Training Requirement

- The Pennsylvania Department of Human Services (DHS) requires Managed Care Organizations (MCOs) to ensure their providers attend at least one MCO-sponsored training during the course of the year. By attending this session, you fulfill that requirement.
- Please complete the attestation provided with your registration or located in the link we will send at the end of the webinar.
- Additional training is required for providers who provide service to Health Partners Plans Medicare members.

Medicare Providers’ FDR Requirements | Health Partners Plans
hpplans.com/fdr-requirements
Agenda

- Introduction to HPP
- Practice Changes
- Lines of Business
- Community HealthChoices
- Lab and Other Benefit Carriers
- Online Tools
- Member Identification Cards
- Provider Manual
- Referral Changes
- Key Departments and Services
- Emergency Department Use Information
- Provider Practice Information and HPP Programs
- Encounter Data
- Access, Appointment Standards and Telephone Availability
- Maternity Services
- Identification of Potential or Actual Abuse
Agenda

- Information on Reportable Conditions
- Infection Control
- Cultural Competency
- Special Needs
- Special HIV/AIDS Services
- Home Care and Durable Medical Equipment
- False Claims Act/FWA
- Member Rights and Responsibilities
- Recipient Restriction Program
- Complaints and Grievances/DHS Fair Hearings
- Balance Billing/Dual Eligible/COB
- Plan Contacts and Resources
- Attestation
Introduction

Health Partners Plans (HPP) was founded over 30 years ago by four local teaching hospitals. Today, HPP is one of only a few hospital-owned health maintenance organizations. Our mission is to help residents of Southeastern and Central Pennsylvania lead healthier lives through innovative health care services that improve access to high-quality care.
Key Facts

• We are nationally recognized for our innovative approach to health care and have a proven track record in creating life-changing programs. **We can help you change lives, too.**

• We serve a diverse range of members throughout Southeastern and Central Pennsylvania.

• We were the first plan in the nation to receive the National Committee for Quality Assurance’s Multicultural Health Care Distinction. We have now received the honor five times because of our outstanding outreach and services that help improve health outcomes in diverse communities.
Practice Changes

- The Network Management department must be immediately notified in writing when any of the following occurs:
  - Additions/deletions of providers
  - Change in payee information
  - Change in hours of operation
  - Provider practice name change
  - Change in practice ownership
  - Telephone number change
  - Site relocation
  - Change in patient age restrictions
  - Tax ID change (must be accompanied by W9)

- Please note: Initial credentialing applications, such as a PDCF form, should be submitted to Credentialing@hpplans.com.

- For Provider data changes, link letter request or terminations, please send these requests to Datavalidation@hpplans.com.
Lines of Business

Health Partners (Medicaid)
- Provides free health coverage for children, teens and adults who qualify. Members are eligible for all benefits covered under the DHS Medical Assistance Program.

KidzPartners (Children’s Health Insurance Program or CHIP)
- Provides health coverage for uninsured children and teens up to age 19 who qualify and are not eligible for Medical Assistance. As part of the new law in 2015, the state administration of CHIP moved from the Pennsylvania Insurance Department (PID) to the Department of Human Services (DHS).

Health Partners Medicare (Medicare Advantage)
- Provides health coverage through three Medicare Advantage (Part C) plans. Members are eligible for all benefits covered under the Centers for Medicare & Medicaid Services (CMS).
Community HealthChoices

Community HealthChoices (CHC) is Pennsylvania’s new mandatory Medicaid Managed Care program that was implemented in Southeastern PA on January 1, 2019.

CHC is a mandatory program for people who are age 21 or older and qualify for program:
- Individuals who have both Medicare and Medicaid
- Individuals who meet Medicaid LTSS (waiver) level of care because they meet nursing facility level of care

CHC plans are effective in the southeast region (Bucks, Chester, Delaware, Montgomery and Philadelphia counties) on January 1, 2019.
Community HealthChoices

- There are three CHC plans:
  - PA Health & Wellness (Centene)
  - AmeriHealth Caritas (Keystone)
  - UPMC

- Members eligible for CHC were notified by the state that they must enroll with a CHC plan. PA auto-enrolled members into one of the three plans if they did not choose a plan.
Community HealthChoices


• Coordination With Medicare at: http://www.healthchoices.pa.gov/cs/groups/webcontent/documents/document/c_269698.pdf


Laboratory and Other Benefit Carriers
Medicaid, Medicare, CHIP

Laboratory
- Quest Diagnostics

Dental Carrier
- Avesis
  1-800-952-6674

Vision Carrier
- Davis
  1-800-260-2849

Note: These numbers should not be given to members.
Behavioral Health Resources

Behavioral Health

- **Health Partners (Medicaid)**
  - **Philadelphia County**: Community Behavioral Health (1-888-545-2600)
  - **Bucks County**: Magellan Behavioral Health (1-877-769-9784)
  - **Chester County**: Community Care Behavioral Health (1-866-622-4228)
  - **Delaware County**: Magellan Behavioral Health (1-888-207-2911)
  - **Montgomery County**: Magellan Behavioral Health (1-877-769-9782)

- **KidzPartners (CHIP)**
  - Magellan Behavioral Health (1-800-424-3702)

- **Health Partners Medicare**
  - Magellan Behavioral Health (1-800-424-3706)
Online Tools

- HP Connect
- NaviNet
- HPP University
  - Training and Education
- Online directory
- Provider Manual
- Online formulary
- Clinical information
- Plan Information
- Provider newsletter

hpplans.com/providers
Provider Portals

- Our provider portals, HP Connect and NaviNet, offer convenient and secure access to important information 24 hours a day.
- While we currently offer two portals, each portal provides unique functionality that is important to your office.
- The chart on the next page will show current HP Connect and NaviNet features.

Contact your office’s current administrator to register, or click the link below:

hpplans.com/providers/portals
## Provider Portals

<table>
<thead>
<tr>
<th>Features</th>
<th>NaviNet</th>
<th>HP Connect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member eligibility</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Member benefits</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Claims status</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Request claims reconsiderations</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Request Authorizations</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Medicare Referrals</td>
<td></td>
<td>Discontinued</td>
</tr>
<tr>
<td>Patient roster reports</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Care Gap Reports</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Chronic Care Management Program (CCMP) Diagnosis Documentation</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Other practice level reports</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>
NaviNet

- You can access these documents by clicking on the Practice Documents option under the Workflow menu.
- If you do not have access to the Practice Documents transactions, please speak with your NaviNet Security Officer.
- If you are not registered with NaviNet, visit www.navinet.net to register for a new account and click on “Providers: Sign up for NaviNet” in the upper right corner.

Call our Provider Services Helpline at 1-888-991-9023 if you have any questions or need more information.
Identification Cards 2020

Health Partners
(Medicaid)
(9-digit ID number)

KidzPartners
(CHIP)
(10-digit ID number)
Health Partners Medicare Prime (HMO-POS)

This is an enhanced plan that offers more benefits than Original Medicare, including prescription drug coverage.
Health Partners Medicare Special (HMO SNP)

This is designed especially for people with Medicare and full Medicaid coverage and provides extra benefits not offered by Medicare or Medicaid.
Health Partners Medicare Simple (HMO-POS)

This offers basic medical and prescription drug coverage with no monthly premium.
Provider Manual

- Reflects current policies and procedures for all lines of business.

- **Most recent updates:**
  - Benefits section
  - Chapter on coverage requirements for Limited English Proficiency (LEP) and nondiscrimination language
  - Stand-alone section on member rights & responsibilities
  - Details on *Healthier You!* — our care management program.

- Find the manual online at [hpplans.com/providermanual](http://hpplans.com/providermanual).
Specialist Referrals

- Specialist referrals are **not** required for Health Partners lines of business. Our members are permitted to “self-refer” for specialist care.

- It is extremely important for specialists to continue to keep a patient’s assigned PCP informed of all care they render to the patient.

- **No Referrals in 2020**
Encounter Data

Member Encounters

- HPP PCPs, specialists, ambulatory surgical centers, ancillary and allied health providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter with a HPP member.

- EPSDT Encounter — Providers should report the appropriate level Evaluation and Management CPT code, plus CPT code EP Modifier and all immunization CPT codes to properly report an EPSDT claim.
Well Child Visits

• The *Bright Future*/American Academy of Pediatrics (AAP) developed a set of comprehensive health guidelines for well-child care, known as the “periodicity schedule.”

• **Prevention**: scheduled immunizations to prevent illness. Children should see a dentist at the first sign of a tooth and establish a dental home and no later than 12 months of age and twice a year for regular oral checkups, teeth cleanings, fluoride treatments and overall oral health.

• **Tracking growth and development**: how much a child has grown/development in the time since their last visit, also discuss the child’s milestones, social behaviors and learning.

• **Opportunity to identify if there are concerns**: development, behavior, sleep, eating or getting along with other family members.

• Sick visits can also be an opportunity for completing a well-child visit (after determining that the condition, illness or injury that led to the sick visit does not impede the ability to complete a well-child visit *and* that the child is eligible for the well-child).
EPSDT Standards

EPSDT: Early and Periodic Screening, Diagnosis and Treatment

- EPSDT standards are comprised of routine care, screenings, services and treatment that allow members under age 21 to receive recommended services set forth by the American Academy of Pediatrics’ Guidelines with ease.

- If, following an EPSDT screen, the provider suspects developmental delay and the child is not receiving services at the time of screening, then the provider is required to refer the child (not over five years of age) through the CONNECT Helpline (1-800-692-7288) for appropriate eligibility determination for Early Intervention Program services.

For the latest guidelines, visit our website at www.hpplans.com/EPSDT or call the Healthy Kids Program at 1-866-500-4571.
Lead Screening Requirements

- All children enrolled in Medicaid must have a minimum of two screenings: a first by age 12 months and a second by age 24 months. If a child between 24 and 72 months (2–6 years old) has no record of screening, a lead screening must be performed as part of the EPSDT well-child screenings, regardless of the individual child’s risk factors.

- Please refer to the recommendations set forth in the EPSDT Periodicity Schedule, located here at [hpplans.com/providers/epsdt-periodicity](http://hpplans.com/providers/epsdt-periodicity)

  — CHIP adheres to the Bright Future guidelines, which can be located here: [https://brightfutures.aap.org/about/Pages/About.aspx](https://brightfutures.aap.org/about/Pages/About.aspx)

  — Medicaid and CHIP share similar guidelines for ensuring that members receive well-child visits.
Claims Filing Instructions

<table>
<thead>
<tr>
<th>Health Partners (Medicaid) and Health Partners Medicare</th>
<th>KidzPartners</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. Box 1220</td>
<td>P.O. Box 1240</td>
</tr>
<tr>
<td>Philadelphia, PA 19105-1220</td>
<td>Philadelphia, PA 19105-1220</td>
</tr>
</tbody>
</table>

Electronic:

- **Payer ID Number:** 80142
- **Claims Clearing House:** Change Healthcare (formerly Emdeon)
- **EFT Payments and Remittances:** ECHO Health, Inc.
- **EDI Support:** EDI@hpplans.com

Timely filing deadlines:

- **Initial Submissions:** 180-days from Date of Service or Discharge Date
- **Reconsiderations:** 180-days from the date of HPP’s Explanation of Payment (EOP)
- **Coordination of Benefits:** 180-days from date of other carriers (EOP)
Claims Reconsiderations

Providers can request a reconsideration determination for a claim that a provider believes was paid incorrectly or denied inappropriately.

Three options to request a reconsideration of a claim:

1. Submit requests through the provider portal, HP Connect.
2. Rapid Reconsideration. Call to speak with a claims reconsideration specialist who can reprocess a claim (or confirm a denial) – Monday to Friday, 8:30 a.m. to 4:30 p.m., by calling 1-888-991-9023, option #1.
3. Submit written requests to:
   Health Partners Plans
   Attention: Claim Reconsiderations Department
   901 Market Street, Suite 500
   Philadelphia, PA 19107
Utilization Management

Providing Appropriate Medical Care for Members

- We are committed to providing our members with the most appropriate medical care for their specific situations.

- Our utilization management decisions are based on medical necessity, appropriateness of care and service, the existence of coverage, and whether an item is medically necessary or considered a medical item.

- HPP does not provide financial incentives for utilization management decision makers that encourage denials of coverage or service or decisions that result in underutilization.
Prior Authorization Process

- Providers should obtain prior authorization at least seven days in advance for elective (non-emergent) procedures and services.
- Your request will be processed according to state and federal regulations.
- Failure to comply with this guideline may result in the delay of medically non-urgent services.
Prior Authorization Process

For elective admissions and transfers to non-participating facilities, the PCP, referring specialist or hospital must call the HPP Inpatient Services Department at 1-866-500-4571.

- We offer the convenience of submitting authorization requests around the clock via HP Connect, our secure provider portal.

- More detailed information can be found in the Utilization Management section of our Provider Manual (Chapter 7).
Home Care and Durable Medical Equipment

- Requests must include a valid Physician Order for Home Health Services and include supporting clinical documentation.
- DME requests must include the correct billing codes for items requested.
- Home Care and DME requests can be submitted via the Health Partners Plans Portal (HP Connect) or Right fax.
Non-Emergent Transportation

- Behavioral Health Transportation does not require prior authorization (effective 12/13/2018).

- Health Partners (Medicaid) ambulance providers must have an active PROMISe ID# and all claims must include a behavioral health ICD-10 diagnosis code.

- All behavioral health transports must be for a level of transport appropriate to the documented need and should be for the transportation of an HPP member to a behavioral health facility.
HPP Fax numbers for Home Health Services and Non-Emergent Transportation

Home Care and Home Infusion
- Fax: 267-515-6633 (Medicare)
- Fax: 215-967-4491 (Medicaid)

Durable Medical Equipment (DME)
- Fax: 267-515-6636 (Medicare)
- Fax: 215-849-4749 (Medicaid)

Shift Care/Medical Daycare
- Fax: 267-515-6667

Non-emergent Transport
- Fax: 267-515-6627
Emergency Care

- Emergency care and post-stabilization services in ERs and emergency admissions are covered services for both participating and non-participating facilities, with no distinction for in-area or out-of-area services. Emergency care and post-stabilization services do not require prior authorization.

- HPP must comply according to our HealthChoices Agreement pertaining to coverage and payment of Medically Necessary Emergency Services.

- Medicaid members are not responsible for any payments.
Emergency Care

- Non-par follow-up specialty care for an emergency is covered by HPP, but our staff will contact the member to arrange for services to be provided in-network, whenever possible.

- Access to PCP care is vitally important to maintaining the health of our members and, when possible, steering them away from the use of ERs when their condition can more appropriately be managed in a PCP office environment. A PCP is required to provide access to care as outlined in the Access and Appointment Standards section of the Provider Manual. In addition, a PCP must be accessible 24/7.

- This information applies to all lines of business.
Clinical Programs: Medicaid and CHIP

Clinical Programs activities focus on both long- and short-term goals for members who may require assistance coordinating their care. Please consider any of these programs for your patients:

- **Baby Partners**: Care coordination for prenatal and postpartum members
- **Care Coordination**: Provides disease education, behavioral health coordination and connection to Community Resources for adult members with multiple co-morbidities
- **Healthy Kids**: Provides disease education, reminders about important preventive services (such as lead screening and connection to services for developmental delay concerns) for members under the age of 21. For Healthy Kids, contact 215-967-4690, option 2, then Option 9.
- **Special Needs Unit**: for adults and children who have identified special needs who may benefit from care coordination

Call the Clinical Programs team at 215-845-4797 and refer any patients for care coordination services.
Care Coordination: Medicare Only

- Case Coordination Services are available for all of our Medicare members in the following plans:
  - Prime
  - Special

- We encourage providers to refer members to our Clinical Programs team when intensive case management or coordination of services is identified by calling 215-845-4797.
Members With Special Needs: Medicaid

- Referrals to the Special Need Unit (SNU) are accepted from all sources, including PCPs, community and hospital social workers, discharge planners and members themselves. SNU staff is available to help address specific needs of our member population.

- To contact the Special Needs Unit, call 1-866-500-4571 or 215-967-4690. Select prompt #2 for provider, then prompt #7 for SNU.
Special HIV/AIDS Services

- **Case Management Services.** Any Health Partners (Medicaid) member diagnosed as being HIV infected is eligible for HIV/AIDS case management provided by the Center of Excellence (COE), regardless of whether that member is assigned to the COE for primary care services. To be reimbursed, HIV or AIDS must be a primary or secondary diagnosis for each service.

- COE is a participating provider or group of providers that offers special medical and social expertise to HIV/AIDS patients and are a recognized provider of coordinated medical and social services to patients with HIV/AIDS and has agreed to provide special services.

- Siblings can also be assigned to these providers as their PCP.
Extra Benefits Through Wellness Partners

Fitness Benefit

- Annual gym membership covered at participating YMCAs and fitness centers
- Medicaid members over 18 years: $24 copay and 12-visit requirement for the first 90 days after enrollment
- Medicaid members under 18 years/CHIP: No copay and 6-visit requirement for the first 90 days after enrollment
- Medicare: No copay and no visit requirement

Visit [hpplans.com/wellnesspartners](http://hpplans.com/wellnesspartners) to learn more!
Access, Appointment Standards and Telephone Availability

<table>
<thead>
<tr>
<th>Access, Appointment Standards and Telephone Availability Criteria</th>
<th>PCP</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine office visits</td>
<td>Within 10 days</td>
<td>Within 10-15 days depending on the specialty</td>
</tr>
<tr>
<td>Routine physical</td>
<td>Within 3 weeks</td>
<td>n/a</td>
</tr>
<tr>
<td>Preventive care</td>
<td>Within 3 weeks</td>
<td>n/a</td>
</tr>
<tr>
<td>Urgent care</td>
<td>Within 24 hours</td>
<td>Within 24 hours of referral</td>
</tr>
<tr>
<td>Emergency care</td>
<td>Immediately and/or refer to ER</td>
<td>Immediately and/or refer to ER</td>
</tr>
<tr>
<td>First newborn visit</td>
<td>Within 2 weeks</td>
<td>n/a</td>
</tr>
</tbody>
</table>

See [Chapter 10.2](#) of the Provider Manual for more information.
### Access, Appointment Standards and Telephone Availability

<table>
<thead>
<tr>
<th>Access, Appointment Standards and Telephone Availability Criteria</th>
<th>PCP</th>
<th>Specialist</th>
</tr>
</thead>
<tbody>
<tr>
<td>EPSDT</td>
<td>Within 45 days of enrollment unless the member is already under the care of a PCP and the member is current with screenings and immunizations</td>
<td>n/a</td>
</tr>
<tr>
<td>Office wait time</td>
<td>30 minutes, or up to one hour if urgent situation arises</td>
<td>30 minutes, or up to one hour if urgent situation arises</td>
</tr>
<tr>
<td>Weekly office hours</td>
<td>At least 20 hours per site</td>
<td>At least 20 hours per site</td>
</tr>
<tr>
<td>Max appointment(s) per hour</td>
<td>6</td>
<td>n/a</td>
</tr>
</tbody>
</table>

- All PCPs must be available to members for consultation regarding an emergency medical condition 24 hours a day, seven days a week. See [Chapter 10.2](#) of the Provider Manual for more information.
Administrative Procedures Regarding Patient Access

Guidelines and Procedures

- While maintaining patient confidentiality, the practice should attempt to notify the patient of missed appointments and the need to reschedule. **Such attempts are recorded in the patient record.** The attempts must include at least one telephonic outreach.

- The practice should have procedures for notifying patients of the need for preventive health services, such as various tests, studies, and physical examination as recommended for the appropriate age group. Notifications are recorded in the patient record.
Maternity Services: Health Partners (Medicaid)

- Members who are confirmed to be pregnant are not subject to limitations on the number of services or copayments. Members are eligible for comprehensive medical, dental, vision and pharmacy coverage with no copayments or visit limits during the term of their pregnancy and until the end of their postpartum care.

- These services include expanded nutritional counseling and smoking cessation services. However, services not ordinarily covered under a pregnant member’s benefit package are not covered, even while pregnant.
Direct Access

- Women are permitted direct access to women’s health specialists for routine and preventive health care services without being required to obtain a referral or prior authorization as a condition to receiving such services. Women’s health specialists include, but are not limited to gynecologists or certified nurse midwives.

Pregnant members and newborns

- If a new member is pregnant and already receiving care from an out-of-network OB/GYN specialist at the time of enrollment, she may continue to receive services from that specialist throughout the pregnancy and delivery-related postpartum care. This coverage period may also be extended if HPP’s Medical Director finds that the postpartum care is related to the delivery.
Determination of Abuse or Neglect

- Upon notification by the County Children and Youth Agency system, HPP must ensure its members receive proper services when under evaluation as possible victims of child abuse and/or neglect and who present for physical examinations for determination or abuse or neglect.

- HPP staff who are designated as mandated reporters, as defined by the Pennsylvania Family Support Alliance, must report suspected child abuse to the appropriate authorities.

- Chapter 8 of the HPP Provider Manual stipulates that providers must report abuse, neglect and/or domestic violence.
Mental Health and Substance Abuse Treatment

- Under HealthChoices, all Medical Assistance members, regardless of the health plan/MCO to which they belong, receive mental health and substance abuse treatment through the behavioral health managed care organization (BHMCO) assigned to their county of residence.

- PCPs who identify a Health Partners (Medicaid) member in need of behavioral health services should direct the member to call his or her county’s BHMCO. The BHMCO will conduct an intake assessment and refer the member to the appropriate level of care.
Opioid Use Disorders: COEs

- PA DHS has designated multiple Centers of Excellence (COEs) to help Medicaid members with opioid use disorder (OUD) throughout PA.

- The goal is to ensure that members with opioid-related substance use disorder stay in treatment to receive follow-up care and are supported within their communities.

- The COEs coordinate care for Medicaid members, and treatment is team-based and “whole person” focused, with the explicit goal of integrating behavioral health and primary care.
Southeast OUD COEs

Philadelphia County
- Temple TWO Program/The Wedge
- Pathways/Project Home/Prevention Point (The Steven Klein Wellness Center)
- Penn Presbyterian Medical Center/Penn Medicine Mothers Matter Program
- Public Health Management Corporation (PHMC)
- Jefferson Maternal Addiction Treatment, Education, and Research (MATER)/Narcotic Addiction Rehabilitation Program of Thomas Jefferson University*

Bucks
- Penn Foundation, Inc.* (Sellersville)
- Family Service Association of Bucks County* (Langhorne)

Delaware
- Center for Integrative Medicine (AIDS Care Group) (Chester)
- Crozer-Chester Medical Center* (Chester)

Montgomery
- Community Health & Dental Care, Inc. (Pottstown)
- Resources for Human Development, Inc. (Norristown)

* Contracted directly with Behavioral Health MCOs
Criteria

- DHS publishes and maintains behavioral health “Medical Necessity Criteria” for the Pennsylvania HealthChoices program.

- If you are interested in learning more about this criteria, refer to the HealthChoices Behavioral Health Services Guidelines for Mental Health Medical Necessity Criteria.
As a reminder, all providers (including physicians, hospitals and laboratories) are required by law to report certain conditions to the Commonwealth of Pennsylvania’s Department of Health (PA DOH).

This requirement is outlined in Chapter 27 (Communicable and Noncommunicable Diseases) of the Pennsylvania Code (28 Pa. Code §27.1 et seq), and on its 2003 addendum (33 Pa.B. 2439, Electronic Disease Surveillance System), located on the official Pennsylvania Code website.

Providers must report the required diseases/conditions to the PA DOH through Pennsylvania’s version of the National Electronic Disease Surveillance System, known as PA-NEDSS.

PA-NEDSS
Reportable Conditions – PA-NEDSS

- Please note: First-time users of PA-NEDSS must register on the website in order to utilize the reporting tool. Additionally, if you are a public health staff member, you and your supervisor must complete the PA-NEDSS Authorization Request Form to obtain access to PA-NEDSS. Contact the PA-NEDSS Help Desk at 717-783-9171 or via email at ra-dhNEDSS@pa.gov for the appropriate version of this form.

Additional Resources:

- PA-NEDSS New User Guide
- Listing of PA reportable conditions (revised 3/2012)
- Pennsylvania Case Definitions
- Pennsylvania Code website
Infection Control – All Lines of Business

<table>
<thead>
<tr>
<th>Mandatory Requirements</th>
<th>Recommended Standards</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Infectious material is separated from other trash and disposed of appropriately.</td>
<td>- Standard precautions are reviewed with staff and documented annually.</td>
</tr>
<tr>
<td>- Medical instruments used on patients are disposable or properly disinfected and/or sterilized after each use.</td>
<td>- The practice site has an OSHA manual.</td>
</tr>
<tr>
<td>- Needles and sharps are disposed of directly into rigid, sealed container(s) that cannot be pierced and are properly labeled.</td>
<td>- Hand washing facilities or antiseptic.</td>
</tr>
<tr>
<td></td>
<td>- Hand sanitizers are available in each exam room.</td>
</tr>
</tbody>
</table>
Pay-For-Performance Program

- Each year, HPP develops Pay-for-Performance (P4P) incentives for our providers, based on specific initiatives that improve the health outcomes of our members. While ultimately benefiting our members, these incentives also offer an opportunity to increase revenue to your office.

- We encourage you to become familiar with our P4P programs and take advantage of every opportunity available to get members in for appropriate treatment.

- For more detailed information or a copy of the manual outlining the changes and details of the P4P program, contact your Network Account Manager (NAM) or the Provider Services Helpline at 1-888-991-9023.
Cultural and Linguistic Requirements and Services – All Lines of Business

- Cultural Competency is one of the main ingredients in closing the disparities gap in health care.

- It requires a commitment from doctors and other caregivers to understand and be responsive to the different attitudes, values, verbal cues, and body language that people look for in a doctor’s office by virtue of their heritage.
To help providers learn more about culturally and linguistically appropriate health care, Health Partners Plans recommends review of the following material:

- This is a free, self-directed training course for physicians and other health care professionals with a specific interest in cultural competency in the provision of care.
- Continuing Medical Education (CME/CE) credits are available. Access the website at cccm.thinkculturalhealth.hhs.gov
HPP providers are required, by law, to provide translation and interpreter services (including sign language) at their practice location.

The HPP Provider Services Helpline will assist providers in obtaining services for members who need a qualified interpreter to be present at the member’s appointment.

To schedule an interpreter to meet one of your patients at the office for an appointment, you can contact the vendor directly at 215-627-2251. Interpreters are available 24 hours a day, 7 days a week. Learn more at www.quantumtranslations.com.
Cultural and Linguistic Requirements and Services

- The Provider Services Helpline can assist the provider in arranging telephone interpretation through the Language Line (a vendor interpretation service provided by LanguageLine Solutions).
- Network Management staff can provide resources for the provider and his or her office staff who are interested in receiving a certificate in medical interpretation.
Members’ Rights and Responsibilities

- HPP members have the right to know about their rights and responsibilities. Exercising these rights will not negatively affect the way they are treated by HPP, its participating providers or other state agencies.

- Members have the right to take an active part in decisions about their health care and/or care plan without feeling as though HPP or its providers are restraining, secluding or retaliating against them.
Members’ Rights and Responsibilities

- HPP’s statement of Member Rights and Responsibilities are provided to our members.

- A list is made available to providers. This list is located in the Provider Manual:

  Member Rights and Responsibilities – Provider Manual (Ch. 14)
Recipient Restriction Program (Medicaid Only)

Program Description

The Recipient Restriction is a program of DHS’s Bureau of Program Integrity (BPI), also referred to as “lock-in” program (requirement of DHS).

- Participants are MEDICAID members only.
- It identifies patterns of misutilization of benefits.
- Recipients may be restricted to a physician, a pharmacy, or both (physician and pharmacy) upon BPI approval.
Program Goals

- Encourage members to efficiently manage their health care needs, obtaining only required services and medications through proper care coordination.

- Establish a relationship with both a provider and pharmacy for the best medical management.

- Provide safeguards against inappropriate use of Medicaid services under the Medical Assistance (MA) program.

- For more information about the Recipient Restriction Program, contact the pharmacy department at, **215-991-4300** or email **PharmacyRecipientRestriction@hpplans.com**.
False Claims Act

- The False Claims Act is the most important tool U.S. taxpayers have to recover the billions of dollars stolen through fraud by U.S. government contractors, including providers, every year.

- Under the False Claims Act, those who knowingly submit or cause another person or entity to submit false claims for payment of government funds are liable for three times the government’s damages, plus civil penalties. DOJ has increased False Claims Act (FCA) penalties by about 2% from between $10,957 and $21,916 to between $11,181 and $22,363 for 2018.

- If you wish to report fraud or suspicious activity, please call the Special Investigation Unit Hotline at 1-866-HP-SIU4U.
Provider Self-Audit

- DHS has an MA Provider Self-Audit Protocol for providers to disclose any overpayments or improper payments.
  - The Self-Audit Protocol is for MA providers that participate in both the fee-for-service and managed care environments.
  - The protocol provides guidance to providers on the preferred methodology to return inappropriate payments to DHS.
Provider Self-Audit

There are various options for providers to conduct an audit:

1. 100 Percent Claim Review
2. Provider-Developed Audit Work Plan for BPI Approval
3. DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample

For more information, please click the link below:

PA DHS - Medical Assistance Provider Self-Audit Protocol
7 Fundamental Compliance Program Elements

1. **Written Policies, Procedures, and Standard Code of Conduct**
   - Articulate the organization’s commitment to comply with all applicable requirements and standards under contract.
   - These policies and procedures are updated or reviewed on an annual basis or when regulation changes.

2. **Establishment of Compliance Office and Compliance Committee**
   - HPP has a full-time Compliance Officer for our Medicaid and CHIP and Medicare lines of business.
   - There is a compliance committee dedicated to ensuring our compliance and ethics run effectively.

3. **Effective Training and Education**
   - The goal is to ensure our providers are well trained and educated on various Medicaid and CHIP laws and regulation requirements.
   - The trainings are provided upon hire and annually.
   - Major required trainings are for Fraud, Waste, and Abuse; Compliance and HIPAA.
7 Fundamental Compliance Program Elements

4. Effective Lines of Communication

– It is important that employees, providers, subcontractors and employees know that HPP has a 24-hour hotline.

– This hotline is to report any misconduct violating Fraud, Waste, and Abuse (FWA), Compliance, HIPAA, or Human Resources laws and regulations.

– **HPP Reporting Channels**
  
  • Compliance Hotline (Anonymous): 1-866-477-4848
  
  • [EthicsPoint Online Reporting Tool](#) (Anonymous)
  
  • Compliance email: compliance@hpplans.com
  
  • Fraud, Waste, and Abuse
    
    – Special Investigations Unit Hotline: 1-866-HPS-IU4U
    
    – SIU email: SIUtips@hpplans.com
7 Fundamental Compliance Program Elements

5. Well Published Disciplinary Guidelines
   - HPP has well established policies and procedures regarding our disciplinary actions for noncompliance, FWA and improper misconduct.

6. Effective System for Routine Monitoring and Auditing
   - HPP conducts external monitoring and auditing of providers’ and subcontractors’ compliance with various laws and regulations regarding:
     • Medicaid and CHIP regulations
     • CMS requirements
     • State and Federal laws and regulations
     • Contractual agreements
7 Fundamental Compliance Program Elements

7. Prompt Response to Compliance Issues

– HPP has procedures in place to address compliance, FWA and HIPAA issues for reported offenses. Providers and subcontractors are instructed to report such issues through the HPP compliance hotline at 1-866-477-4848.

– In doing so, providers are protected by the HPP non-retaliation and whistleblower policy.
Provider Screening and Enrollment

- All enrolled providers are required by DHS to be screened under Code of Federal Regulations (CFR) Part 455 Subpart E.
  - This involves requirements from §455.410 through §455.450 and §455.470 to be met.

- HPP and providers are responsible for ensuring their organization has met DHS screening and enrollment requirements.

- Additionally, state requirements include Medicheck screening in addition to those listed.
Provider Screening and Exclusion

- Under the regulations of 42 CFR §455.436, HPP is required to check the exclusions status of our providers on the “U.S. Department of Health and Human Services-Office of Inspector General’s (HHS-OIG)”
  - List of Excluded Individuals and Entities (LEIE)
  - Excluded Parties List System (EPLS)
<table>
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<tr>
<th><strong>Federal Health Care Fraud and Laws</strong></th>
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Federal Health Care Laws

- For more information on these laws, visit the [Office of Inspector General, A Roadmap for New Physicians](http://oig.hhs.gov/fraud/enforcementactions.asp).

- To review OIG enforcement actions, visit: [http://oig.hhs.gov/fraud/enforcementactions.asp](http://oig.hhs.gov/fraud/enforcementactions.asp)
Revalidation of Medical Assistance (MA) Providers

- All providers must revalidate their MA enrollment (including all associated service locations – 13 digits) every 5 years. Providers should log into PROMISe to check their revalidation date and submit a revalidation application at least 60 days prior.

- Enrollment (revalidation) applications may be found at: [www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994](http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994)
Complaints, Grievances and Appeals

- When HPP denies, decreases, or approves a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member’s legal representative, or healthcare provider or other member’s representative (with the appropriate written consent of the member) to request that HPP reconsider its decision.

- For more information on the complaint, grievance and appeal process refer to our Provider Manual (Chapter 12), or contact the Provider Services Helpline at 1-888-991-9023.
Member Information About Fair Hearings

Department of Human Services Fair Hearings

- In some cases, members can ask DHS to hold a hearing because they are unhappy about or do not agree with something HPP did or did not do.

- These hearings are called “fair hearings.” Members must exhaust HPP’s Complaint or Grievance Process before they can request a Fair Hearing. For more information, consult the Member Handbook’s “Help With Problems” section.
Balance Billing Dual Eligible Members: Medicare/Medicaid

- Partially Dual Eligible members are responsible for their appropriate cost share amounts, as defined by their benefit package and should be billed accordingly.

- Fully Dual Eligible members are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (CHC MCO).

- Medicaid (CHC MCO) will remain the payer of last resort.

- Providers may not balance-bill participants when Medicaid, Medicare or another form of TPL does not cover the entire billed amount for a service delivered.
Coordination of Benefits

- Health Partners Plans’ Medical Assistance plan is payer of last resort, thus is secondary payer to all other forms of health insurance, Medicare or other types of coverage. With the exception of preventive pediatric care, if other coverage is available, the primary plan must be billed before Health Partners Plans will consider any changes.

- Preventive pediatric care is paid regardless of other insurance. After all other primary and/or secondary coverage has been exhausted, providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payer to Health Partners Plans. Secondary claims may also be filed electronically following the HIPAA complaint transaction guidelines.

Health Partners Plans Provider Manual (Chapter 11.20)
Qualified Medicare Beneficiary (QMB)

- The QMB program is a Medicaid benefit that pays Medicare premiums and cost sharing for certain low-income Medicare beneficiaries.

- The law prohibits Medicare providers from collecting Medicare Part A and B coinsurance, copayments and deductibles from those enrolled in the QMB program.

- For more information on this topic, click the link below:

  [The CMS MedLearn Matters article](#)
# Plan Contacts and Resources

<table>
<thead>
<tr>
<th><strong>Provider Services Helpline (9 a.m. to 4:30 p.m.)</strong></th>
<th><strong>1-888-991-9023</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Providers</td>
<td>Prompt 1</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>Prompt 2</td>
</tr>
<tr>
<td>Join our HPP Provider Network</td>
<td>Prompt 3</td>
</tr>
<tr>
<td>Members</td>
<td>Prompt 4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Member Hotlines</strong></th>
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<tbody>
<tr>
<td>Medicare</td>
<td>1-866-901-8000</td>
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<td>Medicaid</td>
<td>1-800-553-0784</td>
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<td>CHIP</td>
<td>1-888-888-1211</td>
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<tr>
<th><strong>Additional Resources</strong></th>
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<tbody>
<tr>
<td>eviCore Radiology authorizations, PT/OT/ST and other expanded services</td>
<td>1-888-693-3211</td>
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<tr>
<td>ECHO Health – electronic funds transfer and remittance advice</td>
<td>1-888-834-3511</td>
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## Plan Contacts and Resources

<table>
<thead>
<tr>
<th>Webpage</th>
<th>URL</th>
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<tbody>
<tr>
<td>Provider website</td>
<td>hpplans.com/providers</td>
</tr>
<tr>
<td>Provider Manual</td>
<td>hpplans.com/providermanual</td>
</tr>
<tr>
<td>HP Connect (Provider Portal)</td>
<td>hpplans.com/hp-connect</td>
</tr>
<tr>
<td>HPP University</td>
<td>hpplans.com/hpp-university</td>
</tr>
<tr>
<td>Provider Directory</td>
<td>hpplans.com/directory</td>
</tr>
<tr>
<td>Formularies</td>
<td>hpplans.com/formulary</td>
</tr>
<tr>
<td>ECHO Health</td>
<td><a href="http://view.echohealthinc.com/">http://view.echohealthinc.com/</a></td>
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Complete Your Attestation

Thank you for your participation in the HPP provider network and for your commitment to our member’s health care needs!

Attestation:

- If you reviewed the training materials electronically, please complete the provider education attestation by accessing the following link:
  
  **Annual Orientation and Training Attestation (AOT)**

- If the link has been disabled, please copy the URL into your browser.

- If you requested a paper copy of the training materials, please complete the attestation form sent along with your materials. Please fax it to Lisa Mallory at 215-967-9249 or email **ProviderEducation@hpplans.com**.