SUMMER 2025

Provider Check Up

Thank you for being a valued provider for members in one or more of our health plans: Health Partners Plans Medicaid, Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage, and/or Jefferson Health Plans Individual and Family Plans.

As we head into summer, we have a new batch of exciting updates and information to help you provide the highest quality care to our members. Inside of this issue of Provider Check Up, you'll find:

- An overview of our 2025 Medicare Rewards Program
- Helpful online health and wellness tools to empower your patients to take charge of their well-being
- Important policy updates
- And more!

What's Inside

New Chronic Wound Care Program

Effective March 3rd, 2025, providers can now refer Health Partners Plans Medicaid and Jefferson Health Plans Medicare Advantage members with chronic wounds to Esperta Health.

Esperta Health is a specialty physician practice that has partnered with us to deliver a complete wound care program for your patients right in their home. This program ensures patients receive expert care from wound-certified specialists who can treat, heal, and prevent their chronic wound from recurring.

Chronic wounds approved for referral include:

- Diabetic Ulcers
- Arterial Ulcers
- Venous Ulcers
- Pressure Injuries or Ulcers
- Chronic Venous Insufficiency Ulcers
- Malignancy-related Ulcers
- Lymphedema-related Ulcers
- Surgical Wounds
- Burns
- Atypical Wounds
- Autoimmune Wounds
- Wounds Caused by Infections
- Non-Healing Wounds
- At-Risk Wounds*

*At-risk wounds: Multiple or significant patient co-morbidities, recurrent infections, prior amputation(s), history of wound-related hospitalization, poor nutrition, weakened immune system including chronic illness such as cancer, diabetes, COPD, immunosuppressant medications, including steroids and biologics.

Working Smarter with Stellar Health

We have partnered with Stellar Health, a healthcare information technology company, whose mission is to enable providers to deliver high-quality care for your patients. What makes Stellar unique for providers is its user-friendly platform that shows open care gaps and provides access to both historical and updated monthly claims data, helping you prepare for more comprehensive patient visits.

Through the Stellar App, a secure web-based tool, providers receive notification of care gaps and potential conditions for your patients. Stellar also provides monthly payments to your practice for your time spent delivering care to your patients through addressing these open care gaps.

To get started or learn more, contact Stellar Health directly at **provider@stellar.health**, or **929-202-7869** (call or text) if you have any questions about the program.

We appreciate your continued collaboration in delivering high quality care and look forward to supporting your efforts to prioritize patient health in 2025.

Lead screening in children is an important preventive measure. Children must have at least one capillary or venous blood test on or before their second birthday. Effective April 21, 2025, we have a contract with Kirby Memorial Health Center to process lead screenings for our members.

To refer a patient to Esperta Health, please:

- Fax the patient referral form to **615-278-1860**
  - Click this link to download the referral form: **https://platform.espertahealth.com/espertahealth/**
- Refer online by going to **espertahealth.com/referral**
- Call Esperta Health at **833-377-3782 – Option 1**
- Send a secure email to **customerservice@espertahealth.com**

Doulas: Partners in Maternal Health

Doula Services

The Medical Assistance Program (Medicaid) provides comprehensive maternity care services for eligible beneficiaries during pregnancy and through the postpartum period. In the managed care delivery system, the Managed Care Organizations (MCOs) utilize maternity care teams, which may include doulas, to provide comprehensive maternity care services. Doulas may also be part of other maternal care services provided by the MCOs.

Effective February 1, 2024, the Medical Assistance Program enacted coverage for doula services enabling MCOs to enter into network agreements with doulas.

What is a doula?

A doula is a trained non-medical professional who provides emotional, informational, and physical support to a pregnant individual, their partner, and family members during pregnancy, labor and delivery, and the post-partum period. Doulas do not make decisions for families, offer medical advice, or interfere at any time with medical providers. They do not take the place of the clinical team nor the family member or partner. Instead, they are an additional layer of support to ensure the best birthing experience for the mom to be.

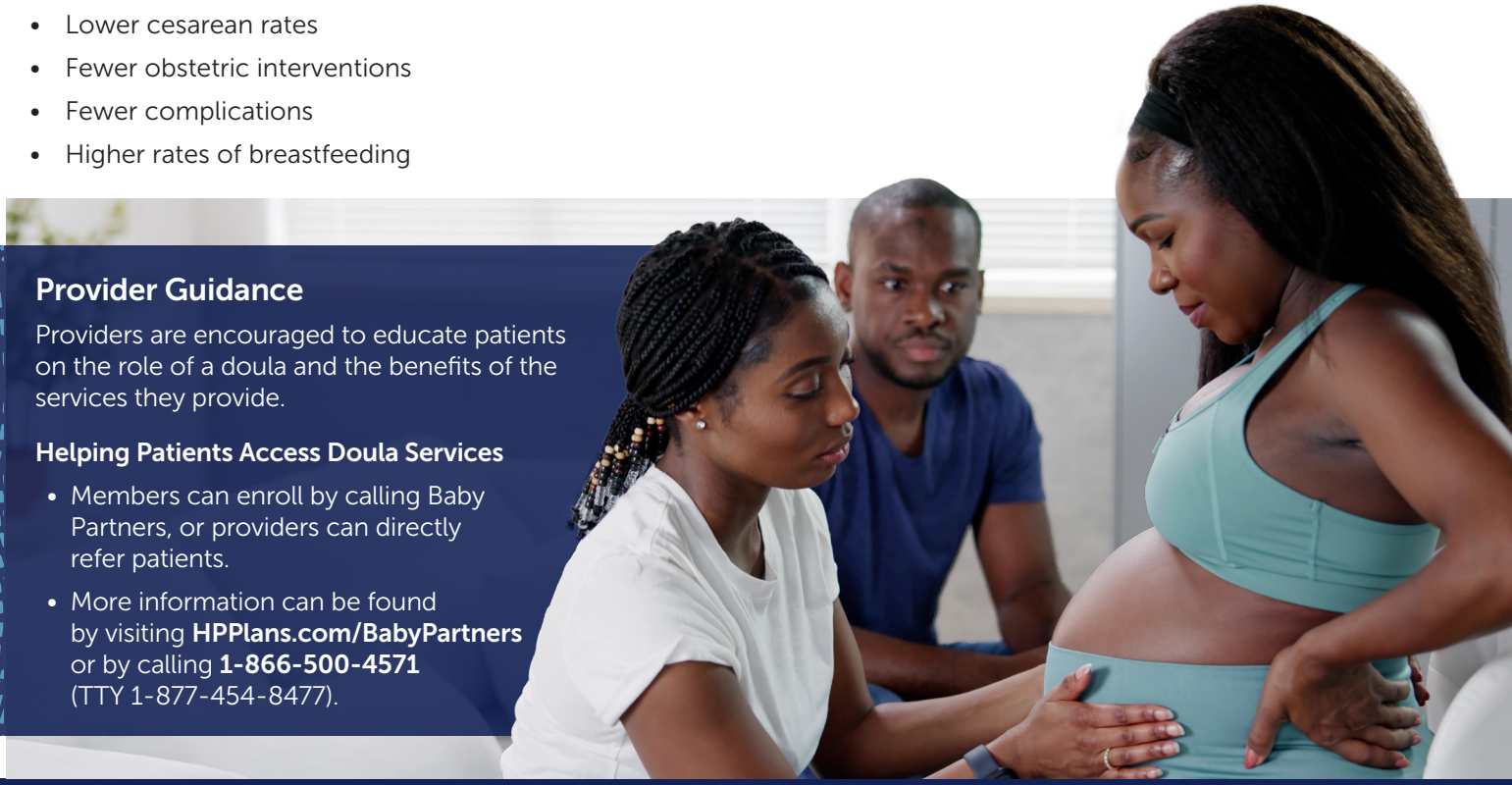
Doula care can have a meaningful effect on improving maternal health. Studies have demonstrated that support from non-clinical providers within Medicaid populations, such as doulas, is associated with:

- Lower cesarean rates
- Fewer obstetric interventions
- Fewer complications
- Higher rates of breastfeeding

What does a doula do?

- Supports and advocates for a woman's birthing preferences and provides childbirth education.
- Helps members get information on pregnancy, childbirth, and early parenting, plus connects them with local resources.
- Accompanies the person in labor in the chosen location of the birth.
- Provides comfort and coaching during labor and delivery and serves as a patient advocate when issues such as pain management or other interventions are raised.
- Helps the client and partner make informed decisions about their care.
- Works to ensure the client feels respected and heard throughout labor and birth.
- Conducts prenatal, postpartum, and bereavement visits throughout the perinatal period, lasting until one year after birth or termination of pregnancy regardless of outcome. Visits can be done both in-person and virtually.
- Offers breastfeeding (lactation) support right after delivery and postpartum as needed.

To become a doula in Pennsylvania, individuals must have a Certified Perinatal Doula license, which is administered by the state certification board, and pay a fee.



Provider Guidance

Providers are encouraged to educate patients on the role of a doula and the benefits of the services they provide.

Helping Patients Access Doula Services

- Members can enroll by calling Baby Partners, or providers can directly refer patients.
- More information can be found by visiting **HPPlans.com/BabyPartners** or by calling **1-866-500-4571** (TTY 1-877-454-8477).

Comprehensive Care for Opioid Recovery

Many people at the highest risk for an overdose death have an opioid use disorder (OUD), however, only approximately 20 percent receive treatment. Access to evidence-based OUD treatment, including Medication-Assisted Treatment (MAT) is limited, often delaying or preventing entry into care, according to the Substance Abuse and Mental Health Services Administration (SAMHSA). Alongside treatment, supportive services like housing, transportation, childcare, and job training are also critical to overall well-being.

Opioid Use Disorder Centers of Excellence (COEs) were introduced in 2016 to address the overdose crisis and engage clients with OUD in treatment. COEs have also created community-based care management teams to support clients with care coordination and recovery support. The community-based care management teams bring together a diverse group of providers to deliver whole-person care, including treatment for OUD, physical health conditions, and mental health needs. They also offer support for housing, transportation, childcare, and employment training.

Visit **Centers of Excellence** webpage to see which Opioid COEs are contracted to serve our Medicaid members. In-Person and virtual services are available.

Opioid COEs are now implementing Fidelity Guidelines. These guidelines aim to promote standardization of the COE program while allowing flexibility for COEs to adapt to the populations and communities they serve. This includes streamlining workflows such as the intake and enrollment process to increase engagement.

Resources:

Centers of Excellence | Department of Human Services | Commonwealth of Pennsylvania

Find Your Local COE

COE Resources

Streamlined In-Home Screening Referrals

We continue to partner with our vendor Healthy Measures to provide in-home screenings for noncompliant members for the following HEDIS measures: HbA1c Control, Kidney Function Evaluation, Diabetes Eye Exam, Controlling Blood Pressure, Lead Screening, and Osteoporosis Screening.

These services play a critical role in improving our members' health outcomes, which, in turn, can enhance your office's quality performance and potentially increase your Quality Care Plus (QCP) revenue.

Once your office has identified the patients who are due for one of the above screenings, our Quality Improvement and Performance outreach team will coordinate the in-home appointment with the patient, typically within 30 days of the referral. Our outreach team will also make reminder calls the day before the scheduled appointment.

After the in-home appointment has been completed, your office will receive the results of the visit **via fax** from Healthy Measures. Results are sent approximately 2-3 weeks after the appointment was completed.

If you would like to refer a member and **they agree to the in-home screening**, please send an email to **QIPReferrals@jeffersonhealthplans.com**. Please include the following details in your referral: patient name, member ID, phone number, and the test(s)/screening(s) needed.

Understanding Medicare Annual Wellness Visits

The Medicare Annual Wellness Visit (AWV) is a crucial preventive care visit covered by Medicare to collect important patient health information and complete health screenings. Ideally, members who are new to Medicare should complete an AWV within the first 90 days of enrollment so they can establish care and address any preventive, care management, or health-related social needs.

We have several resources available on the **Quality and Population Health** page of our website.

- **Provider Resource Guide: Improving Patient Experience** — contains tips for boosting member satisfaction scores.
- **Provider Fact Sheet: Annual Wellness Visits** — contains helpful information including Addressing Care Gaps and Preventive Screenings, Billing and Coding, and Resources to Increase Engagement.

Additionally, our Member website also contains information regarding the **Annual Wellness Visit**.

There are three different types of AWVs that a member may be eligible for:

Welcome to Medicare Visit	Initial Medicare Annual Wellness Visit	Subsequent Medicare Annual Wellness Visit
☐ Medicare pays for one per lifetime ☐ Must be done in the **first 12 months** of Part B coverage	☐ Applies the first time a beneficiary receives an AWV ☐ Patient is eligible **after the first 12 months** of Part B coverage ☐ Patient hasn't completed a Welcome to Medicare Visit in the past 12 months	☐ Applies to all AWV's after a beneficiary's initial AWV ☐ No AWV within the past year

Use Our Quality Management Provider Referral Line for Preventable Adverse Events

To ensure the highest quality of care, and in accordance with the Pennsylvania Department of Human Services and CMS requirements, our Quality Management (QM) department must identify, track and follow up on the following:

- Preventable Serious Adverse Events (PSAE)
- Healthcare Acquired Conditions (HCAC)
- Other Provider Preventable Conditions (OPPC)

We offer a toll-free, anonymous provider reporting line to identify and track such events that are deemed preventable, serious, and adverse. To report an event, call 1-855-218-2314 with the following information:

- Member name, health plan ID#, and/or date of birth
- Date of event
- Description of event
- Location where event occurred

All calls will remain confidential and will be followed up by QM for verification. Our policy is to reasonably track and isolate identified events and account for any payments that may have been made in association with them. Jefferson Health Plans reserves the right to retract payments made for what are deemed preventable events.

Maximize Your Incentives with the ONAF Program

Health Partners Plans Medicaid offers a reimbursement program for the submission of the Obstetrical Needs Assessment Form (ONAF), available to all OB/GYN providers in our network.

Providers are eligible to earn a maximum of a $200 total incentive for the submission of **one complete prenatal** and **one complete postpartum** ONAF form.

All ONAFs must be submitted and accepted electronically via OPTUM.

Payments will be issued on a quarterly basis.

Prenatal ONAFs must be submitted within 7 days of the initial prenatal visit.

Please visit **our website** for more information on our ONAF program.

Baby Partners Provider Hotline is Here to Help

To assist in managing the care of our pregnant and postpartum members, we have established a hotline for our providers to call to quickly connect a member to programming and services we offer.

Our Baby Partners care coordinators are just a phone call away to help make that connection. Please contact us at **833-705-3751**. The hotline is available Monday-Friday during business hours (8:00 AM - 4:30 PM). Calls received after hours will be returned the following business day.

Effective Asthma Management with Asthma Spacers

Asthma is a chronic inflammatory condition that affects 4.6 million children in the United States[1]. In fact, asthma is the most prevalent chronic illness in children and the primary contributor to childhood morbidity from chronic conditions, as reflected in the number of school absences, emergency department visits, and hospitalizations[2].

According to the 2024 Global Initiative for Asthma (GINA) guidelines, the goals of asthma therapy include:

- Achieving good long-term symptom control, including no sleep disturbance, and unimpaired physical activity
- Minimizing future risk of asthma, including no exacerbations, and improved or stable personal best lung function

For the most recent GINA Guideline recommendations, visit **https://ginasthma.org/reports/**.

Encouraging the use of spacers in young children will help ensure proper medication delivery, improve asthma control, and reduce exacerbation risks.

The GINA guidelines recommend the following when choosing an inhaler device for children 5 years old and younger:

Additional Considerations

- **Educate caregivers on proper spacer technique**, emphasizing the importance of slow, deep breaths when using a mouthpiece or a proper seal when using a face mask.
- **If using a face mask,** it should fit tightly around the child's mouth and nose to prevent any medication loss. You can use the following video to give caregivers more information on how an inhaler should be used with a spacer: **https://www.youtube.com/watch?v=sQUUJHzO-XQ**
- **Regular follow-ups** for assessment of symptom control and medication adjustments as needed (every 3-6 months).
- **Ensure children are up to date on any recommended vaccinations,** including influenza and pneumococcal, to reduce the risk of infections that can exacerbate asthma symptoms.

[1]https://acaai.org/asthma/asthma-101/facts-stats/
[2]Asthma-Related School Absenteeism, Morbidity, and Modifiable Factors - PMC

Age Group	Preferred	Alternative
0 to 3 years old	Pressurized metered-dose inhaler (MDI) plus dedicated spacer with face mask	Nebulizer with face mask
4 to 5 years old	Pressurized MDI plus dedicated spacer with mouthpiece	Pressurized MDI plus dedicated spacer with face mask OR nebulizer with face mask or mouthpiece

Vaccinate and Educate: Medicaid Covers Both

What Providers Need to Know

Immunizations, including the annual influenza vaccine, are an important part of preventative medicine for children of all ages, from babies to adolescents. Please speak to your patients and patient's family/caregiver about the recommended vaccines for your patient's age group.

Medicaid providers may bill for vaccine counseling-only visits when Medicaid beneficiaries under age 21, and/or their parent or caregiver, receive counseling about any pediatric vaccines covered under the EPSDT benefit from a qualified health care professional authorized to administer pediatric vaccines, but no pediatric vaccine is administered. Click **here** to read the latest bulletin from DHS. **Please remember to differentiate between vaccine education vs. administration when documenting in the EMR.**

Vaccine counseling-only visits may be provided in addition to another service (including a SARS-CoV-2 vaccine administration, or a COVID-19 vaccine counseling-only visit) and may also be provided via telemedicine. Medicaid providers may not bill vaccine counseling-only visits in addition to a complete EPSDT screen.

Essential Screening for Adolescent Depression

According to data from the National Institute of Mental Health, approximately 20.1% of adolescents aged 12 to 17 in the United States experience a major depressive episode in a given year, with females reporting higher rates of depression than males. That's why it is essential that providers begin screening patients for depression starting at age 12 during routine visits and take appropriate action if a positive result is identified.

What Providers Should Know

To effectively screen for depression, providers must use a validated, age-appropriate screening tool. If a patient screens positive, as a provider you must document a clear follow-up plan, which could include referral to a mental health specialist, medication management, or further assessment.

Examples of Adolescent Screening Tools (Ages 12-17 years):

- Patient Health Questionnaire for Adolescents (PHQ-A)
- Beck Depression Inventory-Primary Care Version
- Mood Feeling Questionnaire (MFQ)
- Center for Epidemiologic Studies Depression Scale (CES-D)
- Patient Health Questionnaire (PHQ-9)
- Pediatric Symptom Checklist (PSC-17)
- PRIME MD-PHQ-2

If you would like to refer a member to our case management program to assist with coordination of care, please contact us at **1-866-500-4571, option #2.**

Treating ADHD in Children? Don't Skip the Follow Up

Attention-deficit/hyperactivity disorder (ADHD) is one of the most common mental disorders affecting children. Symptoms of ADHD include inattention (difficulty staying focused), hyperactivity (excess movement not suited to the setting) and impulsivity (hasty acts that occur in the moment without thought).

Why is this important?

Children and adolescents prescribed ADHD medication are at increased risk for developing serious metabolic health complications that can lead to poor cardiometabolic outcomes in adulthood.

What can providers do?

Screening your patients for ADHD is an essential first step. If medications are prescribed, ensure follow-up care includes the following:

- Schedule a follow-up appointment within 30 days of writing the prescription to monitor for side effects and assess the medication's efficacy.
- Schedule at least 2 additional follow-up appointments over the next 9 months to make sure the medication is working, and the dosage is appropriate.
- If needed, refer your patient to a Mental Health Professional for further evaluation and counseling.
- Encourage telehealth options, such as a telephone visit, e-visit, or virtual check-up, where appropriate.

If you need assistance coordinating care for these members or collaborating with a behavioral health provider, please contact our **Pediatric Care Coordination Department** at **215-967-4690**.

Optimizing COPD Management: Key Strategies and Patient Care Tips

Chronic Obstructive Pulmonary Disease (COPD) is one of the top three causes of death worldwide. Risk factors to COPD include exposure to tobacco smoke, vaping or e-cigarette use, exposure to household pollution, ambient air pollution, wildfire smoke, occupational hazards, and childhood asthma.

The primary goals of managing stable COPD are to alleviate symptoms, enhance exercise tolerance, and improve overall health status. Additionally, treatment aims to reduce the risk of disease progression by preventing exacerbations and minimizing mortality. By addressing both symptoms and risk factors, we can help improve patient outcomes and quality of life.

Medication Optimization Guidelines

Current treatment guidelines recommend patients in Group E and B should be prescribed a combination Long Acting Beta Agonist + Long Acting Muscarinic Antagonist (LABA+LAMA). Single inhaler therapy has been shown to improve adherence to treatment. Pharmacotherapy should be individualized and based on symptom severity, risk of exacerbations, side-effects, comorbidities, and cost.

<table>
<tr><td>2 moderate exacerbation or > 1 exacerbation leading to hospitalization</td><td colspan="2">Group E
LABA+LAMA
*consider LABA+LAMA+ICS if blood eos >300</td></tr>
<tr><td rowspan="2">0 or 1 moderate exacerbation</td><td>Group A
Inhaled Bronchodilator</td><td>Group B
LABA+LAMA</td></tr>
<tr><td>mMRC 0-1 or CAT<10</td><td>mMRC>2 or CAT > 10</td></tr>
</table>

LABA+LAMA on the DHS Preferred Drug List:

- **ANORO ELLIPTA** 62.5-25 MCG/ACT
- **BEVESPI AEROSPHERE** 9-4.8 MCG/ACT
- **STIOLTO RESPIMAT** 2.5-2.5 MCG/ACT

LABA+LAMA+ICS single inhaler therapy is shown to be effective in symptomatic patients who experience frequent and severe exacerbations (Group E, with eosinophil count >300).

On formulary for triple therapy:

- **TRELEGY ELLIPTA** 100-62.5-25 MCG/ACT
- **TRELEGY ELLIPTA** 200-62.5-25 MCG/ACT

Combination SABA+SAMA therapy is shown to be more effective than either agent alone in improving FEV1 and symptoms.

On formulary for combination SABA+SAMA:

- COMBIVENT RESPIMAT 20-100 MCG/ACT

Additional patient counseling notes:

- Regularly assess the patient's inhaler technique and adherence to pharmacotherapy.
- Encourage smoking cessation and provide pharmacotherapy to do so, based on patient's willingness to quit status.
- Complete annual lung cancer screening for COPD patients with smoking history.
- Ensure patients are up to date on COVID-19, Influenza, RSV, Pneumonia, and Tdap vaccinations as appropriate, as these can help reduce the risk of viral respiratory infections that can cause COPD exacerbations.
- Pulmonary rehabilitation improves exercise capacity, symptoms, and quality of life across all groups of COPD severity.

Additional patient counseling notes:

- Regularly assess the patient's inhaler technique and adherence to pharmacotherapy.
- Encourage smoking cessation and provide pharmacotherapy to do so, based on patient's willingness to quit status.
- Complete annual lung cancer screening for COPD patients with smoking history.
- Ensure patients are up to date on COVID-19, Influenza, RSV, Pneumonia, and Tdap vaccinations as appropriate, as these can help reduce the risk of viral respiratory infections that can cause COPD exacerbations.
- Pulmonary rehabilitation improves exercise capacity, symptoms, and quality of life across all groups of COPD severity.

Dental Dispatch

The Primary Care Role in Promoting Oral Health

Oral health is an important component of overall health, and primary care providers are well positioned to use their knowledge and skills to encourage and guide their patients to better oral hygiene habits. While reminding patients to brush twice a day is important, primary care teams can take a more proactive role in promoting oral health during routine visits.

Consider incorporating the following strategies into your patient care:

- Evaluate the fluoride status of the patient's water supply and consider recommending fluoride supplements if necessary.
- Discuss the role of diet and sugars in increasing the risk of dental caries.
- Refer patients to a dentist by the age of 1 to establish a dental home and foster good oral health habits from an early age.
- Encourage the use of mouthguards during sports activities to prevent teeth trauma.
- Apply topical fluoride varnish for patients at moderate to high risk for caries.
- Screen for tobacco or vaping use if appropriate.
- Conduct an oral assessment to see if there are any urgent or emergent conditions requiring immediate attention from a dentist.
- Inspect the oral cavity for manifestations of systemic conditions such as hematologic diseases, diabetes, developmental disorders, rare cancers, etc.

By collaborating with dental providers, primary care teams can achieve a whole-person approach to health and wellness for our members.

Stay Connected by Updating Your Provider Information

Maintaining accurate provider information ensures seamless communication, compliance, and quality care for patients. Providers should regularly verify their enrollment status and demographic information in the DHS PROMISe system to avoid disruptions. This includes checking:

- Service locations
- Revalidation dates
- Active PROMISe ID status

Please visit the **DHS webpage** for requirements and step-by-step instructions.

If your contact details (such as name, address, or phone number) have changed, provider groups can submit the updates on official company letterhead via email to **datavalidation@jeffersonhealthplans.com**.

Lastly, be sure to complete the Quarterly Provider Data Validation form sent via mail to your practice. Completing this form will ensure our systems hold the most current information.

Cultural Competency: A Key to Reducing Health Disparities

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.

Culturally competent providers:

- Understand their own beliefs and biases, explicit and implicit.
- Integrate these factors into their day-to-day provision of care.
- Develop their understanding in stages by building upon previous knowledge and experience.
- Provide the highest quality of care to every patient, regardless of race, ethnicity, cultural background, English proficiency, or literacy.

Participating providers are required, by law, to provide translation and interpreter services (including American sign language services) at their practice location, at the provider's cost. If you need assistance, our helpline can assist you in locating services for members who need a qualified interpreter present at an appointment or telephonically: **1-888-991-9023**.

Non-Discrimination Policy

We recognize the diversity of our members and offer services that are sensitive to these differences. Members enrolled in our plan(s) have the right to receive and expect courteous, quality care regardless of race, color, creed, sex, religion, age, national or ethnic origin, ancestry, marital status, sexual preference, gender identity and expression, genetic information, physical or mental illness, disability, veteran status, source of payment, visual or hearing limitations, or the ability to speak English.

Our non-discrimination policy includes protection for members of the LGBTQ+ community. As a provider, your responsibilities for LGBTQ+ patients include:

- Treating all patients with dignity; respect their identities
- Breaking the cycle of discrimination that creates barriers for LGBTQ+ communities to access healthcare
- Adopting best practices that are inclusive of and welcoming to LGBTQ+ communities
- Providing complete, unbiased, person-centered care that results in risk reduction

How to Report an Issue of Compliance, Privacy, or Fraud

The reporting and investigation of compliance, privacy, or fraud incidents plays a key part in creating a culture of honest and ethical behavior and conduct. Additionally, management of compliance, privacy, or fraud issues is also essential for improving our services and enables the organization to take appropriate actions to mitigate future risks.

You can help to prevent fraud by asking for picture identification in addition to checking their member ID card or number. This will prevent non-members from using stolen or lost member insurance ID cards.

Anyone who becomes aware of a compliance, privacy, or fraud incident, whether it has occurred or is about to occur, should report it. There are several ways to report through the options provided below. If you wish to remain anonymous, you may do so by using the Hotline or our online reporting tool.

To report a compliance, privacy, or fraud incident:

- Call the anonymous hotline: 1-866-477-4848
- To report actual or suspected non-compliance, contact Compliance by emailing: **Compliance@jeffersonhealthplans.com**
- To report actual or suspected privacy or security concerns, contact the Privacy Office by emailing: **PrivacyOfficial@jeffersonhealthplans.com**
- To report actual or suspected FWA concerns, contact the Special Investigations Unit (SIU) by emailing: **SIUtips@jeffersonhealthplans.com**
- Complete and submit allegations related to Compliance, Privacy or FWA anonymously online **here**.

Preclusion Check For Providers

Providers are responsible for verifying prior to hire and monthly thereafter that no one involved in the services that they supply to Medicare Advantage, CHIP, Medicaid, or Individual and Family Plans members are listed on state or federal exclusion databases. This includes all employees, managing owners, medical providers, and any person or business that you contract with for the provision of services to our members. If you provide services to Medicaid or CHIP patients, you can access the OIG/LEIE, EPLS/SAM, and state Medicaid exclusion sites.

What does this mean to you?

As a provider of services to our members, you are receiving state and/or federal funds. There is a prohibition on payments by federal healthcare programs (which includes state programs that receive federal dollars) for items or services furnished by an excluded person or at the medical direction or on the prescription of an excluded person.

What if I don't perform these checks?

If you know or should have known that someone you are paying has been excluded from receiving payment, you could be subject to a civil monetary penalty (CMP) fine or possible prosecution by the HHS OIG. Fines and prosecution may be mitigated by terminating employment immediately and self-reporting to Jefferson Health Plans/ Health Partners Plans and the OIG as soon as you find out that you have been employing someone who has been precluded.

Can Excluded People/Businesses be Eligible Again?

Yes, not all exclusions are lifetime exclusions. However, you must apply for reinstatement re-instatement to Medicare and obtain a Medicaid Medical Assistance Identification Number (MAID) to resume providing services and submitting claims directly, or indirectly, which will be paid for using federal or state dollars.

How to report Fraud, Waste, or Abuse:

If you suspect fraud, waste, or abuse, report it to Jefferson Health Plans' Special Investigations Unit:

- Reports can be made anonymously by phone (**1-866-477-4848**) or online (**https://www.mycompliancereport.com/report?cid=JEFF**).
- Reports can be sent via email: **SpecialInvestigationsUnit@hpplans.com**
- Reports can also be made directly to regulators or law enforcement:
- OIG Hotline: 1-800-HHS-TIPS (**1-800-447-8477**)
- CMS Hotline: 1-800-MEDICARE (**1-800-633-4227**)
- DHS Hotline: 1-866-DPW-TIPS (**1-866-379-8477**)

Pharmacy Formulary Changes

Jefferson Health Plans Medicare Advantage

See below for the most recent formulary, prior authorization, quantity limit, and age edit updates for Jefferson Health Plans Medicare Advantage.

Formularies:

- Jefferson Health Plans Premium Formulary: Special, Dual Pearl (SNP Plans)
- Jefferson Health Plans Core Formulary: Prime, Complete, Silver, Platinum, Flex Plus, Flex Pro
- Jefferson Health Plans Value Formulary: Giveback, Flex, Choice, Choice Plus

Formulary Changes:

- Jefferson Health Plans Premium Formulary: Special, Dual Pearl (SNP Plans) Changes
- Jefferson Health Plans Core Formulary: Prime, Complete, Silver, Platinum, Flex Plus, Flex Pro Changes
- Jefferson Health Plans Value Formulary: Giveback, Flex, Choice, Choice Plus Changes

Health Partners Plans Medicaid

See below for the most recent formulary, prior authorization, quantity limit, and age edit updates for Health Partners Plans Medicaid.

Formulary:

- Health Partners Medicaid

Formulary Changes:

- Medicaid Formulary Changes #177 (updated December 2024)
- Medicaid Formulary Changes #176 (updated November 2024)

Day Supply Limit Change:

As of June 1, 2025, Health Partners Plans Medicaid has placed a new maximum day supply limit that can be dispensed for several medication classes. Prior to June 1, 2025, you could receive up to a 90-day supply of the below medications. With the new limit, your pharmacy can dispense up to a 30-day supply.

Medication Class	Affected Medications	New Limit
Glucagon-Like Peptide-1 (GLP-1) Receptor Agonists	Bydureon, Byetta, Liraglutide, Ozempic, Rybelsus, Trulicity, Victoza	Maximum 30-day supply per fill
Glucagon-Like Peptide-1 (GLP-1) Receptor Agonist/Insulin Combinations	Soliqua, Xultophy	Maximum 30-day supply per fill
Calcitonin Gene Related Peptides (CGRP)	Aimovig, Emgality	Maximum 30-day supply per fill

Health Partners Plans CHIP

See below for the most recent formulary, prior authorization, quantity limit, and age edit updates for Health Partners Plans CHIP.

Formulary:

- RxFlex Formulary Drug Search for Plan - Health Partners Plans CHIP

Jefferson Health Plans Individual and Family Plans

See below for the most recent formulary, prior authorization, quantity limit, and age edit updates for Jefferson Health Plans Individual and Family Plans.

Formulary

- Jefferson Health Plans Individual and Family Plans

Formulary Changes:

- IFP Formulary Changes

Policy Bulletin Updates

Our medical policy bulletins define medical necessity criteria and coverage positions on topics such as medical services, procedures, durable medical equipment, and therapies. Recent policy additions and updates include the following:

Claims Payment Policies

- RB.024.B Professional Telehealth Services (Medicaid and CHIP) – Codes revised and added; Billing and Guideline statement added.
- RB.029.C Diabetes Prevention Program – Code revised and added.
- RB.030.B Newborn Authorizations – Policy statement and guidelines revised.

Visit our website to view our policy bulletin library.

Health Partners Plans, Inc. (HPP), uses Jefferson Health Plans as the marketing name for some of its lines of business. Current lines of business are: Jefferson Health Plans Individual and Family Plans, Jefferson Health Plans Medicare Advantage, Health Partners Plans Medicaid, and Health Partners Plans CHIP. All communications will specify the impacted line of business within the content of the message.

Jefferson Health Plans | Health Partners Plans

PC-420NM-6783

Provider Resources

Jefferson Health Plans

@jeffersonhealthplans