Background
The credentialing of physicians and other providers with Managed Care Organizations (MCOs) is a challenging process for those offering care to patients with Medical Assistance (MA) health insurance. This is especially problematic for safety-net providers, such as Community Health Centers (CHC), that have a patient base of 50 percent or more MA patients. The current process used by MCOs to credential providers is inefficient and inconsistent which results in administrative delays that interfere with access to care and inhibit payment to the Community Health Center.

Community Health Centers experience lengthy MCO credentialing timeframes and the complexity of each MCO having its own application form, review process and timeline. This is also a duplication of effort as each provider has already submitted this same documentation to the PA Department of Human Services (DHS) to be enrolled as a Medicaid provider eligible to provide care to MA patients subscribed to the MCO coverage plans.

How convoluted is the MCO credentialing system? One example is providers, who are credential by an MCO, must re-apply for approval for a new/additional location even if that “new site” is across the street. This bureaucratic red tape leaves health centers and other safety-net providers with the choice of letting the health professional provide the care without billing or assuming the administrative burden of limiting the provider’s patient schedule only to patients covered by MCOs that have credentialed the provider. This often occurs after an exhausting and costly process of recruiting a provider to work in an underserved community.

Community Health Centers commonly experience delays in excess of the industry standard of 45 days to approve an application. Oftentimes there is little to no communication from the MCO about the status of an application. This overly complicated system combined with a primary care provider shortage creates unnecessary access barriers and financial viability issues.

Policy Considerations
- MCOs should utilize a standard process or application for provider credentialing, such as the Council for Affordable Quality Healthcare (CAQH).
- MCOs should meet a specified timeframe to approve applications if there are no errors or additional information needed and be responsible for communicating promptly if addition information is needed.
- Provisional credentialing for providers is a fair means to allow patients access to care and reimbursement to providers for services without sacrificing quality control or accountability.
- Required retroactive payment to providers upon approval of an application fairly allows the provider to be reimbursed for their services and the MCO to review applications at their own pace.
- A standard communication loop would notify the applicant that an application has been received, when it is under review, notice of any error/correction and most importantly, when an application is actually approved.

Legislative Action
We support legislation that addresses the above policy points as an effective approach to addressing this issue that challenges both access to care and the financial status of Community Health Centers and Rural Health Clinics. Any combination of the above will improve the current system and ensure MCO quality controls without sacrificing access and fair reimbursement to providers.