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Health Partners Provider Manual Member Eligibility/Enrollment: Health Partners & KidzPartners



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

Topics:

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

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Overview

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

What is HealthChoices?

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

Enrollment

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

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

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

The Health Partners Member ID Card

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



Figure 3.1: Health Partners ID Card

Verification may be obtained by:

- logging on to Provider Connect at <http://www.healthbpart.com> and using your protected password

- calling the Provider Services Helpline and providing the patient's name and birth date. Monday through Friday, 8:30 a.m. to 5:00 p.m. For more information, see Table 1: Service Department Contact Information on page 1-13.
- accessing the Pennsylvania State Eligibility Verification System (EVS) at **1-800-766-5387**
- submitting an Eligibility Inquiry (Transaction ASC X12N-270) through Emdeon.

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

Third Party Liability

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

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

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

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

Third party liability also relates to automobile insurance and personal injury insurance coverage (homeowner's, etc.). If a member is injured in an accident, the provider should first bill the member's motor vehicle or other accident carrier prior to submitting a claim to Health Partners. Under HealthChoices, Health Partners must notify the Department of Public Welfare (DPW) if we provide reimbursement for the care of a member's auto-related or other accident-related injuries. DPW has the right of recovering monies paid to providers in these instances, should it be discovered another insurer was primary.

Third party liability also includes personal lawsuits brought by a member against a third party. Providers should bill all available medical insurers for any services, even if a member has or intends to bring suit. Under HealthChoices, Health Partners must notify DPW of any personal liability suit. DPW retains the right of subrogation.

Verification of Eligibility

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

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

In addition, providers may verify member eligibility by calling the Enrollment Eligibility department Monday through Friday, 8:30 a.m. to 5:00 p.m. or the Provider Services Helpline, 24 hours a day/seven days a week. For more information, see Table 1: Service Department Contact Information on page 1-13.

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

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

Member Transfers

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

Voluntary Transfers

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

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

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

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

Involuntary Transfers

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

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

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

Disenrollment from Health Partners

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

Voluntary Disenrollment

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

Involuntary Disenrollment

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

- If the member loses Medical Assistance eligibility.
- If there is Pennsylvania Department of Aging (PDA) waiver eligibility beyond 30 consecutive days.
- As the result of a formal grievance or Departmental hearing decision of an appeal (whether filed by the member or the plan).
- If the member becomes an inmate or resident of a public, mental, penal reform, or correctional institution, disenrollment becomes effective the date he/she enters the institution. (Members in Juvenile Detention Centers may be disenrolled only if admitted for more than 35 consecutive days.)
- If the member resides outside the Health Partners service area and requires ongoing services.
- If the member is in a long-term care facility for 30 days.

Health Partners will notify the Department of Public Welfare to initiate disenrollment for a member if the stay in the facility exceeds 30 days. The Medical Assistance Long Term Care Handbook contains fee-for-service instructions necessary to submit invoices for dates of service in excess of 30 days.

- If the member is over 21 and becomes Medicare A and B eligible.
- In the event of the member's death.

Recipient Restriction Program

Health Partners participates in the Pennsylvania Department of Public Welfare Recipient Restriction Program. The program calls for Health Partners to monitor and identify Medical Assistance recipients who improperly or

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

Loss of Medical Assistance Eligibility

Members may lose eligibility for Medical Assistance for various reasons at any time during the month. Claims for treatment delivered prior to the member losing eligibility will be treated like any other claim, and be processed for payment by Health Partners.

Membership Panel

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

Member Status Report

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

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

KidzPartners Eligibility/Enrollment

This is a holding place for the KidzPartners Eligibility/Enrollment section. Please check back later this year for eligibility and enrollment information about our CHIP program.