

B.1. Corporate Experience

- a. Describe the Vendor’s experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:
 - i. Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.
 - ii. Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.
 - iii. A summary of lessons learned from the Vendor’s experience providing similar services to similar populations.
 - iv. How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.

Passport Highlights: Corporate Experience

How We’re Different	Why It Matters	Proof
The Passport team brings an unparalleled 22+ years of experience working with providers and community organizations to elevate member health and well-being in the Medicaid program.	<ul style="list-style-type: none"> In-depth knowledge of member issues and local relationships is essential to coordinate care across providers and community organizations. Commitment as long-term partner for the Commonwealth’s health care priorities has driven program innovation. 	<ul style="list-style-type: none"> Passport supports 300,000+ lives across Kentucky and has received numerous national, regional and local awards for health plan performance and member satisfaction. Passport has consistently been the pilot partner for Department of Medicaid Services (DMS) innovations such as integrating behavioral health and implementing the Kentucky Children’s Health Insurance Program (KCHIP).
Passport’s partnership with Evolent Health supplements our local expertise with national best practices, clinical analytics and pathways, and robust technology and systems.	<ul style="list-style-type: none"> Clinical and operational best practices from leading Medicaid providers nationally. Cutting-edge predictive analytics for early identification of impactable members. Higher member engagement rates for care management interventions. Reduction in inpatient admissions, readmissions and total medical expenses. 	<ul style="list-style-type: none"> Evolent supports over 35 partners nationally across 3.7 million lives. Evolent’s care management programs have delivered externally validated reductions in hospitalization and total medical costs. 57% of Evolent-managed members are enrolled in care programs nationally. 41,000 hospital days avoided annually.

How We're Different	Why It Matters	Proof
<p>Passport's Population Health Management (PHM) program is a fully integrated, member-centric population health model powered by industry-leading analytics and evidence-based practices validated by the National Committee for Quality Assurance (NCQA).</p>	<ul style="list-style-type: none"> Care team proactively identifies members at risk before they incur an avoidable admission. Encourages member participation in preventive services, Social Determinants of Health (SDoH) solutions, engagement activities. 	<ul style="list-style-type: none"> Passport reduced emergency department (ED) visits by 35%, inpatient admissions by 32%, and total medical expense by over 21% for patients in complex care programs. Gift card redemption increased in 2019, which dramatically increased member vaccination rates.
<p>All of our programs and practices are member-focused, connecting our members to community resources through community outreach, engagement and education. These deep, longstanding trusted relationships ultimately create more access points for members.</p>	<ul style="list-style-type: none"> Our leaders and staff participate directly on many local boards and agencies Extensive community presence helps improve outcomes for members, including those who are some of the hardest to reach. 	<ul style="list-style-type: none"> Our team members serve on nearly 200 boards, advisory committees, interagency councils, coalitions, and community health worker (CHW) associations. Passport homeless members visit ED approximately 30% less frequently than the national average (3.57 ED visits per year vs. national average of 5 visits).

B.1.a. Describe the Vendor's experience in the provision of managed care services to the populations specified in this Contract. Include the following information in the response:

Passport Health Plan (Passport) brings to the Commonwealth a unique offering of over two decades of local experience in providing innovative Medicaid managed care services and regularly implementing targeted population health programs and initiatives. We are ready, willing and able to find new approaches to improve health outcomes in the areas of health and wellness, including tobacco use cessation, colorectal screenings, diabetes prevention and care, cancer care, programs for individuals with special health care needs, and behavioral health (BH)/substance use disorder (SUD) interventions, to name just a few.

Local Experience

Passport is headquartered in Louisville, Kentucky, and has a strong, long-standing corporate presence in the Louisville community. We make decisions right here in the Commonwealth, without the need to check in with a corporate office in another



state. In 2013, Passport expanded operations from 16 counties to a statewide presence. We also opened an office in Prestonsburg in early 2015 (~40 employees) to meet the specific needs of members in Eastern Kentucky and to provide economic development to this region. Even more impressive than the location of our offices is that our team members reside in 51 of the 120 Kentucky counties. During our tenure supporting Kentucky Medicaid, we have established a comprehensive provider network, hired and trained staff (including Community Engagement and Provider Relations representatives located across the Commonwealth), established contractual relationships with subcontractors as needed to obtain national best practices, and developed successful operational processes and clinical protocols.

Passport was established in 1997 in response to the desire of both the Commonwealth of Kentucky and the Centers for Medicare and Medicaid Services (CMS) to meet the following goals:

- Improve access and quality of care to Medicaid beneficiaries
- Stabilize growth in Medicaid costs
- Emphasize primary care and prevention

Passport responded by creating a unique model for health care delivery by aligning the interests of the Commonwealth, Medicaid providers and Medicaid recipients. This was ultimately accomplished through the development of a Kentucky-based health maintenance organization (HMO) owned and operated by providers. The original model—adopted under an 1115 waiver and often referred to as the “Partnership Waiver/Model” between the Commonwealth of Kentucky and the CMS—called for a tri-party contract for Medicaid managed care services in Region 3. This contract was made between the Commonwealth of Kentucky, Passport and the Partnership Council. This contractual relationship continued until the waiver was transitioned to a 1915 waiver, at which time the Partnership Council was no longer a party to the contract. However, leadership and governance felt that maintaining tight linkages to additional providers and community members was important to continue.

As a result of that commitment to local community, much of the original partnership model remains intact. While now a committee under Passport’s Board of Directors, the Partnership Council maintains a deep tie to the community, with 32 members representing major categories of providers, members and service providers. The Council assists in the development and oversight of Passport’s clinical programs, including care management (CM), utilization management (UM), quality and pharmacy. Indeed, the depth and breadth of the Partnership Council and its subcommittee structure can be measured by the nearly 100 community providers and volunteers that comprise them.

As a provider-driven organization, we have individuals from the community and local providers with real governance authority at all levels of our governance structure, which is highly differentiated from most other managed care organizations (MCOs).

Passport Leadership

Our leadership team is locally based and has a strong balance between local Kentucky experience and national experience in Medicaid. There is no need to balance other priorities since “the buck stops here” in Kentucky. We believe understanding our population requires our teams and leaders to be engaged in the communities we serve. These experiences provide context for decisions made to support our community-based operating model. Our executives and leaders participate in Kentucky organizations and boards such as St. George’s Institute, Kentuckiana Chapter of the March of Dimes, the Kentucky Derby Festival, American Heart Association Go Red for Women, the Kentucky Colon Cancer Project, the Kentuckiana Health Collaborative, the Jewish Hospital Foundation, WLKY Spirit of Louisville Foundation, the University of Louisville School of Public Health Advisory Board, the Kentucky Board of Psychology Licensure, and many others. Several of our executives are graduates of both Leadership Louisville and Leadership Kentucky and remain active in these organizations.

Member Services

Leadership: With each administration, state program or federal policy change that Passport has faced during our many years serving the Commonwealth, our program has been guided by an experienced Kentucky-based Member Services director and member-focused team. Our Member Services director has 20 years of experience at Passport, and our two Member Services senior managers have 18 years and 10 years of experience at Passport. Our Member/Provider Services team has grown from less than a dozen Member Services representatives (MSRs) in 1997 to over 100 today. Our Member Services team is regularly applauded by our members for the service they provide, as evidenced by a Consumer Assessment of Healthcare Providers and Systems (CAHPS) score of 88% in 2018. The team truly takes the time to care and be there when our members need us most.

Results: In 2019, Passport MSRs responded to 126,382 inbound calls, with a call abandonment rate that is consistently less than 5% and an average speed of answer of less than 30 seconds. We look forward to continuing to enhance our services to continue this legacy of excellent customer service tailored to the needs of Kentucky Medicaid members in the future.

Community focused: Achieving engagement from Kentucky Medicaid members requires a truly personalized approach. We work one-on-one with members in-person in the community, at their provider’s office and even in their homes to help empower them to engage in their health care. Our goal is to persuade members to take control of their health and trust that we will be there to support them every step along the way and in any way that influences their health and well-being. We want them to know that we are there for them, especially when they need us most. Our MSRs are not only able to identify and link to community resources using tools such as Healthify and United Community (Unite US), but they also draw upon their extensive local knowledge, having lived in the community for years.



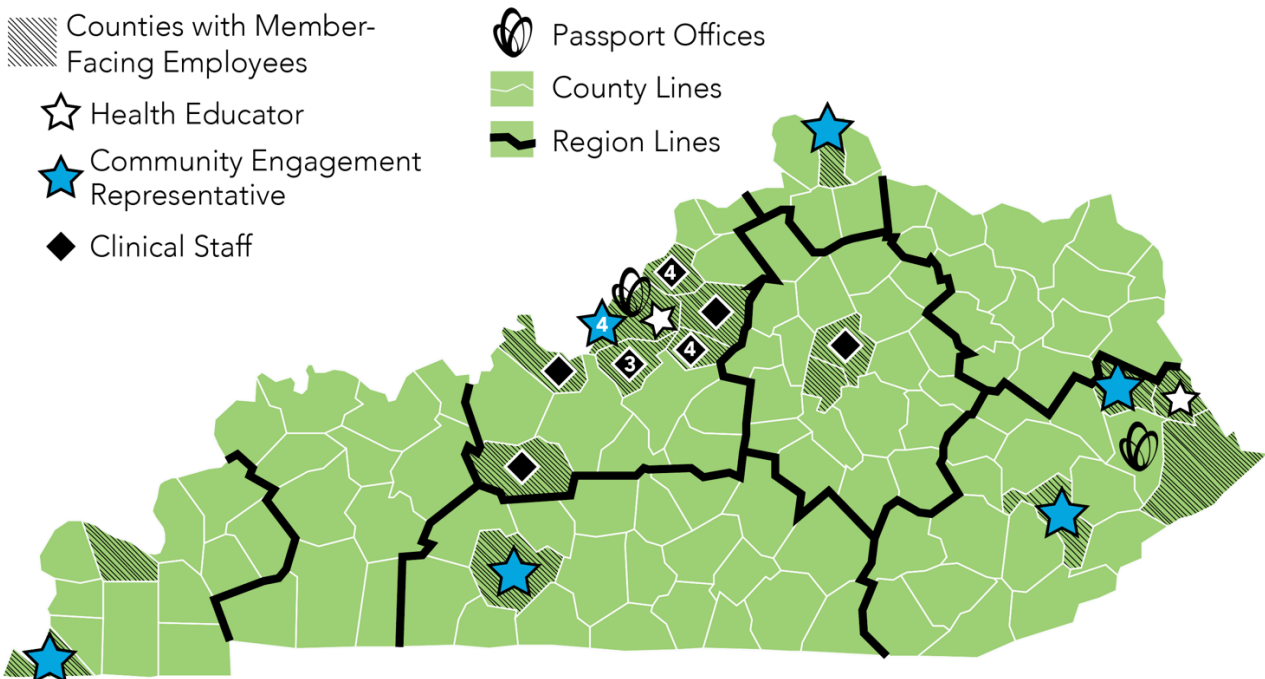
Community Engagement

Our Community Engagement department is the force driving our education and outreach efforts throughout urban and rural Kentucky. Passport has existing statewide representation on a regional basis for Community Engagement representatives to be accessible to members and their community. **Exhibit B.1-1** shows how our current Community Engagement representatives are spread around the Commonwealth, with Community Engagement staff

covering each region. This is also a team effort with many more member-facing staff engaging members. The exhibit, with shading and stars, illustrates that there are individuals throughout the Commonwealth who interact with members each day. There are even more individuals who live throughout the Commonwealth who are not depicted on this map, such as Passport’s Provider Relations representatives, Member Services and Health Integration teams, among others, also playing an important role engaging with additional stakeholders in our communities.

Exhibit B.1-1: Community Engagement Representatives by Region

Engaging with Members within Their Communities



Consistent with our philosophy, Passport Community Engagement staff actively provide health and benefit education to members, participate on many local boards, and collaborate with agencies that support DMS goals and our mission. Passport has documented a sample of the thousands of interactions that have taken place in local communities to address the full spectrum of health and wellness, community engagement and social/environmental issues across the highly diverse communities at the regional, county and city/town level. **Attachment A-1** contains a sample of interactions intended to serve as a description of the deeply embedded relationships that Passport has across the state, not only with the geography, but within each *community*. The breadth of our community-based network is essential in serving vulnerable populations that struggle with access issues and need multidimensional support to address complex health and social issues.

Provider Services and Network Management

Passport team members support our network of providers from within Kentucky. We employ a team of more than 20 Provider Relations representatives who, combined with our population health managers, create an effective bridge between provider operations and clinical quality.

As we know, health care is local. This is especially true in evaluating the delivery network and assessing access and supporting the providers. There are many areas of the Commonwealth where time and distance do not match and might not be recognized when viewed from afar. Whether in the mountains of Eastern Kentucky that make travel more circuitous or in the Land Between the Lakes in Western Kentucky, where there can be miles and miles of shoreland with limited crossings, having an intimate knowledge of our various communities helps develop proactive plans to address and mitigate concerns. Passport has more than a dozen field-based Provider Relations representatives serving providers across the Commonwealth with a high touch, relationship-based service model.



National Experience Supports Successful Provision of Managed Care Services in Kentucky

Our community-centric operating model is supplemented by national experience serving Medicaid populations. We are confident that we can learn from other states and bring those creative solutions to Kentucky. Our operating partner and part owner, Evolent Health, supports over 3.7 million lives across 35 partners in 40 states. Specifically, within Medicaid we can bring lessons learned from 11 partners and 1.7 million Medicaid lives across the country—and approximately 45,000 primary care providers (PCPs). Passport draws upon Evolent Health’s national experience and impressive clinical results, such as enrolling 57% of members in care programs and avoiding 41,000 hospital days on an annual basis. For decades, Evolent has worked with Medicaid managed care health plans across the nation to increase access to quality care, drive down administrative costs and provide a superior experience to their provider networks and

members. Passport can bring these solutions to help Kentucky quickly respond to new regulatory and program developments with the latest innovations.

Passport regularly taps into other provider-driven plans and organizations in Evolent’s national network that serve Medicaid members—SOMOS Community Care (in New York), Lee Health (Florida), Empower Healthcare Solutions (Arkansas), Nicklaus Children’s Health System (Florida), Baptist Healthcare (Florida), South Bend Clinic (Indiana), and CountyCare (Illinois)—to identify paths proven to be successful, taking on a fast-follower approach.

Thanks to this combination of local and national experience and work to improve clinical results together, Passport and Evolent have returned over \$115 million of value to Passport over three years (on average, over \$40 million per year), based on comparisons to national benchmarks. These savings are above and beyond savings that would have been achieved without their support, and they drive down overall costs to the Commonwealth to ensure its Medicaid resources are used most effectively.

B.1.a.i. Experience in implementation of population health management programs and initiatives. Include information about how the Vendor has addressed social determinants of health.

Approach and Experience Implementing Population Health Management Programs and Initiatives

Passport’s Population Health Management Program Implementation Approach

Implementation of PHM programs and initiatives requires regional population health assessment, including understanding SDoH needs, in-depth planning, timely execution, collaboration and ownership with providers, and a framework for evaluating progress to achieving the intended outcomes. Our specialized implementation team partners with the front-line teams to implement programs or initiatives. Providing this level of planning and execution expertise, combined with the clinical and relationship expertise, ensures that member care is not interrupted, and program integrity is maintained.

Passport’s program implementation approach is grounded in the Project Management Body of Knowledge (PMBOK). The internationally recognized framework provides guidance and best practices for planning, measuring and overseeing complex projects and programs over their entire lifecycle. Our flexible, yet disciplined approach ensures appropriate capacity and internal controls are in place to successfully launch new and refined PHM programs on time.

The implementation framework and process has been codified and tested throughout the past 20+ years in more than 50 instances and begins with extensive planning and development of a program implementation plan, as detailed in **Exhibit B.1-2**. The program implementation plan includes tasks and timelines across all domains, ensuring that all areas impacted (e.g., analytics, provider engagement, platform) are planned and tracked. Our implementation lead and Program Management Office are responsible for managing the

implementation in collaboration with the clinical domain leads and ensuring that risks and issues are rapidly mitigated.

As implementation moves through the three phases of launch (go-live, 30 days, 90 days), the operational team progressively starts assuming more responsibility as duties are transitioned from the Implementation team to the Operations team. Agreed upon interim measures of success (e.g., number of patients identified for program, number of program enrollees, percentage engaged) are tracked and shared across the teams. A hotline is set up to ensure front-line staff have a resource to rapidly answer any questions and address concerns. Member calls are monitored; information gleaned is both aggregated and shared across teams for rapid-cycle improvement and adjustments and used for individual coaching opportunities.

Exhibit B.1-2: Key Milestones for PHM Programs and Related Reporting & Analytics

Passport Health Plan Implementation Roadmap & Key Milestones															
	FEB 2020	MAR	APR	MAY	JUN	JULY	AUG	SEPT	OCT	NOV	DEC	JAN 2021	FEB	MAR	
	Requirements			Design, Build & Configuration						Training			Go-Live 1/1/2021		
	Initiation						System Testing		End to Testing						
							Readiness Prep		Readiness Execution				Command Center - Warranty Period (90 Days)		
CLINICAL	Existing Clinical Programs COMPLETE		Finalize Net New Clinical Program Design & Requirements					Identifi / Program Dev & Configuration Complete			New Clinical Program Testing Complete				
REPORTING & ANALYTICS	Compliance and Management Reporting COMPLETE		Finalize Net New Reporting Requirements			Contracting Complete for Provider Network Expansion New Reporting Specifications Complete		Reporting Enhancement Build Complete			Initial Reporting Testing Complete		Production Validation Of Reports		

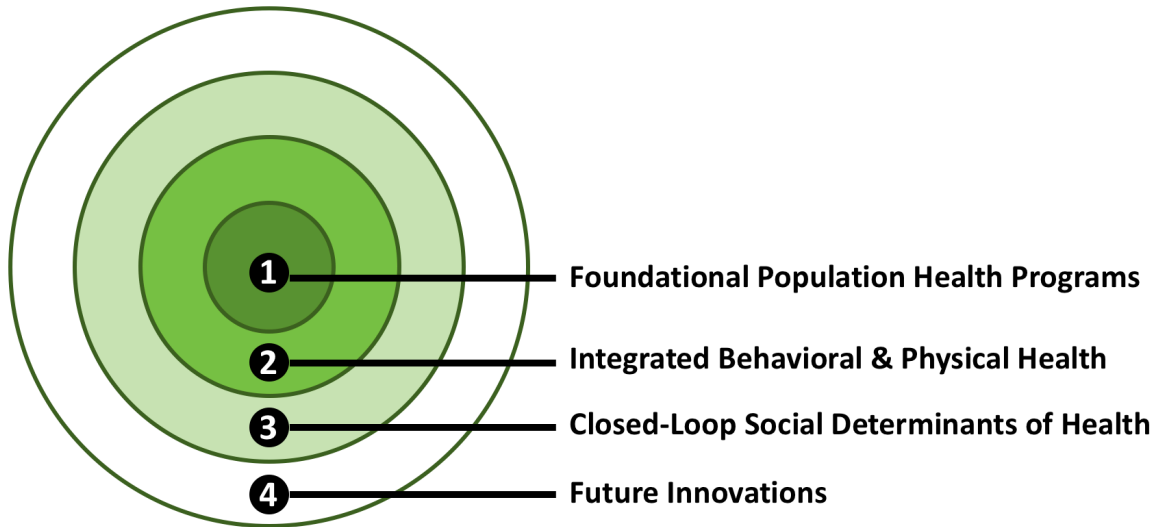
Clinical and operational training is a key component of implementing any PHM program or initiative. Training is delivered in collaboration with the Implementation team and Operations team to the Care team. Participants are trained on the population, SDoH (as they relate to the population), and program goals, as well as goals of DMS and contractual requirements, assessment/screening tools, interventions, outcomes, evaluation methods and technology training when applicable. Information is also shared with providers on how to refer a patient, the goals of the program, collateral provided to patients, roles and responsibilities, and how to get questions answered.

Passport’s Implementation Experience of PHM Programs

Passport has long recognized that its PHM programs must adapt to the evolving needs of our membership. As shown in **Exhibit B.1-3**, Passport began its PHM journey with **Foundational Population Health programs** (1), then we **integrated Behavioral and Physical Health** within our programs (2), and most recently, we introduced our **Closed-Loop Social Determinants of Health** (3) model to address the social needs that impact our members’ health. The basis of our PHM programs is data analytics, which enable us to proactively identify patients to engage and identify opportunities to implement **Future Innovations** (4).

Exhibit B.1-3: Passport's Implementation of PHM Programs

Passport's Implementation of Population Health Management Programs



1) Foundational Population Health Programs

In 2016, Passport implemented an **integrated, member-centric PHM model** with cutting-edge technology and data analytics to perform member risk assessment and stratification to improve population health outcomes. Our predictive modeling tool, IdentifiSM, identifies members for CM services. Passport combines data from multiple sources to use in its population stratification and program eligibility process. For example, we incorporate medical and behavioral claims/encounters; pharmacy claims; laboratory results, when available; health risk assessment results; electronic health records, when applicable; data from health plan UM or CM programs; and advanced data sources, such as the Commonwealth of Kentucky immunization registry. Identifi allows everyone in various departments to access the same information. Data is interconnected, and encounters are loaded so that anyone working with an individual member is able to see the entire picture of the member's health and quality of life based on our claims data, call notes and more.

Central to our predictive modeling approach is our focus on identifying **impactable** members. This means that instead of merely identifying high-risk individuals, we focus on identifying members who require immediate intervention and support due to the presence of indicators that demonstrate physical or behavioral health at risk for decline in the next 12 months. These are the members who present the greatest opportunity for us to help change the trajectory of their health by engaging them in our PHM program, thereby avoiding significant cost.

The implementation of the Identifi technology and associated data analytics provided the base for our **Foundational Population Health programs**, and all other PHM programs we have since implemented. Passport has five Foundational Population Health programs: Catastrophic Care, Complex Care, Transition Care, Condition Care and Maternity Care. In addition to implementing these programs at Passport, our operating partner has implemented these programs over 150 times over the course of eight years with partners across the country, as shown in **Exhibit B.1-4**.

Exhibit B.1-4: Implementation Instances of PHM Programs

PHM Program Name	Catastrophic Care	Complex Care	Transition Care	Condition Care	Maternity Care
Description	Supports high-risk members with medical complexities due to severe illness or injury	Supports high-risk members with high likelihood of admitting due to complex chronic conditions	Supports members with high risk of readmission post-discharge	Supports members with moderate risk of admitting due to unmanaged chronic condition	Support low, moderate and high-risk members with perinatal and postpartum care and coordination
Implementation Instances of PHM Program	22	40	40	32	18

To operationalize the Foundational Population Health programs outlined above, we implemented:

- **Interdisciplinary care teams:** Deployed interdisciplinary teams throughout the local market or telephonically from a centralized location to operate clinical programs, engage patients and support physicians
- Community-based patient engagement strategies: Integrated machine learning technologies, predictive modeling and processes that enable outreach to engage patients in their own care plan
- Quality and provider engagement: Engagement of physicians to identify opportunities to close gaps in care, improve clinical documentation and execute on population health efforts

2) Integrated Physical & Behavioral Health

As Kentucky’s Medicaid program services have grown and evolved in scope, Passport has repeatedly demonstrated its flexibility to adapt and scale up its business model, system infrastructure and employee expertise to successfully meet expanding requirements. For example, Passport facilitated the transition of BH services into managed care. Because Passport had been working closely with membership in the region for 15 years prior to integrating BH services with its medical and pharmacy needs, Passport was well-positioned to assist community mental health center providers navigate this transition. Working with MCOs was completely new to the community mental health centers, which were the only outpatient providers at the time. By providing continuous one-on-one support, Passport successfully helped these providers

overcome the significant transitional challenges associated with adapting their business models to accommodate working with MCOs.

Among the current Passport adult population, over **60%** of our members have three or more chronic conditions (across 47 common chronic conditions, including diabetes, hypertension, obesity, metabolic syndrome, renal disease, epilepsy, and low back pain), and **40%** have at least one BH-related diagnosis (e.g., mood disorder, autism, psychosis, PTSD). Passport’s PHM model of care (MOC) meets these unique needs by fully integrating physical and behavioral health services across the entire health care spectrum. We are acutely aware that medical and behavioral health issues are tightly interconnected, and the effects of chronic medical conditions, prolonged stress, poverty and trauma can have direct and devastating effects on members and their families. Our experience indicates these factors are deeply rooted in SDoH and can contribute to physical and behavioral health complications, which led us to develop and implement the third PHM program: the Closed-Loop Social Determinants of Health Model.

3) Closed-Loop Social Determinants of Health Model

We continuously draw upon our field experience to enhance our integrated whole-person MOC to better serve our members in improving their health and quality of life. As a result, we developed our innovative Closed-Loop Social Determinants of Health Model, which leverages cutting-edge technology and innovative best practices to integrate SDoH into our PHM practices. Passport is in the process of implementing this model to deliver the tailored whole-person care our members need from our highly skilled clinical teams and specialized care management programs.



Identifi integrates dispersed SDoH data sources at different levels (e.g., individual, census block, census tract) across five main domains (housing instability, transportation barriers, food insecurity, financial stress and health literacy). It creates a single Social Needs Index that indicates a member’s risk level, which assesses the potential impact to their health outcomes. Having one single index indicating how an individual’s social needs place health outcomes at risk not only gives us the ability to prioritize members for care management, but it also simplifies the workflow for Care Advisors to integrate social services into the clinical care management plan. We use the index to direct efforts and resources to the most at-risk members and pinpoint their individual needs.

After Identifi has identified members as having social needs, it will populate referrals. Then our case managers, social workers and CHWs can proactively reach out to the members. Conversely, if a member approaches a Community Engagement representative or calls into Care Connectors or Member Services with an SDoH need, our team can address it at that time.

Passport is continually implementing program enhancements to support SDoH. For example, we have implemented:

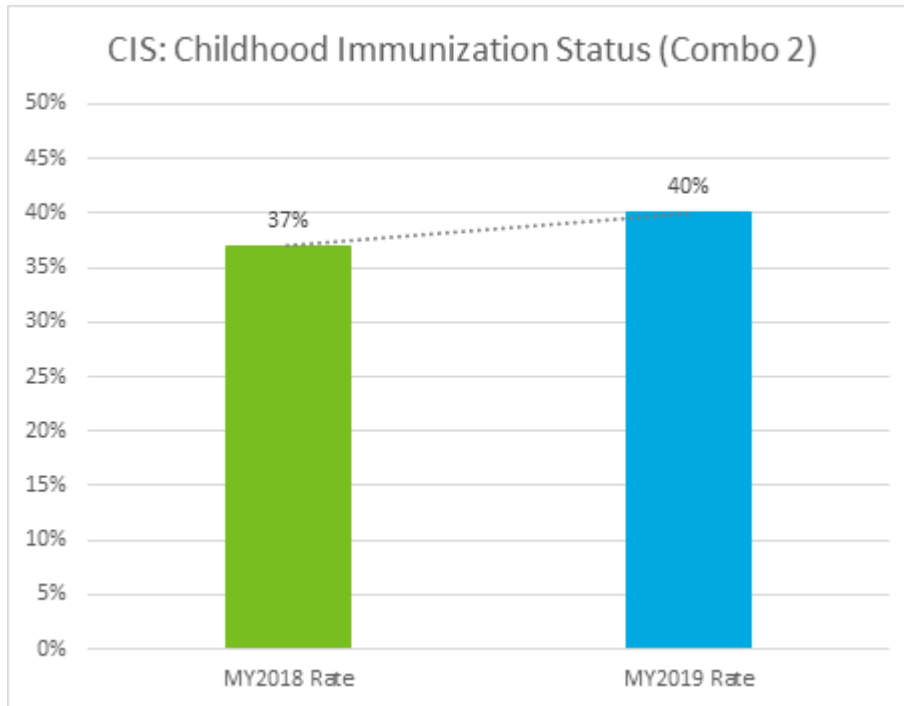
- **Community health workers:** In 2018, we implemented a new program enhancement where our CHWs conduct face-to-face visits in the members' homes, provider offices and in community service organizations. Passport CHWs serve as advocates, helping members schedule doctor appointments, obtain the necessary resources to resolve SDoH barriers, and assess for any literacy or interpretation services needed. Our CHWs teach members how to become engaged in their health care and assume accountability for making necessary resource arrangements.
- **Homelessness supports:** As in other parts of the Commonwealth, the Louisville metropolitan area finds homelessness is becoming an increasingly prevalent social issue. Throughout the 120 counties we serve, Passport care managers help our members find housing options. We work with local providers and meet face-to-face with our members to understand their situations. We enroll homeless members in a care management program, complete an assessment to fully understand their needs, and work with members to set specific goals to help them improve their health and address their housing needs, as applicable. Serving as member advocates, our CHWs use a web-based tool to quickly search and locate housing resources available in the community. Our staff provides this information to members, assisting them as needed to contact the community housing organizations.

Results: In a sample of 2,000 members we screened for SDoH (using Healthify), 1,787 total referrals were made across 451 distinct members, indicating that a portion of the population has multiple needs (on average, approximately four distinct needs requiring a specialized service). Preliminary results show that per member per month (PMPM) costs dropped by approximately 22% (or \$390 PMPM) in the six months after a member acted upon the referral (closed the loop).

4) Future Innovations

Passport continuously analyzes performance measures to identify opportunities for future innovations in our PHM programs. For example, in early 2019 we identified an opportunity to improve the relationship between members and their PCPs and improve screening and participation rates for the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program through Childhood Immunization Status (CIS). We conducted a call campaign for six weeks to contact all members with an open care gap for CIS Combo 2. The team assisted members with scheduling appointments while also providing a brief education about why it is important to stay current on vaccinations. During these calls, we reminded the member's parent or guardian that there is an incentive in the form of a gift card when keeping their appointment. From the first full call campaign, we gleaned lessons learned that led to additional eligibility and claims verifications, collaboration with the care team for members already enrolled in one of our clinical programs, and further assistance for members interested in redeeming incentives. **Exhibit B.1-5** depicts these improved outcomes for CIS Combo 2. Based on the pilot, we believe the program could impact several thousand more members to increase vaccination rates and care compliance.

Exhibit B.1-5: Childhood Immunizations Increased in 2019 as a Direct Result of Passport’s CIS Campaign



*Administrative only rates were pulled for the CIS: Combo 2 measure as of December 2018 and 2019 for accuracy of reporting quality improvement progress. May not reflect the final rates.

Based on the pilot, we believe the program could impact several thousand more members to increase vaccination rates and care compliance. To achieve this, Passport has implemented an EPSDT IVR campaign runs monthly for different age groups. In 2019, there were a total of 143,219 automated outreach calls attempted by our vendor. For members that were not able to be reached by automated means, we attempt to complete a live outreach call. For live EPSDT outreach we made 5,916 attempts and 1,228 members were reached. During the live outreach call we conduct education about EPSDT and the importance of completing those visits. Our reach rate for those live outreach calls was 21% this past year (2019). Members that remain unable to reach receive a mailing. In 2019 we completed a total of 4,668 mailings. At the end of the 2019 EPSDT measurement year, our EPSDT screening rate was 88%.

Effective Implementation: Results of Passport's PHM Programs

We know our implementation of PHM programs has been successful based on our impressive results.

- Member engagement
- Our focus is on ensuring that members are well educated and engaging in their care plans. We have trained over 70 care team members and have improved administrative efficiencies so that nurse case managers are able to help more of our members with their care needs. We have improved performance by doubling the number of members our CMs are effectively engaging with versus historical rates. In 2019, our Care Advisors and Health Educators maintained an average engagement rate of 40% (members with completed assessments out of all members identified for programs), which is 33% higher than corresponding national averages. Ninety-nine percent of Passport members engaged in our care coordination programs have implemented an integrated care plan within 14 days, and 98% of members have been successfully referred to social workers, when needed.
 - Our member engagement metrics do not count a single phone call or mailing as engagement; instead, we consider engagement to be commitment to participate in our programs. The engagement rate is much higher in instances where there is face-to-face conversation between provider and the member, which is why our focus on collaboration with providers leads to much better outcomes for members. To that end, we have embedded Care Advisors in high-density practices, which drives significantly higher engagement rates as a result of direct interaction.¹
- Clinical and financial outcomes
 - An impact study of our Care Management program based on 2018 data found that \$3 million of investment in the program generated \$15 million of reductions in medical spending and better engagement and health outcomes for members.
 - Over the past four years, we have realized an average savings per engaged member of \$6,500, equating to a 5:1 ratio. This is based on a case control study conducted to evaluate the impact of the Complex Care program. We observed that every engaged member had \$6,500 lower costs as opposed to comparable members in the control group. The return on investment (ROI) is estimated based on total savings for all engaged members and total staff costs for running the program.
 - Over the past five years, Passport's incentives and engagement strategies contributed to a significant decrease for the following:
 - 35% decrease in low birth weight deliveries
 - 37% decrease in very low birth weight deliveries
 - 39% decrease in pre-term deliveries (less than 37 weeks)
 - We compared the members who received intervention with a propensity score-matched control group. As a result of this exercise, we found:
 - Complex Care Cohort and Program (n=1,332) → 32% and 20% reduction in inpatient admissions and total medical expense, respectively
 - Transition Care Cohort and Program (n=1,016) → 14% and 8% reduction in 30-day all cause readmissions and total medical expense, respectively

¹ Source: ahrq.gov/professionals/systems/system/delivery-system-initiative/holtropstudysnapshot/index.html

- Catastrophic Care Cohort and Program (n=426) → 33% and 16% reduction in inpatient admissions and total medical expense, respectively
- Our Identifi-produced predictive models outperform industry standards by employing a unique approach—emphasizing not only predictive accuracy but also timeliness. We design and deploy care interventions based on the predictive model’s results. This ensures that not only the right members are stratified, but they are stratified early and at the most impactable moment before their health condition becomes more serious. **Exhibit B.1-6** illustrates how our suite of predictive stratification models target impactable future medical events.

Exhibit B.1-6: Predictive Models Outperform Industry Standards

		Performance
Ambulatory Care Sensitive Model	Predicts the risk of Inpatient/ED utilization for patients (includes peds) with one of five major chronic conditions	c-stat = 0.82
Readmission Risk Model	Real time identification of patients who are likely to be readmitted (unplanned) within 30 days of discharge for any reason	30% more accurate than commonly used LACE tool
Behavioral Health Risk Model	Predicts risk of a BH-related event (inpatient and ED); identifies patients with undocumented BH issues using alternative datasets	2x more accurate than using prior diagnosis alone

B.1.a.ii. Three (3) examples of initiatives the Vendor has implemented for Medicaid managed care programs that have supported improved outcomes. Describe whether such initiatives were cost effective and resulted in sustained change.

Passport has realized impressive outcomes and cost savings as we have improved health for members through the following collaborative initiatives for Kentucky’s Medicaid managed care program:

- 1) Helping Foster Children with Care Management and Support for a Brighter Future**
- 2) Community Health Workers Improve Health Outcomes Through Face-To-Face Interactions**
- 3) Partners in Wellness Program Improves Health for Members with Serious Mental Illness**

1) Helping Foster Children with Care Management and Support for a Brighter Future

Many children in foster care have complex health needs, including higher levels of physical, oral and behavioral health issues than the general pediatric population. A study by the Center for Health Care Strategies shows that children in foster care represent only 3% of children in Medicaid, but 15% of children in Medicaid using behavioral health services.² In addition, foster children represent 13% of those in Medicaid

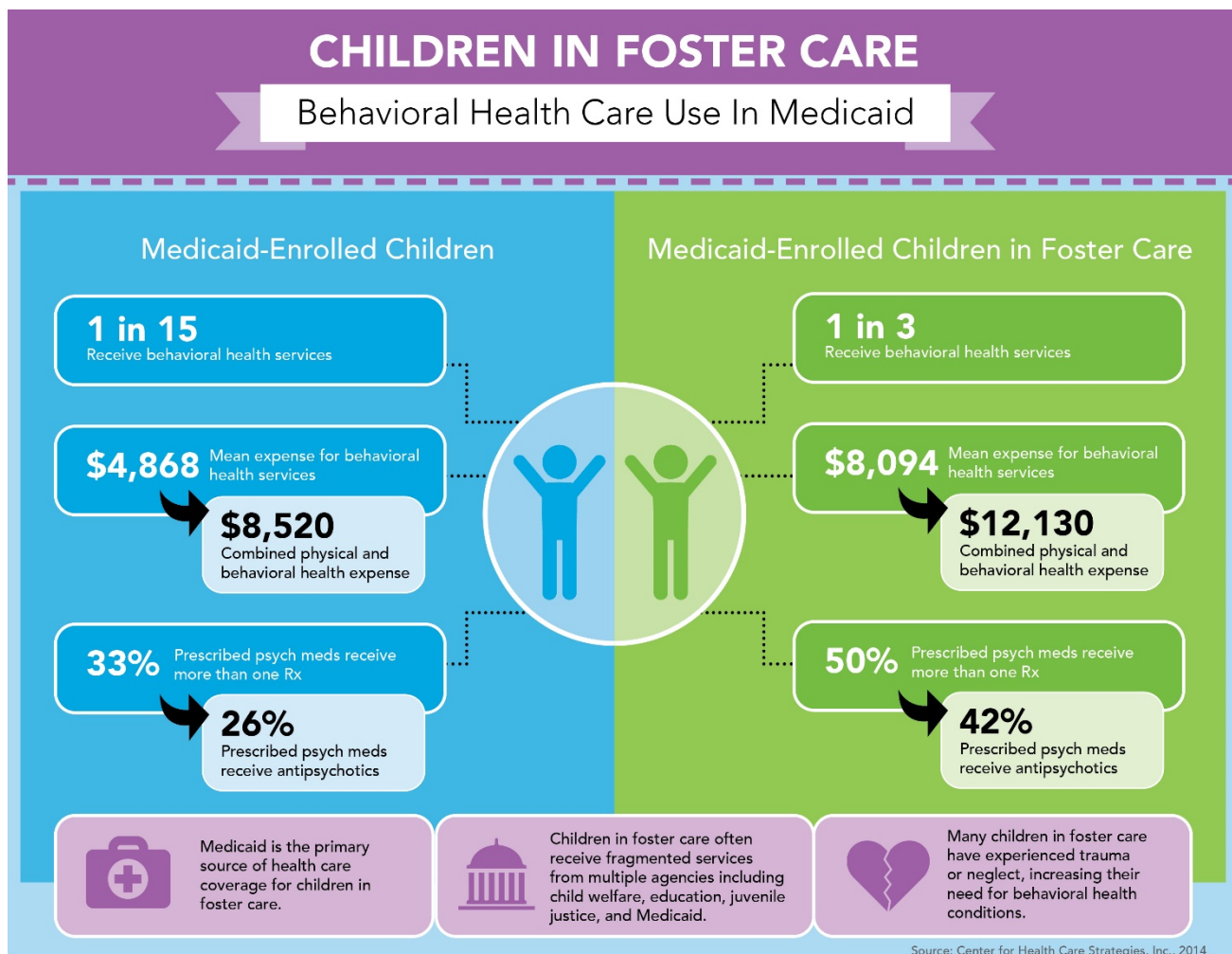
² Source: Centers for Health Care Strategies, Inc. (2014), “Children in Foster Care: Behavioral Health Care Use in Medicaid.”

receiving psychotropic medications, and they are four times more likely to receive these medications than children in Medicaid overall.

There are several factors contributing to the complexity of health care in this population. Foster children are often removed from their biological families due to neglect or abuse, and these traumatic experiences have significant impacts on their health. Foster care members tend to move frequently, and the transitions to new homes and new communities make it difficult to establish a medical home and proper continuity of care.

The individuals caring for foster children also face difficulties. Caregivers and providers often do not know the child’s full medical and developmental history. Without this information, it is challenging to ensure the child has proper care management. Due to their behaviors—which are often adaptations that help them cope with their difficult situations—and lack of information and coordination of care, foster children are prescribed psychotropic medication at a higher rate than other children. This can lead to the overuse of antipsychotic medications and to further medical complications, as illustrated in **Exhibit B.1-7**.

Exhibit B.1-7: Children in Foster Care: Medicaid Behavioral Health Care Use



Passport has a specific Foster Care program to provide the needed care and guidance for these vulnerable children. Serving as their advocate, our Foster Care specialists provide foster children with compassionate and caring support during their transition and time in Department of Community Based Services (DCBS) care. The specialists develop a relationship with the foster children, their caregivers and their social services workers and attentively listen to their concerns and answer any questions they have. Our team focuses their attention and care on the member and caregiver, compassionately guiding them throughout the program.

Passport helps the caregiver identify a PCP to serve as the medical home for the foster child members. The CM process entails performing physical and behavioral health assessments, and monitoring for care gaps, psychotropic medication use and dental care. A member-centric care plan is developed and continuously monitored by our foster care specialist during the duration of the program.

The foster children care planning process includes:

- Reviewing whether third-party liability is on the member's record
- Evaluating the most recent EPSDT exam and provider claims review to check for other well visits, chronic conditions, frequent ED visits, inpatient hospitalizations, etc.
- Reviewing medical, dental, vision, and pharmacy utilization
- Determining whether the member is currently receiving BH services
- Reviewing existing care notes and communications

The foster care specialist performs regular follow-up visits or phone calls and assesses the foster child's progress and notes any findings and further actions required. All information regarding the member's care is documented and recorded in the member's electronic medical record for proper care coordination.

Each foster care specialist is assigned to specific regions across the state to develop collaborative relationships with key state stakeholders and community partners. They serve as liaisons between Passport and DCBS, private foster care agency staff, foster parents and other social services entities. As a part of their role, the foster care specialist continuously communicates with all key stakeholders involved with the foster children's care to review the care plan progress and make updates as needed.

An Innovative Approach to Improving Foster Children's Health and Well-Being

Passport conducted a pilot program providing intensive care management for children and youth in foster care. For the initiative, we partnered with two local provider organizations, Centerstone Kentucky (Seven Counties Services) and ResCare, to provide intensive care management services using a high-fidelity wraparound approach. The pilot program proposed to serve 60 high-risk children between the ages of 4 and 17.5 years old who experienced three or more placements within 24 months and were at risk for entering a group home, psychiatric hospital or 24-hour BH treatment facility. Our goals were to increase the foster child's health and well-being, permanency in the family home, and community placement, and provide needed support to the caregiver. The pilot program was designed for 12 months with a six-month follow-up period. During this time, we continuously monitored and measured the goals for:

- Reduced cost of care
- Improved school attendance and academic performance
- Increased behavioral and emotional strengths
- Improved clinical and functional outcomes
- Increased stability of living situations
- Improved the caregiver’s work attendance
- Reduced suicide attempts
- Decreased contacts with law enforcement

The program assessed the goals with a combination of claims and cost data analysis, interviews and behavioral inventories, specifically the Child and Adolescent Function Assessment Scale (CAFAS). The CAFAS used information from eight life domains: school, home, community (delinquency), behavior toward others, moods and emotions, self-harm, substance abuse, and cognitive thinking (irrational thoughts). The program participants were scored at intake and every three months during the program.

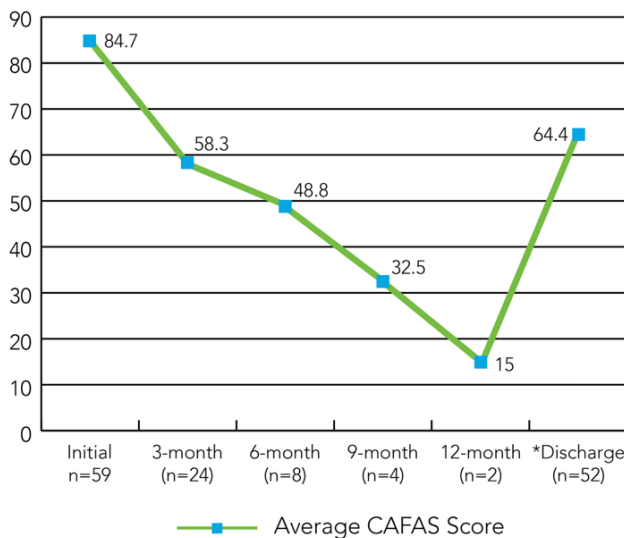
We deployed a high-fidelity wraparound-based team decision-making process, promoting youth and family voice and choice in the health care process and clinical interventions. The program was facilitated by the intensive care manager, and the care team members comprised of the child, identified family or foster family member, DCBS social services worker, treatment providers, Passport clinician and informal network support members.

Improved Outcomes, Cost-Effectiveness and Sustainable Change

Improved outcomes: The children’s health and well-being also increased during the program, with declining CAFAS scores as a positive indicator. Furthermore, the longer the child participated in the program, the more the scores improved, as illustrated in **Exhibit B.1-8**.

Exhibit B.1-8: Foster Care Intensive Care Pilot Study Improved CAFAS Scores

CAFAS Total Score Over Time

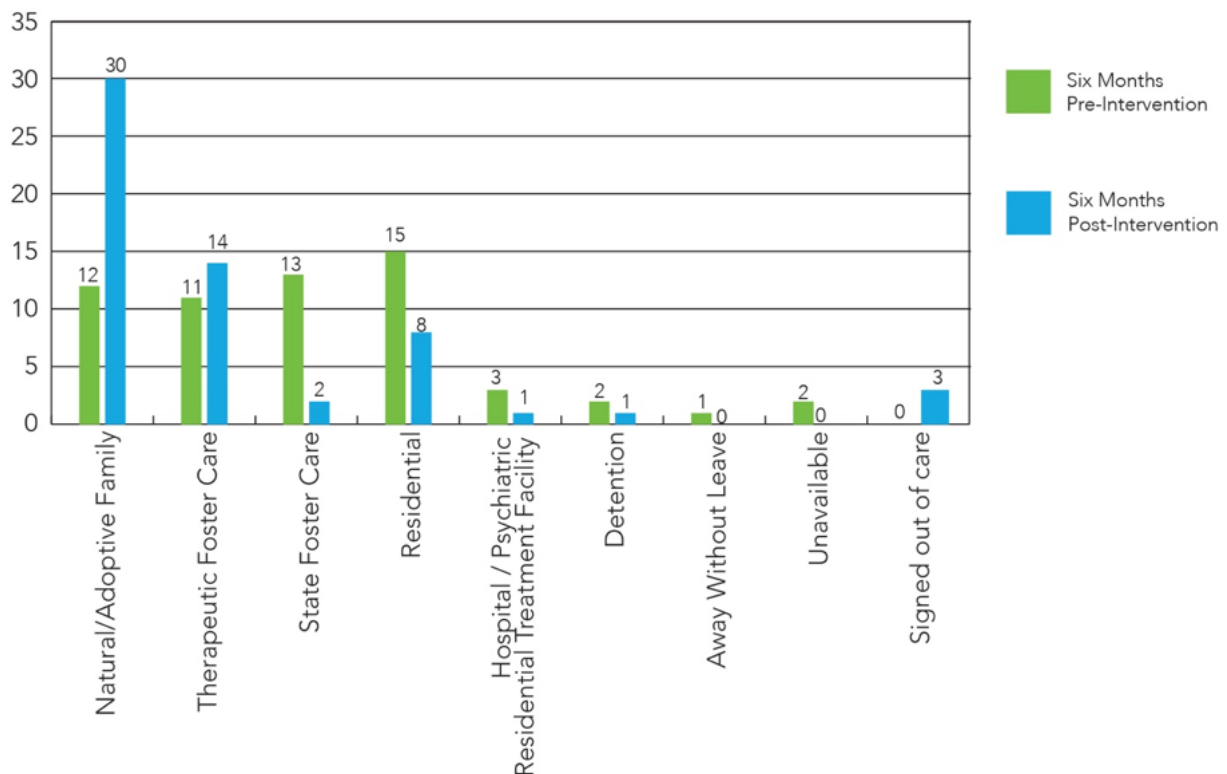


Cost-effectiveness: The pilot program demonstrated that by using an innovative model of interventions for children and youth in foster care, we were able to improve outcomes and decrease costs. Specifically, there was a 150% increase in children being reconnected with their biological or adoptive family six months post-intervention and foster care placement, while the number of children placed in residential care (including psychiatric hospitalization, private childcare residential treatment and detention centers) decreased.

Sustained change: Passport followed these children six months prior to intervention, with placements six months post-intervention, and found sustained change. As shown in **Exhibit B.1-9**, six months post-intervention, over half of the participants were living with their natural family. This was a 150% increase in children living with natural family members compared with six months prior to intervention. Therapeutic foster care also saw an increase of 27% post-intervention. All other placements decreased, some dramatically so. For example, there was a 47% decrease in participants being in residential care. The target goal was 80% of children served by the pilot will be maintaining their current placement or stepping down to a lower level of care. In the follow-up period, 82% of the youth served were either with natural family, a DCBS foster home or in therapeutic foster care.

Exhibit B.1-9: Placements Six Months Pre- and Post-Intervention

Placements 6 Months Pre and Post Intervention



Passport's Dr. David Hanna and Stephanie Stone presented the findings from our foster care pilot at the national Family Focused Treatment Association (FFTA) conference in July 2019. We want to share our experience with others and get feedback on how we might further our pilot concept. We previously presented during our implementation phase at the Children's Mental Health Research and Policy conference with representatives from the Department of Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID) and DCBS about how an MCO and state government agencies uniquely collaborated to create a piloted solution for our state.

2) Community Health Workers Improve Health Outcomes Through Face-To-Face Interactions

In 2018, we implemented a new program enhancement where our CHWs conduct face-to-face visits in the members' homes, provider offices, and in community service organizations. Currently, there are seven CHWs concentrated in an area of Louisville where Passport has a large member population with health outcomes that have historically been lower than for the rest of our population. The CHWs serve as advocates in helping members to schedule doctor appointments, obtain the necessary resources to resolve SDoH, and assess for any literacy and interpretation services needed.

The CHWs use the Healthify resource solutions tool to assist members with SDoH. They first conduct an online questionnaire with the member to gain insights into their personal situation. Using the results of the questionnaire, they search for the most appropriate community resources and social services to fit our members' needs. The Care Coordinators and Care Advisors also use the Healthify resource solutions tool to assist members with finding resources for SDoH. This information is provided to the member, teaching them to become engaged in their health care and take charge of making the resource arrangements. We also proactively make the appropriate appointments on behalf of our members, if preferred, so that they can obtain the needed resources with convenience.

The Healthify tool offers referral information for the following:

- **Behavioral health:** Treatment and supportive services for mental health and SUDs, including rehabilitation, psychiatry, support groups and therapy
- **Education:** Services that provide and promote education, including academic scholarships, special education programs, early childhood education programs, tutoring services, English as a Second Language (ESL) classes and General Educational Development (GED) programs
- **Emergency services:** Immediate and short-term emergency services assistance, including mental health crisis intervention services, emergency shelters, emergency financial assistance, disaster preparedness and response services, and heating and cooling centers
- **Family and youth:** Support services to families and youth, including family counseling, adoption and foster care services, childcare programs, infant and child supplies, parenting support and education, and youth empowerment programs
- **Financial support:** Assistance paying for housing, education, food, transportation, medical expenses, and so on, or that is aimed at improving financial literacy, such as financial education and tax preparation assistance

- **Food services:** Access to adequate and nutritious food, including food delivery, free or low-cost meals, food pantries, food vouchers and farmers' markets
- **Goods services:** Basic goods such as clothing, furniture, medical supplies, and toiletries for free or at a reduced cost
- **Health services:** Resources for navigating, accessing, and paying for health services, including primary and specialist care, medical bill and prescription assistance, wellness programs, health insurance enrollment assistance, and harm reduction services
- **Housing:** Services aimed at improving access to safe and affordable housing, including housing counseling, emergency shelters, low-income housing, financial assistance, supportive housing, and home repair services
- **Legal:** Legal support and advocacy services, including free or low-cost legal representation, citizenship application assistance, support services for individuals involved in the criminal justice system, and assistance with obtaining and changing identity documents
- **Social supports:** General community support services, such as community centers, case management, and benefits assistance, as well as services that are population-specific, such as LGBTQ services, disability services, senior services, and HIV/AIDS services.
- **Transportation:** Services for accessing and paying for transportation, including car repair assistance, free or low-cost transportation, disability-accessible transportation, and driver's education.
- **Employment:** Resources for workers and job seekers, including job search assistance, career counseling, job training resources, supported employment, retirement, and unemployment benefits assistance.

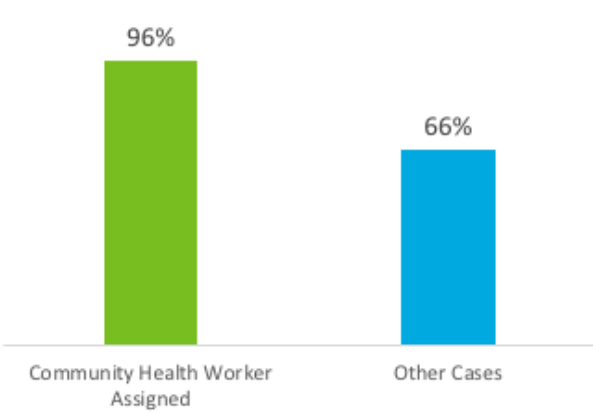
Passport's staff tracks all referrals and activities in our integrated system for proper care coordination. The technology enables us to better serve the most vulnerable population in an expedited manner.

Improved Outcomes, Cost Effectiveness, and Sustainable Change

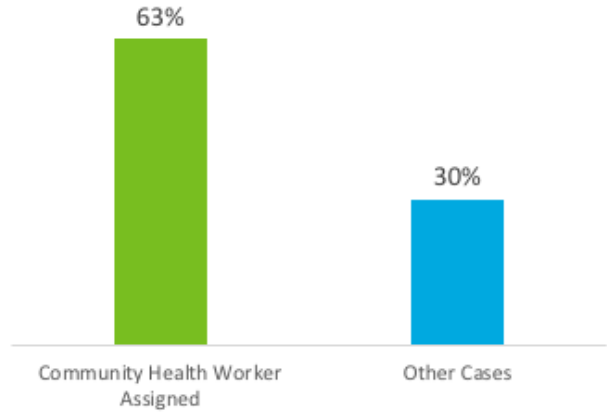
The outcomes reveal that the Community Health Workers initiative increases members' engagement levels and CM program graduation rates. In this program, using CHWs to support our Complex Care program, we found that members' engagement levels increased by 41% and their graduation rates improved by 110% compared to other CM cases. This **resulted in an ROI of nearly 5:1**, demonstrating the cost effectiveness of using CHWs to support our clinical Care Advisors. Since the pilot, we have expanded the program by more than doubling the number of CHWs and have observed similar results, suggesting the intervention is not only cost effective, but also scalable and sustainable. Details of the pilot study are illustrated in **Exhibit B.1-10**.

Exhibit B.1-10: Pilot Study Results of Community Health Workers Program: Engaged Members

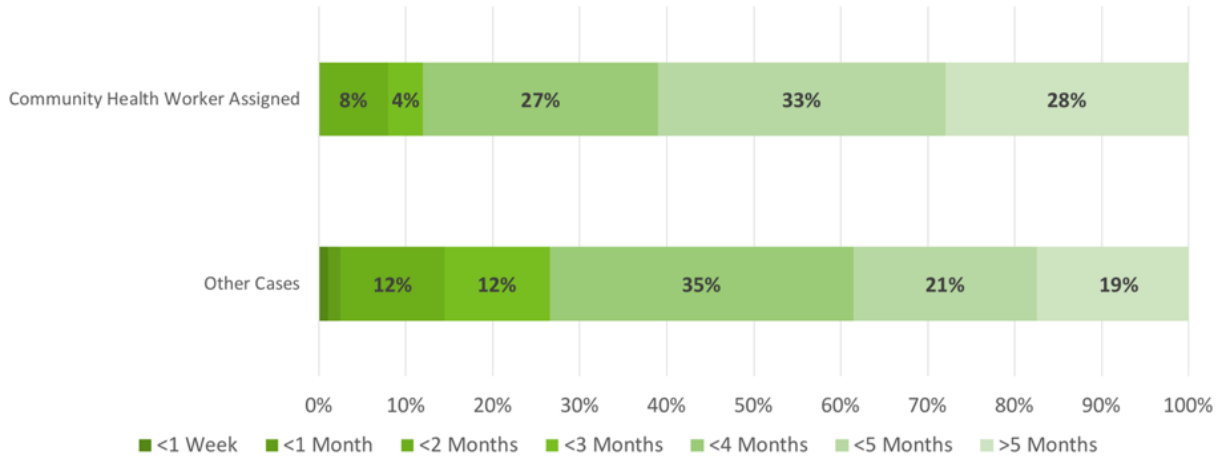
Outreach Rate



Graduation Rate



Complex Care Length of Engagement (Engaged to Closed Date)



3) The Partners in Wellness Program Improves Health for Members with Serious Mental Illness

As part of Passport’s Partners in Wellness program, we collaborated with BH provider Centerstone Kentucky (Seven Counties Services) to provide hands-on complex CM as part of their value-based agreement to deliver the service.

Services included reconciliation of medications, screening and referral to treatment for SUDs, monitoring of blood pressure and body mass index (BMI), referral to dental care, connection to unmet social needs

(SDoH), and screening for diabetes for members with schizophrenia or bipolar disorder prescribed antipsychotics.

Performance incentives were tied to activating members to participate in improving their health and documenting progress toward reaching a health behavior goal, including number of members who smoked and were offered smoking cessation, members who engaged in at least 30 minutes of exercise per week, members who received an annual physical, members' progress toward improving performance on Healthcare Effectiveness Data and Information Set (HEDIS) targets (including follow-up after hospitalization, schizophrenia measures, and alcohol or drug dependence measures), and increased access to social supports.

Centerstone Kentucky (Seven Counties Services) had the opportunity to earn a percentage share of the pool created by savings after the intervention for medical inpatient cost, ED cost and BH inpatient cost. The provider could earn up to 50% of the pool for having achieved savings in these three areas. The other 50% was tied to quality measures of increasing member activation and documenting progress toward a health goal.

Improved Outcomes, Cost Effectiveness, Sustainable Change

The following outcomes were achieved as a result of this unique collaborative program:

- **Longevity:** On average, people with severe mental illness die 25 years sooner due to their comorbid health conditions. We created an integrated program that brings medical case management into the relationship of trust with the BH provider and brings the issue of longevity into the discussion.
- **Improved Outcomes:** Achieved goal of increasing management of health in a community-based setting:
 - 45% reduction in inpatient hospital days
 - 27% reduction in ED visits
 - 69% reduction in hospital readmissions
- **Cost Effectiveness: 63% reduction in combined medical inpatient, ED and BH inpatient expenses**
- **Sustained Change: 142 members with severe mental illness were served for up to six months each over a nine-month period.**
 - Centerstone Kentucky (Seven Counties Services) is expanding this model to other clients.
 - There are plans to study the longer-term impact of this program for the members served.

B.1.a.iii. A summary of lessons learned from the Vendor's experience providing similar services to similar populations.

B.1.a. iv. How the Vendor will apply such lessons learned to the Kentucky Medicaid managed care program.

Through Passport's years of service to the Commonwealth and extensive work with other Medicaid populations across the nation, we have a profound appreciation for this simple truth: Medicaid populations are diverse and full of unique challenges. What works for one region of a state does not always work for

another. Thanks to this long-range perspective and dedication to Kentucky, our immersion in this market and spirit of continuous improvement has highlighted the 10 lessons described in the sections that follow.

These valuable lessons from our experiences have influenced our service model, day-to-day activities and long-term planning, ultimately shaping our service plan for the Commonwealth, members and providers. Through a combination of local and national support, Passport will draw on our lessons learned in Kentucky and across the nation as we strive to continually find new and better ways to improve the health and quality of life of our members while reducing costs for the Commonwealth.

Lessons Learned

1. Aligning for Clear Organizational Accountability Drives Better Results
2. Deploying an Integrated Administrative Platform Prepares for the Future
3. Restructuring Our MOC Engages More Kentucky Medicaid Members
4. Partnering Directly with Providers Achieves Better Coordination of Care
5. Incorporating Community Feedback Improves Processes to Meet Kentucky’s Evolving Needs
6. Customized Tactics Are Required for Unique Segments of the Kentucky Population
7. Reaching Members Requires Collaboration with Multiple Stakeholders
8. Personalized and Face-to-Face Interaction Increases Engagement with Members
9. An Integrated and Holistic Medicaid MOC Is Important
10. It is Beneficial to Apply Lessons Learned from Other Markets

1. Aligning for Clear Organizational Accountability Drives Better Results

Lesson Learned

Passport has recognized the criticality of having unambiguous accountability for performance within the organization. In the complex, interdisciplinary realities of plan operations, allowing processes or structures with too many organizational handoffs, either within the organization or with subcontractors, can create performance gaps if accountability is unclear.

Application of Lesson for Positive Impact

Passport has made advancements in its leadership and accountability frameworks in the last year, with many actions taken recently to reinforce these structures. As a result of the growing relationship with Evolent, Passport has been able to further refine our organizational structure to create alignment, high levels of accountability and measurement mechanisms. This bolstered rigor is reflected in the following:

- Accountability for performance is deeply embedded in the organization structure, with clear lines of authority up to the chief executive officer (CEO) and the Board of Directors. Passport's Board of Directors, composed of community and industry leaders as well as provider owners, has total governance authority for the program that is administered on behalf of the DMS. Passport's CEO, Scott Bowers, is directly accountable to the Board of Directors. Scott is a veteran Medicaid managed care executive and manages a team of executives that report directly to him who direct the day-to-day operations. This team brings a combination of local knowledge and national experience. Many of the executive leadership team are Kentuckians by birth, and all have more than 10 years of experience in health care leadership and/or managed care. This combination is vitally important to translating programs for implementation in our communities.
- The focus of the leadership team at all levels is aligned with our program goals, and clear objectives are fully integrated into these leaders' job descriptions, performance monitoring and compensation models.
- Distinct oversight committees and governance bodies perform fiduciary oversight of the management team yet allow Passport leadership to have full management authority and control over day-to-day performance of the health plan.
- Through our expanded partnership, we are now able to also leverage an increased amount of expertise and resources from other Medicaid plans across the nation. By refining our organizational structure, we are able to move some positions that previously might have been split across subcontractors into Passport. This enables us to reduce redundancies, create efficiencies, establish greater accountability, and streamline reporting and authority structures.

2. Deploying an Integrated Administrative Platform Prepares for the Future

Lesson Learned

An integrated administrative platform has the power to change the trajectory of health outcomes, service quality and cost. When systems are disjointed, we lose the benefit of real-time, holistic views of the operating and clinical landscapes and the underlying data that provides actionable insights, and thus cannot act proactively with maximum effect. By minimizing separately operated components of service and leveraging a central platform, we open the door to added sophistication in data modeling and the feedback loops that allow for continual evidence-based iterations.

Application of Lesson for Positive Impact

At the end of 2017, Passport converted to a new integrated administrative platform to improve service quality by making our operations and member services more scalable and agile. This involved a full migration to an integrated system for eligibility, claims and call center operations. Our leadership team knew that an implementation of this scope and size would be complex and multifaceted, and that we could encounter complications with such a large-scale shift in systems and processes. For example, during the implementation, we experienced challenges with member eligibility data, data configuration and encounters. The Passport team immediately began working to resolve these problems. We have resolved the implementation issues and are now seeing improved results in line with our core objectives that drove the move toward an integrated platform. We have remained committed to the belief that this

administrative platform married with clinical operations will bring faster, deeper insights and serve as the springboard for program innovations. We have evidence of this benefit, including ROI measurements and outcomes of clinical programs.

3. Restructuring Our Model of Care Engages More Kentucky Medicaid Members

Lesson Learned

Passport's traditional model emphasized what might appear to be the most obvious or pressing issue facing the individual (e.g., out of control A1C for patients with diabetes) and tended to engage the member when it was too late to avoid admissions or unwanted episodes. By using machine learning and routinely focusing holistically on all the underlying issues facing the individual, such as BH and social or environmental barriers, the true drivers of the disease are addressed and mitigated much more effectively. In addition, these traditional models failed to maximize the total member population that can be supported for better health outcomes, as they relied on inbound member- or provider-initiated referrals for participation in a care program.

Application of Lesson for Positive Impact

Historically, Passport conducted disease management programs in a way that was very similar to other MCOs in that it was heavily reliant on referrals directly from providers or members themselves. While this model had some impact and benefits, there was often bias in the selection process, and it inherently limited enrollment growth in programs that could have a substantial impact on overall health outcomes. While the previous model led to high satisfaction of those enrolled in programs, graduation rates were not as high as would be expected. Also, when looked at critically, it became clear that many members who needed help were being missed by this inbound approach. These gaps occurred for several reasons, including the following:

- Lack of self-referral
- Lack of provider referral
- Lack of member engagement with providers
- Disproportionate attention devoted to members who had less intense needs that were being managed through self-care

Passport took the following actions to restructure the MOC:

- In 2016, Passport began to deploy a new, comprehensive, member-centric population health model. Passport fundamentally changed our MOC by fully integrating the member's physical well-being, BH, oral health, pharmacy and SDoH services across the entire health care spectrum. We are acutely aware that medical and BH issues are tightly interconnected, and that the effects of chronic medical conditions, prolonged stress, poverty and trauma can have direct and devastating effects on members and their families. Our experience indicates these factors are deeply rooted in SDoH that can contribute to physical and BH complications. We have used our experience to develop our MOC to address the "whole person" to better serve our members in improving their health and quality of life.

- We established strong clinical leadership focused on developing and deploying this new MOC and establishing clear accountability and goals for member impact. As a result, all clinical and quality results are the responsibility of the PHM director, the vice president (VP) of Clinical Operations, and the VP of Health Integration under the oversight of the chief medical officer (CMO). The chief operating officer (COO) has accountability for all health plan operations that are necessary to ensure successful execution of this and all other Passport programs.
- We deployed IT and data integration strategies for action and insights. This new program design also highlighted the need for actionable information to appropriately identify and stratify members for intervention. This has been accomplished via the integration of our data warehouse and will continue to evolve under the direction of our Management Information System Director. This data model allows for a proactive approach based on predictive modeling, to target outreach and engagement to a far larger population than that traditionally reached, and does so early in the process, when engagement can circumvent catastrophic health events and address root issues to decrease the severity of comorbid conditions. This metrics-based view also brings greater focus to key indicators such as graduation rates, decreasing admissions and cost avoidance.

Passport has realized positive outcomes because of this transformation in our PHM program. We have learned that integrating our services and approaching programs from a whole-person perspective is well-received by members and providers and benefits overall health outcomes and the financial bottom line. This impact is summarized in **Exhibit B.1-11**, which shows the relative difference in impact between members engaged in our programs compared to matched control group – or members who are not engaged but are statistically similar to participants on demographics, historical cost and utilization, chronic conditions and risk score, as well as social determinants. These results reflect the impact six months after engagement in our programs.

Exhibit B.1-11: Impact of Passport CM Program and Overall MOC

	Total Medical Expense	Inpatient Admissions	ED Visits
Transitions Care (n=1016)	▼ 8%	▼ 14%	▼ 8%
Catastrophic Care (n=426)	▼ 16%	▼ 33%	▼ 16%
Complex Care (n=1322)	▼ 20%	▼ 32%	▼ 35%

4. Partnering Directly with Providers Achieves Better Coordination of Care

Lesson Learned

Without strong provider coordination, we cannot maximize member health outcomes and depth of member engagement. A common theme we see behind low-cost, high quality Medicaid managed care is close collaboration with provider partners. As a provider-owned plan, Passport has always been a firm believer in

the importance of collaborating with providers with the goal of improving the health and quality of life of our members at both an individual and population level. We believe that sharing and exchanging information and building positive relationships with our provider networks is central to this goal.

Application of Lesson for Positive Impact

The subsections that follow describe examples of Passport’s application of this insight.

We embedded Care Advisors and social workers to work within provider offices and hospitals. We have learned that if a member receives a call from Passport in connection with a provider’s office—such as a Passport Care Advisor calling from a PCP’s office—the member is much more likely to respond and engage in his/her care. Based on publicly available information, the engagement rates for disease management among health plan members is about 13%.^{*} In contrast, the engagement rates at Passport have been consistently high, at 40% or higher. In addition, the engagement rate is much higher in instances where there is a face-to-face conversation between the provider and the member. We have embedded Care Advisors in high-density practices where we see higher engagement rates as a result of direction interaction. Beyond this member-based engagement, this strategy builds deeper connections with individual providers to observe and respond to site-of-care insights.³

We launched pilot programs in close partnership with providers. We are now observing an increased trend of cost savings and positive health and engagement outcomes through close analysis of several recent pilot programs and grants. The subsections that follow describe a representative sampling of these programs.

Emergency Department Reduction Pilot with Park DuValle

The Quality and Population Health Management teams collaborated on 2019 Performance Improvement Project (PIP) intervention aimed at reducing Potentially Preventable Hospital Admissions and ED Visits due to ACSC. Passport has laid the foundation for collaboration with Park DuValle when they are ready to fully launch the intervention. When implemented Passport will provide emergency room utilization information to Park DuValle Community Health Center and in turn, Park DuValle staff outreaches to members who had an ER visit to try to get them in to see their PCP. They will also educate members on appropriate ER use.

These efforts build on Park DuValle’s year-long efforts to coordinate care for its members. The provider gets a daily email from a care coordinator at Norton Hospital alerting them of any Park DuValle member who has visited or been admitted to the ED. Park DuValle then starts their own transition checklist that they use to make sure these members schedule a follow-up with their PCP and any specialist visits needed, obtain necessary medications, receive education about appropriate ED usage, etc.

³ Source: <https://www.ahrq.gov/professionals/systems/system/delivery-system-initiative/holtropstudynapshot/index.html>

Based on preliminary data, ED utilization rates among Park DuValle’s members in this program are lower than market averages. Passport’s provision of ED utilization information from other facilities beyond Norton will increase the success of this initiative.

Partners in Wellness Program

As described in full detail in **Section 2**, we partnered with our largest BH outpatient provider, Centerstone Kentucky (Seven Counties Services), to provide hands-on complex CM as part of their value-based agreement to deliver the service. We created an integrated program called “Partners in Wellness” that would bring medical case management into the relationship of trust with the BH provider. Working with this provider, we supported the development of infrastructure and systems to allow for proactive member outreach. By starting with data exchanges and stratification support, we created the opportunity for Centerstone Kentucky (Seven Counties Services) to engage with both populations of members that had engaged in their care and those that had not yet done so.

This unique collaborative program achieved the following:

- 142 members with severe mental illness were served for up to six months each over a nine-month period.
- There was a 63% reduction in combined medical inpatient, ED and BH inpatient expenses.
- We achieved the goal of increasing management of health in a community-based setting, as demonstrated by the following:
 - 45% reduction in inpatient hospital days
 - 27% reduction in ED visits
 - 69% reduction in hospital readmissions

This collaborative program development sets the stage for expansion of value-based arrangements with Centerstone Kentucky (Seven Counties Services). Together we identified critical data and metrics upon which future program expansions can be built and reliably measured.

Grant to Kentucky Children’s Hospital for Teen Suicide Prevention

Teen suicide rates tripled between the years of 1952 and 1992. Today, those aged 10-20 years are underrepresented in the current health care system due to their usually good health. Only 5% of deaths among this age group are due to illness; the remainder are due to accident, homicide or suicide. In Kentucky in 2013, 46 teens died from suicide, whereas only six died from diabetes. Yet, Kentucky spent only \$0.01 on teen suicide prevention for every \$700 spent on diabetes research. Kentucky Children’s Hospital’s teen suicide prevention program has been attributed with saving somewhere between 2,000 and 3,000 teens from committing suicide between 1997 and 2014. Passport provided a three-year grant to Kentucky Children’s Hospital to bring this pilot program to the Louisville area.

Over three years, this program completed 2,320 preventive visits, identified 243 high risk teens and performed 2,010 total intervention visits in Harrison County, Kentucky. Many poor outcomes were prevented, and there were no completed suicides. The community requested a larger presence for the program, and a clinic was established at Harrison County Hospital once a week. The local health department,

WEDCO, committed to funding the project permanently. The program was later expanded to include Lincoln County.

At least 15% of the members seen were Passport members. Due to the implementation of this program, we were able to avoid Medicaid payments through Passport for approximately 150 clinical visits. This has also helped to avoid costs for other MCOs and will help reduce overall Medicaid costs for this population due to the program's permanent implementation in this community.

Psychotropic Drug Intervention Program

Passport's Psychotropic Drug Intervention Program (PDIP) began in April 2014 and serves as the foundation for the enhanced RxSolve program. PDIP was designed to run an algorithm on pharmacy claims and notify members and providers whenever members had not refilled psychotropic prescriptions as prescribed (the intervention); when there were multiple drugs prescribed from the same psychotropic drug class, suggesting possible polypharmacy; or when a prescription for a psychotropic drug had been written for a suboptimal dosage. About 10% of psychotropic medicines prescribed are prescribed by a psychiatric provider (either a psychiatrist or a psychiatry nurse practitioner). This provides an additional level of support for our members who are receiving psychotropic medications.

Pharmacy claims data was analyzed after the members and providers were notified to see if the notice resulted in a change in behavior. Following the notification and time for potential change in behavior, the members were split into two groups: those associated with a changed behavior and those associated with a lack of changed behavior for each of the three algorithms.

Next, costs for members associated with the behavior change were subtracted from costs for members associated with a lack of behavior change to calculate the net PMPM return. The net savings was then multiplied by the PDIP outcome for that particular algorithm type (percent change in Medication Possession Ratio for non-adherence, behavior change rate for polypharmacy, and suboptimal dosing) to calculate the PDIP savings.

Lastly, the PDIP savings for each category of costs (hospital admissions, ED visits and prescriptions) were summed and multiplied by member months associated with the particular algorithm type to calculate the total savings.

As detailed in **Exhibit B.1-12**, over a four-year period (April 2014 to March 2018), Passport's PDIP achieved the following⁴:

- Total savings for adherence interventions: \$3,510,122
- Total savings for polypharmacy interventions: \$3,172,867
- Total increased spend for suboptimal dosing: \$198,468⁵.

⁴ The reported savings may not be solely attributed to PDIP interventions, as there are other factors unknown to us that could potentially impact the analysis. Such factors include, but are not limited to, benefit design, network reimbursement, changes in health plan drug costs, and formulary design.

⁵ Although suboptimal dosing resulted in more spend overall, the member should have received more efficacious treatment based on increasing the amount of medication prescribed to recommended dosages.

Exhibit B.1-12: PDIP Outcomes and Savings (April 2014 – March 2018)

Intervention	April 2014 – March 2015				April 2015 – March 2016			
	Intervened & Changed Behavior	Intervened & No Behavior Change	Net PMPM Savings	PDIP PMPM Savings	Intervened & Changed Behavior	Intervened & No Behavior Change	Net PMPM Savings	PDIP PMPM Savings
Cost Type for Adherence								
Hospital Admissions	\$175	\$209	\$34	\$7	\$162	\$222	\$60	\$10
Emergency Department	\$40	\$53	\$13	\$3	\$39	\$53	\$14	\$2
Prescription	\$270	\$313	\$43	\$9	\$264	\$351	\$87	\$15
Member months	19,144	18,485	37,629	37,629	24,952	27,646	52,598	52,598
Total Adherence Savings			\$3,422,577	\$718,741			\$8,443,485	\$1,460,757
Cost Type for PolyPharmacy								
Hospital Admissions	\$323	\$200	(\$124)	(\$82)	\$353	\$221	(\$132)	(\$76)
Emergency Department	\$51	\$53	\$2	\$1	\$55	\$56	\$1	\$1
Prescription	\$534	\$603	\$68	\$45	\$549	\$567	\$318	\$183
Member months	4,146	1,988	6,134	6,134	5,082	3,167	8,249	8,249
Total PolyPharmacy Savings			(\$330,837)	(\$219,345)			\$1,541,320	\$887,800
Cost Type for SubOptimal								
Hospital Admissions	\$56	\$150	\$94	\$60	\$221	\$305	\$84	\$48
Emergency Department	\$48	\$61	\$13	\$6	\$53	\$40	(\$13)	(\$7)
Prescription	\$205	\$322	\$116	\$74	\$520	\$351	(\$169)	(\$97)
Member months	556	406	1,292	1,292	1,219	629	1,848	1,848
Total SubOptimal Savings			\$288,469	\$183,465			(\$180,512)	(\$103,975)

		April 2016 – March 2017				April 2017 – March 2018			
Intervention	Intervened & Changed Behavior	Intervened & No Behavior Change	Net PMPM Savings	PDIP PMPM Savings	Intervened & Changed Behavior	Intervened & No Behavior Change	Net PMPM Savings	PDIP PMPM Savings	
Cost Type for Adherence									
Hospital Admissions	\$184	\$204	\$20	\$2	\$55	\$110	\$52	\$6	
Emergency Department	\$44	\$52	\$8	\$1	\$20	\$38	\$18	\$2	
Prescription	\$269	\$337	\$68	\$7	\$253	\$312	\$59	\$6	
Member months	25,824	21,941	47,766	47,766	30,310	32,591	62,900	62,900	
Total Adherence Savings			\$4,587,224	\$463,310			8,105,739	\$867,314	
Cost Type for PolyPharmacy									
Hospital Admissions	\$250	\$273	\$23	\$17	\$103	\$106	\$3	\$2	
Emergency Department	\$57	\$57	(\$1)	(\$1)	\$29	\$45	\$19	\$11	
Prescription	\$520	\$844	\$324	\$240	\$558	\$741	\$183	\$101	
Member months	4,659	2,075	6,733	6,733	4,662	2,184	6,046	6,046	
Total PolyPharmacy Savings			\$2,329,969	\$1,726,507			\$1,406,700	\$777,905	
Cost Type for SubOptimal									
Hospital Admissions	\$161	\$55	(\$106)	(\$74)	\$45	\$130	\$84	\$50	
Emergency Department	\$43	\$44	\$1	\$0	\$33	\$25	(\$8)	(\$5)	
Prescription	\$504	\$377	(\$127)	(\$89)	\$416	\$339	(\$77)	(\$46)	
Member months	1,279	423	1,702	1,702	1,482	506	1,988	1,988	
Total SubOptimal Savings			(\$394,854)	(\$276,003)			(\$3,302)	(\$1,955)	

5. Incorporating Community Feedback Improves Processes to Meet Kentucky's Evolving Needs

Lesson Learned

Regular proactive solicitation of feedback allows for continuous program improvements and is critical as the needs of the community evolve. As a provider-owned, community-based plan, we will continue to evolve and make decisions based on proactive feedback and input from our associates, providers, community partners and members. We approach every initiative with a sense of humility, knowing that often those who can help us determine how to best serve members are those who work directly with them on a daily basis. Seeking this input allows us to understand members' unique challenges and barriers. We are then able to incorporate this perspective into our planning, thereby creating and continually adjusting our programs to better meet the unique needs of Kentucky Medicaid members and the providers and agencies serving them.

Application of Lesson for Positive Impact

Incorporating Feedback from Committees

In addition to our Partnership Council and Quality Member Access Committee (QMAC) as central forums to hear the voice of our wide variety of stakeholders, we also leverage several smaller, more focused committees—such as our Behavioral Health Advisory Committee (BHAC)—in our decision-making processes.

Example: Collaboration Creates Solution that Benefits Members and Providers for Applied Behavioral Analysis Services

When Passport identified that multiple providers were hesitant to join the provider network and deliver Applied Behavioral Analysis (ABA) services, our Health Integration team spent time working with providers to better understand the root of the issue. It was determined that the codes recommended for these services nationally were not part of the DMS fee schedule and were not allowed to be used in Kentucky. We collaborated with Kentucky ABA providers to develop a complete list of codes that were used nationally for these unique services and endorsed by these providers. In review and collaboration with DMS, the code list was expanded. This effort reduced concerns and barriers to provider participation and supported broader availability of these needed services for members.

Example: Collaboration with Providers and State Medicaid Agencies on SBIRT Codes Receives National Best Practice Recognition

Passport is one of seven safety-net health plans from around the country that committed to a joint three-year learning project to help increase the identification of youth who are at risk for SUDs.

The project, led by the Center for Health Care Strategies in partnership with the Association for Community Affiliated Plans (ACAP), makes extensive use of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is an evidence-based approach for identifying members who are at risk for abuse of alcohol or drugs, and is intended to identify not only those members who have SUDs but also those who are at high risk for developing such a disorder, and to reduce their level of risk.

The project that Passport has developed for the effort involves expanding the number of adolescents screened annually for SUD, since many teens begin experimenting with substances during adolescence. Passport has developed regional trainings for providers to teach them how to implement SBIRT, and also developed webinars for providers to complete training in their home communities, as well as continuing education for those who participate in the training. Passport also worked with our providers to break down any barriers to coordinating care for our members who show positive symptoms.

Recognizing how important this initiative was for the Commonwealth, Passport worked with DMS to investigate how it could expand the codes available for SBIRT to ensure that providers could capture their work in this needed area. A challenge discovered once providers began delivering the intervention was that they reported that the CPT codes approved for use could not be used if the intervention took less than 15 minutes. Many times, the intervention took much less than that, and providers thus could not bill for the time spent completing the SBIRT, nor could we track how many were being administered. Our staff worked extensively with DMS to help identify another code that could be used to document the time spent if less than 15 minutes. Now providers can deliver the service and be reimbursed even in such cases.

Passport also leveraged our relationships with our providers to assess the barriers they perceived and advocate for them with the state. Because of the expertise gained from the learning collaborative, we were invited to work with Kentuckiana Health Collaborative (KHC) on creating a provider workbook that walked providers through SBIRT and how it can be used to help address the opioid crisis. The project was funded by the state (via a grant to KHC).

The following excerpt describes this program and our efforts in establishing a national best practice for SBIRT. It is scheduled to be published this summer in a public brief by the Center for Health Care Strategies Inc., a nonprofit policy center dedicated to improving the health of low-income Americans.

Health plans can collaborate with their state Medicaid agency to maximize the use of SBIRT-related billing codes to support enhancements in care for adolescent populations. This includes using billing codes to help incentivize provider uptake of SBIRT and allowing health plans to interpret claims data to support quality improvement initiatives. The Substance Abuse and Mental Health Services Administration is invested in SBIRT and is working with the Centers for Medicare & Medicaid Services to educate practitioners regarding the billing rules.^[7] However, states have the autonomy to “turn on” individual codes. Health plans can educate their state Medicaid agencies about SBIRT implementation issues related to provider billing and can collaborate to devise a strategy that provides coverage for all SBIRT components. Passport Health Plan worked with their state partners to “turn on” H0049 after receiving feedback from their providers that there were significant limitations in only having 99408 and 99409 available. H0049 offers providers the ability to bill for the substance use screen separate from any brief intervention that might occur.

Incorporating Feedback from Members via Surveys and Focus Groups

Passport also regularly conducts annual statewide surveys facilitated by an NCQA-accredited vendor as well as surveys for all care program participants to solicit the member perspective. In-person focus groups with Medicaid-eligible Kentuckians from across the Commonwealth facilitated by our Community Engagement and Marketing teams also are used as a channel to better understand the population's needs, understand awareness and impressions of companies like Passport, and provide information on value-added programs and offerings. Similar sessions are conducted with the BHAC and Pharmacy and Therapeutics Committee. In addition to gaining feedback on overall service, these sessions provide a touch point on the effectiveness of our marketing and branding campaigns as tools to inform and engage members to support their needs, leverage resources, and empower active preventive care and screening self-management to achieve improved health and appropriate utilization.

Passport also conducts surveys of members who are engaged in, or have completed, our care programs. This feedback is vital in helping us modify our programs to improve upon our already high engagement rates and the clinical results of our members. The aggregate information is included in our Program Evaluation and informs modifications in the following year's Program Description.

6. Customized Tactics Are Required for Unique Segments of the Kentucky Population

Lesson Learned

Serving a diverse population requires a vast arsenal of communication approaches, mediums and targeted strategies to reach unique portions of our community with extenuating circumstances that call for deep attention and support. From Johnson county to McCracken county, there are hundreds of communities with unique needs based on location, socioeconomic status, race, gender and other factors. We have learned that custom CM, outreach, and collaborative efforts are needed to help each population improve their health and quality of life while simultaneously reducing overall Medicaid costs.

Application of Lesson for Positive Impact

Over time, based on our lessons learned, we have developed and continually enhanced multiple programs to meet Kentucky's evolving needs, including our refugee and homeless care coordination programs, opioid integrated care program, foster care guardianship program, BH and integrated care, medically frail case management team, Care Connectors and ED navigators, to name a few. We will continue to research and seek input from members, providers and community partners on best practices to serve the evolving needs of special populations.

The following are just a few examples of lessons we have learned from serving these unique populations and developing tailored approaches to meet their needs:

- While working with Kentucky’s **foster care** and adoptive population, we have learned how to coordinate care for children who travel frequently and therefore constantly need to change PCPs. Passport has continuously evolved and adapted our process over the years in an effort to find new and better ways to meet this unique population’s needs. Passport has maintained a dedicated team that works across our own functional areas to ensure that the needs of these children and their families are met. Our team members are experienced in working with the foster care system, and include former DCBS employees, former team members of providers of services such as the Home of the Innocents, and current foster and adoptive parents. This experience is irreplaceable in meeting stakeholders where they are. We understand that changes lie ahead for the administration of benefits for the foster care program as well as members receiving adoptive assistance, and we look forward to addressing these in the Kentucky SKY program.
- Working with Kentucky’s **homeless** population, we have learned that clinical engagement and outreach is extraordinarily difficult, even with free cell phones. We have found success with this population through embedding Care Advisors at family health centers and having BH case managers embedded in, and Community Engagement representatives visit, homeless shelters. By physically meeting with these members one-on-one in the locations they frequent, wherever they may be, we are able to better coordinate their care and help them access medical services in a timelier manner. In the future, we hope to expand this effort and dedicate a full-time Care Advisor to serve the homeless population throughout Kentucky. Through the years, and working with providers such as Kentucky River Community Care, we have come to understand that homelessness in more rural areas does not look the same as it does in Louisville or Lexington, where it is not uncommon to see members moving between residences of family members and friends, which can make identifying and targeting this subpopulation challenging. The options and solutions for keeping a pulse are different from those for more traditional groups. Connections with these members can be pursued through tangential organizations that may surface their housing situation, such as the Homeless Coalition and the Louisville Office of Resiliency.
- Concerning Kentucky’s **refugee** population, we have learned that close collaboration with refugee resettlement agencies, providers and other social service agencies is critical to successful care coordination. Passport has learned that we can best serve these members with an embedded Care Advisor who meets with them in person to develop individual approaches to meet their extremely unique needs.
- Kentucky has an increasing number of **pregnant women addicted to opioids and other substances**. We have adapted our approach to coordinate with social service agencies and providers in an overarching effort to help these expectant mothers detox and give birth to the healthiest babies possible. Examples include a long-term relationship with the Freedom House, a program offered by the Volunteers of America and Chrysalis House in Lexington. Our Health Integration team also has staff members dedicated to researching and developing company-wide processes to address populations such as those affected by the opioid crisis in Kentucky. This staff member works to understand SUD needs and to implement integrated care across departments. This type of staffing allows us to take lessons learned and apply them on an ongoing basis.



7. Reaching Members Requires Collaboration with Multiple Stakeholders

Lesson Learned

Developing active relationships with members exhibiting high levels of engagement can be best supported by working with stakeholders to present and reinforce a unified message about the resources and benefits available. Increasing the variety of stakeholders we actively engage with makes us better able to reach a wide and diverse population.

Application of Lesson for Positive Impact

Based on our 22 years of experience working closely with Kentucky Medicaid members as a community-based plan created by Kentuckians for Kentuckians, Passport has learned that reaching and engaging members requires a collaborative effort with various community partners across the Commonwealth. We work every day with members and multiple other stakeholders to access members in-person and through advocacy agencies to get them the information they need concerning benefits, access to care, preventive services, etc. Passport’s outreach plan spans ongoing interaction and collaboration with the stakeholder groups outlined in **Exhibit B.1-13**. Passport’s first and foremost priority is to educate and empower Kentucky Medicaid members across the Commonwealth. This includes, for example, the homeless, grandparents raising grandchildren, persons with limited English proficiency, those with BH concerns, individuals with disabilities, the elderly, dual-eligibles, young families and pregnant mothers. Together with these stakeholders, we can build multiple channels and interactions to achieve a far reach.

Exhibit B.1-13: Passport Health Plan Outreach Stakeholders

Stakeholder	Passport Health Plan Outreach Description
Advocacy Outreach/ Grassroots	This traditional form of meeting with individuals and groups will be ongoing and includes interactions with faith-based organizations, service providers, interagency groups, community action agencies, local health departments, provider groups and other small coalitions.
Civic Involvement	Our Community Engagement representatives will interact with and make presentations to civic groups throughout the state, including neighborhood and county business associations, rotary clubs, independent business associations, etc.
Business Partnerships	Passport Community Engagement representatives will continue education and outreach efforts by meeting in person with, sending electronic communications to, and joining groups such as local chambers of commerce, the Hotel/Motel Association, Housing Authorities, restaurant associations, etc.

Stakeholder	Passport Health Plan Outreach Description
General Public	In addition to outreach to our members, Passport is committed to improving health in our Kentucky communities. Therefore, we provide health information to anyone we meet in the community—including members of competing MCOs—through local and open-attendance events.
Employer Groups & Outplacement Services	Our Community Engagement representatives will continue to successfully develop relationships with employer groups and outplacement services throughout Kentucky (such as temporary staffing agencies, human resources groups and job fair coordinators) as a means of direct education to both employers and agencies and to unemployed or under-employed individuals.
Education Organizations	Passport has, and will continue to, provide information about Medicaid and health promotion to public and private schools (including community and technical colleges), GED programs and migrant education providers. We will work closely with each school district to reach out to their adult education programs and migrant education initiatives.
Statewide Coalitions	Our Community Engagement representatives participate in statewide groups, such as Enroll America and the National Alliance on Mental Illness (NAMI), that focus on issues relevant to Passport’s current and future priorities for members and providers.

8. Personalized and Face-to-Face Interaction Increases Engagement with Members

Lesson Learned

Contact is critical, but connection is key. While myriad forums exist to bring us together to communicate with members, experience shows that the most effective interactions happen at the personal level. It is through those exchanges that personalized conversations centered on an individual’s experience and situation can be tailored to highlight for them the appropriate messages concerning next steps, support, resources or education and help fulfill their immediate and longer-term needs.

Application of Lesson for Positive Impact

In-Person Member Education Sessions

Passport’s Community Engagement team hosts member outreach and education sessions throughout the year. We achieve optimal member engagement through one-on-one meetings with members, group presentations and general outreach. In fact, in 2018 we conducted 1,101 individual member outreach sessions and 570 member education sessions. Our community



partners help us advertise these events to local members through flyers, e-newsletters and word of mouth.

We are also dedicated to meeting members across the Commonwealth. During 2019’s first quarter alone, we reached members in 98 of the Commonwealth’s 120 counties.

Passport Community Engagement—Going Above and Beyond:

A Passport Community Engagement representative met a member after a recent member education session. The member had been ill for quite some time and had recently broken her leg. She needed a shower chair, but her Kentucky Medicaid benefits did not cover this. The Community Engagement representative was able to contact a local community partner and obtain a brand-new shower chair for the member, free of charge. Our representative picked up the chair and delivered it to the member during her time of need, helping to keep the member safe and prevent a potential inpatient admission due to an otherwise avoidable fall.

9. An Integrated and Holistic Medicaid Model of Care Is Important

Lesson Learned

Technology alone cannot drive results in PHM and value-based care. The greatest impacts and successes are achieved when a model based on advanced technology and data is combined with outstanding leadership and staff. When team members are charged with designing an array of layered care programs around the concept of holistic support, lasting and powerful impacts are felt.

Application of Lesson for Positive Impact

Passport also continues to invest in our support model. For example, we have developed a staffing model to support our Medicaid-specific MOC to address the holistic needs of Medicaid enrollees. This model incorporates nurses, social workers, CHWs, clinical pharmacists, dentists, psychologists and physicians.

Passport’s MOC has been refined over 22 years of serving members through our provider network in Kentucky and receiving input and guidance from all levels of leadership and governance. This is especially true of the provider committees that are part of the Partnership Council structure, such as the PCP work group, the BHAC, and the Quality Medical Management Committee (QMMC), which collectively encompass nearly 100 volunteer clinicians and community members. Our MOC focuses on providing holistic care across the full continuum of health—from wellness services to complex care. The MOC establishes a comprehensive foundation for our Medicaid clinical program design and strengthens our validated predictive model to help identify high-risk, “impactable” Medicaid enrollees. This stratification process identifies members not only by medical, BH and pharmacy service utilization patterns, but also by SDoH, such as housing instability and poor educational attainment, and by BH diagnoses. This stratification engine is continually evolving based on new evidence and learning. As one example, when this process first became a reality at Passport, the BH component was in development, while today it stands as a deeply integrated component that helps us to further support our members.

After stratification, identified members are enrolled in our CM programs that address both physical health and BH across a comprehensive array of conditions and sites of care (ambulatory, inpatient, ED, etc.). We then deploy a broad array of interventions powered by innovative engagement tools—not the least of which are highly trained professionals skilled in motivational interviewing techniques—and support the member, provider and Care Advisor with CHWs, member navigators and an extended care team.

10. It is Beneficial to Apply Lessons Learned from Other Markets

Lesson Learned

We know that being local is an important factor in driving member engagement. In addition, taking best practices in engagement from Medicaid plans across the country and tailoring them for Kentucky has resulted in member engagement rates in our clinical programs that are much higher than industry averages.

Application of Lesson for Positive Impact

Our high member engagement rates are due, in part, to our being local and readily available to our members. Because the personal measures we implement have a significant positive impact on our members’ well-being, we will continue to meet them at doctor appointments, in their homes, in shelters or wherever is most convenient to them to help them get the care they need, when they need it. Because we have also learned that being local allows us to be strongly physician-aligned, we will continue to use our deep relationships with our providers to help us have a meaningful impact on our members based on direct involvement in their care.

Based on learnings from the population across markets, we have also refined our predictive model to consider multiple inputs to identify impactable members, allowing us to engage those who need us the most. Finding the right members who can truly benefit in a meaningful way from our services makes it more likely that we will work with them from start to finish within a program.

Our identification methodology now includes a “readiness to change” component. Those members more likely to be ready to change are prioritized above those who have a lower score in this area. This is a lesson we have learned over time through our collaboration with national Medicaid and Medicare health plans. Passport is excited to continue to bring these ideas to Kentucky.

Conclusion

Passport has been providing the Commonwealth with PHM programs and initiatives for decades, continuously innovating and implementing improvements. As a result of these advancements, today we have in place an integrated, whole-person PHM model that considers all facets of the member—physical well-being, BH and SDoH—to ensure our members get the care they need, when and where they need it.

As we strive to improve our members’ health and quality of life, Passport has and will continue to realize impressive outcomes and cost savings through many forward-thinking, collaborative initiatives we have in place with our community partners. Our NCQA-based practices and valuable lessons we have derived from our experiences over the years have influenced and advanced our service model, day-to-day activities and long-term planning, ultimately shaping our responsive service delivery to members, providers, advocates and the Commonwealth. Through a combination of local and national expertise, Passport will continue to implement programs based on lessons learned in Kentucky and across the nation. We will continue to focus on new and better ways to improve our members’ health and quality of life while reducing costs for the Commonwealth.

Passport has been honored to serve the Kentucky Medicaid and foster care populations for 22 years and will continue to comply with all provisions of the Medicaid Managed Care Contract and Appendices (including Kentucky SKY) as we continue to serve them in the future.