Organized Health Care Delivery Systems (OHCDS)

- During the recent Waiver renewal process, CMS recommended the use of an Organized Health Care Delivery System (OHCDS) model to ensure compliance with provider agreements and direct payment requirements.

- Under most waives, OLTL contracts with an intermediary (AAA or provider organization) which is the provider of record. As the provider of record, the intermediary is responsible for validating provider qualifications and receives payment for the service rendered. In this respect it functions as an OHCDS provider.

- This arrangement is used by some OLTL providers for the following services: Home Delivered Meals, Environmental Modifications, Personal Emergency Response Systems, Community Transition Services, Transportation, and Durable Medical Equipment (DME).

Organized Health Care Delivery Systems (OHCDS) Cont'd

- OHCDS is defined in 42 CFR 447.10 as a public or private organization delivering health services. The State Medicaid Manual (SMM), HCFA-Pub. 45-4, section 4442.3 also describes OHCDSs as they relate to 1915(c) waivers as follows (edited for brevity):

- *An OHCDS must provide at least one service directly (utilizing its own employees) and may contract with other qualified providers to furnish other waiver services. When you use an OHCDS, your provider agreement is with the OHCDS. Since it is the system itself which acts as the Medicaid provider, it is not necessary for each subcontractor of an OHCDS to sign a provider agreement with the Medicaid agency. (However, subcontractors must meet the standards under the waiver to provide waiver services for the OHCDS.) When utilizing an OHCDS to provide waiver services, payment is made directly to the OHCDS and the OHCDS reimburses the subcontractors.*

- The form developed by OLTL would allow AAAs and other provider organizations to continue intermediary billing as an OHCDS and comply with federal requirements.

Pennsylvania Office of Long Term Living (OLTL)

Organized Health Care Delivery System (OHCDS) Provider Enrollment Form

By signing this enrollment form ___ (Agency) is designated as an Organized Health Care Delivery System (OHCDS) provided under 42 CFR § 447.10. As an OHCDS ___ (Agency) has authorization to contract with qualified providers for certain services provided under OLTL waiver programs.

1. The Agency shall comply with all applicable state and federal statutes, regulations, and policies that pertain to participation in the Pennsylvania Medical Assistance Program, including OLTL Waivers.
2. The Agency shall ensure that each waiver participant has a free choice of enrolled Medical Assistance providers for the services the waiver participant is authorized to receive.
3. The Agency shall ensure that each provider it has a contract with meets the qualifications for the service identified in the waiver.
4. The Agency shall accept the waiver payment as payment in full for the service rendered and shall not seek any additional payment from a waiver participant under any circumstances.
5. The Agency shall be responsible for the accuracy of all claims submitted under its Agency number, whether submitted by the Agency or on the Agency's behalf.
6. The Agency shall not bill or receive payment for services that are not authorized in an Individual Service Plan (ISP).
7. The Agency acknowledges that the submission of false or fraudulent claims could result in criminal prosecution and civil and administrative sanctions, including exclusion from participation in Medicare, the Pennsylvania Medical Assistance Program, other State Medicaid programs, and all other Federal and State health care programs.
8. The Agency shall comply with the disclosure requirements specified in federal regulations at 42 CFR Chapter 455, Subpart B (relating to disclosure of information by Providers and fiscal agents).
9. The Agency shall submit claims for waiver services in accordance with instructions issued by the Department.
10. The Agency shall comply with all federal audit requirements, including the Single Audit Act, 31 U.S.C. §§ 7501-7507; the revised Office of Management and Budget (OMB) Circular A-133, Audits of States, Local Government, and Non-Profit Organizations; 45 CFR § 74.26 (relating to non-federal audits); and any other applicable statutes or regulation.

Agency Name: ________

Abbreviation: ___________

Medical Assistance Provider Number: ____________
Address of the Provider shown in number one above:
Street ______________________________
City ______________ State ____________ Zip Code____________

Phone (___)_____________ County__________________

Identify the service(s) provided by your agency staff directly: (Check __ as appropriate)
___Supports Coordination
___Community Transition Services ___Other: _________________

Services subcontracted and billed through the OHCDS agency:
___Environmental Modifications
___Home Delivered Meals
___Personal Emergency Response System
___Transportation (non-medical)
___Specialized Medical Equipment
___Community Transition Services
Other: ___

I certify that the information provided on this Enrollment Form is true and correct to the best of my knowledge.

____________________________ ________________________________
Signature of Authorized Representative Printed Name and Title

Date ____