Jefferson Health Plans

Care Coordination Support for You and Your Patients

June 24, 2026

Welcome!
Please read the participation tips below.

There is no sound until the webinar begins.

Webinar will be recorded. Participation in 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.

Agenda

Care Coordination for Jefferson Health Plans EverWell (Medicaid) and CHIP Members

- Clinical Connections
- Baby Partners
- Pediatric Care Coordination
- Adult Care Coordination
- Support Services
- Additional Programs

Care Coordination for Dual Special Needs Plans (DSNP) Members

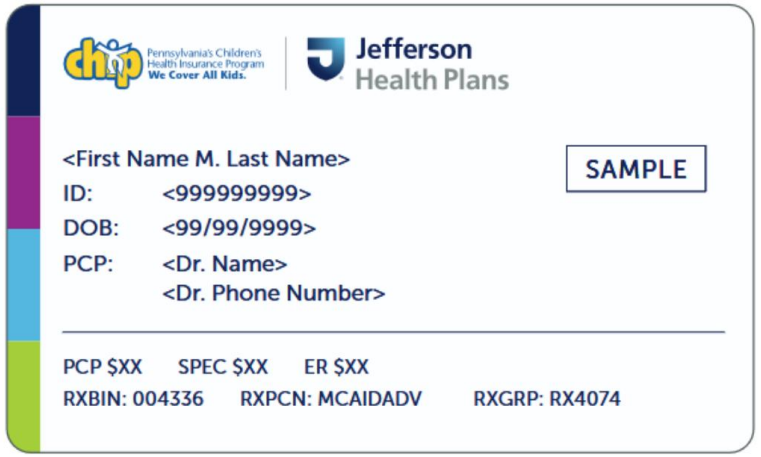
- Resources to Meet Members Needs
- Health Risk Assessment Tool (HRAT)
- Individualized Care Plans (ICP)
- Transition of Care
- Interdisciplinary Care Team (ICT)

*We are redesigning our ACA CM program, and more information will be shared later this year

Jefferson Health Plans Rebranding

Health Partners Plans Medicaid is now called **Jefferson Health Plans EverWell**

Health Partners Plans CHIP is now called **Jefferson Health Plans CHIP**.



- Member benefits will not change.
- Members will be receiving a new ID Card, but Health Partners Plans ID cards will be valid through 2026.

Care Coordination for Jefferson Health Plans EverWell and CHIP Members

Jefferson Health Plans

Medicaid and CHIP Care Management Programs

Designed to address needs of members across the life continuum

Staffed by licensed and non-licensed staff
Supervised by managers with CCM certification- licensed staff obtain CCM certification within
2 years of hire

Program Objectives:

- Support provider's treatment plan and health care goals
- Reduce or eliminate barriers to care, such as social and behavioral health needs

Care Management Programs (continued)

Critical components for all programs:

- Collaboration with member, family/caregiver, health care providers, community agencies, and other government program (as appropriate)
- Member-centric/whole-person focus
- Voluntary, with the ability to opt out at any time by calling our Member Relations or discussing with our Care Coordination staff
- Telephonic, face to face, email
- Follow CM process:
  - Assess Needs
  - Identify Goals
  - Develop Plan to Reach Goals
  - Implement Interventions
  - Evaluate Plan – Goal Achievement or Readjust as needed
- Use of PA Navigate(**Find Help)** to identify resources to address social issues that can adversely impact health (SDOH) outcomes

Examples of Services Provided

- Complete needs assessment of physical, behavioral and social needs as well as SOGI, health literacy and ethnic/cultural preferences
- Assist member to prioritize goals and develop plan to address goals
- Referrals to food resources including medically tailored meals and dietary counseling
- Coordination with community resources and programs to address social determinates of health such as childcare, legal assistance, transportation, access to care, utility, financial, and employment/education
- Assistance with appointment scheduling
- Assistance with arranging transportation through Pennsylvania Medical Assistance Transportation Program (MAPT)
- Link to disease education and understanding their benefits
- Medication adherence tips
- Behavioral health and substance abuse referrals, as needed
- Collaborative care plan goals and interventions with behavioral health MCO
- Transitioning pediatric members to adult benefits and care
- Additional services needed for members with physical or intellectual disability – may qualify for a PA waiver and requires coordination with DHS agencies and programs such as early intervention

Care Management: Medicaid and CHIP

Focus on both long- and short-term goals for members who may require assistance coordinating their care.

Consider any of these programs for your patients:

- Clinical Connections
- Baby Partners Program
- Pediatric Care Management
- Adult Care Coordination

Support Services

- New Member Health Survey
- MANNA Medically Tailored Meals
- Doula Program & Breast Pumps
- BP Cuff with physician order

Clinical Connections

Oversee the member and provider clinical program (EMSU) hotlines

- Triage member and assist with urgent issues
- Determine if follow up indicated and transition to appropriate care coordination program

Outreach post inpatient discharge to assist members in adhering with discharge instructions

- Check in that member following discharge instructions
- Received any applicable medications, equipment, and home care services
- Verify, or help schedule, follow up appointment with PCP/Specialist
- Escalate to Care Coordination program if continued needs identified

Follow up on select responses within Member Health Survey

- Select responses trigger referral for member outreach such as missing food or utility concerns, medications, behavioral health concerns, pregnancy, and health conditions

Perinatal Care Coordination- Additional Programs

Postpartum Home Visit	•Outreach post delivery to ensure postpartum visit is schedule or assist with scheduling •If unable to attend office appointment, member will be offered telehealth or home postpartum visit •Care Coordinator stays connected with mother and child for up to 1 year postpartum
Maternal Home Visiting Referrals	• CBCM Programming to pregnant women and families with children up to 24 months
Breast Pump	• Can order and receive in third trimester • Assist in identification of lactation resources
Doula Services	• Available for any Medicaid/CHIP pregnant member • Offers support during prenatal, birth and postpartum
Blood Pressure Cuffs	• Updated guidelines and order form for Blood Pressure cuff
Medically Tailored Meals	• For High-Risk Pregnancy Medicaid members (Gestational DM, Pre-Eclampsia, Hyperemesis)

Maternal/Child Home Visiting Programs

Non-clinical home visit

Program Eligibility

- Pregnant women
- Families with Children – birth to at least 24 months (some programs can extend to 3-5 years old children)

Examples of programs include:

- Nurse-Family Partnership
- Parents as Teachers
- Early Head Start
- Healthy Families America

Programs focus on:

- Parental education of early childhood development and positive parenting practices
- Assist in detection of developmental delays and connection to additional services
- Promote parent, child and family health and wellness
- Strengthen community connectedness
- Address social issues impacting health and wellness of family

Program Referrals

- Families self-refer
- Baby Partners and Pediatric Care Coordinators educate members and refer pregnant women/families with children 24 months or younger
- Healthcare providers can make referral either directly or contact Baby Partners to make referrals

Monitoring/Reporting

- Programs that have an agreement with us to provide member enrollment data and high-level detail on program interventions

Pediatric Care Coordination

Complex/Rising Risk

- For Medicaid and CHIP members under the age of 21
  - Reminders about important preventive services (such as lead screening and connection to services for developmental delay concerns) for members under the age of 21
  - Coordinate with OCYF as needed
  - Care Coordination and disease education for children with at risk and complex conditions such as
    - elevated lead levels
    - developmental Delay
    - coordination with Behavioral Health MCO
    - Asthma
    - Diabetes
    - Complex NICU graduates

Shift Care/Pediatric LTC -Fragile Children

- Medical members 21 years and younger
- Often receiving shiftcare, medical daycare and/or reside in pediatric long term care facility
- Coordinate with UM team as well as provider to help member select shift care staffing
- Coordinate with Office of Developmental Programs' Family Facilitator and school as needed as well as child's family and healthcare providers

Adult Care Coordination

- Physical and behavioral health care coordination, disease education, connection to supplemental benefits and Jefferson Health Plans programs, community resources for adult members with multiple co-morbidities and/or special needs
- Multiple Referral Sources:
  - Predictive Modeling
  - Member/Provider Referrals
  - Government agency referrals
  - Health Survey trigger responses
  - Behavioral Health MCOs
  - Other internal teams such as Medical Management and Pharmacy
- Conduct needs assessment with member to identify areas Care Coordinator can assist
- Develop plan of care to address goals and monitor intervention and progress

MANNA Medically Tailored Meal Program

Jefferson Health Plans has partnered with Metropolitan Area Neighborhood Nutrition Alliance (MANNA) to provide medically tailored meals to members with complex health care needs and high-risk pregnancy (hyperemesis, gestational diabetes or hypertension, preeclampsia)

This partnership has proved to be successful in helping members

Understand their diet
Manage weight
Improve some important disease state measures like A1c levels
Engage in their own health care

Program consists of 3 meals per day along with nutritional counseling for 12-weeks

At end of 12 weeks, may decide to extend program for additional 6 weeks based on member's progress and adherence with the meal plan

Pennsylvania Medical Assistance Transportation Program (MATP) Overview

The Pennsylvania Medicaid Assistance Transportation Program provides the following:

Non-emergency medical transportation to an individual with Medicaid coverage when the service is received at a medical facility, a doctor/dentist office, hospital, clinic, pharmacy, or supplier of medical equipment.

MATP provides the least costly and most appropriate transportation to member the Medicaid member needs which includes paid mass transit trips on buses or trains or rides in paratransit vehicles.

Medicaid members can receive reimbursement from mileage for parking fees and tolls, when submitting valid receipts, for using their own car or someone else vehicle to get to their medical provider.

Paratransit service picks up and drops off at Members curb or driveway of their residence or destination

MATP Changes in 2026

MATP provides transportation services when the Member has no other available means of transportation for Urgent Short Notice Trips Requests

- During normal business hours, MATP must schedule transportation within 3 hours of the request and corresponding trips must be scheduled within 24 hours of the request.

MATP provides transportation services for hospital discharges, considered an Urgent Short Notice Trip Request.

- Even when requested outside business hours, MATP must schedule and provide trips for hospital discharges within 24 hours of the request, as long as the Physical Health MCO has ensured safe discharge conditions.

Hypertension Management: Blood Pressure Cuffs

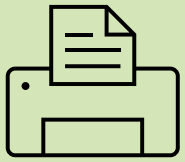
Blood pressure cuffs is an allowable benefit for Medicaid and CHIP members who need to providers to monitor their blood pressure

- A prescription or physician order form is required
- Allow one per year
- All members with hypertension and all pregnant members are eligible
- Age limit for cuff no longer applies
- Cuff must be obtained from DME supplier
- For provider convivence, can complete online order form and send to DME supplier listed

The Blood Pressure Cuff Order Form can be found in the Administrative Forms section of our Form and Supply Requests webpage.

How Can you Refer to Care Management?

Together we can improve health care!

	Call: Clinical Connections: 215-845-4797 (non-perinatal member) Call: **Baby Partners Provider Line**: 833-705-3751 (perinatal member) *Hours: 8:00 AM- 4:30 PM Monday-Friday*
	**EMAIL**: ClinicalConnections@Jeffersonhealthplans.com *Include the* **Clinical Programs Referral Form** *as an attachment.*
	**FAX**: Fax the **Clinical Programs Provider Referral Form** to (215)-845-4181

Clinical Programs Provider Referral Form can be found on our Form and Supply Requests webpage.

Resources & Links

Please visit the Forms and Supply Request page of our website for the following resources		
Clinical Program Provider Referral Form	Blood Pressure Cuff Order Form	Breast Pump Order Form

Please visit our Baby Partners Page for the following resources		
Maternal/Child Home Visiting Program	Baby Partners Resource Guide - with Doula information	Pregnancy Hot Topics and Resource Guide

Additional Resources	
MANNA Program	https://www.jeffersonhealthplans.com/home/providers/clinical-resources/manna-referral-program
Behavioral Health Managed Care Organization Information	https://www.pa.gov/agencies/dhs/resources/medicaid/bhc/bhc-mcos.html
TIPS (Telephonic Psychiatric Consultation Services Program) - for children	https://www.jeffersonhealthplans.com/home/providers/clinical-resources/tips-consultation-service
County Assistance Office (CAO) Contact Information	https://www.dhs.pa.gov/Services/Assistance/Pages/CAO-Contact.aspx
Medial Assistance Transportation Program	http://matp.pa.gov/

DSNP Care Coordination

DSNP Care Coordination-Resources to Meet Member's Needs

All DSNP members are assigned to a Care Coordinator upon enrollment to foster and maintain a strong relationship.

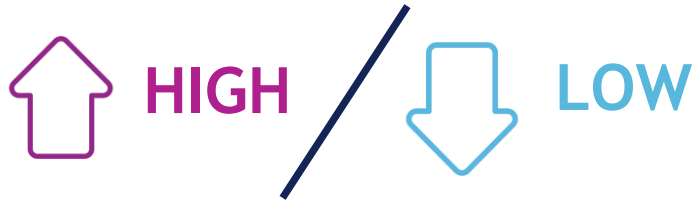
The Care Coordinator, along with all clinical areas, educate DSNP members on self-management techniques and provide pharmacy consultation, behavioral health counseling, and clinical oversight.

The Care Coordinators core functions are to promote the highest level of physical, psychological and social functioning possible for the member and their caregivers.

DSNP: Health Risk Assessment Tool (HRAT)

The HRAT is a CMS approved tool that asks a series of questions designed to assess the medical, functional, cognitive, psychosocial and mental health needs of the member.

This self-reported health risk assessment tool identifies member risk level of care for care coordination:



All DSNP beneficiaries are assessed initially within 90 days of effective date, within 365 days of the last HRAT and with any transition of care or change in condition.

The HRAT is conducted telephonically by Health Assessment Outreach Coordinators and is reviewed by the team leads to evaluate the member's needs and assign to the appropriate Care Coordination team. The assessment can also be mailed to the member or completed in the member portal.

DSNP : Individualized Care Plan (ICP)

ICPs for members are created utilizing a combination of information available including:

- Heath Assessments results
- Utilization and claims data
- Preventive health information, according to the member's age and gender

The ICP is revised at least annually, or when the member has a significant change in health status, such as an inpatient admission.

The goal is to educate and empower the member and/or caregiver to take an active role in managing their healthcare needs.

DSNP: Individualized Care Plan (ICP)

CMS requires that an Individualized Care Plan (ICP)* be completed for each DSNP member within 30 days of Health Assessment completion. A revised ICP will be completed within 30 days of a revised Health Risk Assessment.

***If a member could not be reached or chose not to create a Health Assessment, the ICP will be based on historical claims data.**

The ICP includes:

- Member-specific identified goals
- Medical, pharmacy, preventive, and behavioral health interventions
- Information/access to community resources

DSNP: Individualized Care Plan (ICP)

All members and their PCPs receive a copy of the ICP with clear action steps for the year.

ICPs are based on issues, interventions and goals:

- Issues are identified using the member's answers on the Health Assessment and other communication with member.
- Interventions are tailored to each member's needs.
  The ICP will address member-specific barriers to complying with the plan.
- Goals are reassessed at least annually and adjusted accordingly.

Transition of Care

Transition of Care protocols maintain continuity of care for members, reducing complications and readmissions.

- The Care Coordinator may work with a hospital discharge planner and transitional care managers to identify member's health care needs and address barriers/environmental concerns.
- The member and/or caregivers are educated about member's health status to assist with self-management.

Other events that would trigger an ICP include a practitioner referral, member self-referral, and inappropriate use of resources.

- Both the PCP and/or the member can request a meeting to further discuss the ICP.
- The results are communicated to members and their PCP during the Interdisciplinary Team (ICT) Meeting and via mail after the ICT.

DSNP: Care Coordination Interdisciplinary Care Team (ICT)

Purpose: The ICT is a group of individuals from diverse fields who work together toward a common goal for the member, which is to improve care.

Composition is specific to the member but may include:

1. **Core Team:** Member and/or representative, primary care provider and care coordinator.
2. **Ad hoc:** Medical director, specialist, clinical supervisor, pharmacy, utilization review nurse, behavioral health care coordinator, etc.

DSNP Care Coordination ICT

Member and/or caregiver, in collaboration with the care coordinator, identifies issues and barriers and then prioritizes the goals and set timelines to close these goals.

PCPs are invited to participate in the ICT along with the ICP developed by the Care Coordinator and the member.

Special accommodations will be made for members with hearing, visual impairments, language and literacy barriers, and/or cognitive deficits.

Each member's ICP will be reviewed at least annually.

Formal ICT meetings scheduled 3 days per week include members who have had a recent discharge from an acute inpatient stay or SNF, readmissions or any changes in condition that the care coordinator would like to discuss with the ICT.

Thank You for Attending