example:
	+ Is no longer licensed, or
	+ Is no longer in compliance with licensure or contractual requirements.
* Submittal of false, duplicate, or fraudulent bills.
* Failing to notify Provider Operations promptly of overpayments of which the provider becomes aware or fails to reimburse the Commonwealth promptly for any overpayments.

## Remedial Action

If it is determined, that a provider’s CAP has not been fully implemented and deficiencies still exist, remedial action may be taken against the provider. Remedial action may include monetary sanction and possible termination from OLTL Programs.

## Appeals

Providers may request an appeal of any adverse action by the Department within thirty-three days of the mailing date of the notice. (Per 55 Pa Code Chapter 41.32) However, an appeal request does not stop the action taken by the Department.

If the provider does not request an appeal, the process ends when the thirty-three (33) days have elapsed and OLTL issues a notice of suspension of services or termination. If an appeal is requested, a hearing is scheduled and held, and a decision is rendered.

## Summary

Quality is essential. Documenting actions is essential. Corrective actions are not negotiable. QMETs can provide support and assistance. Providers must address all findings in the agreed-to timeframes.

Now check your understanding of what’s been covered so far by answering these review questions..

## Lesson 4 Knowledge Check

1. If you are providing services only under CHC, QMETs perform monitoring.

True

False

Please pause.

The correct answer is False. CHC-MCOs perform quality monitoring under CHC. QMETS only monitor fee-for-service.

2. The Quality Management Efficiency Teams (QMETs) conduct on-site monitoring visits every 3 years.

True

False

Please pause.

The correct answer is False. QMETs conduct on-site monitoring visits every 2 years.

3. OLTL may require a CAP or initiate remedial action against the provider at any time for non-compliance with federal or State statutes, regulations, or requirements.

True

False

Please pause.

The correct answer is True. OLTL may require a CAP or initiate remedial action against the provider at any time for non-compliance with federal or State statutes, regulations, or requirements.

4. Which of the following should be included in a Quality Management Plan (QMP)? (Select all that apply.)

Measureable goals

Plans for future expansion of services

Data-driven outcomes

Corrective Action Plans

Please pause.

The correct answer is that the following must be included in a Quality Management Plan: Measurable goals, data-driven outcomes, and Corrective Action Plans.

# Lesson 5: OLTL’s Systems

Finally, let’s take a look at the systems that providers use in delivering home and community-based services under OLTL Act 150 and the OBRA waiver. If you are providing services under CHC, please contact the CHC-MCOs for instruction and details on their systems.

## Systems

### Provider Reimbursement and Operations Manage Information System

PROMISe is for billing and eligibility verification.

Training for PROMISe is available on-site at your location. PROMISe representatives will come to your site to train your team on billing and eligibility verification. To request training or support, use the contact information in the Resources Document.

### Home and Community Services Information System

HCSIS is for under 60 waiver and Act 150 service planning and enterprise incident management (EIM).

Training on HCSIS is available online. HCSIS has its own learning management system (LMS). The LMS provides training in both service plan data entry and EIM data entry.

### Social Assistance Management System

SAMS is for Aging Waiver service planning and all Department of Aging program support. Please note that SAMS is no longer used for ongoing Aging Waiver service plans due to the Aging Waiver being transitioned to CHC Waiver effective 12/31/19. SAMS is now only used for legacy Aging Waiver service plan data through the date of service 12/31/19.

### A Note about MCOs

Please note that if a provider is working with an MCO, the MCO has specific systems and processes for its documentation, billing, and quality management.

MCOs are required to train providers on their specific systems and processes.

# Congratulations!

Congratulations! You have completed the second module, Provider Responsibilities, in the OLTL Provider Training.

As a reminder, MCOs may require additional trainings related to the specific procedures they use for billing, quality management, investigations, and other processes.

If you are an enrolled provider, go to [this website](https://oltl-provider.deringconsulting.com/enrolled-provider-responsibilities-completion/) to register completion of this module. If you are not an enrolled provider, go to [this website](https://oltl-provider.deringconsulting.com/not-enrolled-provider-responsibilities-completion/) to register completion of this module.