Provider Manual
Section 11.0
Special Programs

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11.0 Special Programs

11.1 Case Management

11.1.1 Definition

Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation, and advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote quality cost-effective outcomes.

11.1.2 Target Populations

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:

- Children in/or receiving foster care or adoption assistance;
- Blind/Disabled children under the age of 19 and related populations eligible for SSI;
- Adults over the age of 65;
- Homeless;
- Individual with chronic physical health illnesses; and,
- Individuals with chronic behavioral health illnesses.

11.1.2.1 How are Referrals Generated?

Referrals to Case Management are received through many sources:

- Member Services line;
- Passport member and provider inquiries;
- Completed Health Risk Assessments (HRAs);
- Recently discharged members from hospitals or who have required Emergency Room care;
- Outreach calls by RROT case managers to members who have called the 24-hour Nurse Line and require further assistance from our Case Management staff;
- Internal department referrals; and,
- Providers seeking case management referrals for their patients.

11.1.3 How to Request Case Management Services

Practitioners, as well as members and other interested parties, may request case management services. Practitioners may contact the Rapid Response department at (877) 903-0082 from 8:00 a.m. to 6:00 p.m. EST to make a case management referral or by completing the Care Coordination Request Form available online at http://passporthealthplan.com/wp-content/uploads/2015/01/2-cc-care-coordination-request-form.pdf. If you would like to speak with the case manager once he or she is assigned, notify the Rapid Response 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.

11.1.4 Rapid Response Outreach Team

The Rapid Response Outreach (RROT) team was developed at Passport to address members' health questions, to identify members in need of care coordination services, and to address the urgent needs of our members. Our goal is to reduce both unnecessary emergency room visits and in-patient stays, as well as assist in removing barriers to needed healthcare services.

The team consists of Registered Nurses, and Case Management Technicians (under the direction of the clinical staff), with Social Workers, Pharmacists, Pharmacy Technicians and Durable Medical Equipment support staff.

11.1.4.1 What we do

The members of the Passport Rapid Response Outreach Team are trained to assist in the rapid triage of members' needs. The team assists members in investigating and overcoming the barriers to achieving their health care goals. The RROT can assist with:

- Questions concerning how to obtain supplies or services from Durable Medical providers;
- Transportation scheduling;
- Assisting with pharmacy and barriers to receiving medications;
- Collaborating with specialists;
- Coordination of physician appointments;
- Scheduling preventive health screens;
- Facilitating medication access;
- Informing members of the available community resources, assist them in completing the application process and follow through of services;
- Outreaching to members for HEDIS® measures; and,
- Resources for resolution of legal questions such as the creation of advanced directives, living trusts, or other types of legal assistance.

11.1.4.2 Contact the Rapid Response Outreach Team

The Rapid Response Outreach Team can be reached at (877) 903-0082 from 8:00 a.m. until 6:00 p.m. EST, Monday through Friday. After hours, there is a 24-hour Nurse Call Line available to all members at (800) 606-9880.

11.2 Health and Disease Management Programs

11.2.1 Introduction

Passport is committed to working with providers to help keep members healthy by supporting preventative care. One way to do this is through Health and Disease Management programs that ideally prevent or decrease exacerbation of an illness by a comprehensive, integrated approach to care. Passport's Health and Disease Management programs include the Diabetes Disease Management Program, the Chronic Respiratory Disease Management Program, the Congestive Heart Failure (CHF) Program, the Mommy Steps Perinatal Program, and the Obesity Program. Practitioners are informed about the programs through various methods, including Passport's Provider Manual, web site, provider communications, New Provider Orientation Kit, office site-visits by the Provider Relations Specialists, and face-to-face education visits by the disease specific

provider.

11.2.2 Purpose of Programs

Each program emphasizes education for targeted members and providers to improve the overall health, wellness, and quality of the member's life. The goal of the programs is to provide tools to educate the member on promoting improved health through better prevention, detection, treatment, and education. These programs aim to facilitate member understanding and responsibility of the disease process as well as coordination of care between the member and/or caregiver and the provider. Programs focus on increasing both member and provider adherence with well-established and professionally recognized guidelines.

11.2.3 Evaluation of Programs

The objectives, activities, and outcomes of each Health and Disease 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 consist of:

- Measuring participation rates;
- Determining whether the programs have demonstrated improvement in outcomes and quality of care provided to members;
- Evaluating the overall effectiveness of the programs;
- Exploring he barriers and limitations of the programs; and,
- Revising areas as needed to improve effectiveness of the programs.

11.2.4 Type of Disease Management Program

Passport offers the following Disease Management Programs:

- Diabetes Disease Management Program
- Chronic Respiratory Disease Management Program
- Congestive Heart Failure (CHF) Disease Management Program
- Obesity Disease Management Program
- Mommy Steps Program (for Pregnant Members)

Please reference Passport's website at www.passporthealthplan.com for additional program information.

11.3 Children Living in Out-Of-Home Placements

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

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

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, private duty nursing, home health services, and any non-covered services including EPSDT Expanded Services. To pre-certify these services, contact Utilization Management at (800) 578-0636. In addition, non-participating OB providers are required to obtain authorization for OB services.

Children living in out-of-home placements 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 via Passport's Provider Portal at https://phkyportal.valence.care/. Foster Parents/Guardians with questions can call Member Services at (800) 578-0603 and asked to be transferred to the out of home care team.

11.3.1 Foster Care and Guardianship Specialists

The Foster Care-and Guardianship Specialists works in collaboration with the Department for Community Based Services (DCBS) and the Department of Aging and Independent Living (DAIL) to provide ongoing Care Coordination Services for foster care and guardianship members and to identify DCBS or DAIL clients for Case Management Services. The Foster Care-and Guardianship Specialists is are responsible for identifying and correcting problems with special populations including Foster Care, Guardianship, Department of Juvenile Justice, Kinship, Adoption Assistance, and Residents of Psychiatric Treatment Facilities and Group Homes. The Foster Care and Guardianship Specialists serves as a primary contact for foster and adoptive parents, guardians and DCBS/DAIL workers for issues and concerns. Foster Parents/Guardians can call Member Services at (800) 578-0603 and asked to be transferred to the out of home care team.

11.3.2 Homeless Services

Passport provides ongoing face-to-face member/benefits education sessions throughout the year. These sessions are conducted at the various transitional and homeless shelters throughout the state. Special attention is given to those victims of domestic violence residing in emergency shelters.