3 Health Partners Provider Manual

Member Eligibility/Enrollment: Health Partners & KidzPartners

Purpose: This chapter provides an overview of enrollment and eligibility guidelines used by Health Partners' lines of business.

Topics:

- Health Partners enrollment and eligibility guidelines
- KidzPartners enrollment and eligibility guidelines

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Overview

This chapter provides an overview of the various guidelines and tools available to Health Partners and KidzPartners providers in determining the eligibility and enrollment status of patients covered by a Health Partners line of business.

- Free CHIP:

  Provides free health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance.

- Low-Cost CHIP and Full-Cost CHIP:

  Provides low-cost health insurance for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. Families must pay a monthly premium for each child and there are copayments for certain services.

- Medical Assistance:

  Provides free health insurance for children, teens, and adults who qualify.

Enrollment in CHIP and Medical Assistance is based on household size and income.

What is HealthChoices?

HealthChoices is a mandatory state program that requires most Medical Assistance recipients in Bucks, Chester, Delaware, Montgomery and Philadelphia counties to select a health plan and a primary care provider (PCP) for their health care. Providers of health care in the HealthChoices program must be participating with the Pennsylvania Department of Public Welfare (DPW) and have a Medical Assistance identification number.

Enrollment

DPW contracts with an independent vendor, currently MAXIMUS, to provide enrollment assistance services. The vendor is referred to as the Enrollment Assistance Contractor (EAC). Enrollment assistance services include educating and assisting newly-enrolled Medical Assistance recipients in selecting and changing their PH-MCO, referral systems, benefits, and selecting a Primary Care Physician (PCP). The EAC operates a HealthChoices Hotline to intake Medical Assistance recipient calls and to record their change in PH-MCO and PCP selection. Records of these changes are forwarded to DPW and Health Partners via a weekly electronic file. Once an MA recipient has affirmed with Health Partners, he/she may make future changes to his/her PCP directly with Health Partners.

Health Partners members are not required to select a dentist. When dental care is needed, members may self-refer to any primary care dental provider in the Health Partners dental network.

Newborns are eligible for Health Partners' benefits if the mother is enrolled at the time of the child's birth. The parent or guardian must contact MAXIMUS or the Member Relations department to select a PCP for the infant.

The Health Partners Member ID Card

All Health Partners' Medical Assistance members are issued an identification card. However, possession of the Health Partners card does not ensure current member eligibility for Health Partners benefits. And, of course, patients who do not have a Health Partners ID card with them may still be active members. For these reasons, it's important to check eligibility.

Figure 3.1: *Health Partners ID Card*

Verification may be obtained by:

- logging on to HP Connect at *http://www.healthpart.com* and using your protected password;
- calling the Provider Services Helpline and providing the patient's name and birth date. Monday through Friday, 8:30 a.m. to 5:00 p.m. For more information, see Table 1: Service Department Contact Information on page 1-14.
- accessing the Pennsylvania State Eligibility Verification System (EVS) at **1-800-766-5387**; and
- submitting an Eligibility Inquiry (Transaction ASC X12N-270) through Emdeon.

Health Partners members also receive and should always carry a DPW Pennsylvania Access card, which can be used to qualify them for transportation and related services to which they may be entitled. The card does not, however, provide evidence of their eligibility with Health Partners.

Third Party Liability

Health Partners uses DPW's Third Party Liability Resource information as a base for other insurance coverage. If there is evidence of probable other insurance found through secondary claim submission, or contact from other carriers or the member, this information will be recorded on the Health Partners' processing systems. Investigation of other possible insurance will be required prior to payment, except when pre-natal or preventive pediatric care services are involved (not including hospital delivery claims).

Third party liability insurance, employer group insurance, Workers Compensation, and Medicare precede Medicaid as primary payers. Health Partners is the payer of last resort. Claims should be submitted to any other insurance carrier including Medicare prior to submitting to Health Partners. Health Partners will coordinate benefits to pay up to the contracted rate or the Medical Assistance rate. If a primary insurer has paid more than Health Partners would have paid if its coverage were primary, no additional reimbursement will be made.

Members may not realize or remember that their dependent children may have coverage under a working spouse's employer group plan or absent parent required (court-ordered) coverage.

Providers should ask for the most current insurance information at every encounter.

Third party liability also relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident, and the liability insurance is known and established, the provider should first bill the member's liability carrier prior to submitting a claim to Health Partners. Under HealthChoices, Health Partners must notify the Department of Public Welfare (DPW) if we provide reimbursement for the care of a member's auto-related or other accident-related injuries. DPW retains the right of subrogation. Under HealthChoices contract, Health Partners is required to notify DPW of any personal liability lawsuits for purposes of subrogation.

Verification of Eligibility

Each participating PCP site is issued an updated membership panel monthly. Members whose names appear on these lists should be considered active for the period of time indicated. If the member you are treating is not on your current panel, you may not be receiving payment for that member from Health Partners. You should also check eligibility using one of the means below before rendering service.

Eligibility can also be verified by logging on to HP Connect at *http://www.healthpart.com* or accessing the Pennsylvania State Eligibility Verification System (EVS) at **1-800-766-5387**. HMO eligibility status provided by EVS is updated daily. Providers may also submit an Eligibility Inquiry (Transaction ASC X12N-270) through Emdeon.

In addition, providers may verify member eligibility by calling the Enrollment Eligibility department Monday through Friday, 8:30 a.m. to 5:00 p.m. or the Provider Services Helpline, 24 hours a day/seven days a week. For more information, see Table 1: Service Department Contact Information on page 1-14.

Note: *Providers Cannot Refuse to See Members During the Eligibility Period.*

The period between the approval of an individual's Medical Assistance benefits and the effective date of coverage with the PH-MCO is called the "Medical Assistance Fee-for-Service (FFS) eligibility window." As a participating Medical Assistance provider, you are prohibited from denying services to a Medical Assistance recipient during this period. An individual's eligibility must be verified via the Eligibility Verification System (EVS) prior to rendering services. Services rendered during the Medical Assistance FFS eligibility window are to be billed directly to the Department of Public Welfare.

Member Transfers

Both members and providers may find it necessary to modify the doctor-patient relationship that currently exists between a Health Partners member and his or her PCP. This section provides an overview of the two types of transfers available to both members and participating physicians.

Voluntary Transfers

Members may elect to change their PCP by calling Health Partners' Member Relations department and requesting a transfer. Members requesting a change will be issued new membership cards within seven to ten days of the effective transfer date. When care is required prior to the issuance of the new membership panel, we will notify you by phone. As a Health Partners provider, you are expected to facilitate the transfer of records when members choose a new provider.

Health Partners' Member Relations department will reassign any member requesting a new medical provider for both routine and exceptional circumstances.

Routine transfers are done at the member's discretion and will have a future effective date (routinely the first of the upcoming month) with the newly-selected Primary Care site.

Exceptional transfers requiring an immediate transfer and effective date will be accommodated when there are issues of continuity, when a member has travel difficulties, or when a member is no longer comfortable with a PCP.

Involuntary Transfers

Providers have the right to request that a member select another PCP within 30 days, under the following conditions:

- the member demonstrates a pattern of broken appointments without adequate notice; and/or
- the member and the provider have failed to establish an adequate patient/provider relationship.

To implement an involuntary transfer for one of the reasons noted above, you must send a certified letter to the member and a copy to Health Partners (Attn: Member Services department). The letter should indicate the reason for requesting an involuntary transfer. Please note that in accordance with DPW regulations and your Health Partners agreement, severity of illness or medical diagnosis are not acceptable reasons for a transfer. In fact, Health Partners' provider contracts prohibit discrimination on the basis of health status. If the request is approved, Health Partners will contact the member to assist in selecting a new PCP. The transfer to another PCP will occur within 30 days during which time the transferring provider must be available for urgent care. The transferring provider must also facilitate the transfer of records to the new provider.

Disenrollment from Health Partners

Disenrollment from Health Partners coverage may be done on a voluntary or involuntary basis. The following section provides an overview of disenrollment options.

Voluntary Disenrollment

Members may elect to disenroll from Health Partners at any time by calling MAXIMUS's hotline at **1-800-440-3989** and speaking to an enrollment specialist to initiate the disenrollment process. Members maintain coverage through Health Partners and their PCP until the effective date of the disenrollment and membership is established in the HealthChoices MCO of the recipient's choice.

Involuntary Disenrollment

The Department of Public Welfare may choose to disenroll members under the following circumstances:

- If the member loses Medical Assistance eligibility.
- If there is Pennsylvania Department of Aging (PDA) waiver enrollment beyond 30 consecutive days.
- As the result of a formal grievance or Departmental hearing decision of an appeal (whether filed by the member or the plan).
- If the member becomes incarcerated, the disenrollment becomes effective the day before the date he/she enters the institution.
- If the member becomes incarcerated in a Corrrectional Institution or Youth Development Center, disenrollment becomes effective the day before the date he/she enters the facility or inistitution.
- Members in Juvenile Detention Centers may be disenrolled only if admitted for more than 35 consecutive days.
- If the member is admitted to a public inpatient, psychiatric facility.
- In the event of the member's death.
- If the member is over 21 and becomes Medicare Part A and/or B and D eligible.
- If the member resides outside the Health Partners service area and requires ongoing services.
- If the member is in a nursing facility, Health Partners will notify the Department of Public Welfare to initiate disenrollment for a member if the stay in the facility exceeds 30 days. The Medical Assistance Long Term Care Handbook contains fee-for-service instructions necessary to submit invoices for dates of service in excess of 30 days. Health Partners is not responsible if the member is admitted to a nursing facility out of state. In these cases the member is disenrolled the day before the admission date.

Recipient Restriction Program

Health Partners participates in the Pennsylvania Department of Public Welfare Recipient Restriction Program. The program calls for Health Partners to monitor and identify Medical Assistance recipients who improperly or excessively utilize Medicaid services. In cooperation with the Department of Public Welfare's Bureau of Program Integrity, Health Partners will refer members with suspected patterns of inappropriate utilization to the Recipient Restriction Program. These members may be restricted to a certain physician and/or pharmacy, or other provider in this event. Providers requesting information on this program may contact the Health Partners' Pharmacy department at **215-991-4300**.

Loss of Medical Assistance Eligibility

Members may lose eligibility for Medical Assistance for various reasons at any time during the month. Based on determination communicated to the plan by the Department of Public Welfare regarding members coverage Health Partners Enrollment Department will update the member eligibility until the end of the month according to the notification received from DPW. Except under circumstances where the date communicated by DPW should be the expiration date of the members coverage (i.e. member deceased etc...).

Membership Panel

Every month PCPs will receive a Member Panel Report providing an up-to-date listing of the members assigned to each PCP in their practice. These lists should not be used to check eligibility. For more information, see Verification of Eligibility on page 3-7.

Member Status Report

PCPs will also receive a monthly Member Status Report. This report is coded to show encounter exams and periodic exams due, and can be a helpful tool for member outreach and tracking of this information.

Note: *This report should not be used to verify eligibility.*

What is CHIP?

House Bill 20 (HB 20), better known as the Children's Health Insurance Act, was signed into law in December, 1992. HB 20 created the Children's Health Insurance Program (CHIP), designed to provide insurance coverage to children whose families earn too much income to qualify for Medical Assistance, but who could not afford to purchase private insurance.

Pennsylvania's CHIP program would later be used as the model for the federal government's SCHIP program. Legislation for the federal CHIP program was signed into law in August 1997 by former President Bill Clinton.

Recently, Governor Edward G. Rendell's Cover All Kids initiative has expanded CHIP. Now, all uninsured children and teens up to age 19 in the Commonwealth who are not eligible for Medical Assistance have access to affordable, comprehensive healthcare coverage.

Enrollment

CHIP is administered by private health insurance companies that are licensed and regulated by the Pennsylvania Insurance Department. Health Partners contracts with the Commonwealth to offer CHIP, and provides coverage to eligible children in Bucks, Chester, Delaware, Montgomery and Philadelphia counties through its KidzPartners program.

The KidzPartners Member ID Card

All KidzPartners' (CHIP) members are issued an identification card. However, possession of the KidzPartners card does not ensure current member eligibility for KidzPartners benefits. And of course, patients who do not have a KidzPartners ID card with them may still be active members.

DOEREMIFASOLATIDO, MARY Q
3999999999
DOB: 99/99/9999

PCP: DR. JOHN SMITH
999-999-9999
PROV #: 9999999999

PCP $XX SPEC $XX ER $XX RX $XX/$XX

RxBIN: 600428 RxPCN: 02530000

Figure 3.2: *KidzPartners ID card*

For these reasons, it's important to check eligibility. Verification may be obtained by:

- checking the most recent PCP membership panel;
- logging on to HP Connect at *http://www.healthpart.com* and using your protected password;

- calling the Provider Services Helpline or Member Eligibility Helpline and providing the patient's name and birth date (For more information, see Table 1: Service Department Contact Information on page 1-14.);
- submitting an Eligibility Inquiry (Transaction ASC X12N-270) through Emdeon.

Third Party Liability

If there is evidence of probable other insurance found through secondary claim submission, or contact from other carriers or the member, this information will be recorded on the Health Partners' processing systems. Health Partners will contact the primary insurance company to validate the dates of coverage. If a child has obtained other health insurance they are not eligible for CHIP coverage.

Providers should ask for the most current insurance information at every encounter.

Third party liability also relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident and liability insurance is known and established, the provider should first bill the member's liability carrier prior to submitting a claim to KidzPartners. If the other insurance does not initially pay, KidzPartners is obligated to pay and recover monies from the other insurer.

Third party liability also includes personal lawsuits brought by a member against a third party. Providers should bill all available medical insurers for any services, even if a member has or intends to bring suit.

Verification of Eligibility

Each participating PCP site is issued an updated membership panel monthly. Members whose names appear on these lists should be considered active for the period of time indicated. You should check the most current panel of eligible members before rendering service.

Note: *This report should not be used to verify eligibility.*

Eligibility can be verified by logging on to HP Connect at http://*www.healthpart.com* or by submitting an Eligibility Inquiry (Transaction ASC X12N-270) through Emdeon.

KidzPartners offers a direct phone number to verify member eligibility (available Monday through Friday, 8:30 a.m. to 5:00 p.m). Providers can also call the Provider Services Helpline, 24 hours a day/seven days a week. For more information, see Table 1: Service Department Contact Information on page 1-14.

Member Transfers

Both members and providers may find it necessary to modify the doctor-patient relationship that currently exists between a KidzPartners member and their provider. This section provides an overview of the two types of transfers available to both members and participating physicians.

Voluntary Transfers

Members may elect to change their PCP by calling KidzPartners Member Relations and requesting a transfer. Members requesting a change will be issued new membership cards within seven to ten days of the effective transfer date. When care is required prior to the issuance of the new membership panel, we will notify you by

phone. As a KidzPartners provider, you are expected to facilitate the transfer of records when members choose a new provider.

KidzPartners Member Relations will reassign any member requesting a new medical provider for both routine and exceptional circumstances.

Routine transfers are done at the member's discretion and will have a future effective date (routinely the first of the upcoming month) with the newly selected Primary Care site.

Exceptional transfers requiring an immediate transfer and effective date will be accommodated when there are issues of continuity, when a member has travel difficulties, or when a member is no longer comfortable with a PCP.

Members may elect to change their specialist by notifying their PCP and requesting a referral to a new specialist.

Involuntary Transfers

Providers have the right to request that a member select another provider within 30 days, under the following conditions:

- the member demonstrates a pattern of broken appointments without adequate notice; and/or
- the member and the provider have failed to establish an adequate patient/provider relationship.

To implement an involuntary transfer for one of the reasons noted above, you must send a certified letter to the member and a copy to KidzPartners (Attn: Member Relations department). The letter should indicate the reason for requesting an involuntary transfer. Please note that in accordance with your KidzPartners agreement, severity of illness or medical diagnosis are not acceptable reasons for a transfer. In fact, Health Partners' provider contracts prohibit discrimination on the basis of health status. KidzPartners will contact the member to assist in selecting a new PCP. The transfer to another PCP will occur within 30 days during which time the transferring provider must be available for urgent care. The transferring provider must also facilitate the transfer of records to the new provider.

Disenrollment from KidzPartners

Disenrollment from KidzPartners coverage may be done on a voluntary or involuntary basis. The following section provides an overview of disenrollment options.

Voluntary Disenrollment

Members may elect to disenroll from KidzPartners at any time by calling KidzPartners Member Relations department (see Table 1: Service Department Contact Information on page 1-14.). Members maintain coverage through KidzPartners and their PCP until the effective date of the disenrollment and membership is established in the CHIP HMO of the subscriber's choice.

Circumstances Requiring Involuntary Disenrollment

Health Partners is required to disenroll members from the CHIP program under the following circumstances:

- If the member moves out of the state.

- If the child becomes 19 years of age by the end of the current month.
- If private health insurance is obtained or the child is enrolled in the Medical Assistance program.
- If the member becomes an inmate of a public institution for mental diseases.
- In the event of a member's death.

Membership Panel

Every month PCPs will receive a Member Panel Report providing an up-to-date listing of the members assigned to each PCP in their practice. This list should not be used to check eligibility. You should also verify eligibility by logging on to HP Connect at *http://www.healthpart.com*, or by submitting an Eligibility Inquiry (Transaction ASC X12N-270) through Emdeon.