Passport to Health

Mission Statement: Our mission is to manage the delivery of healthcare to Montana Medicaid and Healthy Montana Kids (HMK) Plus members to improve quality and access, while optimizing the use of healthcare resources.
What is Passport to Health?

- The Passport program provides primary care case management related services that include locating, coordinating, and monitoring primary healthcare services.
- Most services must be provided or approved by the member’s Passport provider.
- Passport providers provide primary care, preventive care, health maintenance, treatment of illness and injury, and coordinate members access to medically necessary services (including specialists) by providing referrals.
Passport Program Goals

- **Ensure access** to primary care;
- Establish a **partnership** with the member;
- Provide **continuous and coordinated care** to maximize health outcomes;
- Improve the **continuity of care**;
- Encourage **preventive** healthcare;
- Promote Early and Periodic Screening Diagnosis, and Treatment (**EPSDT**) services;
- **Reduce inappropriate use** of medical services and medications;
- **Decrease** non-emergent care in the emergency room (**ER**); and
- **Reduce and control** healthcare costs.
How is Patient Care Managed?

- Primary Care Provider’s (PCP) Office
  - Passport to Health
    - Health Improvement Program
  - Nurse First
    - Team Care
Who can Participate?

✓ The following provider types are eligible to participate in the Passport program:
  ✓ General Practice;
  ✓ Family Practice;
  ✓ Pediatrics;
  ✓ Certified Nurse Specialist;
  ✓ Physician Assistant;
  ✓ Group/Clinic;
  ✓ Indian Health Service (IHS); and
  ✓ FQHC/RHC.

✓ All other provider types interested in participating must agree to provide primary care services and referrals for members and be approved by the Department.
Passport Enrollment

✔ To enroll in the Passport program, providers must meet the following criteria:
  ✔ Enroll or be enrolled as a Medicaid provider;
  ✔ Provide primary care services; and
  ✔ Sign a Passport provider agreement;

✔ The Passport agreement and other Passport information are available at http://medicaidprovider.mt.gov/passport.

✔ Providers may enroll as a group or solo Passport provider.
  ✔ A solo Passport provider is enrolled in the program as an individual provider with one Passport number. The individual is listed as the member’s Passport provider and is responsible for managing their own caseloads. The solo provider is who the member will see for services.
  ✔ A group Passport provider is enrolled in the program as having more than one Medicaid provider practicing under one Passport number. The group name is listed as the member’s Passport provider. All providers within the group are responsible for managing the caseload. Members may visit any provider within the group without a Passport referral.
Member Elements to a Medical Home

- Members choose one designated primary care provider (e.g., physician, mid-level, IHS, or clinic) to coordinate care;
- Access to the Member Help Line available 8-5 M-F at (800) 362-8312;
- Member outreach and education;
- Member guide; and
- Member website
Provider Elements to a Medical Home

✓ $3 per member per month case management fee;
✓ Monthly member lists (enrollment/disenrollment);
✓ Receive faxed triage reports from Nurse First;
✓ Access to the Provider Help Line: (800) 624-3958;
✓ Access to the Passport Provider Lead: (406) 457-9558;
✓ Passport provider manual;
✓ Provider website www.medicaidprovider.mt.gov; and
✓ Claims history via Montana Access to Health (MATH) web portal.
Passport Provider Requirements

✓ Provide primary healthcare, preventive care, health maintenance, and treatment of illness and injury;

✓ Make reasonable appointment availability based on routine, preventive, urgent, or emergent care needs during posted normal business hours;

✓ Provide for arrangements with or referrals to physicians or other specialists to ensure access to necessary care during normal business hours without compromising quality, promptness, or member provider preference;

✓ Educate about appropriate use of the ER; and

✓ Work with Health Improvement Program (HIP) care managers.

✓ Provide an appropriate and confidential exchange of information among providers, including the HIP program.

✓ Passport providers must provide direction to members in need of emergency care 24/7/365.

✓ Maintain a unified patient medical record for each Passport member, including referrals given or received.

* This is not an all inclusive list.
Passport Provider Changes/Terminations

- Providers are required to notify Conduent of changes to:
  - Member enrollment restrictions (age, gender, caseload);
  - Address;
  - Phone/fax number;
  - Ownership;
  - Business hours; or
  - Providers who are participating under a group Passport number.

- Providers must give written notice to members and the Department at least 30 days prior to the disenrollment/termination date;

- During the 30 days providers must continue to treat or provide referrals for members to ensure continuity of care;

- Changes should be sent to:
  
  Passport to Health Program
  PO Box 254
  Helena, MT 59624-0254
  Fax: 406-442-2328
Provider Caseloads

✓ Providers are encouraged to contact new members to establish care;
✓ Providers may serve as many as 1,000 members per full-time primary care provider;
✓ Providers can suggest that a member change their Passport to them, but they cannot require it;
✓ Once capacity is reached providers have the opportunity to increase their caseload; and
✓ Providers at capacity may have members auto-assigned to them but members will not be able to voluntarily choose them until there are open slots.

✓ To increase caseload capacity send a written request to:
  
  Passport to Health Program
  PO Box 254
  Helena, MT 59624-0254
  Fax: 406-442-2328
Providing Passport Referrals

✓ In most cases, care should start with and be coordinated by the Passport provider;
  • The member’s access to care, whether or not the member has established care, is the Passport provider’s responsibility;

✓ Referrals should be for medically necessary services and given when:
  • There is an urgency that the Passport provider cannot meet;
  • There is a need for services to be performed by someone other than the Passport provider; or
  • Further testing or treatment is needed.
Receiving Passport Referrals

✓ Referrals should be requested **prior** to providing the service(s).
  • It’s OK for the Passport provider to deny a service if it is not emergent and the member is able to see their Passport provider.

✓ Passport referrals and prior authorization are different and some services require both; and
  • Not all services require Passport referral.
  • See the current fee schedule for your provider type to determine what services require Passport referral.

✓ Service limits are the same for Passport members and non-Passport members.
Establishing Care and Referrals

✓ Some examples in which referrals are needed in order to ensure access to medically necessary care even if care hasn’t been established:

  • Member has moved;
  • Member is sick or hurt and far from home;
  • Member is sick or injured and the PCP is unable to see them promptly; and
  • Follow-up care with doctor seen initially through an emergency admittance and surgery.
Referral Tips

✓ You must receive or provide a Passport provider referral for a specific member, service(s), and date(s);
  • Referrals may be for one visit, a specific period, or the duration of a condition. Passport providers may not give their Passport number for “blanket” referrals (any member for any service).
  • Referrals may be provided by the Passport provider or designated office staff.
  • Referrals that require medical judgement must be initiated by a medical professional.

✓ If you do not receive the referral, Medicaid will deny the service if Passport is required;

✓ Once a referral is given, the member cannot be referred to another provider without another referral; and

✓ A facility or non-Passport provider is not authorized to pass on or store a Passport referral number.
  • If a provider suspects their Passport number is being used without authorization they are encouraged to contact the Program Officer.
## Services Exempt From Passport Referral

- Ambulance
- Anesthesiology
- Audiology
- Blood testing
- Case management
- Dental
- Dialysis
- DME
- Emergency
- Eye exams and glasses
- Family planning
- Hearing aids and exams
- Home and Community Based Services (HCBS)
- Home infusion therapy
- Home support and therapeutic foster care
- Hospice
- Hospital swing bed
- Immunizations
- Inpatient lab and x-ray
- Inpatient professional
- Intermediate care facility
- Institution for mental disease
- Lab/Pathology tests
- Mental health (Social worker, professional counselor, psychologist, psychiatrist)
- Mental health center
- Nursing facilities
- OB (inpatient and outpatient)
- Optometrist or ophthalmologist
- Personal assistance
- Pharmacy
- PRTF
- Psychiatrist
- Radiology
- School-based
- STD testing and treatment
- Substance dependency treatment
- Transportation
Passport and American Indians

- American Indian members may choose an IHS to be the PCP, or they may choose a PCP other than an IHS;
- American Indian members may visit any IHS provider without a Passport referral; and
- If a member goes to an IHS and is referred to a third provider, the Passport provider must still provide a referral.
Billing Medicaid Members

✓ To bill a member there must be a signed private pay agreement in advance of providing services (ARM 37.85.406).

✓ Members may be billed for:
  • Non-covered services;
  • Covered but medically unnecessary services;
  • Unable to get Passport referral;
  • Services received when the member is not accepted as a Medicaid member; and
  • Copayments.

✓ Members cannot be balance billed for the difference in the provider’s charges and the Medicaid allowed amount.

✓ Co-pays or bills owed should not affect the Passport relationship.
Member Enrollment and Education

✓ A member’s enrollment in Passport is driven mainly by their eligibility;
  • Approximately 75% of members are enrolled in Passport.
✓ The whole family can have the same Passport provider or everyone can have a different Passport provider based on individual medical needs;
✓ Members may change their Passport provider once a month, but the change will not be effective until the following month; and
✓ Upon enrollment, members receive an enrollment packet as well as a verbal explanation of the Passport program.
Member Auto-Assignment

✓ Passport auto-assigns members to an appropriate provider after 45 days, if they do not choose a provider themselves.

  • Algorithm (in order):
    • Previous Passport enrollment;
    • Claims history;
    • Family Passport enrollment (child/adult);
    • American Indians who have declared a tribal enrollment, and live in a county where there is an IHS/tribal provider; and
    • Random provider who has open slots on their caseload.

✓ Members who are auto-assigned are notified at least 10 days in advance to allow members to select a different provider.
Members Ineligible for Passport

✓ The following member populations are ineligible for Passport:
  • Members in a nursing home or other institutional setting;
  • Dual eligible members (Medicare/Medicaid);
  • Medically needy members (spend-down);
  • Members receiving Medicaid for less than 3 months;
  • Members eligible for Medicaid adoption assistance or guardianship;
  • Members with retroactive eligibility;
  • Members who receive HCBS;
  • Members residing out of state;
  • Members who are eligible for a non-Medicaid plan (Plan First, HMK/CHIP); and
  • Members with presumptive eligibility.
Disenrolling a Passport Member

Providers **may** disenroll members for the following reasons:

- The member has not established care or is seeking care from other providers;
- The patient/provider relationship is mutually unacceptable;
- The member fails to follow prescribed treatment;
- The member is physically or verbally abusive;
- Member could be better treated by a different type of provider, and a referral process is not feasible; and
- Member consistently fails to show up for appointments.
A Provider may not Disenroll a Member due to:

✓ An adverse change in the member’s health status;
✓ Member’s utilization of medical services;
✓ Member’s diminished mental capacity;
✓ Member’s disruptive or uncooperative behavior as a result of special needs;
✓ Member’s inability to pay a co-pay or outstanding bill; or
✓ Any reason that may be considered discrimination (race, age, sex, religion, etc.).
Disenrollment Process

- If you disenroll a member, **you must**, per the signed Passport agreement:
  - Send a notification letter to the member at least 30 days prior to disenrollment;
    - Verbal notification to the member does not constitute disenrollment.
    - Letters must: Identify the member as your Passport patient, specify the reason for disenrollment, and indicate notification of continuing care for 30 days.
  - Continue to provide patient treatment and/or Passport referrals for up to 30 days; and
    - The provider’s 30-day care obligation does not start until a copy of the disenrollment letter is received by Conduent.
- Send a copy of the letter to Passport to Health:
  Passport to Health Program
  PO Box 254
  Helena, MT 59624-0254
  Fax: 406-442-2328
Team Care
Team Care Basics

• Team Care is the restricted services program.
  ✓ Identical to Passport except Team Care adds the restriction to one pharmacy.

• All Passport Rules apply.
  ✓ Some additional rules apply to Team Care enrolled members.
    ✓ When a provider or pharmacy change is requested, per Team Care rules, it must be in writing and the Department determines if it is for a good reason.

• A team coordinates care.
Team Care – Members

• Members may be added for overutilization of services (e.g. multiple ER visits for non-emergent services);
• Restricted to one provider and one pharmacy;
  ▪ Change request must be in writing.
• The member will remain in Team Care for a minimum of 12 months;
• Receive self-care guides; and
• Are encouraged to use the Nurse First Advice Line available 24/7/365.
Team Care Referral Form

Team Care is the Montana Medicaid and HMK Plus lock-in program for members who have a history of using Medicaid or HMK Plus services at an amount or frequency that is not medically necessary. If you would like to refer a member whom you believe is appropriate for Team Care, please provide the following information.

Provider Name: ________________________  Provider NPI Number: ________________________

Provider Phone: ________________________  Provider Fax: ________________________

Member Name: ________________________  Medicaid ID: ________________________

Date of Birth: ________________________

Reason for referral:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Referring Provider Signature: ________________________  Date: ________________________

Reply to: Phone: 1-800-362-8312
Fax: (406)442-2328 or Montana Health Care Programs, Member Help Line
PO Box 254
Helena, MT 59624-0254

For more information about Team Care, contact the Montana Health Care Programs, Member Help Line at 1-800-362-8312 or log on to our website at www.mtmedicaid.org
Team Care
Provider/Pharmacy Change Form

*Must be signed by Montana Medicaid member
Team Care – Providers

- $6 per member per month case management fee;
- Receive monthly member lists (enrollment/disenrollment);
- Receive faxed triage reports when members call Nurse First Advice Line;
- May use pharmacy case management clinicians and HIP care managers to help develop treatment plans;
- Encouraged to write prescriptions to a member’s lock-in pharmacy;
- Review the Prescription Drug Registry for usage; and
- PCP/Pharmacy change request can be found on the Team Care page at: http://medicaidprovider.mt.gov/teamcare.
Team Care – Pharmacists

- Keep record of most Medicaid Rx claims in one pharmacy;
- Access to Prescription Drug Registry for usage and FlexibleRx (Point-of-Sale Drug Processing System); and
- Coordinate with pharmacy case management clinicians.
Team Care and American Indians

• May be assigned to IHS or non-IHS provider;
• May visit any IHS provider without Passport/Team Care referral; and
• May receive medications from any IHS pharmacy when locked into a different pharmacy.
Team Care – Referrals

- Drug utilization review;
- Claims data mining;
- Provider referrals;
- Fraud/Abuse referrals;
- HIP care management referrals; and
- Claims analysis for overutilization (e.g., Emergency Room visits, for non-emergent visits).
Nurse First
1-800-330-7847
Free, confidential health advice
24 hours a day, 7 days a week.
Montana Medicaid and Healthy Montana Kids
Nurse Advice Line

✓ No cost to Montana Medicaid members;
✓ Nurse First Advice Line is available 24/7/365;
✓ Callers are triaged by registered nurses for illness or injury and receive health, disease, and medical advice;
✓ Passport providers are faxed a triage report after a member calls the Nurse First Advice Line; and
✓ Encourage your members to call before seeking treatment: **1-800-330-7847**.
For online health and wellness information, go to dphhs.mt.gov/MontanaHealthcarePrograms.aspx

Select **Additional Health and Wellness information** where you can search for medication and health information on more than 4,000 topics.
Montana Medicaid
Health Improvement Program

A team-oriented approach to care management and chronic disease prevention.
What is the Health Improvement Program?

- Provides care management to high-risk and high-cost members, or others as approved by the Department;
- Designed to prevent or slow the progression chronic diseases, disability or other health conditions; and
- Aims to improve the quality of life and reduce costs.
- Care management is in addition to the care they receive from their Passport provider.
- Passport providers are encouraged to work with HIP care managers and the member in order to produce better health outcomes; and
- Care managers will ask for updated information from PCPs regarding members who have chosen to be part of HIP.
  - Including demographic information, updated contact information, and recent health records.
Who is Eligible and how are Members Identified?

- All members in Passport are eligible for HIP unless their Passport provider is a PCMH or CPC+ provider;
- Members are identified as high risk through predictive modeling software;
- Predictive modeling software uses claims history and demographic information to determine future risk by looking at the entire person and their healthcare needs and utilizations rather than only focusing on certain conditions.
MEDICAID AND HEALTHY MONTANA KIDS (HMK) PLUS HEALTH IMPROVEMENT PROGRAM (HIP)

PROVIDER REFERRAL FORM

The Health Improvement Program (HIP) services Passport to Health Medicaid and HMK plus members with chronic illnesses or those at risk of developing serious health conditions. Your current Passport to Health members will stay with you for primary care, but are eligible for care management through one of the participating health centers. HIP service providers are Community and Tribal Health Centers. Members who are eligible for the Passport to Health Program are enrolled and assigned to a health center for possible care management. Nurses and health coaches certified in professional chronic care may:

- Conduct health assessments;
- Work with you to develop care plans;
- Educate members on 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.

Montana uses predictive modeling software to identify chronically ill members. This software uses medical claims, pharmacy claims 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. If you have a Passport to Health member at high risk for chronic health conditions who would benefit from care management, complete the following form and fax to:

Health Improvement Program Officer
406-444-1861 (fax)

<table>
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<tr>
<th>Today's date</th>
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<tbody>
<tr>
<td>Referring provider name</td>
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<td>Referring provider address</td>
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<td>Referring provider telephone number</td>
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<td>Member address</td>
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<td>Member telephone number</td>
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<td>Medicaid/HMK Plus member ID number</td>
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<td>Member parent/guardian (if applicable)</td>
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<td>Chronic disease(s) for which member is at risk</td>
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<tr>
<td>Referring provider care goals for member</td>
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<td>Referring provider signature</td>
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Who Provides HIP Services?

- Care managers employed by community and tribal health centers throughout the state;
- There are 14 participating centers to service all 56 counties; and
- Care managers serve all members eligible for HIP, regardless of Passport assignment.
14 Community and Tribal Health Centers will service all 56 counties. Care Managers (Nurses and Health Coaches) will be available through the CHCs via telephone and in-person. Access will be less than 200 miles for every eligible client. Nurses and Health Coaches will also travel to clients as needed and as weather and road conditions permit.
What Services are Provided?

✓ Health assessments;
✓ Ongoing clinical assessments;
✓ Treatment plans developed in coordination with member and Passport provider;
✓ Pre-discharge planning and coordination; and
✓ Post-discharge visits.
What Services are Provided?

✓ Education and support for members in self-management;
✓ Optional group appointments (cooking classes, lifestyle/wellness classes, etc.);
✓ Tracking and documenting progress through phone calls and in person visits; and
✓ Assistance with and referrals to local resources for housing, transportation, or other social determinants.
Comprehensive Primary Care Plus (CPC+)
Comprehensive Primary Care Plus (CPC+) – Introduction

- What is the CPC+?
- Who are the providers?
- Which members are included?
- How does it affect other Medicaid programs?
What is CPC+?

• An advanced primary care medical home model that rewards value and quality through innovative payments that support comprehensive care.

• An initiative developed by CMS that transitions Medicare fee-for-service to value-based payments in collaboration with Medicaid and commercial payers.

• Montana was 1 of only 14 regions in the country selected to participate in this 5-year demonstration that will improve primary care in our state; 7 additional regions will join CPC+ in 2018.

• Blue Cross Blue Shield of Montana and PacificSource have also partnered with Medicaid and Medicare in this model; Allegiance will join the Montana CPC+ program in 2018.
51 Montana Practices Signed up with CMS to participate in CPC+

<table>
<thead>
<tr>
<th>City</th>
<th># of Practices</th>
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<tbody>
<tr>
<td>Missoula</td>
<td>8</td>
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<tr>
<td>Billings</td>
<td>8</td>
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<tr>
<td>Great Falls</td>
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<td>Kalispell</td>
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<td>Helena</td>
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<td>Stevensville</td>
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<td>Butte</td>
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<td>Belgrade</td>
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<td>Laurel</td>
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<td>Red Lodge</td>
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Missoula: Total 8

Billings: Total 8

Great Falls: Total 6

Bozeman: Total 2

Kalispell: Total 5
Populations Included in CPC+

✓ All Passport members
✓ Passport exempt:
  • Members with State assigned hardship (members who are usually excluded from Passport due to referral process making coordination of care difficult)
  • Treatment center exemptions
✓ Waivers
  • SDMI
  • Autism (667 Waiver)
  • DDP 0208 (DD Comprehensive Waiver)
  • Big Sky Waiver (SLTC Waiver)
✓ Former Foster Care-FC (members over 18 but under 26)
✓ Subsidized Adoption
✓ Nursing Home residents
✓ Montana State Hospital residents paid by Medicaid
CPC+ Effects on Existing Medicaid Programs

**Waivers:** CPC+ care management will not replace or interfere with the case management provided to members in the waiver programs: SDMI, Autism (667), DDP 0208 (DD Comprehensive Waiver), Big Sky Waiver (SLTC Waiver).

**Health Improvement Program (HIP):** Members attributed to a CPC+ clinic will NOT be eligible for HIP because it would be duplicative services since CPC+ clinics are expected to provide care management.

**Patient-Centered Medical Home (PCMH):** Clinics cannot be both a PCMH and CPC+, they have to choose one program. Medicaid’s PCMH program will continue separately, adjust to align with CPC+, and hopefully expand to more clinics in mid-2017.
CPC+ Effects on Existing Medicaid Programs

- **Passport to Health and Team Care:** Providers with members in Passport or Team Care must still follow all the same program rules and the members will still receive the program benefits but the CPC+ payments will replace the capitation payments for these programs.

- **Passport to Health:** Members enrolled with a Passport provider becoming a CPC+ provider that is part of a multi-clinic health system will see a change.
  - If their Passport provider was Billings Clinic, CPC+ will assign them to a specific clinic within the Billings Clinic health system, such as *Billings Clinic Heights*.
  - Starting January 2017, the member can only go to the specific clinic within the system that they are assigned. Each clinic within CPC+ health systems has separate Passport numbers for CPC+. If members are seen at another clinic or by another provider within the same health system, Passport referrals will be needed.
Member Care Management Contacts

Passport to Health/HIP
Amber Sark
444-0991
asark@mt.gov

Team Care
444-0991
asark@mt.gov

Nurse First
444-4455

PCMH/CPC+
Amanda Eby
444-1292
aeby@mt.gov

Nurse First Advice Line
1-800-330-7847

Medicaid Member Help Line
1-800-362-8312

Provider Help Line
1-800-624-3958

Drug Prior Authorization Unit
1-800-395-7961

Visit our website at:
http://medicaidprovider.mt.gov/