Health Partners Plans

Provider Orientation and Training

2023

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 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.
- In addition to this training, Health Partners Plans requires its Medicare providers to attest that they have fulfilled General Medicare Compliance Program requirements as described on HPP's Delegated Vendor Information webpage at:
  - https://www.healthpartnersplans.com/delegated-vendor-information
  - Medicare providers should review the Delegated Vendor Information Webpage and must submit the HPP's Provider Compliance Attestation annually. HPP will send a Provider Compliance Attestation Notification with further instructions each year regarding how and when to submit the Provider Compliance Attestation.

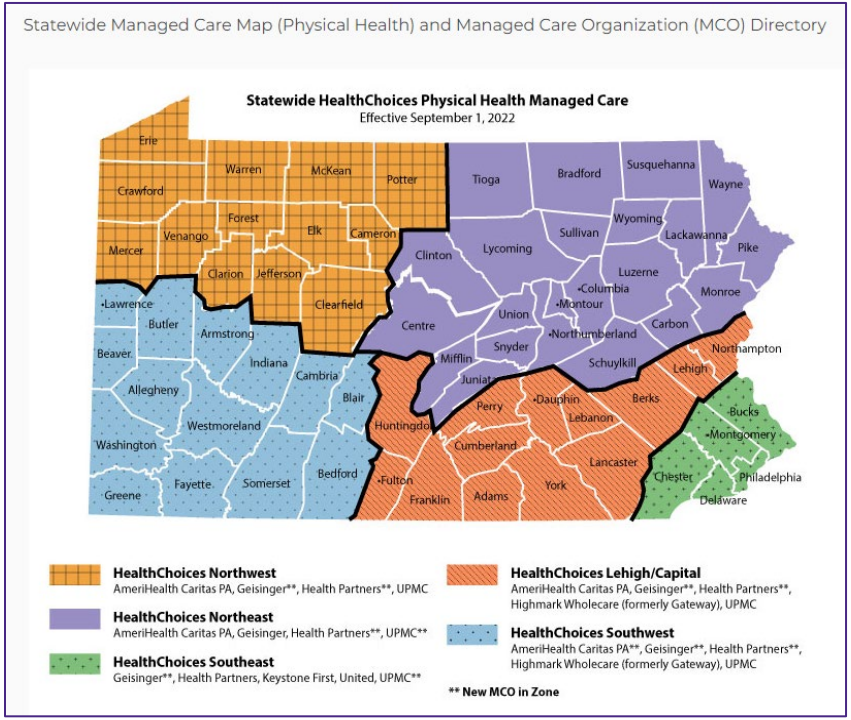
About Health Partners Plans

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

HealthChoices Zones (Medicaid)

Our regions, effective Sept. 1, 2022

- Southeast
- Lehigh Capital
- Northeast
- Northwest
- Southwest



Health Partners (Medicaid) Benefits Overview

NEW in 2023: Health Partners members have $0 copays for covered Medicaid physical health services. This includes $0 copays for prescription drugs.

Health Partners provides all the benefits of Medicaid, including:

- Hospital services
- Lab services
- Prescriptions
- Routine dental care for children and adults
- Checkups and immunizations and for children and adults
- Routine eye exams for children and adults
- Glasses and/or contact lenses for all children (two pairs of glasses or contacts, or one pair of each, covered yearly)
- Members 21 years and older are eligible to receive one pair of eyeglasses or contact lenses each year.

Health Partners Plans HPP

Health Partners (Medicaid) Extra Benefits

- Fitness center memberships
- Nutrition education and counseling
- Wellness Partners; a health and wellness initiative with free events for the community
- Baby Partners program
- Care Management programs
- Member events and education

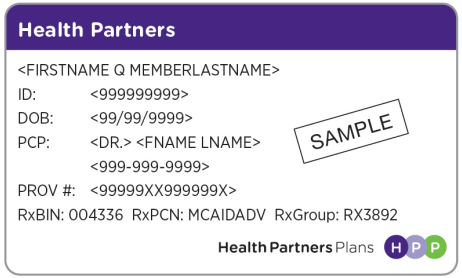
Members' Rights and Responsibilities

- HPP's statement of Member Rights and Responsibilities is provided to our members.
- Chapter 14 of HPP's Provider Manual contains complete information on Member Rights and Responsibilities.

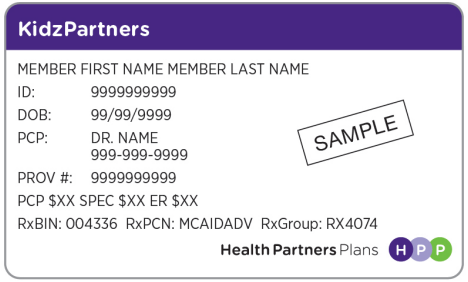
Coordination of Benefits

- 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.
- Chapter 11 of the Provider Manual contains more information.

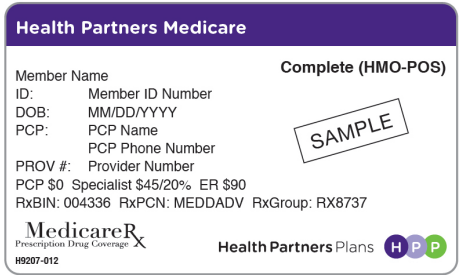
ID Cards for CY 2023



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



KidzPartners (CHIP)
(10-digit ID number)

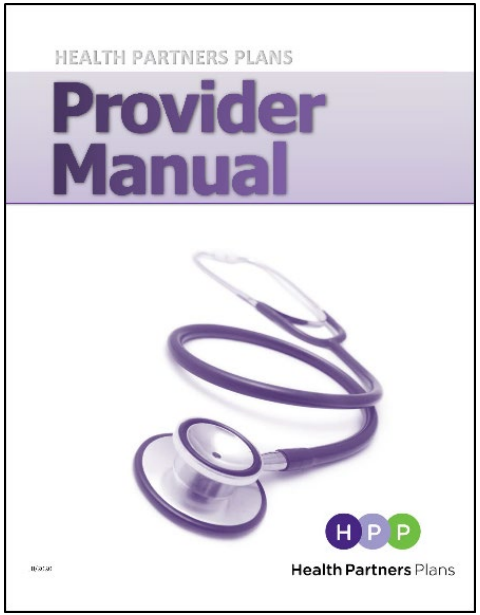


Health Partners (Medicare)

Health Partners Plans

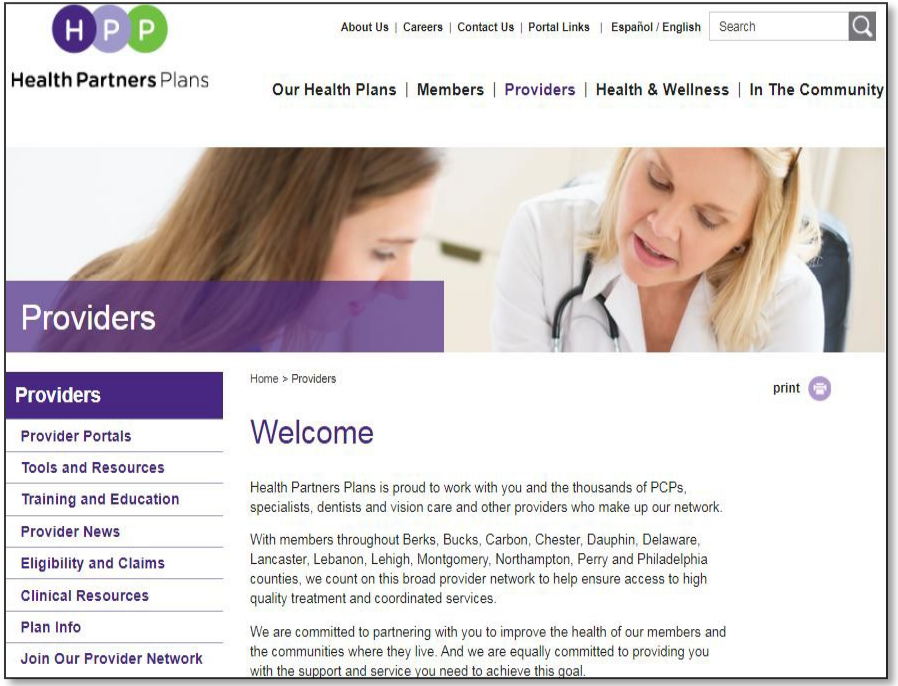
Provider Manual

- Reflects current policies and procedures for all lines of business.
- Updated annually
- Find the manual online at **www.HPPlans.com/providermanual**



Online Tools

- HP Connect (Provider Portal)
- Training and Education
  - HPP University
- Provider Directories
- Provider Manual
- Formularies
- Clinical Resources
- Plan Information
- Provider Newsletters
- Quality and Population Health



Claims Filing Instructions

- **Mailing Address:**
  Health Partners Plans
  Attn: Claims
  P.O. Box 981744
  El Paso, TX 79998-1744
- **Electronic:** Payer ID Number: 80142
- **Claims Clearing House:** Change Healthcare (formerly Emdeon)
- **EFT Payments and Remittances:** ECHO Health, Inc.
  EDI Support: EDI@hpplans.com
- **Pediatric Home Healthcare Services: Claim Submission via HHA eXchange System**
  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)

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Claims Reconsideration

Providers can request a reconsideration determination for a claim that may have been paid incorrectly or denied inappropriately. Reconsiderations must be made timely by the requestor.

Three options to request claims reconsideration:

1. HP Connect (Provider Portal)
2. Call HPP's Provider Services Helpline: **1-888-991-9023**, option #1
   (Monday to Friday, 8:30 a.m. - 4:30 p.m.).
3. Mail:

   Health Partners Plans
   Attn: Claims Reconsideration
   901 Market Street, Suite 500
   Philadelphia, PA 19107

Learn More Online
Timely Filing Protocols and the Reconsideration Process
HPPlans.com/ProviderLearning

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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.

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; Aperture 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 are:
    - Pediatrics
    - Family Practice
    - Internal Medicine
    - Certified Registered Nurse Practitioner (if credentialed as a PCP)

Pathways for Provider Demographics Changes

- Providers must notify, in writing, HPP's Network Management department 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)

Credentialing@hpplans.com	Datavalidation@hpplans.com Fax: 267-515-6650	ProviderData@hpplans.com Fax: 215-967-9274
All changes for **delegated** providers must be submitted to HPP via monthly exports sent to the credentialing team	All provider data changes for **non-delegated** providers, link request to participating providers, terminations	Hospital Based/Facility Based/PT/OT/Speech, links, changes, terminations

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**

Commitment of 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.
- Providers may be contacted for discharge/transition planning for disenrolled members, as HPP may remain responsible for participating in this planning for up to six months from the initial date of disenrollment unless the member chooses a different plan.

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**.

- Submit authorization requests via **HP Connect**.
- For detailed information on Utilization Management, review our **Provider Manual**.

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.

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.

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

Clinical Programs

Objectives

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

Our Clinical Programs are designed to address the needs of our members.

- 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 **FindHelp** (formerly known as 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

- **Healthy Kids**: Care Coordination and 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.

Clinical Programs: Medicaid and CHIP (continued)

- **Special Needs Unit Pediatric**: For complex children who have identified special needs or require shift care and who may benefit from care coordination

- **Care Coordination/Special Needs Adults**: Physical and behavioral health care coordination, disease education, and connection to supplemental benefits and HPP programs, community resources for adult members with multiple co-morbidities and/or special needs

Call the Clinical Programs team at **215-845-4797** and refer any patients for care coordination services.

Dental & Vision Benefits

- Dental Carrier
  - Avesis
  - 1-855-536-7764
- Vision Carrier
  - Davis
  - 1-800-260-2849

Note: Please do not distribute these numbers to members. For internal use.

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 plans.

Member Rewards Programs

HPP Rewards (Medicaid/CHIP)

- Encourages members to complete targeted condition management and preventive health activities
- Activities include certain well-child visits, lead screenings, certain dental visits, diabetes and hypertension management

Wellness Rewards (Medicare)

- Incentivizes Medicare members to complete specific health-related activities in 2023 to earn money on a reloadable gift card
- Activities include diabetes kidney tests, cancer screenings, and medication adherence.

Learn more at
www.HPPlans.com/Rewards

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 (BH-MCO) 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 BH-MCO. The BH-MCO will conduct an intake assessment and refer the member to the appropriate level of care.

Mental Health and Substance Abuse Treatment

Each HealthChoices consumer is assigned a Behavioral Health Managed Care Organization (BH-MCO) based on their county of residence.

For the most recent listings of BH-MCOs by county: visit
https://www.dhs.pa.gov/HealthChoices/HC-Services/Pages/BehavioralHealth-MCOs.aspx

Behavior Health for CHP and Medicare Members

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

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

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.

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 (continued)

- 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.**

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™

Health Partners Plans HPP

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 **www.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:
  - First screening by age 12 months and a second by age 24 months.
  - 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; visit **www.HPPlans.com/EPSDT**
- CHIP adheres to the Bright Futures guidelines, which can be found on the same webpage.
- 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**

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

Our 2023 Medicare Plans

Health Partners Medicare is offering five Medicare Advantage plans with no referrals, expanded supplemental benefits, no medical or Rx deductibles, affordable copays and Part D prescription drug coverage.

Pennsylvania

Complete (HMO-POS)	Prime (HMO-POS)	Special (HMO SNP)

New Jersey

Silver (HMO-POS)	Platinum (HMO-POS)

Medicare Care Coordination

- HPP's care coordination team is made up of a team of nurses and social workers dedicated to helping members with accessing timely and needed care, as well as working with providers to close needed preventive health services (care gaps).
- Members are assigned care coordinator based on their plan type or risk stratification:
  - All DSNP are assigned a Care Coordinator
  - All non-DSNP members are assigned to a care coordinator based on risk level and/or care needs.
  - Providers can refer HPP members for care coordination; call **215-845-4797** to refer members.
  - HPP's Care Coordination team can assist with but not limited to:
    - SDOH issues
    - Behavioral health
    - Food insecurity
    - Coordinating services with CHC plans
    - Coordinate benefits and assist with accessing services
    - Encourage preventive health screenings and education
    - Discuss importance of medication adherence and set up home delivery

Community HealthChoices (CHC) Information

- All Health Partners Medicare dual eligible beneficiaries are enrolled in one of the three Medicaid CHC plans.
  - PA Health & Wellness (Centene)
  - AmeriHealth Caritas (Keystone)
  - UPMC

- Participating physicians **can** provide services to Health Partners Medicare members even you are not participating with CHC plan.

- **Keep in Mind:**
  - Medicare is the **primary** payer and drives the care.
  - Medicaid benefits are accessed after Medicare benefits have been exhausted.
  - Medicaid is **always** the payer of last resort.
  - HPP's Care Coordinator can assist you with coordinating services between Medicare and Medicaid.
  - You can submit claims to the CHC plans regardless of your participating 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)

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).
- 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.

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, click here (cms.gov).

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.
- Each year, HPP surveys our network to determine if Providers are meeting the access, appointment and telephone availability standards, as set by the Department of Human Services (DHS) for Health Partners (Medicaid) and KidzPartners (CHIP) members, and by the Centers for Medicare & Medicaid Services (CMS) for Health Partners Medicare members. We kindly ask that you complete the survey.

Health Partners Plans HPP

Utilizing Telehealth to Improve Patient Access

HPP encourages all providers to utilize telehealth (when appropriate) to improve and expand patient access to care.

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

Qualified members can access phone service through Pennsylvania's Lifeline program

- Lifeline 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 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.

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.

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.

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, 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**

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.

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

A Physician's Practical Guide to Culturally Competent Care is sponsored by DHHS Office of Minority Health. This is a free, self-directed training course for physicians and other health care professionals.

This is a recommended website that offers CME/CE credit and equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse population they serve; **cccm.thinkculturalhealth.hhs.gov**

Learn More Online
Cultural Competency and Linguistic Requirements and Services
HPPlans.com/ProviderLearning

Health Partners Plans HPP

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, at the providers cost.
  - If you need assistance our Helpline can assist providers in locating services for members who need a qualified interpreter present at an appointment or telephonically through Language Line Solutions (an interpretation service).
  - If you need to schedule an interpreter to meet your patient for an appointment, contact the vendor at **215-627-2251**. Interpreters are available 24/7. Learn more at **www.quantumtranslations.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% Claim Review
2. Provider-Developed Audit Work Plan for BPI Approval
3. DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample

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

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 to report compliance issues, including 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
       - 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 agreement

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.

Additional training on Fraud, Waste and Abuse can be found at **HPP University.**

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 Fraud and Laws

The False Claims Act Statute: 31 U.S.C. §§ 3729–3733	The False Claims Act Statute: 31 U.S.C. §§ 3729–3733
The Anti-Kickback Statute Statute: 42 U.S.C. § 1320a–7b(b) Safe Harbor Regulations: 42 C.F.R. § 1001.952	**The Anti-Kickback Statute** Statute: 42 U.S.C. § 1320a–7b(b) Safe Harbor Regulations: 42 C.F.R. § 1001.952
The Physician Self-Referral Law Statute: 42 U.S.C. § 1395nn Regulations: 42 C.F.R. §§ 411.350–.389	**The Exclusion Authorities** Statutes: 42 U.S.C. §§ 1320a–7, 1320c–5 Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)
The Civil Monetary Penalties Law Statute: 42 U.S.C. § 1320a–7a Regulations: 42 C.F.R. pt. 1003	**Criminal Health Care Fraud Statute** Statute: 18 U.S.C. §§ 1347, 1349

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 **HPPlans.com/webinars** 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	www.HPPlans.com/providers
Provider Manual	www.HPPlans.com/providermanual
HP Connect (Provider Portal)	www.HPPlans.com/hp-connect
HPP University	www.HPPlans.com/hpp-university
Provider Directories	www.HPPlans.com/directory
Formularies	www.HPPlans.com/formulary
ECHO Health	http://view.echohealthinc.com/

Provider Relations

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

- Provider Newsletter
- Fax Blasts
- Webinars
- HP Connect Portal
- HPP University
- Provider Relations Representatives
- 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.

Thank You for Joining Us Today

- The presentation has concluded.
- Please use the Q&A panel for all questions.
- For any additional questions that may arise, please email: ProviderEducation@hpplans.com

Complete Your Attestation

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

If you reviewed the training materials electronically, please complete the provider education attestation at www.healthpartnersplans.com/providers/provider-education-attestation

Contact Us

HPPlans.com

Health Partners Plans

Provider Helpline

1-888-991-9023
(TTY 1-877-454-8477)

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Thank You!

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