Jefferson Health Plans | Health Partners Plans

# Annual Training for Network Providers

Wednesday, March 12, 2025

# Welcome!

Please read the participation tips below.

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.

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

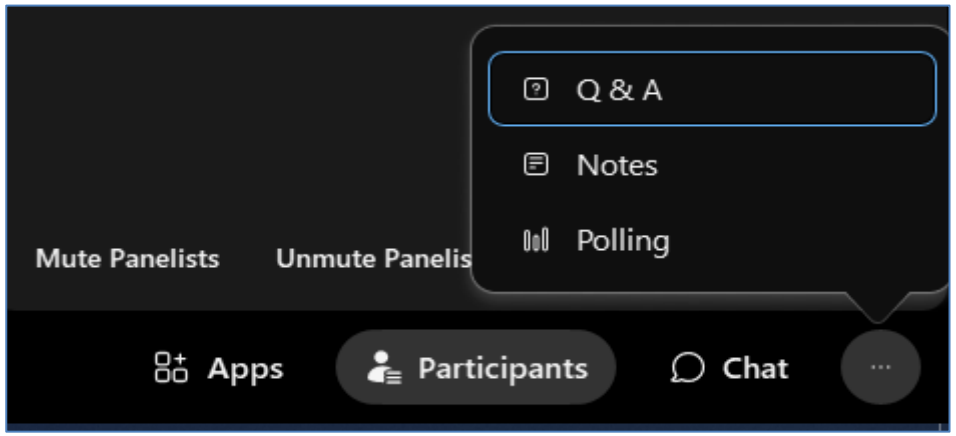
Any questions we are unable to address today, will be answered **following the presentation**.

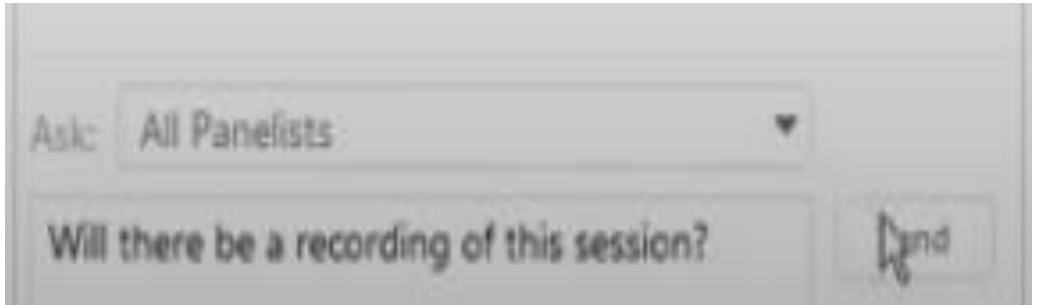
**Technical issues:** Use **chat** for technical issues. Please select **Carrie Thomas** from the Webex chat dropdown.

# Q&A Panel

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

1. To open the Q&A panel, you need to 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. This will ensure questions are not missed.
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**

# Agenda

## Key Takeaways:

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

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

## Additional Information:

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

# Who We Are

Jefferson Health Plans | Health Partners Plans

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

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

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

# Offering High Quality and Affordable Health Plans

**Jefferson Health Plans Medicare Advantage**

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

**Health Partners Plans Medicaid**

**Health Partners Plans CHIP**

# 2025 Product ID Cards

# 2025 Product ID Cards

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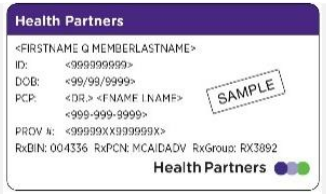
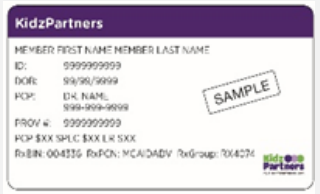
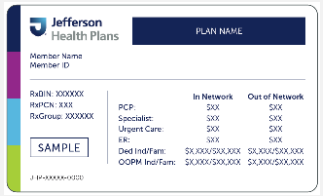
| **Health Partners Plans Medicaid** |  <br>(9-digit ID starting with all numerical digits) | **Payor ID:** #80142<br>**Paper Claims Submissions:**<br>Jefferson Health Plans, PO BOX 211123 Eagan, MN 55121 |
| **Health Partners Plans CHIP** |  <br>(10-digit ID starting with a “3” or a “9”) | **Payor ID:**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

# New Jersey Medicare Advantage PPO Plans

## Effective January 1, 2025, New Jersey Medicare Advantage PPO Plans ONLY!

Electronic Payor ID: #NJ099

Paper Claims Mailing Address:

Jefferson Health Plans
PO Box 211290
Eagan, MN 55121

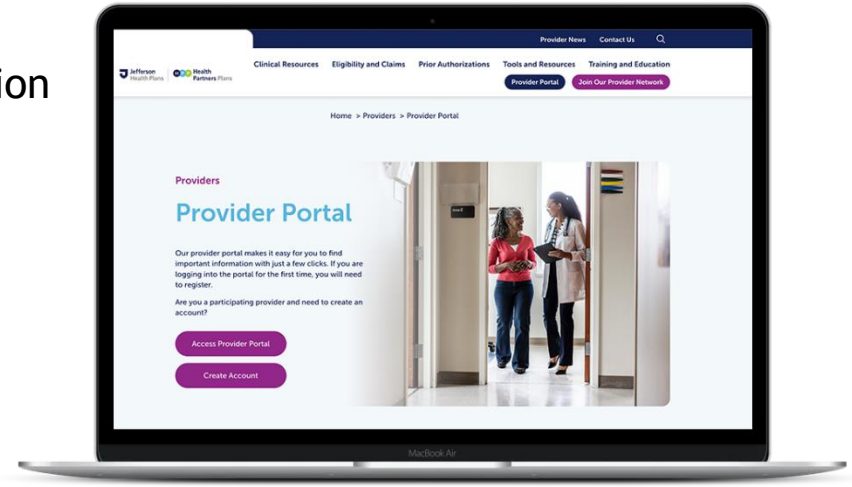

# Provider Tools & Resources

# Simplify Your Workflow with Online Tools & Resources

## Provider portal

Our provider portal makes it easy for you to find important information with just a few clicks. Key features include:

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




## Additional tools and resources

Visit our website to access a full suite of provider resources, including:

- **Provider Manual** – Access policies and procedures
- **Forms & Supply Requests -** Download key forms for claims, authorizations, and appeals
- **Pharmacy Resources** – View online formularies and prior authorizations
- **Training & Education** – Stay up to date with training materials and guidelines.

# 2025 Product Overview

# Health Partners Plans Medicaid Benefits

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

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

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

## Additional Benefits:

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

# Health Partners Plans CHIP Benefits

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

## Health Partners Plans CHIP covers:

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

# Jefferson Health Plans Individual and Family Plans Portfolio (Pennsylvania)

## HMO

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

| Jefferson Health Plans HMO Portfolio: | |
|---|---|
| 3 **Bronze** Plans: | • $0 Deductible<br>• Total<br>• Value |
| 3 **Silver** Plans: | • $0 Deductible<br>• Balanced<br>• Total |
| 3 **Gold** Plans | • $0 Deductible<br>• Total<br>• Value |

## NEW: PPO

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

| Jefferson Health Plans PPO Portfolio: | |
|---|---|
| 3 **Bronze** Plans: | • $0 Deductible<br>• Total<br>• Value |
| 3 **Silver** Plans: | • $0 Deductible<br>• Balanced<br>• Total |
| 3 **Gold** Plans | • $0 Deductible<br>• Total<br>• Value |

# 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)<br>• Prime ($40.90)<br>• Give Back ($0) +$125 Part B |
| NJ | • Silver ($0)<br>• 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)<br>• Flex Pro ($20)<br>• Flex Plus ($37) |
| NJ | • Choice ($0)<br>• Choice Plus ($35) |

## DSNP

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

| State | Product(s) |
|---|---|
| PA | • Special<br>• Dual Pearl |
| NJ | N/A |

# Medicare Beneficiary Information

# Qualified Medicare Beneficiaries (QMB)

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

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

# Identifying QMBs

- To ensure compliance, Jefferson Health Plans Medicare Advantage providers and suppliers should:
  - Implement processes to ensure compliance with QMB billing prohibitions.
  - Make sure their office staff and vendors are using systems to identify the QMB status of Medicare beneficiaries
- To assist in this process, CMS provides  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

# Balance Billing Dual Eligible Members: Medicare/ Medicaid

- Fully Dual Eligible beneficiaries are not directly responsible for their appropriate cost share amounts. These charges are payable by Medicaid (the CHC plan).
- Medicaid (CHC) will remain the payer of last resort.
- Providers may not balance-bill participants when Medicaid, Medicare or another form of TPL does not cover the entire billed amount for a service delivered.
- Please note that Jefferson Health Plans Medicare Advantage Special and Dual Pearl (DSNP) members are fully dual eligible.

# MOC DNSP Training & Attestation

- As a reminder, The Model of Care (MOC) DNSP training is conducted annually to ensure all contracted and non-contracted medical providers and staff receive training on the MOC DSNP as required by CMS.
- Completion of the annual MOC training is mandatory for all providers who serve our DSNP members.
- At least one member of a care team location is required to take the annual training, complete the attestation at the end of the course and distribute the training material to all DSNP care team members.
- For the online training course, click here.
- If you already completed training, but forgot to attest, no worries. You can attest by visiting the following link: https://www.healthpartnersplans.com/home/providers/training-and-education/dsnp

# Community HealthChoices

# Community HealthChoices

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

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

## Keep in Mind:

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

# Community HealthChoices

## Resources

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

# Encounter Data

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

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

# Credentialing

# Provider Credentialing Process for Existing Contracted Entities

Council for Affordable Quality Healthcare (CAQH) must be accurate and currently attested to complete the process 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 Credentialing Process to Link Active Providers

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

# Board Certification Requirements

- **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 approved Board
- PCPs are not required to be Board Certified

**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

# Key Takeaways for Credentialing/Recredentialing

For initial contract, roster and application the providers can use the recruitment link [Join Our Network]

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.

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

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

# Reporting Provider Data Changes

# Provider Demographic Changes

- Please notify the Network Management department immediately in writing when any of the following occurs:
  - Site relocation
  - Full practice terms
  - Site location terminations
  - Telephone number change
  - Change in hours of operation
  - Provider practice name change
  - Additions/deletions of providers
  - Change in patient age restrictions
  - Change in payee information (W-9 required)
- All professional provider data changes must be emailed to datavalidation@jeffersonhealthplans.com

# 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 to ensure we have the most accurate data in our systems
  - Benefits:
    - Provides members with accurate provider information for improved member access and patient satisfaction
    - Allows for timely and accurate claims payments
- For more information or if you have not received your quarterly data validation form, please email datavalidation@jeffersonhealthplans.com

# Medical Records Request

# Medical Records Request from Quality Management

- **We request medical records for many reasons.** For example:
  - Credentialing medical record review (MRR)
  - Star and HEDIS
  - Pay for Performance (P4P)
  - Investigation of Quality of Care (QOC) referrals/Quality of Care Inquiry
  - Complaints/Grievances
- **Per your contract:**
  - Records do not need a patients or head of household release form signed
  - Records are provided at the providers' expense for the quality assurance programs
- **Record Reviews are conducted by trained & licensed clinical staff**

# Medical Records Request from Quality Management

- **If you have a preferred method of medical record collection, please let us know via email:** Quality@jeffersonhealthplans.com. Please include:
  - The office manger or clinical contact
  - Contact person's email, phone number
- **We will provide correspondence with the member's name, DOB, ID number and the reason for the request.**
- **We receive records via many platforms:**
  - Electronic Medical Record (EMR) view or read only access (**preferred**)
    - We work with several EMR systems to retrieve records such as but not limited to: EPIC, Cerner and Athena
    - We will always contact the provider's office prior to retrieving records with the member information and reason for the review.
  - E-mail
  - Secure fax
  - Third Party Vendor
    - Ciox/Datavant
    - MRO Portal

# Prior Authorization

# 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.

# 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, we remain 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 Inpatient Services @ 1-866-500-4571.

# Prior Authorization Submission

## Jefferson Health Plans/ Health Partners Plans

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

## eviCore

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

***Health Partners Plans CHIP does not require 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 Prior Authorization webpage.

To request a prior authorization, the physician or a member of his/her staff should contact our Pharmacy department at 1-866-841-7659, Monday through Friday, 8 a.m. to 6 p.m.

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

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

# Complaints, Grievances, and Appeals

# Complaints, Grievances and Appeals

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

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

**For more information, visit:**

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

# Clinical Programs

# Clinical Programs

## Our clinical programs:

- Support provider's treatment plan and 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: Health Partners Plans Medicaid and Health Partners Plans CHIP

## Baby Partners

Care coordination for prenatal and postpartum members

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

## Bright Futures

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

## EMSU* Pediatrics

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

Connection to supplemental benefits, programs, and community resources

## EMSU* Adults

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

Connection to supplemental benefits, programs, and community resources

Clinical Programs activities focus on both long and short-term goals for members who may require assistance coordinating their care.

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

*EMSU = Enhanced Member Support Unit

# Benefits & Services

# Mental Health and Substance Abuse Treatment

- Under HealthChoices, all Health Partners Plans Medicaid members, regardless of the health plan/MCO to which they belong, can receive mental health and substance abuse treatment through the behavioral health managed care organization (BH-MCO) assigned to their county of residence.

- PCPs who identify a Health Partners Plans 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.

# Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

- EPSDT standards are comprised of routine care, screenings, services and treatment that allow Medicaid members under 21 to receive recommended services set forth by the American Academy of Pediatrics' Guidelines.
  - If, following an EPSDT screening, a provider suspects developmental delay and the child is not receiving services at the time of screening, then the provider is required to refer the child (not over 5 years of age) through the CONNECT Helpline (1-800- 692-7288) for appropriate eligibility determination for Early Intervention Program services.
    - For the latest guidelines, visit our website at: EPSDT / Bright Futures
    - Call our Healthy Kids team at 1-866-500-4571

## Childhood and Adolescent Immunizations

- Immunization Schedules are now available and effective immediately.

# Bright Futures (CHIP)

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

- **Prevention:** Scheduled immunizations; dentist visit at the first sign of a tooth and to establish a dental home at no later than 12 months of age; regular oral checkups (two each year), teeth cleanings, fluoride treatments and overall oral health.
- **Growth and development:** Tracking 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.

# Lead Screening Requirements

- All children enrolled in Health Partners Plans Medicaid must have a minimum of two screenings:
  - First screening by age 12 months and a second by age 24 months.
  - For a child between 24 and 72 months (2-6 years old) with no record of screening, a lead screening must be performed as part of the EPSDT well-child screenings, regardless of the individual child's risk factors.
- Please refer to the recommendations set forth in the EPSDT Periodicity Schedule.
- Health Partners Plans Medicaid and Health Partners Plans CHIP share similar guidelines for ensuring that members receive well-child visits.

# Provider Practice Standards and Guidelines

# Access & Appointment and Telephone Availability Standards

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

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

# Utilizing Telehealth to Improve Patient Access

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

**Pennsylvania's Lifeline Program** is available for free to qualifying low-income households

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

Contact our Provider Service Helpline at **1-888-991-9023** for assistance connecting qualified members to these services. Members can call the number on the back of their ID cards.

## 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.

# What's New?

# Chronic In-Home Wound Care

- **Esperta Health** is a specialty physician practice that delivers a complete In-Home wound care program. This program ensures your patients/our members receive expert care from wound-certified specialists who can treat, heal, and prevent their chronic wound from recurring.
- Effective **January 2, 2025**, providers can now refer chronic wound members, who are enrolled in **Health Partners Plans Medicaid** and **Jefferson Health Plans Medicare Advantage Plans** to Esperta Health.

## How to Refer Patients to Esperta Health

- Refer online or download the referral form at: https://platform.espertahealth.com/espertahealth/
- Fax the patient referral form to 615-278-1860
- Call Esperta Health at 833-377-3782
- Send a secure email to customerservice@espertahealth.com

# Questions

Please use the Q&A panel for all questions.

For any additional questions that may arise, please email: providereducation@jeffersonhealthplans.com

**Upcoming webinars**

Register at: www.healthpartnersplans.com/home/providers/training-and-education/webinars/

# Appendix

# Additional Content

- Plan Coverage Area Maps (Slides 18 & 20)
- Provider Screening and Enrollment (slide 34-35)
- Quality Management Department Contact Information (slide 44)
- Prior Authorization Requirements for Transportation (Slide 50
- Behavioral Health Non-Emergent Transportation Medicaid, Medicare & CHIP (slide 51)
- Members' Rights and Responsibilities (slide 62)
- Comprehensive Member Benefits (slide 63)
- Plan Contacts and Resources (slides 70-71)
- Home Health Services and Non-Emergent Transportation Facsimile (slide 72)

# Thank You for Attending