C.20. Covered Services

a. Provide a detailed description of how the Vendor's operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor's response should address:

   i. Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.

   ii. Approach for coordination with carved-out services (e.g., transportation and transitions to long term supports and services).

   iii. A description of any value-added services the Vendor proposes to provide to Enrollees.

b. Provide the Contractor's approach to assisting Enrollees to access direct access services and second opinions, and referrals for services not covered by the Contractor.

c. Describe the Vendor's proposed approach to the following:

   i. Interfacing with the Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

   ii. Coordinating with the Department to establish collaborative agreements with state operated or state contracted psychiatric hospitals and other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. Describe potential challenges and methods to address such challenges.

   iii. Complying with the Mental Health Parity and Addiction Equity Act.

d. Describe initiatives the Contractor will implement to identify trends in provider-preventable conditions and to educate providers who are identified as possibly needing support in better addressing those conditions.

Passport Highlights: Covered Services

How We're Different	Why It Matters	Proof
We are Kentuckians making decisions for Kentuckians	• Local health plan dedicated to Kentuckians • Better quality of care and health outcomes for our members • Positive member and provider satisfaction	• 22-year history with the Commonwealth. • A local team of 600 dedicated employees supporting Passport, with 89% living locally. • All Behavioral Health leaders are local and licensed Kentucky psychologists. • 81% of our providers would recommend Passport to another provider practice. • Overall member satisfaction scores were 4.5 out of 5 in 2019.
Closely collaborate with community and government agencies to provide member-centric and integrated care to our members, given deep roots cultivated over two decades	• Mitigates barriers to care • Addresses members' medical, behavioral and social needs	• Connecting with approximately 650 community organizations to close the loop on members' medical, behavioral health and Social Determinants of Health (SDoH) needs
Engaging with our provider owners, Partnership Council and provider partners to proactively address members' needs	• Providers are central to guiding policy around our members' care • Identifying opportunities for innovation from engaged providers • Providers are empowered in decisions and solutions	• Over 30 providers participate in our Partnership Council • Partners in Wellness Program reduced medical costs by 63% for members with behavioral health conditions

Introduction

Passport is unique from its competitors in that it has an experienced team dedicated solely to serving Kentucky Medicaid members. With a strong leadership and governance organization structure, we can be agile and adaptable in our operations and expedite decisions to best serve our constituents. We use repeatable and effective processes to provide covered services and value-added services in a member-centric way, whether it is medical and behavioral health or Social Determinant of Health (SDoH) issues.

Throughout our 22-year history, we have partnered with local community agencies and our provider partners to gain their expertise and insights into our membership. We also collaborate with DMS and other governmental agencies to ensure that our members and those with special needs receive the services they need to achieve optimal health.

C.20.a. Provide a detailed description of how the Vendor's operational structure and practices will support integrated delivery of services (i.e., staff, contractors, systems, calls centers, etc.). In addition, the Vendor's response should address:

Passport's Organizational Structure and Corporate Governance Ensures Delivery of Member-Centric Care

Passport's organizational structure and corporate governance are aligned and integrated to support the holistic and seamless delivery of covered services to our members. Passport was founded in 1997 by a group of Kentuckians dedicated to serving Kentuckians. Now, we are the only health plan that is exclusively dedicated to serving Kentucky Medicaid members, with our health plan headquartered in Louisville.

The operations of our organization provide unambiguous accountability and leader ownership for all practices and functions. Our organization structure also provides for clear lines of communication to ensure integrated and coordinated services while exploring and implementing innovative solutions.

At the highest level of the organization is our Board of Directors, which has fiduciary responsibility for the health plan and broad oversight of the health plan's strategic direction and performance. The Board od Directors includes providers and community leaders who have a clear understanding of the impact and importance of the services we are trusted to administer to our members on behalf of DMS.

Next, our executive leadership team (ELT) operates in an agile company work environment. These talented, knowledgeable and experienced executives are totally accountable for the organization's success. As a result, they are able to quickly make decisions and take actions that are in the best interest of our members, providers, and the Commonwealth.

Passport's President and Chief Executive Officer, Scott Bowers, reports to the Board of Directors. While Mr. Bowers has ultimate accountability for Passport's performance and fully meeting the requirements of the Medicaid Managed Care Contract, his executive team is responsible for all health plan functions and practices that ensure the integrated and coordinated delivery of services to Passport's members. Reporting to Scott are the members of the ELT, which include: Chief Operating Officer: Shawn Beth Elman; Vice President and Chief Financial Officer: Scott Worthington, Vice President and Chief Medical Officer: Stephen Houghland, M.D., Vice President and Chief Compliance Officer: David Henley and Vice President and Chief Marketing and Communications Officer: Jill Bell.

Our ELT has a strong balance between local Kentucky experience and national experience in Medicaid. This team is able to make informed decisions in support of our community-based operating model through firsthand engagement and involvement in our Kentucky communities.

Our committee structure also enables us to holistically address integrated delivery of care throughout our organization, channeling DMS' goals through the Board of Directors and down to our Quality Medical Management Committee (QMMC), and through every department in our organization. These committee structures and organizational processes represent hundreds of providers, staff, volunteers, and community leaders investing their time, energy, and extensive and diverse experience to ensure that Passport's fully-integrated and coordinated services to our members are realizing tangible improvements in their overall health and quality of life.

Supporting our ELT is the entire Passport team of approximately 600 team members. Eighty-nine percent (89%) of employees supporting Passport are local. Our team is unique and distinctive in that many of them have over 15 years of experience and are long-tenured. The team members have adopted Passport's company culture of being dedicated to our mission and treating our members with compassion and empathy.

By putting the member first in everything we do, we have developed trust and confidence with our members, and our results reflect it. For example, our member engagement scores for high-risk members consistently range from forty-five to fifty-nine percent (45–59%) versus the industry standard of thirty percent (30%). Additionally, our Consumer Assessment of Healthcare Providers and Systems (CAHPS®) score for overall member satisfaction was 4.5 out of 5 in 2019.

Passport designed and is operating our organizational structure and practices to be internally aligned to coordinating integrated delivery of services.

For a more detailed description of Passport's organizational structure and staffing, please refer to Passport's response for Section B.3: Staffing.

Call Center Operations Support Integrated Delivery of Care

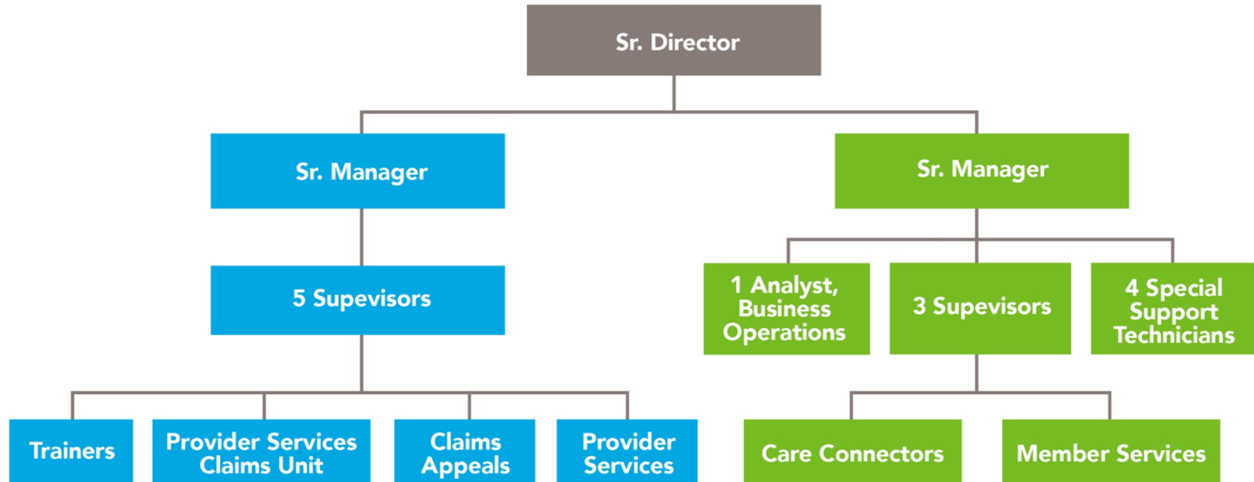
Passport's call center is based in Louisville to best serve both members and providers. All of our call center representatives are local to the area and understand the unique aspects of our members, including their language preferences. In addition, the call center team has a deep understanding of our communities and the unique differences that exist in Kentucky's urban and rural communities. They undergo an extensive training program to be able to inform members of their rights and responsibilities and answer questions regarding Plan benefits. The call center representatives are also responsible for monitoring the selection and assignment of primary care providers (PCPs), facilitating access to providers, informing members of their rights, assisting members in completing health risk assessments (HRAs), aiding with medical transportation services, and handling grievances and appeals. This is all done in an effort to streamline our coordination of covered services.

Our Member and Provider Services team has a vast amount of experience and expertise in call center operations. For example, our Member Services director has twenty (20) years of experience at Passport, and

our two (2) Member Services senior managers have eighteen (18) years and ten (10) years of experience at Passport. Our Member and Provider Services team has grown from less than a dozen (12) Member Services representatives in 1997 to over one hundred (100) today. Passport's is regularly applauded by our members for the service they provide.

Our team is shown below in **Exhibit 20.1.**

Exhibit 20.1 Member Services and Call Center Operations Team Organizational Chart



We measure member satisfaction through an annual satisfaction survey, monitoring member complaint and appeal reports and reviewing average speed of answer and abandonment reports for Member Services areas. Passport's call center consistently handles a large volume of calls in a quality manner to best meet the needs of our members and providers. For example, in the fourth quarter of 2019, Passport Member Services representatives responded to 336,432 inbound calls with a call abandonment rate that is consistently less than 5 percent and an average speed of answer of less than 30 seconds.

Additionally, we monitor our calls for consistency, quality and accuracy. We audit a minimum of 16 calls per month per member service representative (MSR) to provide feedback as well as develop refresher trainings based on trends. Auditors review recorded calls, Supervisors spend time on the floor daily and complete side-by-side reviews, and Managers listen to both live and recorded calls. Supervisors spend time with each individual MSR reviewing their audit results, answering MSR's questions, and providing feedback. The average score for our MSR's for 4th quarter 2019 was 93%. MSRs must score 90% or higher to pass. If MSRs fail to pass for two consecutive months, they are placed on a 30-day performance plan where they are provided additional coaching/training. The MSR must be passing audits by the end of this period. In order to ensure our MSRs provides the most consistent and up to date information available, we have created an innovative, interactive tool which allows our MSRs to search via key words and respond to members confidently and accurately.

We look forward to continuing to enhance our services to continue this legacy of excellent customer service tailored to the need of Kentucky Medicaid members in the future.

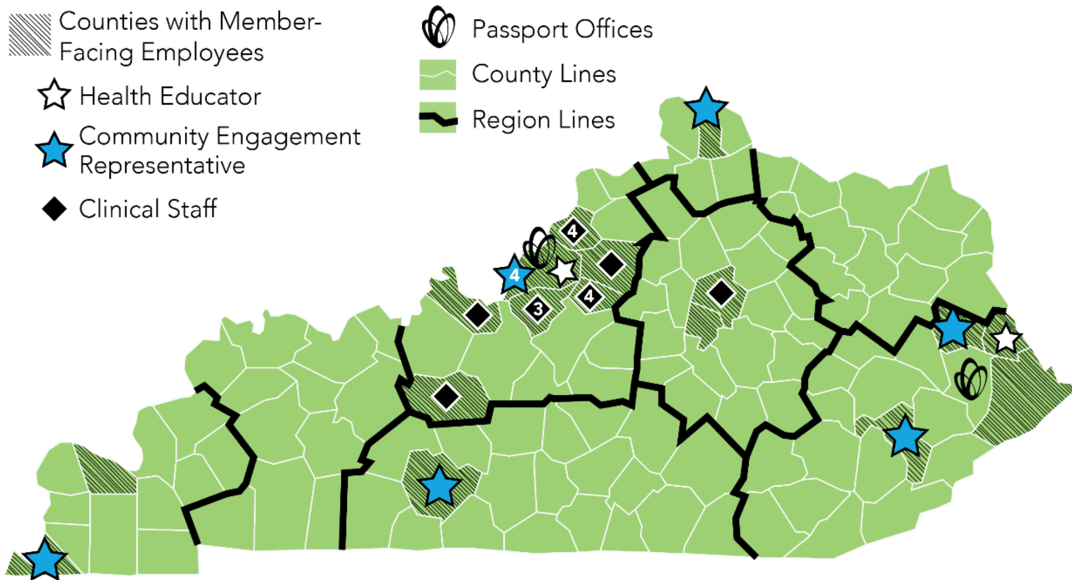
For a full description on Passport's Member/Provider Call Center, please refer to the Enrollee Services Section: C.12.

Ensuring Sustainable Impact Through Community Engagement Efforts

One of Passport's unique differentiators is our unsurpassed level of community engagement. We recognize that although we are local, we cannot achieve sustainable positive clinical results and outcomes in a silo. Instead, we need the specialized expertise and assistance of local community agencies and our provider partners to help us address the member's medical and behavioral health needs as well as SDoH needs.

Our Community Engagement Department drives our in-person education and outreach efforts. Passport has Community Engagement Representatives who are embedded throughout the Commonwealth which allows for regional representation to be locally accessible to members in their communities. **Exhibit C.20-2** shows our current Community Engagement Representatives in blue stars with additional supporting member-facing team members.

Exhibit C.20-2: Community Engagement Representatives by Region



Passport uses a multi-faceted approach in educating and engaging members on topics pertinent to improving their health and quality of life. This involves a vast array of personalized in-person, telephonic and written outreach tactics. We use these tactics in a broad and inclusive manner in all counties throughout the Commonwealth. In 2019, we participated in attending more than 650 community meetings including multiple councils, interagency meetings, associations, coalitions, boards and subcommittees on a statewide basis. This collaboration with community stakeholders includes but is not limited to faith-based

organizations and community ministries, Family Resource and Youth Services Centers, homeless coalitions, housing coalitions, food banks, community action agencies, service provider organizations, extension offices, social service agencies and local Chambers of Commerce. In addition to involvement at the stakeholder levels, we logged over 5,000 outreach activities that had a potential exposure to an estimated 249,000 Kentuckians.

Our Community Engagement team is the force driving our education and outreach efforts at the community level and act as a bridge to our health plan as well as local community resources. We firmly believe that it is imperative to have local member-facing team members who reside in the areas they serve, know and are part of their communities. With this model, we are accessible to the needs of our members and through our outreach efforts, are able to provide our members with the right care at the right time.

Our team also focuses outreach on special populations, such as those experiencing homelessness, the formerly incarcerated, domestic violence victims, and those with limited English proficiency. For example, we partner with targeted local community organizations for special populations, such as the Salvation Army Advisory Board, Phoenix Family Health Center, Family Scholar House, and the Volunteers of America (VOA). This outreach allows us to engage in-person with members and offer personalized assistance with their health issues, access to care, and barriers related to SDoH. These efforts support overall health and quality of life improvements and positively impact the total cost of care.

For a full description of Passport's community engagement efforts, please refer to the Enrollee Services Section: C.12.

Practices Used to Support Integrated Delivery of Care

Passport was founded as a provider-led health plan. Since our inception, providers have been in our DNA. Passport's organizational structure and engagement with providers is differentiated from other national health plans because we collaborate with providers to develop unique innovative solutions and assist in the design, development and oversight of our clinical programs. This distinctive structure allows us to have clinical depth and practical experience that is unsurpassed in the Kentucky area.

For example, as part of Passport's Partners in Wellness Program, we collaborated with behavioral health provider Centerstone Kentucky (Seven Counties Services) to provide hands-on complex care management as part of their value-based agreement to deliver the service. As a result of this unique collaborative program, we created an integrated program that would bring medical case management into the relationship of trust with the behavioral health provider

Specifically, our providers participate in our governance structure and offer ongoing guidance into our clinical programs. This extensive level of engagement enables us to achieve greater member engagement results and clinical outcomes. Our providers are an essential component of our Partnership Council, a committee reporting to our Board of Directors, which has oversight authority for Passport programs,

including Quality, Utilization Management (UM), Care Management, Pharmacy, etc. In addition, the Committee holistically addresses quality throughout our organization, channeling DMS' goals through the Board of Directors and down to our QMMC, our quality improvement committee, through to every department in our organization. The Partnership Council is an approving body for the QMMC. Passport's Partnership Council is comprised of more than 30 individuals representing multiple provider sectors, consumers and community interests (advocates).

Additionally, our provider governance and participation allow Passport to gain practical clinical learnings and insights. Our leaders engage with our providers to gain an understanding of the challenges they face from an operational or clinical perspective and to offer viable solutions. Together, we have collaborated to reduce administrative burdens by streamlining our prior authorizations and pre-certification process, expediting claims payments by reprocessing claims in real time with providers on the phone, and having our Provider Relations representatives conduct face-to-face visits with providers to help resolve issues.

Repeatable Processes to Achieve Integrated Member-Centric Care

Passport has detailed and repeatable end-to-end processes for all key operational functions that clearly identify touch point interdependencies among the functions. For example, our trainers conduct consistency reviews every month to test our MSRs knowledge on core competencies. If any trends in a lack of MSR comprehension are identified, our trainer will rewrite and redistribute policies and processes. This ensures that our teams deliver consistent services and programs to our members. Policies and desktop operating procedures provide context for functions so that individuals can apply thoughtful judgement in the execution of their job duties and the impact their performance ultimately has on each member's whole-person experience.

Every leader within the organization is responsible for keeping his/her functional area's process and procedure documentation up to date. This allows us to make certain that the Passport teams clearly understand what is necessary to deliver covered services in a timely and expedited manner. Our Compliance Department is accountable for regularly reviewing the processes documents with each of our leaders. Once approved, the documents are uploaded and stored into a central electronic repository for employees to reference.

We also require all our vendors and subcontractors to have and maintain up-to-date policies and procedures for an integrated delivery of care model. Our Delegation Oversight Manager serves as the liaison with our vendors to obtain the policies and procedures and works with our Compliance Department and ELT for strict oversight and governance.

Population Health and Care Management Processes for Optimal Delivery of Care

Passport uses an integrated, member-centric population health management (PHM) model by considering all facets of the member – physical well-being, behavioral health and SDoH needs. Passport's PHM program – the first of its kind to receive NCQA PHM accreditation – begins with proactive identification of members. Our predictive modeling and risk stratification algorithms identify members with rising risk, outreaching and intervening before significant adverse health events occur. In this way, our identification of members is

proactive rather than reactive and is able to accurately predict the right members at the right time over 80% of the time (c-statistic = 0.82).

Another differentiating factor is our definition of engagement. While other plans may consider a member to be engaged after one interaction of any type (such as completion of an HRA), we do not. We consider a member engaged after they have agreed to enroll in the program and we have completed a comprehensive needs assessment. We cannot create a meaningful care plan with a member without understanding all the member's needs. The results of this needs assessment is a member-centric care plan that is developed in close collaboration with the member, caregiver and providers. We meet the member where they are using evidence-based practices to support self-management, involving them, their physician and care team throughout the care management and coordination process. The member's providers are central to the development, approval and administration of a successful care plan for each member to ensure 100% alignment across the entire care team. Throughout, Passport measures our results by monitoring and evaluating the impact of clinical programs. To do this, we employ a range of quality measures, such as key performance indicators, outcomes measurement and reporting, trend analysis, utilization management and continuous improvement efforts, to monitor and improve our programs for the benefit of our members. We also conduct rigorous evaluations and controlled studies to understand what programs are effective and *what* makes them effective so we can better direct our staff and care team members to the highest impact activities.

Success Story

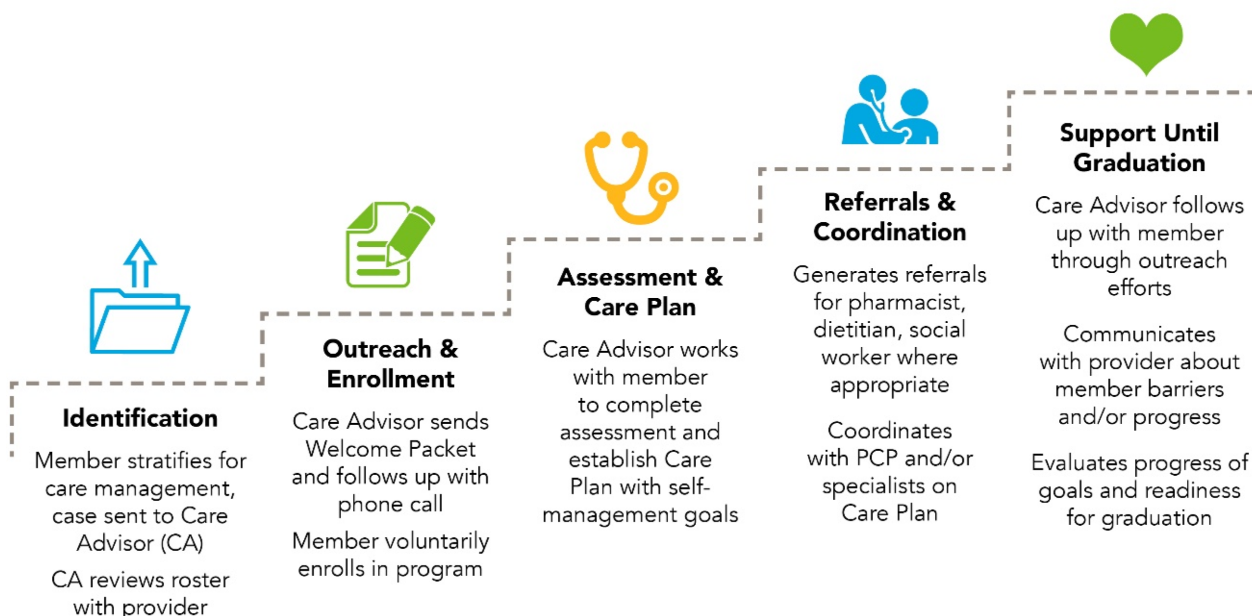
During a face-to-face visit in the hospital, Passport Health Educator Victoria met Passport member Emma* and her family. Emma is a 4 year old girl who was recently diagnosed with leukemia. Victoria met with Emma and her family and learned about her history and set up a time to call Emma's mom, Jenna*, after discharge. During their initial call the day after Emma's discharge from the hospital, Victoria completed a comprehensive medication reconciliation and learned that Emma's medication regimen was one of the most difficult parts of her day. Emma felt so poorly from chemotherapy, she was unable to swallow pills and her daily steroid dose was in pill form. Victoria referred Emma to the Clinical Pharmacist, who was able to speak to Jenna the same day and learn more about Emma's daily medication routine. Victoria and the pharmacist worked together to contact Emma's oncologist, who substituted a liquid steroid for the pill. Jenna expressed such a relief, stating that getting Emma to take her needed medications was a huge anxiety source for her and this was going to make their day to day life much easier! Victoria continued to work with Emma and Jenna for 30 days to ensure she was handling the new liquid well and to address any concerns during that time. By consulting with the Clinical Pharmacist, Emma's needs were handled quickly and efficiently and Jenna was able to rest easy, knowing her daughter was more comfortable and less agitated during their medication routine.

**Members names changed for privacy.*

In addition, we collaborate with our subcontractors to provide a seamless member experience. Care team members have access to view claims and encounter information for these subcontractors, which allows us to identify possible care gaps for members (including dental and eye examinations). When a member has questions or needs assistance accessing dental or vision care, the member's Care Advisor works directly with our subcontractor to resolve the issue. Likewise, Passport's Pharmacy team works with our Pharmacy Benefit Manager to resolve any issues with accessing needed medications. This means that members enrolled in one of our care coordination programs have multiple points of contact at Passport, including their Care Management team member, who can help them remove barriers encountered at each point of care. If a member is not engaged in a care management program and needs this type of assistance, the Care Connectors team within Member Services can provide this same service for the member.

Passport has an end-to-end care management process that offers member identification, outreach and program enrollment, assessment and care planning, referrals and coordination until members successfully reach their goals upon program completion, as illustrated in **Exhibit C.20-3.**

Exhibit C.20-3: Our End-to-End Process for Care Management and Care Coordination



Using Technology and Data for A Closed-Loop SDoH Model

Passport's population health management platform, Identifi, combines SDoH data and models into a unique, easily understandable index that quantifies a member's SDoH risk level. Sophisticated value-based care analytics incorporate community information into the risk stratification and predictive models to identify risk factors for SDoH needs. Because of the importance of psychosocial and socio-economic issues on health outcomes, we leverage a variety of assessment data as well as publicly available data sources to understand a member's needs and close the loop on SDoH issues.

While many other health care organizations make referrals to community-based organizations, very few track those referrals to ensure a successful outcome, let alone attempt to understand the downstream impact on the member's health or social wellbeing. Through Passport's partnership with the Metro United Way, we supported the launch of **United Community** – a community-wide initiative to deploy an innovative, shared technology platform to initiate and close referrals across many organizations, agencies, and services. Passport represents the health plan perspective on the United Community Governing Team, along with the Louisville Metro Health Department for the health provider perspective, Evolve502 for the educational perspective, and Metro United Way for the social services perspective. The United Community's goal to be the first shared community social services record in the country to include the local school system is on its way to reality. The platform was launched in April 2019. Passport has taken the data from our work with connecting members to social service providers and helped to ensure that the providers our members work with most are included in the United Community. We are currently helping to design the analytics tools to evaluate the impact of the partnership and platform; this evaluation will not only assess whether it is improving health outcomes, but also whether it helps to prevent other adverse social outcomes, such as unemployment and incarceration.

To address the needs of those members outside of Louisville metro area, Passport uses an online directory of curated social resources called Healthify. It provides an online questionnaire for members to gain insights into their personal situation. Using the results of the questionnaire, the care team searches for the most appropriate community resources and social services to fit our members' needs. We provide this information to members, teaching them to become engaged in their health care and take charge of making the resource arrangements. We can also proactively make the appropriate appointments on behalf of our members, if they prefer, so that they can obtain the resources they need with convenience.

The tool offers referral information for behavioral health, education, emergency, family and youth, financial support, food, health, housing, legal, social support, transportation and employment services. It also enables us to better serve the most vulnerable populations in an expedited manner.

Our team tracks all referrals and activities in our integrated system for proper care coordination. In a sample of 2000 members that we screened for SDoH using our closed-loop referral application, preliminary results show that PMPM costs dropped by ~22% (or $390 PMPM) in the six months after a member acted upon the referral. Specifically, we observed a 30% reduction in inpatient expense and a 19% reduction in emergency department expense. The most significant drivers of this impact were connecting our members with financial assistance and housing support.

C.20.a.i. Innovative approaches to ensure Enrollees experience whole-person care that integrates their medical and behavioral health benefits and addresses social determinants of health.

Success Story

Passport's Community Health Worker (CHW) Rhonda met Passport member Ronald* while "embedded" or on-site at a provider's office. Ronald was placed on respite care to recover from an appendectomy. During their initial meeting, Rhonda discovered that Ronald, his wife, and his young daughter were all staying at a homeless shelter, where Ronald would return after his recovery from surgery. They were on the waiting list for permanent supportive housing, and Ronald and his wife were both in recovery from substance abuse and struggling with mental health issues.

Rhonda worked with a local provider to continue Behavioral Health services for both Ronald and his wife. Ronald's family was approved for permanent supportive housing and moved into a new apartment, which was completely empty with no furnishings, dishes, or cookware. Rhonda coordinated with a local community partner to obtain a furniture voucher and found a local church who offered to provide cookware and dishes for the family. She also worked with another community agency obtain a toddler bed for their daughter and referred the family to WIC for education and support in introducing more nutritional food in their daughter's diet. Rhonda also helped Ronald and Sarah apply for dental assistance through Dental Lifeline.

Ronald and his wife are now receiving WIC, have applied for SNAP, are receiving dental care, and are working with their Behavioral Health provider to find the best treatment options. Though many barriers were presented, Rhonda helped guide this couple through the process. They are now addressing their needs and maintaining their sobriety, while building a home for their family.

*Member name changed for privacy.

Innovative Approaches to Integrated Care

To Passport, integrated care means caring for our members in a way that simultaneously elevates their physical, psychological and social wellness. This whole-person perspective to health care requires quality research, collaboration and partnerships in the community. We continuously innovate to deliver our members the quality of care they deserve and expect from our organization.

Our most innovative approaches to integrated care include:

- Dedicated Health Integration team
- Partnerships for health transformation
- Next-generation risk assessment tools
- Streamlined referral processes for SDoH

Dedicated Health Integration Team

Passport's integrated model of care is advised by the Health Integration team, which consists of highly experienced and professionally licensed clinicians, doctorate-level psychologists, a substance use disorder (SUD) specialist, and postgraduate-level social work professionals. The team's extensive background,

expertise and credentials are a differentiator for Passport. We have a dedicated group of individuals, known as our Health Integration team, which began expanding in 2014 to increase Passport's opportunities for an integrated whole-person approach, where members can receive collaborative care within their provider relationship of trust. For example, since the expansion, members who are established with a behavioral health provider can get medical services from that provider or their PCP.

Our solutions-focused Health Integration team includes seasoned Kentucky behavioral health providers who partner with Medicaid providers statewide to offer support, reduce barriers, and increase whole person care. The team's objectives are to: identify gaps or opportunities to enhance care, while researching the various components of the gap/opportunity; review the literature to identify and evaluate evidence-based solutions that have worked in other settings; engage providers to build viable solutions, based on the evidence and knowledge of our communities and members; seek feedback from the Behavioral Health Advisory Group, Primary Care Workgroup, and Women's Health Committee, including providers, advocates, and members. Additional team objectives are to build models identifying the risks, benefits, measurement strategies, and expected outcomes; implement new initiatives and measure progress that could include fidelity to any previous models and clinical and financial outcomes; work with Passport internal teams to find reimbursement and contracting solutions; problem-solve barriers to the effective and efficient delivery of care; assist in connecting to other resources across the Commonwealth to provide training, support and aid in addressing SDoH needs.

More on the Health Integration Team Experience

Our Health Integration team members have diverse backgrounds and experiences that enhance the function and perspective of Passport's Model of Integrated Care. Our Health Integration team members with behavioral health experience include:

- **Vice President, Health Integration**: Dr. Liz McKune is a licensed Kentucky Psychologist and the current Chair of the Kentucky Board of Examiners of Psychology. She provides leadership to the Health Integration team to create opportunities for whole-person care for our members by partnering with providers to address gaps in care, building collaborative models for health and wellbeing, and measuring the impact of integrated health efforts on long-term outcomes. Her former professional experiences include:
  - Director of Mental Health for the Kentucky Department of Corrections
  - Director of Professional Affairs for the Kentucky Psychological Association
  - Director of Psychology, Neuropsychology, and Brain Injury Services for Jewish Hospital and St. Mary's Healthcare
  - Clinical Associate Professor and Director of the Health Psychology Emphasis Area at Spalding University School of Professional Psychology (In this role, she trained psychologists to work in integrated care settings.)

  - Health psychologist with experience delivering integrated care in a chronic pain clinic and OB-GYN practice

- **Behavioral Health Program Manager**: Dr. David Hanna is a licensed Kentucky Psychologist and a member of the Kentucky Psychological Association Hall of Fame. He works with behavioral health providers to identify barriers to the delivery of behavioral health services (including problem-solving coding and billing issues, assisting providers in applying the regulations governing the delivery and Medicaid payment for services, and designing programs to address gaps in care). His former professional experiences include:

  - Retired Chief Executive Officer of Community Mental Health Center Bluegrass.org
  - Kentucky Psychological Association President
  - Clinical child psychologist with experience with applied behavioral analysis (ABA) services

- **Behavioral Health Program Manager:** Dr. Jessica Beal is a licensed Kentucky Psychologist. She works with PCPs, specialty medicine providers, and behavioral health providers to assist in creating screenings, workflow, and models of care designed to improve whole-patient care through collaboration and integration of medical care, behavioral health care, and SDoH. Dr. Beal also helps providers navigate billing and coding issues, select outcome measures, apply the regulations governing the delivery and Medicaid payment for integrated health services, and work with our internal teams to provide data to support the practice-specific model of care. Her former professional experiences include:

  - Director of Behavioral Health for the Division of Hematology, Oncology, and Blood and Marrow Transplant for the University of Louisville School of Medicine Department of Pediatrics
  - Assistant Clinical Professor
  - Pediatric Psychologist with experience delivering integrated primary care services

- **Substance Use Disorder Program Manager** - Dr. Cheryl Hall is a licensed Kentucky Psychologist. She works with substance use disorder providers to identify barriers to the delivery of substance use disorder services, including problem solving, coding and billing issues, assisting providers in applying the regulations governing the delivery and Medicaid payment for services, and designing programs to address gaps in care. Her former professional experiences include:

  - Licensed Psychologist Program Administrator for the KY Department of Corrections
  - Clinical psychologist with experience in treating substance use disorders and aging issues

- **Behavioral Health Operations Manager** - Dr. Eric Russ is a licensed KY Psychologist and the current President of the Kentucky Psychological Association. He collaborates with our internal partners, including Beacon Health Options, to monitor operational performance related to the execution of the behavioral health benefit, including regulatory compliance, implementation of system updates, Healthcare Effectiveness Data and Information Set (HEDIS) tracking, and trending of utilization, outcomes, and performance. His former professional experiences include:
  - Lexington Veterans Administration Post-Traumatic Stress Disorder Clinical Team Manager
  - University of Louisville Assistant Clinical Professor/Clinical Psychologist

The team has had significant successes in implementing our integrated Model of Care to improve network adequacy and access for our members. **Exhibit C.20-4** provides some insights and details regarding some of these successes.

Exhibit C.20-4: Results of a Selection of Health Integration Team Solutions:

Challenge	Provider Collaboration to Create Network Adequacy and Access
ABA Providers were not joining network or delivering services. *The codes needed to bill for the service were not part of the approved codes for Medicaid.*	**We took the following actions:** • Partnered with providers to understand issue • Researched codes that ABA providers used nationally and worked with Kentucky providers to generate a list • Shared with DMS so they could evaluate and determine use **Outcome**: Codes were added, providers joined network, and members gained access to service needed
Members were in and out of the hospital due to behaviors rooted in trauma history. *Members were sometimes sent out of state due to inability to get needed trauma treatment in-state. Members needed a longer length of stay in an acute environment to address their trauma through the evidence-based trauma-focused cognitive behavioral therapy (TF-CBT). Some licensure issues needed clarification.*	**We took the following actions:** • Partnered with providers to better understand the issue. • Worked with providers to identify evidence-based solutions for trauma, and jointly determined that TF-CBT seemed appropriate. • Accompanied providers to discuss member needs and perceived licensure barriers with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID). • Obtained DMS permission to provide the needed service in an extended care unit (ECU) setting. • Developed an authorization process and rate to support participation. **Outcomes:** • To date, 78 children have had the opportunity to participate since established in 2013. • 75% reduction in out-of-home, hospital, and residential placements following participation in the program.

<table>
<tr><th>Challenge</th><th>Provider Collaboration to Create Network Adequacy and Access</th></tr>
<tr><td></td><td></td></tr>
<tr><td>Foster members were disrupting their foster care placements due to their behavioral health needs.</td><td>Launched our Foster Care pilot program, which achieved both program goals of improved BH functioning and increased stability in placements while reducing total cost of care.
Outcomes:
Observed a 150% increase in children living with natural and adoptive family members compared with six months pre-intervention for the 59 participants.
Behavioral health functioning improves as measured by the Child and Adolescent Functional Assessment Scale (CAFAS).
Total Cost of Care was reduced by $161 per member per month (PMPM) for participants.</td></tr>
<tr><td>Nationally, Medicaid recipients with severe mental illness (SMI) were found to die 25 years sooner due to their untreated, co-morbid physical health needs.</td><td>Launched the Partners in Wellness Program, an integrated behavioral and medical care management model with 24-hour access to nursing that reduced medical expenses by 63% for members with behavioral health conditions</td></tr>
<tr><td>Kentucky has an opioid crisis. DMS and DBHDID asked MCOs to implement Screening, Brief Intervention and Referral to Treatment (SBIRT) in primary care settings in a preventive effort to identify members with SUDs earlier in the process and connect them with care.

Passport participated in a learning collaborative with other health plans around the implementation of SBIRT. Passport then obtained a grant from the Center for Health Care Strategies to increase the number of adolescents screened.</td><td>Post-implementation, providers reported in our Primary Care Workgroup that they were stopping delivery of SBIRT because the coding rules would not allow them to bill for the services when the total time for the intervention was less than fifteen (15) minutes.
We took the following actions:
Worked with providers to understand the issue by reviewing claims and speaking with billing staff.
Researched nationally how other parts of the country had solved the issue with use of other codes.
Checked with providers to see if identified code appeared to work in Kentucky.
Shared the code with DMS for evaluation and eventual implementation.
Outcomes:
PCPs can now screen for SUDs and get paid, and Passport can better track which members have received the SBIRT service.
As part of the SBIRT grant, part of our quality improvement process included review of utilization. When SBIRT use was low, we engaged providers again directly and through the PCP workgroup to determine additional barriers to implementation and billing. Additional education and training was provided about the new code and adoption of SBIRT.</td></tr>
</table>

Challenge	Provider Collaboration to Create Network Adequacy and Access
Members with SUDs that developed cardiomyopathy were unable to participate in SUD treatment while receiving their IV antibiotic treatment. ***Members were being inappropriately placed in long-term acute care (LTAC) facilities for care so they could get their IV medication.***	**We took the following actions:** • Contacted residential and intensive outpatient program (IOP) SUD providers to understand barriers to having members receive IV treatment. • Worked with providers to review licensure regulations and resources needed to accommodate member needs. • Contracted with providers to create an enhanced residential and IOP service to support the additional medical staff, supplies, and transportation needs to support members with IV medications participation in SUD treatment. • Updated UM process to support this enhanced benefit. • Contracted with providers to deliver service. • Supplied resources to providers needed to deliver service. • Provided members access to the care needed to address their medical and SUD treatment needs at the same time in an appropriate setting.
Miscellaneous Interventions	• Implemented home-based care following hospitalizations to reduce readmissions • Incentivized outpatient providers to increase quality focus in delivery of services • Recently created Select Program to shift the Utilization Management focus with inpatient providers to quality-based metrics for population of members served and reduce pre-authorization administrative burden for individual members by providers

For the future, the Health Integration team plans to expand our innovation efforts to meet the needs of our members and providers. Some key examples include:

- Develop an expedited authorization process for providers to ensure that our members receive timely services to address their needs.
- Implement dental home and initiatives to include clinical pharmacy interventions.
    - Increase telehealth capabilities by contracting with Teledoc. These expanded capabilities will allow members to receive services in an expedited and cost-effective manner without causing abrasion with our network providers.
    - Create processes and methods for members to complete HRAs in a timelier manner; allowing us to quickly gather their data for predictive modeling and risk stratification and thereby enroll them into the right programs at the right time.

A Look at Our Integrated Health Pilots

Our Health Integration team is assertive about seeking out, investigating and implementing new pilot programs with the potential to improve how we deliver services. The Centerstone Kentucky (Seven Counties Services) SMI pilot provided enhanced targeted care management (TCM) to members with a SMI and co-morbid complex or chronic physical health condition. Using its data analytics tools, Passport identified members who met criteria and waived the prior authorization process for Centerstone Kentucky (Seven

Counties Services) to provide TCM. Many of these members had not been previously engaged with behavioral health services. Centerstone Kentucky (Seven Counties Services) provided case managers with training in relevant medical issues and access to a nurse consultant. Over nine (9) months, members had forty-five percent (45%) fewer hospital days post-intervention compared with the pre-intervention period. They also experienced a twenty-seven percent (27%) reduction in emergency department (ED) use and a sixty-nine percent (69%) reduction in number of hospital admissions. Total spend per members served decreased by forty-four percent (44%), with modest increases in behavioral health cost associated with large reductions in medical and pharmacy expense.

Partnerships for Health Transformation

The next innovative approach Passport takes to ensure members receive whole-person care is through our cross-departmental efforts to collectively identify and address the needs of members with support from the community. Our Care Connectors assist members with obtaining resources for eyeglasses, housing, food, financial assistance, utility assistance, and more needs related to SDoH. They also assist with arranging transportation assistance through three-way calls with members and transportation brokers to ensure completion.

In 2018, we implemented a new program enhancement where our community health workers (CHWs) conduct face-to-face visits in the members' homes, provider offices and in community service organizations. The CHWs serve as advocates, helping members schedule doctor appointments, obtain the necessary resources to resolve SDoH needs and assess for any literacy and interpretation services needed.

For the homeless population, we have a social worker available at the Phoenix Family Health Center (a local homeless clinic) at least one (1) day per week to aid homeless members and refer them to nearby services. The same social worker spends one (1) day per week at University of Louisville's 550 Clinic, where she assists members who are HIV+ and have needs surrounding fair housing and other issues. Our case managers also visit two (2) Louisville area homeless shelters for member education and outreach. Passport's Community Engagement team also visits residents of homeless shelters in Louisville and Lexington.

Examples of Specialized Partnerships

We have other, specialized partnerships that transform the delivery of care to our communities to as these solid relationships build is one tool to create more integrated services. These partnerships focus on early childhood development and readiness, food security, asthma awareness and management, diabetes awareness and prevention, and workforce development.

Early Childhood Development and Readiness

In 2016, the Passport Health Equity Program (now called Equity, Diversity and Inclusion Program) became involved with a Metro United Way initiative to improve Kindergarten readiness for all children in Jefferson County, from ages 0 through 4 years. Research shows that children who have an unsuccessful experience in kindergarten are less likely to catch up and do better in later grades, and more likely to drop out of school. In fact, children who receive pre-kindergarten education earn higher wages, have fewer needs for

government assistance and have fewer rates of drug crime involvement over the long term[1]. This information created a compelling case for creating an initiative to collaborate with early childhood councils across the Commonwealth.

Since January of 2017, Community Engagement representatives have increased and targeted outreach in early learning programs in their areas. The Community Engagement team distributed throughout the Commonwealth over 75,000 kindergarten readiness informational cards in the five (5) developmental areas identified by the Governor's Office of Early Childhood. These cards are also available in four (4) other languages found in immigrant populations in Louisville, Lexington and Bowling Green. Also, in 2017, Community Engagement representatives participated, created and partnered with local agencies to hold an early learning event for children ages five (5) years and under in their communities. During these events, children participated in developmental learning activities and received information on the importance of healthy eating and exercise. To date, Community Engagement representatives participate in area Early Childhood Councils, attend kindergarten kickoff events and continue to distribute kindergarten readiness cards.

Food Security and Improving Access

Food access is a SDoH that is a major concern across Kentucky, where an estimated one (1) in six (6) people are food insecure. When communities lack consistent access to healthy, nutritious foods, they often resort to more affordable and accessible food options that may be detrimental to their health. Food insecurity can contribute to chronic health issues, including obesity, heart disease and diabetes.

Passport is actively evaluating the use of a food program for members who have had recent hospitalizations for diabetes or heart disease. Prior to this initiative, in early 2018, Passport partnered with the American Heart Association, Louisville Urban League, Jewish Community Center, Cooperative Extension Service, and Food in Neighborhoods Community Coalition to produce a Dinners & Dialogue Series to discuss the state of food access with local organizations. The four-part series was attended by local executives, chefs, the local food bank, university officials, community organizers and even politicians. Over dinner, participants learned more about food access in Kentucky and were encouraged to design partnerships to improve food access on-site.

The dinner series was followed up by a day-long community conference on food access in the community, titled "The Future of Food Security in Louisville." Dr. Wayne Tuckson, past president of the Greater Louisville Medical Society and respected colorectal surgeon, delivered the keynote address for the event. Other presenters included the Center for Health Equity, the Hunger Innovation Fellow, Jefferson County Public

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[1] The Urban Child Institute. Pre-K matters: Exploring the impact of pre-kindergarten on children and their communities infographic. Link: http://www.urbanchildinstitute.org/sites/all/files/UCI_Infographic_Pre-K_Matters.pdf

Schools and several nonprofits. Passport employees served the heart-healthy vegetarian lunch in partnership with the American Heart Association and local produce vendors.

In early 2019, Passport Population Health Manager Ryan Burt was awarded the prestigious Unsung Hero award by the University of Kentucky School of Social Work for her leadership in organizing these events.

Passport is engaged with a vendor to begin providing post-discharge meals for adult members following hospitalization for diabetes or congestive heart failure. Research shows home-delivered meals support outpatient recovery after hospitalization, reduce readmissions, and help patients manage chronic conditions, avoid hospitalizations and preserve health (Bipartisan Policy Center, 2016). We are currently in the development phase of designing the length of the intervention for each condition. Our plan is to evaluate the effectiveness of a "meals as medicine" program to determine expansion for other conditions.

Healthy Hoops Kentucky for Heart and Lung Health and Awareness

For the past 11 years, Passport has spearheaded a coalition to host an annual asthma screening event targeting children ages 7-14 years who have asthma or breathing issues. The clinical stations are staffed by volunteers from the medical community and nursing and respiratory therapy programs. Participants go through a variety of stations, including vital signs and body mass index (BMI), asthma control test, spirometry screening, asthma quality of life questionnaire, asthma action plan, peak flow meter and spacer training, nutrition counseling, asthma triggers and a medical review. Each participant and his/her family meet with an asthma doctor or nurse practitioner to review the results of the screening and make recommendations based on whether the participant's asthma is controlled. The information from the screening is sent to the participant's PCP or asthma specialist for continued follow-up. After the asthma screening, the children participate in a basketball clinic run by University of Louisville's Darrell Griffith and other local coaches and players. For over a decade, Healthy Hoops Kentucky has been raising awareness and spreading hope for Kentucky families affected by asthma. Looking ahead, we have some exciting changes on the horizon. In 2019, we are developing a new program to replace the current Healthy Hoops Kentucky program, which is administered by AmeriHealth Caritas. In 2020, we hope to launch a newly rebranded program under a different name that will address both asthma and cardiovascular (heart) health in our community.

Eastern Kentucky Partnership for Diabetes Awareness and Prevention

Passport sponsored and participated in a collaborative initiative by the Big Sandy Diabetes Coalition (BSDC) in Eastern Kentucky to implement a community screening and outreach project in Pike, Magoffin, Martin, Floyd and Johnson counties. These screenings are set up in the form of health fairs that offer free blood pressure measurements, baselines such as height/weight/BMI, Hemoglobin A1c screenings and insurance assistance through Kynect and community resource vendors. These health fairs are coordinated with the local hospitals, health departments, universities/colleges and health care MCOs. Through these, the coalition screens and connects people within the community with available resources and programs, such as the Chronic Disease Self-Management Program or Diabetes Prevention Program.

Out of one hundred eighty-three (183) people screened at these events, forty-five (45) were classified as being in the diabetic A1c zone, with scores greater than 6.5; and forty-four (44) were classified as being in the prediabetic A1c zone, with scores between 5.7 and 6.4. Some participants had A1c scores over fourteen (14), which is dangerously high, and did not know they were in the diabetic range. We found that statistically 24.6% of the sample was diabetic, and twenty-four percent (24%) was prediabetic—accounting for nearly fifty percent (50%) of the sample population. According to the Centers for Disease Control and Prevention (CDC) 2014 National Diabetes Report, 9.3% of the U.S. population have diabetes. In our sample, the percentage was over double that number, showing that diabetes is at an epidemic rate in Appalachia.

Next-Generation Risk Assessment Tools

An additional innovative method employed by Passport is its use of external data to detect any SDoH risk factors affecting our members to provide better comprehensive care management services.

Our trusted SDoH data sources include:

- U.S. Census Bureau's American Community Survey (ACS), which tracks more than one hundred (100) data elements regarding education, poverty and housing status by specific neighborhoods
- U.S. Department of Transportation, encapsulating its affordability index, walkability index, food access and supermarket availability by location
- Environmental Protection Agency's Smart Location Database, supplementing our existing social economic and environmental information
- U.S. Department of Agriculture records on food scarcity and deserts
- Data.gov information, which has over 230,000 datasets on demographics, education, community and safety
- Department of Housing and Urban Development, which reports on housing needs by geography
- Google technology (e.g., the technology that allows users to locate amenities in Google Maps) to calculate distances to the nearest pharmacy, grocery store, physician's office and hospital, which may identify potential gaps in the community's access to health care
- Consumer data sources that include household and/or member-level information on key SDoH domains, health behaviors and attitudes

Our system integrates dispersed SDoH data sources at different levels (e.g., individual, census block, census track) across five (5) main domains (housing instability, transportation barriers, food insecurity, financial stress and health literacy). The platform creates a single Social Needs Index, with five (5) levels, that indicates members' risks that could impact their health outcomes. The advantage of having a single index that indicates how an individual's social needs place health outcomes at risk is the ability not only to prioritize members but also to simplify the workflow for Care Advisors to integrate social support into clinical care management. We use the index to direct efforts and resources to the most at-risk members and pinpoint their individual needs. Our provider partners (e.g., Centerstone Kentucky) have also used this tool to better identify member needs as part of our Partners in Wellness Project.

As mentioned earlier, Passport also leverages an Opioid Risk Index to identify members who are overusing or misusing opioids. Our methods are based on the Centers for Medicare & Medicaid Services (CMS) clinical evidence guidelines and the oral morphine milligram equivalent (MME) criteria, which detects an issue if members intake 120mg MME or more of the pain medication across three (3) months. We believe our use of these innovative next-generation assessment tools helps us locate the resources necessary for our members to thrive.

Streamlined Referral Resources for SDoH

As part of Closed-loop SDoH approach, we streamlined our referral resources to address SDoH. This allows members' needs to be quickly addressed to help them be successful in achieving better health and a higher quality of life. Passport's CHWs and social workers use multiple cloud-based resource solutions tools to assist members with SDoH. They first conduct an online questionnaire with members to gain insights into their personal situation. Using the results of the questionnaire, the team then searches for the most appropriate community resources and social services. This information is then shared with our members to encourage them to become engaged in their health care and take charge of making further arrangements. We can also proactively make the appropriate appointments on behalf of our members, if preferred, so that they can obtain the needed resources more conveniently.

Passport's team tracks all referrals and activities in an integrated system for proper care coordination. We are always innovating because we know that technology enables us to better serve our most vulnerable population in an expedited manner.

C.20.a.ii. Approach for coordination with carved-out services (e.g. transportation and transitions to long term supports and services).

Passport's Coordination with Carved-Out Services

Passport's innovative and collaborative culture embraces the perspective that there is no "one size fits all" and "no wrong door" approach to integrated care. Rather, members have the opportunity to reach out for assistance through several options – there is no wrong door. They may call Member Services, Passport's main line or any other number such as Provider Services. The member will then be soft transferred to a Member Services representative (MSR) for assistance. Members may also email us through the website or contact us through the online member portal. They may walk into our office for face-to-face assistance or speak with a local Passport representative at a number of our community engagement outreach events. By having our team members located within the community they can be approached at any time or anyplace. For example, many have assisted restaurant workers, standing in line at the grocery or place of worship

Passport offers a comprehensive array of care management programs for members with acute complex and chronic conditions. We recognize that some members require additional specialized care to address their specific health needs. For transitioning to a skilled nursing facility, Passport's Care Management team assesses the member's needs and discuss options with the member and

Their family. If the member was already in the hospital, which happens frequently, this would be handled by the Transitions team. The Care Advisor or Health Educator would coordinate with the hospital discharge staff around receiving SNF location and transportation to that location. If there were any issues around coverage, the Care Advisor or Health Educator would coordinate with Utilization Management and other departments to resolve the issue. The Health Educator or Care Advisor would help explain to the member and family the process of Medicaid taking over once they have been transferred to the SNF and help to answer any questions. The Transitions Care Team would stay involved in the case, ensuring transfer to SNF went as planned and to serve as a “point person” for any needs that might arise during the process.

When a carved-out service is provided in conjunction with a medical benefit (e.g., transportation request, long-term support services), Passport will coordinate the benefits between carved-out and carved-in services. The UM Department may receive these requests directly from the subcontractor, the Member Services Department and/or from the requesting provider.

If a provider were to call in for a carved-out service for a member, the UM RN Care Advisor will verify that the member is in a Care Management program. If the member is not in a Care Management program, then the UM RN Care Advisor will also make a referral to Care Management if needed to assist in obtaining the service. The UM RN Care Advisor will also follow the referral in Identifi to ensure that the member receives the services they need.

For an excluded service, the UM RN Care Advisor will refer the requesting provider to community resources that can assist.

We also leverage innovative pilots and programming to support our members with special, long term and/or advanced needs and as a result are more likely to access carved-out services. These specialized integrated health programs include:

- Individuals with Special Health Care Needs (ISHCN) Program
- Guardianship Program
- Mommy Steps Program for preconception care, high-risk pregnancy mothers and neonatal care
- Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Program for children under age 21
- Pharmacy Care Management Program
- Prescription “Lock-In” Program aimed at members to properly use prescription medications and medical services for health safety and cost avoidance
- Community Transition Program for incarcerated members to return to society and reduce recidivism
- Transition of Care Programs for adults and newborns to move safely and effectively from an in-patient setting to their home

Individuals with Special Health Care Needs

Passport identifies and addresses the education, support and enhanced care coordination for Individuals with Special Health Care Needs (ISHCN), which provides enhanced care coordination, education and support

to this vulnerable population. Our Care Advisors give additional care to these members due to their personal situation and knowing that they are at an increased risk for chronic physical, developmental, behavioral or emotional conditions. All our efforts go to ensuring our special needs members receive timely and appropriate services, equipment and resources to support them in achieving improved health.

Members with special health care needs may face physical, behavioral or environmental challenges daily, which place both their health and ability to fully function in society at risk. Our approach delivers holistic care management that attends to their medical and behavioral health conditions as well as any SDoH that may hinder their ability to live a quality life.

With this approach, we extend health care services for individuals with special needs who meet certain criteria, such as children in/or receiving foster care or adoption assistance; blind/disabled children under age nineteen (19) and related populations eligible for Supplemental Security Income (SSI), including adults over the age of sixty-five (65); homeless (upon identification) individuals with chronic physical illnesses; children receiving EPSDT special services; children receiving services in a pediatric prescribed extended care facility or unit; and adult guardianship.

Passport's ISHCN service is comprehensive in providing the needed resources and services to our members. We take a sensitive and caring approach to ensuring that they receive highly coordinated care, and we strive to engage members' primary care and specialty providers to support the treatment plan. Our Care Advisors take the time to properly educate members about their health conditions, risks and symptom management, and we offer health coaching as an additional service.

We place emphasis on members receiving high quality care, especially as they transition to the home setting. Our care team facilitates and coordinates all the necessary arrangements, ensuring that members have the needed equipment, resources and services in a timely manner, including special transportation services. In the home environments, our team evaluates whether members and their caregivers have the adequate support and resources for care, including access to PCPs and any specialists. If it is determined that additional support is required, our care team proactively arranges for the services and makes appointments on members' behalf.

The member's care plan is an instrumental component of the program. Our Care Advisors are conscious of the member's condition and carefully review their current medication regimen to prevent adverse effects or interactions, while promoting medication adherence and identifying and addressing any barriers to their care plan. We want to increase quality of care and avoid any hospital readmissions by educating the member and caregiver while also coordinating access to care in the right setting and at the right time.

Identifying Individuals with Special Health Care Needs for Tailored Care Management Services

Passport's philosophy is that it is critically important to rapidly identify special needs members and enroll them in the proper care management program. Members are identified in multiple ways, including medical and pharmacy claims, laboratory results, health risk assessments, electronic medical record data, UM authorizations, hospital admission, discharge and transfer feeds, our Care for You free 24-hour nurse advice

line, state eligibility feeds and referrals from members themselves, caregivers, family members, providers and community agencies.

Once member data is received, Passport utilizes our system to stratify members into three risk levels. Using an evidence-based-medicine process and the latest medical guidelines, Passport offers special needs members the appropriate level of care in a timely manner. The risk levels for our ISHCN members are based on functional, emotional and intellectual abilities as well as on specific diagnoses.

Upon enrollment in the program, our Care Advisors complete an assessment with the member to determine the most appropriate care plan for his/her situation. In particular, Care Advisors assess if the member is experiencing any ongoing conditions warranting a specialized treatment or level of care management. Care Advisors also evaluate the member's living situation, level of caregiver support, health barriers or any other SDoH that may impede progress in the program.

After the assessment is complete, Care Advisors develop an individualized care plan or action plan tailored to the member's needs. A care plan, designed for high-risk members, includes any member-specific preferences or barriers to care, prioritized program goals, self-management activities, referrals to specialists or community-based services, a schedule for follow-up interactions and a program assessment. For lower-risk members or those with less complex special needs, the care team creates an action plan focusing on the member's goals, personal preferences and care coordination needs.

Medication reviews are a critical component of the care planning process. Passport has discovered that a lack of communication regarding medication therapy to the member, caregivers and transition health care facilities links to poor member outcome and creates potential medication errors. Medication errors are also linked to members' lack of understanding regarding their pharmacy treatment regimen. Some of the steps we take to reduce medication errors include having our Care Advisors perform an initial medication review with the member and at each clinical session. The member's comprehensive medication list is also available in our secure system for our care team's review, and our care team can adjust the pharmacy regimen to fit to the member's current or changing health status.

During the program, the care team closely monitors and evaluates members to determine their level of progress and any barriers in achieving their goals. In cases where the member is having difficulties in adhering to the treatment plan, the care team identifies the root cause of the health barrier. Many times, health barriers can be attributed to members' physical or mental disabilities, financial, language, hearing, motivation, culture or confidence issues and SDoH issues. Our Care Advisors work diligently to offers viable solutions to get the member back to advancing in his/her care plan goals.

Engaging Members and Providers through Education and Extensive Outreach Efforts

Our Community Engagement Team is assigned to regional areas across the Commonwealth to provide health and wellness education and health screenings. Community Engagement representatives hold events at local schools and civic and community centers to foster the early detection and testing medical conditions

affecting children in Kentucky. For example, in Floyd County, Kentucky, Passport participated in a "Backpack to School" event that provided free sports physicals, A1C testing, dental services and cholesterol screenings to members. Passport presented 800 free backpacks filled with much needed school supplies to the children at the event.

To encourage our members, between the ages of nine and 13 years old, to have preventative health screenings, Passport offers gift cards to use at retail stores, drug stores or a restaurant of their choice.

Rewards for Young Members

Young members, through the Passport Member Rewards Program, can receive the following gift card incentives for:

- Visits to a PCP for a well-child examination (Eligible from 0-21 years old)
- Annual flu shots each year, with children under the age of two years receiving two flu shot doses to be eligible to receive the reward
- Immunizations:
  - **Meningococcal** – The immunization must be administered between the child's 11th and 13th birthday.
  - **Tdap** – Children must have the immunization between their 10th and 13th birthday.
  - **HPV** – Young members must have three immunization shots between their ninth and 13th birthday
- One annual dental visit. Children aged two to 20 can earn an additional gift card incentive for visiting a dentist two times a year.

Community Transition Program

It can be difficult for incarcerated members to transition from a correctional facility back into the community. Many times, members suffer from behavioral health and/or SUDs and lack the necessary life-skills to adjust to society. To help our members, we provide member-centric care for physical and behavioral health services and address any SDoH issues they may have (i.e., literacy challenges, lack of education or job skill training) and needs they may experience in the future (i.e., employment, housing, transportation needs). We believe that it is important to begin the care management planning process early to allow time for the members to receive the needed resources and support to learn successful physical and behavioral health self-management skills. Our goal is to teach them to become healthy, productive, law-abiding citizens to reduce recidivism.

Passport participates in the National Governors Association's Re-entry Pilot Program, which is currently underway with DMS and the Department of Corrections. The program begins once we are notified of the member's anticipated release date from a correctional facility. Our care management team contacts the member to develop a pre-release care plan, which includes assessing needs and health condition, assessing medically frail status, creating program goals and determining necessary interventions. This member-centric care plan specifically addresses the following:

- Primary health

- Behavioral health
- Oral health care
- SDoH issues
- Identified needs that are not covered (i.e., medications, durable medical equipment, incontinence supplies, supplemental nutrition, phone access)
- Prescription assistance

Passport provides supportive care, outreach efforts and access to a network of community-based and psychosocial services. Our Care Advisors also assist with pre-authorizations for health care treatments that members will need during and after their transition into the community. Post-release, our Care Advisors outreach weekly to the members to evaluate their targeted care plan, review their utilization patterns and measure their program progress.

At this time, Passport has been notified of relatively few incarceration cases but has provided care management services to one hundred percent (100%) of those members. We will continue our care management services for members reported to be released from a correctional facility to help in their recovery and rehabilitation. On a monthly basis, we send reports about the National Governors Association's Re-entry Pilot Program to DMS and participate in calls with other managed care companies, DMS and the Department of Corrections. Passport fully supports this initiative and DMS/Department of Corrections goals in helping members live healthy lives and reduce recidivism.

Transition Care Program for Adult Members

Passport provides a Transition Care Program to help members safely and seamlessly transition back to their home from an inpatient setting and to stay healthy at home. Our care team develops and coordinates a member-centric transition of care plan to help our members remain in their home environment and have a lower risk for hospital or ED readmissions.

Passport's Transition Care Program is designed with specific goals to improve member health:

- Providing high-quality member care and reducing avoidable readmissions
- Improving adherence to the hospital discharge care plan
- Educating members and their caregivers about medical and behavioral diagnoses and self-management activities
- Improving care coordination for members across care settings
- Assisting members and their caregivers in identifying questions or concerns they have about their diagnoses or treatment plan and preparing them for an informed discussion with their provider
- Improving medication adherence
- Increasing member satisfaction rates and health outcomes

The Transition Care Program initiates prior to a member's discharge from the hospital. Our Care Advisors and Health Educators work closely with the hospital discharge planning team to effectively coordinate and

implement the discharge plan. Collectively, they provide proper continuity of care as members transition and achieve stabilized health.

After receiving the discharge notification, our Care Advisors and Health Educators contact the member within 24- 48 hours to begin the enrollment process for our Transition Care program and schedule a telephonic or home visit. Every effort is made to make members and caregivers feel respected, comfortable and at ease. Care Advisors first take the time to carefully listen and answer the member's questions. We then perform an assessment to identify any special needs the member may have, determine any health risks, reconcile medications for adherence and ensure that proper support resources are available. The assessment information is essential in developing the individualized care plan with the member, our team, caregiver and provider.

The care plan details the member's health status and goals, equipment required in the home, current medications and adherence plan, caregiver support needs, needed referrals to community resources, member education and health progress measures. Serving as a member advocate, the Care Team arranges for any post-discharge outpatient provider appointments and coordinates services for any special accommodations (i.e., caregiver support, durable medical equipment, medications and referrals to community resources). A key component of the transition care program is member education. The Care Advisor/Health Educator thoroughly reviews the educational materials with our members, so they fully understand the information and can begin to successfully self-manage their condition.

During the process, the Care Advisor or Health Educator shares information with the member's providers to fully engage them in the development of the care plan, seek their input for treatment and convey all information discovered through the care management outreach efforts. The team works to confirm the member is receiving the necessary care and services for health stabilization.

We are passionate about our members' success in their transition. Members are continuously monitored and evaluated through weekly outreach efforts until the end of the program. At that time, our Care Team determines whether the member has achieved the following program milestones and goals and can graduate from the program based on our defined criteria. If our members require further care and would benefit from additional care management, the team makes all the necessary referrals.

Passport assesses the impact of the Transition Care Program on an annual basis for quality assurance. We are dedicated to ensuring that the program meets both member needs and our goals for higher quality outcomes. Our Quality Management team collects data on program processes and medical outcomes to measure the results against established performance goals specific to each condition and the overall program. The specific measures that Passports uses for its analysis include avoidable inpatient hospitalizations, avoidable ED visits and other data points (i.e., ED visits/1,000, urgent care visits/1,000, ED observations/1,000 and specialist visits/1,000).

Member satisfaction is always a fundamental element of our quality assurance process. Passport wants to ensure that our members receive quality care from our team and are satisfied with the services we provide. Passport's Member Services team surveys callers to determine if they are satisfied with our services. Since we initiated this survey, we have received feedback from 40 percent of the callers who were invited to

participate. On a scale of 1-10 with 10 being the most satisfied, we received an average rating of 9.43 for questions asking how members would rate the knowledge of the MSR, if they were treated with dignity and respect, if the call was handled to their satisfaction, and how they would rate their overall experience with Passport. The survey results are shared with departmental managers and quarterly with ELT. We plan to continue these surveys and continually improve our services based on feedback from our members.

C.20.a.iii. A description of any value-added services the Vendor proposes to provide to Enrollees.

Value-Added Services to Promote Healthy Behaviors and Disease Prevention

Health Incentives

As also stated in Section C.9, to improve health outcomes, Passport continuously looks for opportunities to encourage members to get screenings and address other social determinants of care. Passport's Member Rewards Program emphasizes to members the value of preventive health care and community engagement. It provides vouchers or gift cards from retail stores, drug stores, or restaurants for completing appropriate wellness activities. We revise this program annually based on Passport's Population Assessment, HEDIS® performance, and other inputs, to align with Passport's quality improvement activities**. Attachment C.9-1_2021 Proposed Member Rewards** summarizes our proposed 2021 program, including which members are eligible, what incentives are available, and what screenings or tests must be completed to earn the incentive. The attachment also shows how the incentives align with the 2019 DMS quality strategy goals.

In 2019, member's use of health incentives was lower than expected. We evaluated potential barriers and have made it a focus in 2020 to increase awareness and make it easier for members to earn these rewards. Our community engagement team is positioned through events, social media, and targeted texting campaigns to bring broader awareness of the health incentives. To make it easier for members we partnered with a new vendor in 2019 to administer the incentives.

Even with low participation counts in 2019, health incentives offered through the Member Rewards Program have contributed to a three-percentage point improvement in the Childhood Immunization Status (CIS) Combo 2 measure rate in 2019. One hundred forty members took advantage of the rewards program, and CIS improved from 37% to 40%.

Over the past five years, the Member Rewards Program has contributed to a:

- 35% decrease in "low" birth weight deliveries
- 37% decrease in "very low" birth weight deliveries
- 39% decrease in preterm deliveries (less than 37 weeks)
- 46% improvement in Adolescent Immunization, Combo 1 (Meningococcal, Tdap/Td) achieving and maintaining above the Medicaid Quality Compass 90th percentile

SafeLink Phones

We also offer members free SafeLink Phones with no-charge monthly cellphone calling and data plans with unlimited text messages. Members can also sign up for the plan using their personal cell phone depending on their preference. The program allows members to place free calls to Passport for assistance and delivers targeted text messages with health tips and reminders.

Texting Initiative to Engage Members

In 2018, Passport began using texting services for members to help communicate basic health and benefit information. Passport's Marketing team in collaboration with our Clinical and Quality teams work to develop educational campaigns, and with permission from DMS, other social media platforms and new technologies specifically to address the health concerns of our members.

C.20.b. Provide the Contractor's approach to assisting Enrollees to access direct access services and second opinions, and referrals for services not covered by the Contractor.

Supporting Member Access to Direct Access Services, Second Opinions, and Referrals for Services Not Covered by Medicaid

Direct Access

We know that time is of the essence for some members' situations; so we work diligently to accommodate their needs and schedules. First, Passport educates members on the direct access services via our call center, member handbook, new member welcome call, member newsletter, Passport's website and their providers. We also ensure that members, guardians and providers know what direct access services are. Our team also maintains a large quality network to meet the needs of members wherever they are. We also monitor the utilization of these services as well as any member or provider complaints that might indicate confusion or access problems. Our Care Connectors help support members as needed with transportation services and other SDoH needs.

Passport's **Direct Access Services** is the ability of the member to make an appointment with a participating provider without a PCP referral, prescription or health plan authorization in most instances. There are a number of direct access provider types and services in which Passport members can make appointments without a referral or prescription from their PCP. These include:

Access to Preventive Health Services

- Adult and pediatric immunizations
- Screening and evaluation for sexually transmitted diseases
- Screening and evaluation for tuberculosis
- Women's health services specifically cervical cancer screening and breast cancer screening
- Voluntary family planning services

Access to Specialty Care

- Routine outpatient behavioral health services including substance use disorder treatment
- Routine vision care services, including diabetic retinal exams and the fitting of eyeglasses provided by ophthalmologists, optometrist, and opticians
- Routine dental services and oral surgery services and evaluations by orthodontists and prosthodontists
- Maternity care
- Chiropractic
- Orthopedic care
- Treatment for sexually transmitted diseases
- Treatment for tuberculosis
- Treatment for HIV-related conditions and other communicable diseases

Access for Individuals with Special Health Needs

- Members with special health care needs determined through an assessment to need a course of treatment or regular care monitoring as appropriate for the member's condition and identified needs
- Services provided by the Commission for Children with Special Health Care Needs or the University of Louisville WINGS Clinic

Second Opinions

Despite existing patient-physician relationships, we understand that there are situations where the health information communicated to a member (parent/guardian) may not be understood and/or is worth double-checking. Members may benefit from a second opinion; particularly in instances where they may be attempting to confirm a diagnosis or are dealing with persistent symptoms or complex situations with multiple providers.

At the member's request, Passport allows a second opinion related to a surgical procedure or diagnosis and treatment of complex and/or chronic conditions, either within Passport's provider network or outside the network, without cost to the member. Passport informs the member about the right to request a second opinion at the time of enrollment and during member phone calls when appropriate.

Second opinions assist the member to:

- Increase knowledge of condition and healthcare options
- Confirm the diagnosis is appropriate
- Ensure that they will receive the most appropriate and optimal treatment plan

In the event a member requests to schedule a second opinion with a non-participating provider outside of the Passport network, Passport will:

- Determine if a participating provider is available through the UM authorization process and establish medical necessity for the non-participating provider
- Contact the provider to evaluate if they are interested in joining the Passport network
- Provide expense reimbursement associated with travel for the second opinion providing the visit was authorized and it is for a covered service.

Passport's call center and Care Connectors can assist the member in locating a qualified physician for a second opinion. If a member/parent/guardian is uncomfortable with clinical recommendations, there is a high likelihood that the member will refuse to take any action and delay important treatment. To make this decision-making process easier for our members and expedite the decision process toward obtaining needed care, Passport's Member Services team and Care Advisors are trained to compassionately help members understand their right to a second medical opinion. After evaluating the member's level of comfort and understanding, they may also recommend obtaining a second opinion when it makes sense. We also educate our provider network on the utilization of second opinions to reinforce our philosophy of "member-centered care."

Referrals for Services Not Covered

Kentucky has a comprehensive Medicaid health benefit package, therefore the number of requests made for non-covered services are infrequent. When we do receive a request, Passport first verifies the accuracy of the request, by contacting the requesting provider and member to assure that the information is correct. Once the request is confirmed, Passport works with the member and the provider to identify services from other sources. Some examples of non-covered services include eyeglasses for adults or assistance with food, housing, and the payment of bills. When a non-covered service is truly needed, we employ efforts to meet the member's needs using our resource guides to assist members to obtain necessary non covered services. Using the example of eyeglasses for adults, we connect the member with community resources to provide the glasses at no cost. This is often performed in conjunction with our Care Connectors team; however, members, caregivers, and/or providers can make the referral.

The process is different for children who qualify for EPSDST special services which does allow for the coverage of medically necessary services that are not part of the Medicaid state plan. If the request is for an eligible child, the request is reviewed for medical necessity. If determined to be medically necessary, then the service is approved. Urgent requests are completed within 24 hours and non-urgent requests are completed within two days.

If the identified provider is not a member of our provider network, an out-of-network review would take place as well as a review for medical necessity.

A last option for non-covered medical services is to collaborate with DMS to determine if there is a compelling reason to allow for provision of the service on an exception basis. In this circumstance, the Passport Medical Director would be actively involved to support that no other options are available to meet the medically necessary need.

C.20.c. Describe the Vendor's proposed approach to the following:

C.20.c.i. Interfacing with the Department and Department for Behavioral Health, Developmental, and Intellectual Disabilities.

Interfacing with DMS and DBHDID

Passport values our two-decade history of collaborative relationships with both DMS and the Department for Behavioral Health, Developmental, and Intellectual Disabilities (DBHDID), who each have a key role in supporting the health of our members. Our Behavioral Health and Health Integration teams work diligently to maintain compliance with specific contract requirements and find great value in the quarterly meetings with DBHDID and regular Behavioral Health Director meetings with DMS.

In addition to these required meetings, Passport has an extensive history of additional collaboration with the DMS and DBHDID. Several examples are outlined below.

Passport's Participation in Interim Settlement Agreement Improves Access to Quality Housing

Passport participates in workgroups designed to address the implementation of the Interim Settlement Agreement, which will facilitate discharge of those who desire a personal care home to community living.

Collaboration on Passport's Foster Care Pilot Lays Foundation for Statewide Implementation

We worked closely with DBHDID, DMS and DCBS on our Foster Care Pilot, which laid the foundation for enabling DBHDID to bring High Fidelity Wraparound (HiFi) training and implementation to Kentucky. This group's input was critical for designing a program that was evidence-based and had the necessary supports to provide the training and supervision necessary for the intervention implementation. Regular meetings occurred with DBHDID during the program design process to obtain input from the DBHDID team. Once Passport had selected working with the High-Fidelity Wraparound Model, representatives from DBHDID were able to write and secure a national grant to bring in national trainers to establish a "train the trainer" model from Kentucky. Passport's Senior Director of Clinical Operations, Stephanie Stone, recently gave a presentation about this unique collaboration between an MCO with state agency partners in order to implement this intervention with representatives from DCBS and DBHDID at the Research & Policy Conference on Child, Adolescent, and Young Adult Behavioral Health in Tampa, Florida.

Data Sharing with DMS/DHBDID Improves Quality of Service for Members with Severe Mental Illnesses (SMI)

Collection and analysis of behavioral health data is part of our ongoing quality assurance efforts. When a potential practice improvement opportunity was identified through this process, Passport approached both DMS and DBHDID with an initiative to flag trends observed in care delivery for our members to ask they have

noticed similar trends in their data to better understand the needs of our member population. DBHDID encouraged the sharing of any additional analyses we have done outside of mandatory reporting in order to collaborate and identify challenges or barriers to care.

One example of this collaboration is assessing the causes and formulating a response to the variability in both delivery of the Therapeutic Rehab Program Service and levels of utilization of the service. Passport prepared a summary of claims data about the service utilization and conducted site visits to understand what happened during service delivery and then shared our analysis with DBHDID and DMS. In parallel, DMS evaluated updating the billing codes for the delivery of the service as they had also noticed a significant spike in utilization. DBHDID shared how critical access to this service is for members with severe mental illness. Since we have a team member who is a retired community mental health center executive that is the DBHDID safety net group of providers, we had the last 30-year historical knowledge of the implementation and development of the service.

We shared our plan to address the variability in quality of the service with DMS and DBHDID to ensure that our efforts to address poor performance did not put the service at risk. Our plan included returning to an authorization process for the delivery of the service in the community mental health center setting as this is where the most variability was observed. By adding authorization, we could ensure that treatment goals were appropriate and that members were getting the service they need. We returned to the authorization requirement that had been turned off for community mental health centers in 2013 in the Fall of 2019 to better address the variability we observed in the quality of the service across the Commonwealth and lack of connection to overall treatment goals. Having the input of DMS and DBHDID and their experience with the service, along with our team's experience, helped us arrive at a decision for moving forward for better ensuring the quality of the service.

SBIRT Model Collaboration Reduces Barriers to Innovative Services

The collaboration and partnership Passport have shared with DBHDID has been extremely helpful in reducing barriers to initiating innovative services to meet the needs of Kentuckians. Passport participated in three different national learning collaboratives during our implementation of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. DBHDID and DMS sought to implement this evidence-based practice as an effort to prevent or promote early identification of substance use disorder in Kentucky. Passport participated in an SBIRT collaborative sponsored by the Association of Community Affiliated Plans (ACAP) in 2014 in Dallas, Texas. DBHDID was able to send their substance use disorder program director to participate in the ACAP kick-off along with the Passport Behavioral Director. This was an opportunity for Passport and the Commonwealth to participate together in a learning collaborative that included shared lessons learned with other states. Having DBHDID participate in the organization meeting with other plans and state agencies was helpful in identifying barriers and how we might address these as we helped bring SBIRT to Kentucky.

C.20.c.ii. Coordinating with the Department to establish collaborative agreements with state operated or state contracted psychiatric hospitals and other Department facilities that individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID) use. Describe potential challenges and methods to address such challenges.

Collaborating to Ensure Access to Services for Persons with Co-Occurring Behavioral and Developmental Disabilities

Passport is contracted with all state operated or state contracted psychiatric hospitals and has been for several years. We also partner to coordinate care with other Department facilities that serve individuals with co-occurring behavioral health and developmental and intellectual disabilities (DID).

Collaborating with DMS to Alter Allowed Payments for Adult Members in State Hospitals

Until recently, Kentucky Medicaid MCOs were prohibited from paying for services provided at state hospitals for adult members. Passport worked closely with DMS in the implementation of providing payment for services delivered by "Institutions for Mental Disease" (IMD) for up to 15 days per month for each member that is hospitalized there. By allowing MCOs to pay for services at an IMD, DMS has created the opportunity for Passport and other MCOs to improve access to care for all Kentucky Medicaid members in this challenging situation. We will continue to seek similar collaborative methods in the future to address other potential challenges that could arise related to payment structures.

Passport Has Experts Dedicated to Addressing Potential Challenges

Passport has dedicated Behavioral Health (BH) Care Advisors and Guardianship Specialists who are experts at collaborating with state-led facilities to ensure the needs of members with co-occurring behavioral health and DID needs are met. With their years of experience, they have developed strong business relationships which helps to break through barriers. They employ specific interventions to help members with co-occurring behavioral health and developmental and intellectual disabilities ensure they get the care they need. These interventions include (but are not limited to):

- Providing in-person discharge planning support to ensure the successful transition of care and reduce the risk of readmission.
- Participating as active members of the state facility treatment team meetings.
- Making repeated attempts to reach each member discharging from state psychiatric facilities.
- Assisting members in completing Health Risk Assessments (HRA) to identify any opportunities to involve nurse care management.
- If SDoH needs are identified during the HRA, completing an additional screen through Healthify to aid in connecting members to community resources.
- Building relationships to better understand the needs outside of the screening process.

- To facilitate these transition services, Passport covers ABA services for adult members with IDD.
- Working in collaboration with the specific staff at community mental health facilities (CMHCs) funded by DBHDID for the development and implementation of crisis plans
- Connecting adults with IDD and mental health concerns with appropriate evidence-based treatment for dual diagnosis.

This team of experts will continue to work closely with facilities in developing continually innovative methods to address unique future challenges.

Helping Members Return to Communities of Origin

Passport understands the importance of helping individuals served by these state-led facilities to have opportunities to live in their community outside of a facility. Facilities must have a strong system of community supports to transition members into for care.

To improve this situation, we have worked closely with the facilities and DBHDID as they have endeavored to implement the Interim Settlement Agreement to assist individuals in returning to their communities of origin. We understand the particular challenges for these transitions such as the development of independence readiness skills. In the future, we will continue to work closely with providers to ensure community supports are in place to help our members navigate living more independently.

Collaborating with National Associations to Improve Clinical Practice Guidelines

As the behavioral health field continues to evolve, one of the potential challenges for this population is staying abreast of national best practices. In the future Passport will continue to seek expertise and collaborate with national organizations to bring improved clinical standards to our Kentucky Medicaid members. In fact, we have already begun addressing this concern for Individuals with Developmental and Intellectual Disabilities (DID). We are currently participating through the Kentucky Psychological Association with the American Psychological Association to create a new Clinical Practice Guideline for working with individuals with DID. The increased attention and focus on DID should help better articulate challenges and learn about the best practices around the country for working with individuals who have DID. The document should provide a gold standard for care when completed. Passport will share the final CPG once it is completed with our BHAC, DBHDID, and the DMS Behavioral Health Directors group for review and possible implementation.

Using Data and Working with Providers to Address Frequent Readmissions and Prolonged Residence

Passport will address potential challenges for this population through the use of data to identify problems, and by working with our provider partners to determine satisfactory resolutions that may benefit both the members and providers. For example, our Health Integration team recognizes that a particular concern for some members who have SMI or co-occurring behavioral health and IDD needs is that they have frequent hospital readmissions and may reside in Personal Care Homes for many years. We recently had identified through our data that there was a small group of members in Western Kentucky who had reduced their

readmissions to Western State Hospital. The team reached out to a provider who provided services in that part of the Commonwealth to see what might be impacting this change. The provider stated that Western State Hospital had called the Personal Care Home where he had a contract to work with members and asked the same question. The provider talked about how he was using licensed staff to deliver a Therapeutic Recreation Program and had several insights into helping members worked toward preventing readmissions and increasing movement of members toward independence. He is currently summarizing information about his experience and how we might expand this different approach in other parts of the Commonwealth. Passport has arranged for him to present his finding to the DBHDID Commissioner.

Providing Unique Solutions to Address Trauma Symptoms for Adults with IDD

Trauma symptoms and difficulty with regulation of emotions are relatively common among adults with IDD. There are specific adaptations of dialectical behavioral therapy for adults with IDD which we encourage providers to use. We have contracted with agencies that historically serve individuals with IDD and provided consultation around meeting the needs of non-waiver individuals in the state Medicaid plan. To address these types of challenges in the future, we will continue to seek innovative methods and best practices, and work with our provider partners to offer quality care which will address the unique needs of adult members with IDD.

Improving Communication with Providers

Effective communication between providers and MCOs for the unique needs of this population requires continual effort and improvement. Passport suggests the following to help address this challenge:

- Responsive and effective care management strategies, such as transition supports, rely significantly on timely identification of admission and discharges in both hospitals and emergency departments. Collectively, we would like to establish a better process for the identification of admissions and discharges in a timely manner at the state led facilities with the MCOs to occur.
- We recommend reconvening a group that met at the direction of the DBHDID Commissioner including the state-led facilities, the CMHCs, and the MCOs to return to the discussion of improving transition of care by region around the Commonwealth. Additional services have been added to the continuum and with experience now by some of the CMHCs with value based contracting it seems appropriate to reconvene and look at solutions to support the facility to community transitions collectively.
- Encourage use of Kentucky Health Information Exchange (KHIE) by state-led facilities and MCOs to share information.

We look forward to the opportunity to collaborate closely with these facilities and providers in the future to address additional challenges as they arise, in an effort to improve the health and quality of life of our members.

C.20.c.iii. Complying with the Mental Health Parity and Addiction Equity.

Compliance with Mental Health Parity and Addiction Equity

Passport has achieved and remains in compliance with the Mental Health Parity and Addiction Equity Act of 2008 and 42 C.F.R. 438 Subpart K. As required by DMS, Passport conducted a mental health parity analysis to ensure access to mental health and SUD is treated equally with medical health services. We have gathered BH/SUD benefit design, policies and procedures (including UM policies) and claims payment information and compared to this to the medical program. Parity was examined in the areas of medical necessity criteria development, prior authorization, concurrent review, prior notification, retrospective review, outlier management, experimental/investigational determinations, medical appropriateness reviews, practice guideline selection/criteria and blanket exclusions for court ordered or involuntary treatment that is medically necessary. Our analysis was shared with DMS and we were considered in compliance with the Mental Health parity and Addiction Equity Act expectations. Regular reviews to ensure components are up to date and meet the spirit of parity will be conducted.

The importance of parity is that it:

- Reduces the stigma of mental health by treating these conditions comparably with physical health conditions
- Promotes overall wellness among the membership
- Decreases barriers to the access of mental health and SUD treatment

Ongoing parity compliance is continually demonstrated by reviewing and comparing the physical and behavioral health benefit management, including pharmacy, upon contract implementation and any time a change is made to the benefit structure. During this review the following items will be assessed:

- Quantitative treatment limits
- Non-quantitative treatment limitations
  - Preauthorization and pre-service notification requirements
  - Fail-first protocol
  - Geographical limitations
- Financial requirements
  - Deductible
  - Out-of-pocket maximum
  - Copayments and coinsurance

As part of ongoing efforts to maintain parity compliance, the items above are monitored using the DMS-created parity tool. Our ongoing, multidisciplinary workgroup will remain focused on parity compliance.

C.20.d. Describe initiatives the Contractor will implement to identify trends in provider-preventable conditions to educate providers who are identified as possibly needing support in better addressing those conditions.

Monitoring, Interventions and Education to Curb Provider Preventable Conditions

As a local health plan embedded in the community for more than 20 years, our collaborative relationships with providers are a strength. Many of our team members are Kentucky-licensed professionals who have worked their entire career in Kentucky side by side with our providers. The Health Integration team alone has five team members and collectively they have 100 years of experience delivering care in Kentucky to Kentuckians. We understand how important and challenging it is to look at trends in provider-preventable conditions with providers to identify barriers and opportunities for education and support to improve health outcomes. These provider relationships are critical for addressing performance improvement opportunities related to quality of care, including provider preventable conditions (PPC). Passport monitors for Category I and II PPCs as defined by the Centers for Medicare & Medicaid Services (CMS) as well as the Agency for Healthcare Research and Quality (AHRQ) Prevention Quality Indicators (PQI). We also prospectively monitor for potential concerns. The PQIs identify issues of access to outpatient care, including appropriate follow-up care after hospital discharge. This allows for identification of admissions and readmissions that might have been avoided through high-quality outpatient care. Time is spent sharing any concerns from the analysis of preventable conditions with providers including education about their performance compared to other like-sized provider groups to better understand the trends we see. We then partner with providers who perform at a lower level for preventing conditions to develop targeted action plans for improvement including addressing barriers and connecting to education and resources to help them better manage provider-preventable conditions.

Passport uses the latest tools, research and methods to support the identification and deterrence of provider-preventable conditions. Specifically, Passport tracks and assesses trends of:

- Claims and utilization data especially readmissions
- Provider complaints
- Member complaints
- Sentinel events

Our teams work diligently to proactively identify potential gaps of care and resolve them before the member experiences a preventable complication. Through our Identifi system, we monitor claims information to track trends in PPCs at the provider and facility level. We also monitor member and other provider complaints that suggest a potential PPC. Passport is able track 42 measures to identify potential gaps of care, and the system generates insights into the specific issues and creates a roster of “Patients with Care Gap Opportunities.” In addition, our clinical and Quality teams are trained to identify indicators that might alert us to a potential PPC. The team regularly incorporates sentinel events and referrals into the Passport

patient safety program. Issues, concerns and events are taken to the appropriate committee for review and decision-making. Provider education is provided by a Medical Director or the Chief Medical Officer supported by other health plan members.

The Population Health team serves as a primary resource for best practices, training, and questions when working through care gaps in Identifi. In addition, the CMO and Medical Directors actively participate with the interdepartmental team and providers to identify opportunities for improvement and corrective action plans (CAPs). These CAPs are monitored by our Quality Department to assure that the interventions occur and progress toward issue resolution. Updates and final findings are presented to the QMMC.

Case Study

Passport is currently working with an inpatient behavioral health facility that appeared to have one physician provider with a much higher readmission rate during our routine review of our readmissions data. Passport has met with the facility and provider to learn more about this provider and the impacted members. We conducted a chart review as part of the process. During the chart review, it appeared that the impacted members served by this provider also had regular use of restraints during their stay. We are now working closely with both the facility and provider to ensure the safety of our members, but also to learn more about the model of care and how restraint is used. The facility had already obtained a grant to increase the knowledge and practice of trauma informed care.

While it is not a HEDIS metric or information available in claims data, both Passport and the provider agree that reducing use of unnecessary restraints is in the best interests of the members. Passport has been asked to partner with the hospital's clinical leadership to help learn more about the restraint prevalence as we have a couple of clinical team members with experience in reducing use of restraints in a psychiatric facility. We have jointly established quality goals with the facility of reducing use of restraint and readmissions of members. Our next step is to determine if this provider is an outlier in restraint-use compared to other providers, through additional review of other provider charts. This collaboration could not be possible without the strong partnership and trust we have with the facility as this information is not available in claims data; the transparency being provided comes from a shared desire for members to receive the best care possible. We are working with our provider partner to help reduce use of unnecessary restraints and readmissions by providing support, sharing data, learning together with the provider, and sharing the clinical expertise of our team members to improve the quality of care provided to our members.

With the implementation of KHIE, Passport will be able to enhance connectivity and efficiency in several areas. Real time information about admissions, readmissions and transitions will provide Passport the opportunity to quickly and effectively respond to identified issues. We will be less reliant on lagging claims data or self-reported information. This access will also allow us the ability to decrease the burden of providers recreating connections to our systems, thus decreasing time, cost and frustration.

Beyond CAPs when a PPC does occur, Passport also has a payment policy that excludes payment for PPCs and hospital acquired conditions. Our Provider Network Management team has a provider-oriented webinar

that specifically address PPCs. In additional we will provide in office training on the policy via our Provider Network Management team.

Conclusion

Passport has a dedicated and experienced team of Kentucky providers that knows the marketplace and the needs of our members. We use repeatable and effective processes to provide covered services to ensure that our members receive a person-centered care plan that address their medical and behavioral health service needs, as well as consider how SDoH contribute positively or negatively in achieving their goals for wellness.

We have been a part of the Kentucky health care system more than two decades and as such have established strong relationships with local community agencies and our provider partners to gain their expertise and insights into the needs of our members. Passport also collaborates with DMS and other governmental agencies to ensure that our special needs members receive the care management services they need to achieve optimal health. These relationships have led to beneficial collaborations for our members. For example, Passport identifies provider-preventable trends through data or interaction with providers and members. We then share these trends with our provider partners to better understand the trends and help improve the care delivered to our members. We work in tandem, provider to provider, to educate and ensure they have access to the information needed to change these provider-preventable trends. Our clinical team members are open to sharing the experiences they have in the delivery of care, connecting providers to other clinical resources, and learning how we can work together to increase the quality of care.

Our organization is committed to developing innovative programs to further enhance our capabilities. We leverage technology solutions to continuously improve our current programs and gain insight into new offerings. Passport is committed to leveraging our leaders, team members, systems, providers, community, and resources toward serving our Medicaid populations. We are prepared to deliver the covered services mentioned in the contract and within this response.

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.