C.25. Enrollees with Special Health Care Needs

a. Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 "Enrollees with Special Health Care Needs." Include a summary of how the Contractor's experience in providing services to these populations has informed the approaches.

b. Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:

   i. Approach to identifying Enrollees.

   ii. Process for screening and assessing individual Enrollee needs.

   iii. Approach to providing education to Enrollees and caregivers.

   iv. Approach to providing transition support services.

Passport Highlights: Enrollees with Special Health Care Needs (ESHCNs)

How We're Different	Why It Matters	Proof
Local innovation and collaboration with Department for Medicaid Services (DMS) resulting in powerful initiatives impacting the Commonwealth	From 2015-2017, Passport developed and implemented an Intensive Care Management pilot for youth in foster care based on DMS concerns related to receiving treatment out of state.	• Results of the pilot indicated 150% increase in return to biological or adoptive parent(s) six (6) months post treatment. • A 20-point improvement in the Child and Adolescent Functional Assessment Scale (CAFAS), illustrating an improvement in overall functioning.
Passport's collaboration with the provider community is strong in Kentucky	As a provider-driven health plan, our first instinct is to work *with* our provider network to support behavior change and empower members to engage in their care.	In 2018, Passport had the highest physician screening rate of adolescent tobacco (77.94%) and alcohol (70.59%) use among all managed care organizations (MCOs) in Kentucky.
Hands-on approach to addressing the needs of members experiencing homelessness through community-based and in-person care team support	• An in-person approach is essential to meeting the needs of a homeless population. • Local team members visit homeless shelters across the state, providing education on health care needs and coordinating care.	Passport members experiencing homelessness visit the emergency department (ED) on average 3.5 times per year versus the national average of 5.0 (or 30% less frequently than the national average).

Introduction

Passport is passionate about our Enrollees with Special Health Care Needs (ESHCNs). For over two decades, Passport has been serving the Commonwealth and, in that time, have gained extensive experience serving ESHCNs. Our comprehensive care management and coordination programs are designed to address the unique needs of members who are at high risk related to chronic physical, developmental, behavioral, neurological or emotional conditions and who may require a broad range of primary, specialized medical, behavioral health and/or related services. Our multidisciplinary member-centric approach with specialized care management and coordination services engages the member and primary caregiver(s), primary care provider (PCP), and specialist(s) to ensure continuity of care. We place each member at the forefront of everything we do.

Our field-based service model was founded on the belief that locally based staff, embedded in the community and knowledgeable about community and member issues, is the best way to ensure access, high service standards and an integrated approach to health.

C.25.a. Describe innovative approaches and evidence-based practices the Contractor proposes to use in providing services to Enrollees defined in Section 35.0 “Enrollees with Special Health Care Needs.” Include a summary of how the Contractor’s experience in providing services to these populations has informed the approaches.

Innovative Approaches and Evidence-Based Practices

Passport offers a member-centric, evidence-based program dedicated for ESHCNs that provides enhanced care management, coordination, education and support to these vulnerable populations. Our efforts focus on ensuring that our ESHCNs receive timely and appropriate services, equipment and resources to support them in achieving improved health. Our multidisciplinary care team is dedicated to fully assisting the member by assessing his/her needs, developing an individualized care plan, creating specific interventions, evaluating his/her progress and referring him/her to needed resources. This is all done to help our members find the path to better health and well-being.

ESHCNs may face physical, behavioral or environmental challenges daily that place both their health and ability to fully function in society at risk. Our approach delivers holistic care management attending to their medical and behavioral health conditions, dental and vision needs, and any Social Determinants of Health (SDoH) that may hinder their ability to live a quality life. Passport’s Care Advisors understand the impact trauma has on the overall physical and behavioral health of all members, and that adverse childhood experiences (ACEs) can have negative and long-lasting effects on health and well-being. This aligns with the Kentucky State Health Improvement Plan 2017-2022 efforts for improving awareness of ACEs. Passport’s Health Integration team is working with providers to understand appropriate timing for the screening of ACEs and how to become more trauma-informed in their care of patients.

We use a multifaceted and integrated clinical model using evidence-based medicine and a coordinated team approach. This enables Passport to comprehensively assess, monitor, measure, evaluate and implement integrated clinical strategies specifically designed for ESHCNs. This is an end-to-end care management program that offers member identification, outreach and program enrollment, assessment and care planning, and referrals and coordination until members successfully reach their goals, as illustrated in **Exhibit C.25-1**.

Exhibit C.25-1: Our End-to-End Process for Care Management and Care Coordination Services for ESHCNs

Innovations in Passport's Approach to Supporting ESHCNs

Passport has demonstrated our commitment to developing and implementing new, better and more effective ways to solve the problems facing our members. Recent innovative approaches to support our ESHCNs and improve health outcomes include:

1. **Real-time risk stratification** to identify and outreach ESHCNs sooner than traditional methods
2. **Social Needs Index (SNI)** to power Passport's Care Compass program in addressing social gaps
3. **Identif[SM] Engage** mobile application to facilitate real-time bi-directional communication with the care team
4. **Remote care telemonitoring** to educate and empower ESHCNs to self-manage their health
5. **Award-winning new member videos** as an additional communication format to facilitate access to appropriate programs and service

These approaches are explained in more detail below and additional examples of Passport's innovations can be found below under the heading "**How Providing Services to ESHCNs Has Informed Our Approaches."**

1. Real-Time Risk Stratification

Members with multiple chronic diseases can have their health deteriorate in a matter of weeks, even days. For such members, there is a specific window of opportunity to intervene and change course to improve their outcomes. The population health programs face a major disadvantage in keeping tabs on members' changing health due to the outdated information from claims. Most MCOs rely on claims-based stratification. In this process, it takes three months after a member's hospitalization or ED visit to get detailed information about it to include in stratification models. By the time a care manager reaches out to the member, that person may have already had additional hospitalizations or other encounters. In an analysis of thousands of high-risk members in Complex Care, Evolent Health found that roughly $19,000 per member was spent in the three-month span between the clinical encounter and the reporting of claims data.

Real time stratification will solve this time lag by leveraging real-time data sources such as hospital ADT, Utilization Management (UM) notifications, lab results and prescriptions in stratification processes. By re-scoring members **daily** through this process, we can quickly reprioritize our Care Advisors' work lists to direct them to the highest-need individuals on a given day. Reaching members at the right time is also effective in improving member engagement. A national pilot of Real-time Risk Stratification showed that total number of members engaged and assessed for care management increased by 44 percent after real-time stratification was piloted. Improved engagement rates were related to identifying the members with highest need in real-time, when the support was most needed.

Real-time Stratification Pilot Results

- Average days between last encounter and outreach:
- Claims-based stratification: 96
- Real-time Stratification: 3

Additionally, member engagement rates improved by 44% with timelier outreach

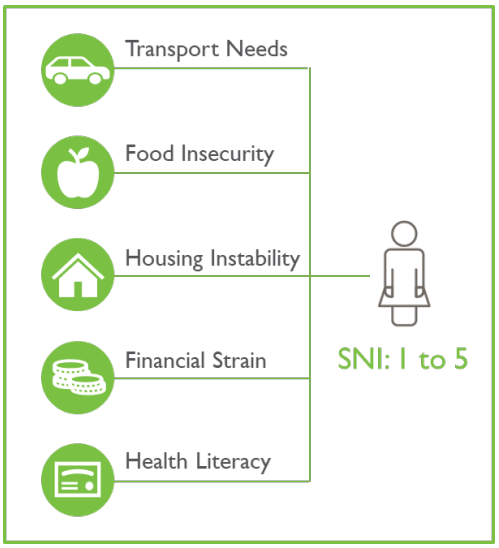
Passport will be launching real-time stratification once Kentucky HIE connection goes live in 2020.

2. Social Needs Index (SNI) to Power Passport's Care Compass Program

To proactively identify and address social needs of our members so they are empowered to improve their health and able to engage in their healthcare. The lack of member-specific insights and data creates a challenge to proactively identify and support members with social needs. Sources of Social Determinants of Health (SDoH) data are disaggregated and lack standardization, and the healthcare industry predominately relies on screening members to understand their needs. Members who have their basic needs met such as adequate food, stable housing, and employment are better able to focus on the activities necessary to improve their health outcomes.

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. As shown in **Exhibit C.25-2**, a single score indicating an individual's severity of social needs across five domains (housing, finances, food, transportation, and health literacy) allows Passport to better prioritize members who most need resources and provides care advisors an easy mechanism to integrate social support into clinical care management.

Exhibit C.25-2: Five domains of the Social Needs Index (SNI) that produces a score from 1 to 5 based on level of need



The SNI is updated as often as new SDoH information is generated through HRAs or acquired from external datasets. It uses machine learning algorithms to combine the following two components to determine risk of an adverse health outcome:

1. *Community strain*, which is represented by an aggregated score indicating the social strains for the community that a member lives in, serves as the foundation of the overall social needs index for a member. It is determined using public data sources such as:

- U.S. Census Bureau's American Community Survey (ACS) that tracks more than 100 data elements regarding education, poverty and housing status by specific neighborhoods.
- U.S. Department of Transportation encapsulating their affordability index, walkability index, food access and supermarket availability by location
- Environmental Protection Agency's (EPA) Smart Location Database provides air quality and pollution information
- U.S. Department of Agriculture (USDA) records on food scarcity and deserts

2**.** *Individual social needs*, which are extracted from consumer data, HRA, member eligibility files, claims, UM notes, and care notes. For developing individual (and household) profiles, we use 200+ data elements to evaluate housing situation (renter or homeowner), household Income, education level (e.g. high school, college, etc.), household composition (living alone vs family), access to automobile, and job profile and occupation.

In 2019, Passport conducted a pilot demonstrating that the SNI was able to accurately predict those with the highest social needs and conduct outreach. Among the members with a SNI of 5 (highest score) who were outreached and assessed, 100% reported at least one SDoH need and 90% reported multiple needs. Food (34%), employment (23%), and housing (16%) were the most reported social needs.

In Q3 2020, the SNI will be available to all members of the care team across programs, but will especially power the Care Compass program, which is designed to support member needs comprehensively through care coordination, support, and customer service. This program is fully developed, with implementation

planned for mid- to late 2020. Members who do not stratify into one of our other population health management programs, but who have identified care coordination needs due to barriers or SDoH, will receive support and assistance through our Care Compass program. Members engaged in one of our other programs can also receive assistance through Care Compass as a supplement to other program interventions. Care Compass will help to address the stressors in a member's life which are impacting the member's short and long-term health outcomes.

The Care Compass program will help members navigate the complexity of the health care system while empowering them through self-management skill building. The Care Compass team, including Care Coordinators, Community Health Workers, and Social workers connect the member with resources and services and then follow up to ensure the referral was completed and adequately met the member's health and social needs. Specific services include:

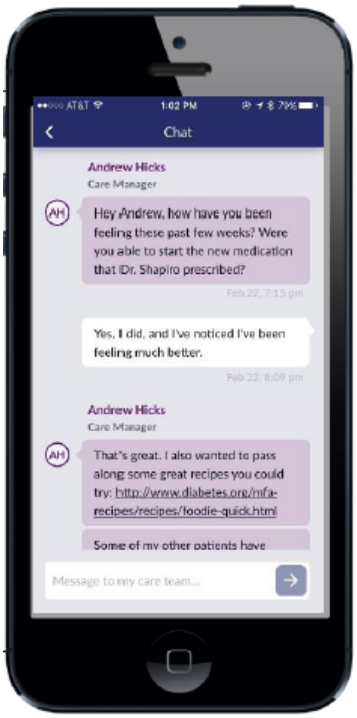
- Identifying needs and available resources
- Resolving barriers
- Facilitating referrals
- Scheduling and coordinating appointments
- Supporting gap closure
- Coordinating transportation

3. Identifi Engage Mobile Application

Passport is drawing on the popularity of mobile technology to engage members. We understand that texting or chatting can be cost-effective and a more engaging, interactive and immediate method of communication than a phone call, mail or email. Because of this, Passport is adding the use of the Identifi℠ Engage mobile application to its suite of member engagement tools.

Identifi℠ Engage is a mobile app supported on both Android and iOS platforms that is aimed at fostering member engagement to effectively manage care and improve outcomes. It is designed for members and their designated caregivers to easily interact with their Passport care management team. The secure mobile application provides bidirectional messaging (chat) capability between the care team and member (see **Exhibit C.25-3**). Chat messaging supplements traditional telephonic and in-person communication, allowing frequent and convenient communication between members and care advisors to maintain program engagement while limiting interruptions in members' daily lives. Identifi℠ Engage also provides an additional channel for providing directions and interventions to the member (e.g., links to resources, recipes, etc.). A subset of Passport care

Exhibit C.25-3. Screenshot of Identifi℠ Engage Chat



management staff piloted the tool in 2019 and tested its capabilities, providing feedback to the development team along the way.

In 2020, Identifi℠ Engage will be available to all of our care management staff for use with members engaged in any Care Management (CM) program. We believe this technology may be especially useful for some of our members with special needs because some members will already be familiar with chatting/texting technology. They may be more communicative with their Care Advisor using this mode of communication than they would be via phone or face-to-face interaction.

4. Remote Care Telemonitoring

Passport uses remote care telemonitoring to assist special needs members in managing their chronic disease symptoms and provide them with the tools to recognize worsening symptoms before going to the ED or hospital. The technology is geared for members diagnosed with chronic conditions such as diabetes, asthma, chronic obstructive pulmonary disease (COPD) and heart disease who would benefit from continuous health monitoring. When appropriate, the Care Advisor incorporates remote telemonitoring into the member's care management plan by arranging for the member to obtain a specialized tablet, blood pressure cuff, oximeter and weight scale, which are all Bluetooth connected. The tablet transmits the member's vital sign information to our Care Advisors for monitoring any changes in his/her health status.

By integrating remote telemonitoring into a member's care plan, the Care Advisor can help empower the member to better manage his/her own health. By using technology and with the support of the Care Advisor, members become better educated on how to "read their numbers," what the numbers should be and what steps they can take to bring those numbers under control.

Daily survey questions regarding the member's condition are also posed to the member on the tablet. By tracking changes in the member's symptoms, the Care Advisor educates the member on what his/her symptoms mean and when to call his/her PCP. Targeted education can also be sent by the Care Advisor and viewed instantly on the specialized tablet by the member.

Passport is continuing to explore which conditions can best be impacted with its remote care telemonitoring program. Other conditions we will evaluate for this program in 2020 include obesity, hypertension for members with high risk, and high-risk pregnancy.

5. New Member Engagement Videos

Exhibit C.25-4: Sample Screenshots of Passport New Member Videos

Using local actors and filming in our Louisville headquarters, our in-house marketing team crafted a series of five New Member Videos as part of our new member experience strategy. Our new member videos cover topics such as: what's in the New Member Kit, 'about the HRA form'; seven simple steps for new members; the importance of having a PCP; how to sign up for texts, emails and social media, and how to earn member rewards (see **Exhibit C.25-4**). The videos are part of our New Member Web Page; we promote them on Facebook, Twitter, Instagram and LinkedIn. **In the fall of 2019, the New Member videos were awarded both a silver and bronze Digital Health Award for excellence in crafting high-quality digital health media.** Due to the success of these videos, we are proposing to create a series of videos specifically targeting ESHCNs and specific services and programs to support them in their care.

Evidence-Based Practices to Support ESHCNs

All of Passport's practices to support ESHCNs are evidence-based and include three key components: research-based evidence, clinical expertise and the member's values or preferences. Over the past 22 years, Passport has implemented many important practices for this population, including the following highlights. Passport's care management teams utilize motivational interviewing to engage members in its programs, and PHM staff are trained in principles of trauma-informed care. Passport's Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program is based on evidence-based medicine, including the quality compass clinical guidelines addressing body mass index (BMI), childhood and adolescent immunizations, lead screening, annual dental visits, nutrition education, counseling for physical activity and well-child visits for children reaching the milestones of fifteen (15) months and three (3), four (4), five (5) and six (6) years old.

Supporting Increased Substance Use Disorder Screening and Treatment Through Screening, Brief Intervention and Referral to Treatment (SBIRT)

As of 2016, Kentucky ranked fifth among states with the highest number of drug overdose-related deaths.[1] As opioids have become a crisis in Kentucky, SBIRT becomes a more important tool for early intervention. In 2016, Passport was one of seven Association for Community Affiliated (ACAP) health plans across the

[1] www.khcollaborative.org/2018/08/sbirt-toolkit-released-for-healthcare-providers-to-address-opioid-crisis

country to participate in a three (3)-year learning collaborative through the Center for Health Care Strategies that specifically focused on improving the use of SBIRT[2] for adolescents in primary care settings. As part of its participation, Passport offered PCPs, including those who are utilized more frequently by its foster care members, the opportunity to participate in virtual training for the use of SBIRT with adolescents. Passport also offered assistance with improving workflows, understanding appropriate coding and assessing impact to help reduce barriers to implementation of SBIRT by these pediatric providers. Through this grant process, we determined that one of the barriers to tracking the use of SBIRT by providers was the availability of CPT codes, in that there was not a code on the fee schedule for an intervention of less than fifteen (15) minutes. Passport worked with state partners to re-evaluate the fee schedule to ensure that a broader range of SBIRT codes became available to providers. Passport has ensured that PCPs can bill for SBIRT on the same day as a well-child check to help providers better fit SBIRT into their workflows.

In 2018, Passport had the highest physician screening rate of adolescent tobacco use (77.94%) and alcohol use (70.59%) among all Kentucky MCOs. This demonstrates that our efforts are working, and we look forward to continuing to make improvements with SBIRT.

Passport would like to work with DMS and other MCOs to examine ways to create a standardized SBIRT form for providers, expand billing for follow up brief intervention, and to better assess/understand if a member is referred to treatment secondary to an SBIRT positive screen. Passport would like to help practices develop a standard for using SBIRT and when and how to refer members. Passport has already offered SBIRT training, resources and tools for its provider network to support these efforts.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) for Adolescents with Trauma History

Passport noticed a trend of adolescent members who were in and out of the hospital due to behaviors rooted in their trauma history. Members were sometimes sent out of state due to inability to get needed trauma treatment in-state. Passport determined that these members needed a longer length of stay in an acute environment to address their trauma using an evidence-based or evidence-informed practice. Some providers were willing to partner in this effort, but there were some licensure issues which needed clarification. Passport worked with providers to identify evidence-based solutions for trauma and jointly determined that TF-CBT seemed appropriate. Passport accompanied providers to discuss the issue with the Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) regarding member needs and perceived licensure barriers. DMS gave approval for providers to provide the needed service in an ECU setting. Passport developed an authorization process and a rate to support participation. This allowed River Valley Behavioral Health (River Valley) to begin serving Medicaid members in this unique program.

[2] www.chcs.org/resource/improving-access-to-screening-brief-intervention-and-referral-to-treatment-in-primary-care-for-adolescents-implementation-considerations

River Valley's TF-CBT program provides a unique service for children with trauma-related psychiatric symptoms. Passport Health Plan contracts with this program for an extended care unit service and extended length of stay to monitor outcomes to ensure value for its members. Members who participate typically have already tried other treatment modalities that have failed.

This program's design includes allowing additional time for the member to address the impact of his/her trauma on his/her behavioral health in a structured, evidenced-based manner. River Valley's TF-CBT program is situated within its Psychiatric Residential Treatment Facility (PRTF). During the program, members are guided in developing their trauma narrative about their past experiences. Members then learn alternative ways of coping to apply to the past trauma experience. These new coping skills are designed to help address any recurrence of trauma symptoms and prepare the member with new strategies to address future stressful events.

On average, Passport members spend one hundred and twenty-three (123) days in the program. Among the services offered are individualized assessment and engagement, psychoeducation, relaxation, affect modulation, cognitive coping, developing a trauma narrative and developing skills for enhancing future safety. Weekly family involvement, if available, is also part of the program.

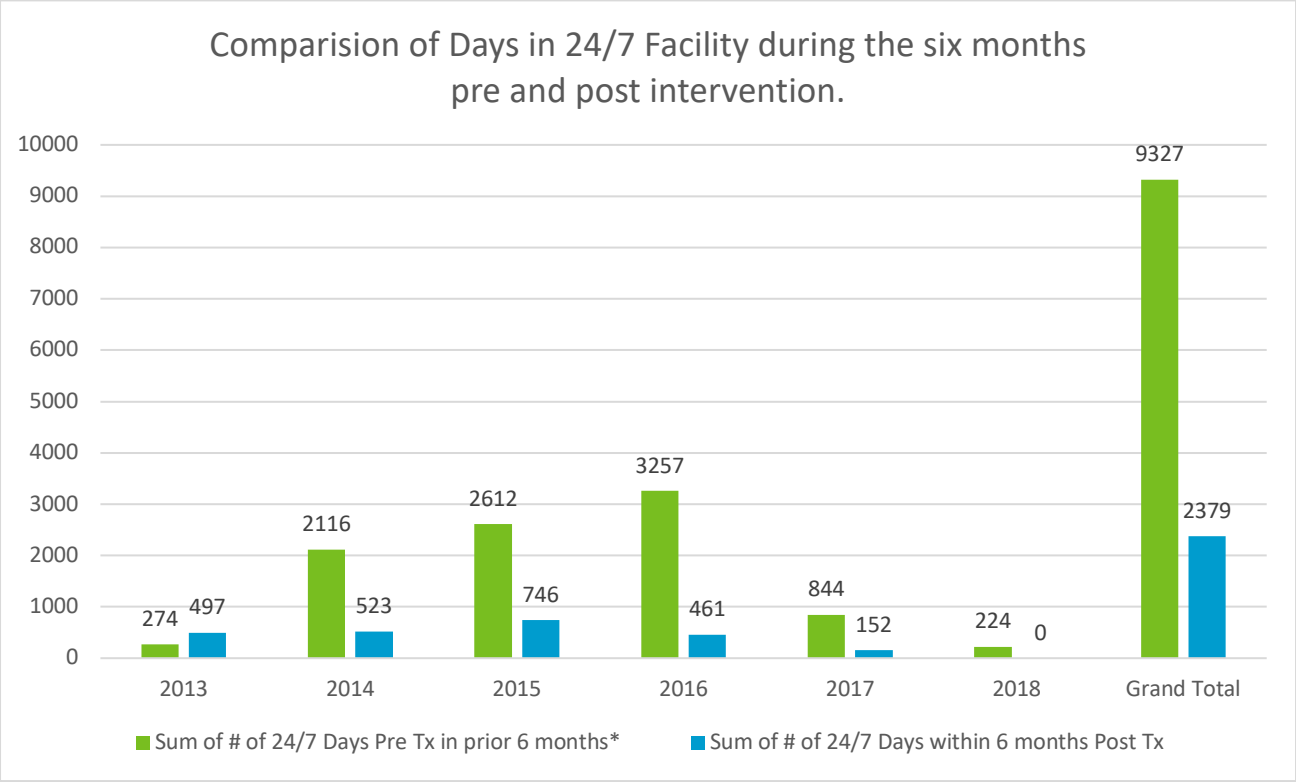
Exhibit C.25-5 gives the percentage of placement settings for members who have participated in the program.

Exhibit C.25-5: Percentage of Placement Settings

Percentage of Placement Settings	
Placement Prior to Intervention	**Percentage of Participants**
Foster care	60%
Previously in foster care	18.67%
Natural family/legal guardian	21.33%

After initiating the partnership with River Valley, Passport was able to demonstrate significant reductions in out-of-home, residential and hospital placement for members served by the program. Of note, members entering this program had high rates of facility-based care prior to enrolling in the program. Facility-based care includes psychiatric hospitals, PRTFs and similar settings. Pre- and postintervention results by year are shown in **Exhibit C.25-6**. There was a seventy-five percent (75%) reduction in such placements following participation in the River Valley TF-CBT program from 2013 through 2018. We value this partnership with River Valley and expect this to continue well into the future.

Exhibit C.25-6: Comparison of Days in a 24/7 Facility



"Trauma-Focused Cognitive Behavioral Therapy is an evidence-based treatment for children and adolescents impacted by trauma and their parents or caregivers. Research shows that TF-CBT successfully resolves a broad array of emotional and behavioral difficulties associated with single, multiple and complex trauma experiences."[3]

Applied Behavior Analysis (ABA) for Members with Special Developmental Needs

"'Applied behavior analysis' means the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior."[4]

While there was a clear need for Passport's members to have access to this valuable service, Passport noticed that ABA providers were not joining its network or delivering services to members. Passport's Health Integration team partnered with providers to understand the issue. The team learned that the codes needed

[3] http://tfcbt.org
[4] http://apps.legislature.ky.gov/law/statutes/statute.aspx?id=31292

to bill for the service were not part of the approved codes for Medicaid. The Health Integration (HI) team researched codes that ABA providers used nationally and worked with Kentucky providers to ensure that the list was complete. Passport shared this list with DMS so it could evaluate and determine use of the codes. Codes were ultimately added, providers joined the network and members gained access to needed services.

How Providing Services to ESHCNs Has Informed Our Approaches

Passport has 22 years of experience serving some of the Commonwealth's most vulnerable individuals. Through our day-to-day work in the community with members and providers, we have learned a lot about the most effective approaches to meeting our members' needs and achieving the desired outcomes. We modify, develop and implement new programs and policies with population-specific approaches to improve the management of members' chronic medical and behavioral health conditions and to impact barriers in members' lives related to SDoH, with an overarching goal of improving the health and quality of life of Passport's special needs populations. These initiatives are informed by evaluation of current programs, annual review of national clinical standards, literature reviews, outcome analyses, and member and provider satisfaction surveys.

Below are examples of adapted services and implemented innovative approaches that have informed our model:

1. Caring for young ESHCNs through a pediatric psychotropic drug intervention plan (P-PDIP)
2. Helping foster children with care management and support for a brighter future
3. Embedding care managers into the community to meet ESHCNs where they are
4. Serving our homeless members to assist with housing needs and SDoH
5. Connecting our homeless ESHCNs to community opportunities and resources
6. Providing a guardianship program for vulnerable members to make sound medical decisions
7. Providing care management and care coordination services to members with serious mental illness (SMI)

Caring for Young ESHCNs

Passport offers additional care and enhanced care coordination for members under twenty-one (21) years old. We understand that young members can feel afraid and uneasy during program treatment and when transitioning to a new medical home, especially to a skilled nursing facility or private-duty nursing care. Our compassionate and caring care team collaborates with the member, caregiver, provider and nursing facility/private-duty nursing staff to assist with all care coordination needs and manage the care planning process and the transition of care. Passport's Care Advisors make all the arrangements for all in-home, covered services or carve-out services, such as Prescribed Pediatric Extended Care, on members' behalf.

Passport implemented a performance improvement plan for antipsychotic monitoring for children and adolescents. The P-PDIP took a multipronged approach to improving Healthcare Effectiveness Data and

Information Set (HEDIS) measures for a population including children with special health care needs. The project goal was to use a cohesive and coordinated approach to improving prescribing patterns and the management of children and adolescents on antipsychotic medications. The scope of the project included provider interventions targeted at implementing clinical practice guidelines to help ensure that antipsychotic medications for children and adolescents are prescribed and filled appropriately. And members are monitored per American Academy of Child and Adolescent Psychiatry (AACAP) recommendations and reference materials. The project also entailed written provider education materials, support tools, our behavioral health hotline and a toll-free psychiatrist hotline. In addition, the plan consisted of member and caregiver interventions, including telephone outreach, educational materials on psychotropic medications, when to seek care, behavioral health provider network access and an emphasis on ongoing prescriber monitoring. The plan interventions included pharmacy prior authorization age edits, adoption of clinical practice guidelines (CPGs) and increasing behavioral health provider access statewide. Passport was able to stratify both member and provider data to guide intervention development. The performance improvement plan results included the following: rates for metabolic monitoring for children and adolescents on antipsychotics decreased 10.8% from the baseline; use of multiple concurrent antipsychotics in children and adolescents decreased 49.6% from the baseline; follow-up visits for children and adolescents on antipsychotics decreased 1.1% from the baseline; and use of higher-than-recommended doses of antipsychotics in children and adolescents decreased 31.3% from baseline measurement.

Passport has been working with a two-year-old with cerebral palsy, with a significant past medical history having been born at 33 weeks with fetal growth restriction, protein C deficiency, stroke in utero, congenital heart disease, osteogenesis imperfect, protein S deficiency history, tethered cord syndrome and Beckwith-Wiedemann syndrome. The child was not able to stand independently consistently and only for less than 30 seconds at most. Through Passport's care management interventions and working with her physicians, she had successfully been using an extra-small Rifton pacer (facilitates waling mobility and transition to ground walking) for six months at home and in clinic. However, her current loaned gait trainer was to be removed from the family home due to the child aging out of early intervention services at that time. Our care managers were able to work with the child's physician and Passport's medical director to continue with the Rifton pacer under EPSDT special services, and she continues to progress in her ability to walk independently.

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

Many children in foster care who qualify as individuals with special health care needs have complex health needs, including higher levels of physical, oral and behavioral health issues than the general pediatric population. A study by the Center for Health Care Strategies shows that children in foster care represent only three percent (3%) of children in Medicaid, but fifteen percent (15%) of children in Medicaid using behavioral health services.[1] Additionally, foster children represent thirteen percent (13%) of those in

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

There are several factors contributing to the complexity of health care in this population. Foster children are often removed from their biological families due to neglect or abuse, and these traumatic experiences have significant impacts on their health. Foster care members tend to move frequently, and the transitions to new homes and new communities make it difficult to establish a medical home and proper continuity of care. The individuals caring for foster children also face difficulties as well. Caregivers and providers often do not know the child's full medical and developmental history. Without this information, it is challenging to ensure that the child has proper care management. Due to their complex conditions and lack of information, foster children are prescribed psychotropic medication at a higher rate than other children, which can lead to the overuse of antipsychotic medications and further medical complications.

Passport has a specific foster care program to provide the needed care and guidance for these vulnerable children. Serving as their advocates, our specialists provide foster children with compassionate and caring support during their transition and care program. The specialists develop a relationship with the foster children and their caregivers, attentively listen to their concerns and answer any questions they have. Our team focuses its attention and care on the member and caregiver, compassionately guiding them throughout the program.

Once a foster child is enrolled in the program, the specialist works with the caregiver to identify an appropriate medical home for the foster child member. The care management process entails performing physical and behavioral health assessments and monitoring psychotropic medication use and dental care.

The foster care program initial review includes:

1. Evaluating the most recent EPSDT exam and provider claims review to check for other well visits, chronic conditions, frequent ED visits and inpatient hospitalizations
2. Examining the dental, vision and pharmacy claim history
3. Reviewing medical and pharmacy utilization
4. Determining whether the member is currently receiving behavioral health services
5. Reviewing existing care notes and communications

The Foster Care Specialist follows up regularly with members and caregivers and assesses the foster child's progress, noting any findings and further actions required. All information regarding the member's care is documented and recorded in Identifi for proper care coordination.

Each Foster Care Specialist is assigned to specific regions across the state to develop collaborative relationships with key state stakeholders and community partners. They serve as liaisons between Passport and the Department of Community-Based Services (DCBS), private foster care agency staff, foster parents and other social services entities. As part of his/her role, the Foster Care Specialist continuously communicates with all key stakeholders involved with the foster children's care to review the care plan report findings and, with permission from the DCBS, the current foster parent or caregiver to discuss the member's medical needs and provide ongoing support.

"Boys and Girls Haven consistently receives the utmost best quality services from Passport Health for the youth we serve. The staff are quick to respond and work diligently to ensure that services required to stabilize the youth are done efficiently and from a best practice perspective. We serve the young adult population in a few of our programs, and just a few weeks ago a member called us to remind us about recertification of benefits for a couple of youth before they turned 19. We were quite impressed! It solidified to our team how Passport members always go above and beyond for a population that is often times marginalized and underserved. We are happy to have them working alongside of us!"

—Stacy Brindley, Director of Transitional Living and In-Home Foster Care, Boys and Girls Haven

Foster Care Innovation and Centerstone Kentucky (Seven Counties Services)

Passport conducted a pilot program from March 2015 to March 2017 providing intensive care management for children and youth in foster care. For the initiative, we partnered with two (2) local provider organizations—Centerstone Kentucky Inc. (Seven Counties Services) and ResCare—to provide intensive care management services using a high-fidelity wraparound approach. The pilot program proposed to serve sixty (60) high-risk children between the ages of four (4) and 17.5 years old who had experienced three or more placements within twenty-four (24) months and were at risk for entering a group home, psychiatric hospital or twenty-four (24)-hour behavioral health treatment facility. Our goals were to increase the foster child's health and well-being, permanency in the family home and community placement and to provide needed support to the caregiver. The program duration was twenty-four (24) months with a six (6)-month follow-up period. During this time, we predicted that we would see positive outcomes for enrolled members, including:

1. Reduced cost of care
2. Improved school attendance and academic performance
3. Increased behavioral and emotional strengths
4. Improved clinical and functional outcomes
5. Increased stability of living situations

6. Improved work attendance for the caregiver
7. Reduced suicide attempts
8. Decreased contact with law enforcement

Program evaluation was completed via a combination of claims and costs data analysis, interviews and a behavioral inventory, the CAFAS. The CAFAS uses information from eight life domains: school, home, community (delinquency), behavior toward others, moods and emotions, self-harm, substance abuse and cognition (irrational thoughts). The program participants were scored at intake, every three (3) months during participation, and at discharge.

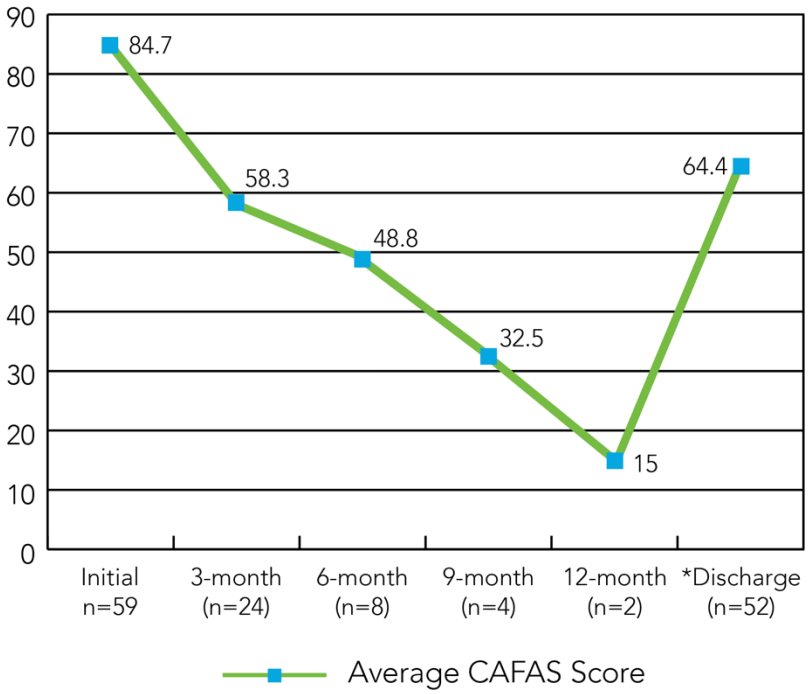
We deployed a high-fidelity wraparound-based team decision-making process promoting youth and family voice and choice in the health care process and clinical interventions. The program was facilitated by the Intensive Care Manager, and the care team members were the child, an identified family or foster family member, DCBS social service worker, treatment provider, Passport clinician and informal network support members.

The pilot program was successful and demonstrated that, by using an innovative model of interventions for children and youth in foster care, we can improve outcomes and decrease costs. Specifically, there was a one hundred and fifty percent (150%) increase in children being reconnected with their biological or adoptive family six (6) months post-intervention and foster care placement while the number of children placed in residential care—including psychiatric hospitalization, private childcare residential treatment and detention centers—decreased.

During the pilot program, the health and well-being of the participating children also increased, as evidenced by declining CAFAS scores (as shown in **Exhibit C.25-7**). Furthermore, the longer the child participated in the program, the greater the scores improved.

Exhibit C.25-7: Behavioral Health Outcome

Behavioral Health Outcome



Behavioral health functioning was assessed using the CAFAS. CAFAS scores decreased with longer lengths of service being associated with greater improvement.

The pilot program confirmed the effectiveness of high-fidelity wraparound with certain special needs pediatric populations. Passport supports the use of this evidence-based practice with education to providers and parent/caregivers about how the very specific techniques used in this model can impact positive emotional and behavioral change for children/youth and help families stay together.

Embedding Care Managers into the Community to Meet SHCN Members Where They Are

Passport strives to provide programs to better serve its ESHCNs. We believe in meeting our members where they are, wherever that may be, including at a homeless shelter, inpatient facility or personal care home. For example, we have **embedded Care Advisors** who are on-site weekly at provider offices, inpatient facilities, Emergency Departments (EDs), and other locations in the community where we can personally connect with our members. For example, we have members of our team embedded on-site at Family Health Centers, Shawnee Christian, and Park Duvall. Our pediatric and maternity specialists will often accompany members to critical provider visits to ensure continuity care across all parts of the continuum (see callout box below).

We also embedded Care Team members onsite at homeless shelters, such as Wayside Christian Mission, to connect with some of our most vulnerable members. Our team initiated this approach after we conducted an analysis of our behavioral health readmissions and identified that the members being readmitted were experiencing homelessness at a much higher rate than the general Passport population. Passport also has a social worker embedded at the Family Health Center Phoenix and the University of Louisville's 550 Clinic,

which are locations where homeless individuals seek primary and specialty care. This social worker provides education, care coordination and assistance with accessing needed resources.

Our Embedded Care Team Solving Problems through Integrated Rounds

Austin* is a young Passport member who was a heart transplant recipient and relied on a breathing tube due to his asthma. Upon joining the plan, Austin stratified for our pediatric Catastrophic Care. His case was assigned to Drea, a RN Care Advisor who works **onsite at UofL pediatric specialty clinics**. Drea met with Austin's provider in-person, who anticipated Austin's needs around social resources, medical equipment, and other care would be complex, and the family could use additional support. They arranged for Drea to join Austin's next appointment. Shortly thereafter, Austin was hospitalized for a respiratory virus and sent home with a percussion vest, which loosens and removes secretions that can contribute to infection. Drea discussed Austin's case at **Passport's Integrated Rounds** – which includes clinical, behavioral and social experts across care management, utilization management and quality – and was made aware that Austin's authorization for the vest was awaiting outstanding documentation of follow-up visits with a pulmonologist. Drea sprang into action, knowing that Austin had completed his follow-up visits, but that record of the visit had not been submitted with the authorization request. Given her relationship with the provider, Drea contacted the pulmonologist office and had them fax the record to the DME provider. Within 2 hours, the UM nurse had received the clinical details she needed and approved Austin's vest. *Member name was changed for privacy

Passport also uses its care management and UM Care Advisors on-site at its largest behavioral health inpatient facility to aid in care coordination. Our team coordinates with providers and members before they are discharged, which is extremely effective, particularly if the member is experiencing homelessness.

Passport's community health workers (CHWs) are in the community every day at members' homes, provider offices, community service organizations and anywhere else its members will be. CHWs focus on overcoming barriers to obtaining needed care, including addressing needs related to SDoH so that members can better focus on their health care needs.

Our guardianship specialist (GS) and behavioral health guardianship case manager attend quarterly care planning meetings for members with SMI. The GS visits members at personal care homes across the state to better understand their needs and to build relationships with staff. Our hope is to support the efforts of DBHDID's interim settlement agreement in trying to increase integration of members into community supports and out of facilities if they desire to do so.

In addition, Passport participates in several groups with community providers, advocates and members to better understand the current environment and problem solve for barriers. We are actively involved in the Kentucky Mental Health Coalition, National Alliance for Mentally Ill (NAMI), Children's Alliance and the Kentucky Psychological Association as collaborative partnerships to help our members live healthier lives.

We have learned that being in the community with our members, providers and social service agencies allows us to best understand the needs of our communities, which informs the adaptations we make to programs and new initiatives we implement.

Serving Our Homeless Members to Assist with Housing Needs and SDoH

Passport realizes that many of its members face serious challenges in their daily lives related to SDoH, including homelessness. According to the National Alliance to End Homelessness, approximately 3,688 people are homeless in Kentucky on any given night. This issue affects individuals across the Commonwealth, although the urban areas of Louisville and Lexington have more affected individuals than Kentucky's rural areas.[5]

Homelessness is characterized as being extremely impoverished and lacking stable housing. It affects many types of individuals, such as single adults, families, senior citizens, veterans, and unaccompanied youth and children. The National Alliance to End Homelessness reports that from 2007 to 2018, the rate of homelessness continued to decline in Kentucky.

Passport recognizes that every member's situation is unique. The causes of homelessness can differ, the resources needed can vary, and a member can experience homeless for various lengths of time. Domestic violence is the leading cause of homelessness among women. Other important factors include a lack of affordable housing, unemployment, low wages, poverty, mental illness, substance abuse and the lack of needed resources. Passport offers its members a holistic and member-centric approach in offering services and resources specific to their situation. We understand that our homeless members, young and old, can experience a range of emotions, including feeling depressed, fearful, vulnerable or abandoned.

The Homelessness and Housing Action Research Network classifies homelessness in three categories:[6]

1. **Chronic homelessness** describes an individual who has either been continuously homeless for a year or more, or who has had at least four (4) periods of homelessness in the past three (3) years. Many of these individuals also struggle with mental health disorders. These members of the homeless population use about half of the services available.
2. **Episodic homelessness** is when an individual has experienced three (3) or more episodes of homelessness within the past year. These individuals tend to move in and out of homelessness.

[5] National Alliance to End Homelessness (2018). Homelessness Statistics: *State of Homelessness in Kentucky*. Retrieved May 15, 2019.

[6] Housing and Homelessness Research Action Network (2018). *Types of Homelessness*. Retrieved May 14, 2019. https://hharn.org/types-of-homelessness.

Many individuals in this population also struggle with chronic unemployment, mental health problems and disabling conditions.

3. **Transitional homelessness** is the most common type of homelessness and describes people who use homeless services for a brief period (typically around fifty-four [54] days). These individuals often are homeless as a result of situational circumstances, such as housing affordability.

    - Our homelessness strategy is multifaceted, with targeted goals to:
    - Improve the health of Kentucky's homeless population
    - Ensure that members have access to quality care in a manner that offers respect, dignity and equality to all homeless members
    - Identify issues related to SDoH in a timely manner
    - Help members remove health and social barriers, including housing insecurities, and assist in locating community resources to help them in their journey to better health
    - Support local homeless agencies and advocates in their efforts to improve living conditions and quality of life for all homeless Kentuckians

By assisting members with physical and behavioral health services and locating community resources to address the root causes of their SDoH, we can help them break the cycle of homelessness.

Addressing Housing Issues and Health Care Together

Geoff* was a member participating in our Complex Care program. During the initial assessment, the RN Care Advisor discovered that Geoff was staying with his adult son, with no place else to go. He had been on disability but was no longer receiving that because he had started to work. He subsequently had to quit his job because he couldn't physically handle it. The Care Advisor referred Geoff to Jessica Cordova, a Passport community health worker. Jessica met with Geoff and learned that he had actually made three months' worth of deposit payments on a mobile home and had one remaining payment. He did not have enough money to make the payment due to his loss of income. Jessica also learned that the deposit payments he had already made were nonrefundable. She connected Geoff with Southwest Community Ministries, which gave him half of the remaining payment he owed on the mobile home. With this assistance, Geoff had enough money to make the final payment! He was extremely relieved to be moving into his own home. Once this stress was off his shoulders, he was able to focus on his health and made a plan to quit smoking, which was written into his care plan.

*Member name changed for privacy

Passport's Pathways Program Connects Our Homeless ESHCNs to Community Opportunities and Resources

Passport's Pathway Program assists its ESHCNs in finding the resources to better health, including homelessness. We recognize that it can be a long and stressful journey, so our team offers steps and

guidance throughout the process. The program includes identifying care gaps, SDoH, collaborating with local community resources, building health programs and measuring outcomes.

One avenue of the Pathways program to address homelessness is through comprehensive care management programs. Whether the members require medical or behavioral health services, we identify their needs and help them find programs and services to fit their needs. Regardless of their condition, Passport honors the "No Wrong Door" policy in helping its members. Through our care management programs, we identify the member's needs and conduct member health assessments to determine their needs, including their current housing situation. If it is determined that the member is homeless, our Care Advisors develop a member-centric care plan with the member with specific goals, including resources to address their housing insecurities.

In the Louisville metropolitan area, homelessness is a prevalent social issue. Passport care management teams work collaboratively to find housing options for members in this area. Case managers work on-site with providers in the Louisville area and meet face-to-face with our members to understand their situation. Once the member is Medicaid-eligible, we enroll him/her in a care management program with specific goals to help him/her improve their health and remove social barriers, such as homelessness.

Another gateway into the Passport Pathways program is through the work of CHWs, who assist members with health and social issues, including housing needs that affect their quality of life. The CHWs conduct face-to-face visits in the member's homes, providers' offices and community service organizations, assisting members in obtaining the necessary resources for safe and stable housing. Serving as member advocates, CHWs use a web-based tool to quickly search for and locate housing resources available in their community. Our staff provides the information to members, empowering them to take charge of their health and contact the community housing organizations, or we can make the contacts on their behalf if they prefer.

It is important for staff members working at shelters to be well-informed of Medicaid programs. Our team provides quarterly training sessions to educate the facility staff on Medicaid benefits, Passport's program and service offerings, and community agencies. These educational sessions allow the shelters' staff to be better informed of available resources in assisting homeless individuals.

Passport places a strong emphasis on internal staff education to better serve its members. Our team members attend frequent diversity and inclusion training to better embrace our members of a different race, ethnicity, gender, sexual orientation or religion. The Passport team also participates in a poverty simulation training to learn about the challenges and difficulties its members encounter daily. This poverty simulation teaches our staff to be more caring, compassionate and empathetic when interacting with our members. In addition, Passport gains insights into the lives of its members and gives back to the community by volunteering at Kentucky shelters and food banks.

Guardianship Program for Vulnerable Members to Make Sound Medical Decisions

According to the National Guardianship Association, guardianship is a legal process "utilized when a person can no longer make or communicate safe or sound decisions about his/her person and/or property or has become susceptible to fraud or undue influence." Passport finds that members in state guardianship often have fragmented health care, resulting in care gaps for both medical and behavioral health and increased hospital readmissions.

To address this issue, Passport employs a GS who acts as a liaison between Passport and the Department for Aging and Independent Living (DAIL), personal care homes, state psychiatric hospital social workers, community mental health centers (CMHCs) and other key stakeholders. The GS builds relationships with state partners in each DAIL region throughout the Commonwealth.

By developing these stakeholder relationships, the guardianship liaison can better serve our disabled members. Our Guardianship program entails member health assessments, establishment of a medical home, psychotropic medication use monitoring, behavioral health evaluations, coordination of specialized medical care and the determination of dental treatment services needed.

When a member first enters state guardianship, our GS requests the DAIL service plan and then performs a review with the member, which includes:

- Examining whether third-party liability is on the record for the member
- Reviewing the medical records for well visits, chronic conditions, frequent ED visits, inpatient hospitalizations and any information from electronic medical records (EMRs)
- Analyzing vision and dental claims history as well as pharmacy utilization
- Determining if the member is currently enrolled in an external care management program
- Analyzing existing care notes and communications

Information from the service plan and the above review are incorporated in the member's assessment, which is used in determining problems, goals and interventions to include in the member's care plan.

The GS communicates with the member's guardianship social service worker regarding the review and requests permission from the legal guardian to contact the member's personal care home or caregiver, when applicable, to discuss the member's medical needs and provide ongoing support. Our specialists record all care notes for transparency to our care team and schedule follow-up visits for proper care coordination. Passport consults with the legal guardian regarding health care decisions when needed.

When individuals with SMI are transitioning out of psychiatric hospitals, personal care homes and other institutional settings back into the community, the GS and guardianship behavioral health case manager work together to assess the member's current physical and behavioral health needs within fourteen (14) days of the transition. They use the Person-Centered Recovery Plan (when available) in conjunction with level-of-care determination and UM criteria to assess and approve the member's transition of care and service needs. Together, the team helps the member manage the transition of care with the intent of preventing a readmission and being able to successfully maintain the lowest level of care appropriate for the member.

Passport completes required reporting on guardianship cases monthly, or at the frequency requested by the DMS. Passport has policies in place related to track, analyze, report and, when indicated, directive action plans on indicators that measure utilization, access, complaints and grievances, and services specific to the DAIL population.

Providing Care Management and Care Coordination Services to Members with SMI

Passport ensures that care management services are offered to all members meeting the designation of SMI, with or without the co-occurrence of substance use or developmental disability. Our experience indicates that CMHCs are the provider selected most frequently for mental health and behavioral health needs for those with or without SMI. We have contracted with one hundred percent (100%) of the available CMHCs in Medicaid regions throughout Kentucky and will continue to engage these providers.

In addition to the CMHCs, we continue to identify independent providers and prescribers with expertise in caring for the SMI population. For example, Passport works closely with two independent agencies, Bridgehaven and New Leaf, in Louisville to support recovery-oriented community integration for individuals with SMI. Our identification includes data analysis and working with hospitals, PRTFs and advocates. Identification of non-CMHC prescribers allows us to fill service gaps and provide care alternatives for members who prefer not to use a prescriber located in a CMHC. Support is also provided to PCPs who may be prescribing psychotropic medications to members in recovery. Passport has implemented the Psychiatric Decision Support Line to provide consultation with psychiatrists having a variety of specialties for primary care providers (PCPs) who may be managing medications for members in recovery or with less intense behavioral health needs in the primary care environment.

The behavioral health continuum of services available in Kentucky is provided by members of the provider community and is supplemented by programs offered by Passport. Specific programs offered by Passport and/or provided by community and provider groups include:

1. **Promotion:** These strategies are designed to create environments and conditions that support behavioral health, reduce stigma and support individuals to withstand challenges. Promotion strategies also reinforce the entire continuum of behavioral health services.
2. **Prevention:** Delivered prior to the onset of a disorder, these interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as use of substances by women who are pregnant or postpartum; underage alcohol use; prescription drug misuse and abuse; developing co-morbid conditions with chronic illness and disease; and illicit drug abuse. Examples of prevention services provided by Passport include:
    - **Universal (population based):** Prescriber education on prescription drug misuse and preventive prescribing practices.
    - **Selective (at-risk groups based on demographics):** Prevention education for new immigrant families living in poverty with young children and peer support groups for adults with a history of family mental illness and/or substance abuse.

- **Indicated (at-risk groups based on behaviors):** Information and referral for young adults who violate campus or community policies on alcohol and drugs; HRA screening, consultation, and information and referral for women who are pregnant or postpartum and who receive health care at the local health department for possible alcohol or drug use screening.

3. **Treatment:** These services are interventions for people diagnosed with a substance use or other behavioral health disorder.
4. **Recovery:** These services support individuals' compliance with long-term treatment and aftercare.

C.25.b. Describe the Contractor's approach to facilitate access to appropriate services for Individuals with Special Health Care Needs to include:

i. Approach to identifying Enrollees.

Approach to Identifying Members

Using HRA Data to Identify Members

For the last two (2) decades serving the Commonwealth, Passport has used HRAs to capture members' health risk factors. Over time, our process has evolved to provide better health outcomes for our members. Today, Passport uses real-time data analytics to rapidly identify member risk factors. Within hours, our care management team is informed of updates to members' health status, allowing us to promptly engage with members and their providers. Together, we develop a personalized care management program for members to learn to self-manage their condition.

Passport has incredible compassion for its members, especially those with special health care needs. We are committed to always putting our members first and at the center of everything we do. Our care management team uses a personalized, member-centric approach to help members improve their health and quality of life regardless of their condition. It is our core mission.

One way that Passport achieves this is through early identification and engagement of ESHCNs who would benefit from care management services. Our experience shows that by identifying our high-risk members early in the process, we can provide them with individualized, effective care management and care coordination programs. We have written policies and procedures in place to govern how members with complex physical and behavioral health conditions are identified. This leads to better health outcomes for our members in a cost-effective manner.

Passport's goal is to have every newly enrolled member, who has not been enrolled in the prior twelve (12)-month period or who is pregnant, to complete an HRA within the first ninety (90) days of enrollment. This is part of our **New Member Onboarding 90-Day Plan** (described in C.12 Enrollee Services) to improve timely identification of ISHCN along with new member understanding, use of, and experience with Passport ISHCN programs and supports.

We provide a variety of convenient ways for our members to complete the assessment because we know that each member has different needs and preferences. Passport first connects with members through its new member welcome packet, which includes the HRA. Members are encouraged to complete the HRA questionnaire and mail it back with the enclosed prepaid return envelope. We provide oral interpretation for all non-English languages when requested to assist with understanding and completing the HRA. We are also able to help members with special communication needs, such as the disabled, blind, deaf and aged, when requested.

Passport's HRAs are specifically tailored to Medicaid members. Both our adult and pediatric HRAs contain a comprehensive list of questions addressing the member's medical history, physical health status, psychological well-being, social and environmental factors, barriers to care and SDoH. Specifically, our HRAs address the following:

1. Demographic information, including current contact information, culture, race, ethnicity, education level, language preferences and living arrangements
2. Physical health status regarding activity levels, use of assistive devices and assistance with daily living activities
3. Medical history addressing diagnosed chronic conditions, medication use, dental care and any recent ED visits
4. Behavioral health status for identification of behavioral health conditions (i.e., bipolar, schizophrenia, depression and anxiety) and medication use
5. Lifestyle conditions regarding a history of smoking, alcohol use or substance abuse
6. Barriers to health, including safety, accessing medications, getting to doctor appointment and the ability to manage personal finances
7. SDoH regarding food, housing, clothing, employment and transportation needs

The pediatric HRA has additional questions regarding the child's BMI, recent immunizations, childhood developmental issues, education barriers, social support services, special medical services or equipment used in the home. Passport analyzes this information to determine the appropriate health care services necessary for the young member and support for their parent or caregiver, which is critically important for children with special health care needs.

By identifying and engaging members early in the process and getting them into the proper care management program, we have seen extremely positive results. Passport has seen reductions in medical spending, thirty (30)-day readmissions rates, inpatient admissions and monthly ED visits by using predictive analytics, case management, disease management and UM services.

In addition, Passport continuously connects and follows up with members to complete the HRA through:

- **New member welcome calls:** Our Care Connector outreach representatives conduct customer-friendly calls introducing members to Passport and completing the HRA.
- **Targeted telephonic outreach:** Passport's call center representatives make targeted outreach calls to members to obtain their HRA information. The call center operates from 7 a.m. to 7 p.m. EST to accommodate all members statewide.

- **Reminder postcards:** Passport reinforces the importance of the HRA by mailing reminder postcards to members encouraging them to complete the questionnaire.
- **Automated telephonic messages:** For members who have not yet completed the HRA, Passport employs automatic telephonic auto-dialer campaigns as an additional reminder.
- **Member newsletters:** Passport provides HRA information in its newsletter, *MyHealthMyLife*, which is offered in both English and Spanish.
- **Member website:** Members can complete both the adult and pediatric HRAs on Passport's member website, MyPassportPlan, for easy and convenient access. The website is available in both English and Spanish.
- **New member page:** Passport's new member landing page includes completing the HRA as one of the seven (7) key steps a new member should take. A link to the HRA is embedded there for ease of access and completion.
- **Face-to-face meetings:** Often, members prefer to conduct the HRA in person, and Passport is flexible in accommodating their needs.
- **CHWs** perform HRA assessments in members' homes or other community locations to identify members' risk factors.

- **Embedded Care Advisors** at select provider offices or community health centers assist members with the HRA assessment as needed.
- **Members walk-ins** at a Passport office for assistance may be asked to complete an HRA after their problem has been resolved.

Passport realizes that members' health status or socioeconomic conditions may change over time, so the care management team reassesses the needs of members as new data/information is received or on a monthly basis. This reassessment ensures that Passport can provide the necessary services for continual health care improvement.

Once members complete the HRA, Passport's Care Connectors document the members' responses into Identifi. If any risk factors are detected, including those for special health care needs, action items are generated for the care management team to review. With this capability, our highly skilled registered nurse (RN) and behavioral health professional Care Advisors gain insights into the members' health status and begin to proactively engage with members for care management and coordination with their PCP. All HRA information is recorded at the time of receipt and stored within the centralized and secure system. Passport takes privacy of personal health information very seriously and enforces stringent protocols for accessing member information. Only care team members can view and update a member's information.

Over the last three years, 17,805 Passport members have participated in the Special Needs Care Management Programs.

2017: 3,340 members

2018: 6,973 members

2019: 7,392 members

Passport understands that a completed HRA is the first opportunity to understand the members' health status. With an initial view of members' condition, our Care Advisors can engage and enroll them into the appropriate Care Management program to begin their journey to better health.

Identifying and Stratifying ESHCNs for Comprehensive Care Management

HRAs are one critical piece of data to support identification of high-risk members, as are referrals from physicians within the network. Passport's philosophy, however, is that it is critically important to rapidly identify our special needs members and enroll them in the proper care management program as early as possible and not be dependent upon the completion of an HRA or a referral. Members are identified in multiple ways in addition to the HRA, including medical and pharmacy claims, laboratory results, EMR data, UM authorizations, our Care for You free 24-hour nurse advice line, state eligibility feeds and referrals from members themselves, caregivers, or family members, providers and community agencies.

To identify these ESHCNs, Passport uses an advanced technology platform that is deeply rooted in evidence-based medicine and is purposely built for identifying members' health risks and driving improved medical performance. To identify ESHCNs, we use a diverse data set. The platform derives insights from multiple sources, including enrollment and eligibility data; medical, pharmacy and behavioral health claims; laboratory results; HRA information; medical assessment screening results; data collected through clinical, UM, health management or health coaching programs; EMR data; and information from our Care for You 24/7 free nurse advice line. Other sources of data include referrals from physicians, caregivers, members themselves and hospital discharge planners.

Our behavioral health stratification methodology is different because it identifies members who may not have a behavioral health diagnosis documented on a claim. It does this by looking at pharmacy claims for medications that are typically prescribed to individuals with certain behavioral health diagnoses. The algorithm also picks up provider specialties that may indicate a serious behavioral health condition. Opioid risk is an inclusion in our behavioral health model as well. For example, a member with a known behavioral health diagnosis who is prescribed an opioid may be at higher risk of developing a substance use disorder, and thus would be included in the group of members stratified for high-risk behavioral health intervention.

Our high-risk maternity and newborn stratification methodology is continually developing to overcome the challenges related to identifying members early in their pregnancy. We use a combination of claims, lab results and prescription information. Our model uses a two-tiered matching algorithm to match a mom's pregnancy history with the baby's record. Using all of this information, we are learning to predict potential complications for both mom and baby, helping us to better target our outreach to the most at-risk pregnant women or new moms/babies. Passport also uses external data to detect any SDoH risk factors affecting our members to provide better comprehensive care management services.

The SDoH data sources include:

- U.S. Census Bureau's ACS, which tracks more than one hundred (100) data elements regarding education, poverty and housing status by specific neighborhoods

- U.S. Department of Transportation data, encapsulating their affordability index, walkability index, food access and supermarket availability by location
- EPA's Smart Location Database, which supplements our existing social economic and environmental information
- U.S. Department of Agriculture records on food scarcity and food deserts
- Data.gov information, with over 230,000 data sets on demographics, education, community and safety
- Department of Housing and Urban Development data that reports on housing needs by geography
- Google technology (e.g., the technology that allows users to locate amenities in Google Maps) to calculate distances to the nearest pharmacy, grocery store, physician's office and hospital, which may identify potential gaps in the community's access to health care

Identifying Homelessness Across Disparate Data Sets

Passport set out to identify housing insecurity across multiple data sources. Below is the breakdown of the primary data source for the identified cohort:

- 17%: Claims data
- 38%: Community-level data to map addresses to homeless shelters
- 21%: Natural Language Processing (NLP) on EMR data showing provider assessment of housing stability
- 10%: Patient-reported HRA data
- 14%: Consumer data to identify recent evictions

Our system integrates dispersed SDoH data sources at different levels (e.g., individual, census block, census track) across five (5) main domains (housing instability, transportation barriers, food insecurity, financial stress and health literacy), all of which are critical to the different types of individuals who qualify as having special health care needs. The platform creates a single SNI (with five [5] levels) that indicates members' risk that could impact their health outcomes. The advantage of having a single index indicating how an individual's social needs place health outcomes at risk is not only the ability to prioritize members, but also the simplification of the workflow for Care Advisors to integrate social support into clinical care management. We use the index to direct efforts and resources to the most at-risk members and pinpoint their individual needs.

Using Technology and Data Analytics for HRA and Stratification of ESHCNs

Based on the above data sources, we determine eligibility for our ESHCN program based on the following inclusion criteria:

Having one or more of the following primary diagnoses:

- Intellectual Disabilities
- Severe Cognitive Functional Impairment
- Emotional Disorder
- Gaucher's Disease
- HIV/AIDS
- Schizophrenia
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS)
- Ventilator Dependency
- Friedreich's Ataxia
- Spinal Cord Injuries and -*plegias* (mono, di, para and quadra)
- Spina Bifida
- Muscular Dystrophy

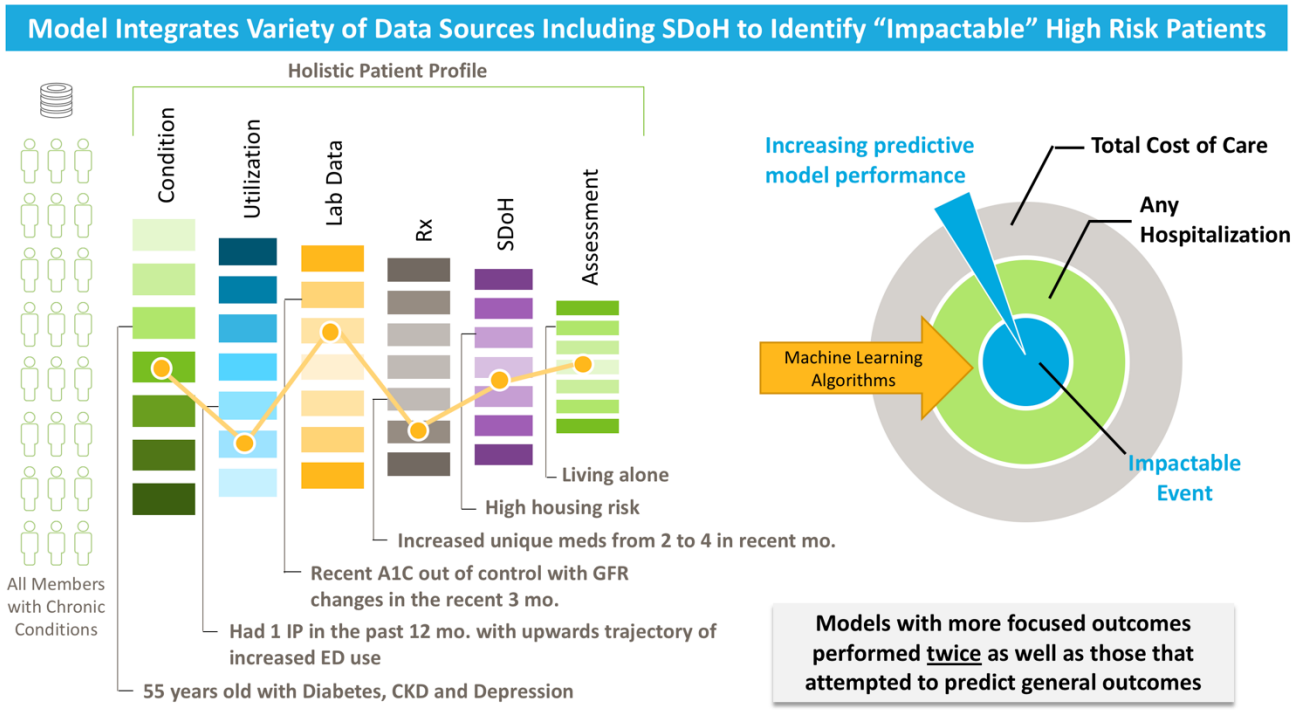
- Sickle Cell Disease
- Huntington's Disease
- Lewy Body Disease
- Parkinson's Disease
- Spinal Muscular Atrophy
- Fetal Alcohol Syndrome
- Attention Deficit Hyperactivity Disorder (ADHD)
- Epilepsy
- Down Syndrome
- Cerebral Palsy
- Autism
- Bipolar Disorder
- Substance Use Disorder
- Mood Disorders
- Anxiety Disorders
- Autism

Or other risk factors, including:

- Individuals with chronic behavioral health illnesses
- Children in, or receiving, foster care or adoption assistance
- Blind/disabled children under age 19 and related populations eligible for Supplemental Security Income (SSI)
- Adults over the age of 65
- Homeless (upon identification)
- Individuals with chronic physical illnesses
- Children receiving EPSDT special services
- Children receiving services in a Pediatric Prescribed Extended Care facility or unit
- Members in adult guardianship
- Members under the age of twenty-one (21) who require enhanced care coordination and are receiving services in a skilled nursing facility or private-duty nursing services in their family home or other community-based setting
- Co-occurring behavioral and physical health conditions

We understand that not every ESHCN requires the same intensity of care management or support. To effectively prioritize clinical outreach and management for our ESHCNs, we determine the predicted risk of a member incurring an avoidable acute event in the year following identification. We determine this risk level through a machine-learning algorithm that uses scientific factors to predict an impactable event. The data factors include member's medical and health condition, utilization rates for both medical and pharmacy, clinical data, pharmacy information, SDoH data, member health assessments and engagement levels, as illustrated in **Exhibit C.25-8**.

Exhibit C.25-8: Data Sources to Identify Impactable Events



Our predictive models outperform industry standards by taking a unique approach—emphasizing not only predictive accuracy but also timeliness. We design and deploy care interventions based on the predictive model's results. This ensures that not only that the right members are stratified, but that they are stratified early and at the most impactable moment, before their health condition becomes more serious.

The predictive models focus on member care, which is very different from typical payer models. Their risk stratification platforms have been designed to generate premiums rather than manage member care. The challenge in using a payer-designed risk stratification tool for member care lies in the potential generation of a large number of false positives, because these systems err on the side of predicting too many negative events to avoid unexpected costs to the payer. Thus, there is a risk of losing physician engagement in health management due to inaccurate predictions.

One of the most frequently cited measures of predictive performance is the model's *c-statistic*, which is the measure of the area under a receiver operating characteristic (ROC) curve. A c-statistic of 0.5 indicates a random chance at predicting a future event (e.g., a coin toss), while a value of 1 is a perfect predictor. A model with a c-statistic of 0.8 or higher is considered to have strong predictive ability. In 2012, the Mayo Clinic presented a meta-analysis of the performance of risk stratification methods at predicting inpatient and ED encounters at the Academy of Health Conference. Our c-statistic is 0.82, significantly higher than the rest of the industry and indicative of strong predictive ability.

Each time we receive new member eligibility, medical and social data, we recalculate the risk score, because we recognize that having a dynamic stratification process is critical to linking our member to the appropriate

level of care. Based on the risk score, members are either categorized as low risk or high risk in terms of their overall likelihood of incurring an adverse event in the near future.

C.25.b. ii. Process for screening and assessing individual Enrollee needs.

Passport's Screening and Assessment Process

Upon enrollment in the program, our Care Advisors and Health Educators complete an assessment with the member to determine the most appropriate care plan for their situation. The Care Advisors/Health Educators assess if the member is experiencing any ongoing conditions warranting a specialized treatment or level-of-care management. Our Care Advisors/Health Educators first conduct a comprehensive screening assessment (member needs assessment) of members in collaboration with their caregiver and provider. This assessment captures information regarding the member's demographics, home and living environment, level of caregiver support, health status, provider information and access, personal safety, social stressors or SDoH, barriers to care, need for long-term services and support (LTSS), connections to available community and government resources, and other relevant risk factors (lifestyle habits, educational and literacy needs, etc.).

The initial assessment/screening includes the following factors:

- Clinical history
- Medication adherence
- Utilization history, including inpatient admissions and ED visits
- Health status, including medical and behavioral health condition-specific issues
- Activities of daily living
- Presence of cognitive or functional limitations
- Mental and socioeconomic health status needs, preferences and barriers
- Cultural and linguistic needs, preferences or limitations
- SDoH
- Health risks and behaviors
- Visual and hearing needs, preferences or limitations
- Needed equipment, services and resources
- Caregiver availability and involvement
- Member's available benefits and community resources

Passport also offers its members additional health assessments and screenings to target specific medical issues, including the following:

- **Comorbidities assessment:** Members often develop other health conditions, including behavioral health issues, that affect their cognitive and physical abilities and have a major negative effect on the initially targeted condition.
- **Depression screening:** Program interventions or care referrals are initiated for those members who screen within target thresholds on the Patient Health Questionnaire-9 (PHQ-9) or indicate psychological distress that frequently and significant impacts their daily functioning.
- **Screening for child/adolescent psychosocial functioning:** The Pediatric Symptom Checklist-17 (PSC-17) is a parent/caregiver-completed measure that covers a broad range of emotional and behavioral problems and provides an assessment of psychosocial functioning. Program interventions or care referrals are implemented for those members who screen within targeted thresholds.
- **Anxiety screening:** Passport identifies members with indications of severe anxiety using the Generalized Anxiety Disorder screener (GAD-7). Interventions or care referrals are provided to those members who screen within the target thresholds.
- **Substance use disorder screening:** Passport identifies members with possible substance use disorder using the CAGE-AID tool. Interventions or care referrals are provided to those members who screen within the target thresholds.
- **Psychosocial assessment:** There are psychological factors that may negatively influence the member's adherence to the treatment plan or program interventions. Passport identifies social, emotional or financial barriers, and interventions are adjusted to meet the member's needs and increase their accessibility and engagement into the program.

Sticking with a Member and Breaking Down Barriers

Our behavioral health risk stratification identified Jack as a member with rising risk. During initial outreach, Jack was unsure about enrolling in the program. Using motivational interview techniques, Care Advisor Shannon Derrick was able to identify several ways to support Jack, such as finding him a PCP that fit his work hours. Jack agreed to participate in the program, even though he had been sober from alcohol and cocaine for 62 days, and he felt as though he had all the support he needed. During a scheduled follow-up call just a few weeks into the program, Jack shared with Shannon that he had relapsed, lost his job, and was currently intoxicated and using cocaine. He wanted to return to a detox center. Jack presented Shannon with multiple barriers to getting to a detox center. Jack was obviously unable to drive himself to detox. He did not want to ask anyone for a ride other than his father, who was working and unable to take him for a walk-in appointment. Shannon worked hard to find a detox center with an open bed. She coordinated with Landmark, who held an open bed and would provide an Uber ride for Jack. Jack refused the Uber, but Shannon was again able to coordinate with Landmark to adjust the admit time for Jack so his father could bring him to detox after work. Shannon got permission from Jack to call his father and share the information about the detox program. The member called Shannon from the detox center the next day to thank her.

Developing Member-Centric Action and Care Plans for Better Health Outcomes

Once the assessment is submitted within the Identifi platform, rules using evidence-based medicine and the member's response to the HRA areas of need are executed, and recommended clinical actions are created for our care management team to review. From these recommendations, the Care Advisor or Health Educator develops an individualized action plan or care plan tailored to the member's needs.

A care plan, designed for high-risk members, includes any member-specific preferences or barriers to their care, prioritized program goals, self-management activities, referrals to specialists or community-based services, a schedule for follow-up interactions, and a program assessment. For example, the care plan for a high-risk individual with sickle cell disease, with a secondary psychiatric condition, who is also homeless, would be organized around a multidisciplinary team effort to secure stable housing and address the member's behavioral health condition, while learning how to manage sickle cell disease. Other factors would be affecting behavior change to reduce pain crises and infection while addressing other social, environmental and behavioral barriers that adversely impact medication adherence and whole health.

For lower-risk members or those with less complex special needs, the care team creates an action plan focusing on the member's goals, personal preferences and care coordination needs. For example, we may identify a low-risk member, such as a child receiving EPSDT special services, in need of an additional pair of eyeglasses (after the Medicaid Vision Program has paid for the first two pairs in a year), who lives in a stable and supportive home with his parents and siblings. For this member, our action plan is primarily focused on care coordination through our care connectors team to facilitate his eyeglasses voucher.

In addition, the care team is responsible for identifying all relevant barriers preventing a member or caregiver from adhering to his/her physician's treatment plan and access to care. There are multiple forms of barriers, including physical or mental disabilities, financial, language, hearing, motivation, culture and confidence level, as well as SDoH. It is a core responsibility of the primary staff to identify options and solutions for mitigating and removing barriers. For example, the mother of the child in the low-risk example above speaks and understands only Arabic. The care team is responsible for working with Member Services to secure foreign language interpretation resources and staff to support her through the voucher process.

Passport's Care Advisor selects relevant interventions with the member or caregiver to create a tailored care plan that is consistent with the member's provider clinical treatment plan. Each care plan describes the member's medical problems, goals and interventions (PGIs) and includes specific medical and health details, including:

- Documentation of current medications
- Identification of barriers to the member meeting their goals
- Specific, Measurable, Attainable, Realistic, Timely (SMART) goals
- Member's and caregiver's prioritization of goals
- Member self-management plan

- Interventions to achieve identified goals
- Facilitation of member referrals to resources and a follow-up plan
- Education on Passport's benefits and community resources
- Monitoring and assessment of progress toward the goals of the care plan

Passport recognizes that members have different requirements and engagement levels. With our adaptable model, our Care Advisors/Health Educators can modify the care plans/action plans with graduated goals that can be targeted and prioritized by members and their providers. If a member's condition or situation changes, goals are easily adjusted to fit the needs. As an example, the low-risk member requiring an additional pair of eyeglasses may also present with signs of ADHD as the care team works with him and his mother to secure his voucher. In this case, the Health Educator may decide to adjust his action plan to include a referral and assessment of the child by a psychologist.

To track these changes and all interactions, our care team documents every case management action by saving the care notes and member correspondence directly into Identifi for easy tracking, access and viewing. Each member's medical history is retained and then integrated into their EMR for proper care coordination.

Members and their care support team are fully involved in care planning. The care support team can include family members, caregivers, member's PCP, formal and informal support or service providers, as well as others involved in the member's care or selected by the member. Together, they identify care planning participants, the method for participation in care planning, timelines and the method for information sharing. The Care Advisor uses Identifi to track care planning meetings, gather relevant information to support development of the care plan, and guide the member and care planning participants through the person-centered planning process.

As part of our care management process with ESHCNs, we also confirm that they have appropriate network access by ensuring that they have referrals to appropriate specialists, that providers accept our ESHCNs, and that ESHCNs are able to access the full spectrum of care, including vision, dental and behavioral health services.

C.25.b.iii. Approach to providing education to Enrollees and caregivers

Providing Education to ESHCNs Engaged in Care Management

Passport's clinical and communications teams work together to develop culturally competent educational materials specific to the unique needs of our members. Our award-winning health literacy materials are based upon CPGs and other evidence-informed, research-based knowledge available in the health care industry. We take care to ensure our member-focused materials are written at a sixth-grade reading level. Educational materials are available in various mediums, including videos and written materials on our website, audio topics available via our Care for You 24/7 free nurse advice line, and in printed materials.

Printed materials are disseminated to ESHCNs and their parents/caregivers/legal guardians both through the work the integrated care team performs with the ESHCNs who are engaged in care management, and more broadly to members who are not currently engaged in care management efforts, through community

engagement and education efforts. Many printed materials are available in English and Spanish, and we can translate any educational piece into the language the member speaks or reads, including Braille. The ten (10) most commonly spoken languages (other than English) among Passport members are:

5. Spanish
6. Arabic
7. Somali
8. Nepali
9. Swahili
10. Kinyarwanda
11. French
12. Vietnamese
13. Karen
14. Mandarin Chinese

Our member information is inclusive of health educational materials that cover topics including, but not limited to, asthma, diabetes, smoking cessation, depression, substance use disorder, maternity, healthy sleep, pre- and postnatal care, COPD, heart disease, foster care, obesity, and health prevention and promotion materials. Our materials reinforce our messaging around teaching self-management skills, so our ESHCNs can learn to cope with and manage symptoms of their conditions and move toward better health and quality of life.

Passport has an engagement initiative for new members to help us improve timely identification of ESHCNs. This initiative is focused on helping new members understand and use programs and supports available to them via Passport. More detailed information about our new member initiative can be found in the response in **Section C.12.e Member Services.**

Our new member engagement and education strategy includes the use of videos. Passport strives to keep its new members engaged throughout their first ninety (90) days on the plan. We have created a series of short instructional videos designed to guide our new members during this time. Video topics include:

- The New Member Kit, which walks members through all material they will be receiving in the mail and how these materials can help them
- The HRA form
- Seven simple steps for new members to complete during the new member onboarding process
- Choosing a PCP
- How to sign up for texts and emails, and how to follow Passport on social media
- The perks of being a Passport member and how to earn member rewards

Two of these videos, “Choosing a PCP” and “Earn Rewards,” recently won Digital Health Awards. These videos are available on our new member webpage and shared through Passport’s social media accounts. Passport also uses social media to assist with engaging and educating members.

Forming a Highly Skilled and Integrated Team Centrally Focused on ESHCNs

Our care management program fully supports the member and provider relationship. We understand this connection is vital in the development of the care plan, in the prevention of medical complications and incidents, and in creating a positive member experience. We encourage PCPs and specialists to be a part of the care management process.

Passport's practice is to form a highly integrated and member-centric team, including all clinical disciplines and specialties across the organization. The multidisciplinary team uses the broad clinical skills and expertise of a care team manager, Care Advisor, registered dietitian, social worker, clinical pharmacist, Health Educator, CHW, program coordinator, the member's PCP, and family or caregiver—all of whom are all centrally focused on the member. The team's approach is to identify barriers to care and action planning, to empower the member, to support behavior modification, to close care gaps and to coordinate care. Additionally, the team converges to discuss the member's **medication adherence level, incidents of medical complications, education level of condition (health literacy), physical functioning, emotional well-being, issues related to SDoH and barriers to the member receiving care.** Together, they provide the needed care management services for members to be successful in achieving their health care goals.

Using Program Interactions and Interventions for a Comprehensive Care Management Plan to Provide Support and Education for Engaged ESHCNs

Passport's PHM programs are focused on teaching members how to self-manage their conditions and navigate health care and social services systems independently. We use interventions tailored to members' specific condition(s), individualized needs and risk levels to promote health literacy and improved self-care and management of their conditions. These education-focused interventions include, but are not limited to:

- **Teaching members condition monitoring, including self-monitoring** (e.g., foot and skin care for patients with diabetes). This includes reminders about tests members should perform themselves or have their practitioner complete.
- **Teaching members treatment plan adherence** (including medication adherence) and progress tracking.
- **Teaching members how to communicate with providers** about their health conditions, self-management/condition-monitoring activities and care plan/goal progress. This includes how to prepare for a visit to a physician provider, such as writing down important questions/issues.
- **Sharing programs and materials for healthy behaviors:** Educational materials and programs encourage members to develop healthy behaviors (e.g., nutrition and activity) and reduce unhealthy behaviors (e.g., tobacco use).
- **Providing support to the caregivers:** Passport's care management team identifies types of support that members need to be successful in their care management program. With the member's consent, we deliver information to the caregiver to ensure they understand the member's condition so they can effectively provide the needed support. This includes:
  - Direct caregiver interaction—increasing caregiver's emotional resources to improve their ability to support the member.
  - External/community-based resources as appropriate (e.g., caregiver support groups, respite, development of coping skills).

    - Additional caregiver resources to address physical limitations, adaptive devices needs, barriers to meeting care needs and treatment requirements, visual or hearing impairment needs, as well as language or cultural needs.
- **Referrals to address resource gaps and additional education and support measures,** such as access to a registered pharmacist, a dietitian, behavioral health specialists and community resources to address SDoH and identify financial assistance resources. The Care Advisor also coordinates services such as durable medical equipment, home care and ancillary services for the member, leveraging local community resources.

During the program, the care team closely monitors and evaluates members to determine their level of progress and any barriers in achieving their goals. In cases where the member is having difficulties in adhering to the treatment plan, the care team identifies the root cause of the health barrier. Sometimes health barriers can be attributed to lack of knowledge or understanding by the member. Our Care Advisors work diligently to close gaps in knowledge or understanding in order to get the member back to advancing in their care plan goals.

Some of our more targeted educational interventions with ESHCNs are detailed in the following section.

Providing Education to ESHCNs Through Community Education and Engagement Efforts

Passport recognizes that not all ESHCNs will be directly engaged in care management efforts, and that many will need education and outreach to support their eventual engagement in Passport's care management programs. Passport has a multifaceted approach to outreach to all members to educate them on available benefits and the full spectrum of health, disease, social and environmental issues that are extremely germane to ESHCNs. Outreach techniques include:

- **New member welcome calls:** Our care connector outreach representatives conduct customer-friendly member welcome calls introducing members to Passport. During this call, the representative conducts the HRA, asking members questions about their health and well-being status and assisting in them in making an appointment with their PCP for an initial medical assessment.
- **Award-winning health literacy educational materials:** Passport's corporate communications team has specialized award-winning writers and designers to create member and provider materials. This team uses best practices and their years of experience working closely with the members, providers, pharmacies and community partners to produce educational materials. Over the years, this team has won numerous awards for health literacy and creative design.
- **Disease-specific mailings**, including a disease-specific assessment for new members.
- **Postcard reminders** for specific overdue screenings.
- Face-to-face contact with **embedded care managers** in high-volume PCP offices and hospitals.
- **One-on-one outreach** for high-risk members.
- **New Member Handbook**, which contains information about our special programs and their contact information.

- **Targeted telephonic outreach**, on-hold telephonic messages and automated outbound call technology.
- **Collaboration with community agencies** to host and participate in community events, such as health fairs and screening events.
- **Member newsletters:** Passport provides information in its newsletter, *MyHealthMyLife,* which is offered in both English and Spanish.

We also perform specialized outreach to provide our members with extended health education. For instance:

- **Member texting and emailing:** As a best practice in communicating health-related information, Passport leverages a new texting platform and a secure member portal. Outreach is done in collaboration with provider offices to reach members for visits, reinforcing the provider as the key relationship with the member.
- **Identifi Engage:** Passport is leveraging Engage, a mobile app supported on both Android and iOS platforms that is aimed at fostering member engagement to effectively manage the care and improve outcomes. Designed for members and their designated caregivers to easily interact with their care team, the secure mobile application provides bidirectional messaging (chat) capability between the care team and member. It also provides the ability to influence member behavior by pushing the right interventions to the member.
- **Health outcome campaigns:** Passport uses Interactive Voice Response (IVR) calls and live follow-up calls for health outcome campaigns and brochures for options outside the ED for addressing the management of chronic conditions with their PCP. Passport seeks out regular feedback about the effectiveness of communication.
- **Member outreach specialists:** Passport member outreach specialists work to build relationships between the PCP and the member. They make outreach calls to members on behalf of providers to understand why members are using EDs instead of their provider, and they educate the member on more appropriate options for care.
- **CHW program:** In 2018, we implemented a new program where our CHWs conduct face-to-face visits in the member's homes, in provider's offices and in community service organizations. CHWs serve as advocates in helping members to schedule doctor appointments, obtain the necessary resources to resolve SDoH, and assess for any literacy and interpretation services needed. Information is provided to the member, teaching them to become engaged in their health care and to take charge of making the resource arrangements.
- **Homeless services:** Passport provides ongoing face-to-face member/benefits education sessions throughout the year. These sessions are conducted at the various transitional and homeless shelters throughout the state. Special attention is given to those victims of domestic violence residing in emergency shelters.
- **Care connector outreach representatives** conduct customer-friendly member welcome phone calls, introducing members to Passport. During this call, the representative conducts the HRA, asking members questions about their health and well-being status, and assists in them in making an appointment with their PCP for an initial medical assessment.

- **Health Educators in the community:** Passport's team of Health Educators collaborate with organizations through the state, such as Health Access Nurturing Development Services (HANDS) programs, public libraries, social services agencies and others to provide education within communities on relevant health topics. Recent training topics provided by our Health Educators include vaping, nutrition, chronic disease management and bullying. Our Health Educators have an extensive library of curriculum they use to share knowledge with Kentuckians throughout the Commonwealth.

Most importantly, Passport recognizes that in order to engage individuals with special health care needs in the community, you must be in the community. Therefore, our community engagement representatives are out in our communities every day. Passport has documented a sample of the literally thousands of interactions that have taken place in local communities to address the full spectrum of health and wellness, community engagement and social/environmental issues across the highly diverse communities at the regional, county and city/town level. This sample of interactions is included in please see **Attachment A-1_Passport Community Engagement Examples** and is intended to serve as a description of the deeply embedded relationships Passport has across the state, not only with the geography but within each community.

When we talk about community, we are talking about *our* community, whether that is people who are homeless, refugees, immigrants, internationals, people who are deaf or hard of hearing, grandparents/families raising children, foster families, people who learn differently, individuals with substance use disorders, people in domestic violence situations, former inmates, those with disabilities or special health care needs, or individuals experiencing barriers to accessing care—no matter their race, ethnicity, language, gender identity or age.

"Over the past five (5) years, Passport has been an essential partner with Catholic Charities in providing culturally sensitive services to our shared refugee families. Catholic Charities has been fortunate to have Paige Kolok on site to be available to serve refugee families. Without this partnership, families would not be able to address their health care needs, which would most likely jeopardize their ability to thrive and enter the workforce. Paige Kolok has been an essential part of this program. Her welcoming demeanor and her expertise in providing culturally sensitive services has proven to be an excellent introduction for newcomers to the complex world of health care. This program exhibits Passport's commitment to serving at-risk and marginalized populations such as newly arrived refugee families."

Colin Triplett, Resettlement Director—Migration and Refugee Services, Catholic Charities

In these interactions in our communities, with our neighbors, we assist members in addressing their barriers to care, which could include:

- **SDoH** such as housing, clothing, food security, transportation, education, record expungement, accessibility and domestic violence/safety.
- **Health-related Issues** such as dental, wellness and behavioral health, prevention/health education, vision, nutrition, substance use, heart health, respiratory care and cancer care.
- **Communitywide issues** that create barriers to well-being, such as early childhood education, kindergarten readiness, school supplies, workforce-ready skills and after-school care.

We have served these communities for the past twenty-two (22) years with passion and enthusiasm because these are our neighbors, in our community. We are extremely proud of the impact we have had on our fellow Kentuckians and look forward to the opportunity to continue to do so well into the future.

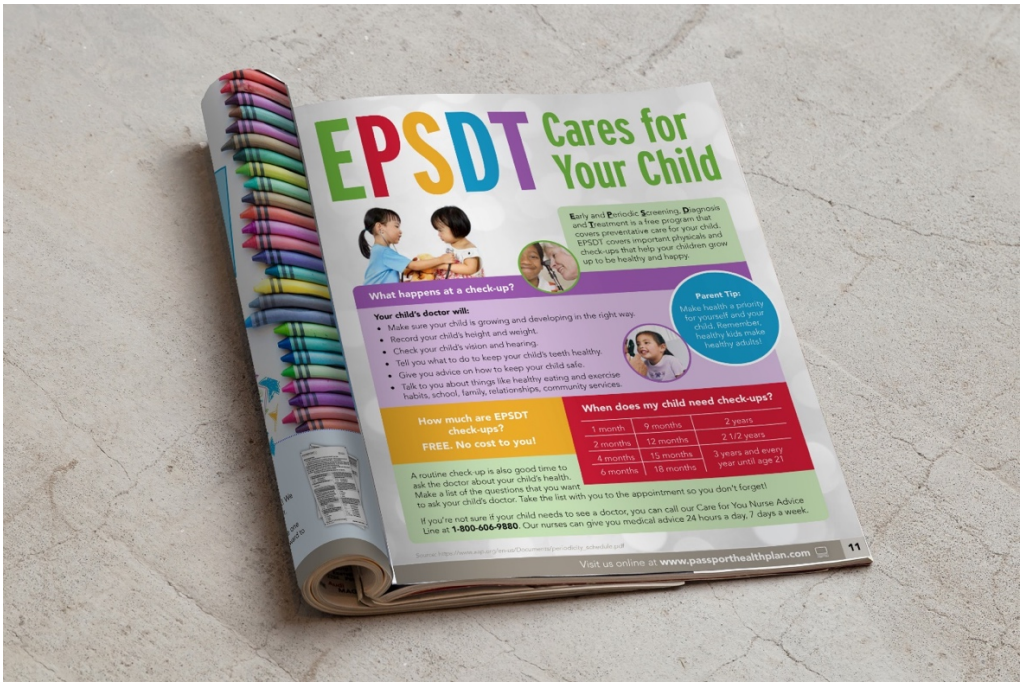
Some additional examples of education for ESHCNs are below.

Educating Young Members on the Importance of Early Periodic Screening and Diagnostic Testing

Education and guidance are critical components of the EPSDT program. Our Care Advisors educate our young members and their caregivers on proper nutrition, physical activity and risky behaviors related to sexual activity, alcohol, substance abuse and tobacco use. We also have targeted outreach efforts geared to EPSDT-eligible members who have not received the recommended schedule of health screens, immunizations and annual participation. The outreach efforts inform and stress the importance of EPSDT through various means, including:

- Postcard notifications are mailed to caregivers of all newborn members advising of EPSDT screenings.
- Auto-dialer system is used to contact members regarding the availability of preventive dental care, the recommended schedule for EPSDT screens and immunizations, and the importance of follow-up when referred for special services. For convenience, members have the option to speak directly to a care connector if they require additional information.
- Home visits are provided to members who are unavailable by phone.
- The Member Handbook offers information on our EPSDT program, member eligibility criteria, and an early periodic screening and diagnostic testing schedule.
- Information on our member website for the EPSDT program and offerings.
- Our member newsletter*, MyHealthMyLife,* offers informational articles on the importance of EPSDT screenings and immunizations, as illustrated in **Exhibit C.25-9.**

Exhibit C.25-9: Member Newsletter Articles on the Importance of EPSDT for Children



Engaging Members and Providers Through Education and Extensive Outreach Efforts

Our community engagement team is assigned to regional areas across the Commonwealth to provide health and wellness education and health screenings. The community engagement representatives and Health Educators hold events at local schools and civic and community centers to foster the early detection and testing for medical conditions affecting children in Kentucky. In 2018, our community engagement representatives conducted outreached to children and their parents at over 1,500 community events, addressing healthy nutrition and preventive and dental health, and they provided sports physicals. For example, in Floyd County, Kentucky, Passport participated in a "Backpack to School" event, providing free sports physicals, A1c testing for diabetes, dental services and cholesterol screenings to our members. Passport presented 800 free backpacks filled with much needed school supplies to the children at the event.

Provider engagement and education are essential elements to the success of our EPSDT program. Passport conducts orientation sessions for EPSDT clinicians regularly and provides them with ongoing support regarding the administration of EPSDT preventive care, billing and claims processes, the required components of a complete EPSDT screening, and the importance of outreach and education to EPSDT-eligible members and their families. As a part of educational efforts, we also conduct provider outreach visits, workshops and roundtable meetings, as well as offer educational materials such as the Quick Reference Guide, Provider Orientation Kit, EPSDT Orientation Kit, Passport Provider Manual, Provider EPSDT

Education Toolkit and information about Passport's provider portal website in order to support efforts to increase EPSDT participation, compliance rates and identified health outcomes.

Passport's community engagement team refers many ESHCNs to community agencies that have special intake processes to help them in crisis. These organizations include Women's Crisis Centers, Mental Health America of Northern Kentucky, Sun Behavioral Health, The Northern Kentucky Emergency Shelter, Family Promises Shelter and St. Elizabeth Hospital. We also refer individuals with special health care needs to the Brighton Center, a nonprofit organization whose mission is to create opportunities for individuals and families to reach self-sufficiency through family support services, education, employment and leadership. We also hold member education and outreach events at their centers. Our team collaborates with these agencies for community health meetings, holds one-on-one advocate meetings and provides their staff with health education meetings.

In addition, the Passport community engagement team works with the Disability Empowerment Conference, an advocacy group for individuals with special health care needs. Our team holds an annual forum to address the needs of this population, especially for the medically frail.

Providing Community Outreach Efforts and Health Education to the Homeless

As a part of the Pathways program, Passport develops relationships with and learns from other community homeless advocates. We have a long history with the Coalition for the Homeless. Since 1997, Passport has been a member of the Coalition and has worked with various homeless and transitional shelters throughout Kentucky. Our team performs quarterly outreach efforts to shelters, offering health and wellness education sessions. The curriculum includes information about the importance of preventive health, well-child visits and immunizations, how to choose a PCP, and instructions for accessing transportation and community resources. Our staff nutritionist and Health Educators conduct educational classes on health and wellness, proper nutrition and promoting healthy lifestyles to help members and their families.

Some homeless or transitional shelter houses provide specialized services for victims of domestic violence. We understand that survivors of domestic violence require supportive services to help them heal from the trauma of abuse and improve their economic security and well-being. Passport's team is there to help. Our caring and compassionate staff offers information on Medicaid, on our plan's medical and behavioral health programs and services, and on available community resources. It is critical for victims of domestic violence to have safe, stable housing to reduce their risk of both homelessness and future violence.

C.25.b. iv. Approach to providing transition support services.

Transition Care Program for ESHCNs

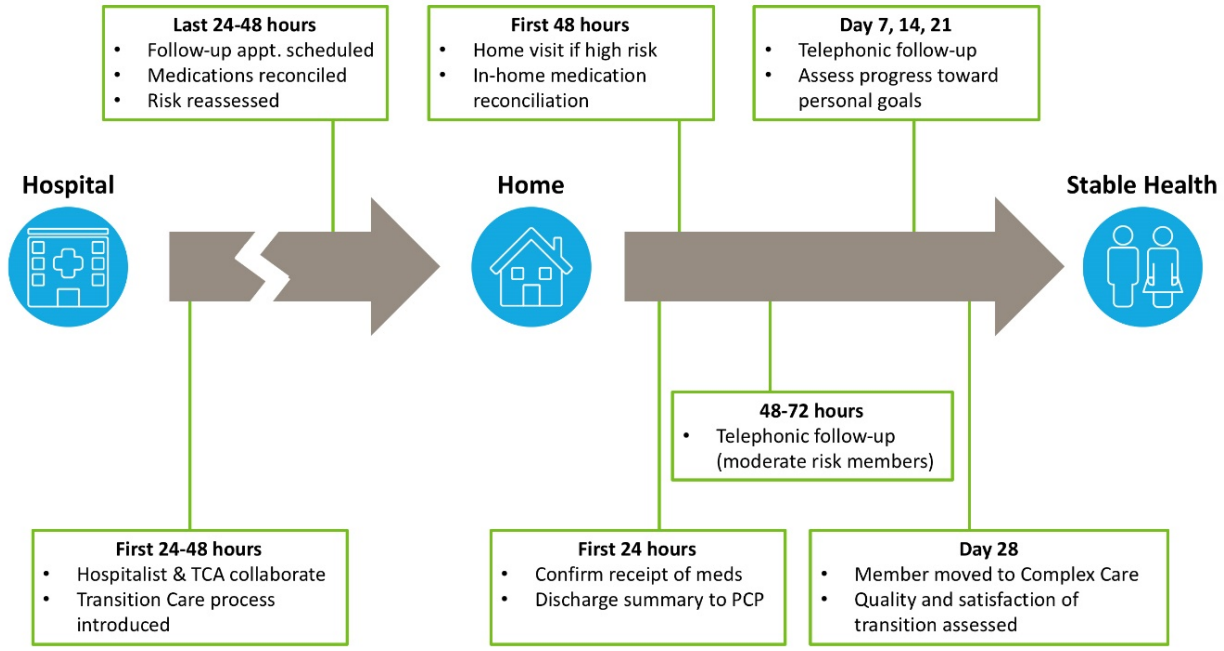
Passport provides a Transition Care program for our high-risk members to safely and seamlessly transition back to their home. Our care team develops a member-centric transition-of-care plan and coordinates the appropriate level of care to help our members remain in their home environment and have a lower risk for hospital or ED readmissions.

Passport's Transition Care program is designed with specific goals to improve the health of our membership. The program goals include:

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

The Transition Care program initiates prior to a member's discharge from the hospital. Our Care Advisors and Health Educators work closely with the hospital discharge planning team to effectively coordinate and implement the discharge plan. Collectively, they provide proper continuity of care as members transition and achieve stabilized health, as illustrated in **Exhibit C.25-10.**

Exhibit C.25-10: Our Transition Care Program Process



After receiving the discharge notification, our Care Advisors and Health Educators contact the member within 24-48 hours to begin the enrollment process and schedule a telephonic or home visit. Every effort is made to make the members and their caregiver feel respected, comfortable and at ease. Our Transition Care team begins by taking the time to carefully listen to and answer the member's questions. We then perform an assessment to identify any special needs the member may have, determine any health risks,

reconcile their medications for adherence, and ensure the proper support resources are available. The assessment information is essential in developing the individualized care plan with the member, our team, the caregiver and the provider.

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

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

Transitioning Members with SMI from an Inpatient Setting

Continuity of care following discharge from a psychiatric hospital, personal care home or other institutional setting is one of the most critical times for people with behavioral health needs. Passport, as a provider-sponsored plan, understands these high stakes and takes this risk very seriously. Every member who is leaving one of these institutional settings and moving into the community is assigned a Care Advisor or other care management team member for outreach. The team's responsibility starts at the time of admission, establishing contact with the facility to immediately engage so that discharge planning begins early. Passport uses the member's Person-Centered Recovery Plan (where applicable), level of care determination and UM criteria to assess and approve the member's transition of care and service needs.

The CM staff participates in transition planning and collaborates with the facility to review the discharge plan, work on behalf of the member to address barriers to completion and work directly with the member immediately after discharge to schedule the required follow-up appointments (and then remind the member of their scheduled follow-up appointments). A comprehensive physical and behavioral health assessment is scheduled within fourteen (14) days of the transition. This assessment includes a screening for medication adherence.

The care team verifies that the member's follow-up care appointment was kept and completed. If a no-show or reschedule occurred, the care team works with the member to identify and address the barrier to care that prevented the appointment from being completed or to reschedule the appointment with the same provider or, in some cases, identify a new provider and schedule the required visit.

Offering ESHCNs Prescribed Pediatric Extended Care for Nonresidential Health Care

Prescribed Pediatric Extended Care is a nonresidential health care for children from six (6) weeks through age twenty (20) with medically complex conditions requiring continuous therapeutic or skilled nursing supervision. A number of criteria can be used to describe medically complex conditions as "serious and complex." These could include severity of the illness, degree of impairment or disability, and level of need for comprehensive care management. A *covered disability* is defined according to the Americans with Disabilities Act (1990) as pertaining to persons with a physical or mental impairment that substantially limits a "major life activity," persons with a record of such an impairment, or persons who believe that others regard them as having such an impairment.

Prescribed Pediatric Extended Care Program (PPECP) is an alternative to in-home nursing for children with complex medical needs/conditions. This alternative program may allow up to twelve (12) hours of care, five (5) days a week. Services include skilled nursing; respiratory care; developmental and educational programs; nutrition; occupational, physical, and speech/language therapy; social services; recreation; transportation; nurse practitioner (NP)/advanced registered nurse practitioner (ARNP); and access to medical care and physicians.

There are four levels of care for individuals with special health care needs for Prescribed Pediatric Extended Care:

1. Level I is considered when the member has a single-system disease requiring four (4) hours of nursing services weekly, with a home health aide providing care and oversight during the day
2. Level II is considered when the member has multisystem disease requiring eight (8) hours of nursing services weekly, with a home health aide providing care and oversight during the day
3. Level III is considered when the member has both multisystem disease and developmental needs requiring an RN/licensed practical nurse (LPN) hourly
4. Level IV is considered when the member has high-tech multisystem needs requiring continuous, ongoing daily assessment and observation by RN/LPN

Partnering with Family Health Centers—Phoenix's Health Care for the Homeless

Passport partners with Family Health Centers—Phoenix's Health Care for the Homeless program, which conducts Louisville's common assessment team (CAT). The CAT conducts vulnerability assessments on homeless individuals to determine what type of housing is most appropriate. The assessment asks questions related to the individual's physical health, mental health, substance use and other vulnerabilities. Individuals with higher scores are more vulnerable and are appropriate candidates for Permanent Supportive Housing programs, which must take referrals from the CAT. Permanent Supportive Housing participants must have a chronic disability and be in need of case management services.

Since beginning in 2014, the CAT has conducted assessments on 5,570 adults and transitioned 2,413 individuals from homelessness to Permanent Supportive Housing, with thirty-two percent (32%) of CAT participants self-identified has having a chronic health condition, forty-eight percent (48%) with a physical disability, and fifty-two percent (52%) with a chronic mental health condition.

Partnering with the Community to Make Our Members a Priority

Richard* is a patient at Family Health Center (FHC) – Phoenix, which provides health care for the homeless. Richard has complex needs, is an amputee, and was recently hospitalized. Rhonda, a Passport Community Health Worker, received a referral from FHC, Richard was recovering from his recent hospitalization at Wayside Christian Mission Respite Care, where she is onsite weekly. Rhonda met with Richard and his sister, Susan (his caregiver), in person and completed an assessment. Rhonda learned that getting to and from appointments was a struggle for Richard because he did not have transportation. His wheelchair did not have a footrest, which made it even more difficult because he had to try to hold his leg up when being pushed or transported. The family's time at Wayside would be coming to an end soon, leaving them without shelter. Susan was without a job but was interested in finding one. Rhonda worked with Richard and his sister to develop an action plan to address their needs. Rhonda worked to find shelter at the Salvation Army for both Richard and Susan. She coordinated transportation services with Federated Transportation to get Richard to and from appointments. Project CARAT donated a power wheelchair so that Richard could travel without assistance. Rhonda was able to obtain clothing for Susan to wear to job interviews. She also helped the family to secure documentation from Richard's PCP to ensure his place on the Housing Authority wait list for permanent housing. She worked with Susan to get proof that she was his trained caregiver so she could reside with Richard and take care of him in the future.

*Member name was changed for privacy

Conclusion

Passport is dedicated to its ESHCNs. We have transformed our programs and developed innovative solutions to address these special needs members. Our team is constantly exploring ways to improve the quality of care in a cost-effective manner. Our model of care (i) offers comprehensive care, (ii) ensures that care is highly coordinated with members' providers for a seamless member experience, (iii) provides a tailored and member-centric approach to address their "whole person" needs, (iv) offers access to care through our vast provider network and, most of all, (v) ensures quality and safety for each and every one of our members.

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.