Jefferson Health Plans | Health Partners Plans

Annual Training for Network Providers

Wednesday, December 10, 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.

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

Topics Covered

- Medicare Beneficiary Information
- Community HealthChoices
- Provider Data Changes
- Medical Records Request
- Prior Authorization
- Complaints, Grievances and Appeals
- Clinical Programs
- Benefits and Services
- Provider Practice Standards and Guidelines
- Cultural and Linguistic Requirements and Services
- Reminders

What's New

- Behavioral Health Updates
- 2026 Medicare Advantage Plans
- 2026 Individual and Family Plans
- Product ID Cards
- Pharmacy Updates

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

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

What's New?

Behavioral Health Update

- Beginning January 1, 2026, members enrolled in our **Health Partners Plans CHIP, Jefferson Health Plans Medicare Advantage and Jefferson Health Plans Individual and Family Plans** will receive their behavioral health benefit through Optum Behavioral Health.

- **Member benefits/coverages will not change with this transition**.

- Magellan will continue to provide BH services for Health Partners Plans Medicaid

Pharmacy Updates

Glucagon-Like Peptide-1 (GLP-1) Agonists

- Effective **January 1, 2026**, the Department of Human Services (DHS) is making a change to the Medical Assistance prescription drug benefit. This change applies to all Pennsylvania Medicaid plans, including Health Partners Plans Medicaid.
- **What is Changing?** Drugs containing a GLP-1 receptor agonist for the treatment of overweight or obesity will no longer be covered unless the member also has a condition for which a GLP-1 receptor agonist remains a covered prescription drug benefit.
- **Impacted GLP-1 medications include:**

Mounjaro (tirzepatide)	Trulicity (dulaglutide)
Ozempic (semaglutide)	Victoza (liraglutide)
Rybelsus (semaglutide)	Wegovy (semaglutide)
Saxenda (liraglutide)	Zepbound (tirzepatide)

- This change is authorized by 62 P.S. § 443.6(g), as amended by Act 2011-22, and 55 Pa. Code § 1121.54.
- Coverage for GLP-1 drugs currently authorized for overweight or obesity will end **December 31, 2025.**
- If your patient is taking a GLP-1 drug for a condition other than overweight or obesity, a new prior authorization request may be needed to determine eligibility for continued coverage starting **January 1, 2026**.

Statewide Preferred Drug List for 2026 Benefit Year

GLP-1 RECEPTOR AGONISTS

Preferred Agents	Non-Preferred Agents
Ozempic *(semaglutide)* Pen[PA, QL]	Bydureon BCise *(exenatide microspheres)* Autoinjector[QL]
Rybelsus *(semaglutide)* Tablet[PA, QL]	Liraglutide Pen[QL]
Trulicity *(dulaglutide)* Pen[PA, QL]	Mounjaro *(tirzepatide)* Pen[QL]
Victoza *(liraglutide)* Pen[PA, QL]	Wegovy *(semaglutide)* Pen[QL]
	Zepbound *(tirzepatide)* Pen[QL]

- Saxenda (liraglutide) will no longer be covered for any indication.

- Obesity Treatment Agents that do not contain a GLP-1 receptor agonist will continue to be covered by the MA Program.
  - Drugs that are designated as preferred in the Obesity Treatment Agents Statewide PDL therapeutic class will be available without prior authorization (e.g., phentermine capsule, phentermine tablet) as long as quantity limits/daily dose limits are not exceeded.

Glucagon-Like Peptide-1 (GLP-1) Agonists Summary

Preferred GLP-1s for 2026	Ozempic, Trulicity, Rybelsus, Victoza	Members filling preferred GLP-1s who received a disruption letter will not meet our automatic PA criteria for 2026. Based on HPP data, these members did not have a diabetes diagnosis from healthcare economics data OR they did not fill an antidiabetic drug (excluding metformin and SGLT2 agents) If the member is diabetic and claims are processed with a DM diagnosis at the pharmacy POS, the claims will pay. If there is an update to the members health care profile they will also meet the automatic PA. If a PA request is received that indicates the member has diabetes, the request will be approved for 12 months.
Non-preferred (NPD) DM GLP-1s for 2026	Mounjaro, Liraglutide	Members filling a NPD GLP-1 for DM will be disrupted and will need to meet the new 2026 GLP-1 prior authorization criteria
Non-preferred GLP-1s for obesity, OSA, MASH, MACE, and other FDA approved indications excluding use for obesity or overweight only	Wegovy, Zepbound	Members with obesity/overweight WITH OSA, MACE, or MASH will be required to meet the new 2026 GLP-1 prior authorization criteria. Members with obesity/overweight WITHOUT an FDA approved indication will no longer be able to get approval for the drug.
GLP with Obesity/Overweight indication only	Saxenda	Members filling Saxenda will no longer be able to get Saxenda as it is only FDA approved for obesity/overweight

Dipeptidyl peptidase-4 (DPP-4) Inhibitors

- The changes listed below will go into effect on **January 1, 2026**.

Therapeutic Class	Preferred Drugs	2026 Update
Hypoglycemics, DPP-4 inhibitors	Janumet, Janumet XR, Januvia, Jentadueto, Jentadueto XR, Tradjenta	All preferred DPP-4 inhibitors will require prior authorization

Biosimilars

Therapeutic Class	Non-Preferred Drug	Preferred Alternative(s)
Cytokine and CAM Antagonists	Actemra	Tyenne*
	Adalimumab HIGH Concentration Products: Adalimumab-adaz, Adalimumab-adbm (BI labeler), Amjevita, Hadlima, Humira	Adalimumab-aaty (CF) 100 mg/mL* Simlandi (CF) 100 mg/mL*
	Adalimumab LOW Concentration Products: Adalimumab-aacf, Adalimumab-adbm (BI labeler), Humira, Yusimry	Adalimumab-fkjp (CF) 50 mg/mL* Hadlima 50 mg/mL*
	Otulfi, Selarsdi, Stelara, Steqeyma, Yesintek	Pyzchiva*

- Cytokine and CAM Antagonists formulary changes to the Statewide Preferred Drug List for 2026 benefit year for members enrolled with Health Partners Plans Medicaid.
- Updated preferred alternative(s) are included for reference. These changes will go into effect on **January 5, 2026**.

*Prior authorization required. Members with an active prior authorization approval for a non-preferred drug will be able to switch to a preferred alternative biosimilar without requiring a new request for the duration of their existing authorization.

Of note, these medications will only be available through in-network Specialty pharmacies. Health Partners Plans Medicaid is working with these Specialty pharmacies for possible interchange.

Additional Information and Resources

- 2026 Statewide Preferred Drug List and prior authorization clinical guidelines will be posted prior to January 1, 2026 at **papdl.com**.
- Medical Assistance bulletins are available now at the links below:
  - 01-26-37 A Medical Assistance Bulletin entitled: Coverage Change and Prior Authorization of GLP-1 Receptor Agonists (Formerly Hypoglycemics, Incretin Mimetics/Enhancers and Obesity Treatment Agents) - Pharmacy Services
  - 01-26-38 A Medical Assistance Bulletin entitled: Prior Authorization of Hypoglycemics, DPP-4 Inhibitors (Formerly Hypoglycemics, Incretin Mimetics/Enhancers) - Pharmacy Services
  - 01-26-39 A Medical Assistance Bulletin entitled: Coverage Change and Prior Authorization of Obesity Treatment Agents - Pharmacy Services
- For the most up-to-date information regarding Health Partners Plans formularies, please visit our online formulary at **HPPlans.com/Formulary**.
- For more information, call our Pharmacy Department at **215-991-4300** or our Provider Services Helpline at **1-888-991-9023** (Monday to Friday, 9 am to 4:30 pm).
- Prompt PA: Prior Authorizations can be submitted online at **https://hpp.promptpa.com**

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*

State	Product(s)
PA	• Complete ($0) • Prime ($32.70 - was $40.90) • Give Back ($0) +$140 Part B (was $125)
NJ	• Silver ($0) • Elite ($0) - NEW

PPO

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

State	Product(s)
PA	• Flex ($0) • Flex Pro ($18 - was $20) • Flex Plus ($32.70 - was $37)
NJ	• Choice ($0) • Choice Plus ($29 - was $35)

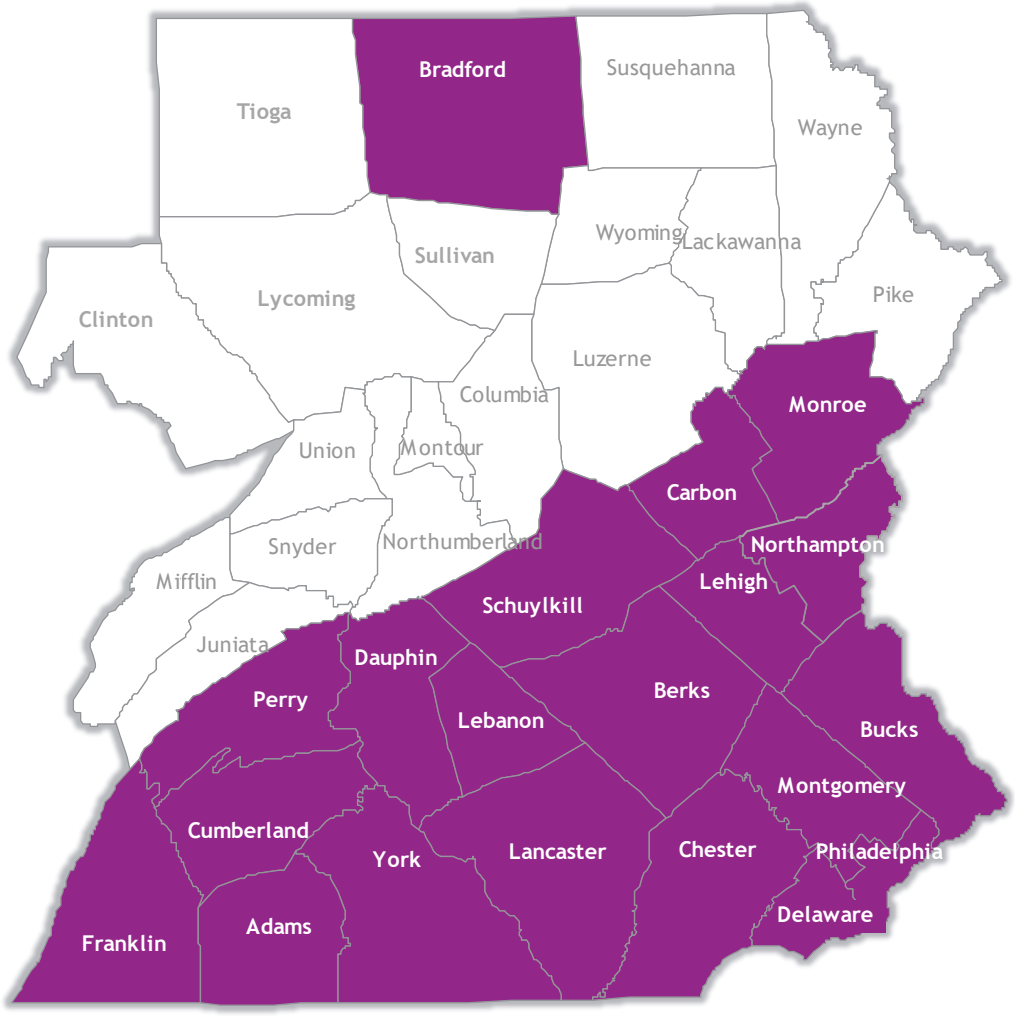
DSNP

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

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

Jefferson Health Plans Medicare Advantage HMO & PPO Counties in PA

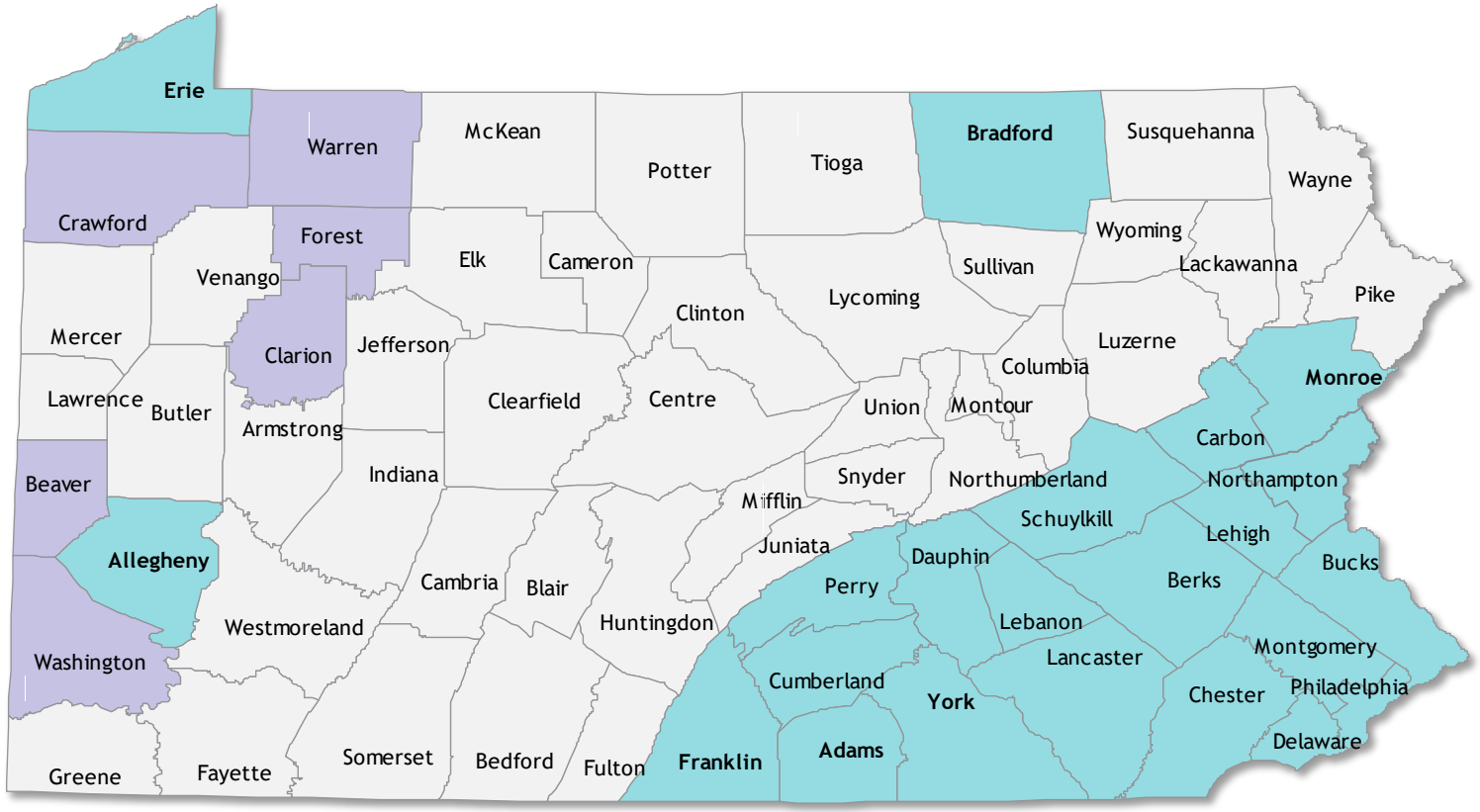
Pennsylvania



Service Area 2026

Jefferson Health Plans Medicare Advantage HMO D-SNP Counties in PA

Pennsylvania



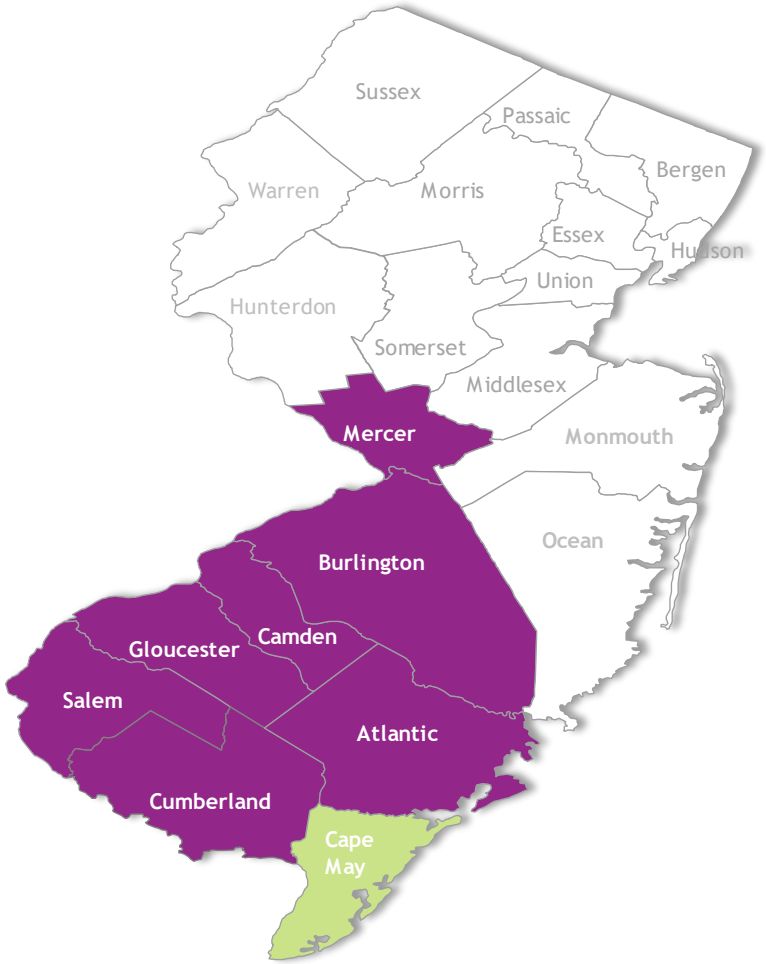
Service Area 2025

Expansion Counties for 2026

(Note: Current MA DSNP service may include additional areas in PA

Jefferson Health Plans Medicare Advantage Counties in NJ

New Jersey



Service Area (All NJ Products)

Expansion Counties (All NJ Products)

Individual & Family Plans (ACA) – 2026 Footprint

PPO

- 3 Bronze plans
- 3 Silver plans
- 3 Gold plans

HMO

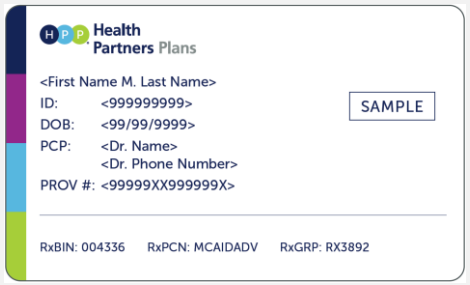
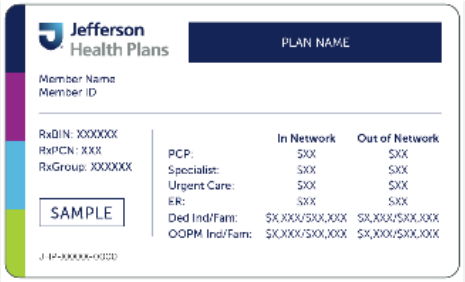
- 3 Bronze plans
- 3 Silver plans
- 3 Gold plans

HMO and PPO 2025 Service Area

New 2026 Service Area for HMO and PPO portfolios

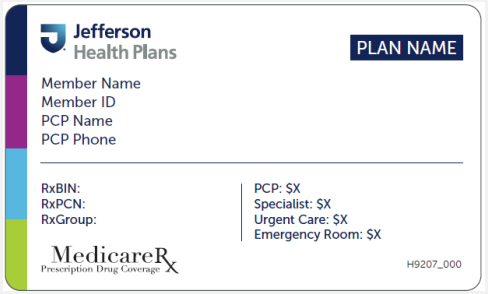
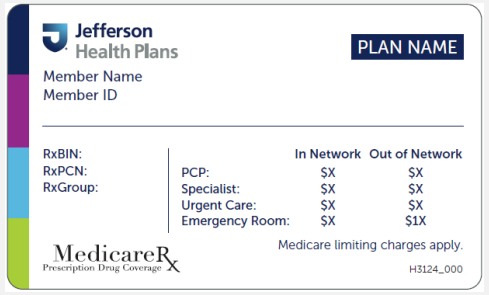
Product ID Cards

Product ID Cards

Health Partners Plans Medicaid **Payor ID# 80142** (9-digit ID - all numerical digits)		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")			**PO Box 21228** **Tampa, FL 33622**
Health Partners Plans CHIP **Payor ID# 80142** (10-digit ID starting with a "3" or a "9")		Issued beginning 9/9/2025	**PO Box 21228** **Tampa, FL 33622**

Effective **December 1st, 2025:** Imagenet will be responsible for the intake of all paper claims submissions.

2025 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

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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.

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 Plus or QMB only) 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)

Reporting Provider Data Changes

Provider Demographic Changes

Providers are recredentialed 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.

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

Reminder to Revalidate MA Enrollment

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

Medical Records Request

Medical Records Request from Quality Management

We request 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 (PA) Overview

- ***Effective 10/1/2025, PA 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, the **PCP, referring specialist, or hospital** must 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.

Urgent/Expedited Requests

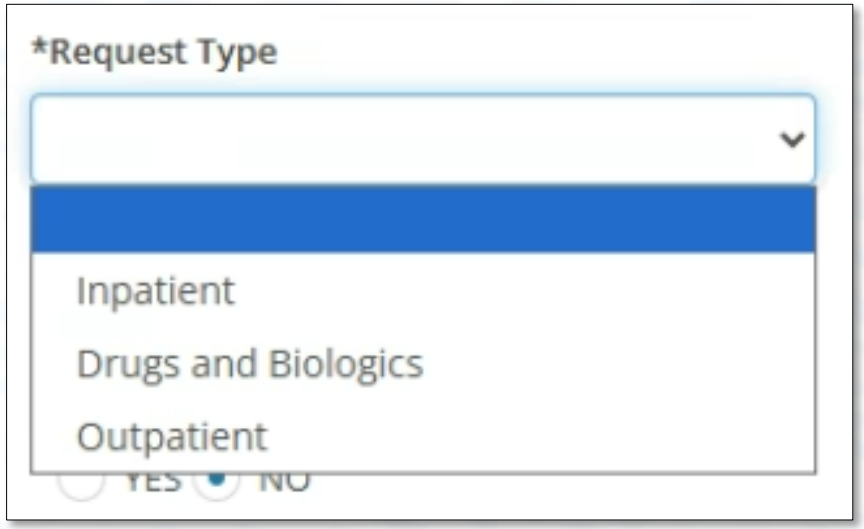
- Providers must request prior authorization at least **7 days in advance** for non-emergent services. Requests are processed per **state and federal regulations. *Failure to follow this timeline may delay non-urgent services.**
- **Expedited requests must meet one of these criteria points.** Requests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

Urgent/Expedited Care Services	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.

- For more information, please see our Urgent and Expedited Authorization Requests Tip Sheet.

Prior Authorizations for Medications

We have noticed a recent trend: Prior Authorizations for Medications are being submitted incorrectly.



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

Submitting a Medication Prior Authorization incorrectly may result in delays.

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.

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 both long and short-term health care goals for members
- 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: 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

- Connection to supplemental benefits, programs, and community resources

MANNA

- Delivers medically tailored meals to members with complex health needs and high-risk pregnancies.
- For more information, please visit: MANNA Referral Program

- Please 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 Programs Provider Referral Line: 215-845-4797

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 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.**

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.

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.

The Provider's Role with LGBTQ+ Patients

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

Annual Requirements

Regulatory 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

2025 Access and Availability Survey

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

aasurvey@jeffersonhealthplans.com

ADA Compliance Attestation

Per federal and state regulations, all participating Medicaid/CHIP 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 chat 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

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

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 11-13)
- Provider Tools and Resources (Slides 24-25)
- Quality Management Department Contact Information (slide 40)
- Prior Authorization Information (Slide 44-46)
- Members' Rights and Responsibilities (slide 57)
- Comprehensive Member Benefits (slide 58)
- Non-Discrimination Policy (slide 65)
- Plan Contacts and Resources (slides 70-72)

Thank You for Attending