Passport Advantage (HMO SNP) is an HMO Special Needs plan with a Medicare contract and an agreement with the Kentucky Department for Medicaid Services. Enrollment in Passport Advantage depends on contract renewal.

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Training Objectives

At the conclusion of this training, the following learning objectives will be addressed:

- Dual Special Needs Plan (SNP) requirements
- Describe Model of Care (MOC) components:
  - Description of the SNP population
  - Care coordination – explain how Passport Advantage and providers coordinate care for duals
- Provider network
- Quality measurement and performance improvement
- Describe provider role and support within MOC context
Dual Special Needs Plan (SNP)

A dual special needs plan compared to Original Medicare:

- Is a Medicare Advantage Prescription Drug Plan (MA-PD) with additional requirements, primarily around Model of Care (MOC). The MOC is a framework of how a plan addresses the unique needs of its membership.

- Covers all Original Medicare (FFS) benefits, including A/B and D (prescription drugs)

- Must have a contract with the State Medicaid agency to either provide or coordinate Medicaid benefits; Passport Advantage must coordinate Medicaid benefits

*Per CMS requirements, a Special Needs Plan (SNP) must provide Model of Care training to their contracted providers*
Passport’s Special Needs Population

• Eligible for **full** Medicaid benefits; must involuntarily dis-enroll a member that loses full Medicaid status
  – be entitled to Medicare Part A
  – be enrolled in Medicare Part B

• Resides within service area counties: Bullitt, Hardin, Jefferson, Nelson

• Can enroll members living in the community and those in an institutional setting
Anticipated Prevalent Diagnoses

<table>
<thead>
<tr>
<th>Medical Diagnoses</th>
<th>Behavioral Health Diagnoses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>Bipolar</td>
</tr>
<tr>
<td>Hypertension</td>
<td>Depressive Disorder</td>
</tr>
<tr>
<td>Chronic Airway Obstruction</td>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Heart Disease and Failure</td>
<td>Anxiety</td>
</tr>
<tr>
<td>Back/Leg Pain</td>
<td></td>
</tr>
<tr>
<td>Arthritis</td>
<td></td>
</tr>
<tr>
<td>Hypercholesterolemia</td>
<td></td>
</tr>
</tbody>
</table>

*Full benefit duals are much more likely to be chronically ill compared with a regular Medicare population, especially for 5 or more chronic illnesses*
## Vulnerable Subpopulations

<table>
<thead>
<tr>
<th>Population</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple hospitalizations</td>
<td>2 or more within 6 months, including medical or behavioral health</td>
</tr>
<tr>
<td>Readmission</td>
<td>Within 30 days of prior inpatient discharge</td>
</tr>
<tr>
<td>Long-term Skilled Nursing Facility (SNF) residents</td>
<td>Members who transition from community, or currently reside in a long-term facility</td>
</tr>
<tr>
<td>Poly and/or high risk pharmacy utilization</td>
<td>10 or more prescriptions; high risk medication use by those 65 and older; lack of adherence to diabetes, hypertension or cholesterol medications</td>
</tr>
<tr>
<td>End of Life or Advanced Illness</td>
<td></td>
</tr>
<tr>
<td>Serious mental illness (SMI)</td>
<td>Members with a diagnosis of schizophrenia and/or bipolar disorder</td>
</tr>
</tbody>
</table>
## Benefits Chart – DSNP Members

<table>
<thead>
<tr>
<th>Benefit</th>
<th>Original Medicare</th>
<th>Passport Advantage</th>
<th>PHP/MCO</th>
<th>DMS</th>
<th>Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare A/B</td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Hospice</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Clinical Trials</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Medicare Cost Sharing</td>
<td></td>
<td></td>
<td>X</td>
<td>X</td>
<td>$0</td>
</tr>
<tr>
<td>Supplemental Benefits</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Prescriptions (based on Subsidy- LIS level 1)</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Prescriptions (based on Subsidy- LIS level 2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Generic- $3.30; All others - $8.25</td>
</tr>
<tr>
<td>Prescriptions (LIS level 3- Institutionalized)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>OTC medications</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Routine Eye Care</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>Routine Dental</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
<tr>
<td>NON-emergent Transportation</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td>$0</td>
</tr>
</tbody>
</table>

*Passport Advantage is financially responsible for A/B benefits; not for Medicaid benefits or cost sharing.*
• Supplemental benefits are in addition to the standard Medicare covered services
• Supplemental benefits cannot replicate a Medicaid benefit
• No deductible is applied for the following supplemental benefits:
  – Up to $125 annually for eye glasses and/or lenses (routine vision screening covered under Medicaid benefit)
  – One pair of dentures every 60 months
    • Medical Necessity is required
  – Hearing aid one every year (one or both ears)
    • Up to $500 per Hearing Aid
Preventive Services

• No coinsurance, copayments or deductibles for all Original Medicare Preventive Services that are offered at zero dollar cost sharing

Referral Requirements

• Referrals are not required for mental health and psychiatric specialty services

• Referrals from the member’s assigned PCP is required for:
  – Specialists Visits
  – Other Health Care Professionals Visits
Cultural & Linguistics Standards

- Provide language assistance services at no cost to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation.
- Provide to patients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- Assure the competence of language assistance provided. Family and friends should not be used to provide interpretation services (except on request by the patient).
- Make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups represented in the service area.
Continuity of Care Standards

Passport Advantage is required to monitor our provider’s medical records for continuity of care.

Examples of the monitoring criteria are:

• At each office visit, the history and the physical performed are documented and reflect appropriate subjective and objective information for presenting complaints, including any relevant psychological and social conditions affecting the patient’s medical/behavioral health.

• The working diagnosis is consistent with the clinical findings.

• The plan of action and treatment is consistent with the diagnosis and includes medication history, medications prescribed; including the strength, amount, and directions for use, as well as any therapies or other prescribed regimen.

• Lab and other studies are ordered as appropriate.

• Additional details and requirements are found in your Provider Manual.
Access and Availability

• Passport Advantage is required to monitor our provider’s access and availability.
• The provider network is designed to meet the unique needs of the dual population for access, availability and specialty.
• Passport members select a primary care physician who has contractual accountability for making appropriate and timely referrals to specialists.
• All practitioners are required to be accessible 24/7, which may include approved coverage standards.
• Access to care standards is assessed as part of Quality improvement activities.
Medical records should be complete and legible and include the legible identity of the provider and the date of service. 

Medical records must include the NCQA’s guidelines for 21 core elements for medical record documentation. 

Medical records, in any media type (paper, electronic health record) must be compliant with all HHS, CMS and DMS requirements, including signature standards. 

Additional details and requirements are found in your Provider Manual.
Model Of Care-Care Coordination Requirements

Care Coordination Requirements

• Health Risk Assessment (HRA) supplements stratification and results integrated within a member’s Individualized Care Plan (ICP)
  – Initially – comprehensive HRA within 90 days of the effective date
  – Significant change in condition or Transitions of Care
  – Annually – re-assessment at least every 365 days

• HRAT – Health Risk Assessment Tool
  – Collects information on the medical, functional, psychosocial and mental health of each member; also can be collected via the phone
  – Series of outreach attempts by phone
  – Includes questions that address the member’s general health, medical history, activities of daily living, caregiver support, nutritional status, social needs, behavioral health, physical health, medication usage, etc.
  – Includes questions specific to the Health Outcomes Survey so that comparisons can be made from initial assessment to re-assessment

Individualized Care Plan (ICP) – action-oriented with goals, outcomes and services and benefits to be provided. Created for every member, whether reached and assessed, or not

• Created using information from:
  – Claims (medical, BH, pharmacy); Medicare risk score data; Practitioner reported information, when available & Member self-report via HRA and other assessments

• Reviewed and updated by the Interdisciplinary Care Team (ICT)
  – At initial creation
  – With change in health status or transitions in care
  – Annually

• ICP shared with member and PCP/other practitioners

• Essential Components:
  – Medical History, Member Preferences, Advance Medical Directive, Member’s personal high level self-management goals and objectives, Identified problem list and potential barriers, Short and longer term goals and interventions by priority and timeframes for reevaluation, Stratification Level, Notes, Alerts
  – Following establishment of goals, interventions are tailored specifically to the member’s needs, and may include, but not limited to Education about their diagnoses, Complex Case Management, Identification of additional services, Education and support on self-management, Assistance with coordinating provider visits and services, Identifying and coordinating “gaps in care”, relevant community resources and Medicaid benefits

Members are managed through a dedicated care manager approach using RNs, LCSWs, LPNs and medical directors
<table>
<thead>
<tr>
<th>ICP Components</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical History</td>
<td>Assessment of medical, psychosocial and cognitive needs; frailty</td>
</tr>
<tr>
<td>Member Preferences</td>
<td>Language and cultural preferences for health care and communication (mail, phone); Caregiver status; Articulated stressors</td>
</tr>
<tr>
<td>Advance Medical Directive</td>
<td>Articulated member wishes and status of documentation</td>
</tr>
<tr>
<td>Member’s personal high level self-management goals</td>
<td>Articulated goals provided by member and/or caregiver</td>
</tr>
<tr>
<td>and objectives</td>
<td></td>
</tr>
<tr>
<td>Identified problem list and potential barriers</td>
<td>Articulated by member and/or caregiver and augmented by care management staff</td>
</tr>
<tr>
<td>Short and longer term goals and interventions by</td>
<td>Identification of member and care management system generated goals based on health status, medical/behavioral health history, care gaps and social needs as determined by systemic triggers, care manager and ICT. Unmet goals are triggered as interventions and/or alerts to the care management team</td>
</tr>
<tr>
<td>priority and timeframes for reevaluation</td>
<td></td>
</tr>
<tr>
<td>Stratification Level</td>
<td>Determined based on available information, such as HRAT, additional assessments, pharmacy and medical claims, MMR and HCC results, care management interaction</td>
</tr>
<tr>
<td>Notes</td>
<td>Open text notes gathered by the care management team through engagement with the member and/or ICT</td>
</tr>
<tr>
<td>Alerts</td>
<td>System triggered care management team outreach or interventions based on unmet goals, gaps in care, and/or revised member health status</td>
</tr>
</tbody>
</table>
Care Coordination Requirements (continued)

**Interdisciplinary Care Team (ICT)** – to coordinate care

- Development process and personnel – pharmacy, medical claims, member information (demographics)
- MMR/enrollment system – comprehensive assessment
- Includes both Medicare and Medicaid services and benefits
- Documentation and maintenance
- Updates & modifications
- ICT includes: Professionals, paraprofessionals and non-professionals with knowledge, skill and expertise necessary to accurately identify the comprehensive array of the member’s needs, identify appropriate services and design specialized interventions responsive to those needs
- ICT Team Roles & Responsibilities: “drives member care management”, reviews and provides feedback and suggestions for modifications and interventions. The intended focus of the ICT is the successful execution of the member’s ICP and subsequent optimizing the member’s health status and outcomes.

- Internal and external resources coordinated by a case coordinator or care manager (member, caregiver, PCP, other specialists/providers)
- Internal resource expertise includes
  - medical
  - behavioral
  - pharmacist
  - psychosocial
- Multidisciplinary approach to coordination of care
- Members and/or their caregiver have access to the care management staff via a toll-free phone number
- **Care Manager – Primary Point of Contact**
  - Care Manager coordinates the external ICT participants on behalf of the member, including conversations with their PCP, specialists and /or community resources
  - Care manager assists the member in articulating questions to ask providers
  - Care manager documents discussions and decisions; all internal ICT participants document their activities within the care management system
- Internal records are audited and results are reviewed by the Director of Quality and Director of Provider Network Management for educational and improvement opportunities
## Potential ICT Participants

<table>
<thead>
<tr>
<th>Potential ICT Participant</th>
<th>Roles &amp; Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacist</td>
<td>Review medication therapy and adherence and offer suggestions to enhance</td>
</tr>
<tr>
<td>Medical Director and/or Psychiatrist</td>
<td>Review clinical care recommendations and interventions</td>
</tr>
<tr>
<td>Behavioral Health (Psychologist, LSW, LCSW)</td>
<td>Review and offers modifications/interventions related to behavioral health care</td>
</tr>
<tr>
<td>Medical (RN)</td>
<td>Provides review and offers modifications/interventions related to medical care</td>
</tr>
<tr>
<td>Care Manager: Case Manager or Care Coordinator</td>
<td>Primary clinician assigned to the member. Accountable for convening the ICT.</td>
</tr>
<tr>
<td>Clinical Support Associate (CSA)</td>
<td>Assists care manager by facilitating member outreach, appointment scheduling, transportation, addressing gaps in care, etc.</td>
</tr>
<tr>
<td>Member’s Primary Care Physician</td>
<td>Supports ICT on clinical care recommendations and interventions</td>
</tr>
<tr>
<td>Contracted Specialists and/or non-practitioner healthcare providers</td>
<td>Supports ICT on clinical care recommendations and interventions</td>
</tr>
<tr>
<td>Community Resources</td>
<td>Supports ICT with social recommendations and interventions</td>
</tr>
</tbody>
</table>
Specialized Network

• Network contracting focused on existing comprehensive Passport Health Plan Medicaid provider network – awareness of population needs and preferences, benefits and contractual obligations associated with Medicaid recipients.

• PCP and other provider collaboration with the Interdisciplinary Care Team (ICT) and Individualized Care Plan (ICP).

• Evidence based clinical practice guidelines – utilization of services; address gaps in care; document any exceptions to guidelines in the medical record.

• Support care transition protocols and coordinating continuity of care.

• The PCP office is a member of the care team and serves as the coordination hub for the individualized care plan.

• Annual Model of Care training.
## Authorization Requirements

<table>
<thead>
<tr>
<th>Category</th>
<th>Authorization Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>All inpatient, including acute, psychiatric and skilled nursing facility (3 day inpatient stay waived)</td>
<td>Outpatient hospital services (select procedures and observation stays)</td>
</tr>
<tr>
<td>Partial hospitalization</td>
<td>ASC Services (select procedures)</td>
</tr>
<tr>
<td>Home Health Services</td>
<td>DME (greater than $500 rental or purchase)</td>
</tr>
<tr>
<td>OT/PT/ST Services</td>
<td>Prosthetics/medical supplies (greater than $500 rental or purchase)</td>
</tr>
<tr>
<td>Outpatient diagnostic procedures/tests/lab services (high tech/high cost procedures)</td>
<td>Part B drugs (greater than $400 per dose, excluding chemotherapy)</td>
</tr>
<tr>
<td>Outpatient diagnostic/therapeutic Radiology Services (high tech/high cost services)</td>
<td>Out of Network (OON) requests</td>
</tr>
</tbody>
</table>
Quality Improvement Program

• Components of the QI Program is consistent with Passport’s Medicaid business and includes:
  – QI Program Description
  – QI Work Plan
  – QI Evaluation
  – Chronic Care Improvement Program
    – relevant to SNP population
  – Quality Improvement Project(s)
Clinical Practice Guidelines

• Evidence based clinical practice guidelines promote the use of nationally recognized and accepted practices for providing the right care at the right time

• The Plan updates its clinical practice guidelines minimally every two years

• Clinical Practice Guidelines address the most prevalent diagnoses anticipated within the D-SNP population
  – Standards of Medical Care in Diabetes
  – Prevention, Detection, Evaluation and Treatment of High Blood Pressure
  – Chronic Obstructive Pulmonary Disease
  – AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary & Other Atherosclerotic Vascular Disease
  – Practice Guidelines for the treatment of Patients with Major Depressive Disorder
  – Adult Preventive Health
CMS Designated MOC Measurable Goals & Health Outcomes

• Improving access to healthcare services
• Improving access to affordable health care
• Improving coordination of care and appropriate delivery of services through direct alignment of the HRA, ICP and ICT
• Improving care transitions across all health care settings and providers
• Ensuring appropriate utilization of preventive health services
• Ensuring appropriate utilization of services
• Ensuring appropriate utilization of chronic condition services and improving member health outcomes
Ongoing Performance Improvement Evaluation of the MOC

- Progress on goals is monitored and reviewed by the Quality Medical Management Committee, as specified in the QI work plan.
- Annually, a formal evaluation is conducted of the quality improvement plan, including MOC performance data.
- Results are analyzed for root cause and to identify barriers to achieving desired results; the Plan-Do-Study-Act (PDSA) methodology is utilized for improvement activities.
- Results are disseminated through various communication methods to:
  - internal staff
  - committees
  - board of directors (BOD)
  - members
  - providers
Provider Role & Support for Model of Care

- Encourage members to complete Health Risk Assessment and to call care coordination
- Review a member’s individualized care plan and make modifications, as relevant
- Participate on a member’s interdisciplinary care team, when possible
- Assist with discharge needs when notified of a transition of care
- Integrate MOC documents within the member’s medical record
Initial, Annual Training & HIPAA

• Annually, providers are required to attest or provide copies of staff and provider certificates of completion of:
  – Fraud, Waste & Abuse Training
  – General Compliance or Code of Conduct
  – Passport Advantage’s Model of Care

• Providers are required, per CMS, to use the Fraud, Waste & Abuse Training and General Compliance provided in the Medicare Learning Network catalogue.

• Annually, providers are required to provide a HIPAA training class for themselves and their staff.
Next Steps

1. Ensure all providers and employees are trained on Passport Advantage’s Model of Care as well as additional Compliance Training & Requirements as listed in the 2016 Provider Attestation

2. Ensure completed Attestation has been submitted to Passport by Authorized Representative
Resources

• Medicare Managed Care Manual
• Medicare.gov
• Passport Advantage Model of Care
• Passport Advantage 2017 Evidence of Coverage
• Passport Advantage 2017 Summary of Benefits

Questions?

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  – (502) 212-6652