Jefferson Health Plans | Health Partners Plans

JEFFERSON 200

Provider Annual Orientation and Training (AOT)

Wednesday, December 11, 2024

Welcome!
Please read the participation tips below.

There is no sound until the webinar begins.

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

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

Technical issues: Use chat, select Carrie Thomas from panelist from the Webex chat dropdown.

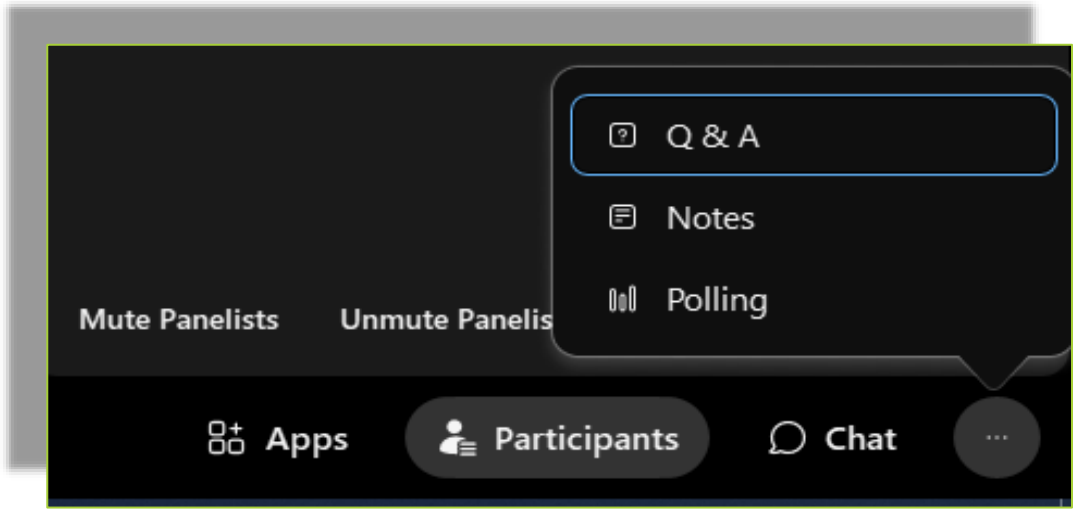
Questions: Please use the **Q&A Panel** when asking questions.

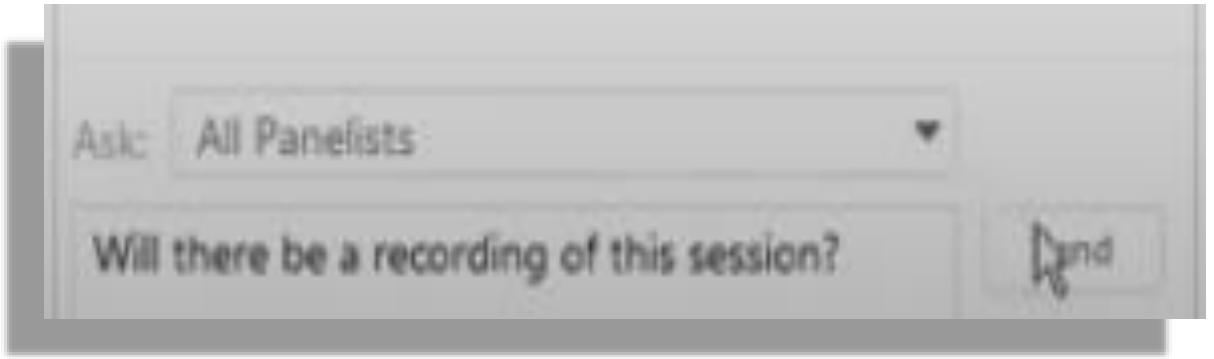
Any questions we are unable to address today, will be answered following the presentation.

Q&A Panel

As an attendee, you can ask questions using Q&A Panel.

1. To open the Q&A panel, click on the ellipses at the bottom right of the screen for 'More Panels' and click on Q&A.
2. Select “All Panelist” from the drop-down menu.
3. Type your question in the message box.
4. Click “Send.”





Training Requirement

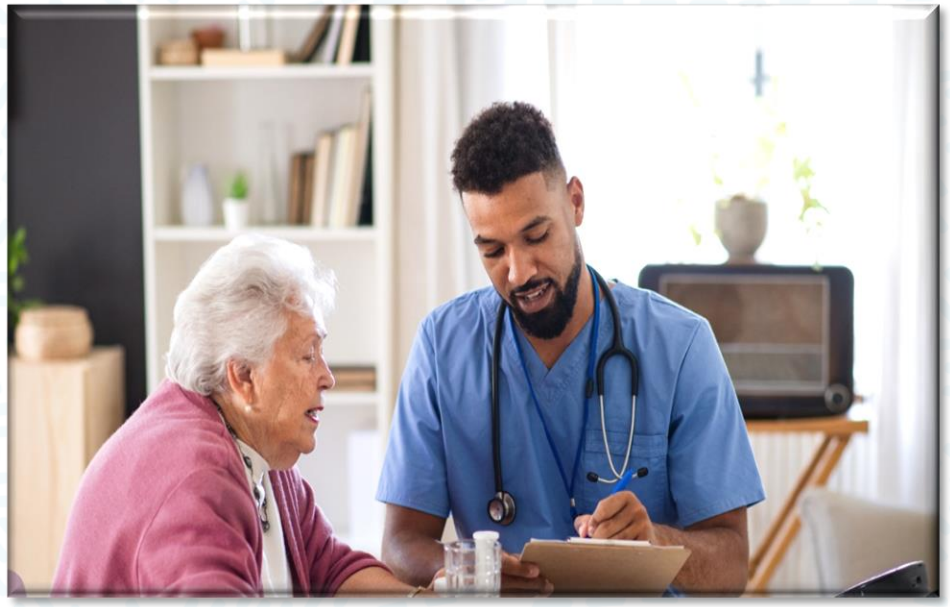
- The Pennsylvania Department of Human Services (DHS) requires Managed Care Organizations (MCOs) to ensure their providers attend at least one MCO-sponsored training during the course of the year. *By attending this session, you fulfill that requirement.*
- Additional training is required for providers who provide service to Medicare members.
  - Medicare Providers' FDR Requirements | Jefferson Health Plans
    - Delegated Vendor Information
  - **Please complete the attestation by using the link provided at the end of the webinar. This webinar is not fully completed until the attestation is submitted. Please ensure you attest at the end of training.**

Jefferson Health Plans | Health Partners Plans

JEFFERSON 200

Jefferson Health 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.

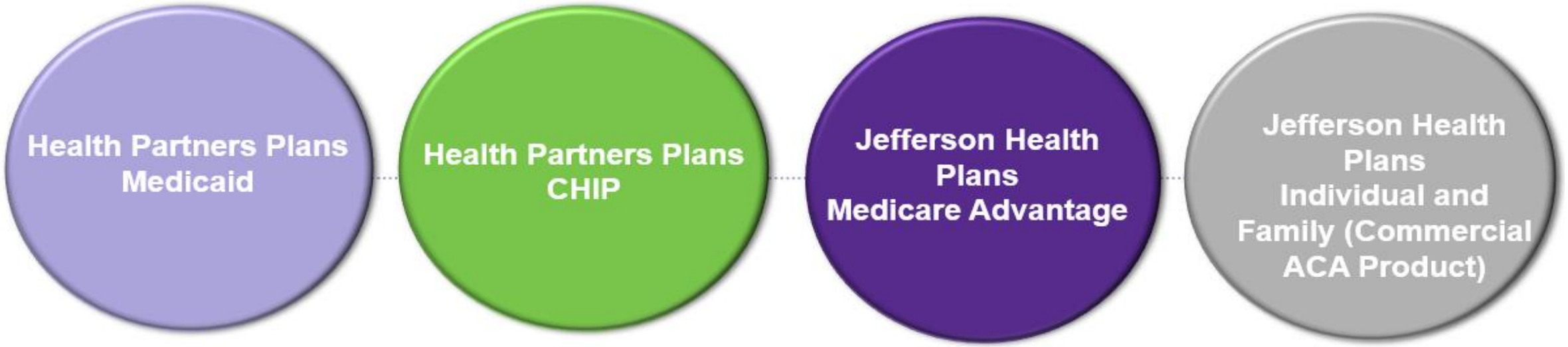


Thank you for being part of our provider network and helping us to improve the health outcomes of our members.

Agenda

- Product Overview
- Claims
- Credentialing
- Utilization Management and Prior Authorization
- Complaints, Grievances and Appeals
- Clinical Programs
- Online Tools and Resources
- **An attestation link will be provided at the conclusion of the webinar**

Product Overview



- Coverage for people of all ages

Health Partners Plans Medicaid Benefits

Our members have $0 copays in 2024 for covered Medicaid physical health services and prescription drugs.

Jefferson Health 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)
- Health Partners members aged 21 years and older are eligible to receive one pair of eyeglasses or contact lenses a year.

Additional Benefits

- Teladoc®, 24-hour medical help line for assistance when you need it
- Fitness center memberships
- Nutrition education and counseling
- Wellness Partners; a health and wellness initiative with free events for the community
- Baby Partners program
- Care Management programs
- 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 Pennsylvania.

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: 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*

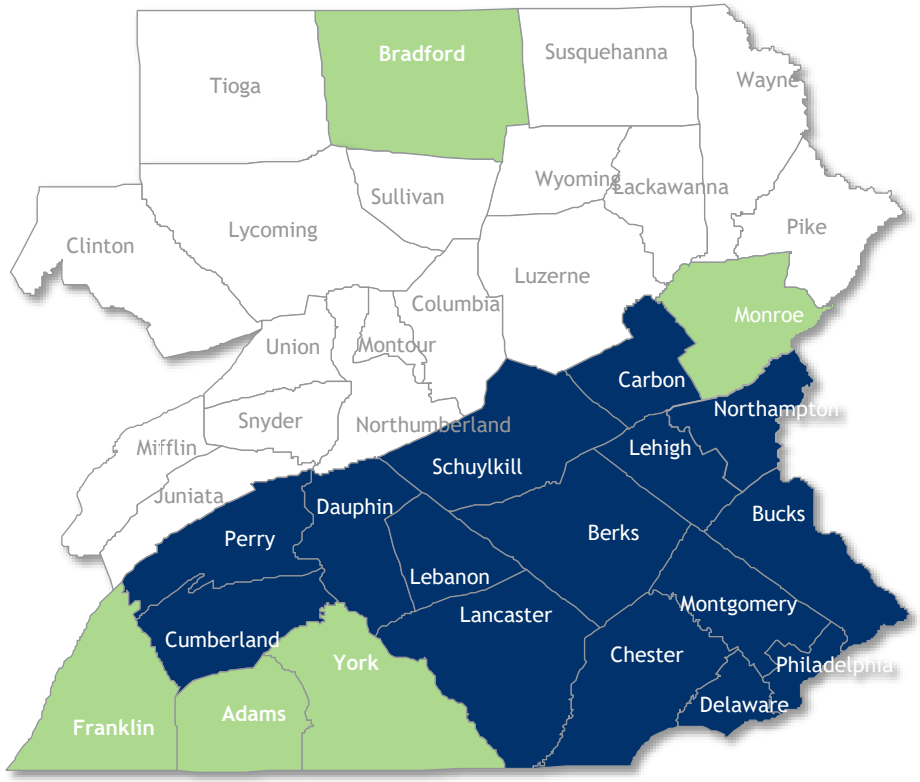
State	Product(s)
PA	• Flex ($0) • Flex Pro ($20) • Flex Plus ($37)
NJ	• Choice ($0) • Choice Plus ($35)

DSNP

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

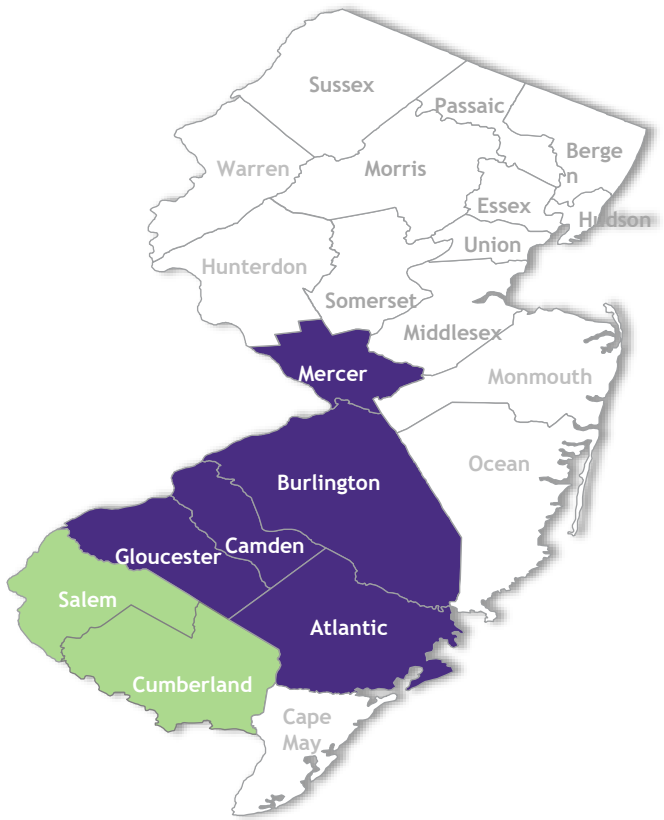
State	Product(s)
PA	• Special • Dual Pearl
NJ	N/A

2025 Medicare Advantage – Expansion markets



2024 Service Area

2025 Expansion counties (all products)



2024 Service Area

2025 Expansion counties (all products)

Note: Current view is not JHP full-service area, additional counties could be available

Individual and Family Plans- ACA Portfolio in 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

Individual & Family Plans (ACA) – 2025 Footprint

Jefferson Health Plans

Existing service area (will continue to only offer HMO product)

Expanded service area for both HMO and PPO

Expanded service area for HMO

Jefferson Health Plans | Health Partners Plans

Special and Dual Pearl (HMO SNP) Plan Reminders

- 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.
- You **do not** need to be participating with Medicaid Community HealthChoices plans to provide services to a Jefferson Health Plans Medicare Advantage member.
- Providers **can** submit claims to the CHC plan regardless of their status with the CHC plan.

Specialist Referrals

- Specialist referrals are not required for any of our plans. Our members are permitted to “self-refer” for specialist care.
- It’s important for specialists to keep a member’s assigned PCP informed of all care they render to the member.

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, Medicare providers and suppliers should:

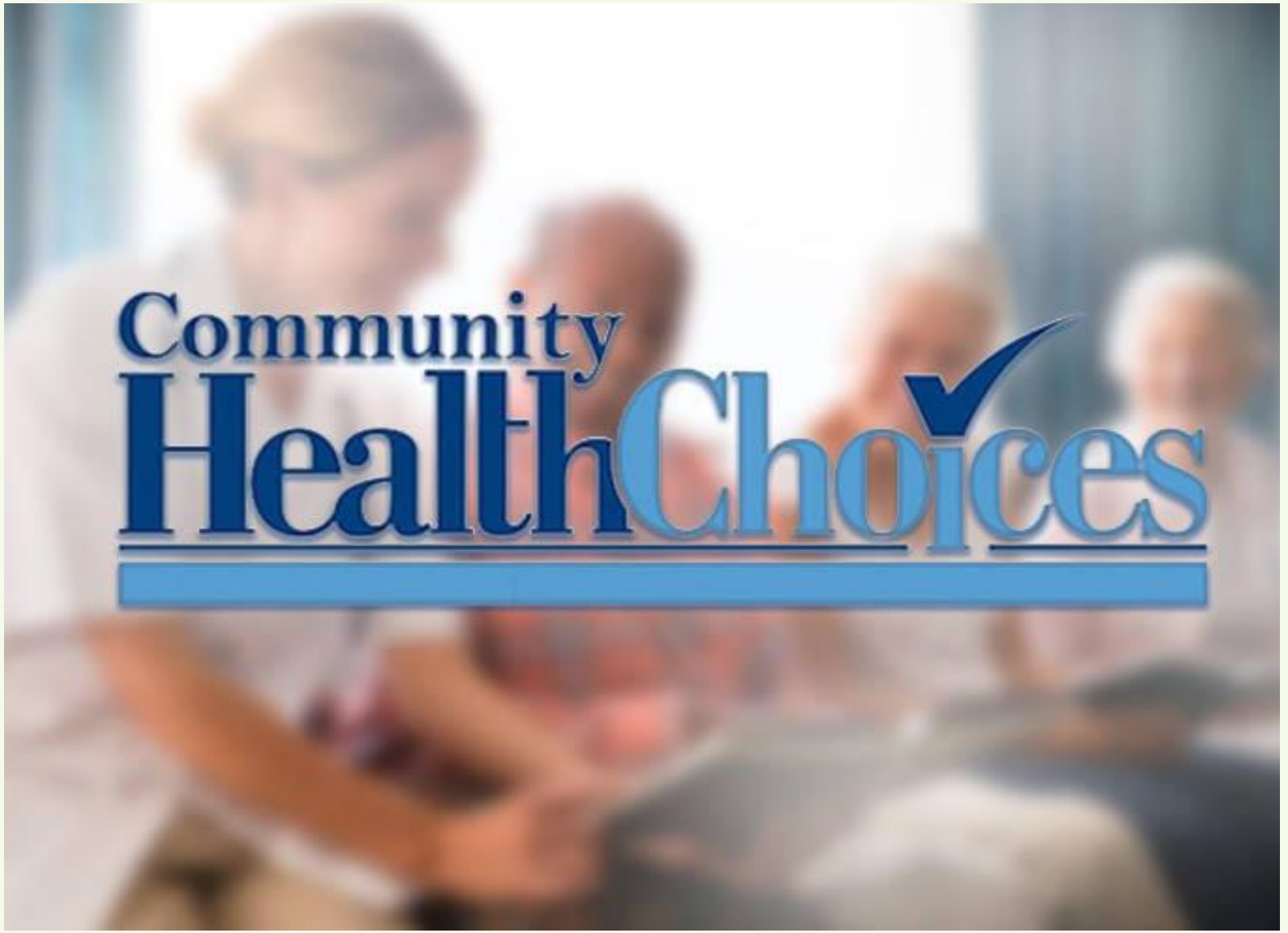
- Implement processes to ensure compliance with QMB billing prohibitions.
- Make sure their office staff and vendors are using systems to identify the QMB status of Medicare beneficiaries

To assist in this process, CMS provides a number of 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

Community Heath Choices



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

- Jefferson Health Plans 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 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 and Links

- 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


M+
M−
MR
MC
%
9
8
7
6
5
SEVEN BAHT AND
Total
Total Amoun
ment until the buyer has done.
ผู้จ่ายของ
ผู้ตรวจสอบ

Clearing House: Smart Data Solutions

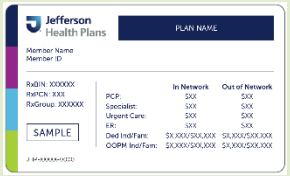
- Smart Data Solutions (SDS) is fully connected to accommodate Electronic Data Interchange (EDI) claim submissions for our Payor IDs.
- Providers may sign-up through the SDS provider portal by emailing SDS directly at stream.support@sdata.us.

Smart Data Solutions

- When submitting to Smart Data Solutions, include the following information:
  - First Name
  - Last Name
  - Email
  - Phone
  - Organization name, NPI, and Tax ID
  - The Jefferson Health Plans Payor ID(s) listed on the next slide.

If you have any questions, please contact the Provider Services Helpline at 1-888-991-9023 (Monday to Friday, 9 a.m. to 5:30 p.m.)

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 *to be identified in the plan name on the card	  (7-digit ID number starting with a “5”)	**HMO: Payor ID:** #80142 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121 **PPO: Payor ID:** #RP099 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 21921 Eagan, MN 55121
Jefferson Health Plans Individuals and Families	 (12-digit ID, starting with a “J”)	**Payor ID:** #80142 **Paper Claims Submissions:** Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121

NEW For NJ Medicare Advantage PPO Plans **ONLY***

Electronic Payor ID:

NJ099

PAPER CLAIMS MAILING ADDRESS

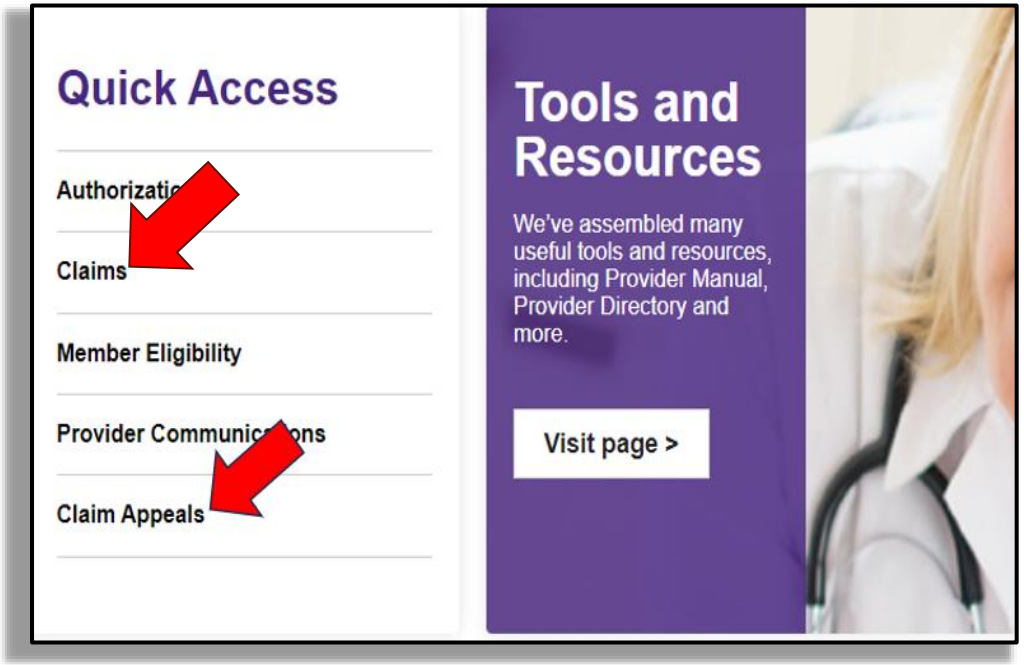
Jefferson Health Plans
PO Box 211290
Eagan, MN 55121

Effective 1/1/2025

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.

Timely Filing	
Initial Submissions	180-days from Date of Service or Discharge Date
Reconsiderations	180-days from the date of Jefferson Health Plans' Explanation of Payment (EOP)
Coordination of Benefits	60-days from date of other carriers (EOP)



Other Claims

Behavioral Health Claims

Must submit to Behavioral Health MCO
For latest listing of BH-MCO's by county, please visit DHS HealthChoices Behavioral Health-MCO
For KidzPartners (CHIP) and Health Partners Medicare contracts with Magellan Behavioral Health

Dental Claims

- **Avēsis** (Dental): 1-800-952-6674, www.myavesis.com/providers/

Vision Claims

- **Davis Vision**: 1-800-773-2847, www.davisvision.com/eye-care-professionals

Claim Payment Policy

Policy Bulletin Library provides reimbursement rules and billing guidelines necessary to ensure timely and appropriate payment

Coordination of Benefits

- Health Partners (Medicaid) is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). With the exception of preventive pediatric care, if other coverage is available, the primary plan must be billed before Jefferson Health Plans will consider any charges.

- After all other primary and/or secondary coverage has been exhausted, providers should forward a secondary claim and a copy of the Explanation of Payment (EOP) from the other payor to Jefferson Health Plans. Secondary claims may also be filed electronically following the HIPAA compliant transaction guidelines.

➢For more information, visit

Provider Manual Chapter 12: Provider Billing & Reimbursement

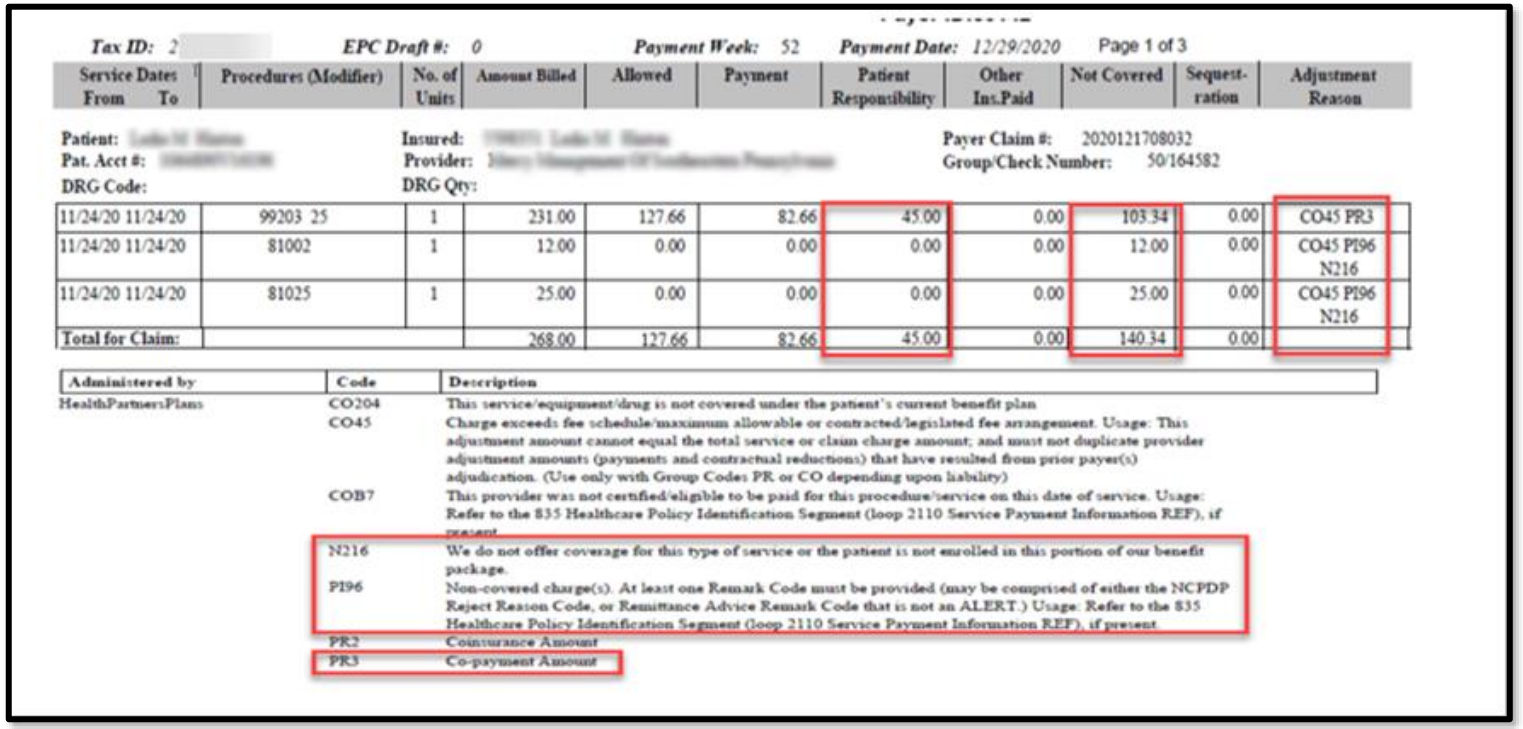
Understanding Offsets and Credit Balances

- **Understanding Offsets**
  - Offset is created when a payment is returned to Jefferson Health Plans for payment received on specific claims.
  - A returned check is often accompanied with a letter explaining why the funds paid should be returned.

- **Understanding Credit Balances**
  - A Credit Balance is the amount owed to Jefferson Health Plans as a result of claim payments/overpayments made to a provider. Once a claim is identified, it is retracted, and a credit is formed.
  - These credits are subtracted from each claim submitted afterward until the balance is satisfied.
  - If the total credits exceed the amount owed, your EOP will show a payment of $0.

Explanation of Payment

Explanation of Payment (EOP) can be found through the Provider Portal - Claims Status Search.



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	

Patient: Insured: Payer Claim #: 2020121708032
Pat. Acct #: Provider: Group/Check Number: 50/164582
DRG Code: DRG Qty:

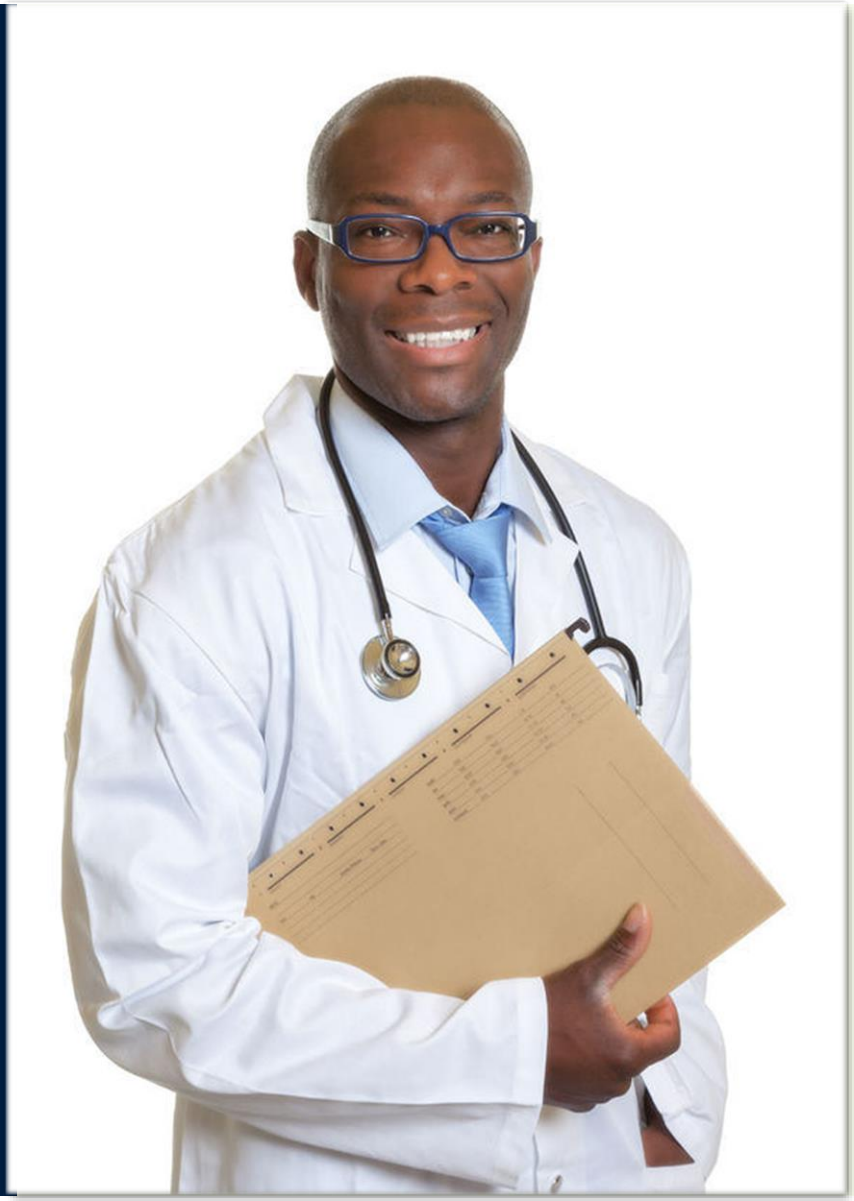
Administered by	Code	Description
HealthPartnersPlans	CO204	This service/equipment/drug is not covered under the patient's current benefit plan
	CO45	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Usage: This adjustment amount cannot equal the total service or 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	Coinsurance 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 with a Jefferson Health Plans member.

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.

Credentialing



Provider Credentialing Process for Existing Contracted Entities

Council for Affordable Quality Healthcare (CAQH) must be accurate and currently attested, which will help Jefferson Health Plans complete the process much faster. Also be sure the demographic information with DHS is current.

Ancillary credentialing requires a unique credentialing application which can be requested by our Contracting Department to initiate the process

Primary Source Verification process will be completed by our vendor Sutherland – they may reach out for additional information.

Provider Demographic Changes

Network Management department must be immediately notified in writing when any of the following occurs. All professional provider data changes are emailed to:

datavalidation@jeffersonhealthplans.com

- Additions/deletions of providers
- Change in payee information (W-9 required)
- Change in hours of operation
- Provider practice name change
- Telephone number change
- Site relocation
- Site location terminations
- Full practice terms
- Change in patient age restrictions

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 he following:

- Group Name
- Group NPI
- Individual NPI
- Tax ID
- Effective date of the linkage
- Complete address (including phone/fax number)
- Contact information

Key Takeaways for Credentialing/Recredentialing

Our goal is to process all credentialing applications within 60 days, providing all requirements are submitted timely.

We are required to verify and update your information every 90 days. Our directories are fed by the information you supply.

It's so important that the state enacted the "No Surprise Act" to ensure directory accuracy.

For initial contract, roster and application the providers can use the recruitment link https://www.healthpartnersplans.com/providers/join-our-provider-network/provider-recruitment-form

For more information on Credentialing/Recredentialing, visit Chapter 11: Provider Practice Standards & Guidelines

Board Certification Requirements

- PCPs are not required to be Board Certified
- Specialists are required to be Board Certified in the specialty in which they are applying
  - Must be an ABMS/AOA Board or a Jefferson Health Plans recognized approve Board
  - Primary Care Practitioner Specialties are:
    - Pediatrics
    - Family Practice
    - Internal Medicine
    - Certified Registered Nurse Practitioner (if credentialed as a PCP)

Revalidation of Medical Assistance Providers

- All providers must revalidate their MA enrollment (including all associated service locations – 13 digits) every 5 years. Providers should log into PROMISe to check their revalidation date and submit a revalidation application at least 60 days prior.

- Providers should check the Department of Human Services (DHS) PROMISe system on a routine basis to confirm demographic data, including all service locations and revalidation dates to ensure information is current and have an active PROMISe ID. Please visit the DHS website for requirements and step-by-step instructions.

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

Utilization Management and Prior Authorization

Utilization Management (UM) Overview

- Our Utilization Management (UM) department is committed to providing members with the most appropriate medical care for their specific situations.
- UM's decisions are based on medical necessity, appropriateness of care and service, the existence of coverage, and whether an item is medically necessary or considered a medical item.
- Jefferson Health Plans does not provide financial incentives for utilization management decision makers that encourage denials of coverage or service or decisions that result in under-utilization.
    - For more information, visit our Provider Manual Chapter 8: Utilization Management

Prior Authorization Process Overview

- Providers should obtain prior authorization at least **7 days** in advance for elective (non-emergent) procedures and services.
- Requests will be processed according to state and federal regulations.
- Failure to comply with this guideline may result in the delay of medically non-urgent services.
- Providers may be contacted for discharge/transition planning for disenrolled members as in some circumstances, Jefferson Health Plans remains responsible for participating in this planning for up to **six (6) months** from the initial date of disenrollment unless the member chooses a different plan.
- For elective admissions and transfers to non-participating facilities, PCP, referring specialist or hospital must call the **Jefferson Health Plans Inpatient Services Department** @ 1-866-500-4571.

Prior Authorization Submission: Jefferson Health Plans & Evicore

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

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

***Health Partners Plans CHIP does not require prior authorization for therapy services.**

Prior authorizations are processed either through our **Provider Portal** or **eviCore**, depending on the service. Please refer to our Prior Authorization Management Tools to determine the appropriate submission type.

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 Jefferson Health Prior Authorization webpage.

To request a prior authorization, the physician or a member of his/her staff should contact Jefferson Health Plans' 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

Behavioral Health Non-Emergent Transportation Medicaid, Medicare & CHIP

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

Health Partners (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 a Jefferson Health Plans member to a behavioral health facility.

Home Health Services and Non-Emergent Transportation Facsimile

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

Complaints, Grievances and Appeals

Complaints, Grievances and Appeals

- When Jefferson Health Plans denies, decreases, or approves 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 that Jefferson Health Plans reconsider its decision.

- In some cases, a member can ask DHS to hold a hearing because they disagree with a Jefferson Health Plans' decision. A member must exhaust Jefferson Health Plans' Complaint or Grievance Process before they request a Fair Hearing.

  - For more information, visit
    - Health Partners (Medicaid) Member Handbook
    - For more information, visit our Provider Manual Chapter 13: Complaints, Grievances, and Appeals or eLearning course, Complaints, Grievances and Medical Necessity Reviews: Learn The Process or call Provider Services Helpline at 1-888-991-9023.

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 (formerly known as Aunt Bertha) to identify SDoH resources

Clinical Programs: Medicaid and CHIP

Baby Partners

Care coordination for prenatal and postpartum members

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

Healthy Kids

Care coordination and disease education for members under 21

Reminders about important preventive services such as lead screenings.

SNU Pediatrics

Care coordination for complex children who have identified special needs or require shift care

Connection to supplemental benefits, programs, and community resources

SNU 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 who may require assistance coordinating their care. **Call the Clinical Programs team at 215-845-4797 and refer any patients for care coordination services.**

Benefits & Services

Members' Rights and Responsibilities

- Jefferson Health Plan members have the right to know about their Rights and Responsibilities. Exercising these rights will not negatively affect the way they are treated by Jefferson Health Plans, its participating providers or other State agencies.
- It is your obligation and duty as a Jefferson Health Plans provider 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 in our: [Provider Manual Chapter 15: Member Rights & Responsibilities]

Member Rewards Programs

Wellness Rewards (MA)

- **Encourages members to complete targeted condition management and preventive health activities**
- **Activities include member portal registration, annual wellness visit, flu vaccine and screenings**

Health Partners Plan (Medicaid)

- Incentivizes Medicare members to complete specific health-related activities in 2024 to earn money on a reloadable gift card
- Activities include well-child visits, diabetes management, hypertension management, dental exam, and medication adherence.

Health Partners Plans CHIP

- Activities include well-baby visit, lead screenings, and dental exams.

➢ Learn more at 2024 Member Rewards Programs

Mental Health and Substance Abuse Treatment

- Under HealthChoices, all Medicaid members, regardless of the health plan/MCO to which they belong, may 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 Health Partners (Medicaid) member in need of behavioral health services should direct the member to call his or her county's BH-MCO. The BH-MCO 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.

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 (Medicaid) members are not responsible for any payments.

Emergency Care

- Non-par follow-up specialty care for an emergency is covered by Jefferson Health Plans, 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, visit our Provider Manual Chapter 11: Provider Practice Standards & Guidelines

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 healthpartnersplans.com/providers/clinical-resources/epsdtbright-futures or call our Healthy Kids team at 1-866-500-4571.

- **Childhood and Adolescent Immunizations**
  - 2024 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 how much a child has grown and developed in the time since their last visit; discussing the child's 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.
    - For more information on EPSDT/Bright Futures, visit https://www.healthpartnersplans.com/providers/clinical-resources/epsdtbright-futures

Lead Screening Requirements

- All children enrolled in 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, located at EPSDT Periodicity Schedule and Coding Matrix. Medicaid and CHIP share similar guidelines for ensuring that members receive well-child visits.

Antipsychotic Medications For Pediatric Members

Antipsychotic medication prescribing in children and adolescents can increase a child's risk for developing serious metabolic health complications associated with poor cardiometabolic outcomes in adulthood. Given these risks, it is important to ensure appropriate management even if the drug has been prescribed elsewhere, family physicians should closely monitor these patients by requesting that they receive a metabolic screening.
If you require assistance with coordinating care for these members or collaborating with a behavioral health provider, please contact our Healthy Kids department at 215-967-4690.

	Baseline	1 month	2 months	3 months	6 months	Reassess
Weight (BMI)	x	x	x	x	x	Q 3 months
Waist cir-cumference	x	x	x	x	x	Q 3 months
Blood pressure	x			x	x	Q 3 months for 1 year then annually
Fasting glucose	x			x	x	Q 3 months for 1 year then annually
Fasting lipid profile	x			x		Annually

Comprehensive Member Benefits

- A comprehensive overview of all benefits and services for members can be found in the Provider Manual Chapters 4-7
- Chapter 4: Health Partners (Medicaid) Benefits
- Chapter 5: Jefferson Health Plans Medicare Advantage Benefits
- Chapter 6: KidzPartners Benefits
- Chapter 7: Jefferson Health Plans Individual and Family Plan Summary of Benefits

Medicare Care Coordination

Medicare Care Coordination

- Jefferson Health Plans' care coordination team is made up of a team of nurses and social workers dedicated to helping members with accessing timely and 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 Jefferson Health Plans members for care coordination @ 215-845-4797
  - Jefferson Health Plans' 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

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.

- We can help qualified members access a phone service through Pennsylvania's **Lifeline Program**
  - Lifeline is available for free to qualifying low-income households
  - Your patient will qualify if they are receiving Medicaid coverage, including Medicare Dual Special Needs members

- Jefferson Health Plans can help qualified patients access these State funded phones and increase your office visit compliance by contacting our **Provider Service Helpline at 1-888-991-9023**. Members can call the number on the back of their ID cards.

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.

Maternity Services: Health Partners (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.

Direct Access

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 Jefferson Health Plans's 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 in order 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, Jefferson Health Plans must ensure its 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.
- Jefferson Health Plans 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 our Provider Manual Chapter 9: Quality Management it stipulates that providers must report abuse, neglect and/or domestic violence.

Infection Control

Mandatory Requirements	Recommended Standards
• 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.	• 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.

Cultural and Linguistic Requirements for members with Limited English Proficiency (LEP)

- Participating providers are required, by law, to provide translation and interpreter services (including American sign language services) at their practice location, at the providers cost.
    - If you need assistance our helpline can assist providers in locating services for members who need a qualified interpreter present at an appointment or telephonically. Please contact our Provider Services Helpline at 1-888-991-9023.
- A Physician's Practical Guide to Culturally Competent Care is sponsored by DHHS Office of Minority Health. This is a free, self-directed training course for physicians and other health care professionals.
    - This is a recommended web site that offers CME/CE credit and equips health care professionals with awareness, knowledge, and skills to better treat the increasingly diverse U.S. population they serve.
        - cccm.thinkculturalhealth.hhs.gov

Fraud, Waste and Abuse (FWA) & Compliance

Fraud, Waste, and Abuse

- Special Investigations Unit (SIU)
  - Jefferson Health Plans prohibits 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.

- Examples of Illegal and/or Unethical Conduct
  - Providers up-coding claims or submitting claims for services not provided
  - Providers providing false statement to obtain credentials (MediCheck)
  - Providers paying members incentives for patronage
  - Pharmacist paying provider kickbacks for referrals
  - Members selling membership cards or allowing others to use their membership ID numbers to obtain services
  - Members selling obtained through the program
  - Members obtaining medication services or equipment not medically necessary for their conditions
  - Employees selling Health Partners Plans' information
  - Employees accepting money or gifts in exchange for manipulating some part of Health Partners Plans’ system

    - For more information, please visit Fraud, Waste and Abuse page on our website: Fraud, Waste & Abuse Information | Health Partners Plans

FWA False Claims Act

- 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.

- If you wish to report fraud or suspicious activity, please call the Special Investigation Unit Hotline at 1-866-477-4848.

FWA False Billing & Procedural Neglect

- False Billing
  - Services already paid for or never rendered
  - Upcoding: Billing to increase revenue instead of billing to reflect actual work performed
  - Unbundling: Billing for each procedure separately instead of using grouping that is to be billed together
  - Forging physician signatures when such signatures are required for obtaining reimbursement

- Procedural Neglect
  - Perform medically unnecessary procedures
  - Falsified diagnoses to justify additional tests or overstated treatments

7 Fundamental Compliance Program Elements

- 1. **Written Policies, Procedures, and Standard Code of Conduct**
  - Articulate the organization's commitment to comply with all applicable requirements and standards under contract.
  - These policies and procedures are updated or reviewed on an annual basis or when regulation changes.
- 2. **Establishment of Compliance Office and Compliance Committee**
  - Jefferson Health Plans has a full-time Compliance Officer for our Medicaid and CHIP and Medicare lines of business.
  - There is a compliance committee dedicated to ensuring our compliance and ethics run effectively.
- 3. **Effective Training and Education**
  - The goal is to ensure our providers are well trained and educated on various Medicaid and CHIP laws and regulation requirements.
  - The trainings are provided upon hire and annually.
  - Major required trainings are for Fraud, Waste, and Abuse; Compliance and HIPAA.

7 Fundamental Compliance Program Elements

- 4. Effective Lines of Communication
  - It is important that employees, providers, subcontractors and employees know that Jefferson Health Plans has a 24-hour hotline to report compliance issues, including misconduct violating Fraud, Waste, and Abuse (FWA), Compliance, HIPAA, or Human Resources laws and regulations.
  - Jefferson Health Plans Reporting Channels
    - Compliance Hotline (Anonymous) : 1-866-477-4848
    - EthicsPoint Online Reporting Tool: (Anonymous)
    - Compliance email: compliance@Jeffersonhealthplans.com
    - Fraud, Waste, and Abuse
      - Special Investigations Unit Hotline:1-866-477-4848
      - Email: SIUtips@Jeffersonhealthplans.com

7 Fundamental Compliance Program Elements

- 5. Well Published Disciplinary Guidelines
  - Jefferson Health Plans has well established policies and procedures regarding our disciplinary actions for noncompliance, FWA and improper misconduct.
- 6. Effective System for Routine Monitoring and Auditing
  - Jefferson Health Plans conducts external monitoring and auditing of providers' and subcontractors' compliance with various laws and regulations regarding:
    - Medicaid and CHIP regulations
    - CMS requirements
    - State and Federal laws and regulations
    - Contractual agreements

- 7. Prompt Response to Compliance Issues
  - Jefferson Health Plans has procedures in place to address compliance, FWA and HIPAA issues for reported offenses. Providers and subcontractors are instructed to report such issues through the Jefferson Health Plans compliance hotline at 1-866-477-4848.
  - In doing so, providers are protected by the Jefferson Health Plans non-retaliation and whistleblower policy.
  - Additional training on Fraud, Waste and Abuse can be found on our website.

MA Provider Self-Audit Protocol

- The DHS Medical Assistance Provider Self-Audit Protocol allows providers to disclose any overpayments or improper payments:
  - 100 Percent Claim Review
  - Provider-Developed Audit Work Plan for BPI Approval

- Intended for MA providers that participate in both the fee-for-service and managed care environments.

- The protocol provides guidance to providers on the preferred methodology to return inappropriate payments to DHS.

- Providers also have the option for conducting an audit via the DHS Pre-Approved Audit Work Plan with Statistically Valid Random Sample (SRVS)

Recipient Restriction Program: Medicaid Only

- The Recipient Restriction is a program of DHS's Bureau of Program Integrity (BPI), also referred to as "lock-in" program (requirement of DHS).
  - Participants are Medicaid members only.
    - It identifies patterns of misutilization of benefits.
    - Recipients may be restricted to a physician, a pharmacy, or both (physician and pharmacy) upon BPI approval.
      - For more information on the Recipient Restriction Program, contact the pharmacy department @ 215-991-4300 or email PharmacyRecipientRestriction@JeffersonHealthPlans.com.

Provider Screening and Enrollment

- All enrolled providers are required by DHS to be screened under Code of Federal Regulations (CFR) Part 455 Subpart E.
    - This involves requirements from §455.410 through §455.450 and §455.470 to be met.
- Jefferson Health Plans and providers are responsible for ensuring their organization has met DHS screening and enrollment requirements.
- Additionally, state requirements include Medicheck screening in addition to those listed.

Provider Screening and Enrollment

- Under the regulations of 42 CFR §455.436, Jefferson Health Plans is required upon enrollment and monthly thereafter to check the exclusions status of our providers on the following "U.S. Department of Health and Human Services-Office of Inspector General's (HHS-OIG)" data bases:
  - List of Excluded Individuals and Entities (LEIE)
  - Excluded Parties List System (EPLS)

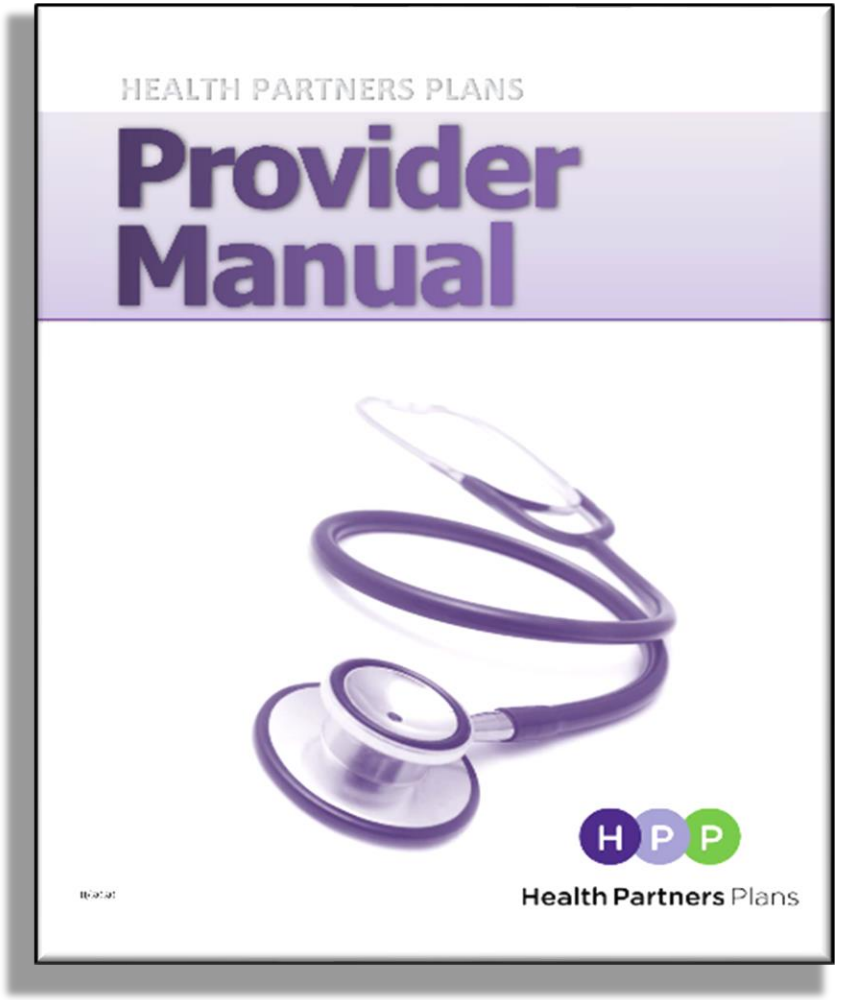
- Additionally, State requirements include Medicheck screening.

- In-network providers are also responsible for conducting the same above screen process for their owners, staff, subcontractors/downstreams and report upwards any true matches.

- Screening against all exclusion databases must be done both prior to hire/contracting and monthly thereafter. Providers should maintain documentation of the screenings and results, and should notify Jefferson Health Plans immediately, should anyone be identified on one of these exclusion sites.

Online Tools

- Welcome Providers
  - Provider Manual
  - Training and Education
  - Provider Portal
  - Provider Directories
  - Formularies
  - Clinical Resources
  - Plan Information
  - Provider Newsletters
  - Quality and Population Health



Provider Portal

The following transactions and services are available through the provider portal, powered by HealthTrio:

- **Eligibility and Benefits -** It's important to verify a patient's eligibility before rendering services to a member. It's recommended to verify eligibility on the date of service, and each time the patient is seen. Benefit plan information is available on the eligibility screen.

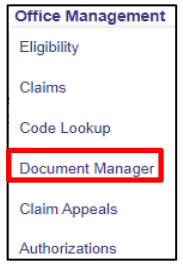
- **Claim Status Inquiry** - Providers can search for claims from the Patient Management and Office Management menus.

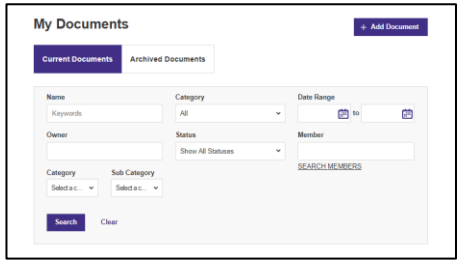
- **Claims Appeals (Reconsiderations)**- Providers can submit claim appeals and check their status within the provider portal. There is an option to appeal claim decision at the top left corner of the screen. To begin an appeal, select **Claim Appeals**. This will open the Appeal Details screen.

- **Authorization Requests** - Allows a provider to enter service requests online for electronic submission to the health plan. We offer electronic entry of Admission, Outpatient, Specialist, Homecare, and Transportation service request types.

Provider Portal

- **Document Manager** - Supports the uploading and sharing of many kinds of documents between users. This feature supports advanced search capability, categorization and archival of documents, linkage of documents to claims and authorizations and comments between users.
  - Care Gap Report
  - QCP Reports
  - Stars Report
  - HEDIS Site Report
  - Member Roster





- **Provider Communications** – Important news about Jefferson Health Plans updates, policy, notifications and educational webinars.
  - If you have a business need for these functions and currently do not have access to provider portal, please click the Register/Access by clicking https://hppprovider.healthtrioconnect.com/app/index.page
- **Resources**
  - Provider Registration Guide (PDF)
  - Local Admin & User Guide (PDF)
  - Initial User Login Guide (PDF)
  - Username and Password Reset Guide (PDF)
  - HP Connect Frequently Asked Questions (PDF)

Federal Health Care Fraud and Laws

The False Claims Act Statute: 31 U.S.C. §§ 3729-3733	The False Claims Act Statute: 31 U.S.C. §§ 3729-3733
The Anti-Kickback Statute Statute: 42 U.S.C. § 1320a-7b(b) Safe Harbor Regulations: 42 C.F.R. § 1001.952	**The Anti-Kickback Statute** Statute: 42 U.S.C. § 1320a-7b(b) Safe Harbor Regulations: 42 C.F.R. § 1001.952
The Physician Self-Referral Law Statute: 42 U.S.C. § 1395nn Regulations: 42 C.F.R. §§ 411.350-.389	**The Exclusion Authorities** Statutes: 42 U.S.C. §§ 1320a-7, 1320c-5 Regulations: 42 C.F.R. pts. 1001 (OIG) and 1002 (State agencies)
The Civil Monetary Penalties Law Statute: 42 U.S.C. § 1320a-7a Regulations: 42 C.F.R. pt. 1003	**Criminal Health Care Fraud Statute** Statute: 18 U.S.C. §§ 1347, 1349

Federal Health Care Laws

- For more information, visit the Office of Inspector General, A Roadmap for New Physicians.
  - To review OIG enforcement actions, visit: https://oig.hhs.gov/fraud/enforcement/

- The PH-MCO must create and disseminate written materials for the purpose of educating its employees, providers, subcontractors and subcontractor's employees about healthcare fraud laws, the PH-MCO's policies and procedures for preventing and detecting Fraud, Waste and Abuse and the rights of individuals to act as whistleblowers.

Plan Contacts and Resources

Provider Services Helpline 888-991-9023 9:00-4:30 pm	Medical Providers	Prompt 1
	Pharmacies	Prompt 2
	Join Jefferson Health Plans Provider Network	Prompt 3
	Member Services	Prompt 4
Additional Resources	Utilization Management	866-500-4571
	Care Coordination	215-845-4797
	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	855-218-2314
	Skilled Nursing Facilities and Rehabilitation	215-991-4395 Fax: 215-991-4125
	KidzPartners (CHIP) Magellan Behavioral Health	800-424-3702
	Jefferson Health Plans Medicare Magellan Behavioral Health	800-424-3706

Plan Contacts and Resources

Providers	JeffersonHealthPlans.com/providers
Provider Manual	Healthpartnersplans.com/providermanual
Provider Portal	Healthpartnersplans.com/hp-connect
Training & Education	Healthpartnersplans.com/training
Provider Directories	Healthpartnersplans.com/directory
Formularies	Healthpartnersplans.com/formulary
ECHO Health	https://www.echohealthinc.com
Claims	Healthpartnersplans.com/claims
Contracting	Contracting@jeffersonhealthplans.com

Complete Your Attestation

Attestation:

- If you reviewed the training materials electronically, please complete the provider education attestation by accessing the following link:

Annual Orientation and Training Attestation (AOT)

- If the link has been disabled, please copy the URL into your browser.
  - https://www.healthpartnersplans.com/providers/provider-education-attestation?tot=Orientation

Appendix

Additional Content

- Product Coverage maps (slides 11 & 13)
- SDS Submission Requirements (slide 23)
- Coordination of Benefits (slide 28)
- Provider Credentialing Process to Link Active Providers (slide 35)
- Emergency Care (slide 55-56)
- Early and Periodic Screening, Diagnosis and Treatment (slide 57)
- Antipsychotic Medications For Pediatric Members (slide 60)
- Medicare Care Coordination (slide 62-63)
- Administrative Procedures Regarding Patient Access (slide 67)
- Maternity Services: Health Partners (Medicaid) (slide 68)
- Direct Access (slide 69)
- Infection Control (slide 72)
- Cultural and Linguistic Requirements and Services (slides 73-75)
- Fraud, Waste and Abuse (FWA) & Compliance (slides 76-79)
- 7 Fundamental Compliance Program Elements (slides 80-82)
- MA Provider Self-Audit Protocol (slide 83)
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