It Matters to Passport Monthly Provider Forum

July 28, 2021

PASSPORT HEALTH PLAN
BY MOLINA HEALTHCARE

Agenda

- Meet the Provider Services Team
- Important Plan Updates and Reminders
- Upcoming It Matters to Passport Forum Dates
- Care Management Overview
- Open Forum/Provider Feedback

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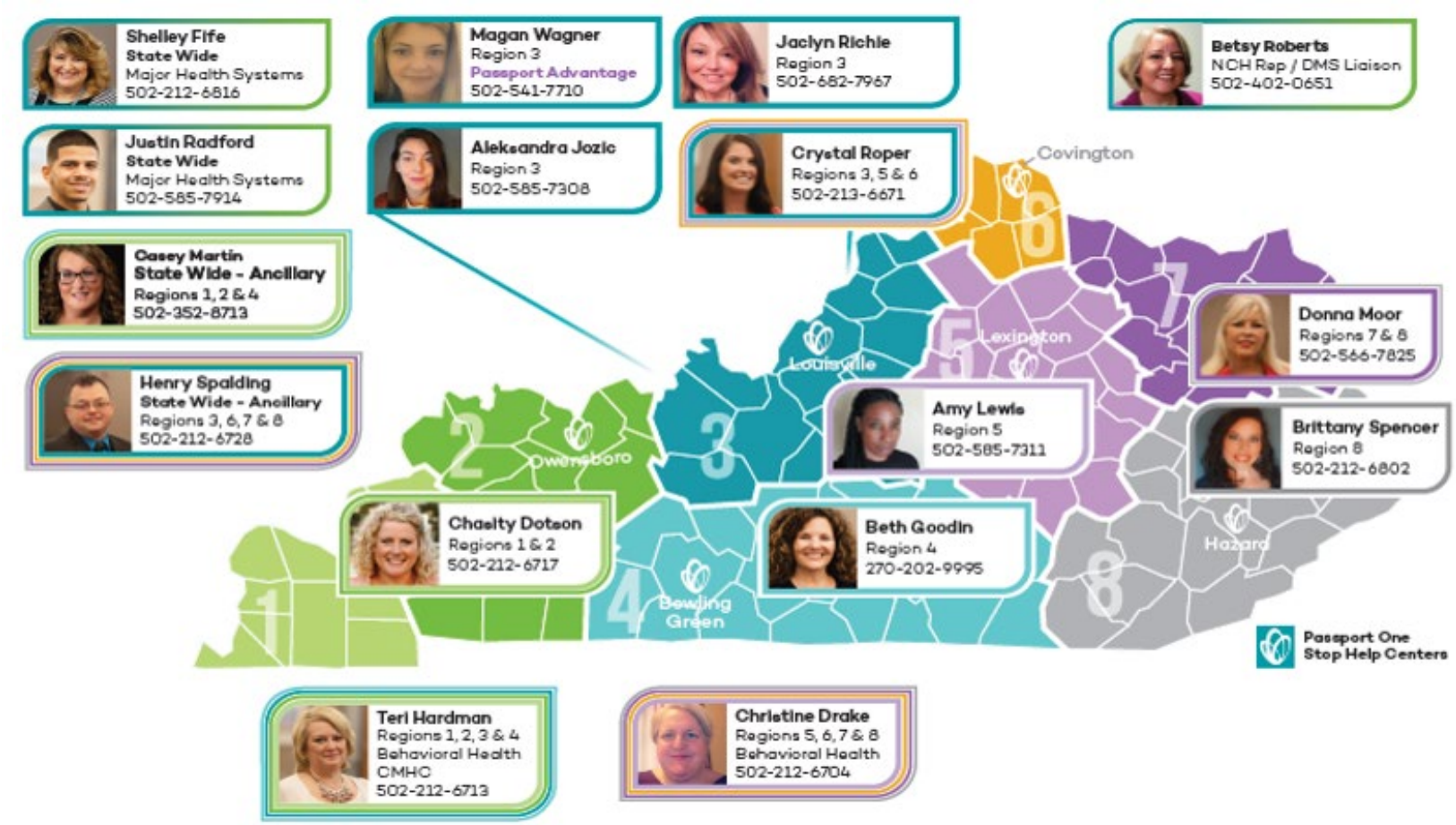
Meet the Provider Services Team

Your dedicated Provider Services Representative is always a phone call or email away!



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Important Updates and Reminders

Prior Authorization Look-up Tool
To determine if a PA is required prior to services being rendered, consider using the Prior Authorization Look-up Tool

CAHPS and HEDIS Tip Sheets Available
NCQA Tip Sheets for CAHPS and HEDIS are available under the Resources tab of the Passport Health Plan Payer Space in the Availity Portal

COVID-19 Vaccine Incentive for Members
Passport members who receive the vaccine on or after June 1, 2021 may quality for a $100 gift card to Wal-Mart, Amazon, Kroger or CVS. For more information or for a flyer to give to your Passport members click here.

Reporting Missed or Canceled Appointments
Don't forget to report missed and/or canceled appointments via KY HealthNet.

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Upcoming It Matters to Passport Forum Dates

Mark your calendars and join us for our monthly virtual forums!

- August 25, 2021 – Behavioral Health and Substance Use Disorder
- September 29, 2021 – Quality
- October 27, 2021 – Community Engagement/Health Education
- November 17, 2021 – EPSDT
- December 15, 2021 – A Year in Review

Visit www.Passporthealthplan.com/ItMatters for more information or to register!

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Care Management Overview

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Four Levels of Care Management

LEVEL I
HEALTH PROMOTION AND WELLNESS

For Enrollees whose physical or behavioral health conditions are low acuity, but whose unmet needs put them at risk for future health problems and compromise independent living

- Focuses on disease prevention, health promotion, and Enrollee self-management
- Goal is to achieve Enrollee wellness and self-management through improved access to timely care, advocacy, education, identification of support resources, and facilitation throughout the continuum of care

LEVEL II
MANAGEMENT OF CHRONIC CONDITIONS

For Enrollees at risk for re-hospitalization, post-Transition of Care intervention, or with care management needs that warrant triage

- Goal is to reduce the burden of disease through education and coordination of care
- Care management team collaboratively assesses Enrollee's needs, creates care plan with prioritized goals, and facilitates appropriate and timely access to primary and specialty care as needed

LEVEL III
COMPLEX CARE MANAGEMENT

For Enrollees who have experienced a critical event or diagnosis that requires extensive use of resources

- Goal is to improve functional capacity and regain optimal health
- Care manager leads creation of care plan with prioritized goals and a multidisciplinary team including caregivers, PCP/medical home, specialists, and others

LEVEL IV
INTENSIVE NEEDS

For Enrollees with need for stabilization and/or end-stage diagnoses

- Goal is to stabilize Enrollee's health status, improve ability to cope with the severity of the condition, and improve quality of life as defined by Enrollee's preferences and goals
- Care manager facilitates and updates (as needed) care plan with prioritized goals and engages multidisciplinary team to provide services in the least restrictive setting

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Care Team Members

Multi-Disciplinary Team	Level I	Level II	Level III	Level IV
Health Manager	✓			
Care Manager		✓	✓	✓
Transition of Care Coach		✓	✓	✓
Community Connector		✓	✓	✓
Housing Specialist	✓	✓	✓	✓
SUD Navigator		✓	✓	✓
Peer Support Specialist		✓	✓	✓
EPSDT Coordinator	✓	✓	✓	✓

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Transition of Care (ToC)

- ToC Coaches work with enrollees for 30 days after discharge from an inpatient setting
- Assess for needed resources, DME, and dietary needs
- Assess for enrollees' knowledge of health condition and self management skills
- Set personalized goals, assistance with new medication concerns or questions, coordination of care, and education on health conditions
- Educate on the importance of attending the follow up appointment after hospitalization and scheduling appointments when needed

ToC's Goal: reduce readmissions by helping the enrollee recognize signs and symptoms early to prevent the need for ED and inpatient treatment

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Chronic Kidney Disease/Kidney Failure Model of Care

- Target enrollees with Kidney Failure, CKD 5, CKD 4, and CKD 3b; will work with members with CKD 3a and below as well, based on CM capacity
- Case Manager RNs with experience and/or additional training in working with individuals with kidney disease
- CKD and KF-specific screeners (initial and follow-up) to assess/monitor progression of the condition
- Frequency of contact is based on enrollee's disease stage
- Goals are to improve quality of life and slow progression of the disease

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Opioid Use Disorder Model of Care

- Enrollees with confirmed diagnosis or illicit use
- Substance Use Disorder Navigators with experience and/or training in working with individuals with SUD act as the CMs for this model of care
- Use ASAM and NIDA assessments (initial and full/ongoing) to assess enrollee needs
- Frequency of contact is based on enrollee's risk level.
- Risk levels (2-4) are determined from NIDA responses, utilization, and other factors
- Goal is to move enrollees farther on their recovery journey; reduce risks, increase member self-management of OUD

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Coordinated Services Program (CSP)

- Previously known as “Lock-In.”
- Goal is to prevent death or injury from prescription drug abuse while preventing Medicaid fraud, waste, or abuse.
- Create an avenue for enrollee behavior change with management support, monitoring and limiting the member to a single pharmacy/provider/setting for care needs.
- Enrollees can decline CM services; however, they cannot decline provider/facility/pharmacy limits.
- Enrollees can appeal a decision within 30 days of notification.

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Pregnancy Risk Screening and High Risk OB Case Management

- All identified pregnant enrollees receive high risk maternity screening assessment
- Enrollees receive referral to address SDOH needs, information Passport benefits and member rewards, and state/community benefits such as WIC, Healthy Start, etc.
- High Risk enrollees are followed closely throughout their pregnancy by an experienced OB RN Case Manager
- High Risk enrollees receive risk specific education on their condition(s)
- Post partum depression screening performed after delivery
- If ongoing needs are present after the post partum period, enrollees and/or their infants are referred for ongoing case management

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EPSDT

- Coordination of benefit for EPSDT eligible enrollees
- Care Management provided by Care Managers with a clinical background in pediatrics/child/adolescent healthcare
- CM outreach to all enrollees who have requested EPSDT Special Services to ensure they have access to medically necessary services and to screen SDoH needs
- Coordinate with PCP's to meet preventive care needs of EPSDT enrollees

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My Health – Healthy Behaviors Programs

Tobacco Cessation

- Members 18+ who are ready to quit tobacco use
- Specially trained Health Educator works closely with members to develop tobacco cessation plan of care and supports members through the quit process

Weight Management

- Members 18+ who are interested in losing weight
- Case Manager works with members to develop weight management plan to help achieve weight loss goals

Nutrition Consult

- Members of any age
- Registered Dietitian works with member and provider to understand health concerns related to nutrition and develop a nutrition plan of care

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Identifying Enrollees for Care Management

Identification Method	Process
Risk Stratification	Based on claims, utilization, and software; model includes SDoH and likelihood to engage
New Enrollee Welcome Calls	Contact Center can transfer Enrollees to Care Management based on identified condition/need
Nurse Advice Line/BH Crisis Line	Daily triage reports sent to Care Management identifying Enrollees for follow-up
HRAs	All new Enrollees and annually thereafter
Referrals	From providers, CBOs, Commonwealth Agencies, and other Passport teams (Nurse Advice Line, medical directors, Utilization Management, Care Management)
Self-referral	Includes caregiver referral
Population Needs Assessment	Identifies health characteristics of the population filterable by geography (e.g., obesity by county), age, gender, race etc.

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Additional Benefits for Passport Members (1 of 2)

Members can receive gift cards in amounts of $10-$50 for Amazon, CVS, or Walmart for completion of certain preventive screenings:

- Annual adult well visit
- On time well child visits for 1-3-year-olds
- PAP test
- Annual mammogram
- Annual dentist visit
- Annual diabetic retinal exam
- Postpartum visit within 7-84 days of delivery
- Chlamydia screening (females 16-24)
- Follow-up visit within 7 days of inpatient stay

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Additional Benefits for Passport Members (2 of 2)

- **Cell Phone**
  - Free cell phone with Unlimited Talk & Text and 4.5 GB of data each month
- **Weight Watchers membership**
  - Free 13 week membership (members ages 18+ with BMI greater than or equal to 27)
- **GED testing and rewards**
  - Vouchers to take the GED test for free and a $50 gift card after passing
- **Asthma**
  - Allergy-free pillowcase and mattress cover (members with asthma who complete 3 months of CM)
- **Car or Booster Seat**
  - Free for expectant mothers that attend a prenatal visit during the first trimester or within 42 days of enrollment
- **School and Sports Physicals**
  - Free sports or school physical annually
- **Adult Eyeglasses or Contacts**
  - $100 every 2 calendar years for one pair of eyeglasses or buying contact lenses

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Care Management Referrals

Email: CareManagement_KY@passporthealthplan.com
Phone: 800-578-0775
*Select the Care Management option

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Open Forum Q&A

Q: To verify, at this time prior authorizations are not required for behavioral health services, correct?

A: Correct. Per DMS all BH-related services currently do not require a prior authorization. Click here for the latest DMS guidance.

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