

Passport to Health Program

What Is Passport to Health? (ARM 37.86.5101–5120, ARM 37.86.5303, and ARM 37.86.5201–5206)

Passport to Health is the primary care case management (PCCM) program for Montana Medicaid and Healthy Montana Kids (HMK) *Plus* members. The four Passport programs encourage and support Medicaid and HMK *Plus* members and providers to establish a strong doctor/patient relationship and ensure the appropriate use of Medicaid and HMK *Plus* services:

- Passport to Health Primary Care Case Management
- Team Care
- Nurse First Advice Line
- Health Improvement Program

Medicaid and HMK *Plus* members who are eligible for Passport must enroll in the program (about 70% of Montana Medicaid and HMK *Plus* members are eligible). Each enrollee chooses a Passport provider who is typically a physician, mid-level practitioner, or primary care clinic. Passport members may change their Passport provider up to once per month, but the change may not be effective until the following month, depending on the date the choice is made.

Passport to Health Primary Care Case Management (PCCM) (ARM 37.86.5101–5120)

The Passport providers deliver PCCM services to their members. This means they provide or coordinate the member's care and make referrals to other Montana Medicaid and HMK*Plus* providers when necessary. Under Passport, Medicaid and HMK *Plus* members choose one primary care provider and develop an ongoing relationship that provides a medical home. The medical home is a concept that encourages a strong doctor–member relationship. An effective medical home is accessible, continuous, comprehensive, coordinated, and operates within the context of family and community.

With some exceptions, all services to Passport members must be provided or approved by the member's Passport provider or Medicaid/HMK*Plus* will not reimburse for those services. (See the section titled Services That Do Not Require Passport Provider Approval later in this chapter.) The member's Passport provider is also referred to as the primary care provider (PCP).

Team Care (ARM 37.86.5303)

Team Care is designed to educate members to effectively access medical care. Members with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. Members enrolled in Team Care are also enrolled in Passport. Team Care follows the same Passport rules



Medicaid does not pay for services when prior authorization or Passport requirements are not met.



Different codes are issued for Passport approval and prior authorization, and both must be recorded on the claim form, if appropriate.

and guidelines for referrals, enrollment/disenrollment, prior authorization, and billing processes. Team Care members are locked in to one provider and one pharmacy, and must show the reason for the change. Providers are encouraged to make a referral to the Team Care Program Officer if they feel one of their members is appropriate for the program. A Passport provider receives an enhanced case management fee of \$6 per member per month for Team Care members. When checking Medicaid or HMK *Plus* eligibility on the MATH web portal, a Team Care member's provider and pharmacy will be listed. Providers are encouraged to write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy.

Nurse First Advice Line

The Nurse First Advice Line at 1.800.330.7847 is a 24/7/365, toll-free, and confidential nurse triage line staffed by licensed registered nurses and is available to all Montana Medicaid, HMK *Plus*, and HMK members. There is no charge to members or providers. Members are encouraged to use the Nurse First Advice Line as their first resource when they are sick or hurt. Registered nurses are available 24/7/365 to triage members over the phone and recommend appropriate care. Health coaches are also available to answer general health or medication questions. Nurses do not diagnose or provide treatment. The Nurse First Advice Line will fax a triage report to the Passport PCP when one of their members calls to be triaged.

Passport providers are encouraged to provide education to their members regarding the appropriate use of the emergency department (ED), including using the Nurse First Advice Line before going to the ED.

Health Improvement Program (ARM 37.86.5201–5206)

The Health Improvement Program (HIP) is for Medicaid and HMK*Plus* members with chronic illnesses or risks of developing serious health conditions. HIP is operated statewide through a regional network of 14 community and tribal health centers. Medicaid and HMK *Plus* members eligible for the Passport Program are enrolled and assigned to a health center for case management. Current Passport members stay with their PCPs for primary care, and are eligible for case management services through HIP. Nurses and health coaches certified in professional chronic care will conduct health assessments; work with PCPs to develop care plans; educate members in self-management and prevention; provide pre- and post-hospital discharge planning; help with local resources; and remind members about scheduling needed screening and medical visits.

Medicaid uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy and demographic information to generate a risk score for each member. Although the software will provide a great deal of information for interventions, it will not identify members who have not received a diagnosis or generated claims. PCPs may also identify and recommend Passport members at high risk for chronic health

conditions that would benefit from case management from HIP using the HIP referral form included at the Health Improvement Program link on the provider [website](#).

In practice, providers will most often encounter Medicaid and HMK *Plus* members who are enrolled in Passport. Specific services may also require prior authorization (PA) even if the member is a Passport enrollee. Passport referral and approval requirements and PA requirements are described below. Specific PA requirements can be found in the provider fee schedules.

Role of the Passport Provider

- Must be enrolled as a Montana Medicaid provider.
- Sign and agree to the terms of the Primary Care Provider Agreement.
- Accept enrollees in the order in which members are enrolled. Providers are automatically assigned Passport enrollees as long as they have openings and the enrollees meet the PCP defined restrictions.
- Develop an ongoing relationship with Passport members for the purpose of providing continuity of care.
- Provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordination of member's access to medically necessary specialty care by providing referrals and follow-up.
- Work with the Health Improvement Program (HIP) care managers to coordinate care for active HIP members.
- Identify and refer members to the Team Care Program whose utilization of services is excessive and inappropriate, with respect to medical need.
- Provide an appropriate and confidential exchange of information among providers.
- Educate and assist members in finding services that do not require Passport referral (e.g. family planning, mental health services, and other services).
- Educate members about the appropriate use of office visits, the emergency department (ED) and urgent care clinics.
- Provide or arrange for Well Child checkups, EPSDT services, lead screenings, and immunizations.
- Maintain a unified patient medical record for each Passport enrollee. This must include record of all approved referrals given to or received from other providers. Providers must transfer a copy of the member's medical record to a new primary care provider if requested in writing and authorized by the member.
- Provide all documentation requested by the Department (or its designee). The Department may review provider records to assure appropriate, timely, reasonably priced, quality services are being provided to Montana Medicaid/HMK *Plus* members.

- May not discriminate against protected classes or in the enrollment/disenrollment of Passport members.
- Provide or arrange for suitable coverage for needed services, consultation, and approval or denial of referrals during normal business hours.
- Provide 24-hour availability of information for how to seek emergency services.
- Arrange for coverage for normal office hours during periods of absence.
- Offer interpreter services for all patients with limited English proficiency.

Providing Passport Referral and Authorization

Passport referral is needed for most medically necessary services that the member's Passport provider does not provide. Referrals can be made to any other provider who accepts Montana Medicaid/HMK *Plus*. Referrals can be verbal or in writing, and must be accompanied by the provider's Passport referral number. Providers are required to document Passport referrals, given or received, in the member's records, a spreadsheet, or in a log book. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time specific period, or the duration of a condition. See the Passport Referral and Approval section on the next page for details.

Member Disenrollment

A provider may disenroll a Passport member for the following reasons:

- Provider/patient relationship is mutually unacceptable.
- Member has not established care.
- Member is seeking primary care elsewhere.
- Member fails to follow prescribed treatment (unless this lack of compliance is a symptom of the medical condition).
- Member is abusive.
- Member could be better treated by a different type of provider, and a referral process is not feasible.
- Member consistently fails to show up for appointments.

Providers cannot terminate a provider-member relationship in mid-treatment. Providers cannot terminate a provider/member relationship in mid-treatment. A written disenrollment notification must be sent to the member at least 30 days prior to disenrollment. Verbal notification to the member does not constitute disenrollment. The provider remains responsible for the care of the member until the disenrollment process is complete. A copy of the member's disenrollment notification must be mailed or faxed to Xerox and Passport to Health. During these 30 days, the provider must continue to treat the member or refer the member to another provider. The provider's 30 day care obligation does not start until a copy

is received by Xerox and Passport to Health. The Passport Program will not disenroll members from a PCP without written notification from the provider. Members may also request disenrollment from a Passport provider by completing a provider change form or by contacting the Member Help Line.

Termination of Passport Agreement

To terminate a Passport agreement, notify Passport to Health in writing at least 30 days before the date of termination. Termination is effective on the first day of the month following notice of termination, or the first day of the second month following notice of termination, whichever allows a 30-day time period to elapse. It is important to also give members at least 30 days' notice before termination to allow them enough time to choose another Passport provider. To ensure continuity of care during these 30 days, the provider must continue to treat the members or refer them to another provider.

Utilization Review

Passport providers' utilization patterns are analyzed on a regular basis. When a provider's average rates for service utilization are consistently high or low, the provider may be asked to furnish information regarding unusual practice patterns.

Caseload Limits

Passport providers may serve as few as one or as many as 1,000 Medicaid members. Group practices and clinics may serve up to 1,000 members for each full-time equivalent provider.

Member Eligibility Verification

Member eligibility verification will indicate whether the member is enrolled in Passport. The member's Passport provider and phone number are also available, and whether the member has Full or Basic Medicaid coverage. To check a member's eligibility, go to the MATH web portal. Other methods of checking member eligibility can be found in the Member Eligibility and Responsibilities chapter of this manual.

Medicaid Services – Provider Requirements

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the Provider Requirements chapter of this manual and in the Covered Services chapter of the provider type manual. PA and Team Care requirements must also be followed. Referrals do not supersede any other Montana Medicaid program requirements such as: medical necessity, eligibility, prior authorization requirements and service limits.

Passport Referral and Approval (ARM 37.86.5110)

If a member is enrolled in Passport, most services must be provided or approved by the member's Passport provider. While Passport referral and approval is needed for most medically-necessary services that the member's Passport provider does not provide there are some exceptions (see *Services That Do Not Require Passport Provider Approval* in the following section).

Making a Referral

Referrals can be made to any other provider who accepts Montana Medicaid. Referrals can be verbal or in writing, and must be accompanied by the Passport provider's Passport approval number. Passport providers are required to document Passport referrals in the member's records or in a log book. Documentation should not be submitted with the claim. The Passport provider establishes the parameters of referrals, which may be for a one-time visit, a time-specific period, or the duration of an illness or pregnancy. An optional referral form is available at the Passport link on the Montana Medicaid Provider Information [website](#).

Receiving a Referral as the Non-PCP

The member's Passport provider must be contacted for approval for each visit unless another time parameter was established. Passport referrals may be provided by the Passport provider; a medical professional covering for him/her; or designated office staff. Many Passport referral requests are administrative in nature, such as providing a referral when a member is injured and far away from home, and may be provided by designated non-medical staff. Passport referrals that require medical judgement, such as referrals to specialists, must be initiated by the PCP or a medical professional covering for him/her. It is best to get Passport approval in advance, in writing, and specific to services and dates. Using another provider's Passport number without approval is considered fraud. If a provider accepts a member as a Medicaid member and provides a service that requires Passport provider approval without the member's Passport provider's approval, Medicaid will deny the claim. If a provider tries unsuccessfully to get approval from the PCP, the provider cannot bill the member. The provider can bill the member if the member agreed to pay privately before services were rendered (ARM 37.85.406).

For details on when providers can bill Medicaid members, see the Billing Procedures chapter in the Medicaid billing manual for your provider type.

If a Passport provider refers a member to you, do not refer that member to someone else without the Passport provider's approval, or Medicaid will not cover the service.

Passport Approval and Prior Authorization (PA)

Passport approval and PA are different, and both may be required for a service. PA refers to a list of services that require prior authorization through a Department contractor, Mountain-Pacific Quality Health. See the *Additional Medicaid Requirements for Passport Members* in the *Passport to Health Provider Handbook*, and the Medicaid billing manual for your specific provider type for more information on PA and Passport.

Services That Do Not Require Passport Provider Approval (ARM 37.86.5110)

- Ambulance
- Anesthesiology
- Audiology
- Blood lead testing
- Case management services
- Dental
- Dialysis (home and freestanding)
- Durable medical equipment
- Emergency services
- Eye exams and eyeglasses
- Family planning
- Hearing exams and aids
- Home- and community-based services
- Home infusion therapy
- Home support services
- Hospice
- Hospital swing bed
- Immunizations
- Intermediate care facilities
- Laboratory/Pathology tests
- Licensed professional counselor
- Licensed social worker
- Mental health center services
- Nursing facilities
- Obstetrics
- Optometrists and ophthalmologists
- Personal assistance services in a member's home

- Pharmacy (For Team Care members, providers are encouraged to write all Medicaid and HMK *Plus* prescriptions to the designated pharmacy)
- Psychiatric Residential Treatment Facilities
- Psychologists
- School-based services
- STD testing and treatment
- Substance dependency treatment
- Therapeutic Foster Care
- Transportation (commercial and specialized non-emergency)

Passport and Emergency Services (ARM 37.86.5110)

Passport providers must provide **direction** to members in need of emergency care 24 hours each day, 7 days a week. For more information on direction, education, and suitable coverage for emergency care, see the *Passport to Health Provider Handbook*.

- **Emergency services provided in the ED.** Passport provider approval is not required for emergency services. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Non-emergencies in the ED will not be reimbursed, except for the screening and evaluation fee and any appropriate imaging and diagnostic services that are part of the screening. For more information, see Emergency Services on the Montana Medicaid Provider Information [website](#) or in the Medicaid billing manual for your provider type.
- **Post stabilization and Passport.** Services for members admitted through an emergency room (identified by the presence of Revenue Code 45X or 65X on the claim) will be exempt from Passport requirements and from cost share requirements.

Passport and Indian Health Services

Members who are eligible for both Indian Health Service (IHS) and Medicaid may choose an IHS or other provider as their Passport provider. Members who are eligible for IHS do not need a referral from their Passport provider to obtain services from an IHS. However, if IHS refers the member to a non-IHS provider, the Passport provider must provide a referral or Medicaid will not pay for the services.

Complaints and Grievances

Providers may call Provider Relations to report a complaint that something inappropriate has taken place. A grievance is a written complaint and must be addressed to the Passport Program Officer. See the *Passport to Health Provider Handbook* for a full review of complaints, administrative reviews and fair hearings.

Getting Questions Answered

Important phone numbers and addresses are found on the [website](#). Provider and member help lines are available to answer almost any Passport or general Medicaid question. Providers may call Provider Relations to discuss any problems or questions regarding your Passport members, or to enroll as a Passport provider. Providers can keep up with changes and updates to the Passport program by reading provider notices, newsletters, and other information at the [Passport to Health](#) link on the Montana Medicaid Provider Information website. For claims questions, call Provider Relations.

Becoming a Passport Provider (ARM 37.86.5111–5112)

A primary care provider (PCP) can be a physician, primary care clinic, or mid-level practitioner (other than a certified registered nurse anesthetist) who provides primary care case management by agreement with the Department. The Department allows any provider who has primary care within his/her professional scope of practice to be a PCP. The Department does, however, recognize that certain specialties are more likely to practice primary care. The Department actively recruits these providers. In addition to fee-for-service reimbursement, Passport providers receive a primary case management fee of \$3.00 per month per month.

To enroll in Passport, Medicaid providers must complete and sign a Passport provider agreement. The Passport provider agreement and the *Passport to Health Provider Handbook* are available on the Provider Information [website](#). Providers may also call Provider Relations for information on becoming a Passport provider and to get the Passport provider agreement.

Solo Passport Provider

A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The solo provider is listed as the member's Passport provider. The solo provider is responsible for managing his/her individual Passport caseload. For details on referral documentation, see Passport Referral and Approval in this section of the manual. Case management fees are paid to the individual provider under the solo provider's Passport number in addition to the fee-for-service reimbursement.

Group Passport Provider

A group Passport provider is enrolled in the program as having one or more Medicaid providers practicing with one Passport number. The group name will be listed as the member's Passport provider and could be a private group clinic, rural health clinic, federally qualified health center, or IHS clinic. All participating providers sign the Passport agreement group signature page and are responsible for managing the caseload. As a group provider, members may visit any provider within the group practice without a Passport referral. Case management fees are paid to a group under the group Passport number in addition to the fee-for-service reimbursement.

Passport Tips

- Verify the member's Medicaid eligibility and Passport provider at each visit before treating the member by going to the [MATH web portal](#) or by using one of the other methods described in the Member Eligibility and Responsibilities chapter of this manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not the member's Passport PCP, include the Passport PCP's Passport approval number on the claim, or it will be denied.
- The same cost sharing, service limits, and provider payment rules apply to Passport and non-Passport Medicaid members and services.
- For claims questions, refer to the Billing Procedures chapter in this manual, or call Provider Relations.