Provider Orientation and Training

2021

PartnerUp Health Partners Plans HPP

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 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

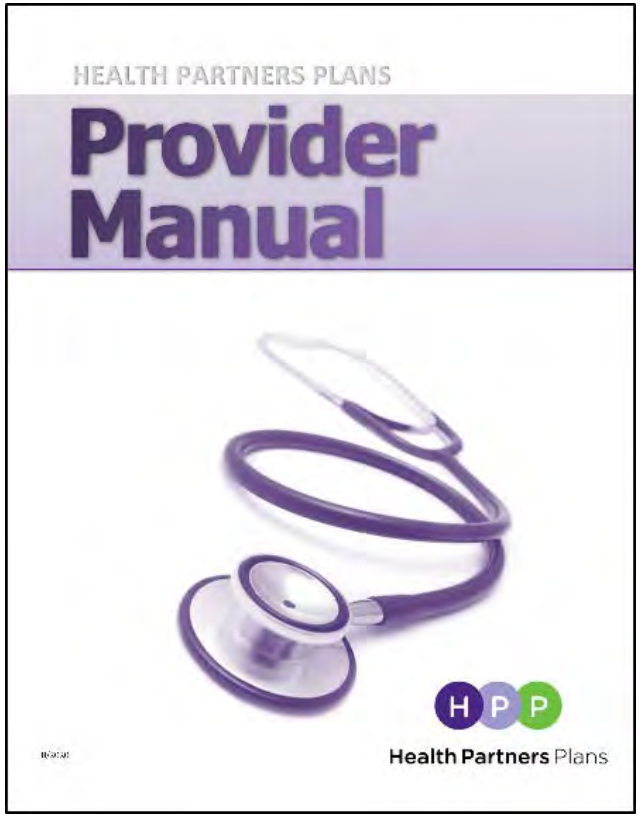
hpplans.com/fdr-requirements

About Health Partners Plans

- Serving the community for nearly 35 years
- Coverage for people of all ages

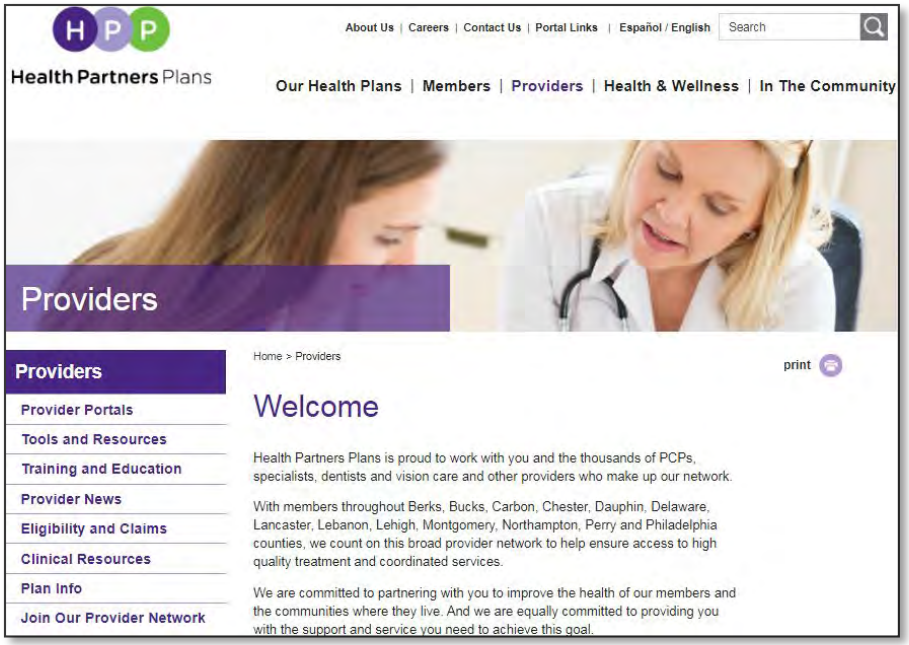
Provider Manual

- Reflects current policies and procedures for all lines of business.
- Updated annually
- Most recent updates:
  - Benefits across all lines of business
  - Coverage requirements for Limited English Proficiency (LEP) and nondiscrimination language
  - Member rights & responsibilities
  - Updated details on our care management programs
- Find the manual online at **hpplans.com/providermanual**



On-line Tools

- HP Connect
- NaviNet
- HPP University
  - Training and Education
- Provider Directories
- Provider Manual
- Formularies
- Clinical Resources
- Plan Information
- Provider Newsletters



hpplans.com/providers

Our Provider Portals

- Our provider portals, **HP Connect** and **NaviNet**, offer convenient and secure access to important information 24/7.
- 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 visit **hpplans.com/providers/portals**

Provider Portals

Features	NaviNet	HP Connect
Member eligibility	X	
Member benefits	X	
Claims status	X	
Request claims reconsiderations		X
Request authorizations		X
Patient roster reports	X	
Care gap reports	X	
Chronic Care Management Program (CCMP) diagnosis documentation	X	
Other practice level reports	X	

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.

Laboratory and Other Benefit Carriers

- Laboratory
  - Quest Diagnostics
- Dental Carrier
  - Avesis
  - 1-800-952-6674
- Vision Carrier
  - Davis
  - 1-800-260-2849

Note: Please do not distribute these numbers to members.

Identification Cards 2021

Health Partners (Medicaid)

(9-digit ID number)

KidzPartners (CHIP)

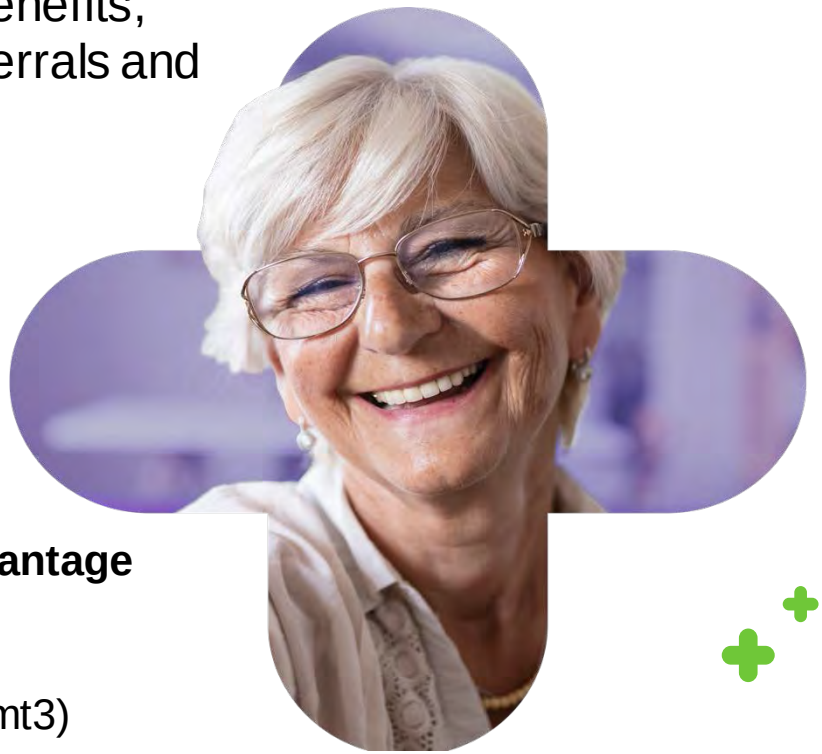
(10-digit ID number)

Health Partners (Medicare)

Medicare 2021 Plan Offerings

- Health Partners Medicare offers three Medicare Advantage plans with comprehensive benefits, including affordable doctor visits, no referrals and prescription drug coverage.

  - ✓ **Prime (HMO-POS)**
  - ✓ **Complete (HMO-POS)** **New for 2021!**
  - ✓ **Special (HMO SNP)**



Health Partners Plans' 2021 Medicare Advantage Plans
Oct. 27 & Oct. 29, 2020
Recording | Presentation (Password: uWpwjmt3)

Health Partners Medicare: Better Than Ever in 2022!

Health Partners Medicare Complete

Offering great medical and prescription drug coverage plus generous allowances for popular ancillary benefits, our Complete plan has a $0 monthly plan premium.

Health Partners Medicare Prime

An enhanced plan that offers more benefits than Original Medicare, along with prescription drug coverage. Prime is a high-value plan with low out-of-pocket costs and generous allowances for popular ancillary benefits.

Health Partners Medicare Special

Special offers great medical and prescription drug coverage along with generous allowances for a wide range of supplemental benefits. Special is designed specifically for beneficiaries with both Medicare and full Medicaid benefits.

Health Partners Medicare 2022 Provider Webinars Register now at:
hpplans.com/provwebinars

PartnerUp Health Partners Plans HPP

Community HealthChoices

- Beneficiaries who are enrolled in a CHC plan are covered under Medicare and Medicaid or are receiving waiver services.
- There are three Community HealthChoices (CHC) plans:

PA Health & Wellness (Centene)	AmeriHealth Caritas (Keystone)	UPMC

- Health Partners Medicare 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.

CHC Reminder for Providers

- As a participating provider, you **can** provide services to Health Partners Medicare members even if they are enrolled in a CHC (Medicaid) plan.
- You **do not** need to be participating with the CHC plans to provide services to Health Partners Medicare patients.
- Medicare is the **primary** payer and drives the care.
  - Medicaid benefits are accessed after Medicare benefits have been exhausted or a service is not covered under Medicare.
  - HPP's Care Management staff will coordinate services between Medicare and Medicaid.
  - Medicaid is **always** the payer of last resort.
- Providers can submit claims to the CHC plans regardless of their contracting status with the CHC plans.

Community HealthChoices

- CHC Fact Sheet
- Adult Benefit Package
- Long-Term Services and Supports Benefits Guide
- Coordination With Medicare
- Populations Served By CHC
- Eligibility Verification System (EVS)

Community HealthChoices

Balance Billing Dual Eligible Members: Medicare/Medicaid

- Fully Dual Eligible beneficiaries are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).
- Medicaid (CHC) 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.
- **Please note that Health Partners Medicare Special (HMO SNP) members are fully dual eligible.**

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

Specialist Referrals

- **Specialist referrals are not required for HPP members. Our members are permitted to "self-refer" for specialist care.**
- It is extremely important for specialists to continue to keep a member's assigned PCP informed of all care they render to the member.
- No referrals for any of our 2021 plans.

Well-Child Visits

The **Bright Futures/American Academy of Pediatrics (AAP)** developed a set of comprehensive health guidelines for well-child care, known as the "periodicity schedule." It includes:

- **Prevention**: Scheduled immunizations; dentist visit at the first sign of a tooth and to establish a dental home at no later than 12 months of age; regular oral checkups (two each year), teeth cleanings, fluoride treatments and overall oral health.
- **Growth and development:** Tracking how much a child has grown and developed in the time since their last visit; discussing the child's milestones, social behaviors and learning with parents/guardians.

Bright Futures™

prevention and health promotion for infants, children, adolescents, and their families™

Well-Child Visits (continued)

- **Identify concerns:** Well-child visits are an opportunity to speak with parents about a wide variety of issues, including developmental, behavioral, sleeping, eating and relationships with other family members.
- **Sick visits:** Determine if the condition, illness or injury that led to the sick visit impedes with the ability to complete a well-child visit and that the child is eligible for a well-child visit.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- EPSDT standards are comprised of routine care, screenings, services and treatment that allow Medicaid members under 21 to receive recommended services set forth by the American Academy of Pediatrics' Guidelines.
- If, following an EPSDT screening, a 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 5 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 **hpplans.com/EPSDT** or call HPP's Healthy Kids team 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 at **hpplans.com/EPSDT**
- CHIP adheres to the Bright Futures guidelines, which can be located at **brightfutures.aap.org/about/Pages/About.aspx**
  - Medicaid and CHIP share similar guidelines for ensuring that members receive well-child visits.

Recommended Child and Adolescent Immunization Schedule

- Pennsylvania Department of Human Services (DHS) released Medical Assistance Bulletin #99-20-03 – 2020 Recommended Child and Adolescent Immunization Schedule on Nov. 12, 2020. This bulletin issued the CDC's Recommended Child and Adolescent Immunization Schedule for ages 18 years or younger.

- HPP wants to ensure that all participating providers are aware of this bulletin. Please carefully review the 2020 immunization schedule for detailed information on the appropriate dosages and ages for the administration of vaccines and replace your current immunization schedule with the 2020 immunization schedule attached to the bulletin. Providers can also find information about the 2020 immunization schedule in our Provider Manual.

- **Medical Assistance Bulletin #99-20-03 2020 Recommended Child and Adolescent Immunization Schedule**

Mental Health and Substance Abuse Treatment

- Under HealthChoices, all Medicaid 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.

Behavioral Health Resources

- **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)

Antipsychotic Medications For Pediatric Members

- Antipsychotic medication prescribing in children and adolescents can increase a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood.
- Given these risks, it is important to ensure appropriate management even if the drug has been prescribed elsewhere, family physicians should closely monitor these patients by requesting that they receive a metabolic screening.
- If you require assistance with coordinating care for these members or collaborating with a behavioral health provider, please contact our Healthy Kids department at **215-967-4690**.

	Baseline	1 month	2 months	3 months	6 months	Reassess
Weight (BMI)	x	x	x	x	x	Q 3 months
Waist circumference	x	x	x	x	x	Q 3 months
Blood pressure	x			x	x	Q 3 months for 1 year then annually
Fasting glucose	x			x	x	Q 3 months for 1 year then annually
Fasting lipid profile	x			x		Annually

Encounter Data

- Participating 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 an HPP member.
- EPSDT Encounters: 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.

Coordination of Benefits

- Health Partners (Medicaid) is payer of last resort, thus is secondary payer to all other forms of health insurance (e.g., Medicare). With the exception of preventive pediatric care, if other coverage is available, the primary plan must be billed before HPP will consider any charges.

- 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 HPP. Secondary claims may also be filed electronically following the HIPAA complaint transaction guidelines.

Provider Manual (Chapter 11.20)

Claims Reconsideration

- Providers can request a reconsideration determination for a claim that a provider believes was paid incorrectly or denied inappropriately. Reconsiderations must be made timely by the requestor.

Two options to request a reconsideration of a claim:

1. Submit requests through HP Connect.
2. Rapid Reconsideration: Call to speak with a claims representative who can assist, when appropriate, getting a claim reprocessed. Call **1-888-991-9023**, option #1 (Monday to Friday, 8:30 a.m. to 4:30 p.m.).

Claims Filing Instructions

Health Partners Plans Att: Claims
P.O. Box 1220
Philadelphia, PA 19105-1220

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: 60-days from date of other carriers (EOP)

Practice Changes

- Providers must notify, in writing, HPP's Network Management department immediately 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**.
- **Please remember to complete your quarterly Provider Data Validation form.**

HPP's Provider Credentialing Process

A single-page Provider Data Collection Form (PDCF) kick starts the credentialing process; submit to our email inbox at credentialing@hpplans.com

CAQH must be accurate and currently attested, which will help HPP complete the process much faster

Primary Source Verification process will be completed by our vendor Aperture – they may reach out for additional information.

Ancillary credentialing requires a unique credentialing application which can be requested by our Contracting Department to initiate the process

Processing Timelines

HPP's goal is to process all credentialing applications within 60 days, providing all requirements are submitted timely.

Applications submitted without additional follow-up by HPP are completed much faster.

Board Certification Requirements

- Specialists are required to be Board Certified in the specialty in which they are applying
  - Must be an ABMS/AOA Board or an HPP recognized approve Board
- PCPs are not required to be Board Certified
  - Primary Care Practitioner Specialties include:
    - Pediatrics
    - Family Practice
    - Internal Medicine
    - Certified Registered Nurse Practitioner (if credentialed as a PCP)

Revalidation of Medical Assistance 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**

Help & Support

- Questions and Inquires about **Contracting**?
  - Contracting@hpplans.com
- Questions and Inquires about **Credentialing**?
  - Credentialing@hpplans.com
- Questions and Inquiries about **Provider Data Changes**?
  - DataValidation@hpplans.com

Utilization Management

Providing Appropriate Medical Care for Members

- Our UM department is committed to providing members with the most appropriate medical care for their specific situations.
- UM's 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**.
- 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 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.
- Health Partners (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

Objectives:

- Support provider's treatment plan and health care goals
- Reduce or eliminate barriers to care—such as social, behavioral health needs

Clinical Programs (continued)

- Designed to address needs of members across the life continuum
- Staffed by licensed and non-licensed staff
- Critical components for all programs:
  - Collaboration with member, family/caregiver, health care providers and community agencies, as appropriate
  - Member-centric/whole-person focus
  - Voluntary, with the ability to opt out at any time by calling HPP Member Relations or discussing with the HPP Care Coordinator
  - Telephonic, face to face, email, social media, in the community and in provider offices
  - Use of Aunt Bertha to identify SDoH resources

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**: Disease education, behavioral health coordination and connection to Community Resources for adult members with multiple co-morbidities

Clinical Programs: Medicaid and CHIP (continued)

- **Healthy Kids**: 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.

Special Needs Unit

- 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.

- Visit HPP University and access our recent webinars page at **hpplans.com/provwebinars**

Medicare Care Coordination

- Care Coordination Services are available for all Medicare members:
  - Special (all members are Care Managed)
  - Prime and Complete (referral driven)
- Providers can refer members to our Care Coordination team for care management or coordination of services by calling **215-845-4797.**

Special HIV/AIDS Services

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

Fitness Benefits

- 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: Access to the SilverSneakers fitness center network

Visit **hpplans.com/wellnesspartners** to learn more!

Member Rewards Programs

HPP Rewards (Medicaid/CHIP)

- Encourages members to complete targeted condition management and preventive health activities
- Many rewards activities are tied to Quality Care Plus (QCP) and Maternity Quality Care Plus (MQCP) programs
- Activities include well-child visits, lead screenings, dental visits, diabetes and hypertension management
- Learn more at **hpplans.com/rewardslist**

Wellness Rewards (Medicare)

- Incentivizes Medicare members to complete specific health-related activities in 2021 to earn money on a reloadable gift card
- Medication adherence activities and preventive health activities are tied to current measures in QCP program
- Activities include diabetes kidney tests, cancer screenings, and medication adherence
- Visit NaviNet or contact your NAM to learn more

Provider Incentive Programs

Quality Quality Care Plus (QCP)

- Designed to recognize and reward providers' quality performance through several incentive programs:
  - Clinical Quality Performance
  - HEDIS
  - STARS

Maternity Quality Care Plus (MQCP)

- Designed to recognize and reward maternity care providers' quality performance:
  - Timeliness of initial visit
  - Post-Partum Care
  - ONAF submission
  - Cesarean section rate

Access, Appointment Standards and Telephone Availability

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

See **Chapter 10.2** of the Provider Manual for more information.

Access, Appointment Standards and Telephone Availability

Access, Appointment Standards and Telephone Availability Criteria	PCP	Specialist
EPSDT	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	n/a
Office wait time	30 minutes, or up to one hour if urgent situation arises	30 minutes, or up to one hour if urgent situation arises
Weekly office hours	At least 20 hours per site	At least 20 hours per site
Max appointment(s) per hour	6	n/a

- 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. **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.

Direct Access (continued)

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 of abuse or neglect. This includes reporting to Adult Protective Services any suspected abuse or neglect of members over the age of 18.
- 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.

Reportable Conditions – PA-NEDSS

- 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**.

Reportable Conditions – PA-NEDSS

- 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. 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 Code website**

Infection Control

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

Cultural and Linguistic Requirements and Services

- 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.

Cultural and Linguistic Requirements and Services

To help providers learn more about culturally and linguistically appropriate health care, Health Partners Plans recommends review of the following material:

- "*A Physician's Practical Guide to Culturally Competent Care*," sponsored by DHHS Office of Minority Health.
- 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**

Cultural and Linguistic Requirements and Services for members with Limited English Proficiency (LEP)

- Participating providers are required, by law, to provide translation and interpreter services (including American sign language services) at their practice location.
- The Provider Services Helpline can assist providers in obtaining services for members who need a qualified interpreter present at an 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 24/7. Learn more at **www.quantumtranslations.com**.

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 is provided to our members.
- **Chapter 14 of the Provider Manual** contains complete information on Member Rights and Responsibilities.

Recipient Restriction Program: Medicaid Only

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.

Recipient Restriction 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**.

Fraud, Waste and Abuse: 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 to $11,665-$23,331 per false claim, effective June 2020.
- If you wish to report fraud or suspicious activity, please call the Special Investigation Unit Hotline at **1-866-HP-SIU4U**.

Fraud, Waste and Abuse: Provider Self-Audit

- The DHS **MA Provider Self-Audit Protocol** allows providers to disclose any overpayments or improper payments.
  - Intended 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.

Fraud, Waste and Abuse: Provider Self-Audit

Providers have options for conducting 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

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)

Federal Health Care Laws

- For more information, visit the **Office of Inspector General, *A Roadmap for New Physicians***.

- To review OIG enforcement actions, visit: **https://oig.hhs.gov/fraud/enforcement/**

- The PH-MCO must create and disseminate written materials for the purpose of educating its employees, providers, subcontractors and subcontractor's employees about healthcare fraud laws, the PH-MCO's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the **rights of individuals to act as whistleblowers.**

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, 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**.
- Visit **HPP's webinars page** to review the "Complaints, Grievances and Appeals/Learn the Process" presentation

Complaints, Grievances and Appeals - Fair Hearings

- In some cases, a member can ask DHS to hold a hearing because he/she is unhappy about or do not agree with something HPP did or did not do.
- These hearings are called “fair hearings.” A member must exhaust HPP’s Complaint or Grievance Process before he/she can request a Fair Hearing. For more information, consult Chapter 8 of the **Health Partners (Medicaid) Member Handbook**.

Plan Contacts and Resources

Provider Services Helpline (9 a.m. to 4:30 p.m.)	1-888-991-9023
Medical Providers	Prompt 1
Pharmacies	Prompt 2
Join our HPP Provider Network	Prompt 3
Members	Prompt 4
Member Services	
Medicare	1-866-901-8000
Medicaid	1-800-553-0784
CHIP	1-888-888-1211
TTY	1-877-454-8477
Additional Resources	
eviCore Radiology authorizations, PT/OT/ST and other expanded services	1-888-693-3211
ECHO Health – electronic funds transfer and remittance advice	1-888-834-3511

Plan Contacts and Resources

Webpage	URL
Providers	hpplans.com/providers
Provider Manual	hpplans.com/providermanual
HP Connect (Provider Portal)	hpplans.com/hp-connect
HPP University	hpplans.com/hpp-university
Provider Directories	hpplans.com/directory
Formularies	hpplans.com/formulary
ECHO Health	http://view.echohealthinc.com/

Utilizing Telehealth to Improve Patient Access

HPP encourages all Providers to utilize telehealth when appropriate to improve and expand patient access to care.

Why use Telehealth:

- Covered reimbursable service
- Reduces patient barrier to accessing timely care for non-emergent or routine care
- Increases patient ability to access primary care, specialists and behavioral health visits for chronic conditions and medication management
- Improves your ability to monitor clinical signs for certain chronic medical conditions (e.g. blood pressure, blood glucose, weight gain)
- Increases patient compliance with needed after hospitalization follow up visits
- Improves your no show rates

Challenges:

- Not all HPP members have a phone therefore limiting their access to Telehealth

HPP Can Help Qualified Members Access a Phone Service through Pennsylvania's Life Line Program

- Life Line is available for free to qualifying low-income households
- Your patient will qualify if they are receiving Medicaid coverage, including Medicare Dual Special Needs members

We can help your HPP qualified patients access these State funded phones and increase your office visit compliance by having your office contact our Provider Service Helpline at 1-888-991-9023. Members can call the number on the back of their ID cards too.

Provider Relations

Provider Relations relies on multiple ways of communications to reach our provider network.

- Provider Newsletter
- Fax Blasts
- Webinars
- HP Connect
- HPP University
- NaviNet
- Network Account Managers
- Provider Education Specialists

Provider Check Up

PartnerUp with Health Partners Plans!

HPP Participating Providers Newsletter | FALL 2020

How to Help Patients Know When to Stop Medications

Health Partners Plans encourages providers to talk with their patients about all of the medications they take and when to stop taking them, if appropriate.

1. Set expectations about how long to take the medication.
Talk with your patients about how long they may need to take a medication. Help your patients understand if they need to take the medication for a set time (like an antibiotic) or long-term.

Best Practice: Remind your patients to bring a list of all medications to each doctor's visit. Discuss how long they should take each medication and determine if some medications can be stopped.

2. Stop for the right reason.
Has the medication worked as intended? Have symptoms resolved? Are there any negative side effects? Has your patient experienced any problems taking the medication?

Best Practice: Remind your patients to bring a list of all medications to each doctor's visit. Discuss how long they should take each medication and determine if some medications can be stopped.

3. Ask your patient if they have experienced any side effects.
Explain what happens when suddenly stopping medications. For example, some antidepressants may cause anxiety, dizziness and fatigue.

Best Practice: Ask your patients how they feel while taking these medicines. An alternative medicine may be available if they are experiencing negative side effects. Make sure your patients understand any risks associated with stopping medications and that they should never make this decision without consulting you.

4. Educate patients about the risks of stopping too quickly.
It's very common for people to stop taking an antibiotic before "completing the course" or to stop taking a medication altogether.

Best Practice: Talk with patients about the impact of stopping a medication early, including negative side effects and health outcomes, and about the dosage of their medications and how often should they be taking them.

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.

- https://www.healthpartnersplans.com/providers/provider-education-attestation?tot=Orientation