

C.23. Behavioral Health Services

- a. Provide a comprehensive description of the Contractor’s proposed Behavioral Health Services, including the following:
 - i. Current or planned delegation to delegate all or part of the provision of Behavioral Health Services to another entity.
 - ii. Process for monitoring and evaluating compliance with access and care standards.
 - iii. Proposed innovations to develop and maintain network adequacy and access.
 - iv. Process for follow-up after hospitalization for Behavioral Health Services within the required timeframes.
 - v. Process for ensuring continuity of care upon discharge from a Psychiatric Hospital.
- b. Describe the Contractor’s approach to meeting the Department’s requirements for operating seven (7) days a week, twenty-four (24) hours a day emergency and crisis hotline as defined in RFP Attachment C “Draft Medicaid Managed Care Contract and Appendices.”
- c. Describe the Contractor’s approach to coordination and collaboration between the Contractor, Behavioral Health Providers and the PCP as defined in RFP Attachment C “Draft Medicaid Managed Care Contract and Appendices.”

Passport Highlights: Behavioral Health Services

How We're Different	Why It Matters	Proof
Fully integrated behavioral health (BH) and physical health (PH) care, with a focus on eliminating social barriers to improve outcomes and reduce spend	<ul style="list-style-type: none"> BH and PH are linked closely together, as a member's mental health status directly impacts the ability to maintain optimal physical health. Without seamless integration of care, long-term outcomes are difficult to achieve 	<ul style="list-style-type: none"> Weekly integrated care rounds for complex, high-risk members coupled with whole-person care management has demonstrated a 25% reduction in total expense and 22% reduction in inpatient (IP) admissions
Multiprong strategy to improve access, not just adequacy, to behavioral health services and care	<ul style="list-style-type: none"> Barriers to care and treatment exacerbate health problems and lead to poor outcomes and excess spend. Less than half of adults with mental illness in Kentucky receive any form of treatment (SAMHSA, 2015) 	<ul style="list-style-type: none"> Removed member copays for BH services Increased telehealth access showed a four-fold increase in BH claims in 2019 A 22% growth in BH network between 2018 and 2019
Superior predictive analytics to identify the most impactable members, including those without a documented BH diagnosis	<ul style="list-style-type: none"> Many members who need BH services may not have a documented diagnosis that would facilitate traditional methods of identification 	<ul style="list-style-type: none"> Risk stratification tool that accurately identifies members before an adverse event over 80% of the time, even without a documented diagnosis
Innovative Value-Based Payment Arrangements with providers to encourage high-quality integrated BH care	<ul style="list-style-type: none"> Aligned provider incentive models coupled with administrative and clinical practice support is critical for the delivery of integrated care 	<p>Partners in Wellness Incentive with Centerstone Kentucky (Seven Counties Services) resulted in:</p> <ul style="list-style-type: none"> 34% in combined medical IP, emergency visits, and BH IP expenses 45% in IP hospital stays 27% in emergency visits 69% in hospital readmissions

Introduction

John, a 41-year-old from Kentucky, struggles with multiple chronic health conditions, including major depressive disorder, substance use disorder (SUD), chronic obstructive pulmonary disease (COPD) and hypertension. In the last three (3) years, John has lived at multiple addresses in central Louisville and is now homeless. While he has had numerous inpatient admissions and emergency department (ED) encounters, he has not had any successful or sustainable follow-up care plans. John does not have a consistent care team; thus, his treatment lacks continuity and accountability. Due to poor overall health management, he is a high-cost health consumer, yet he remains very ill and at risk for further decompensation. John is a real-life example of an individual struggling to navigate an outdated health care system in which services and needs are mismatched.

John's story—and those of many other community members—highlights the difficulties of those with complex and comorbid diagnoses as they navigate a system of services ill equipped to meet their BH, PH and social services needs. In 2019, twenty-two percent (22%) of Passport members had a BH diagnosis, with the top five percent (5%) accounting for forty-four percent (44%) of total claims expense for this cohort. These statistics account for people diagnosed with a BH condition. Many people with BH conditions remain undiagnosed, misdiagnosed or untreated due to social stigma or barriers to accessing appropriate care.

In 2019, 22% of Passport members had a BH diagnosis, with the top 5% accounting for 44% of total expense

Approximately sixty percent (60%) of people with BH conditions go untreated, which results in a negative impact to quality of life. This is particularly concerning when undiagnosed BH issues such as anxiety and depression coexist with medical conditions, resulting in poor PH and BH outcomes. The presence of a BH condition along with a chronic medical condition is also directly linked to substantial increases in overall health expenditures. In 2019, Passport's inpatient service utilization for members with a primary diagnosis of a BH condition accounted for only two percent (2%) of total inpatient expenditures. However, inpatient services with *any* BH diagnoses (including substance use disorder) accounted for forty-four percent (44%) of total inpatient expenditures, suggesting that BH plays a major role in comorbid PH conditions and is a significant contributing factor to the risk of poor outcomes.

Passport has long-standing, deep relationships with local BH and primary care providers, as well as community health advocates around the Commonwealth. Through these relationships, Passport understands the challenges that providers face in delivering the *right* integrated care at the *right* time to those members who need it most. Passport provides holistic, integrated BH care for members across the care continuum and uses advanced technology and analytics to identify members who are most impactful.

- C.23.a. Provide a comprehensive description of the Contractor’s proposed Behavioral Health Services, including the following:
- C.23.a.i. Current or planned delegation to delegate all or part of the provision of Behavioral Health Services to another entity.

Strong Partnership Ensures Success of Our Behavioral Health Program

Passport has partnered with Beacon Health Options (Beacon), the largest BH organization in the country, which serves more than 40 million individuals across fifty (50) states. Beacon maintains full National Committee for Quality Assurance (NCQA) Managed Behavioral Health Organization accreditation and provides a full spectrum of high-quality care for a wide range of partners, including regional and specialty health plans; employers and labor organizations; and federal, state and local governments. Beacon works with Medicaid programs that serve 14 million members across the country and has been instrumental in transforming the way BH performance is measured and care is delivered.

While we have selected the nation’s leading managed BH organization as our partner, we also understand and acknowledge the challenges we have had in our work with Beacon in the past. We have learned from these experiences and have refined the relationship, resulting in a new partnership that fundamentally changes accountability and provides clear incentives to outperform expectations on access and care standards. Under our new arrangement with Beacon:

- Passport built an integrated whole-person care model delivered jointly
- Passport continues to maintain control of the provider network
- Passport continues oversight on any utilization management (UM) changes

Passport holds Beacon accountable for successful delivery of administrative services through a rigorous oversight structure that includes more stringent SLAs, with higher penalties tied to termination.

In July 2019, Passport and Beacon entered into a capitated arrangement to bring a highly refined and nationally tested model to Department for Medicaid Services (DMS). A summary of the accountable partner by function is summarized in **Exhibit C.23-1** below.

Exhibit C.23-1: Accountability Partners by Function

Function	Accountable Partner
BH program governance and oversight	Board of Directors, Partnership Council, Quality Medical Management Committee (QMMC), Behavioral Health Advisory Committee (BHAC)
BH program daily oversight and Vendor management to existing and enhanced service-level agreements	Passport
BH policy and medical necessity execution oversight	Passport
BH claims processing and claims payment	Passport
BH network contracting	Passport
BH and PH integration	Passport and Beacon
BH network strategy and payment strategy	Passport and Beacon
BH quality management	Passport and Beacon
BH crisis line	Beacon
BH UM execution	Beacon

Stringent Vendor Oversight to Address Member and Provider Opportunities

Passport ushered in a new era of integration and accountability in 2019 and will continue to build on those improvements. We have listened to DMS and the member, provider and stakeholder communities and seek to lead the statewide charge in setting new quality standards for managed care organizations (MCOs). In order to execute this vision, we instituted a number of enhancements that result in objective performance that is measured by five (5) new SLAs between Passport and Beacon (see **Exhibit C.23-2**). Performance against these measures is reported through the aforementioned cascading governance structure, including the BHAC, QMMC and Delegation Oversight Committee, reporting directly to the Board of Directors.

Exhibit C.23-2: New SLAs with Beacon

Goal	Service-Level Agreement	Program Enhancement(s)
Support quicker claims payments through increased support to providers experiencing difficulty with clean claims submissions for pregnancy/SUD claims	<p>For impacted providers, Beacon provides a weekly defined block of time to provide claims support. Beacon tracks resulting clean claims submission performance.</p> <p>As of July 1, 2019, Beacon launched a weekly concierge technical consult session for providers who had incompatibility issues with the UB-04 claims submission for SUD services on pregnancy primary claims for.</p>	<p>By the end of 2019, 99% of claims were processed within 30 days of submission.</p> <p>In 2020, Passport will migrate all BH claims processing, adjudication and payment to the its medical claims platform to provide one door for claims submission. This single-system approach should benefit those providers with integrated PH and BH services.</p>

Goal	Service-Level Agreement	Program Enhancement(s)
Increase transparency on the approach, timeline and accountability for operational and system changes	Beacon provides a monthly report of status, priority and expected completion date for the tracking and management of progress pertaining to system configuration changes. Once a mutually agreeable timeline is determined for each project and requirements are finalized, 80% of projects will be completed within five (5) business days of the agreed upon timeline.	On July 1, 2019, Passport instituted a new project management discipline and process by which new projects are estimated, scheduled and managed through implementation. This “plan the work, work the plan” approach establishes deadlines for changes and deliverables. Penalties are included in our SLAs for completion expectations.
Accelerate transition for foster care members to a safe placement during and after the decertification process	Case manager contacts provider within one (1) week of decertification for an aftercare update. Case manager remains in weekly contact with Department for Community Based Services (DCBS) worker and facilitates transition planning when placement is imminent.	Passport has instituted a new process and policy for follow-up and transition of some of our most vulnerable members. Our foster care/childcare expert care team resources are accountable via policy to maintain weekly contact with the DCBS social worker to address barriers to care and to support the member. Passport ensures safe and smooth transitions.
Ensure continued strength in performance and accountability for clinical results	Beacon will maintain or improve upon baseline 30-day readmission rate. Passport and Beacon established a 12-month, 30-day readmission baseline (using 12 months of experience + 3 months run-out; e.g., April 2018 through March 2019), and Beacon will maintain or improve upon that baseline for an annual period starting July 1, 2019. For Q4 2019, Beacon exceeded its baseline readmission rate.	Readmission rates have been maintained since July 2019 with targeted reduction efforts set to launch in 2020. For example, Passport has established a relationship with UofL–Peace Hospital, our largest provider, where our case manager is onsite two (2) days a week for collaborative discharge planning with the providers and the member. As we evaluate this promising model, we will identify other providers to engage.

Behavioral Health Advisory Committee Guides Passport’s Integrated Whole-Person Behavioral Health Care Model

To successfully provide seamless integrated care for our members, Passport created the provider-driven BHAC. The BHAC is made up of community providers, advocates and consumers who meet quarterly to provide input on policy; clinical practice guideline adoption; proposed models of care, inclusive of new, innovative approaches; and overall performance. Formal participation (as well as ongoing informal input) in our programs by statewide Kentucky providers in our governance



structure leads to greater member engagement and improved outcomes, and it allows us to be a better steward of the Commonwealth's resources. The BHAC is accountable for ensuring that Passport and Beacon work collaboratively to create a seamless experience for our members, with no handoffs. Members of our BHAC include:

- Kathy Dobbins, LCSW, CEO, Wellspring
- Jessica Estes, DNP, APRN, Estes Behavioral Health and executive director for Kentucky Board of Nursing
- Don Rogers, MA, licensed psychological practitioner, chief clinical officer, Bluegrass.org
- Chris Peters, MD, psychiatrist, University of Louisville School of Medicine associate professor, Department of Pediatrics, Child and Adolescent Psychiatry
- Ramona Johnson, MSN, APRN, president/CEO, Bridgehaven
- Sheila Schuster, PhD, licensed psychologist, advocate, Kentucky Mental Health Coalition
- Susan Turner, peer support specialist, Bridgehaven

The BHAC has made recommendations that have helped shape Passport policy in many ways. For example:

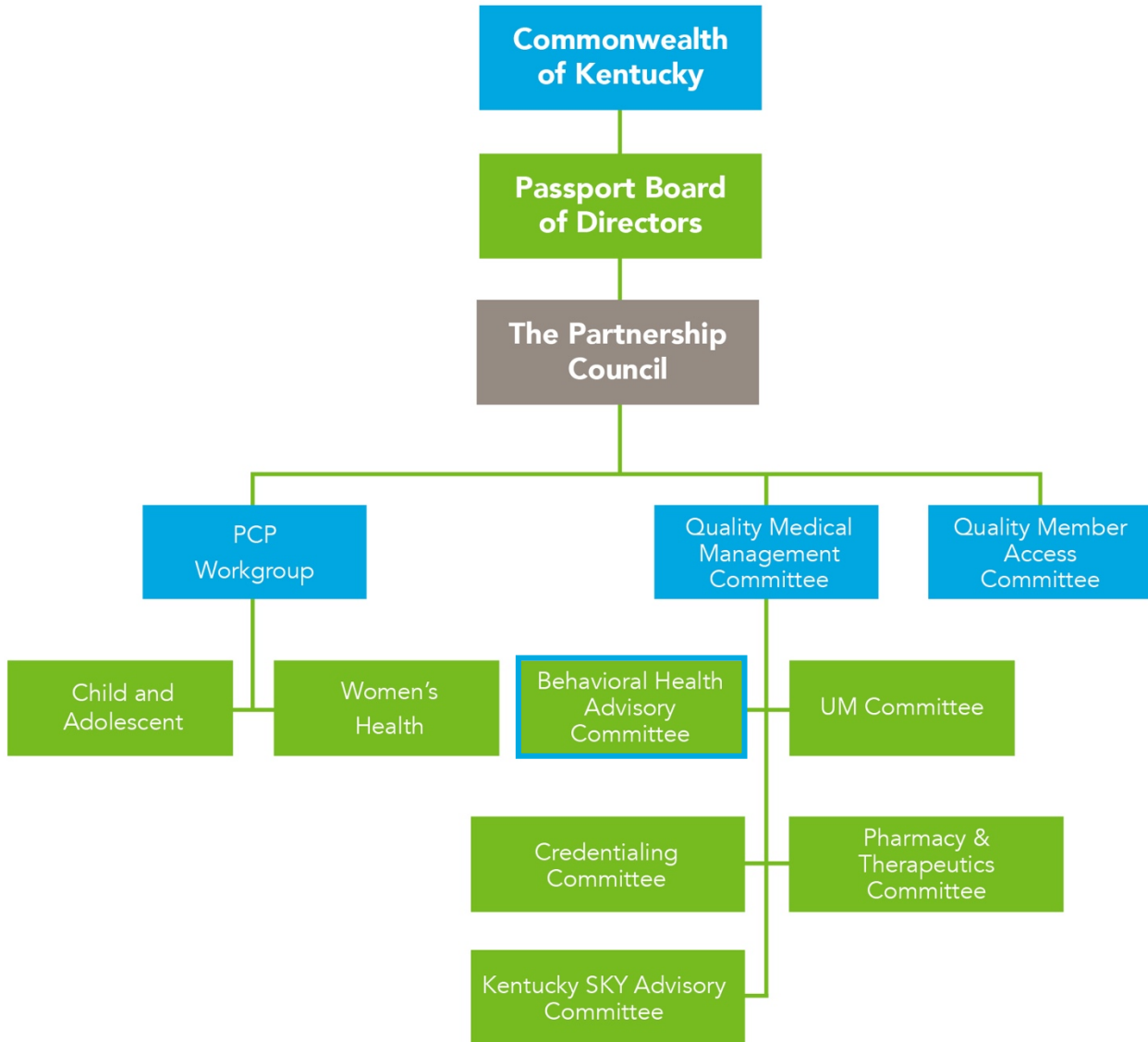
- **Drug formulary changes:** The BHAC provided solid clinical evidence for having select stimulants be a nonpreferred choice for members, except in children and adolescents with active prescriptions. The Pharmacy and Therapeutics (P&T) committee adopted the recommendation.
- **Social Determinants of Health (SDoH) communications:** BHAC committee members assisted Passport in designing a new communication to our members about our SDoH philosophy that emphasized connection to community and opportunities (versus support) to promote member empowerment. Their feedback included perspectives from providers, advocates and members, and it helped to increase the receptivity of the message for members with serious mental illness (SMI).
- **Support for holistic care for foster care members:** The BHAC helped Passport design the accountability processes in implementing the evidence-based model of care, provider interactions and member experience. This input resulted in bringing to Kentucky high-fidelity wraparound services, an evidence-based practice that uses train-the-trainer supervision to ensure fidelity to the model.

The BHAC reports directly to the QMMC, Passport's Quality Improvement Committee (QIC), alongside Credentialing, P&T, UM and Kentucky (SKY) advisory committees. Child & Adolescent and Women's Health committees report up through the PCP Workgroup. The QMMC provides input and oversight for all quality improvement (QI) activities throughout the health plan and provider network and is directly accountable to the Partnership Council, which is responsible for quality and outcomes of the services provided by the network, Passport or any subcontractors. Oversight of the Partnership Council is provided by Passport's Board of Directors, as illustrated in **Exhibit C.23-3**. The Board of Directors is our highest internal level of oversight and includes the important provider voice to hold us accountable in the work we do every day.

Our providers are not just advisors; they have true accountability through participation in each level of this cascading governance structure. Several of our BHAC provider members have moved to the next level of oversight, QMMC, to ensure an integrated approach that improves health and quality of life. Furthermore, the chair of the Partnership Council is a BH provider in the community. Having provider input is critical to ensure that our services are integrated at each rung of the ladder, from the bottom to the top. The BHAC

reviews and provides feedback on compliance reports, with the option to escalate any concerns through the QMMC up to the Board (see **Exhibit C.23-3**).

Exhibit C.23-3: Passport’s Governance Structure



Integrated Whole-Person Care Drives Passport's BH Services Approach

Passport's approach to providing exceptional BH services starts with the identification of high-risk, high-need members and delivery of integrated and coordinated care across the continuum. Our commitment to provide whole-person care means that we consider the member as a complete individual, factoring in physical, behavioral and social needs. This holistic approach is the basis of the Passport Model of Care (MOC), an innovative, member-centric approach that incorporates health status, benefit plan design and SDoH to help empower and engage members. Our MOC supports these goals with the following steps:

1. Aggregate disparate data into a **whole-person profile** to understand all member needs
2. **Stratify members at highest risk** of incurring an adverse event, regardless of documented BH diagnosis
3. **Engage and assess** members for effective integrated BH services
4. Create holistic **member-centric care plans** to achieve better whole-person health
5. Provide **integrated care management services and interventions** that are clinically effective and culturally sensitive
6. Engage all providers caring for a member to ensure **seamless coordination across settings and specialties**
7. Responsibly discharge or close the case to **ensure member well-being and continuity of care**

A summary of our integrated components can be found in **Exhibit C.23-4** and explained in more detail in the sections that follow.

Exhibit C.23-4: A Summary of Passport’s Integrated Components of BH

	Traditional Care	Passport’s Integrated Approach
Data	Two (2) separate and disconnected claims systems for PH and BH services	One front door to receive and process all claims, regardless of primary diagnosis or specialty, to be implemented in 2020. Single data warehouse with comprehensive member records consisting of BH and medical administrative data, clinical data, SDoH and member self-reported information.
Stratification	Separate identification protocols for BH risk and PH risk that often overlap and conflict, resulting in uncoordinated outreach and fragmented care	Combined BH/PH stratification algorithm and protocol that identifies members by overall risk for specific adverse events in the context of the member’s collective conditions across BH and PH. These include assessing members for SMI and severe emotional disability (SED), as well as co-occurring developmental disabilities, SUDs and tobacco use.
Assessment/Screening	None or stand-alone BH screening tools and assessments that are often underutilized	Embedded evidence-based validated BH screening tools, such as depression severity screening (e.g., PHQ-9, PHQ-A), anxiety screening (GAD-7), alcohol and substance use screening (CAGE-AID), screening for nicotine use, screening for age-appropriate developmental norms, or Pediatric Symptom Checklist (PSC-17) within single comprehensive assessment across physical, behavioral, social, nutritional and environmental domains.
Care Plan	Separate and often conflicting BH and PH care plans that result in member and family confusion, as well as poor adherence	Our solution provides an integrated care plan that encompasses comprehensive BH and PH information and incorporates member-centered goals related to BH needs and any health behaviors impacting co-occurring PH conditions.

	Traditional Care	Passport’s Integrated Approach
Care Team	Separate BH and PH care teams that do not communicate and attempt to assign members to a single category, regardless of co-occurring conditions	Multidisciplinary care team, including nurse Care Advisors and BH Care Advisors, who work together as members of a single care management team, sharing cases and cross-consulting with each other as a member’s needs require.
Programs and Interventions	Separate and distinct BH and PH programs, requiring members to bounce between different programs and care teams that have only part of the holistic picture	Members will be identified for the most appropriate program based on their PH and BH conditions, predicted risk for an upcoming avoidable event, or needs that warrant care management intervention. All programs have been designed to assess and address a member’s holistic needs, including physical, behavioral, emotional and social. All needs will be met while the member is enrolled in one (1) program, by using a collaborative multidisciplinary care team approach supported by an integrated case rounding process.
Workflow & Documentation Tool	Two (2) documentation platforms that are not interoperable. Information gathered in one (1) platform is unavailable to staff working in the other platform, resulting in redundant and contradictory care.	All care management activities— PH and BH—are guided by and documented within a single care management system (Identifi SM) that includes protocols and workflows for PH, BH and substance use conditions, and which automatically generates a single integrated care plan for the member.
Provider Engagement & Communication	No communication, or fragmented communication (only PH or only BH providers are engaged)	Multidisciplinary care team works collaboratively with the PCP, BH provider and other specialist(s), communicating member needs to all providers and providing smooth transitions across services.

Addressing SDoH Needs Through Innovation and Community Engagement

BH and PH are linked closely together, as a member’s mental health status directly impacts the ability to maintain optimal physical health. Failure to link BH and PH results in poor health outcomes and higher preventable costs. In turn, chronic medical conditions can have a significant impact on BH and decrease a member’s ability to engage in their BH treatment and recovery plan. This dynamic is often amplified by basic unmet social needs, such as safe and stable housing, available transportation and access to healthy food. Our MOC considers these needs holistically and uses evidence-based medicine to comprehensively assess and address each member’s unique behavioral, physical and psychosocial needs. This ensures members receive the appropriate care, interventions and support they need to fully engage in treatment. Our member-centered plans are sensitive to the full spectrum of needs of our members, and our multidisciplinary care team is responsive to a member’s functional level.

Our **closed-loop SDoH model** magnifies the impact of our Population Health model in achieving improved outcomes for our members.

Using our locally driven, community-based model, Passport has been an early innovator in the national movement to address SDoH. This model has been honed over our two decades in Kentucky based on deep experience working with the population and understanding the specific needs and gaps in each neighborhood and community, and by creating multiple access points and service providers within the health network. Specifically, Passport’s member-level social data and advanced analytics—coupled with its embedded community partnerships and thought leadership to address current limitations in local health care and social services delivery systems—result in higher member engagement and improved health outcomes.



Proactive Identification of Social Needs Using Machine Learning

One of the most pressing challenges to proactively identifying and supporting members who have social needs is the lack of member-specific insights and data. To address this, Passport relies on the **Social Needs Index (SNI)**—a unique, easily understandable score that quantifies a member’s SDoH risk level correlated to adverse health outcomes. In 2019, Passport conducted a pilot program demonstrating that the SNI was able to accurately predict those with the highest social needs, after which Passport conducted SDoH outreach. Among the members with high SNI scores who Passport contacted and assessed, one hundred percent (100%) reported at least one (1) SDoH need, and 90% reported multiple needs. Food (thirty-four percent [34%]), employment (twenty-three percent [23%]) and housing (sixteen percent [16%]) were the most reported social needs. Given the success of the pilot program, we will make the SNI available for all Passport members in 2020.

Tracking SDoH Referrals Through United Community and Healthify

While many 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 well-being. Through Passport’s partnership with Metro United Way, we supported the launch of United Community—a communitywide initiative to deploy an innovative shared technology platform to initiate and close referrals across many organizations, agencies and services, as well

as create and maintain a social services record for citizens of the community. The United Community Governing Team includes Passport (representing the health plan perspective), the Louisville Metro Health Department (the health provider perspective), Evolve502 (the educational perspective) and Metro United Way (the social services perspective). United Community’s goal of becoming the first shared community social services record in the country to include its local school system is on the way to reality. The platform launched in April 2019. Passport has taken the data from our work with connecting members to social service providers and helped to validate the Unite Us tool and ensure that the providers who our members work with most are included in the United Community. We are currently participating in the design of the analytics tools to evaluate the impact of the partnership and platform not only in improving health outcomes, but also in preventing other adverse social outcomes, such as unemployment and incarceration.

While Passport will continue to support the success and expansion of United Community beyond Jefferson County, we have also invested in Healthify as our statewide solution to closed-loop referrals. Healthify is a web-based platform that curates the highest quality Kentucky-wide social services into an online directory of BH resources, education, emergency services, family and youth services, financial support, food services, goods services, health services, housing, legal support and advocacy services, social supports, transportation and employment. It also offers built-in SDoH assessments and the capability to track referrals. Using the SNI, care managers will be able to support members with high social needs or who are referred to care with identified social needs, and they can track the outcomes of those referrals to understand impact. In a sample of 2,000 members that we screened for SDoH, 1,787 total referrals were made across 451 distinct members, indicating that a portion of the population has multiple needs (on average approximately four (4) distinct needs requiring a specialized service). Preliminary results show that members utilized fewer acute services resulting in an approximate twenty-two percent (~22%) reduction in per member per month (PMPM) costs in the six (6) months after a member acted upon the referral (i.e., closed the loop).

Safe Living Situations Allow Members to Focus on Health

One member with multiple BH and medical needs had mobility issues and was involved in a domestic violence situation. Her care manager helped her secure appropriate medical equipment, find accessible housing, connect to vocational rehabilitation, access education on nutrition, reconnect to mental health treatment, finish Hep C treatment and build an immediate safety plan. She obtained a motorized wheelchair and filed a domestic violence order (DVO) against her perpetrator. The member is now working full time with less pain and in safe living arrangements.

Identifying and Stratifying Members for Appropriate Early Intervention

Passport’s BH Care is a population health management program specifically designed for:

- Members who (i) have a BH condition(s) in the absence of a PH condition(s), (ii) are experiencing significant symptoms or functional limitations, (iii) have intensive needs requiring care coordination and (iv) are at high risk of unplanned care utilization, including ED visits and acute inpatient admissions, related to suboptimal management of their BH condition(s).
- Members who (i) have a BH condition(s) in addition to a co-occurring chronic medical condition(s), (ii) are experiencing significant symptoms or functional limitations, (iii) have intensive needs requiring care coordination and (iv) are at high risk of unplanned care utilization, including ED visits and acute inpatient admissions, related to suboptimal management of their BH condition(s), as listed in **Exhibit C.23-5**.

Exhibit C.23-5: Common Diagnoses for Members Eligible for Passport’s BH Care

Members eligible for Passport’s BH Care Program services may be diagnosed with, or be at risk for, one or more of (but not limited to) the following BH conditions:

Members 18 years of age or older	Members under the age of 18
<ul style="list-style-type: none"> • Serious mental illness (SMI)—any mental, behavioral or emotional disorder resulting in serious functional impairment, which substantially interferes with or limits one (1) or more major life activities • Anxiety disorders • Bipolar disorder • Depressive disorders • Dissociative disorders • Eating disorders • Obsessive-compulsive disorders • Personality disorders • Schizophrenia spectrum and psychotic disorders • SUDs 	<ul style="list-style-type: none"> • SED—any mental, behavioral or emotional disorder that results in functional impairment, which substantially interferes with or limits functioning in family, school or community activities • Adjustment disorders • Anxiety disorders • Attention deficit hyperactivity disorder • Bipolar and related disorders • Depressive disorders • Disruptive, impulse control and conduct disorders • Dissociative disorders • Elimination disorders • Feeding and eating disorders • Learning disorders or intellectual disabilities • Neurodevelopmental disorders (autism spectrum disorder, tic and Tourette’s disorder, stereotypic movement disorder) • Obsessive-compulsive-related disorders • Schizophrenia spectrum and psychotic disorders • Sexual and gender identity disorders • SUDs • Trauma and stressor-related disorders

Passport systematically evaluates all member data against a set of identification and stratification criteria to identify eligible members and stratify by risk to determine level of interventions needed. Members are identified for BH intervention in multiple ways, using both automated (AI-driven algorithms) and manual (query and clinical referral-based) processes from numerous data sources.

Aggregating Disparate Data into an Innovative Whole-Person Profile to Identify “Impactable” Members

In order to ensure members are receiving appropriate care, it is important to collect and manage the right information and to have a single source of truth for advancing health outcomes. Passport will create meaningful and actionable whole-person profiles by leveraging three (3) main capabilities:

- **Integrating BH claims and medical claims into a single warehouse, supplemented with clinical data** from various sources, such as labs, health risk assessments (HRAs), hospital discharge information, data collected from care management, and UM and information from our free 24-hour health information line, Care for You. These data sources are normalized and stored in the same data warehouse as the claims data, which allows for real-time identification of members in need of holistic support.
- **Adding SDoH from multiple and highly variable sources.** In addition to claims data, Passport incorporates community-level data (see callout at right) for the past four (4) years. More recently, we added specificity by leveraging consumer data to understand better the individual- and household-level social risk and social needs. For example, we now know that household-level income data is eighty percent (80%) more accurate in determining likelihood of adverse health outcomes than census-tract level median income. This level of SDoH information is critical in identifying specific needs such as housing insecurity, food insecurity, transportation barriers and other access-to-care issues that can be proactively addressed by our care teams.

Our Trusted SDoH Data Sources

- U.S. Census Bureau’s American Community Survey
- U.S. Department of Transportation
- Environmental Protection Agency’s Smart Location Database
- U.S. Department of Agriculture
- Data.gov
- Department of Housing and Urban Development
- Google technology
- Household-level consumer data

Below is a comprehensive list of all data sources Passport uses today to accurately predict an adverse outcome **before it occurs**, so our BH teams can intervene to prevent it from happening.

- Enrollment data
- BH claims or encounters
- Medical claims or encounters
- Pharmacy claims
- Health information line
- SDoH
- Assessment screening results
- Practitioner referrals
- Laboratory results
- Electronic medical/health records
- Data collected from health management or wellness programs
- Data collected through UM and care management activities

Stratification for Early Intervention for Members at Highest Risk of Incurring an Adverse Event

Our stratification is not based solely on diagnosis but rather on a unique combination of hundreds of data elements across clinical history, functional status, gaps in care and SDoH to predict the likelihood of an adverse outcome, including avoidable hospitalization (BH or PH related) and avoidable or nonemergent ED utilization (BH or PH related). Identifying rising-risk BH members who are likely to have adverse events has data and technical challenges, such as:



- **Lack of documented BH diagnosis.** To tackle this issue, we created an algorithm to identify “hidden” members by inferring conditions based on other utilization signals.
- **Disorganized pain medication information.** For this we created the Opioid Risk Index, using the Centers for Medicare & Medicaid Services’ oral morphine milligram equivalent (MME) conversion factors to create MME dosage, along with other risk factors such as number of prescribers and overlap days, which is a critical component of the model.
- **Difficulty identifying activities of daily living (ADLs).** We created a risk score based on evidence in dependencies in ADLs, such as use of home oxygen, psychiatric illness, etc.

Our proprietary predictive modeling and member profiling platform (Identifi) uses cutting-edge machine learning (ML) and artificial intelligence (AI) techniques, such as neural networks, gradient boosting and clustering algorithms, to identify members who are most likely to incur future avoidable acute events. These models assess hundreds of risk factors, such as prior BH-related ED utilization, changes in BH medication (type, dose and class), socioeconomic factors indicating income and access to food and transportation, and diagnosis of other comorbid conditions.

The algorithms are also able to discern between members with documented BH issues and members who have risk factors but have not been diagnosed with a mental illness. The targeted hidden members, which can account for an additional thirteen percent (13%) of the stratified population, are discovered using information such as pharmacy data, geographic place of medical service, provider specialty, PH2/PHQ9 and other member-reported data, as illustrated in **Exhibit C.23-6**. In this example, members A and B are nearly identical—they both are between the ages of thirty-five (35) and forty-five (45) and have had an ED visit in the last twelve (12) months, with six (6) or more specialist visits. They both have a prescription history of medication for depression and pain management, with signs of poor adherence. They both admitted for an unplanned and avoidable inpatient stay, with an average cost of \$17,500. But only member A had a documented BH diagnosis. A standard stratification approach would not capture member B member. Passport’s AI-driven algorithm allows our care teams to identify these hidden members who are at risk for a future adverse event and offer intervention and treatment before the adverse event occurs.

Passport’s BH risk stratification algorithms can accurately differentiate between patients who will and will not incur avoidable acute utilization in the future more than 80% of the time.

Exhibit C.23-6: Advanced Algorithms Detect Hidden Members for Integrated BH Services

	Documented BH Diagnosis	Undocumented BH Diagnosis
Case Example:	Member A 	Member B 
Age Group	35-45 years old	
Past 12mo Utilization	1 ER visit, 6+ Specialist/PCP visits, 1 MRI	
Medication History	Antidepressants, Pain Meds (Nonadherence Indicated)	
Avoidable Inpatient Stay (12mo post-identification)	Yes	
Total Cost of Inpatient Stay	~ \$17,500	
Identified by Traditional BH Stratification	✓	✗
Identified by Passport BH Stratification	✓	✓

Members are assigned a risk score according to the BH risk level. Based on the predictive modeling output scoring, members are assigned to one (1) of three (3) distinct algorithm-guided pathways based on risk of incurring one (1) or more avoidable acute event (BH or PH related) in the following twelve (12) months. Each pathway is specifically tailored to support different levels of acuity and medical comorbidity (see **Exhibit C.23-7**).

Exhibit C.23-7: Assigning Members a Risk Score

Risk of Incurring an Avoidable Acute Event (BH or PH)	Comorbidity	Designated Program
Moderate BH Risk	Without PH comorbidity	Behavioral Health Care
	With PH comorbidity	BH Integrated Population Health Program
Rising BH Risk	Without PH comorbidity	Behavioral Health Care
	With PH comorbidity	BH Integrated Population Health Program
High BH Risk	Without PH comorbidity	Intensive Care Management
	With PH comorbidity	Integrated Intensive Care Management

BH is dynamic and, as such, so is our stratification process. A member’s identified risk level can change as their condition or situation changes and can transition between our integrated BH programs as his/her needs change. For example, risk scores are updated at a minimum monthly, but if additional data sources or information become available, scores can be refreshed more frequently to ensure we are delivering the right care at the right time. Furthermore, members can also be referred to the BH program through the following avenues:

- UM processes
- Care management team staff managing the member in another care management or population health management program, such as Complex Care, Condition Care or Transition Care
- Care management team staff completing a health risk assessment, as applicable
- Practitioner referrals including, but not limited to, PCPs, specialists and BH providers
- Ancillary providers, BH MCOs, disability management programs, employer groups or staff from community agencies
- 24-hour nurse advice line (health information line) or crisis line, as applicable
- Internal departments, such as Pharmacy
- Self-referral by a member or caregiver

Engage and Assess Members for Effective Integrated Behavioral Health Services

Passport provides a multifaceted approach to case finding, outreach, engagement and enrollment of individuals with BH challenges and medical comorbidities. If we are unable to reach members telephonically, **Passport deploys a “boots on the**

ground” case-finding protocol that sends specially trained care coordinators and community health workers into the community to knock on doors, visit shelters and encampments, talk to local law enforcement and community service providers, etc., to locate difficult-to-find individuals and enroll them in services. Based on our twenty-two (22) years of experience in working closely with Kentucky Medicaid members as a community-based plan created by Kentuckians for Kentuckians, Passport has learned that reaching and engaging members often requires a collaborative effort with various community partners across the Commonwealth. See **Exhibit C.23-8** for examples of locations or events where we conduct outreach, educate and enroll members into care services, showcasing the deeply embedded relationships Passport has not only across the state, but within each community.



Exhibit C.23-8: Examples for Community Outreach and Community Engagement

Examples of locations and/or events in our community where we conduct outreach, educate and enroll our members into our care services	
<ul style="list-style-type: none"> • Community ministries • Homeless shelters • City and community development centers (e.g., The Neighborhood Place) • SUD recovery centers (e.g., The Healing Place) • Prisons • Community kitchens (especially in the western counties, where rural areas provide additional needs for members needing nutritional assistance) • Community centers • Libraries • Pregnancy centers 	<ul style="list-style-type: none"> • Health departments and other health care facilities • Community action agencies • Apartment complexes • Mental health and SUD facilities • Churches • Re-entry facilities • Extension offices • Colleges • Career centers • Goodwill and other thrift centers and food pantries • Salvation Army • Numerous other advocacy locations

All members enrolled in our programs will receive a comprehensive program-specific screening to assess their physical, behavioral, social and emotional needs. Evidence-based BH screening tools are incorporated within each program-specific assessment/screening and are administered if appropriate for the member’s age. Examples of the validated screening tools include, but are not limited to, PHQ-9, GAD-7, PHQ-A, CAGE-AID and PSC-17. These tools are first administered during the initial assessment/screening, and follow-up screenings are completed at regular intervals as applicable to re-evaluate a member who has had a positive screen.

The program-specific assessments/screenings will evaluate the member’s needs, and may include topics such as:

- Conditions, problems and comorbidities, including physical, behavioral and lifestyle risks
- Depression, anxiety and substance use screenings
- Psychosocial status and stressors
- Current health status, including condition-specific issues and treatments
- Personal safety concerns
- Functional limitations related to ADLs/independent activities of daily living (IADLs), including BH impact on ADLs/IADLs
- Mental health status and cognitive functioning
- SDoH, such as stable housing, financial security, adequate food resources, etc.
- Life-planning activities

- Cultural and linguistic preferences
- Visual and hearing needs and limitations
- Caregiver support, involvement and resources
- Member’s personal concerns, goals and preferences
- Barriers to accessing care
- Tobacco use screening and cessation assistance
- Medication management and barriers to adherence

In 2019, 99% of Passport’s highest risk PH members (who engaged in our Complex Care program) were screened for BH conditions.

The assessments incorporate rules that auto-generate a problem list to be included in the member-centered care plan and action items, which are activities the care team will do in follow-up to the assessment. Action items may include provider notification, referrals (e.g., BH, Registered Nurse (RN) Care Advisor, Pharmacy, community resources), and follow-up assessments for rescreening PHQ-9 or GAD-7 positive scores. Upon completion of the assessment and member engagement in a program, goals will be developed in collaboration with the member, and interventions will be initiated.

Create Holistic Member-Centric Care Plans to Achieve Total Health

All members of the multidisciplinary care team collaborate with the member, his/her caregivers, BH and other necessary providers to develop an individualized member-centric care plan. The care plan includes member-specific preferences, barriers, prioritized goals, self-management activities, referrals, a schedule of follow-up interactions and a process to assess progress. The clinical team’s activities are targeted to facilitate the achievement of the member’s health goals and to resolve issues/barriers.

In 2019, 99% of program participants had a comprehensive care plan completed across all physical, behavioral and social domains.

Each goal has associated interventions that are specific for the member’s individualized priorities and needs, as well as identified barriers that may impact the member’s ability to fully achieve the desired goal(s). The care team is responsible for identifying all relevant barriers preventing a member/caregiver from adhering to his/her provider’s treatment plan. It is a core responsibility of the care team to identify options and solutions to mitigate and remove barriers. In addition to the problems, goals and interventions, the member’s care plan may include information, such as a symptom response plan or self-management plan. During each follow-up interaction, members are assessed for additional needs, concerns and support that they may need for developing self-management skills and completing interventions to achieve their defined goals.

Members’ cases with complex behavioral, physical and social needs can be discussed in **integrated care rounds**—a dedicated weekly interaction between the care team and licensed psychiatrists, psychologists and other medical professionals, designed to coordinate member care, determine care priorities, establish

goals and finalize or move forward the member's care plan. Cross-discipline collaboration occurs daily between care managers to ensure timely resolution of all biopsychosocial needs.

Ongoing interactions with members will occur at regular intervals based on their individualized needs, risk levels and programs in which they are engaged.

Establish Program Goals That Are Member-Centered and Linked to Positive Outcomes

Passport's approach is to integrate BH into all care management and population health management programs. This is achieved with a holistic, multidisciplinary approach of assessing and addressing the member's specific needs. The purpose of integrating BH into all programs is to support members in achieving optimal BH and PH, everyday functioning and improved quality of life by helping them overcome barriers to treatment and recovery and prevent BH condition-related exacerbations and complications.

We have designed our integrated BH care program with specific goals to:

- **Identify** members with high-risk or complex medical/BH conditions, regardless of confirmed BH diagnosis
- **Empower** members to be active participants in improving their health and emotional well-being across all aspects of their lives
- **Support** members/caregivers in developing relationships with their health care team and community-based support services
- **Improve** care coordination for members/caregivers in collaboration with their PCP, BH providers, specialty providers and services, including mental, health, social, educational, spiritual and vocational support
- **Overcome** barriers that may prevent the member from adhering to the BH and primary care provider's plan of care or following through with the treatment needed for management of their conditions
- **Educate** members/caregivers to increase understanding of their BH and PH condition(s), how to identify signs indicating a worsening condition and how to work with their provider to develop a symptom response
- **Connect** members/caregivers to community-based or peer support programs to ensure access to adequate BH support and resources

To measure achievement against these goals, members in the program must be able to:

- **Demonstrate** knowledge of their condition and participate in development of a plan for ongoing self-management
- **Identify** members of their health care team and know how to engage them for support
- **Identify** at least one (1) support resource available within their community
- **Show** maintenance or improvement on assessed relevant screening tools since initial assessment
- **Demonstrate** knowledge of their prescribed behavioral medications, reason for taking these medications, and benefits of adhering to a medication regimen

Assemble the Right Interdisciplinary Care Team to Fully Address All Member Needs

To accomplish these program goals, Passport relies on a multidisciplinary team to address the broad spectrum of member needs. Passport’s BH care management team is composed of an interdisciplinary group who are all Kentucky-licensed, including roles such as:

- Care team manager
- BH care advisor/manager
- RN care advisor/manager
- Registered dietitian
- Licensed pharmacist
- Community health worker/care coordinator (licensure not currently available in KY)
- Addiction specialist
- Foster care/child expert
- Medical director or associate medical director
- BH provider quality manager

Leverage Technology to Reduce Variation of Evidence-Based Interventions

All care team members use Identifi to ensure consistent workflows, integrated care planning and seamless coordination across PH and BH. Identifi is a clinical documentation system that automates the evidence-based clinical guidelines and algorithms used to perform the clinical assessment and ongoing management of the member. Identifi is at the center of Passport’s population health management solution, with a growing set of automated features to provide accurate and timely documentation of the interactions with, and the actions of, the member/caregiver, providers and the care team. All care team notes and care plan modifications are visible in the Identifi system and available to the full care team. Identifi leverages care guidelines and evidence-based screening tools (such as the PHQ-9, GAD-7 and PSC-17) to ensure the member treatment plan and adherence to evidence-based standards of practice are assessed.

The assessment leverages branching logic to allow follow-up questions to be skipped depending upon the response to the initial question. For example, if a member screens positive on a PHQ-2, Identifi will automatically jump to the remaining questions on the PHQ-9. In addition, logic is applied for the automated creation of member goals and action items aimed at ensuring consistent delivery of the program. From an ongoing management perspective, Identifi has a standard care plan template that includes a library of problems, goals and interventions (PGIs), which are informed by evidence-based clinical guidelines. Based on these clinical guidelines and the member’s needs and preferences, the care team can establish priority problems, member-centered goals and interventions with the member to facilitate self-management of his/her condition(s).

The system automatically documents the care management team member’s name, date and time of action on the case or when an interaction with the member has occurred. The care management team member assigns the next follow-up within the system, based on the member’s needs and requests. All successful interactions and unsuccessful attempts with the member/caregiver or provider(s) are documented in the

member's record in Identifi. Staff are trained to schedule the next interaction with the member at the end of each call and create an action item reminder to prompt the next interaction with the member.

Case Study in Whole-Person Care: Passport Member John

John is a 41-year-old single male with diagnoses of major depressive disorder and alcohol use disorder. He has had more than fifty (50) inpatient admissions since January 2015, three (3) of which were inpatient detox and three (3) of which were substance-use residential admissions. John is also homeless and has limited sober supports. Because of his lack of stability, he also has a history of treatment noncompliance. He repeatedly presents for treatment, reporting suicidal ideation with a plan to shoot himself (he reports he has access to a gun) or to jump off a bridge. He reports a history of suicide attempts by cutting or overdose, though none of his suicide attempts are clearly documented. John also has medical issues including COPD, oxygen dependence and hypertension. In addition to John's chronic medical issues, he has an open wound on his leg. He presents at the hospital with suicidal thoughts each time his wound is bad. He stays at the hospital long enough for the wound to begin to heal and then discharges again. When he is homeless, he cannot care for his wound appropriately, and as a result becomes distraught and readmits for suicidal ideation.

John's Repeated Emergency Services Become Integrated Care

John was initially identified for our integrated BH program through our stratification algorithms, which flagged him as high risk based on his acceleration of acute utilization in recent months, his new psychotropic medication prescriptions and his change of address from a residential address to that of a homeless shelter. Our BH Care Advisor initially attempts to call John through his listed contact number, but the line is disconnected. The Care Advisor deploys a community health worker (CHW) out to John's last known address, a local homeless shelter, where she locates him and is able to educate him on the benefits of our integrated care program. Once his identity is confirmed and he has consented to the program, the CHW is able to conference in the BH Care Advisor for a full risk assessment, which identifies John's medical, behavioral and social needs. John's case is immediately discussed in Passport's integrated care rounds with our behavioral and medical professionals to finalize his integrated care plan.

How We Provided Holistic Support for John

The RN Care Advisor helped John obtain placement in a specialized medical bed at a homeless shelter. He was able to stay in the bed until his wound fully healed, and this setting also allowed for use of his O2 concentrator. The shelter placement allowed for contact between John and his BH Care Advisor, who was able to facilitate appropriate discharge and referral to the local community mental health center (CMHC) for assessment of both his depressive symptoms as well as potential need for substance use treatment. This assessment allowed John to establish more consistent mental health treatment, which led to an increased motivation to remain compliant with established appointments. In addition, the CHW initiated the process to find John stable housing and connected him to a community organization that provides monthly Transit Authority of River City (TARC) bus passes so he could attend his appointments each week. The BH Care

Advisor was in communication with John's BH providers through regular phone calls and secure email to share and receive input on John's updated care plans. As the case evolved, John's situation was monitored in weekly integrated rounds as he progressed through his treatment plan. Today, John is living in stable and supportive housing, is compliant with his psychotropic medications, and is seeing a PCP regularly to monitor his COPD and hypertension.

C.23.a.ii. Process for monitoring and evaluating compliance with access and care standards.

Monitoring and Evaluating Program and Standards to Ensure Access and Care Standard Compliance

Passport will monitor and evaluate the following program standards specified in the draft contract to ensure compliance through a combination of top-down monitoring, from network adequacy reports, and through continued monitoring of quality measures with bottom-up input from care teams, flagging any issues while working with individual members.

- Establish and adhere to guidelines and procedures to ensure accessibility, availability, referral and triage to effective PH and BH care, including emergency BH services (e.g., suicide prevention and community crisis stabilization)
- Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions
- Identify a method to evaluate the continuity and coordination of care, including (i) member-approved communications between BH care providers and PCPs and (ii) referral patterns between physical and behavioral providers
- Protect the confidentiality of member information and records

Our governance and accountability structure will allow us to maintain performance at or above expected levels as we provide a focused, integrated and highly tailored experience for the member and provider to improve health outcomes and overall well-being.

Establishing and Adhering to Guidelines and Procedures to Ensure Access to Care

Passport has an active and engaged BHAC composed of providers, consumers and advocates who regularly review clinical practice guidelines for adoption by Passport. The guidelines, once adopted, are posted on the plan's website under provider resources and communicated to providers via e-news. Adherence to acceptable care standards is regularly monitored through integration of information from chart audits, consumer feedback and complaints, regular contact with our provider community, especially high-volume providers, and information gathered during routine prior authorization and UM activities. For example, BHAC identified two (2) areas in which members had needs for improved quality of service delivery: prescription of psychotropics in children and medication-assisted treatment for opioid use disorder. We addressed these needs by providing clinical practice guidelines (CPGs) to providers about services based on industry best practices. These CPGs included the 2011 Practice Parameter for the Use of Atypical Antipsychotic Medications in Children and Adolescents (AACAP 2011) and The American Society of Addiction Medicine (ASAM) National Practice Guideline for the Use of Medications in the Treatment of Addiction

Involving Opioid Use. A differentiated strength of Passport is our data analytics capacity that allows us to monitor unusual patterns of service delivery that may indicate care is not being delivered according to evidence-based guidelines and best clinical practices. **Passport staff regularly review performance metrics to look at compliance with best practices across all BH, inpatient, outpatient and diversionary services.**

Monitoring Network Adequacy to Ensure Access to Care

Passport ensures accessibility and availability of qualified providers to all members through several access points, including but not limited to open access to specialists (no PCP referral required), telehealth availability and an efficient UM process. Passport works directly with providers to identify unmet needs through analytics, UM process trends, patient readmission rates and provider/member feedback. Passport’s network provides a continuum of care to ensure the member has access to care at the appropriate level. Passport ensures that upon decertifying a member at a certain level of care, there is access to providers for continued care at a lower level, if such care is determined medically necessary. Passport coordinates and collaborates with providers on discharge plans and criteria.

Passport will maintain a member education process to help members know where and how to obtain BH services. Its Member Manual contains information for members on how to direct their BH care, as appropriate. Passport encourages members to participate in the selection of the appropriate BH individual practitioner(s) who will serve them and provides the member with information on accessible in-network providers with relevant experience.

Promoting Information Sharing Among Providers to Promote Adherence to Care Standards and Support Substance Use Disorder Prevention and Psychopharmacological Medication Management

Passport uses advanced prescription analysis technology to improve prescription procedures to support SUD prevention and psychopharmacological medication management. Specifically, the system leverages algorithms and measurements to determine and compare adherence, polypharmacy, suboptimal dosing, excessive dosing, SUD management and opioid management. The technology uses the process shown in **Exhibit C.23-9**.

Exhibit C.23-9: Passport’s Prescription Analysis Technology Process



In addition to helping us identify potential provider issues, the system allows us to provide robust information content to support and inform providers of best proactive and clinical guidelines. One resultant report is the Prescriber Summary Report, which provides a list of Passport members who were flagged for Quality Indicators (QIs), helping prescribers see which practices fall outside the standard of care.

Our prescription analytics program's output is reviewed by a team of clinical experts to rule out false positives before the data are translated into actionable interventions. These interventions are shared directly with individual providers via a Patient Profile Report and provides a member-specific prescription claims history with flags for associated QIs, so providers can shape individual treatment. The information packet includes clinical considerations for every flagged indicator, giving providers an educational overview of clinical issues and the evidence base.

Over the last 18 months, Passport observed a 22% reduction in unique opioid users, due largely to targeted programs around opiate stewardship and safety.

Evaluating and Supporting Continuity and Coordination of Care Between BH and PH Providers

BH providers are required to communicate (with member consent) with PCPs on a regular basis. Our contracted providers are required to send initial and quarterly (or more frequently if clinically indicated) summary reports of a member's BH status to the PCP (with the member's or the member's legal guardian's consent). The purpose of this reporting is to ensure coordination between the PCP and BH provider and improve the quality of member experience. Passport measures and monitors compliance (see **Exhibit C.23-10**) through chart audits. For providers who do not meet the goal of eighty percent (80%) compliance, we meet with them to discuss barriers and create corrective action plans that the providers report back on to us. **To improve performance with specific providers, Passport has included these measures as part of a performance-based incentive.** In addition, this expectation was added to our value-based agreement with Centerstone Kentucky (Seven Counties Services) so that they are held accountable for communicating with the referring provider and PCP for initiation, ongoing treatment and discharge information. Due to the importance Passport places on the communication and coordination between BH and PH providers, fields were added to the Centerstone Kentucky (Seven Counties Services) electronic health record (EHR) before starting the value-based contract to aid them in tracking this information.

Exhibit C.23-10: Passport’s Methods for Monitoring Compliance

Continuity and Coordination of Care: Outpatient to Outpatient	Goal
Is there evidence in the chart that at least one (1) Release of Information, Authorization or Consent was obtained to speak with at least one (1) other Outpatient (OP) mental health or OP substance use disorder treatment provider?	80%
Is there evidence that the OP treatment provider contacted, collaborated with, received clinical information from, or communicated in any way with another OP provider regarding the member’s clinical care?	80%
Continuity and Coordination of Care: Outpatient to PCP	
Is there evidence in the chart that a Release of Information was obtained to communicate with the PCP? (PCP must be identifiable.)	80%
Is there evidence that the OP treatment provider contacted, collaborated with, received clinical information from, or communicated in any way with the PCP?	80%

Protecting the Confidentiality of Member Information and Records

Member privacy and confidentiality must always be maintained and monitored by our Health Insurance Portability and Accountability Act (HIPAA) compliance programs. Passport implements medical record standards that cover confidentiality, organization, documentation, access and availability of records. Passport has adopted the NCQA standards, as approved by DMS. Passport revises its standards as needed to conform to new NCQA and DMS recommendations. Providers must agree to these requirements in their contract and have ongoing access to Passport’s standards via the Provider Manual.

Medical record confidentiality policies and procedures must comply with state and federal guidelines, HIPAA and Passport policy. Documentation in the medical records must be timely, legible, current, detailed and organized to permit effective and confidential member care and quality review. Complete medical records include, but are not limited to, medical charts, prescription files, hospital records, provider specialist reports, consultant and other health care professionals’ findings, appointment records, and timeliness of services provided to the member. The member record must be signed by the provider of service, and if a member were to change PCPs, the records are to be forwarded to the new provider within ten (10) days of the member authorizing the transfer with signature.

Passport ensures provider compliance with medical record standards by performing regular audits. Audits are conducted by Passport’s Quality Assurance team at least every three (3) years. The team executes on-site reviews of practitioners’ offices, procedures and chart samplings. Audits typically:

- Demonstrate the degree to which providers are complying with clinical and preventive care guidelines
- Allow for tracking and trending of individual and planwide provider performance over time

- Include mechanisms and processes that allow for the identification, investigation and resolution of quality of care concerns
- Include a mechanism for detecting instances of overutilization, underutilization and misutilization

Practitioners must achieve an average score of eighty percent (80%) or higher to be considered in compliance. Passport monitors practitioners who score less than eighty percent (80%) through corrective action plans and re-evaluation.

Monitoring Adherence to Program and Standards

NCQA Health Plan Accreditation



Passport's Health Plan Accreditation by NCQA helps us ensure we adhere to rigorous quality standards. BH is woven throughout all standards to ensure whole-person health is addressed. Passport has held Health Plan Accreditation from NCQA since 2002. Health Plan Accreditation provides a comprehensive, rigorous framework for improving and measuring quality and helps ensure we meet requirements, including protecting the confidentiality of member information and records. To achieve and maintain Health Plan Accreditation, NCQA evaluates Passport on:

- Quality management and improvement
- Population health management
- Network management
- UM
- Credentialing and re-credentialing
- Members' rights and responsibilities
- Member connections
- Medicaid benefits and services

Passport's BH Program Outcomes

Passport evaluates the success of our BH clinical program on an individual member basis, as well as an overall population basis.

As members progress through the BH care process, Passport works diligently to gather insights and outcomes for performance improvement. As we work to transform this process to be as member-centric as possible, we have identified a few common goals for measurement purposes:

- Member demonstrates knowledge of condition(s) and self-management/recovery plan
- Member has shown improvement in initial screening score (PHQ-9, GAD-7)
- Member has established relationships with their health care team and community-based support services and knows how to navigate these services
- Member follows medication regimen, as prescribed
- Member has completed appropriate screening/rescreening of tools
- If member was admitted and discharged, the member completed the recommended follow-up care included on his/her discharge plan

Passport evaluates annually the success of each of the clinical programs offered through the Population Health Management (PHM) program on a population-wide basis by collecting data on process or outcome measures, measures of cost/utilization and member experience, and participation rates. These program evaluations are publicly available on our website: passporthealthplan.com/quality-improvement/.

Quality improvement activities include measuring, trending, analyzing and interpreting results against performance goals or benchmarks for the program.

For each program, the following metrics are tracked and reported:

- Participation rate (engaged vs. identified members)—annually and monthly
- Member engagement year over year—annually and monthly
- Top ten (10) comorbid diagnoses
- Referral sources
- ED and inpatient utilization pre/post engagement
- Cost trends for ED and inpatient utilization and 30-day readmissions
- Total cost of care (vs. propensity score matched control group)
- Program discharge status
- Achievement of care plan goals
- Satisfaction results for services received
- Satisfaction results for improvement of health and quality of life

Program-specific metrics are tracked and reported, including Healthcare Effectiveness Data and Information Set (HEDIS) and Healthy Kentuckian metrics relevant to specific conditions.

For each program, specific barriers are identified, with associated opportunities to correct or mitigate the barriers. A summary of key initiatives associated with each program is documented to ensure Passport achieves its overall goals for continual quality improvement and transformation. The data in the report informs planned activities for future years, which are also documented in the Program Evaluation.

At least annually, member experience with programs is evaluated through member feedback obtained through a satisfaction survey and complaints data. This allows for identification of opportunities to improve satisfaction with the program. Member active participation rates are measured annually by collecting the number of members who have received at least one (1) interactive contact. Interactions with members will include activities such as educational mailings, Interactive Voice Response (IVR) surveys and staff phone interactions. Action is taken as needed for metrics that do not meet the goal(s) or are deemed an opportunity for improvement. Interventions or actions to make improvements to identified areas of the programs are implemented to maximize health outcomes, experience and satisfaction, and effectiveness.

In a case-control study of Passport’s integrated BH program, participants showed a reduction of 25% in total expense and 22% in inpatient admissions, compared to their matched controls.

C.23.a.iii. Proposed innovations to develop and maintain network adequacy and access.

Innovative Ways to Develop and Maintain Network Adequacy and Access

Innovation is at the heart of Passport’s vision for the future. By leveraging our deep roots in the community and our longstanding relationships with providers, we are providing innovative access points for our members. We support and streamline processes for open access to BH specialists (versus requiring a PCP referral), reimbursement for telehealth services, and specialized BH network management. Passport’s BH offerings provide members with access to a full continuum of recovery and resiliency-focused BH and SUD services through a network of contracted providers. Our leaders engage with providers face-to-face to gain an intimate understanding of their holistic pain points and help them solve them through informal consultation and advisory services that often go beyond the business relationship with our plan. The primary goal of these services is to provide medically necessary care in the most clinically appropriate and cost-effective therapeutic settings. By ensuring that all Passport members receive timely access to clinically appropriate BH services, Passport believes that quality clinical services can help lead to improved health outcomes for our members. We continuously innovate to advance our goal of providing the right care at the right time across settings. Some recent innovations geared toward developing and maintaining network adequacy and improving access to care are described in the following paragraphs.



Innovation 1: Passport Will Waive Member Copays to Increase Access to Services

There are many reasons why people do not access needed health services, especial BH services. Passport’s BHAC provided us with feedback that providers, advocates and members in the community felt that copays were a significant barrier for members to access services. As a result, we are **removing copays for all Behavioral Health services**: inpatient, outpatient and diversionary levels of care. We feel strongly that by lifting these copays we are helping our members get one step closer to the help they need and deserve by ensuring their financial circumstances are not limiting their use of needed direct access services. Other ways we are exploring to remove barriers include encouraging practice design transformation that incorporates whole-person integrated care, whether through true integration or co-location of BH and PH services. We are dedicated to helping find solutions for more available and effective health services in the communities where we live and work.

Innovation 2: Passport’s Health Integration Team Brings Unmatched Expertise to the Community

Passport’s Integrated Health Team consists of highly experienced and professionally licensed clinicians, doctorate-level psychologists, a SUD specialist and post-graduate level social work professionals. The Integrated Health Team 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 BH provider can get medical services in a BH setting and the member can get BH services in their PCP setting. This team continues to

innovate and support providers, meeting them where they are, to answer questions and help them address their most difficult challenges.

Our solutions-focused Integrated Health Team includes seasoned Kentucky BH providers that 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 input from the Behavioral Health Advisory Group, Primary Care Workgroup and Women's Health Committee, including providers, advocates and members
- 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 state to provide training, support and aid in addressing SDoH

Health Integration Team Consults with Providers to Improve Risk Assessments

After our quality monitoring via chart audits revealed significant lack in the adequacy of risk assessments, Dr. David Hanna provided training, case consultation and supervision around evidence-based strategies for youth with SED to Uspiritus and recently consulted with a large CMHC around evidence-based assessment and clinical management of suicide risk.

All of our Health Integration staff 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 BH experience include:

- Dr. Liz McKune, Vice President, Health Integration and Kentucky Licensed Psychologist
- Dr. David Hanna, Behavioral Health Program Manager and Kentucky Licensed Psychologist
- Dr. Jessica Beal, Integrated Health Program Manager and Kentucky Licensed Psychologist
- Dr. Cheryl Hall, Substance Use Disorder Program Manager and Kentucky Licensed Psychologist
- Dr. Eric Russ, Behavioral Health Operations Manager and Kentucky Licensed Psychologist
- Dr. William Nunley, Medical Director, Beacon, and Kentucky Licensed Psychiatrist
- Dr. Sarah Johnson, Associate Medical Director, Beacon, and Kentucky Licensed Psychiatrist/Addiction Medicine

The team has had significant success in implementing our Integrated Model of Care to improve network adequacy and access for our members. **Exhibit C.23-11** provides insights and details regarding some of these successes.

Exhibit C.23-11: Results of a Selection of Integrated Health Team Solutions

Challenge	Provider Collaboration to Create Network Adequacy and Access
<p>Applied Behavior Analysis (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.</p>	<p>Passport took the following actions:</p> <ul style="list-style-type: none"> • 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 • Codes were added, providers joined network and members gained access to needed services
<p>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.</p>	<p>Passport took the following actions:</p> <ul style="list-style-type: none"> • Partnered with providers to better understand the issue • Worked with providers to identify evidence-based solutions for trauma and jointly determined TF-CBT seemed appropriate • Accompanied providers to discuss issue with Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) regarding member needs and perceived licensure barriers • Worked with DBHDID to obtain Office of Inspector General (OIG) permission to provide the needed service at an Extended Care Inpatient (ECU) level of care through the Early Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit in an acute care setting • Developed an authorization process and rate to support participation <p>To date, seventy-eight (78) children have had the opportunity to participate since the program was established in 2013. There has been a seventy-five percent (75%) reduction in out-of-home, hospital and residential placements following participation in the program. Other MCOs now contract for this service from this provider to meet the needs of Kentucky’s children.</p>

Challenge	Provider Collaboration to Create Network Adequacy and Access
<p>Members with SUDs who developed endocarditis were unable to participate in SUD treatment while receiving their IV antibiotic treatment.</p> <p>Members were being inappropriately placed in long-term acute care facilities (LTACs) for care so they could get their IV medication.</p>	<p>We took the following actions:</p> <ul style="list-style-type: none"> • 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 assist members with IV medications participating in SUD treatment • Updated UM process to support this enhanced benefit • Contracted with providers to deliver service • Supplied providers with resources 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

Innovation 3: Provider Quality Managers

Passport has engaged provider quality managers (PQMs) to work with our BH team. With support from a national PQM team at Beacon, our local PQM provides clinical support and technical assistance to providers, enabling them to focus resources on member care and quality initiatives rather than administrative processes. Our local PQM, along with other members of our behavioral team, meet with up to ten (10) providers a month to share clinical and quality data and strategy.

We compare clinical and quality results against historical provider data and the market aggregate, highlighting opportunities to improve performance, and share this data with providers. Measures reviewed include HEDIS and readmission rates, length of stay, care transitions, timely aftercare appointments, and outlier utilization. We collaborate with providers to identify best practices and implement new treatment approaches that enhance clinical programming and improve outcomes for members.

Innovation 4: A New Approach to UM

In November 2019, Passport began a new partnership with UofL Health–Peace Hospital, our largest inpatient BH provider. For all adult admissions, we have changed our approach to UM to focus on clinical and quality outcomes. Passport’s BH partner, Beacon, has implemented this program in multiple markets nationwide and seen significant improvement in care delivery. For members in this program, continued stay reviews have been eliminated, easing the administrative burden of the facility. We have instituted a monthly collaborative meeting focused on key clinical and quality metrics, including average length of stay, follow-up rates for aftercare, readmission and discharge planning. We use the metrics to drive collaborative discussion

around evidence-based clinical and systems strategies that will help improve care of adult members admitted to this hospital.

Innovation 5: Lexington Home Visit Program

Building and maintaining an adequate network with a selection of providers in the communities we serve is supplemented with innovative contracts with providers such as our home visit program in the Lexington area. For the home visit program, in 2019, we partnered with two community-based providers to provide home visits following hospitalization to review discharge plans and provide support during the transition to outpatient care. We will seek to expand this type of program after studying its efficacy.

Innovation 6: Behavioral Health Telehealth Support

Telehealth throughout Kentucky is constantly evolving. Passport is committed to the innovation and evolution of telehealth, as demonstrated by Passport’s participation in the workgroup responsible for drafting telehealth legislation, as well as the legislative testimony of Passport’s BH operations manager and past president of the Kentucky Psychological Association, Eric Russ, Ph.D. Dr. Russ provided important and powerful testimony from the provider perspective during the comment period in support of new legislation that was passed into law and effective in late 2019.

We have established a network of providers that offers telehealth visits to members who are unable to travel to their outpatient therapist. Following the implementation of the new telehealth regulation that allowed for all Medicaid-licensed provider types to provide telehealth services, Passport saw a nearly fourfold increase in claims for BH services, with 3,984 claims processed in Q3-Q4 2019 compared with only eight hundred ninety (890) claims processed in Q1-Q2 2019. We will continue to monitor telehealth utilization in 2020 to assess for impact to access and care.

Many rural Passport members in foster care can access BH services through telehealth. For example, the Bingham Child Guidance Center at the University of Louisville provides telemedicine support for members who are not able to access a physical location. In the past, we helped connect rural CMHCs with Bingham Child Guidance to help establish tele-psychiatric coverage in rural communities. We also supported a grant to provide psychiatric fellows in training and their supervisor the opportunity to deliver consultative psychiatric services via telehealth in a rural pediatric practice until the practice created its own integrated model. Our provider recruitment efforts will continue to seek out and recruit providers with local practices that can offer this service to our members.

Following the implementation of the new telehealth regulation, Passport saw a nearly fourfold increase in BH services claims, with 3,984 claims in Q3-Q4 2019 compared with only 890 claims in Q1-Q2.

Innovation 7: Specialized Behavioral Health Provider Network Management Team

Passport developed a strong team of PNM staff dedicated solely to BH statewide. This team, composed of a manager and two provider representatives, actively supports network providers in all aspects of the interaction with Passport as well as conducts outreach work to engage and recruit new providers. They are supported by licensed psychologists, who are members of the Health Integration Team described above and provide clinical and practice support to providers about effective practice within the Medicaid environment.

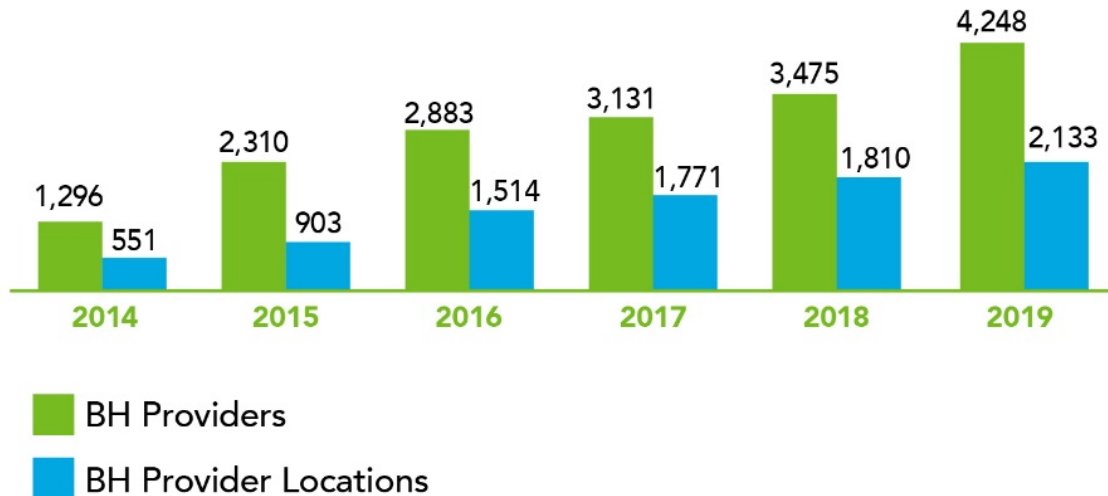
In addition to this work, Passport has a unique approach to working with providers to develop services that meet the specialized BH needs of our members to better achieve our mission of improving health and quality of life through whole-person care. Through the relentless pursuit of excellence and vision of becoming the leading model of collaboration and innovation in health care, Passport's dedicated Health Integration Team continuously identifies gaps or opportunities for enhancing care through:

- UM process
- Direct care coordination and care management experiences with members
- Feedback from our BHAC, Primary Care Workgroup, Women's Health Committee and QMMC
- Interactions with providers, community advocates, governmental partners, NCQA, other health plans through Association for Community Affiliated Plans (ACAP) and America's Health Insurance Plans (AHIP), business partners and members
- Continuous review of what works and effective evidence-based practices
- Collaboration with our Business Strategy & Development Team
- Analysis of data trends and predictive analytics tools

The results of this integrated effort at engaging and supporting BH providers is evident in **Exhibit C.23-12**, which shows that the consistent growth in our network of BH providers and provider locations has outpaced the growth of unique BH utilizers. We have seen further growth of our BH network by nearly twenty-two percent (22%) between 2018 and 2019.

EXHIBIT C.23-12: The Number of Passport’s BH Providers and Provider Locations Has Consistently Grown Since 2014

Number of BH Providers and BH Provider Locations in Network



C.23.a.iv. Process for follow-up after hospitalization for Behavioral Health Services within the required timeframes.

Supporting Members After Hospitalization for Behavioral Health Services

Despite providing our members with high-performing care management and extensive referral resources, we realize that some members require inpatient care. Passport’s transition processes support our members in efficiently moving out of the hospital and into effective self-management.

Collaborative Discharge Planning

Passport understands that transition care coordination should involve multiple stakeholders in the member’s care and extend beyond the days following the discharge. As required by the contract, Passport ensures that members are scheduled for outpatient follow-up within seven (7) days or continuing treatment prior to discharge. When a member is discharged, our care managers work collaboratively with Beacon’s utilization review clinicians and acute care facilities to ensure appropriate discharge plans are developed and shared with members, family and caregivers, if applicable. To ensure continuity of care, prevent readmissions, and facilitate effective transitions of care, care managers conduct proactive outreach to members and their providers and, if applicable, families and caregivers post-discharge from an acute facility. This outreach includes assessment of the member’s understanding of his/her discharge plan, assessment of

the member's knowledge of discharge medications, reinforcement of the discharge/treatment plan, evaluation of gaps in care and barriers to treatment adherence, crisis planning, evaluation of safety in the home and support of the member's self-management skills. During transitions of care, care plans will be reviewed with the member and his/her treatment team to determine whether modifications are necessary to meet the member's transitional needs and, with member input, care plans will be modified as necessary.

To facilitate collaboration, we have also arranged for a care manager to be on-site with our largest inpatient provider, UofL Health–Peace Hospital, two (2) days per week. This on-site presence and relationship create a valuable opportunity to engage with the provider(s), review and understand the discharge plan and interact with our member to establish lines of communication before discharge. With a collaborative discharge planning process, we can begin working with the member and follow-up care providers to secure the right appointments after discharge.

Outpatient Follow-Up Within Seven (7) Days

Follow-up outpatient treatment is scheduled to occur within seven (7) days from the date of discharge. If a member misses this follow-up appointment, Passport will ensure that the BH provider contacts the member within twenty-four (24) hours to reschedule. Our members receive direct calls from after-care coordinators to remind them of their outpatient appointment within seven (7) days of discharge from an inpatient psychiatric hospitalization. If a member fails to show for an appointment, the provider must attempt to contact them within twenty-four (24) hours. Our care team also attempts to contact the member. If needed, our care team will assist in securing or rescheduling appointments. If a member's benefits end during treatment and program participation, their care manager will reach out to provide alternatives and resources for continuing care and guidance on how to access services. Members transitioning from child or adolescent (pediatric care) to adult care are assisted with referral and linkage to adult services, when needed, to ensure they receive age-appropriate BH services.

Some of our larger outpatient providers currently have value-based contracts in which follow-up after hospitalization is one of the target quality metrics. Beacon has a priority performance standard which tracks readmission rates and is linked to members not achieving appropriate connection follow-up after hospitalization. Beacon and Passport are held accountable for this by the BHAC and our other governance structure. Passport and our provider owners understand the importance of appropriate coordination of care, especially following hospitalization. Performance on these metrics has steadily improved over the years, yet our goal is to significantly increase performance in getting members connected to appropriate after-hospitalization care.

Following an inpatient stay, we know that members often need long-term support to get their lives back on track. In cases where members receive services from safety-net providers, such as Rural Health Clinics, Federally Qualified Health Centers (FQHCs) and CMHCs, we coordinate with agencies across the Commonwealth. Our goal is to ensure that the member transitions seamlessly from the safety net provider

into our program for proper continuity of care. Information about provider performance compared to others in the network is supplied quarterly to providers via Provider Quality Review meetings.

C.23.a.v. Process for ensuring continuity of care upon discharge from a Psychiatric Hospital.

Continuity of Care After Discharge

The period following a psychiatric hospitalization is one of the most vulnerable times for people with BH needs. A longitudinal study by P. Qin and M. Nordentoft (2005) found that women were two hundred forty-six (246) times more likely and men were one hundred two (102) times more likely to die by suicide in the crucial week following hospitalization. Passport understands these high stakes and takes this risk very seriously. **Every member who has a BH hospitalization is assigned a care manager for outreach.** The care manager's responsibility starts at the time of admission, establishing contact with the facility to immediately engage so that discharge planning begins early.

The care manager collaborates with the facility to review the discharge plan, works on behalf of the member to address barriers to completion and works directly with the member immediately following discharge to schedule the required follow-up appointments. The care manager makes reminder calls regarding the upcoming appointment and helps the member troubleshoot barriers to keeping the appointment. The care manager may also engage a registered nurse to conduct a medication reconciliation exercise on behalf of the member and before their follow-up care if a need is identified. Immediately following the date of the follow-up care appointment, the care manager will also call the provider to verify that the appointment was kept and completed.

If a no-show or reschedule occurred, the care manager is then responsible for recontacting the member to identify and address the barrier to care that prevented the appointment from being completed, rescheduling the appointment with the same provider or, in some cases, identifying a new provider and scheduling the required visit.

Passport assigns a care manager prior to or on the date of discharge and, depending on the specific needs of the member, provides basic, targeted or intensive care management services to members with SMI and co-occurring conditions who are discharged from a state-operated or state-contracted psychiatric facility or state-operated nursing facility.

The care manager and other identified BH providers participate in discharge planning meetings to ensure compliance with federal Olmstead and other applicable laws. In these meetings we focus on ensuring needed supports and services are available in the least restrictive environment to meet the member's individual BH and PH needs, including psychosocial rehabilitation and health promotion. Following discharge, the BH service provider will follow up with the member to ensure the community supports are meeting his/her needs. Passport will also ensure the BH service providers assist members in accessing free or discounted medication through the Kentucky Prescription Assistance Program (KPAP) or other similar programs.

For members committed by a court of law or voluntarily admitted to the state psychiatric hospital, Passport will coordinate with BH providers and state-operated or state-contracted psychiatric hospitals and nursing facilities regarding admission and discharge planning, treatment objectives and projected length of stay. Passport has contracted with all state-owned and -contracted psychiatric hospitals. All Passport provider agreements reference expected compliance with the Provider Manual, where our expectations regarding continuity of care following hospitalization are stated. Providers must schedule an appointment for a follow-up visit within seven (7) days prior to discharge. Providers must also contact the member within twenty-four (24) hours if they fail to appear for their scheduled appointment. In addition, our BH care manager and guardianship liaison participate in quarterly continuity of care meetings hosted by the state-operated or state-contracted psychiatric hospitals to aid in the coordination and transition of care.

In addition, Passport is holding ourselves and our BH partner, Beacon Health Options, more accountable for children in the unique pre-discharge space of having been decertified for failure to meet medical necessity, and not having a placement at the next level of care for a variety of reasons. Collectively, we feel these components will greatly improve our discharge planning and the decertification process for children. Our accountability plan to better address children who are decertified and ready for discharge is presented in **Exhibit C.23-2**, which details enhancements to the SLAs with Beacon.

Improving Continuity of Care with The Ridge

Passport has recently initiated a demonstration project in the Lexington area. We have partnered with two community-based providers to provide home visits following hospitalization to review discharge plans and provide support during the transition to outpatient care. The Ridge psychiatric hospital has also partnered to help identify members and support the transition of care to the outpatient transitional providers. This project was initiated in 2019, and we look forward to learning more about its efficacy. We have plans to use in other parts of the Commonwealth if it successful in helping members more effectively transition into care.

Increasing Treatment Options for Members with Substance Use Disorders

Passport has roughly 35,000 members with a diagnosis of SUD (eleven percent [11%] of all members) who contribute approximately \$448 million in total expense, likely due to poor coordination and treatment of multiple comorbidities. This expense is divided between medical (sixty-five percent [65%]), behavioral (sixteen percent [16%]) and pharmacy (nineteen percent [19%]), suggesting the complex and interdependent nature of the conditions affecting this cohort.

Passport has been an active partner in the expansion of coverage and access to care for members with SUD with the 1115 Medicaid demonstration waiver. We have facilitated member access to short-term residential stays (up to thirty [30] days), methadone prescription coverage and methadone treatment-related

transportation (for youth and pregnant members) in conjunction with DMS. Passport built our systems for the new Behavioral Health Service Organization subprovider types. We have been actively participating in the current DMS Phase II of the implementation process for requiring providers delivering SUD services to have their programs certified to an ASAM level of care, including meetings and calls. We have worked closely with providers and DMS during the development of the attestation process to be used during the transition to ASAM-level certification for programs.

In addition, Passport will be launching innovative demonstration projects, described below, to combat opioid dependency.

Community Collaboration Drives Substance Use Disorder Service Quality

In the ongoing drive to work with providers who offer evidence-based, quality services for our members who have BH diagnoses, Passport incorporates quality metrics to evaluate and monitor program efficacy. Passport is currently representing community-based health plans on the American Psychiatric Association and NCQA Mental Health and Substance Use Disorder Technical Expert Panel to develop outcome metrics for the Center for Medicare and Medicaid Services. These metrics will determine quality and new incentive programs for BH providers. Passport also serves on the Opioid Use Disorder subgroup to establish best practice metrics for the delivery of opioid use disorder services. Passport understands the importance of collaborating with other BH professionals to define quality for mental health and SUD services, as well as developing standardized metrics to determine outcomes and align payment incentives.

Virtual Peer-to-Peer Support for SUD

Passport is currently working with a Kentucky-based company, Stay Clean, to expand SUD services and support to Passport members. Stay Clean is a web-based app that facilitates direct virtual care for members; provides online access to informal peer support groups such as AA, NA, Cocaine Anonymous and AL-ANON; and has a repository of information related to SUD. Stay Clean offers a clinical treatment protocol delivered completely online, including a tested, reliable and secure telehealth network and an EHR. All clinical treatment is delivered by certified and licensed alcohol and drug counselors working directly with those with SUDs as well as with codependents, a recognized diagnosis in itself. Members are connected to peer support after treatment to provide support and guidance as needed. Clinical service, including assessment, can be delivered individually or where appropriate in groups, scheduled at times convenient for the client and from the security of their home, and is intended to augment, not replace, current treatment or twelve (12)-step programs.

Passport has worked closely with Stay Clean to provide feedback about their program and business model as it completed development and moved into production this year. The developers of Stay Clean are currently piloting the program and will have over 1,000 local active users (including many Passport members) by Q3 2020. At the completion of the pilot in 2020, Passport will work with Stay Clean to provide increased access to treatment and much-needed supportive services to members in the SUD recovery process.

Opioid Prescriptions and Provider Prescription Patterns

Kentucky is facing a crisis of opioid use that continues to grow. The rate of overdose deaths involving opioid prescriptions rose steadily from 1.0 deaths per 100,000 persons in 1999 to 10.2 deaths per 100,000 persons in 2017. **Exhibit C.23-13** highlights the severity of the issue.

Exhibit C.23-13: Opioid Use in Kentucky: A Crisis

2017 Data	Kentucky	U.S. National Average
Opioid-Involved Deaths per 100,000 Persons	27.9	14.6
Opioid Prescriptions per 100 Persons	86.8	58.7

To better understand prescribing patterns, we performed a retrospective cohort analysis using a national database of medical and pharmaceutical claims in the U.S. between 2012 and 2018. We identified opioid-naïve members who received their initial opioid prescription in a primary care office setting. For Passport members who returned for a follow-up appointment within thirty (30) days, we differentiated between those who saw a different clinician (exposure) versus those who returned to the same initial prescribing clinician (control). We compared rates of long-term opioid use, adjusting for differences in initial prescription and member characteristics. Members who saw a different clinician during their follow-up appointment experienced a thirty-three percent (33%) reduction in their rates of long-term opioid use (adjusted odds ratio 0.67 [ninety-five percent (95%) confidence interval: 0.52, 0.86]). This suggests that in the primary care setting, scheduling a member with a second medical opinion early in their opioid journey may significantly curb rates of long-term opioid use. Based on these results, we plan to engage select PCPs in a demonstration project to determine the impact of second medical opinions early in a member's exposure to opioids.

Pharmacogenomic Testing to Prevent Opioid Dependency

It is widely acknowledged that individual responses to pain and pain control using opioid analgesics are variable.¹ Some individuals experience complete relief using a standard dose, whereas others require a much higher or lower dose. Some individuals receiving opioid treatment become addicted, whereas others do not. Because of these significant interindividual differences, successfully achieving pain control and avoiding adverse events in all individuals remains an elusive goal. Although many different factors contribute to the individual pain response, significant research effort has demonstrated a strong genetic

¹ Stamer, U. M., Zhang, L., and Stüber, F. (2010) Personalized therapy in pain management: Where do we stand? *Pharmacogenomics*; 11:843–64.

component to pain sensitivity and response to opioids.² More recently, pharmacogenetics companies have made significant progress in the development of a noninvasive DNA test to understand an individual's likelihood of developing a dependency. We intend to partner with one such company, Prescient Medicine, to better understand the benefits of testing prior to initiating opioids. Prescient Medicine has a current product in the final phases of approval by the Food and Drug Administration that will help predict who has an increased likelihood of developing dependency on opioids based upon algorithms. This information will be beneficial in guiding providers in developing plans to manage pain.

Preferred Provider for Urine Drug Tests to Improve Quality and Support Best Practices

SUD care and treatment requires careful monitoring of substance use through urine drug tests (UDTs). Passport has partnered with an industry leader in laboratory services, Prescient Medicine, to support providers through expert reporting capabilities, access to peer education and improved turnaround times. Use of UDTs is often presumptive, which results in higher utilization costs despite high rates of error and duplicative tests. Passport's decision to make Prescient Medicine the preferred provider for UDT lab services will help significantly curb this cost and provide accurate, useful data to help ensure providers are adhering to best practices when ordering UDTs.

Prenatal Substance Exposure and Dependency in Pregnant Women

Pregnant women in the Medicaid population face unique challenges related to SDoH. They face the stress of daily survival while trying to make the right choices so they can deliver a healthy baby. Often their PH and BH, as well as the substances they use, are secondary priorities compared to food, housing, safety and access to services that may help them.

To better support this population outside of Region 3, Passport is working with 180 Health Partners to provide a unique blend of direct services by a nurse, social worker, counselor or professional peer combined with improved access to traditional medical or nonmedical providers, such as residential treatment, IOPs and counseling, while focusing on addressing the SDoH that are impacting the mom and baby. The hybrid nature allows Passport to adjust the care delivery model to meet each new mother's unique needs on her journey to a healthier birth, stabilizing her life and reducing her stress while preventing relapse to substances that are dangerous to her baby.

² Nielsen, L. M., Olesen, A.E., Branford, R., Christrup, L. L., Sato, H., and Drewes, A. M. (2015) Association between human pain-related genotypes and variability in opioid analgesia: An updated review. *Pain Prac*;15:580–94.

Through this partnership, Passport’s services for this population focus on:

- Stabilizing all aspects of the mother’s and family’s lives
- Cortisol (stress) reduction for both the mother and baby pre-and post-pregnancy
- Relapse prevention, both short and long term
- Awareness of the impact of commonly used substances on the baby

As their lives stabilize, new mothers take ownership of their recovery and make choices to achieve the outcomes they desire. **Exhibit C.23-14** describes the outcomes that have been observed for new mothers who have participated in the 180 Health Partners program.

Results include avoiding preventable negative birth outcomes and significant impact on MCO compliance with quality expectations such as pre- and post-natal visits, well-baby visits, election of long-acting reversible contraception (LARC) and smoking cessation programs

Exhibit C.23-14: Outcomes tale for mothers who participated in the mothers who received 180 Health Partners services

Metric	Today	With 180 Program
Stress Level/Stigma	High	71.4% report decrease
Reproductive Plan	Rare (less than 25%)	74% execute on a plan
Substance Use	Erratic and uncontrolled	65% report decreased use
Medication-Assisted Treatment (MAT)	Low	74% on MAT at birth
Access to BH	Very difficult/low	100% receive BH
Recovery	Not in a recovery program	Start recovery program
Tobacco Use	High	75% report decrease
Gestation Period	55% >37 weeks	88% > 37 weeks
Breastfeeding	Less than 15%	80% of those allowed to
Post-Partum Visits	Low (less than 20%)	Greater than 55%

C.23.b. Describe the Contractor’s approach to meeting the Department’s requirements for operating seven (7) days a week, twenty-four (24) hours a day emergency and crisis hotline as defined in RFP Attachment C “Draft Medicaid Managed Care Contract and Appendices.”

Emergent Mental and Behavioral Health Crises: Seven (7) Days a Week, Twenty-Four (24) Hours a Day Emergency and Crisis Hotline

We understand that immediate BH help and support is an important resource for our members. Members may call Passport’s Crisis Hotline during a mental health emergency/crisis and be immediately connected with a **licensed BH professional** – day, night and weekends. We typically handle crisis calls via our dedicated hotline or through our customer service line. Our crisis line is staffed by trained personnel twenty-four (24)

hours a day, seven (7) days a week, three hundred sixty-five (365) days a year, and is available toll-free throughout the Commonwealth.

Face-to-face emergency services are also available twenty-four (24) hours a day, seven (7) days a week. Our Crisis Hotline is **never** answered by any automated means. For calls received by our Crisis Hotline:

Passport's Crisis
Hotline handled
20,863 calls in 2019

- Ninety-nine percent (99%) are answered by a licensed clinician by the fourth ring.
- Callers never receive a busy signal.
- There is a call abandonment rate of seven percent (7%) or less.
- Callers can immediately connect to the local suicide hotline's telephone number and other crisis response systems through our patch capabilities to 911 emergency services.
- We never impose maximum call duration limits and allow calls to be of sufficient length to ensure adequate information is provided to the member.
- We meet cultural competency requirements and provide linguistic access to all members, including the interpretive services required for effective communication.

Our Crisis Hotline BH clinicians are all independently licensed clinicians with the training and experience to identify signs and symptoms of crisis. They will quickly execute a crisis assessment to understand the severity of the situation and intervene with the member. Training topics for Crisis Hotline BH clinicians include:

- Crisis assessment, including identification of:
 - Safety to member
 - Safety to others
 - Desire to cause harm vs. desire and means to cause harm
 - Severity and urgency of crisis situation
 - Need for immediate intervention by law enforcement due to a safety risk
- Crisis response, including:
 - How to access and deploy emergency response resources for the member's current location, such as Mobile Crisis Outreach provided through our BH provider network, emergency medical services (EMS) and/or local law enforcement
 - Process for creating referrals to provider(s) for follow-up care and to Interdisciplinary Care Team for case review and engagement in Passport's Care Management program
 - Sharing all information pertaining to the crisis call to Care Management in the clinical system so that the member's clinical record is up to date and complete
 - If a call is deemed to be nonemergent, discussion of existing treatment details, professional/social supports and positive coping skills

The Crisis Hotline BH clinicians are responsible for working with the member to deescalate or stabilize while the appropriate resources are activated to intervene with the member. The clinician will remain on the line to assist as needed. After a crisis situation is resolved, follow-up care may be provided by a BH or PH team member. The determination of which team will take primary responsibility will be made during joint rounds held by the care management team.

Passport has also completed an internal study looking at the effectiveness of local crisis stabilization services in prevention of hospitalization for child and adolescent members. In response to the findings, we developed a work group with leadership representation from Passport, Beacon and Centerstone Kentucky (Seven Counties Services) staff to explore more effective ways of using the crisis service and promoting adequate follow-up care with the intent of savings lives.

We monitor our Crisis Hotline’s performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated.

C.23.c. Describe the Contractor’s approach to coordination and collaboration between the Contractor, Behavioral Health Providers and the PCP as defined in RFP Attachment C “Draft Medicaid Managed Care Contract and Appendices.”

Coordination and Collaboration with BH Providers and the PCP

Passport believes in the considerable benefits of individualized care management. Our goal is to make the care management experience personal by focusing on meeting the unique needs of each member. The needs of each member are different and, in order to achieve improved and sustained health outcomes, we recognized that a transformation of care management was important. Passport is investing in care management staff and resources for our Medicaid populations.

The programs deliver interventions to members based on their individual needs and risk level and may include:

- Completion of a comprehensive assessment and/or screening, which includes coaching, education and self-management support during the interaction
- Development of a care plan that identifies personalized goals and is designed in collaboration with the member
- A Welcome Letter that explains the program, hours of operation, the importance of self-management, etc.
- Mailing of condition-specific educational booklets and/or other educational materials at the member’s request
- Ongoing outreach to the member at regular intervals appropriate to address the member’s needs and in accordance with the program specifications
- Appointment and transportation assistance
- Education about and linkage to available state and community-based resources, including wellness programs, crisis support resources, peer support and web-based resources
- Assistance with the coordination of available benefits and BH services
- Coordination of care among providers, including BH providers, PCPs, health homes and other medical providers
- Support and coordination of services during transitions of care to ensure safe transitions

- Motivational interviewing to support behavior change and member engagement
- Self-management support, BH education and coaching to improve knowledge and self-management skills
- Provision of condition-specific self-management tools and assistance in developing self-management strategies
- Support to members and providers in the development of and adherence to crisis plans
- Interventions to address barriers to care and treatment adherence
- Attendance and participation in wraparound meetings, case conferences and Integrated Care Team meetings to further coordinate the member's care when and where deemed appropriate

These interventions encourage members to be actively engaged in their care and provide feedback to our care management team about the member's evolving needs throughout the process.

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

The collaborative care service model has been shown to double the effectiveness of depression care, improve physical functioning and significantly reduce health care costs (outpatient mental health, pharmacy, other outpatient costs, inpatient medical costs and inpatient mental health/substance use disorder costs). Passport's Collaborative Care Program follows the core principles of this evidence-based service model:

- Members with BH-related symptoms are screened and referred.
- The Behavioral Health Care Team reviews medical history, psychiatric history and validated measures with PCPs and has access to a comprehensive member record within the Identifi platform.
- The Integrated Care Team, which includes licensed Kentucky psychologists, provides consultation and treatment recommendations to PCPs to support treatment initiation and adjustments.
- The Integrated Care Team monitors progress, provides twenty-four/seven (24/7) support and updates PCPs on additional psychiatric input.

Provider engagement is a major component of our integrated BH

program. As a provider-focused organization, Passport understands the importance of the member-provider connection. To support integrated BH, PCPs will screen for and may be managing medications related to



**Providers are
in Our DNA**

BH needs. Our team contacts the PCPs who are managing BH treatment for members to make them aware of the BH benefits available to enhance care. We make our team of BH professionals, including licensed psychiatrists across numerous specialties from Beacon's national clinical team, available to PCPs for psychiatric consultations through our Passport Psychiatric Decision Support Line (PDSL). These consultations can be used to validate and understand psychiatric medication guidelines and have been shown to reduce prescribing errors at the point of care rather than after our pharmacy analytics solution (RXSolve) identifies them.

While providers are often reluctant to have an MCO work with them on high-level practice transformation, Passport meets providers where they are and provides discrete consultation to help move each engaged provider toward a member-centered, whole-member approach to care. To support this effort, we are changing our physician satisfaction form to better assess collaboration and barriers to collaboration so that we can work with providers to improve collaboration and coordination of care. Through our consultation, we educate providers on tools available to them—such as the Kentucky Health Information Exchange (KHIE) access portal—and the benefits of using them. Our integrated care program manager also works directly with PCPs to encourage BH screening (depression, anxiety and SUD at a minimum) and best practices for internal follow-up and referral to BH providers.

**PCPs can call
Passport's SBIRT
Line to help
connect members
who have a positive
screen for risky
alcohol or drug use
behaviors with the
right services.**

Not only is screening for BH concerns part of quality preventive care, but it is a pathway to collaborative and integrated care models for better whole member care. Through consultation and provider education, BH providers are likewise encouraged to screen for PH problems and refer the member back to their PCP as needed. Passport has introduced a Screening, Brief Intervention, and Referral to Treatment (SBIRT)-specific phone line for PCPs to call if they have a positive screen for risky alcohol or drug use behaviors and need assistance helping the member find the right services. Care managers will reach out to the member to conduct additional screening and connect the member with appropriate resources to provide whole-person care. The care manager will inform the PCP of outcomes of any outreach made at their request. Passport offers training on coordination and quality of care, such as BH screening techniques for PCPs and new models of BH interventions. Passport has developed policies and procedures which are provided to the DMS for approval regarding clinical coordination between BH service providers and PCPs, with approval subject to Section 4.4 of the draft contract. We require that BH service providers refer members with known or suspected and untreated PH problems or disorders to their PCP for examination and treatment. BH providers only provide PH care services if they are licensed to do so. We also require that BH providers send initial and quarterly summary reports of a member's BH status to the member's PCP, with the member's consent. These requirements are specified in Passport's Provider Manual.

Supporting Collaboration Between BH Providers and PCPs Through SBIRT

Passport recommends a Performance Improvement Project (PIP) to implement an SBIRT program, with a strong focus on the referral to treatment (RT) aspect. By focusing on RT, we will address early identification and build a stronger collaboration between the member's PCP and BH/SUD providers for those identified as at risk or within the misuse level for substances. Our proposed SBIRT PIP will work to identify individuals earlier and connect them with treatment.

Helping PCPs Better Understand BH Issues in Children

Passport has made available training modules, prepared by a child and adolescent psychiatrist at Bingham Child Guidance Center, to aid PCPs in better understanding BH conditions. These modules were created as part of a grant to improve the prescribing of psychotropic medication to Kentucky children and adolescents.

While many providers use the SBIRT approach to screen members, not all use a standardized screening tool. The program would issue a standardized tool to evaluate members in a consistent manner. Further, while screening is straightforward for providers, intervention and RT can be a challenge due to the time constraints and workflow adjustments needed. There is also a perceived lack of community resources for the RT component. As of 2016, Kentucky ranked fifth among states with the highest number of drug-overdose-related deaths.³ As opioids have become a crisis in Kentucky, SBIRT becomes a more important tool for early intervention. However, billing codes for SBIRT have not evolved in this time to meet the changing needs for the full activities required for SBIRT. The PIP could examine ways to expand billing for follow-up to SBIRT or to better assess if a member is referred to treatment secondary to a positive SBIRT screen. The PIP could potentially help practices develop a standard for using SBIRT and when and how to refer members. For this reason, this PIP would be an excellent choice for a collaborative PIP across all MCOs to improve prevention and early identification and treatment.

Providers also are informed of the Passport PDSL. The PDSL is a service to BH providers to offer PCPs consultations with a team of psychiatrists for questions regarding BH interventions, including those related to medications.

PDSL services were put in place based on concerns raised by the Child and Adolescent subcommittee of our PCP Workgroup, which had concerns over the number of children who needed follow-up and psychotropic medication refills. Many pediatricians did not feel comfortable with the medications and/or dosages their patients were being prescribed. Investigation as to why this was happening noted limited psychiatric access, especially outside Jefferson County. Because of this, Passport initiated the PDSL. Access to psychiatric care in limited access areas was developed, and our BH program offered training to providers on these medications. From this effort, other subsequent initiatives followed, including SBIRT training, resources and tools. A positive “side effect” of this response to an immediate need was the development of stronger integration between BH services and primary care, which is a cornerstone of Passport’s whole-person approach to care.

³ <https://www.khcollaborative.org/2018/08/sbirt-toolkit-released-for-healthcare-providers-to-address-opioid-crisis/>
Accessed 6/5/2019.

Other examples of working directly with BH providers and PCPs include:

Example #1: Billing and Workflow Design with a Federally Qualified Health Center

Passport has consulted on billing for BH services within a FQHC and worked to understand the difference between interventions to change problematic health behaviors impacting PH outcomes versus BH conditions. We also evaluated workflows to improve use of BH approaches during medical appointments for improved BH and medical outcomes.

We then collaborated with providers focused on addressing chronic health conditions to maximize impact of their internal BH providers. We assessed how their team coordinated care with local CMHCs to avoid duplication of services.

Other results, lessons learned and/or outcomes achieved include:

- Improved identification of members appropriate for a chronic care health home
- Increased frequency of data sharing with provider to allow for improved understanding of utilization and cost patterns of members
- Improved workflow and internal collaboration between BH and medical staff at the FQHC to fill care gaps related to insufficient psychiatric services in the area
- Collaborations with new clinics regarding ideal clinic design for integrated care workflow

Example #2: New Delivery Model with Hardin Intensive Health

Passport attended monthly in-person meetings with Hardin Intensive Health in Central Kentucky with member-specific data on utilization and cost trends. We then met with their BH providers to shape their care delivery model, which had been traditional co-location but expanded to include the use of motivational interviewing (MI) skills to address health behaviors.

We also reviewed their BH and health behavior screening process and identified care gaps in offering tobacco cessation. We also worked with nurse practitioners (NPs) to focus on the social needs of members and discussed the Population Health approach to their focus on food insecurity.

Other results, lessons learned and/or outcomes achieved include:

- Hardin Intensive Health added a section specific to low glycemic foods for diabetic individuals.
- Hardin Intensive Health added tobacco cessation to its interventions.
- Hardin Intensive Health, NPs and the Passport chief medical officer (CMO) and pharmacy worked together to address barriers to Hepatitis C (Hep C) treatment, as noted by the Integrated Health Team.
 - Hardin Intensive Health and NPs went through extensive Hep C training and are now able to suggest medical interventions more directly with providers, which increases access and reduces the need for members to seek specialty care for routine visits outside of their communities.
- Ongoing engagement with medical and billing teams addressed missed opportunities for care and increased use of SBIRT within their practices.

Example #3: Practice Transformation with Shawnee Christian

Passport's Integrated Health Team worked directly with the CEO of Shawnee Christian Healthcare Center (located in west Louisville) on practice transformation. We assisted the organization in developing their desired MOC, including job description assistance, search committee reviews and integrated care expertise. We also worked with their BH providers to better understand coding practices, SDoH screening tools and appropriate clinical layout.

We provided consultation to providers when they switched EHR to clarify progress versus process and/or psychotherapy notes, and the privacy settings needed for each. We worked with the BH team on how to create progress notes that were more appropriate for charting health behavior changes to ensure that the member-centered approach is maintained, as well as interoperability for physicians. Last, we worked with them on ensuring that all informed consent within the clinic reflected the collaboration between providers and met requirements for 42 CFR Part 2.

Other results, lessons learned and/or outcomes achieved included:

- Trained Shawnee Christian Healthcare Center staff in adolescent SBIRT
- Identified BH providers in the community for referral as needed
- Supplied education on billing, coding and their relationship to health outcomes
- Provided full-day observation of clinic to help address workflow as BH increased presence in the medical clinic
- Reviewed SDoH screening tools and how to refer to Passport for assistance with resolution of barriers to care
- Consulted regarding clinic layout during construction of new space to enhance opportunity for collaboration between medical and BH providers
- Worked with treatment team and local schools (workgroup made up of Shawnee Christian Healthcare Center and school staff) to build models for school-based health care clinics with a focus on integration and collaboration

Example #4: Optimizing Staffing and Services at Audubon Area Community Care Clinic

As part of a new relationship with the Audubon Area Community Care Clinic (Western Kentucky), our Integrated Health Team is working with the clinic to develop their care model. This project includes helping the clinic optimize their current staffing and addressing the lack of psychiatry services for members in the area. We listened to the challenges faced by the Chief Executive Officer and presented a new proposed MOC that the executive shared with her board members for approval.

We are continuing to build this relationship, as the clinic is soon relocating, and discussing opportunities within the new space to increase member activation.

Example #5: Resolving Billing Concerns at Foothills Health and Wellness Center

The Integrated Health Team met with the Foothills Health and Wellness Center in Eastern Kentucky to assist with their concerns over billing for their BH provider and answer their questions regarding additional staff resources to fill the BH needs of the region.

Other results, lessons learned and/or outcomes achieved included:

- Provided education on Health and Behavior Assessment/Intervention (HBAI) versus traditional mental health codes
- Worked with staff to view gaps in BH schedule (secondary to no-shows) as an opportunity to increase their integrated care offerings and member coordination

Supporting PCPs in Delivering Whole-Person Care

Our Vice President of Health Integration, Dr. Liz McKune, has been an NCQA Certified Content Expert for the Patient Centered Medical Home (PCMH), and our Integrated Care Program Manager, Dr. Jessica Beal, is trained in the PCMH model to better advise providers interested in advancement toward PCMH certification. They have presented at state-level association annual conventions for both BH and medical providers (Kentucky Psychological Association [KPA] and Kentucky Primary Care Association [KYPCA]) to educate on integrated care models, best practices for care coordination, collaboration and integration, and the importance of a whole-member approach to care regardless of the provider's discipline.

Passport requires, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected BH problems and disorders. PCPs may provide any clinically appropriate BH services within the scope of their practice. Such contract provisions and screening/evaluation procedures will be submitted to the Department for approval. **Passport also trains network PCPs on how to screen for and identify BH disorders, our referral process for BH services, and clinical coordination requirements for such services.** We include training on coordination and quality of care, such as BH screening techniques for PCPs and new models of BH interventions.

Passport has policies and procedures regarding clinical coordination between BH service providers and PCPs and will provide them to DMS for approval. We require that BH service providers refer members with known or suspected and untreated PH problems or disorders to their PCP for examination and treatment, with the member's or the member's legal guardian's consent. BH providers may only provide PH services if they are licensed to do so. This requirement is specified in all Provider Manuals.

We require that BH providers send initial and quarterly (or more frequently if clinically indicated) summary reports of members' BH status to the PCPs, with the member's or their legal guardian's consent. This requirement is specified in all Provider Manuals.

Passport understands that appropriate information sharing and careful monitoring of diagnosis, treatment, follow-up and medication usage are especially important when members use PH and BH systems simultaneously. Passport has and will continue to:

- Establish guidelines and procedures to ensure accessibility, availability, referral and triage to effective PH and BH care, including emergency BH services (i.e., suicide prevention and community crisis stabilization)
- Facilitate the exchange of information among providers to reduce inappropriate or excessive use of psychopharmacological medications and adverse drug reactions
- Identify a method to evaluate the continuity and coordination of care, including member-approved communications between BH care providers and PCPs
- Protect the confidentiality of member information and records
- Monitor and evaluate the above, which shall be a part of the Quality Improvement Plan

We also understand that the Department shall monitor referral patterns between physical and behavioral providers to evaluate coordination and continuity of care. Drug utilization patterns of psychopharmacological medications are closely monitored. We understand that the findings of these evaluations will be provided to us.

Multidisciplinary Community Partnerships to Deliver Integrated Behavioral Health

In addition to supporting collaboration between BH providers and PCPs, to meet the full spectrum of behavioral, physical and social needs of our members, Passport also fosters partnerships with many community organizations throughout Kentucky. At its heart,



Passport is a dedicated group of **Kentuckians Serving Kentuckians** focused on increasing access to health care. With over two decades of local experience and local leadership in Kentucky Medicaid, our long-term commitment in the market and alignment with provider owners allows us to work with local agencies, community-based organizations (CBOs) and network providers to share data, drill down to root causes, coordinate actions and measure results. For a population that struggles to engage in their health and access basic social needs, trust is essential. Our team has delivered member service, coordinated care, educated members and established meaningful relationships with CBO staff and has worked diligently to earn the trust of the local communities we serve.

Louisville Health Advisory Board Behavioral Health Subcommittee

Another example of our community partnerships is our work with the Louisville Health Advisory Board (LHAB), which includes businesses, government, schools, and civic and nonprofit organizations. The goal of LHAB is to improve the physical, mental and social well-being of Louisville, with the goal of increasing quality of life. Passport has actively been involved in LHAB since the inception and is part of the BH subcommittee that has contributed significantly to initiatives such as:

- Advancing the city-wide Zero Suicide Initiative
- Increasing participation in the Question, Persuade, Refer (QPR) suicide prevention training throughout the region
 - During National Suicide Prevention Week, LHAB trained over 2,200 individuals with Passport’s assistance.

- Passport offers elective, evidence-based QPR training to all employees.
- Developing suicide fatality reviews, using Passport-led research on other models across the country
- Meeting with the Jefferson County Coroner’s Office to discuss improvements for tracking and responding to suicide cases

Jefferson County Public Schools Behavioral Health Committee

Another example is our engagement with Jefferson County Public Schools (JCPS). Our Integrated Health Team participates in initiatives and projects to better address the needs of students in the community to improve their long-term success academically and in the workforce. In 2016-2017, Dr. Jessica Beal and Dr. Liz McKune served on a JCPS Behavioral Health Committee made up of various community partners to provide feedback and assist with planning so the school district could better meet the social and emotional needs of children, including those with SED. Dr. Beal is currently participating in the Bingham Fellows Group charged with improving student achievement and reducing barriers to success for children in Jefferson County. Passport is actively working to expand strategic partnerships like these statewide to engage more organizations in using the latest models of community BH.

Implementing Value-Based Payment with Centerstone Kentucky (Seven Counties Services)

Centerstone Kentucky (Seven Counties Services) had been a provider with us since the BH benefit started in 2013. They were initially paid only on a **Fee-for-Service** basis. Our first value-based arrangement with Centerstone Kentucky (Seven Counties Services) was a **Pay for Performance** model, where they had the opportunity to earn additional dollars for demonstrating that they were putting recommended procedures in place and building relationships to increase seven (7)- and thirty (30)-day follow-up after hospitalization. Later, the incentive was enhanced to increase the number of discharged members receiving their seven (7)- and thirty (30)-day follow-up appointments. Payments were made quarterly for earned incentives.

Our second arrangement with Centerstone Kentucky (Seven Counties Services) was a **Blended Case Rate/Bundle of Services**. Centerstone Kentucky (Seven Counties Services) had the opportunity to bundle a group of services and receive payment for delivery of high-fidelity wraparound services in the foster care pilot. They also had an opportunity to earn an incentive on top of this if they achieved their quality performance targets for the two primary goals of the pilot:

1. Percentage of children who maintained their foster care placement or returned to their natural family
2. Percentage of children who improved their functioning on a standardized assessment

Payments on the Blended Case Rate/Bundle of Services arrangement occurred monthly, with any earned incentives paid out at the end of the program.

Our current value-based arrangement with Centerstone Kentucky (Seven Counties Services) is a **Shared Savings Model**. There are two opportunities to earn these Shared Savings incentives:

- **Population Incentive:** Centerstone Kentucky (Seven Counties Services) members are identified and agreed upon before the measurement period begins. Members are measured for a quarter. Pre-quarter and end-of-quarter expenses per member are compared (after allowing a quarter for claims lag). A pool is created from any savings on medical inpatient stays, BH inpatient stays, and ED visits. Thirty percent (30%) of the savings, over a quarter, for the agreed-upon members is placed into an “incentive pool.” Centerstone Kentucky (Seven Counties Services) has the opportunity to “earn” this incentive pool. Half of the pool is awarded for achieving a savings. The other half is tied to the following quality measures:
 - Follow-up after hospitalization
 - Documenting members’ Body Mass Index (BMI) and having a plan for addressing if it is outside the normal range
 - Documenting member’s tobacco use and, if he/she uses tobacco, having an intervention
 - Documenting obtaining release and sharing of records with PCP
 - Documenting obtaining release and sharing of records with referring provider
 - Completing hemoglobin A1C screenings for members with schizophrenia or bipolar disorder
 - Documenting suicide risk assessments for members with major depressive disorder at least every six (6) months
 - Screening members for SUD and linking to treatment if needed
- **Partners in Wellness Incentive:** Centerstone Kentucky (Seven Counties Services) is provided a list of two hundred (200) members (in advance of the quarter), beginning with their members with an SMI and their members with the most expense due to their health care utilization. Centerstone Kentucky (Seven Counties Services) is also provided a list of members (who are not currently with Centerstone Kentucky [Seven Counties Services]) with an SMI and the higher expense rates, but the listed members will not have been engaged in care. They have the opportunity to engage these members into the Partners in Wellness Program, an integrated behavioral and medical case management model with twenty-four (24)-hour access to nursing. Again, this is a Shared Savings Model with pre- and post-measurement for a quarter before and at the completion of the quarter (after allowing another quarter for claims lag). Thirty percent (30%) of any savings over the quarter from medical inpatient stays, BH inpatient stays and ED visits is placed into an “incentive pool.” Centerstone Kentucky (Seven Counties Services) can earn half of the incentive pool by closing the quarter with a savings. The other half of the pool is tied to specific quality metrics for the intervention’s two primary goals:
 1. Member activation
 2. Documentation of member having a health goal with documented progress measured toward achieving the goal

Additional health behaviors and performance on HEDIS targets are documented to possibly use as baseline clinical metrics for future value-based relationships. As we continue the relationship, our metrics will remain focused on the member receiving whole-person integrated care in an effort to improve overall health and well-being.

We shared our program design in a presentation by Stephen Bartels, M.D., M.S., from the Substance Abuse and Mental Health Services Administration—Health Resources and Services Administration (SAMHSA-HRSA)

Integrated Health Solutions-engaged Dartmouth Health Promotion Research Team at the University of Louisville. He strongly supported the idea of focusing on patient activation and PH goals for outcomes for members with SMI. He also reported they have emerging research that found that focusing on symptoms of mental illness results in only incremental change. Dr. Bartels indicated that, for transformative change, the focus needed to be on overall health, even though the program was originally designed for individuals with SMI. The integrated, whole-person approach helps members make impactful changes. The results of this value-based experience align with this emerging research (see **Exhibit C.23-15**).

Exhibit C.23-15: Results from Partners in Wellness Incentive Program

The program served one hundred forty-two (142) members with SMI for up to six (6) months over a nine (9)-month period.

Within that period, we observed the following impact:

- Thirty-four percent (34%) reduction in combined medical inpatient, emergency and BH inpatient expenses
- Forty-five percent (45%) reduction in inpatient hospital stays
- Twenty-seven percent (27%) reduction in ED visits
- Sixty-nine percent (69%) reduction in hospital readmissions

These initial results suggest we have created an integrated program that could bring medical care management into the relationship of trust with the BH provider and help us promote appropriate utilization of intensive care resources

Supportive Housing Lowers Inpatient Care Costs

Through an Improved Health Outcomes Program (iHOP) grant funded by Passport, WellSpring assessed the impacts of permanent supportive housing among adults with serious and/or persistent mental illness over a two (2)-year period.

The results, published in 2018, were promising: In the one (1)-year span prior to entering permanent supportive housing, the aggregate cost of inpatient care for patients in the study totaled more than \$2.5 million. In the following year, after being placed into supportive housing, inpatient care costs for this group dropped by more than fifty-two percent (52%). ED costs decreased by nearly half. Ultimately, placing patients in supportive housing for just one (1) year resulted in \$18,000 in savings per patient during the first year.

“Passport will continue working with organizations like WellSpring to determine new approaches to improve behavioral health among Kentucky’s Medicaid population,” said Dr. Liz McKune. “From providers and insurers to patients and nonprofits, many in the Commonwealth have a vested interest in improving health, including behavioral health. This is a statewide effort that requires all hands on deck.”

CONCLUSION

Passport delivers a fully integrated approach to whole-person care for members like John, incorporating behavioral, physical and social care at all levels. Through our work with similar members over the past 22 years, we have a deep understanding of the complex needs of this population. This is the foundation on which we have built our unique identification and stratification process. Using our predictive modeling and member profiling platform, Identifi, we identify vulnerable individuals like John who are most likely to incur future avoidable events. We monitor and assess these members to address their needs and provide them with the appropriate level of ongoing care.

To ensure we continue to deliver high quality, whole-person care, we monitor and evaluate our network and programs for compliance with access and care standards and have developed numerous innovations and partnerships to extend our reach. Passport has increased oversight and structural accountability for delivery of BH services to members. We engage in collaborative discharge planning to support our members after hospitalization and assign a care manager to every member who has a BH hospitalization to ensure continuity of care after discharge. We have developed specialized programs and extra supports for high-risk populations such as those with SUD, conditions such as Acute Stress Disorder (ASD), trauma from interpersonal violence or other emergent mental and BH crises. These supports include a twenty-four/seven (24/7) crisis line answered by licensed clinicians.

Passport uses an evidence-based collaborative care service model which includes provider engagement as a major component. To support integrated BH, PCPs can screen for and may be managing medications related to BH needs. Our team contacts the PCPs who are managing BH treatment for members to make them aware of the BH benefits available to both members and providers to enhance care. Passport's integrated care is rooted in technology, but our approach is personal. Our holistic care empowers long-lasting, meaningful changes to our members' health and lives. Passport continues to provide this quality of care while meeting all DMS requirements.

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.