



Initial Orientation and Training for Network Providers

Training Requirement

The Pennsylvania Department of Human Services (DHS) requires Managed Care Organizations (MCOs) to ensure their providers attend at least one MCO-sponsored training during the course of the year. *By attending this session, you fulfill that requirement.*

Newly contracted providers, by attending this **Initial Orientation and Training for Network Providers** training, you will fulfill your annual requirement. In subsequent years, you will meet this requirement by completing the **Annual Training for Network Providers**, which is a condensed version with enhanced content.

Additional training is required for providers who provide service to Medicare members.

- Medicare Providers' FDR Requirements | Jefferson Health Plans
 - [Delegated Vendor Information](#)

Agenda

Key Takeaways:

- ✓ Who We Are
- ✓ Product ID Cards
- ✓ Provider Resources
- ✓ Reporting Changes

An attestation link will be provided at the conclusion of the webinar

Additional Information:

- Product Overview
- Community Health Choices
- Claims
- Credentialing
- Utilization Management
- Complaints, Grievances, & Prior Authorization
- Clinical Programs
- Online Tools & Resources

Who We Are



Jefferson Health Plans/Health Partners Plans is a not-for-profit Pennsylvania-licensed Managed Care Organization (MCO) providing comprehensive healthcare coverage in Pennsylvania and New Jersey.

Our focus is on improving health outcomes through a wide range of initiatives that support member compliance and help to eliminate barriers to care.

Thank you for being part of our provider network and helping us to **improve the health outcomes of our members.**

Offering High Quality and Affordable Health Plans



[Jefferson Health
Plans Medicare
Advantage](#)

[Jefferson Health
Plans Individual
and Family Plans](#)
(Commercial ACA product)

[Health Partners
Plans Medicaid](#)

[Health Partners
Plans CHIP](#)

Click on any of the links to learn more about our plans.

What's New?

Jefferson Health Plans Rebranding

Health Partners Plans Medicaid is now called **Jefferson Health Plans EverWell**
Health Partners Plans CHIP is now called **Jefferson Health Plans CHIP**.



What this means for you and your practice:

- This is a name change only.
- Your existing contracts, reimbursement, credentialing, and contact numbers remain unchanged.
- The same teams will continue to provide you with timely support and problem-solving.
- We remain committed to open communication, clear policies, transparent reimbursement, and accessible, easy-to-use provider tools.
- Members will receive the same coverage, benefits, and access to care. They will receive a new Jefferson Health Plans ID card in the mail. Until then, please expect members to use their current Health Partners Plans ID card. Both ID cards will be valid through 2026.

Behavioral Health Training for Primary Care Providers



Because PCPs are often the first point of contact for mental health concerns, it is essential to have a strong understanding of behavioral health, as roughly 75% of patients present with conditions involving significant psychological components.

- **Optum Health Education** is offering a *free*, three-part on-demand training series (3.5 credits available) designed to strengthen primary care providers' ability to identify, treat, and appropriately refer patients with behavioral health needs. Each module highlights key HEDIS measures and provides practical strategies to improve quality outcomes.

For more information and registration, please visit:

<https://www.optumhealtheducation.com/primary-care-behavioral-health>

Updates to Health Plans

Jefferson Health Plans: Medicare Advantage Plan Portfolios

HMO

- For members that qualify for an LIS or are willing to pay a premium for lower cost sharing and Max out of Pocket.
- Robust network in Eastern PA
- Aligned to Jefferson Health System

PPO

- Ideal landing spot for members outside base service area.
- Positioned to perform strongly within and outside of Jefferson core footprint.

DSNP

- Members qualifying for Dual Eligible SNP plans
- Members looking to maximize the value of their health insurance products

State	Product(s)
PA	<ul style="list-style-type: none"> • Complete (\$0) • Prime (\$32.70 - was \$40.90) • Give Back (\$0) +\$140 Part B (was \$125)
NJ	<ul style="list-style-type: none"> • Silver (\$0) • Elite (\$0) - NEW

State	Product(s)
PA	<ul style="list-style-type: none"> • Flex (\$0) • Flex Pro (\$18 - was \$20) • Flex Plus (\$32.70 - was \$37)
NJ	<ul style="list-style-type: none"> • Choice (\$0) • Choice Plus (\$29 - was \$35)

State	Product(s)
PA	<ul style="list-style-type: none"> • Special • Dual Pearl • Select - NEW
NJ	N/A

2026 Product ID Cards

Product ID Cards

Health Partners Plans Medicaid

Payor ID# 80142

(9-digit ID - all numerical digits)

Health Partners Plans

<First Name M. Last Name>
 ID: <999999999> SAMPLE
 DOB: <99/99/9999>
 PCP: <Dr. Name>
 <Dr. Phone Number>
 PROV #: <99999XX999999X>

RxBIN: 004336 RxPCN: MCAIDADV RxGRP: RX3892

Issued
beginning
7/30/2025

**PO Box 21228
Tampa, FL 33622**

Jefferson Health Plans Individual and Family Plans

Payor ID# 80142

(12-digit ID, starting with a “J”)

Jefferson Health Plans PLAN NAME

Member Name
Member ID

RxBIN: XXXXXX
 RxPCN: XXX
 RxGroup: XXXXXX

	In Network	Out of Network
PCP:	SXX	SXX
Specialist:	SXX	SXX
Urgent Care:	SXX	SXX
ER:	SXX	SXX
Ded Ind/Fam:	\$X,XXX/\$XX,XXX	\$X,XXX/\$XX,XXX
OOPM Ind/Fam:	\$X,XXX/\$XX,XXX	\$X,XXX/\$XX,XXX

SAMPLE

J-12-XXXXXX-XXXX

**PO Box 21228
Tampa, FL 33622**

Health Partners Plans CHIP

Payor ID# 80142

(10-digit ID starting with a “3” or a “9”)

Health Partners Plans

<First Name M. Last Name>
 ID: <999999999> SAMPLE
 DOB: <99/99/9999>
 PCP: <Dr. Name>
 <Dr. Phone Number>
 PROV #: <99999XX999999X>

PCP SXX SPEC SXX ER SXX

RxBIN: 004336 RxPCN: MCAIDADV RxGRP: RX4074

Issued
beginning
9/9/2025

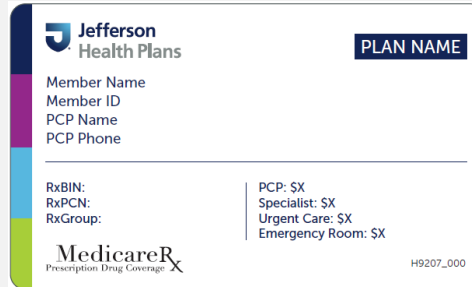
**PO Box 21228
Tampa, FL 33622**

Imagenet is responsible for the intake of all paper claims submissions.

Product ID Cards - Medicare Advantage

**Jefferson Health Plans
Medicare Pennsylvania
HMO/DSNP Payor ID# 80142**

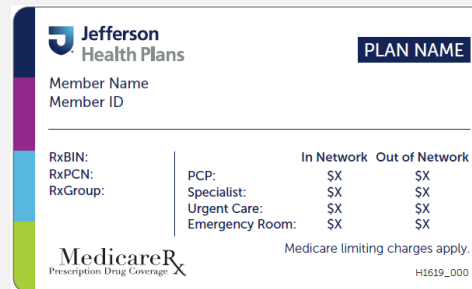
(7-digit ID number starting with a "5")



**PO Box 21228
Tampa, FL 33622**

**Jefferson Health Plans
Medicare Pennsylvania
PPO Payor ID#RP099**

(9-digit ID starting with all numerical digits)

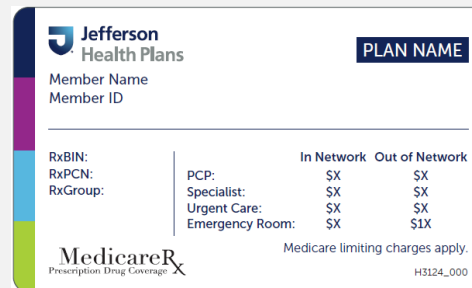


**PO Box 21247
Tampa, FL 33622**

**Jefferson Health Plans
Medicare New Jersey**

**HMO Payor ID#80142
PPO Payor ID#NJ099**

(7-digit ID number starting with a "5")



**PO Box 21367
Tampa, FL 33622**

*When a patient presents without a Member ID card, check Provider Portal for eligibility

*Older versions of Member ID cards are still valid

Checking Eligibility

Providers may verify member eligibility by:



Logging on to our [Provider Portal](#)



Calling the Provider Services Helpline (1-888-991-9023)

- Use the automated system 24/7 to enter either the patient's member ID, or the patient's name and birth date.



Accessing the **Pennsylvania State Eligibility Verification System (EVS)** at 1-800-766-5387

- Providers must use the DHS Pennsylvania Access card to access the Department's EVS and verify the member's eligibility.

Medicare Beneficiary Information

Qualified Medicare Beneficiaries (QMB)

The **Qualified Medicare Beneficiary (QMB)** eligibility group is a Medicaid eligibility group through which states pay Medicare premiums and cost-sharing for certain low-income Medicare beneficiaries.

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All Medicare providers and suppliers, including pharmacies, are prohibited by Federal law from billing Medicare beneficiaries in the (QMB) eligibility group for Medicare Part A or Part B cost-sharing.

This includes **Medicare Part A and Part B** deductibles, coinsurance, and copayments.

Identifying QMBs

- To ensure compliance, Jefferson Health Plans Medicare Advantage providers and suppliers should:
 - Implement processes to ensure compliance with QMB billing prohibitions.
 - Make sure their office staff and vendors are using systems to identify the QMB status of Medicare beneficiaries
- To assist in this process, CMS provides several ways for plans to identify the QMB status of their enrollees, including:
 - Medicare Advantage Medicaid Status Data File
 - Monthly Membership Detail Data Report (MMR)
 - MARx User Interface (MARx UI)
- For a full explanation of how to identify QMBs, please visit [The CMS MedLearn Matters article](#)

Balance Billing Dual Eligible Members: Medicare/Medicaid



Fully Dual Eligible beneficiaries are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).



Medicaid (CHC) will remain the payer of last resort.



Providers may not balance-bill participants when Medicaid, Medicare, or another form of TPL does not cover the entire billed amount for a service delivered.



Please note that Jefferson Health Plans Medicare Advantage Special and Dual Pearl (DSNP) members are fully dual eligible.

Community HealthChoices

Community HealthChoices

Community HealthChoices (CHC) plan beneficiaries are 21 or older and have both Medicare and Medicaid or receive long-term support through Medicaid. There are three CHC plans:

- PA Health & Wellness (Centene)
- AmeriHealth Caritas (Keystone First CHC/AmeriHealth Caritas Pennsylvania CHC)
- UPMC

Keep in Mind:

- Our members eligible for CHC were notified by the state that they must enroll with a CHC plan.
- Pennsylvania auto-enrolled members into one of the three plans if they did not choose a plan.
- Medicare is the **primary** payor and drives the care. Medicaid benefits are accessed after Medicare benefits have been exhausted.
- As a participating provider, you can provide services to Jefferson Health Plans Medicare Advantage members and submit claims, even if they are enrolled in a CHC (Medicaid) plan.
- Our Care Coordinator can assist you with coordinating services between Medicare and Medicaid.

Community HealthChoices

Resources

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



Claims Overview

Clearing House: Smart Data Solutions

- **Smart Data Solutions (SDS)** is fully connected to accommodate Electronic Data Interchange (EDI) claim submissions for our two Payor IDs.
- Providers may sign-up through the SDS provider portal by emailing SDS directly at stream.support@sdata.us.



Claims Status and Reconsideration

- The [Provider Portal](#) can be used to check the status of a claim, or to request a reconsideration determination.
- Reconsiderations must be made timely by the requestor. Please be sure to have the claim number available to initiate your request.

Resources

- [Claim Payment Policy Bulletins](#) provides reimbursement rules and billing guidelines necessary to ensure timely and appropriate payment
- [Quick Reference Guide](#) contains information for Behavioral, Dental, and Vision Claims

Timely Filing

Initial Submissions

180-days from date of service or discharge date

Reconsiderations

180-days from the date of Explanation of Payment (EOP)

Coordination of Benefits

60-days from date of other carriers (EOP)

Explanation of Payment

Explanation of Payment (EOP)

Found through the [Provider Portal](#) - Claims Status Search



Claim Status Search Results

[View EOP](#) Claim Number Status P



Tax ID: 2 EPC Draft #: 0 Payment Week: 52 Payment Date: 12/29/2020 Page 1 of 3

Service Dates From To	Procedures (Modifier)	No. of Units	Amount Billed	Allowed	Payment	Patient Responsibility	Other Ins.Paid	Not Covered	Sequest-ration	Adjustment Reason
11/24/20 11/24/20	99203 25	1	231.00	127.66	82.66	45.00	0.00	103.34	0.00	CO45 PR3
11/24/20 11/24/20	81002	1	12.00	0.00	0.00	0.00	0.00	12.00	0.00	CO45 PI96 N216
11/24/20 11/24/20	81025	1	25.00	0.00	0.00	0.00	0.00	25.00	0.00	CO45 PI96 N216
Total for Claim:			268.00	127.66	82.66	45.00	0.00	140.34	0.00	

Administered by	Code	Description
HealthPartnersPlans	CO204	This service/equipment/drug is not covered under the patient's current benefit plan
	CO45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or claim charge amount, and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability)
	COB7	This provider was not certified/eligible to be paid for this procedure/service on this date of service. Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
	N216	We do not offer coverage for this type of service or the patient is not enrolled in this portion of our benefit package.
	PI96	Non-covered charge(s). At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Usage: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present
	PR2	Coinurance Amount
	PR3	Co-payment Amount

Encounter Data



Participating 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.



For professional claims, providers who are registered as home health providers, hospice providers, certified nutritionists, DME, X-ray clinics, and renal dialysis providers must include the referring provider on their claim submissions. The data can be submitted in the referring provider loop (2310A) or the ordering provider loop (2420E), whichever is appropriate to your claim situation.



Claims that do not include a referring provider may be subject to denial/retraction.

Credentialing

Credentialing and Recredentialing

Applications Facility and Ancillary Provider credentialing application can be found on our website at: [Credentialing](#)



Our goal is to process all credentialing applications within 60 days of receipt of a complete application.



Individual providers are recredentialled within 36 months or less. Providers are notified four months prior to their recredentialing due date.



For more information, please visit our [Provider Manual Chapter 11: Provider Practice Standards & Guidelines](#)

Reminder to Revalidate MA Enrollment



MA Revalidation:
the Pennsylvania Department of Human Services (DHS) requires all providers to maintain active enrollment, which includes ensuring **all service locations are actively registered.**



PROMISE System Check:
Providers should regularly review PROMISE to confirm demographic details, service locations, revalidation dates, and ensure their **Medical Assistance ID (MAID)** is active.



Enrollment (revalidation) applications located at:
http://www.dhs.pa.gov/provider/promise/enrollmentinformation/S_001994

Failure to enroll/revalidate **all registered service locations** with DHS will result in non-payment of claims for services rendered at the unenrolled location(s)

Reporting Provider Data Changes

Ensuring Accurate NPI for Post-Acute Referrals



We are receiving post-acute referrals that sometimes include outdated NPIs or facility names. If a facility has been sold, renamed, changed ownership or had an NPI change, it may affect network participation status.

- Please ensure referrals reflect the most up-to-date details, including the accepting facility's current legal name and NPI.
- Accurate information helps us confirm network status and support appropriate placement without delays.

Changes in demographic information should also be communicated via email at datavalidation@jeffersonhealthplans.com so we can maintain an accurate Provider Directory

Provider Demographic Changes

Providers are recredentialled within 36 months or less. If there are changes before this time, please notify the Network Management department immediately in writing when any of the following occurs:



- Site relocation
 - Full practice terms
 - Site location terminations
 - Telephone number change
 - Change in hours of operation
 - Provider practice name change
 - Additions/deletions of providers
 - Change in patient age restrictions
 - Change in payee information (W-9 required)
- All professional provider data changes must be emailed to datavalidation@jeffersonhealthplans.com

Quarterly Provider Data Validation

Provider data validation forms are mailed to all non-delegated provider practices quarterly. It's imperative that these forms are reviewed and returned as soon as possible

Benefits:

- Provides members with accurate provider information.
- Allows for timely and accurate claims payments.

When you receive your **Provider Data Validation Form** from Press Ganey, be sure to respond as directed.

Medical Records Request

Medical Record Request Confusion

We request medical records for many reasons, including:

- Credentialing medical record review (MRR)
- Pay for Performance (P4P)
- Complaints/Grievances
- Stars and HEDIS
- Investigation of Quality of Care (QOC) referrals/Quality of Care Inquiry



Per your contract: Records do not need a patients or head of household release form signed and records are provided at the providers' expense for the quality assurance programs

- Electronic Medical Record (EMR) view or read-only access *is the preferred method.* However, we receive records via many platforms.
- If you have a preferred method of medical record collection, please let us know at: Quality@jeffersonhealthplans.com.

Please include:

The name of office manger or clinical contact
Contact person's email, phone number

Utilization Management and Prior Authorization

Utilization Management (UM)



Our UM department is dedicated to ensuring members receive the most appropriate care for their specific needs. Decisions are based on medical necessity, appropriateness of care and services, coverage availability, and whether an item qualifies as a medical necessity.



We follow product-specific definitions of medical necessity, National and Local Coverage Determinations (NCDs & LCDs), and 2024 InterQual® criteria—specifically from the Subacute and SNF modules.



UM decision-makers are not offered financial incentives that encourage coverage denials or under-utilization of services.



For more information, visit: [Provider Manual Chapter 8: Utilization Management](#)

Prior Authorization (PA) Overview

- Prior Authorization requests should be submitted through the designated provider portal.
- [Prior Authorization Management Tools](#) are available to determine the appropriate submission type.
- **Drug specific PA** forms are available on our [Prior Authorization](#) webpage.
- **Non-Participating Facility Transfers:** For elective admissions or transfers, call:
Inpatient Services at 1-866-500-4571.
- **Disenrollment Planning:** Providers may be contacted for discharge/ transition planning for disenrolled members. We may remain responsible for up to 6 months post-disenrollment unless the member selects another plan.

Viewing an Authorization

If you have submitted an authorization request that you are now unable to locate, please follow the timeframes below before checking on its status:

- **Urgent Requests:** Wait 24 to 48 hours before checking status.
- **Standard Requests:** Wait 7 days before checking status.

Pharmacy

- There are specific medications on the formulary that require prior authorization.
- Drug specific prior authorization forms are available to help expedite the process with specific clinical criteria on our [Prior Authorization](#) webpage.



The [Recipient Restriction Program](#) is a Pennsylvania Department of Human Services initiative that identifies Medical Assistance members who excessively or improperly use Medicaid services. These members may be restricted to a certain physician and/or pharmacy.

To request a prior authorization, or for more information on the Recipient Restriction Program, contact our [Pharmacy department](#) at [1-866-841-7659](tel:1-866-841-7659), Monday through Friday, 8 a.m. to 6 p.m.

Requests can also be faxed to 1-866-240-3712.

In the event of an immediate need after business hours, please call [Member Relations](tel:1-800-553-0784) at: [1-800-553-0784](tel:1-800-553-0784). The call will be evaluated and routed to a clinical pharmacist on-call 24/7.

Urgent/Expedited Requests

- Providers must request prior authorization at least **7 days in advance** for non-emergent services. Requests are processed per **state and federal regulations**. ***Failure to follow this timeline may delay non-urgent services.**
- **Expedited requests must meet one of these criteria points.** Requests not meeting this criteria may be processed under the standard timeframe for your line of business.

Urgent/Expedited Care Services

Care needed within 24 hours to prevent an Emergency Medical Condition

Urgent/Expedited Medical or Severe Condition

A serious illness or injury that should be treated within 24 hours to prevent it from becoming a crisis or emergency.

*Also includes care needed to avoid delays in hospital discharge or admission.

- For more information, please see our [Urgent and Expedited Authorization Requests Tip Sheet](#).

Prior Authorizations for Medications



Please take care to submit Prior Authorizations for Medications correctly.

Medications requests must be submitted under **Drugs and Biologics, rather than Outpatient.**

*Request Type

Inpatient

Drugs and Biologics

Outpatient

YES NO

Submitting a Medication Prior Authorization incorrectly may result in delays.

Complaints, Grievances, and Appeals

Complaints, Grievances and Appeals

When we deny, decrease, or approve 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 a reconsideration.

In some cases, a member can ask DHS to hold a hearing because they disagree with our decision. A member must exhaust our Complaint or Grievance Process before requesting a Fair Hearing.

For more information, visit:

- [Health Partners Plans Medicaid Member Handbook](#)
- [Provider Manual Chapter 13: Complaints, Grievances, and Appeals](#)
- eLearning: [Complaints, Grievances and Medical Necessity Reviews: Learn The Process](#)

Clinical Programs

Clinical Programs

Our clinical programs:

- Our team of licensed and non-licensed staff supports provider treatment plans by helping members reach their health goals, reducing social and behavioral barriers to care, and addressing needs across the life continuum.

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 Member Relations or discussing with a Care Coordinator
- **Variety of Communications**: Telephonic, face to face, email, social media, in the community and in provider offices
- **Use of PA Navigate** to identify Health Related Social Needs (HRSN) resources

Health Related Social Needs (HRSN)

Health Related Social Needs are the conditions in the environment where people are born, grow, work, live and age.

HRSN includes factors such as:



Food insecurity



Economic Stability



Housing stability



Transportation Needs



Childcare needs



Exposure to Violence



Utility Needs



Education Needs

You may use PA Navigate to identify Health Related Social Needs (HRSN) resources.

For more information, please visit our website at: [Quality and Population Health](#)

Enhanced Member Services Unit (EMSU): Health Partners Plans Medicaid and CHIP

Baby Partners

- Care coordination for prenatal and postpartum members
- Connection to local resources, such as food, diapers, car seats

(833)-705-3751

Clinical Care Management:

- Provides discharge screenings, health risk assessment follow-up and disease education for members who are not associated with other Health Plan programs.

EMSU Pediatrics

- Care coordination for complex children who have identified special needs or require shift care
- Connection to supplemental benefits, programs, and community resources

EMSU Adults

- Connection to supplemental benefits, programs, and community resources

Clinical Care Management: Jefferson Health Plans Medicare Advantage and Individual and Family Plans

The Care Coordinator team works with members and their providers to address barriers and connect needed resources

Clinical Care Management Team supports members with:

- Accessing and coordinating care
- Finding community resources for Health-Related Social Needs (HRSN)
- Receiving education related to their condition.
- Complete a [Clinical Programs Referral Form](#) to refer any member for services.
- Send completed forms to ClinicalConnectons@jeffersonhealthplans.com or Fax: 215-845-4181
- For additional assistance please call the **Clinical Care Management Provider Referral Line**: 215-845-4797

For DNSP Members

A **Health Risk Assessment (HRA)** is completed which identifies the below needs or barriers.

Medical	Functional	Cognitive
Psychosocial	Mental Health	Health-related social needs of barriers

Benefits & Services

Mental Health and Substance Abuse Treatment

- Under HealthChoices, all Health Partners Plans Medicaid members, regardless of the health plan/MCO to which they belong, can receive mental health and substance abuse treatment through their behavioral health managed care organization (BH-MCO).
- PCPs who identify a member in need of behavioral health services should direct them to their county's BH-MCO, who will conduct an intake assessment and refer the member to the appropriate level of care.
- Each HealthChoices consumer is assigned a BH-MCO based on their county of residence.

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 a provider performs a screening and suspects developmental delay, and the child is not receiving services, refer the child (not over 5 years of age) through the [CONNECT Helpline \(1-800- 692-7288\)](tel:1-800-692-7288) for appropriate eligibility determination for Early Intervention Program services.

- For the latest guidelines, visit our website at: [EPSDT / Bright Futures](#)
- Call our Pediatric Clinical Care Management team at 1-866-500-4571

Childhood and Adolescent Immunizations

[Immunization Schedules](#) are now available and effective immediately

Lead Screening Requirements

Children under the age of 2 should have a minimum of 2 lead screenings. For more information, visit: [Lead Screening](#)

Bright Futures (CHIP)

The Bright Futures/American Academy of Pediatrics (AAP) developed a set of comprehensive health guidelines for well-childcare, 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 growth and development since their last visit; discussing milestones, social behaviors and learning with parents/guardians.
- **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.

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.
- Our plans must comply according to our HealthChoices agreement pertaining to coverage and payment of medically necessary emergency services.
- Health Partners Plans Medicaid members are not responsible for any payments.

Emergency Care

- Non-par follow-up specialty care for an emergency is covered, 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.
- For more information, can be found in our: [Provider Manual Chapter 11: Provider Practice Standards & Guidelines](#)

Comprehensive Member Benefits

A comprehensive overview of all benefits and services for members can be found in the Provider Manual:

- [Chapter 4: Health Partners Plans Medicaid Benefits](#)
- [Chapter 5: Jefferson Health Plans Medicare Advantage Benefits](#)
- [Chapter 6: Health Partners Plans CHIP Benefits](#)
- [Chapter 7: Jefferson Health Plans Individual and Family Plans Benefits](#)

Medicare Care Coordination and Member Rewards

Medicare Care Coordination

- Our care coordination team consists of nurses and social workers dedicated to helping members access 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 our members for care coordination at 215-845-4797
- Our Care Coordination team can assist with but not limited to:
 - ✓ SDoH issues
 - ✓ Behavioral health
 - ✓ Food insecurity
 - ✓ Coordinating services with Medicaid 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

Medicare Advantage Wellness Rewards

- The **Wellness Rewards Program** incentivizes Medicare Advantage members to complete specific health-related activities to earn money on a reloadable card.
- Leveraging the rewards program and encouraging your patients to complete these activities can help you improve your performance on these QCP measures.
- **Activities Included for the 2025 Calendar Year:**



Annual Wellness Visits



Breast Cancer Screening



Colorectal Cancer Screening



Member Portal Sign-Up



Flu Shot



Filling Certain Medication Prescriptions

Visit our website here for a full [list of wellness rewards](#)

Provider Practice Standards and Guidelines

Access & Appointment and Telephone Availability Standards for Medicaid/CHIP

Access, Appointment Standards and Telephone Availability Criteria	PCP	Specialist
Routine office visits	Within 10 days	Within 10-15 days, depending on 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

Department of Human Services (DHS) and Centers for Medicare & Medicaid Services (CMS) have set access, appointment, and telephone availability standards. **The Access and Availability Survey must be completed at the site level annually.**

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.

Utilizing Telehealth to Improve Patient Access

We encourage all providers to utilize telehealth when appropriate to improve and expand patient access to care.

Pennsylvania's Lifeline Program

is available for free to qualifying low-income households

Your patient will qualify if they are receiving Medicaid coverage, including Dual Special Needs members.

Contact our **Provider Service Helpline** at **1-888-991-9023** for assistance connecting qualified members to these services.

Maternity Services: Health Partners Plans Medicaid

- Pregnant members are not subject to limitations on the number of services or copayments. These 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.

Women

- 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 our Medical Director finds that the postpartum care is related to the delivery.

PA-NEDSS Reportable Conditions

- First-time users of PA-NEDSS must register on the website to utilize the reporting tool. Additionally, if you are a public health staff member, you and your supervisor must complete the Authorization Request Form to obtain access. PA-NEDSS Contact the PA-NEDSS Help Desk at 717-783-9171 or email at ra-dhNEDSS@pa.gov for the appropriate version of this form.
- As a reminder, all providers (including physicians, hospitals and labs) are required by law to report certain conditions to the PA DOH through PAs version of the National Electronic Disease Surveillance System, known as PA-NEDSS.
- **Additional Resources:**
 - PA-NEDSS New User Guide
 - Listing of PA reportable conditions (revised 3/2012)
 - Pennsylvania Code website
 - 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.

Determination of Abuse or Neglect

- Upon notification by the County Children and Youth Agency system, we must ensure our 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.
- Our staff who are designated as mandated reporters, as defined by the Pennsylvania Family Support Alliance, must report suspected child abuse to the appropriate authorities.
- For more information, visit: [Provider Manual Chapter 9: Quality Management](#).
 - It stipulates that providers must report abuse, neglect and/or domestic violence.

Infection Control

Mandatory Requirements

- 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.

Recommended Standards

- 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 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.
- Members have the right to receive services provided in a culturally and linguistically appropriate including: LEP, limited reading, vision, hearing skills, and those with diverse cultural and ethnic backgrounds. All providers are required, by law, to provide translation and interpreter services including qualified sign language interpreters.

Resources Available to Members

Member needing translation or language services, including sign language and TTY services, can call our **Member Relations line at 1-800-553-0784 (TTY 1-877-454-8477)**.

We have an online interpreter service that provides over 140 languages and is available 24 hours a day, seven days a week.

There is no cost to members for this service.

Americans With Disabilities Act

- As per Section 504 of the Rehabilitation Act of 1973, we require practitioners to abide by ADA requirements. These include:
 - Handicapped parking spaces and restrooms
 - Access ramps where applicable

If a practitioner's site does not meet ADA standards, alternatives include:

- Home visits
- Access at another site that meets ADA requirements
- Bathroom facilities elsewhere in the building or portable bathroom facilities

The [Americans with Disabilities Act \(ADA\)](#) requires providers to attest that their practice locations meet certain standards. You can use this link to attest. [ADA Compliance Attestation](#)

Fraud, Waste and Abuse (FWA) & Compliance

Special Investigations Unit (SIU)

We prohibit all illegal and/or unethical conduct by members, employees, and providers.

- Our **Special Investigations Unit (SIU)** proactively addresses questionable activity and investigates referrals of illegal and unethical conduct.
- Investigative findings are forwarded to state and/or federal law enforcement agencies for appropriate legal action upon a substantiated finding of fraudulent conduct.

Effective Lines of Communication

We have a 24-hour hotline to report compliance issues, including misconduct violating FWA, Compliance, HIPAA, or Human Resources laws and regulations.

Reporting channels include:

- FWA & Compliance Hotline (Anonymous): 1-866-477-4848
- compliance@Jeffersonhealthplans.com
- FWA Email: SIUtips@Jeffersonhealthplans.com

DHS [Medical Assistance Provider Self-Audit Protocol](#)

Allows providers to disclose overpayments or improper payments:

- 100 Percent Claim Review
- Provider-Developed Audit Work Plan for BPI Approval

For MA providers participating in both fee-for-service and managed care

- Provides guidance on returning inappropriate payments to DHS.
- Providers may also conduct an audit via the DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SRVS)

For more information, please visit the [Fraud, Waste and Abuse \(FWA\)](#) page on our website:

FWA – Unethical Conduct, False Billing & Procedural Neglect

Illegal and Unethical Conduct	False Billing - Services already paid for or never rendered	Procedural Neglect
Providers providing false statement to obtain credentials (MediCheck)	Upcoding: Billing to increase revenue instead of billing to reflect actual work performed	Perform medically unnecessary procedures
Providers up-coding claims or submitting claims for services not provided	Unbundling: Billing for each procedure separately instead of using grouping that is to be billed together	Falsified diagnoses to justify additional tests or overstated treatments
Providers paying members incentives for patronage	Forging physician signatures when required for reimbursement	
Pharmacist paying provider kickbacks for referrals		

FWA False Claims Act and Anti-Kickback Statute

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.

Anti-Kickback Statute (AKS)

- Prohibits knowing and willful remuneration, or compensation, to induce or reward patient referrals or the generation of business involving any item or service payable by the federal healthcare programs. Compensation includes anything of value and can take many forms besides cash.
- Kickbacks in healthcare can lead to overutilization, increased program costs, corruption of medical decision making, patient steering, and unfair competition.
- Criminal penalties and administrative sanctions for violating the AKS include fines, prison terms, and exclusion from participation in federal healthcare

Annual Reminders

Annual Reminders

- As a contracted provider, there are several requirements that must be completed annually. If you have not already done so, please complete these items by the end of the year.

D-SNP Model of Care Training

This training ensures providers understand the specialized care and services offered to dual-eligible beneficiaries.

[Attestation link](#)

2026 Access and Availability Survey

Survey to determine if Medicaid/CHIP providers are meeting the access, appointment, and telephone availability standards

aasurvey@jeffersonhealthplans.com

[Quality Intake Survey](#)

This survey helps us better identify ways to collaborate on shared goals, quality initiatives, and better outcomes for your patients, our members.

[ADA Compliance Attestation](#)

In accordance with the Pennsylvania Department of Human Services (DHS) and Centers for Medicare/Medicaid Services (CMS), we require practitioners to comply with ADA requirements.

View [Chapter 11](#) of our [Provider Manual](#) for more information on Access and Availability Standards and ADA Compliance.

*Additionally, please visit our [Webinars](#) page for other upcoming trainings.

MOC DNSP Training & Attestation

Annual Model of Care (MOC) DNSP Training Requirement

Mandatory for all providers serving DNSP members, per CMS guidelines.

At least one care team member per location must complete the training, submit the attestation, and share the materials with the rest of the team.

- Click Here for the [Online Training Course](#)
- Click Here for the [Attestation link](#)

American with Disabilities Act

- As per Section 504 of the Rehabilitation Act of 1973, we require practitioners to abide by ADA requirements. These include:
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 - Access ramps where applicable

If a practitioner's site does not meet ADA standards, alternatives include:

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The [Americans with Disabilities Act \(ADA\)](#) requires providers to attest that their practice locations meet certain standards. You can use this link to attest. [ADA Compliance Attestation](#)

Provider Tools & Resources

Online Tools & Resources

Quickly find important information on our [Provider Portal](#) and [Website](#).

Provider Portal

The [Provider Portal](#) contains:

- **Eligibility & Benefits** – Verify patient coverage instantly.
- **Claims Management** – View claims status and submit claims reconsideration requests with ease.
- **Authorization Requests** – Submit and check prior authorizations in real time.

Website Resources

- [Prior Authorizations](#)– View online formularies PA guidelines and request forms
- [Tools and Resources](#)–Provider Manual, Directory, Formularies, Policy Bulletin Library, Form & Supply Requests, Training & Education [Quick Reference Guide](#)
- [Clinical Resources](#) - Preventative and clinical care guidelines, developmental screening information, and telehealth resources.

Appendix

Thank You for Attending