SECTION 9
LOCAL HEALTH DEPARTMENTS AND MO HEALTHNET MANAGED CARE HEALTH PLANS

ELIGIBILITY

MO HealthNet participants in certain counties within the state of Missouri are enrolled in one of the Managed Care health plans that have a contract with the MO HealthNet Division to provide benefits to these participants. With very few exceptions, a MO HealthNet participant MUST enroll in a MO HealthNet Managed Care health plan if they are in one of the designated categories of assistance and reside in one of the designated counties.

When the local health department checks the participant's MO HealthNet eligibility, if the participant is enrolled in a MO HealthNet Managed Care health plan, the name of the plan and other plan information will be provided. Eligibility can be checked either through MO HealthNet's Interactive Voice Response (IVR) at (573) 751-2896 or by logging on to the agency's Internet billing web portal, emomed.com. **PROVIDERS MUST VERIFY THE ELIGIBILITY STATUS AND MANAGED CARE HEALTH PLAN ENROLLMENT STATUS BEFORE PROVIDING SERVICES TO PARTICIPANTS. THE PLAN IS RESPONSIBLE ONLY FOR A CLAIM IF THE PARTICIPANT IS A MEMBER OF THE HEALTH PLAN ON THE DATE THE SERVICE IS PROVIDED.**

MO HealthNet Managed Care participants are given fifteen (15) calendar days from the time of their eligibility for managed care to select a health plan. All members of a family are encouraged to select the same health plan. If a family does not select a health plan within the fifteen (15) day window, the state agency will automatically assign the family to a health plan. The health plan will then auto assign the participant to a Primary Care Provider (PCP). Once a member chooses a health plan or is assigned to a health plan, the member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. This applies to the member's initial enrollment and to any subsequent enrollment periods where the member changed health plans.

All members will have a twelve (12) month lock-in to the selected health plan to provide a solid continuum of care. Under certain circumstances, participants may change their health plans and/or PCPs prior to the end of the twelve (12) month period. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan. Unless the mother chooses a different health plan for her child, the child will remain with the mother's health plan.

Each participant receives Managed Care health plan educational material provided by the contracted enrolling agent, Wipro Infocrossing Healthcare Services. Wipro Infocrossing Healthcare Services is responsible for educating, enrolling, and entering the enrollment information into the proper systems.

Participants identified as eligible for MO HealthNet Managed Care are not enrolled in a health plan until sometime after the plan is selected. When providers check eligibility through IVR/emomed.com information for a specific date of service, if a plan is not listed, the participant's services are not MO HealthNet Managed Care and services should be billed MO HealthNet Fee-For-Service for that date of service. Managed Care health plan information on the IVR and emomed.com is subject to change daily.

SERVICES

When participants need medical care, they are instructed to call their Primary Care Provider (PCP) unless it is an emergency situation. The participant is instructed further that, if they need the care of a specialist, their PCP must first make the referral to the specialist. The PCP's responsibilities include but may not be limited to the following.

- Coordination of handling the participant's medical records
- Provision of check-ups and vaccinations
- Keeping track of medical records
- Referral to a specialist when necessary
- Prescribing medication
- Admission to a hospital when necessary

Some services provided by public health agencies remain outside those provided by MO HealthNet Managed Care health plans and are not considered plan benefit services even when provided to a qualified Managed Care health plan participant. These services are reimbursable on a fee-for-service basis by the MO HealthNet Division and include:

- SAFE/CARE examinations when furnished by a SAFE trained MO HealthNet enrolled provider
- Environmental lead assessments for children with elevated blood levels
- Laboratory tests performed by the Department of Health and Senior Services as required by law (e.g. metabolic testing for newborns, blood lead testing, etc.)

There is freedom of choice for birth control and family planning services. The participant does not have to see their PCP. A qualified MO HealthNet provider, including local health departments, does not need a referral for those specific services. Claims for birth control and family planning services are to be sent to the appropriate MO HealthNet Managed Care health plan.

Managed Care health plan participants may go to a public health department for childhood immunizations and screenings, diagnosis and treatment for sexually transmitted diseases or tuberculosis, and to be tested for HIV/AIDS.

When a MO HealthNet Managed Care health plan participant has no form of transportation to a medical appointment, the participant is instructed to call their plan for assistance with transportation arrangements. However, some members' benefits do

not cover transportation.

COVERED SERVICES FOR LOCAL HEALTH DEPARTMENTS

When a local health department provides and bills a Managed Care health plan for eligible services provided to a MO HealthNet Managed Care participant, the health plan must reimburse the health agency at the current MO HealthNet Fee-for-Service reimbursement rate unless other reimbursement rates have been negotiated. This arrangement is outlined in the contract between the MO HealthNet Managed Care health plan and the MO HealthNet Division.

These services include:

- Childhood Immunizations
- STD and TB screening, diagnosis, and treatment
- HIV screening and diagnosis
- Family planning services
- Childhood lead screening, diagnosis, treatment follow-up

The managed care health plans use the CMS-1500 for billing paper claims. If a claim is denied, call the health plan's provider relations department for assistance in understanding the denial.