Jefferson Health Plans | Health Partners Plans

Annual Training for Network Providers

Wednesday, September 17, 2025

Welcome!

There is **no sound** until the webinar begins.

Webinar **will be recorded**. Participation in the webinar is agreement to recording.

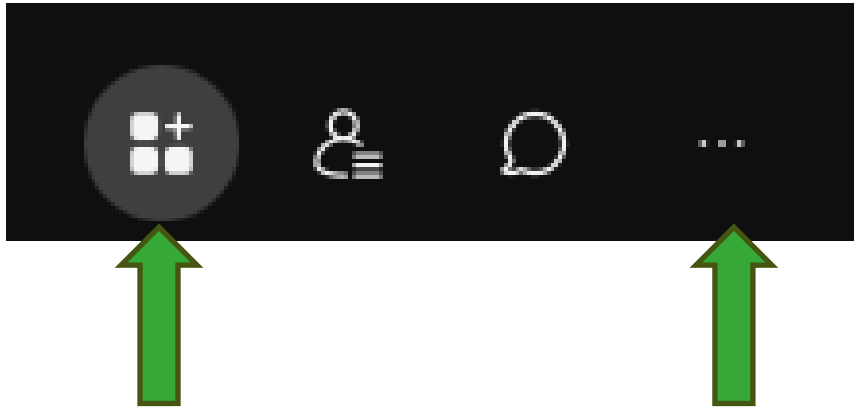
All participants phones have been **muted** except for the presenter.

Any unanswered questions today, will be addresses **following the presentation**.

Please use the chat for any technical issues.

Polling and Q&A in Webex

Slido Q&A can be accessed through either the Apps or the Ellipsis icons located at the bottom right corner of your screen.



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.*

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

Additional Information:

- 2025 Product Overview
- Community Health Choices
- Encounter Data
- Clinical Programs
- Credentialing
- Member's Rights and Responsibilities
- Provider Practice Standards and Guidelines - A&A Survey
- What's New at Jefferson Health Plans/Health Partners Plans

Who We Are

Jefferson Health Plans | Health Partners Plans

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

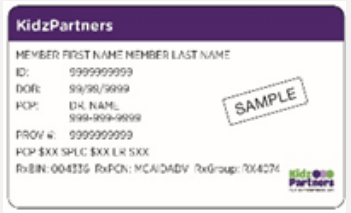
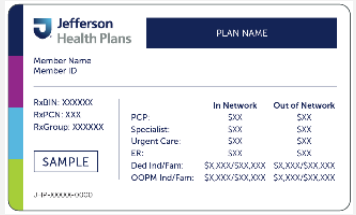
Jefferson Health Plans Individual and Family Plans
(Commercial ACA product)

Health Partners Plans Medicaid

Health Partners Plans CHIP

2025 Product ID Cards

2025 Product ID Cards

Health Partners Plans Medicaid		(9-digit ID starting with all numerical digits)	**Payor ID:** #80142 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121
Health Partners Plans CHIP		(10-digit ID starting with a “3” or a “9”)	**Payor ID:** #80142 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121
Jefferson Health Plans Medicare Advantage	 	(7-digit ID number starting with a “5”)	**<u>HMO:</u> Payor ID:** #80142 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121 **<u>PPO:</u> Payor ID:** #RP099 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 21921 Eagan, MN 55121
Jefferson Health Plans Individual and Family Plans		(12-digit ID, starting with a “J”)	**Payor ID:** #80142 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121

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

Jefferson Health Plans Medicare - New Jersey (HMO and PPO)

Member ID is 7 characters, starting with "5"; PPO or HMO is identified on the ID card

HMO **Payor ID: #80142**

PPO **Payor ID:#NJ099**

HMO: PAPER CLAIMS SUBMISSIONS:

Jefferson Health Plans
PO Box 211123
Eagan, MN 55121

PPO: PAPER CLAIMS SUBMISSIONS:

Jefferson Health Plans
PO Box 211290
Eagan, MN 55121

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 & Eduction Quick Reference Guide
- Clinical Resources - Preventative and clinical care guidelines, developmental screening information, and telehealth resources.

2025 Product Overview

Health Partners Plans Medicaid Benefits

Our members have $0 copays in 2025 for covered Medicaid physical health services and prescription drugs

Health Partners Plans Medicaid Plans provides all the benefits of Medicaid, including:

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

Additional Benefits:

- Fitness center memberships
- Nutrition education and counseling
- Member events and education

Health Partners Plans CHIP Benefits

Health Partners Plans CHIP is available to children up to age 19 at low or no cost, based on household income and is offered in all counties within PA.

Health Partners Plans CHIP covers:

- Doctor and well-childcare visits
- Prescriptions
- Dental checkups and cleanings, and orthodontics (including braces when medically necessary)
- Eye exams and eyeglasses
- Mental health and substance abuse services
- Nutrition counseling
- Fitness center membership
- And much more!

Jefferson Health Plans Individual and Family Plans Portfolio (Pennsylvania)

HMO

- **3** Bronze plans *(1 new plan launch for 2025)*
- **3** Silver plans *(Term'd 3 Off-X plans for 2025)*
- **3** Gold plans (*1 new plan launch for 2025)*

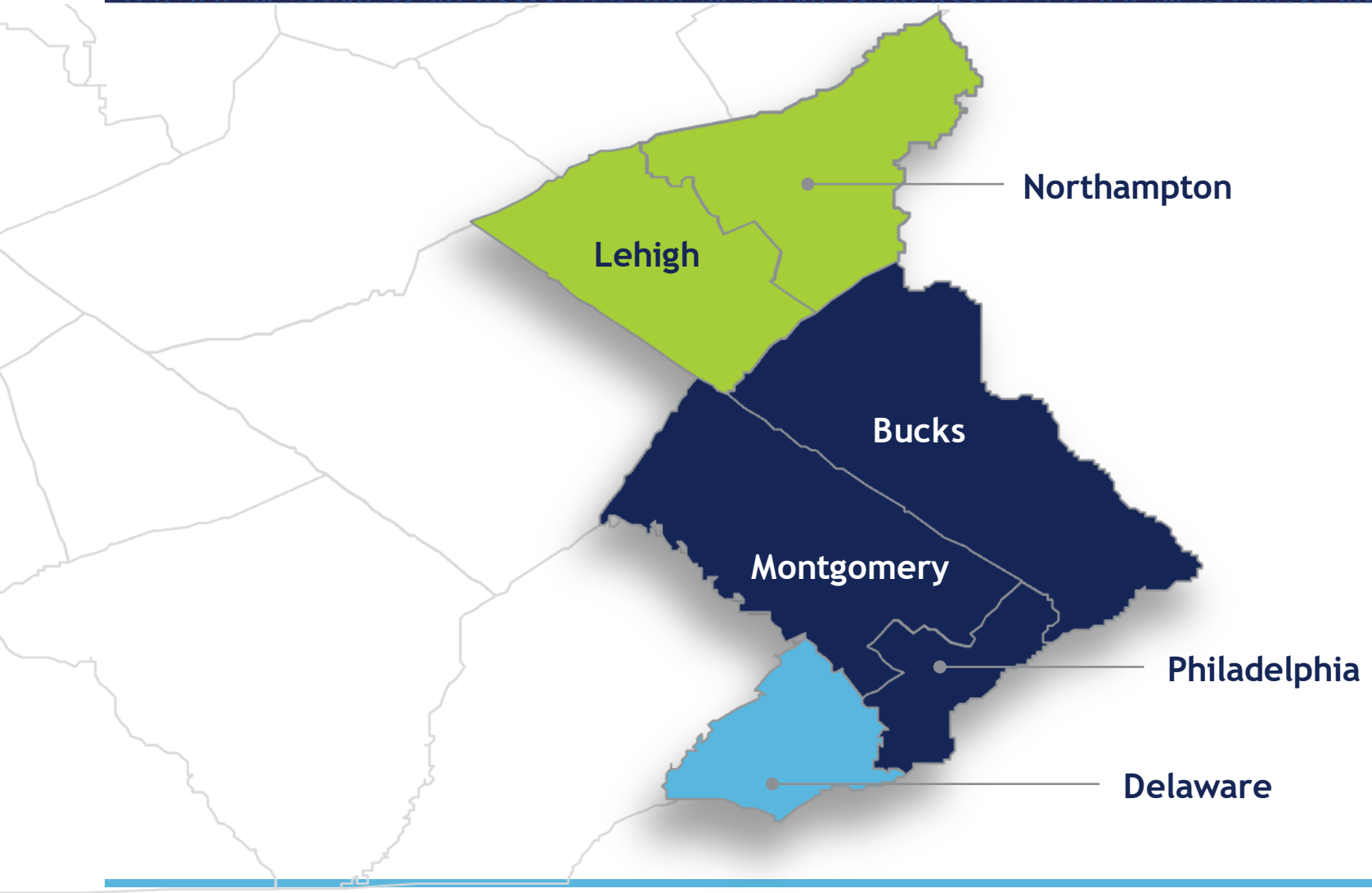
Jefferson Health Plans HMO Portfolio:	
3 **Bronze** Plans:	• $0 Deductible • Total • Value
3 **Silver** Plans:	• $0 Deductible • Balanced • Total
3 **Gold** Plans	• $0 Deductible • Total • Value

NEW: PPO

- **3** Bronze plans
- **6** Silver plans
- **3** Gold plans

Jefferson Health Plans PPO Portfolio:	
3 **Bronze** Plans:	• $0 Deductible • Total • Value
3 **Silver** Plans:	• $0 Deductible • Balanced • Total
3 **Gold** Plans	• $0 Deductible • Total • Value

Jefferson Health Plans Individual & Family Plans – 2025 Service Area



- Existing service area (HMO)
- Expanded service area (both HMO and PPO)
- Expanded service area (HMO)

Jefferson Health Plans Medicare Advantage Plan Portfolios

HMO

- Strong HMO offering for members that qualify for an LIS or are willing to pay a premium for lower cost sharing and MOOP
- Positioned to perform strongly in Eastern PA region with robust network
- Aligned to Jefferson Health System and positioned to perform strong in Jefferson core footprint

State	Product(s)
PA	• Complete ($0) • Prime ($40.90) • Give Back ($0) +$125 Part B
NJ	• Silver ($0) • Platinum ($30)

PPO

- Ideal landing spot for members that want to be outside base service area.
- Positioned to perform strongly within and outside of Jefferson core footprint on with robust network

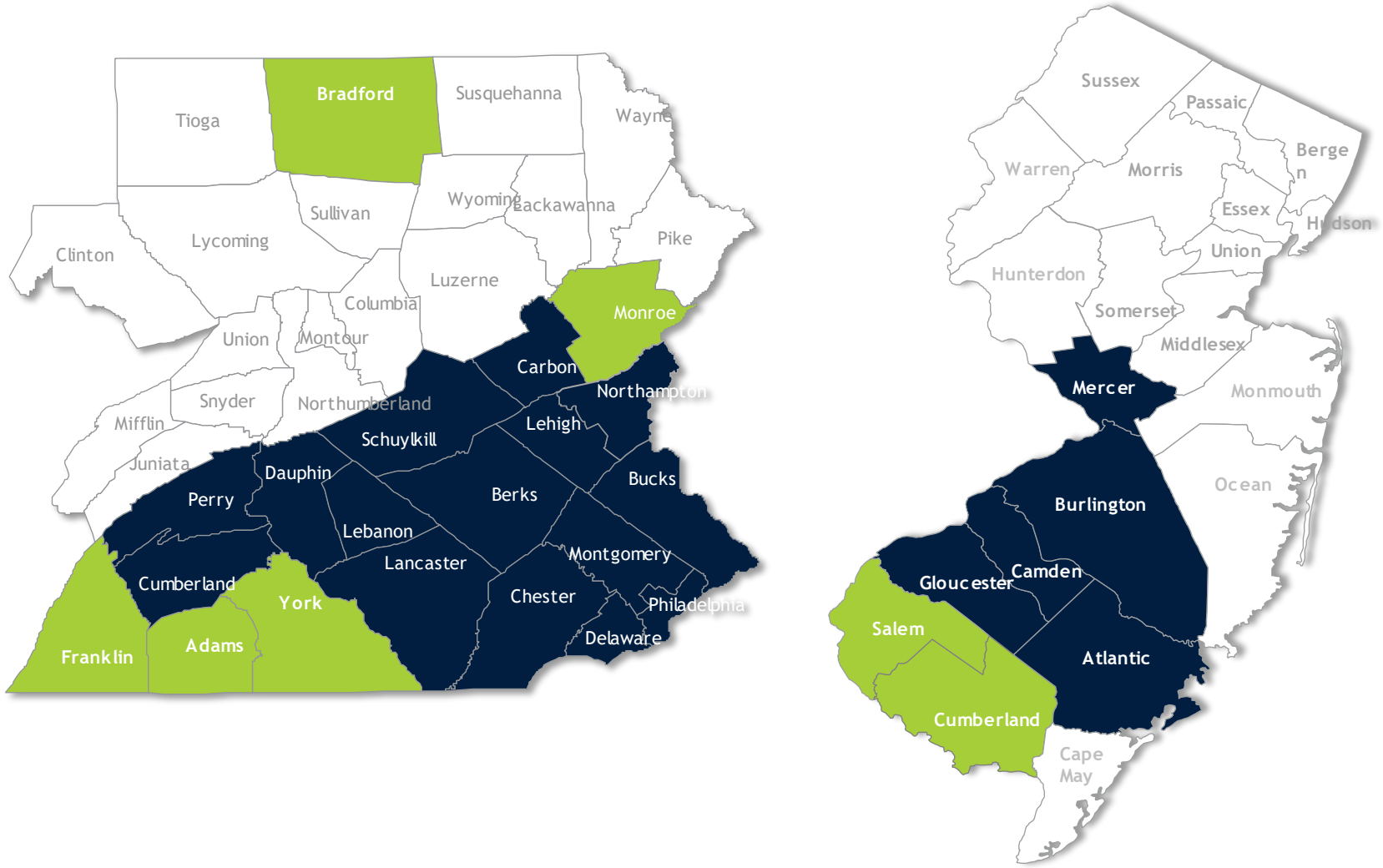
State	Product(s)
PA	• Flex ($0) • Flex Pro ($20) • Flex Plus ($37)
NJ	• Choice ($0) • Choice Plus ($35)

DSNP

- Special and Dual Pearl plan members have both Medicare and Medicaid coverage.
- Special plan members are also referred to as Dual Special Needs Plan (DSNP) members.

State	Product(s)
PA	• Special • Dual Pearl
NJ	N/A

Jefferson Health Plans Medicare Advantage – 2025 Expansion Markets



2024 Service Area

2025 Expansion counties (all products)

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.

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.

MOC DNSP Training & Attestation

Annual Model of Care (MOC) DSNP Training Requirement

Mandatory for all providers serving DSNP 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**

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)

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 recredentialed 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

Provider Credentialing Process to Link Active Providers

- Participating provider groups that would like to link an actively participating provider should submit a signed, linkage request on company letterhead to datavalidation@jeffersonhealthplans.com with the following:
  - Group Name
  - Group NPI
  - Individual NPI
  - Tax ID
  - Effective date of the linkage
  - Complete address (including phone/fax number)
  - Contact information

Revalidation of Medical Assistance Providers

MA Revalidation:
Providers must revalidate MA enrollment (including 13-digit service locations) every 5 years. Check PROMISe for your due date and apply at least 60 days in advance.

PROMISE System Check:
Providers should regularly review PROMISe to confirm demographic details, service locations, revalidation dates, and ensure their PROMISe ID is active. Visit the DHS website for instructions and requirements.

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

Reporting Provider Data Changes

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.

For more information or if you have not received your quarterly data validation form, please email datavalidation@jeffersonhealthplans.com

Provider Demographic Changes

- 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

Medical Records Request

Medical Records Request from Quality Management

Jefferson Health Plans/Health Partners Plans requests medical records for many reasons. For example:

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

Per your contract:

- Records do not need a patients or head of household release form signed
- Records are provided at the providers' expense for the quality assurance programs

Record reviews are conducted by trained & licensed clinical staff.

Medical Records Request from Quality Management

We receive records via many platforms:

- Electronic Medical Record (EMR) view or read-only access *(preferred)*
  - We work with several EMR systems to retrieve records such as but not limited to: EPIC, Cerner and Athena
  - We will always contact the provider's office prior to retrieving records with the member information and reason for the review.
    - E-mail
    - Secure fax
    - Third Party Vendor
    - Ciox/Datavant
    - MRO Portal

- If you have a preferred method of medical record collection, please let us know at: Quality@jeffersonhealthplans.com.
- **Please include:**
  - The office manger or clinical contact
  - Contact person's email, phone number
- We will provide correspondence with the member's name, DOB, ID number, and the reason for the request.

Quality Management Department Contact Information

Reason for Medical Record Request	Email Address	Fax
STARS-HEDIS initiative	Hedis_records@jeffersonhealthplans.com	215-967-9230
Care Gaps	Caregap_records@jeffersonhealthplans.com	215-967-9230
Audit	Audit@jeffersonhealthplans.com	215-967-4477
QOC/Complaints	Quality@jeffersonhealthplans.com	267-515-6648
CIOX/Datavant	Smart Request Portal ID#1336327	
MRO Portal	Quality@jeffersonhealthplans.com	

Prior Authorization

Prior Authorization Overview

Prior Authorization (PA) Overview

- PAs are processed either through MHK on our Provider Portal or eviCore, depending on the service.
  - ***Effective 10/1/2025, Fax submissions will no longer be accepted.***
- Use our Prior Authorization Management Tools to determine the appropriate submission type.
- Drug specific PA forms are available on our Prior Authorization webpage.
- *Specialists do not need referrals for any of our plans but must keep the PCP informed of all care rendered.*

MHK Best Practices

- Begin by searching for the member in HealthTrio:
  - ***Date of Birth (DOB), Member ID, and Last Name.***
- Navigate from left to right, top to bottom.
- Always use the navigation buttons within the application.

***HealthTrio times out after 20 minutes of inactivity**

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.

- **Non-Participating Facility Transfers**: For elective admissions or transfers, the **PCP, referring specialist, or hospital** must call **Inpatient Services at 1-866-500-4571**

Processing Guidelines

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

Urgent/Expedited Care Services	Urgent/Expedited Medical or Severe Condition
Care needed within 24 hours to prevent an Emergency Medical 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.

- Requests not meeting this criteria may be processed under the standard timeframe for your line of business.
- For more information, please see our Urgent and Expedited Authorization Requests Tip Sheet.

Prior Authorization Submission

PAs are processed either through MHK on our Provider Portal or eviCore.

JEFFERSON HEALTH PLANS/HEALTH PARTNERSPLANS

- Clinics
- Short procedure units
- Ambulatory surgery centers
- Services performed in-office
- Hospital outpatient departments

eVICORE

- Oncology
- Joint & Spine Surgery
- Cardiology Studies/Procedures
- Chemo Home Infusion Medications
- Interventional Pain Management
- Advanced Radiology services
- Therapy services (PT, OT and ST)*

Health Partners Plans CHIP does not require PA for therapy services.

Prior Authorization Submission: 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.

To request a prior authorization, the physician or a member of his/her staff should contact our Pharmacy department at 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 at 1-800-553-0784. The call will be evaluated and routed to a clinical pharmacist on-call 24/7.

Prior Authorization Requirements for Transportation

Health Partners Plans Medicaid Jefferson Health Plans Medicare Advantage Jefferson Health Plans Individual and Family Plans	
Required	**Transportation**
No	**•Non-Emergent Land**
Yes	**•Air** **•Water**

Non-participating providers may require authorization as a condition of payment based on the member's individual coverage.

For information on products/services that require authorization as a condition of payment for out of network services, please contact the Utilization Management/Prior Authorization line at 1-866-500-4571, prompts 2 and 4.

Behavioral Health Non-Emergent Transportation

Behavioral health non-emergent (stretcher) transportation does not require prior authorization for all lines of business.

Health Partners Plans Medicaid ambulance providers must have an active PROMISe ID# and all claims must include a behavioral health ICD-10 diagnosis code.

All behavioral health transports must be for a level of transport appropriate to the documented need for our members to a behavioral health facility.

Effective January 1, 2025, we are removing the requirements for medical necessity reviews/prior authorization requirements for non-emergent land transportation for Jefferson Health Plans Medicare Advantage members.

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:

- Support provider's treatment plan and health care goals
- Reduce or eliminate barriers to care, such as social, behavioral health needs
- Designed to address needs of members across the life continuum
- Staffed by licensed and non-licensed staff

Critical components for all programs:

- Collaboration with member, family/caregiver, health care providers and community agencies, as appropriate
- Member-centric/whole-person focus
- Voluntary, with the ability to opt out at any time by calling Member Relations or discussing with a Care Coordinator
- Telephonic, face to face, email, social media, in the community and in provider offices
- Use of Find Help to identify SDoH resources

Clinical Programs activities focus on both long and short-term goals for members.

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

Clinical Programs: Health Partners Plans Medicaid and Health Partners Plans CHIP

Baby Partners

Care coordination for prenatal and postpartum members

Connection to local resources, such a food, diapers, car seats

Bright Futures

Important guidelines and reminders for preventative care and services for pediatric members aged 21 and under

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

Care coordination for adult members with multiple co-morbidities and/or special needs

Connection to supplemental benefits, programs, and community resources

Clinical Programs activities focus on both long and short-term goals for members.

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

*EMSU = Enhanced Member Support Unit

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 the behavioral health managed care organization (BH-MCO) assigned to their county of residence.

- PCPs who identify a member in need of behavioral health services should direct them 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, following an EPSDT screening, a provider suspects developmental delay and the child is not receiving services at the time of screening, then the provider is required to refer the child (not over 5 years of age) through the CONNECT Helpline (1-800- 692-7288) for appropriate eligibility determination for Early Intervention Program services.
  - For the latest guidelines, visit our website at: EPSDT / Bright Futures
  - Call our Healthy Kids team at 1-866-500-4571

Childhood and Adolescent Immunizations

- Immunization Schedules are now available and effective immediately.

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.

Lead Screening Requirements

- All children enrolled in Health Partners Plans Medicaid must have a minimum of two screenings:
  - First screening by age 12 months and a second by age 24 months.
  - For a child between 24 and 72 months (2-6 years old) with no record of screening, a lead screening must be performed as part of the EPSDT well-child screenings, regardless of the individual child's risk factors.

- Please refer to the recommendations set forth in the EPSDT Periodicity Schedule.
- Health Partners Plans Medicaid and Health Partners Plans CHIP share similar guidelines for ensuring that members receive well-child visits.

Members' Rights and Responsibilities

- Our members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by our participating providers or other state agencies.
- It is your obligation and duty as one of our providers to comply with these standards and uphold our Members' Rights.
- Members also have responsibilities, including the duty to work with their health care service providers.
- A comprehensive statement of Member Rights and Responsibilities provided can be found here: Provider Manual Chapter 15: Member Rights & Responsibilities

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

Provider Practice Standards and Guidelines

Access & Appointment and Telephone Availability Standards

Access, Appointment Standards and Telephone Availability Criteria	PCP	Specialist
Routine office visits	Within 10 days	Within 10-15 days, depending on the specialty
Routine physical	Within 3 weeks	n/a
Preventive care	Within 3 weeks	n/a
Urgent care	Within 24 hours	Within 24 hours of referral
Emergency care	Immediately and/or refer to ER	Immediately and/or refer to ER
First newborn visit	Within 2 weeks	n/a

- All PCPs must be available to members for consultation regarding an emergency medical condition 24 hours a day, seven days a week.
- For more information, visit our Provider Manual Chapter 11: Provider Practice Standards & Guidelines

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.

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.

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.

American 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

What's New?

Blood Pressure Resource Guide

Hypertension is one of the most common chronic conditions among the patient population we serve. Controlling high blood pressure is an important step in preventing other adverse health outcomes like heart attacks, stroke, kidney disease, and other serious conditions.

We have created a guide that can serve as a foundation for your office to:

- Learn more about the Controlling Blood Pressure (CBP) measure
- Understand how you can impact your QCP incentive
- Discover how we can support you and your care team

Visit Disease and Medication Management to view the Blood Pressure Resource Guide.

EVV Claims Submission via HHAeXchange - Home Health/Shift Care

- Effective September 1, 2025, all Electronic Visit Verification (EVV) claims billed by Home Health/Shift Care providers for Health Partners Plans Medicaid members must be billed through HHAeXchange.
- EVV claims directly submitted to Health Partners Plans Medicaid will be rejected, which will cause delays in claims processing and payments.

HHAeXchange provides a free EVV and billing tool for member placement, scheduling, authorization management, communication, and EVV compliance for home health aide services.

Visit www.hhaexchange.com to submit claims and for additional resources.

Topical Fluoride Varnish

Topical Fluoride Varnish (TFV) is an effective preventive treatment that reduces tooth decay in children and adolescents. The American Academy of Pediatrics (AAP) and the American Academy of Pediatric Dentistry (AAPD) recommend TFV through age 21 as part of routine care. Early and regular application is especially important for young children to improve long-term oral health and reduce invasive procedures.

The Department of Human Services (DHS) has removed the mandatory TFV training requirement. Now, MA-enrolled physicians, physician assistants (PAs), and CRNPs can provide TFV services to MA beneficiaries. These changes aim to lower administrative barriers, increase provider participation, and enhance oral health outcomes for children in Pennsylvania.

For more information on TFV and other Oral Health Resources, visit our website at: Oral Health Resources

Plan Contacts and Resources

Provider Services Helpline 888-991-9023 9:00-5:00 pm	Medical Providers	Prompt 1
	Pharmacies	Prompt 2
	Join our Provider Network	Prompt 3
	Member Services	Prompt 4

Additional Resources	Utilization Management	866-500-4571
	Care Coordination	866-500-4571
	eviCore Radiology auths, PT/OT/ST and other expanded services	888-693-3211
	ECHO Health – electronic funds transfer and remittance advice	888-834-3511
	Quality Management	215-991-4283
	Skilled Nursing Facilities and Rehabilitation	215-991-4395 Fax: 215-991-4125
	Health Partners Plans CHIP Magellan Behavioral Health	800-424-3702
	Jefferson Health Plans Medicare Magellan Behavioral Health	800-424-3706

Plan Contacts and Resources

Providers	https://www.healthpartnersplans.com/home/providers/
Provider Manual	https://www.healthpartnersplans.com/home/providers/tools-and-resources/provider-manual/
Provider Portal	https://www.healthpartnersplans.com/home/providers/provider-portal/
Training & Education	https://www.healthpartnersplans.com/home/providers/training-and-education/
Provider Directories	https://www.healthpartnersplans.com/home/providers/tools-and-resources/provider-directory/
Formularies	https://www.healthpartnersplans.com/home/providers/tools-and-resources/formularies/
ECHO Health	http://www.echohealthinc.com/
Claims	https://www.healthpartnersplans.com/home/providers/eligibility-and-claims/
Contracting	Contracting@jeffersonhealthplans.com

Home Health Services and Non-Emergent Transportation Facsimile

Home Care and Home Infusion	Fax: 267-515-6633 (Medicare) Fax: 215-967-4491 (Medicaid, Individual and Family Plans)
Durable Medical Equipment (DME)	Fax: 267-515-6636 (Medicare) Fax: 215-849-4749 (Medicaid, Individual and Family Plans)
Shift Care/Medical Daycare	Fax: 267-515-6667
Non-emergent Transport	Fax: 267-515-6627

Regulatory Requirements

- 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.

Annual Training for Network Providers (ATP)
A comprehensive overview of our plans and essential information to meet our members' needs.

2025 Access and Availability Survey
Survey to determine if providers are meeting the access, appointment, and telephone availability standards
aasurvey@jeffersonhealthplans.com

D-SNP Model of Care Training
This training ensures providers understand the specialized care and services offered to dual-eligible beneficiaries.

ADA Compliance Attestation
Per federal and state regulations, all participating providers are required to attest that their practice locations meet the requirements set forth by the Americans with Disabilities Act (ADA).

*Additionally, please visit our Webinars page for other upcoming trainings.

Questions

Please use the Slido Q&A panel for any questions.

For additional questions, please email: providereducation@jeffersonhealthplans.com

Please take a moment to complete the post-webinar survey. Your feedback is greatly appreciated.

Upcoming webinars

Register at: hpplans.com/webinars

Appendix

Additional Content

Due to time considerations, the following content was not covered during our live presentation, but is included here for your review.

- Plan Coverage Area Maps (Slides 18 & 20)
- Provider Screening and Enrollment (slide 34-35)
- Provider Demographic Changes (slide 39)
- Quality Management Department Contact Information (slide 44)
- Prior Authorization Information (Slide 48-51)
- Members' Rights and Responsibilities (slide 62)
- Comprehensive Member Benefits (slide 63)
- Plan Contacts and Resources (slides 74-76)

Thank You for Attending