

# Provider Manual

## Section 12.0

### Special Programs

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# 12.0 Special Programs

## 12.1 Case Management

### 12.1.1 Definition

Case Management assists members in obtaining and coordinating needed medical and social services. The case manager, who is either an RN or a social worker, contacts members and performs an assessment to identify specific needs. A treatment plan is established that works in conjunction with the medical plan and the member. The PCP receives a copy of the goals of the case management plan along with the name and telephone number of the assigned case manager. Practitioners may contact the case manager with any questions or concerns.

### 12.1.2 Target Population

Members who may benefit from case management are those with ongoing complex medical needs. The following may warrant case management; however, these are certainly not all-inclusive.

Members who:

- Need ongoing rehabilitation services.
- Have spinal cord or brain injury.
- Have had a recent cerebral vascular accident.
- Are candidates for organ or bone marrow transplant.
- Are children with chronic medical problems whom parents are having difficulty managing.
- Are HIV+ or have AIDS.
- Need assistance with pain management services.
- Need extensive and persistent wound care.
- Have frequent hospitalizations or emergency room visits.
- Have psychosocial concerns that impact medical conditions.
- Members who have sickle cell disease.

### 12.1.3 How to Request Case Management Services

Practitioners, as well as members and other interested parties, may request case management services. Contact the Case Management department at (800) 578-0636, ext. 77915 or (502) 585-7915. If you would like to speak with the case manager once he or she is assigned, notify the intake coordinator when you make a case management request. Participation in Case Management is voluntary, and the member has the right to decline any or all parts of the program.

## **12.2 Health and Wellness Management Programs**

### **12.2.1 Introduction**

As health care moves toward preventive care, Passport Health Plan is committed to working with providers to help keep members healthy. One way to do this is through Health and Wellness Management programs that ideally prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care. Passport Health Plan health and wellness management programs include the Diabetes Disease Management Program, the Asthma Disease Management Program, and the Mommy & Me Perinatal Program. Practitioners are informed about the programs through various methods, including the Plan's Provider Newsletter, web site, New Provider Orientation Kit, and office site-visits.

### **12.2.2 Purpose of Programs**

Each program strives to improve health outcomes for its participating members through program-specific provider and member interventions. These programs are intended to complement and assist with the care given by the practitioner, and to increase members' adherence to treatment plans. These clinical and nonclinical interventions are based on well-established and professionally-recognized guidelines. Clinical guidelines (see Section 15) specific to each program are reviewed and updated at a minimum of every two years, or when new recommendations become available. These guidelines are available on our web site, [www.passporthealthplan.com](http://www.passporthealthplan.com), or by calling the quality improvement nurse at (800) 578-0636, extension 78434.

### **12.2.3 Evaluation of Programs**

The objectives, activities, and outcomes of each health and wellness management program are continually evaluated and measured against national standards. Updates and revisions are made as needed, with the programs being reviewed at least annually. Reviews consists of:

- Evaluating the overall effectiveness of the programs.
- Exploring and removing barriers to and limitations of the programs.
- Revising areas as needed to improve effectiveness of the programs.

### **12.2.4 Diabetes Disease Management Program**

#### **12.2.4.1 Member Identification**

All Plan members 18 years of age and older with a diagnosis of diabetes or gestational diabetes are eligible for the program, regardless of length of enrollment. Members are identified for the program through:

- Data collected through the Utilization Management (UM) process. Examples include, but are not limited to, hospital census report, pre-certification data, Personal Information Form (PIF), Health Risk Assessment (HRA), 24 Hour Nurse Advice Line, claims, pharmacy data, and concurrent review data.

- Referrals from other Passport Health Plan departments. Examples include, but are not limited to, Case Management, Member Services, and other disease managers.
- Referrals from providers.
- Self-referrals from members.

#### **12.2.4.2 Diabetes Disease Management Program Objectives**

The objectives of the Diabetes Disease Management Program is to improve the health status and decrease complications of adult members with diabetes through improved member and practitioner compliance with the American Diabetes Association (ADA) standards of care by:

- Increasing practitioner adherence to American Diabetes Association (ADA) Guidelines regarding HbA1c testing, LDL-C testing and results, nephropathy monitoring, and dilated retinal exams (DRE).
- Increasing member compliance with ADA guidelines regarding HbA1c testing, LDL-C testing, nephropathy monitoring, DREs, and blood pressure treatment.

#### **12.2.4.3 Diabetes Disease Management Member Interventions and Benefits**

Diabetes is a complex condition with multiple comorbidities; therefore, actions are directed to multiple areas. In addition, the Medicaid population often has unique behavioral and psychosocial areas of concern that must be addressed along with the medical condition(s). Specific member interventions and benefits may include the following:

- Expansion or clarification of benefits such as coverage of group or individual formal diabetes education.
- Availability of a medical social worker and a behavioral health liaison to assist with psychosocial, lifestyle, or behavioral issues that may create barriers to compliance with the practice guidelines.
- Availability of a medical case manager to assist members whose disease is complicated by multiple comorbidities that may be primary over diabetes or may be aggravating the diabetes.
- Availability of a diabetes disease manager five days a week to answer members' questions concerning diabetes and assist members with self-management skills.
- Quarterly member educational mailings and individualized mailings as needed. Rotating topics promoting self-care management.
- Mailings reminding members of ADA-recommended testings.
- Individual assistance with selecting a DRE practitioner and scheduling the appointment.

#### **12.2.4.4 Diabetes Disease Management Assistance to Practitioners**

The program works to assist the practitioner by:

- Educating practitioners about the Diabetes Disease Management Program and making available samples of the educational materials provided to members.
- Distributing Kentucky Diabetes Network (KDN) flow charts to practitioners' offices for their use in quality tracking of patient testing as recommended by the ADA Standards of Care.

- Notifying practitioners of their members identified with diabetes and providing periodic updates of each member's status regarding ADA recommended testing.
- Providing information from the Plan's pharmacy benefits manager regarding member-specific prescribing patterns of diabetic agents and associated medications.
- Providing clinical practice guidelines based on the ADA Standards of Care (see Section 15).

## **12.2.5 Asthma Disease Management Program**

### **12.2.5.1 Member Identification**

Plan members ages two to 56 years identified as having persistent asthma are eligible for the program regardless of length of enrollment. Members are identified as having persistent asthma through:

- Data collected through the Utilization Management (UM) process, examples include, but are not limited to, hospital census report, ER Utilization reports, pre-certification data, and concurrent review data.
- Referrals from other Passport Health Plan departments, examples include, but are not limited to, Case Management, Member Services, and other disease management programs.
- Referrals from providers.
- Self-referrals from members.
- Referrals from hospital asthma educators.
- Data collected through the Personal Information Form (PIF)/Health Risk Assessment (HRA).
- Emergency room (ER) claims identifying members with diagnosis of asthma.

### **12.2.5.2 Asthma Disease Management Program Objectives**

The objective of the Asthma Disease Management Program is to improve the health status and decrease complications of members with asthma by:

- Increasing provider adherence to National Institute of Health (NIH) Asthma Guidelines, including prescription of appropriate medication, specifically prescription of long term controller medications as measured by HEDIS<sup>®</sup> methodology.
- Increasing member compliance with recommended treatment, including use of anti-inflammatory medication for treatment of persistent asthma.

### **12.2.5.3 Asthma Disease Management Member Interventions and Benefits**

Specific member benefits and interventions may include, but are not limited to the following:

- Availability of an asthma disease manager five days a week to answer members' questions concerning asthma self-management and to assist members with coordination of care between PCPs and specialists.

- Mailing of quarterly disease-specific educational materials, including information regarding peak flow meters, action plans, medications, disease process, and coordination of care with the practitioner.
- Distribution of asthma action or school plans depending on age.
- Dissemination of member self-management educational materials, including self-instruction video, through high volume practitioner offices.
- Mailings of annual postcard reminders for flu/pneumonia vaccine.
- Telephone calls from asthma nurse case manager to assess needs, develop plan of care, and evaluate effectiveness.
- Telephone or in-person member contact to evaluate and revise care plan as needed.
- Coordination with the social worker case manager for psychosocial needs/concerns as needed.
- Distribution of educational materials to individual members specific to identified medical or social needs.
- Distribution of letters to members not on a controller, advising the member to discuss the letter with the practitioner.
- Home visits by trained home health nurse for environmental assessment, as needed.

#### **12.2.5.4 Asthma Disease Management Assistance to Practitioners**

The program works to assist the practitioner by:

- Educating practitioners about the Asthma Disease Management Program and making available samples of the educational materials provided to members.
- Notifying practitioners of members identified with asthma, members enrolled into one-on-one care management, and member compliance with treatment plan (including the frequency of refills for controller medications and reliever medications, ER visits for uncontrolled asthma, inpatient admissions, referrals to specialist, and consideration of lifestyle issues such as smoking, pregnant, and immunizations via quarterly provider reports).
- Providing information from the Plan's pharmacy benefits manager regarding any asthma medication concerns for individual members.
- Providing updated clinical practice guidelines based upon the NIH guidelines.

#### **12.2.6 Mommy & Me Program (for Pregnant Members)**

##### **12.2.6.1 Member Identification**

All Plan members identified as pregnant are eligible for the program. Eligible members are identified through:

- Referrals from providers - at the time of the initial prenatal visit, providers precertify member's prenatal care and delivery. These include OB providers, Departments of Health, and teen pregnancy programs.
- Referrals from PHP's Member Services department- any member call where the member is identified as pregnant is forwarded to the Mommy& Me program via the electronic inquiry system.

- Case Management/Special Needs - members who are in active case management who are also pregnant are referred to Mommy & Me.
- Subcontractors - all agencies contracted to provide services to PHP members are requested to contact the Mommy& Me program upon identifying a pregnant member.
- EPSDT - outreach staff in EPSDT inform members of the Mommy& Me program during telephone contacts regarding childhood immunization and screenings.
- Presumptive Eligibility (PE) - Any pregnant female who presents to an OB office or Department of Health can apply for limited prenatal benefits. This information is forwarded to the Mommy & Me program on a weekly basis with PE status.
- Self-referrals from members - members receive information about the program as part of the new member welcome packet and may contact a program representative directly by telephone.
- Personal Information Forms (PIF)/Health Risk Assessment (HRA) -new PHP members are requested to complete and return a health self-assessment form as part of the New Member Welcome Packet and indicate an actual or possible pregnancy and risk factors. This information is forwarded to the Mommy & Me program on a weekly basis.

### **12.2.6.2 Mommy & Me Program Objectives**

The objective of the Mommy & Me Program is to improve maternal and infant outcomes for Passport Health Plan members through both member and practitioner interventions. Specific objectives include:

- To increase the percentage of pregnant members who initiate early prenatal care.
- To increase the number of prenatal visits.
- To increase the percentage of members who receive their six-week postpartum visits from their OB practitioners.
- To decrease the incidence of low-birth weight babies (<2500 gms).
- To decrease the incidence of very low birth weight babies (<1500 gms).
- To decrease the incidence of preterm delivery.

### **12.2.6.3 Mommy & Me Program Member Interventions and Benefits**

The Mommy & Me Program stratifies members as low-, medium-, or high-risk based upon the following:

- OB history.
- Lifestyle habits.
- Psychosocial needs.
- Medical history.

Members are placed on a specific track with the intensity depending upon their risk stratification. Education and assistance with meeting both medical and social needs are stressed, including exchange of information with the obstetrical practitioner and coordination of any needed services with available community resources. Interventions and benefits are based upon a multifactor approach and may include the following:

- Mailing of a comprehensive pregnancy and baby care book, *Mommy & Me Basics: A Guide to a Healthy Pregnancy Delivery and Baby Care*, to all eligible members.

- Welcome packet includes information on how to contact Mommy & Me representatives, information about prenatal classes and benefits, 24-Hour Nurse Advice Line, available community resources, WIC, and transportation.
- Telephonic outreach and education regarding good prenatal care and assistance with prenatal classes.
- Postpartum home visit and/or six-week telephone call or visit as needed. Additional telephone calls to assist with scheduling six-week follow-up visit and newborn follow-up visit with practitioners may also be provided.
- Visit to newly delivered mothers in hospital postpartum units to educate and assist with scheduling the postpartum practitioner visit.
- Assistance with rescheduling missed OB appointments and overcoming barriers that may contribute to further missed appointments, such as transportation and language.
- Telephone calls from nurse perinatal health managers to assess needs, develop plan of care, and evaluate effectiveness of care plan with frequency determined by medical and social needs.
- Written educational materials specific to the member's identified medical or social risk factors.
- Referrals for medically-necessary home visits by registered nurses must be authorized by the Plan.

#### **12.2.6.4 Mommy & Me Program Assistance to Practitioners**

The program works to assist the practitioner by:

- Educating practitioners about the program and making available samples of the educational materials provided to members.
- Providing clinical guidelines based upon the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (see Section 15).
- Providing quarterly reports detailing member eligibility, ER utilization, acute hospitalization, and summary information regarding deliveries and birth outcomes.

### **12.3 Children Living in Out-Of-Home Placements**

This term refers to children living in one of the following:

- Foster care.
- Department of Juvenile Justice.
- Psychiatric residential treatment facilities.
- Group home.
- Adoption assistance.

Due to the nature of children requiring an out-of-home placement, the Department for Medicaid Services (DMS) sometimes moves children outside of the Passport Health Plan service area where the Plan may not have participating providers.

Children living in out-of-home placements do not choose a PCP. Participating or nonparticipating practitioners with a valid Kentucky Medicaid Identification (MAID) number may provide medical

treatment for these children. Children living in out-of-home placements can be treated by specialists without a referral. They require prior authorization for the following services only: inpatient hospital admissions, global OB, private duty nursing, skilled services provided at a special needs daycare, and home health services.

Behavioral health care is a direct access service, is reimbursed on a fee-for-service basis, and may be provided by any behavioral health professional accepting Medicaid. Behavioral health care services for Passport Health Plan members are reimbursed through KyHealth Choices.

Children living in out-of-home placements can be identified by the code “1302/1399 – No PCP Required” located on their Passport Health Plan card where the name of the PCP usually appears. These children may relocate often and may present for treatment without a card or with a card that is not current. Providers may contact Provider Services at (800) 578-0775 to verify eligibility and out-of-home placement status. Eligibility may also be checked at [www.passporthealthplan.com](http://www.passporthealthplan.com). Questions may be directed to the special populations liaison at (502) 585-7309.