



Coming Soon
APRIL 2026

Provider Satisfaction Survey

Our **annual provider satisfaction survey** will launch April 2026 and we hope you'll take a moment to share your feedback.

This survey serves as the foundation for key improvement initiatives that we undertake each year, and your feedback is critical to making sure we address the issues that are important to you.

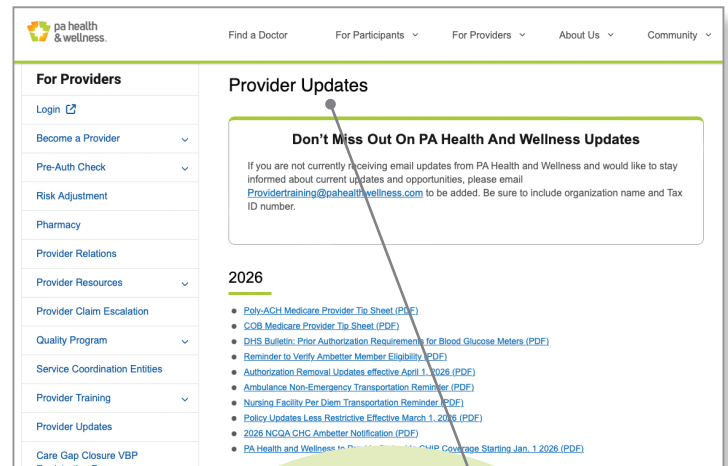
We look forward to learning about how we can continue to improve your experience in doing business with us. Please keep an eye out for our survey in the coming weeks.



Home & Community Based Services (HCBS) Annual Training for Provider Type 59 Available now!

The 2026 HCBS Provider Training is available now! This is an annual training requirement for all Home and Community Based Services (HCBS) Providers contracted with PHW's Community HealthChoices (CHC) Plan. At least one person from each organization (Tax ID#) must complete this training annually. Credit for completion will be given when attestation is received.

- [2026 Home and Community Based Services Provider Annual Training](#)
- [2026 HCBS Training Attestation](#)
- [2026 Annual HCBS Training Handout \(PDF\)](#)



Provider Updates

Please visit

<https://www.pahealthwellness.com/providers/provider-updates.html> regularly to stay up to date on updates from PA Health & Wellness.

If you'd like to be added to our email list to receive updates to your inbox reach out to Providertraining@pahealthwellness.com. Be sure to include organization name and Tax ID number in this request.



Provider Data Management Updates

PA Health and Wellness (PHW) is committed to maintaining accurate and up-to-date provider information for our Participants. Providers are responsible for promptly reporting all demographic and practice updates to PHW. Updates should be submitted directly to the Provider Data mailbox at PHWproviderdata@pahealthwellness.com. Billing address updates **must** include a copy of your W-9.

PA Health and Wellness (PHW) will be performing audits via phone calls to verify the information in the Find-A-Provider directory. To support the integrity of the Find a Provider directory, please ensure the following:

- **Keep Contact Information Up to Date**
Reported office phone numbers must be the numbers participants use to schedule appointments.
- **Timely Status Updates**
Notify PHW promptly of any provider status changes (e.g., leaving the group, retirement).
- **Ensure Credentialing Documents are Submitted Accurately**
 - Groups: When submitting information for initial credentialing and recredentialing, ensure that documents are not expired or will not expire within 60 days of submission
 - Practitioners: CAQH must be attested every 60 days and remain current at the time of Credentialing or recredentialing. Provider specialties need to be listed with CAQH and/or NPPES.

- If the above requirements are not met credentialing may be closed for insufficient information.
- **Panel Updates**
PHW must be advised of any changes to provider panels, such as age or gender restrictions, open or closed panels, or hat code (Primary Care Provider vs. Specialist).
- **Practitioner Enrollments**
New Practitioner Enrollment forms can be found at: <https://www.pahealthwellness.com/providers/become-a-provider/CredentialingForms.html>.
- **OLTL/HCBS Contracted Providers**
To submit changes or updates please utilize the OLTL Change Form found here: <https://www.pahealthwellness.com/providers/become-a-provider/CredentialingForms.html> and include a copy of your W-9.
- **LTSS Addendum Forms**
LTSS Addendum forms, which include full time equivalent counts, can now be found on the website at https://www.pahealthwellness.com/content/dam/centene/Pennsylvania/pdfs/O31826A-PHW-PR_LTSS%20Addendum-Fillable.pdf.

Thank you for your partnership in maintaining accurate provider information and supporting access to care for our Members.



Reminder: Pennsylvania Medicaid Hospice Certification Requirements

Hospice providers participating in Pennsylvania Medicaid must obtain and maintain a valid Certification of Terminal Illness (CTI) and any required prior authorization in accordance with 42 CFR §418.22 and Pennsylvania Medical Assistance policy. The initial CTI and authorization documentation must be completed and retained in the participant's medical record within two (2) calendar days of the hospice election. Providers must complete and document recertification of terminal illness at the start of each subsequent hospice benefit period, including each required 60 day certification period under 42 CFR §418.22(b). Failure to meet certification, recertification, or timeliness requirements may result in noncompliance, including potential claim denial or recoupment.

Please visit <https://www.ecfr.gov/current/title-42> to view the full regulatory language of 42 CFR §418.22.

Thank you for your continued commitment to compliance and quality care.

COE Fidelity Guidelines

The Department issued updated Centers of Excellence (COE) Fidelity Guidelines in August 2024 to ensure the delivery of consistent, evidence-based services for members with opioid use disorder (OUD). These guidelines establish minimum requirements for COE enrollment, assessment completion, care management activities, and discharge practices.

Providers designated as COEs are required to comply with the following program requirements:

- Medication for Opioid Use Disorder (MOUD) is not a condition of participation in COE care management. Members are eligible to receive COE services regardless of MOUD utilization.
- Member engagement is required on a monthly basis, with a minimum of fifteen (15) minutes of documented contact per month.
- Required assessments must be completed within established timeframes, including, but not limited to:
 - Social Determinants of Health (SDOH) screening within seven (7) calendar days
 - ASAM assessment within seventy-two (72) hours
 - BARC-10 assessment within thirty (30) calendar days of enrollment and every six (6) months thereafter
- Members may not be discharged from COE services solely due to positive drug screens or lack of improvement.

COEs are responsible for ensuring that enrollment processes include member consent, eligibility verification, same-day intake assessments, and complete and accurate REDCap documentation, in accordance with Department and program requirements.

PA Health & Wellness remains committed to supporting providers in the delivery of COE services and to improving recovery outcomes for members with OUD.



Critical Incident Refresher

A critical incident is an event that jeopardizes a participant’s health or welfare, as defined in the CHC Agreement and the Critical Incident Management Bulletin.

The Office of Long-Term Living (OLTL) Critical Incident Management Unit monitors provider compliance with critical incident requirements, including reporting, investigations, documentation, and notification timeframes. These requirements are outlined in the OLTL Critical Incident Management Bulletin (Critical-Incident-Management-Bulletin.pdf). Noncompliance may result in corrective action by OLTL.

Beyond ensuring the immediate safety of participants, the critical incident management system provides OLTL with data to evaluate the strengths and gaps within Service Coordination (SC) and provider networks. This data helps identify incident trends, assess agency response effectiveness, and guide mitigation efforts to prevent future incidents.

Critical Incident Reporting Requirements

1. First Section of Incident Report

The MCO, SC, or provider that discovers or becomes aware of a critical incident must submit the First Section of the report to OLTL through the Enterprise Incident Management (EIM) system within 48 hours. If the incident is discovered on a weekend or holiday, the 48-hour timeframe begins at 12:00 a.m. on the next business day.

2. Notification to the Service Coordinator

Providers must notify the participant’s Service Coordinator within 24 hours of discovering or learning of the incident.

- This notification must be clearly documented in the EIM report on the “**Agencies Contacted**” page.
- Notification must not be made through HHAexchange and should occur via phone, email, or another mutually agreed-upon method.

- The MCO or SC must begin the investigation within 24 hours of discovering the incident or being notified by the provider.
- This communication is essential to preventing duplicate case creation in EIM when the SC has already reported the event. It also provides an opportunity to share information and ensure reporting accuracy. Collaboration!

3. Notification to the Participant

Agency staff must inform the participant (and their representative, if requested) that a critical incident report has been filed within 24 hours. Notification must be provided in a cognitively and linguistically accessible format. If the participant’s representative is suspected of involvement, they should not be notified.

These procedures ensure timely reporting and investigation of critical incidents while keeping participants and their representatives appropriately informed.

Bi-Annual Staff Training

PHW’s next required training session will be held on **Wednesday, April 15, 2026, at 10:00 A.M.**

- For more information or to register for this training please visit the Provider Training page of our website, <https://www.pahealthwellness.com/providers/provider-training.html>.
- Recordings of this training are also available on the Provider Training page under the Past Special Topics. Recordings will update a week or so after the live webinar has concluded.

Questions?

Please contact CIReports@PaHealthWellness.com for additional guidance or clarification.

Special Supplemental Benefits for the Chronically Ill (SSBCI)

Special Supplemental Benefits for the Chronically Ill (SSBCI) can be offered to Medicare Advantage (MA) members who have one or more complex chronic conditions, are at high risk for hospitalization or adverse health outcomes and require intensive care coordination. SSBCI aims to improve overall health outcomes for the chronically ill population by addressing social needs beyond traditional medical care such as food, housing, transportation, and gaps in care. The program is designed to support individuals by offering additional services beyond standard Medicare coverage.

Members must qualify for SSBCI benefits

Members must meet all three criteria to qualify:

- The member must require intensive care management.
- The member must be at high risk for unplanned hospitalization.
- The member must have a documented and active diagnosis for a qualifying chronic condition.

To begin the SSBCI manual eligibility process, members must schedule an **in-person office visit or contact** their healthcare provider to request the attestation be completed. If an office visit is required to complete the attestation, the provider will evaluate the member’s health status during the visit and determine if they meet SSBCI criteria.

For more information on these special supplemental benefits, your role as a Provider in this process and access to the attestation please visit PHW’s SSBCI webpage at <https://www.pahealthwellness.com/providers/resources/SSBCI.html>.





Glycemic Status Assessment for Patients With Diabetes (GSD): Best Practices

Why This Matters

Accurate and complete A1c documentation supports appropriate diabetes care and ensures results can be captured for quality reporting under the Glycemic Status Assessment (GSD) measure.

Acceptable Documentation:

- A1c laboratory reports
- A1c results documented in a progress note with a specific test date

Non Acceptable Documentation:

- Use of nonspecific terms such as “recent” or “last”
- Documentation of ranges or thresholds without an exact value

Important Reminder: Providers must document all HbA1c and GMI values, including the exact numeric result and date of testing, for patients with diabetes.

Quick Tip: When documenting HbA1c or GMI in your clinical note, always include both the numeric value and the test date to ensure the result can be used for quality reporting.

Description	Codes*
HbA1c Lab Test	CPT: 83036, 83037
HbA1c Level Less Than 7	CPT II: 3044F
HbA1c Level Greater Than/Equal to 7 and Less Than 8	CPT II: 3051F
HbA1c Level Greater Than/Equal to 8 and Less Than/Equal to 9	CPT II: 3052F
HbA1c Greater Than 9.0	CPT II: 3046F

*Codes subject to change.

Note: Do **not** include a modifier when using CPT II codes



Meeting Appointment Accessibility Standards

Are your patients able to obtain the services when they are needed?

Availability is key to participant care and treatment outcomes. PA Health & Wellness does monitor compliance with these standards quarterly and uses the results of monitoring to ensure adequate appointment availability and reduce the unnecessary use of emergency rooms. Please review the appointment availability standards in the Provider Manual Here:

1. CHC & Medicare: <https://www.pahealthwellness.com/providers/resources/forms-resources.html>
2. Marketplace: <https://www.ambetterhealth.com/en/pa/provider-resources/manuals-and-forms/>

24 Hour Access

PA Health & Wellness PCPs and Specialty Physicians are required to maintain sufficient access to facilities and personnel to provide covered physician services and shall ensure that such services are accessible to Participants as needed 24 hours a day, 365 days a year as follows:

- A Provider’s office phone must be answered during normal business hours
- During after-hours, a Provider must have arrangements for one of the following:
 - Access to a covering physician
 - An answering service
 - Triage service
 - A voice message that provides a second phone number that is answered
 - Any recorded message must be provided in English and Spanish, if the Provider’s practice includes a high population of Spanish speaking Participants



Components of an Appointment Agenda

The layout of the printable Appointment Agenda has been updated, based on feedback received on the Workflow Summary document

The Appointment Agenda will feature a table-style format offering a more streamlined display of available insights

Checkbox responses have been expanded to four columns

Agenda, Patient & Provider Details

Insight Information

Signature

Any person in the practice who supports the completion of the Agenda at the point of care may sign and submit the completed Agenda

QR Code

Providers may scan the QR Code or click on the URL for additional resources, Provider Survey and a Provider Facing FAQ document

Barcode

Agendas may show “Not Risk Eligible” or “Not Comp Eligible” under the barcode in the upper right-hand corner for those Agendas not eligible for compensation

There are four available responses for each insight listed on the Appointment Agenda:

Active & Documented

• Condition remains active, or insight is clinically relevant and should be documented on a claim using appropriate coding standards, when applicable

Resolved/Not Present

• The condition is resolved, inactive, or the insight is not relevant to the patient’s current clinical status

Addressed Previously

• The insight was resolved in a prior visit (during current year) and does not require further action

Patient Referred

• The insight requires evaluation by a specialist or another provider

New Fax Number

	Risk Adjustment	High Complexity	Quality	Clinical	DOH
Medicare	✓	✓	✓	✓	X
Marketplace	✓	✓	✓	✓	X

2026 Risk Adjustment Incentive Payout

Threshold % of Agendas Completed	Bonus Paid Per Paper Agenda Submission	Bonus Paid per Electronic Agenda Submission
<50%	\$50	\$100
>=50% TO 80%	\$100	\$200
>=80%	\$150	\$300

2026 Comprehensive Insight Incentive Payout

Medicare \$150

Marketplace \$100

NOTE:

- The CoC+ program is in addition to our health plan's other provider compensation programs and does not replace them.
- See below tables for compensation amount.
- All Appointment Agendas must be submitted by January 31, 2027 to qualify (eligible members must have a DOS by 12/31/2026).

Contact Information

- Please reach out to PHW_RiskAdjustment@PaHealthWellness.com for any questions.
- Your PHW Risk Adjustment Specialist will manage the bonus calculation, reconciliation, and payment processing.
- You may also email or fax paper agendas to
 - Agenda@centene.com / Fax: (844)-608-0465

Clinical Documentation Improvement (CDI) Q1 2026 Webinars

Learn more about: Risk Adjustment methodologies, accurate and compliant documentation practices, and coding strategies aligned with regulatory standards. Webinars are open to providers, non-physician practitioners, coders, billers, and administrative staff involved in clinical documentation and coding.

Advance registration is required. Please scan the QR Code below to review the 2026 CDI Webinar Schedule.

Topics include

- Specialty-Specific Risk Adjustment Best Practices
- From Errors to Excellence: Compliance in Risk Adjustment
- Enhancing Diabetes Outcomes through Accurate HCC Coding
- Decoding HCC's: Avoiding the Most Missed and Misunderstood
- How to Select the Proper ICD-10-CM Code in Just 5 Steps
- Risk Adjustment Essentials Across Multiple Lines of Business
- Pediatric Risk Adjustment Coding: Best Practices for Precision and Compliance
- HCC Coding of Neoplasms Made Simple
- The Three C's of Risk Adjustment: Code, Capture and Compliance – Best Practices
- Medicare Risk Adjustment: A Practical Guide
- Avoiding Documentation Errors in Risk Adjustment Chart Reviews
- Risk Adjustment Integrity: Strengthening Coding and Documentation Accuracy



NEW On-demand Risk Adjustment Training for Providers available 24/7!



New Program Offering Free Internet Access for HCBS Members

Staying connected to care, essential resources, and loved ones is especially important for individuals receiving Home and Community Based Services (HCBS). To help address barriers to connectivity, a new program is now available that offers free internet service to eligible HCBS members.

This program is intended to support participants who may face challenges living independently at home by improving access to reliable internet service. By helping bridge the digital divide members can stay connected to their care teams, accessing online resources, and maintain communication with family and other supports.

By helping reduce digital access barriers, this initiative supports greater independence and engagement in the services and supports that help our members thrive at home.

Additional information about the free internet program is available at:

<https://www.pahealthwellness.com/members/ltss/member-resources/internet-essentials-program.html>.



Caregiver & Participant LGBTQ+ Resources

The resources below are available to help you support inclusive, affirming care for LGBTQ+ participants and their caregivers and may be shared to promote access to appropriate health, wellness, and community supports.

Pennsylvania Based Organizations:

- [Persad Center](#) – 2 locations in Western PA
- [Allies for Health + Wellbeing](#) – Pittsburgh
- [LGBT Elder Initiative \(LGBTEI\)](#) – Philadelphia
- [William Way LGBT Community Center](#) - Philadelphia
- [LGBT Center of Central PA's Aging with Pride program](#) - Harrisburg
- [NEPA Pride Coalition](#) – NE Pennsylvania
- [NW Pride Alliance](#) – NW Pennsylvania

Many more resources can be found by visiting the [Pennsylvania LGBTQ Organization Directory](#).

National Organizations:

- [National LGBTQ+ Health Education Center](#)
- [Human Rights Campaign](#)
- [National Resource Center on LGBT Aging](#)

Hotlines:

- [Trevor Project Lifeline](#)
- [Trans Lifeline](#)
- [SAGE LGBT National Senior Hotline](#)



Fraud, Waste and Abuse

There are several things, as a Provider, that can be done to reduce and mitigate the risk of False Claims Act liability. Making sure there is an understanding of the rules that relate to the services and good being billed. The information included in claims should always be as accurate and complete as possible. It is also important to ensure there is awareness of any potential billing problems. Below are resources related to Fraud, Waste, and Abuse:

FALSE CLAIMS ACT:

The False Claims Act establishes liability when any person or entity improperly receives or avoids payment to the Federal government. The Act prohibits:

- Knowingly presenting, or causing to be presented a false claim for payment or approval
- Knowingly making, using, or causing to be made or used, a false record or statement material to a false or fraudulent claim
- Conspiring to commit any violation of the False Claims Act
- Falsely certifying the type or amount of property to be used by the Government
- Certifying receipt of property on a document without completely knowing that the information is true
- Knowingly buying Government property from an unauthorized officer of the Government
- Knowingly making, using, or causing to be made or used a false record to avoid or decrease an obligation to pay or transmit property to the Government.

For more information regarding the False Claims act, please visit: <https://downloads.cms.gov/cmsgov/archived-downloads/smdl/downloads/smd032207att2.pdf>

STARK LAW:

The Physician Self-Referral Law, commonly referred to as the Stark law, prohibits physicians from referring patients to receive "designated health services" payable by Medicare or Medicaid from entities with which the physician or an immediate family member has a financial relationship unless an exception applies.

For more information regarding the Stark Law, please visit: <https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/>

ANTI-KICKBACK STATUTE:

The Anti-Kickback Statute prohibits offering, paying, soliciting, or receiving remuneration to induce referrals of items or services covered by Medicare, Medicaid, and other federally-funded programs.

For more information regarding the Stark Law, please visit: <https://oig.hhs.gov/compliance/physician-education/fraud-abuse-laws/>



Reporting Fraud, Waste and Abuse

If you suspect fraud, waste, or abuse in the healthcare system, you must report it to PA Health & Wellness and we'll investigate. Your actions may help to improve the healthcare system and reduce costs for our participants, customers, and business partners.

To report suspected fraud, waste, or abuse, you can contact PA Health & Wellness in one of these ways:

- PA Health & Wellness anonymous and confidential hotline at **1-866-685-8664**
- Pennsylvania Office of Inspector General at **1-855-FRAUD-PA (1-855-372-8372)**
- Pennsylvania Bureau of Program Integrity at **1-866-379-8477**
- Pennsylvania Department of Human Services **1-844-DHS-TIPS (1-844-347-8477)**
- Mail: Office of Inspector General, 555 Walnut Street, 8th Floor, Harrisburg, PA 17101
- Mail: Department of Human Services, Office of Administration, Bureau of Program Integrity, P.O. Box 2675, Harrisburg, PA 17105-2675

You may remain anonymous if you prefer. All information received or discovered by the Special Investigations Unit (SIU) will be treated as confidential, and the results of investigations will be discussed only with persons having a legitimate reason to receive the information (e.g., state and federal authorities, corporate law department, market medical directors or senior management).

Medical Necessity Appeal

Providers or Participants may request an appeal related to a medical necessity decision made during the authorization or concurrent review process orally or in writing:

Mail to:

PA Health & Wellness
Attn: Complaints and Grievances Unit
1700 Bent Creek Blvd, Suite 200
Mechanicsburg, PA 17055

Email:

PHWComplaintsandGrievances@PAHealthWellness.com

Phone: 844-626-6813 **TTY:** 711

NOTE: PHW will not accept data stored on external storage devices such as USB devices, CD-R/W, DVD-R/W, or flash media.

We can't wait to meet you!

Provider Relations is your primary contact for PA Health & Wellness, including Wellcare and Ambetter.

We're here to be your partner. My primary focus is to drive resolution, provider performance, ongoing education and more!

Feel free to reach out with any questions, concerns, or even just to say, "hello!".



Get to know our Provider Relations team even better by visiting <https://www.pahealthwellness.com/providers/ProviderRelations.html>



Get connected with our Provider Relations Team at PHWProviderRelations@PAHealthWellness.com

Thank you for continuing to provide our Members with high quality and compassionate care. We're looking forward to our continued partnership.

Self-Audit and Overpayment Refund Submission

Provider Self-Audit findings may also be disclosed to PA Health & Wellness using the online webform, located here: <https://www.pahealthwellness.com/providers/resources/provider-self-audit.html>.

When needing to submit a refund check for claims overpayments checks should be made payable to PA Health & Wellness. The submission should also include a list of the claims that were overpaid.

Mail to:

PA Health & Wellness
P.O. Box 3765
Carol Stream, IL 60132-3765



Provider Newsletter



1700 Bent Creek Blvd, Suite 200, Mechanicsburg, PA 17050

