



Annual Training for Network Providers

March 11, 2026

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

- New and Trending
- Health Plan Updates
- Member Eligibility, Benefits, and Billing Reminders
- Provider Data Changes
- Prior Authorization
- Complaints, Grievances and Appeals
- Clinical Programs
- Benefits and Services
- Cultural and Linguistic Requirements and Services
- Reminders
- Tools and Resources

What's New

- Behavioral Health Updates
- Laboratory Network Updates
- Claims Reconsiderations and Appeals
- Community Health Workers

Who We Are



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

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

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

Offering High Quality and Affordable Health Plans



[Jefferson Health
Plans Medicare
Advantage](#)

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

[Health Partners
Plans Medicaid](#)

[Health Partners
Plans CHIP](#)

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

What's New?

- Behavioral Health Update
- Laboratory Network Updates
- Claims Reconsideration/Appeals Process
- Community Health Workers

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](#). Optum is available at 1-877-614-0484 (Monday -Friday, 8 a.m. to 8 p.m. ET.)

- Member benefits/coverages will not change with this transition.
- **Health Partners Plans Medicaid** members should continue to be directed to their county's BH-MCO, who will conduct an intake assessment and refer the member to the appropriate level of care.

Laboratory Network Updates

LabCorp has recently joined our provider network, alongside Quest and Health Network Lab Medicine.

LabCorp currently operates 230 laboratory draw sites throughout Pennsylvania, New Jersey and surrounding states; providing our members with expanded access to over 650 laboratory sites.

This partnership will further improve access for our members so they can better manage routine checks, chronic conditions, and their overall health.

Service locations and draw sites are now available in our [Provider Directory](#).

Claims Reconsideration/Appeals Process

- As a reminder, **all claim reconsiderations** must be submitted via the **provider portal**. This will allow for single path submissions, making reporting/tracking much easier and more straightforward, and will provide quicker, more accurate responses to your claim issues.
- When requesting a claim reconsideration for multiple claims with the same denial reason, ***please ensure that all affected claims are listed on the approved claim submission spreadsheet***. The template can be found on the [Claim Reconsideration](#) page of our website:
- Please note in the comment section of the reconsideration a brief description of the issue with the attached claims. Attach the spreadsheet to your reconsideration request to facilitate the research and review process.

As a reminder, claim reconsideration requests must be filed within 180 days from date of the explanation of payment (EOP).

Health Partners Plans Medicaid covers Community Health Workers

- Effective January 1, 2026, Health Partners Plans Medicaid covers up to three (3) visits for CHW services per year that are recommended and billed for by a licensed practitioner of the healing arts enrolled in the Medical Assistance program

Includes: physicians, physician assistants, certified registered nurse practitioners, certified nurse midwife, licensed professional counselor, licensed marriage and family therapist, licensed clinical social worker, or licensed psychologist, CHW services.

- Information regarding the certification requirements is available at [Certified Community Health Worker \(CCHW\) | Pennsylvania Certification Board](#).
- A Promise ID Number is needed for CHWs that are rendering services being billed for by a provider.

Services & Medical Conditions

- Recommended as part of preventive healthcare for patients with a chronic condition or are at risk for a chronic condition
- Recommended based on the provider's screening and assessment of a patient
- Documented in the patient's plan of care in the medical record and include recommendations for:
 - Education and assistance to help the patient to self-manage their disease, disability, health condition or progression of a health condition
 - Addressing barriers affecting the patient's health
 - Screening for health-related social needs; and
 - Help with receipt and navigation of local and accessible relevant healthcare, community resources, and support groups.

CHW Appropriate Medical Conditions

• Asthma	• COPD	• Diabetes
• Heart Disease	• Hypercholesterolemia	• Hypertension
• Obesity	• Pre-Diabetes	• Use of multiple medications

Community Health Worker Overview

CHW visits must be documented in the plan of care in the medical record and must include:

- Date, time, duration, location and modality of the visit
- Summary description of any assistance with appointment scheduling
- Description of the patient's diagnosis or risk comprehension and self-management skills
- Results of any screenings completed
- Summary description of assistance with and navigation of local and accessible relevant healthcare, community resources, and support groups
- Summary of educational interventions provided specific to each disease, medical condition, or health related issue
- Documentation of relevant evidence-supported informational and/or educational healthcare materials provided
- Summary description of support for medication adherence, if applicable
- Recommendations provided for community and/or county resources, healthcare events, and healthcare related services.

CHW Claims

In order to be listed as a rendering provider on a claim for CHW services, the CHW must be enrolled with DHS.

- ✓ CHWs will enroll as Provider Type 13, defined as “Non-Traditional Provider,” with a Provider Specialty Code of 139.
- ✓ It is not necessary for CHWs that will not be billing for services to enroll with DHS at this time.
- ✓ MCOs do not need to credential CHWs according to NCQA standards.

- CPT codes for CHW services include **98960, 98961 and 98962**
- The CPT code must be billed with a U2 modifier.

New and Updated Webpages



[Antibiotic Stewardship](#) - Antibiotic stewardship involves coordinated efforts to ensure antibiotics are prescribed and used appropriately, minimizing adverse effects and combating resistance.

- We created this page to keep you better informed of these efforts and provide resources to assist in preserving antibiotic efficacy.

The [Clinical Care Guidelines](#) and [Preventive Care Guidelines](#) have been split into two separate pages to help you better find the information you need quickly.



[Clinical Care Guidelines](#) - We encourage our participating providers to take an active role in the ongoing management of member care, particularly members with chronic conditions.



[Preventive Care Guidelines](#) - We encourage providers to review preventive care with their patients. This webpage includes examples of evidence-based guidelines.

GLP-1 Prior Authorizations

- Effective **January 1, 2026**, the Department of Human Services (DHS) changed the Medical Assistance prescription drug benefit. This change applies to all Pennsylvania Medicaid plans, including Health Partners Plans Medicaid. *Drugs containing a GLP-1 receptor agonist for the treatment of overweight or obesity are no longer be covered unless the member also has a condition for which a GLP-1 receptor agonist remains a covered prescription drug benefit.*
- **We are still experiencing a high volume of Prior Authorization requests for GLP-1 drugs for the treatment of overweight or obesity.**
- 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.
- The complete 2026 Statewide Preferred Drug List and prior authorization clinical guidelines can be found at papdl.com

Trends

Urgent/Expedited Requests

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

Urgent/Expedited Care Services

Care needed within 24 hours to prevent an Emergency Medical Condition

Urgent/Expedited Medical or Severe Condition

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

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

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

Medical Record Request Clarification

We request medical records for many reasons, including:

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



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

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

Please include:

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

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	

Health Plan Updates

Jefferson Health Plans: Medicare Advantage Plan Updates

HMO

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

PPO

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

DSNP

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

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

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

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

Member Eligibility, Benefits, and Billing Reminders

Check Eligibility Before Each Visit/Service

Providers may verify member eligibility by:



Logging on to our [Provider Portal](#)



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

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



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

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

Coordination of Benefits

- Health Partners Plans Medicaid is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). Except for preventive pediatric care, if other coverage is available, the primary plan must be billed before we 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/Health Partners 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](#)

Review Member Benefits for Coverage and Prior Auth Requirements

We offer comprehensive overviews of all member benefits

Provider Manual	
Health Partners Plans Medicaid	• Chapter 4
Health Partners Plans CHIP	• Chapter 6

Website Resources	
Jefferson Health Plans Medicare	• Medicare Plan Details
Jefferson Health Plans Individual and Family Plans	• Individual and Family Plans Details

If a Member has Primary Insurance, Remember...

- Health Partners Plans Medicaid is the payor of last resort; therefore, is secondary payor to all other forms of health insurance coverage (e.g., Medicare). Except for preventive pediatric care, if other coverage is available, the primary plan must be billed before we 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.
- For more information, visit: [Provider Manual Chapter 12: Provider Billing & Reimbursement](#)

Remember Medicare Beneficiary Billing Guidelines

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.

Medicare Beneficiary Information - 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 DSNP members are dual eligible.

Medicare Beneficiary Information - 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.

Medicare Beneficiary Information - Community HealthChoices

Resources

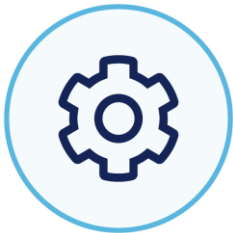
- [CHC Fact Sheet](#)
- [Adult Benefit Package](#)
- [Long-Term Services and Supports Benefits Guide](#)
- [Coordination With Medicare](#)
- [Populations Served By CHC](#)
- [Eligibility Verification System \(EVS\)](#)



Submit Encounter Data




Participating providers must provide encounter data for professional services on properly completed CMS-1500 forms or electronic submission in an ASC X12N 837P format for each encounter.



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

Reporting Provider Data Changes

Provider Demographic Changes

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

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

• All professional provider data changes must be emailed to datavalidation@jeffersonhealthplans.com

Quarterly Provider Data Validation

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

Benefits:

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

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

Reminder to Revalidate MA Enrollment



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



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



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

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

Prior Authorization

Prior Authorization (PA) Overview

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

Viewing an Authorization

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

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

Pharmacy

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



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

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

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

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

Complaints, Grievances, and Appeals

Complaints, Grievances and Appeals

When we deny, decrease, or approve a service or item different than the service or item requested because it is not medically necessary, a written grievance may be filed by the member, member's legal representative, healthcare provider or other member's representative (with the appropriate written consent of the member) to request a reconsideration.

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

For more information, visit:

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

Clinical Programs

Clinical Programs

Our clinical programs:

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

Critical components for all programs:

- **Collaboration** with member, family/caregiver, health care providers and community agencies, as appropriate
- **Member-centric** whole-person focus
- **Voluntary** with the ability to opt out at any time by calling Member Relations or discussing with a Care Coordinator
- **Variety of Communications:** Telephonic, face to face, email, social media, in the community and in provider offices
- **Use of PA Navigate** to identify Health Related Social Needs (HRSN) resources

Health Related Social Needs (HRSN)

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

HRSN includes factors such as:



Food insecurity



Economic Stability



Housing stability



Transportation Needs



Childcare needs



Exposure to Violence



Utility Needs



Education Needs

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

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

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

Baby Partners

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

(833)-705-3751

Clinical Connections:

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

EMSU Pediatrics

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

EMSU Adults

- Connection to supplemental benefits, programs, and community resources

Care Coordination: Jefferson Health Plans Medicare Advantage and Individual and Family Plans

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

Care Coordination supports members with:

- Accessing and coordinating care
- Finding community resources for Health-Related Social Needs (HRSN)
- Receiving education related to their condition.

- Complete a [Clinical Programs Referral Form](#) to refer any member for services.
- Send completed forms to ClinicalConnectons@jeffersonhealthplans.com or Fax: 215-845-4181
- For additional assistance please call the **Clinical Programs Provider Referral Line**: 215-845-4797

For DNSP Members

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

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

Benefits & Services

Mental Health and Substance Abuse Treatment

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

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

EPSDT standards are comprised of routine care, screenings, services and treatment that allow Medicaid members under 21 to receive recommended services set forth by the American Academy of Pediatrics' Guidelines.

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

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

Childhood and Adolescent Immunizations

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

Lead Screening Requirements

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

Bright Futures (CHIP)

The **Bright Futures/American Academy of Pediatrics (AAP)** developed a set of comprehensive health guidelines for well-childcare, known as the “periodicity schedule.”

It includes:

- **Prevention:** Scheduled immunizations; dentist visit at the first sign of a tooth and to establish a dental home at no later than 12 months of age; regular oral checkups (two each year), teeth cleanings, fluoride treatments and overall oral health.
- **Growth and development:** Tracking growth and development since their last visit; discussing milestones, social behaviors and learning with parents/guardians.
- **Identify concerns:** Well-child visits are an opportunity to speak with parents about a wide variety of issues, including developmental, behavioral, sleeping, eating and relationships with other family members.
- **Sick visits:** Determine if the condition, illness or injury that led to the sick visit impedes with the ability to complete a well-child visit and that the child is eligible for a well-child visit.

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

Provider Tools & Resources

Online Tools & Resources

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

Provider Portal

The [Provider Portal](#) contains:

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

Website Resources

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

Annual Reminders

Annual Reminders

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

D-SNP Model of Care Training

Coming Soon

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

[Attestation link](#)

2026 Access and Availability Survey

Coming Soon

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

aasurvey@jeffersonhealthplans.com

Quality Intake Survey

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

ADA Compliance Attestation

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

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

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

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 Resources

Providers Website

<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

Thank You for Attending