

Primary Care Provider Workshop

September 21, 2011

Our mission is to improve the health and quality of life of our members

Agenda

- Organizational Updates
- Passport Health Plan & Passport Advantage Plan Successes
- Passport Health Plan & Passport Advantage Plan Updates
- Health Management Overviews
 - Case Management
 - Pharmacy
- 2011 Member Satisfaction Survey Results
- Passport Advantage - 2012
- Provider Website Resources
- Questions & Answers

About Us

Passport Health Plan is a Medicaid managed care plan that serves the Medicaid and KCHIP population in 16 counties of the Commonwealth of Kentucky.

The Plan was established in 1997 by a group of providers with a history of caring for Medicaid members. Those providers include:

- The University of Louisville Medical School Practice Association
- The University of Louisville Hospital
- Jewish Hospital & St. Mary's Healthcare
- Norton Healthcare
- The Louisville/Jefferson County Primary Care Association, which includes the Jefferson County Health Department and Louisville's two federally qualified health centers – Family Health Centers and Park DuValle

Organizational Updates

Provider Relations Department

- In early 2011, the Provider Relations department underwent some structural changes:
 - Management Team:
 - **Tim Doss**, Vice President of Operations
 - **Peg Patton**, Associate Vice President of Provider Network Management
 - **Jennifer Ecleberry**, Senior Manager of Provider Relations
 - Provider Relations Representative territory assignments have been revised to better serve you.

Passport Health Plan has moved!

In August 2011, Passport Health Plan moved to a new office building in Southern Jefferson County. Our new address is:

Passport Health Plan

5100 Commerce Crossings Drive

Louisville, KY 40229

502/585-7900 (Phone)

502/585-6060 (Fax)

Passport Health Plan Senior Leadership Team

There are several new faces on the PHP Senior Leadership Team. We are proud to introduce our Leadership team to you.

William B. Wagner, MSSW
Chairman of the Board

Bill is the Executive Director of Family Health Centers, Inc., with over 30 years experience in health care. He is one of Passport Health Plan's founders, has served on the Partnership Council since 1998, and now serves as our Interim Chairman of the Board.



Mark B. Carter
Chief Executive Officer

Mark has worked in the health care industry for over 31 years, at Dean Dorton Allen and Ford, Jewish Hospital and St. Mary's Healthcare and others. He serves as our Chief Executive Officer.



Jill Joseph Bell

Vice President and Chief Communications Officer

Jill has served in various roles at Passport Health Plan since 1998. She is responsible for Communications, Community Outreach, Member Services and Government Relations.



Loree Ching

Associate Chief Financial Officer

Loree is a Certified Public Accountant with more than 24 years experience in Accounting, with over 15 years experience as a leader in Healthcare finance. Her responsibilities include financial functions in the areas of internal auditing, statutory filings, and investments. Ms Ching is also an active participant with the Board of Directors and related Committees.



Tim Doss

Vice President of Operations

Tim rejoined Passport Health Plan during 2010 after 10 years with Humana. Tim has overall responsibility for plan operations and is leading the transition from AMHP to PHP.



David Henley

Vice President and Chief Compliance Officer

David is an attorney and retired United States Army captain who comes to us from Wellpoint in St. Louis, where he focused on corporate compliance. He is responsible for our corporate compliance.



Stephen J. Houghland, M.D.

Vice President and Chief Medical Officer

Steve is an Internist and currently serves as an Associate Professor of Medicine at the University of Louisville. He is responsible for our Medical Management programs.



Mary Kay Jett

Vice President of Human Resources

Mary brings over 20 years of executive business and HR experience in the healthcare, financial and technology industries. She is responsible for Human Resources.



Peg Patton

Associate Vice President, Provider Network Management

Prior to joining Passport Health Plan, Peg served in regional roles for various national payors. She is responsible for Provider Network Management including Provider Relations, Network Development, Reimbursement, Credentialing, and Provider Communication.

**Christie Spencer**

Vice President of Clinical Operations

Christie is a highly accomplished and innovative health care executive who comes to Passport from RxCrossroads here in Louisville. She is responsible for providing leadership, direction and strategic vision for all medical management functions.

**David A. Stanley**

Vice President and CFO

David has more than 30 years of financial experience in the healthcare setting. He is responsible for all financial functions of the Plan.



Passport Health Plan Re-Branding Initiative

Managed Medicaid in Kentucky

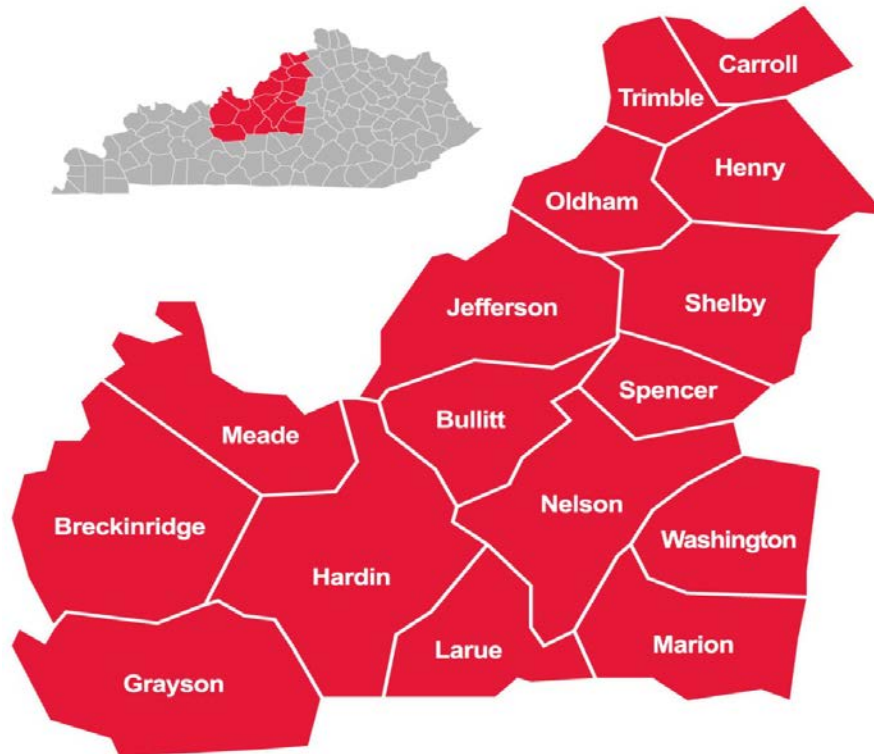
Managed Medicaid in Kentucky

- Effective October 1, 2011, 3 new managed care organizations will enter the managed Medicaid market throughout the state of Kentucky :
 - ✓ CoventryCares of Kentucky,
 - ✓ Kentucky Spirit Health Plan, and
 - ✓ WellCare of Kentucky.
- Passport Health Plan will continue to be the exclusive managed care organization in Region 3 of Kentucky.
 - Region 3 includes Jefferson County and the 15 surrounding counties.

Managed Medicaid in Kentucky

If you need guidance on the managed Medicaid initiative outside of Region 3, please reference the newly established DMS website for managed care:

<http://medicaidmc.ky.gov/Pages/index.aspx>



PHP and PAD Plan Successes

Passport Health Plan

NCQA Survey & Ranking

- Ranked as the 13th best Medicaid health plan in the country by the National Committee for Quality Assurance (NCQA).
 - NCQA's Insurance Plan Rankings 2011-2012 - Medicaid
- Recently completed the NCQA survey for renewal of our Excellent Accreditation status for the 9th year in a row. Final results are still pending, but preliminary results are very positive.

Plan Accomplishments

- The PHP Outreach Department participated in **over 500 events in 2010**, including Heartland Festival, Ham Days, Back to School events, various Chamber of Commerce events, and faith based health fairs.
- Produced the **9th annual Cultural and Linguistic Services Conference**, *“Patient Centered Care: Achieving Cultural and Linguistic Competency in Healthcare”* for 185 attendees. CME’s and CEU’s offered.
- Executed **KCHIP awareness campaign** and assumed responsibility for coordinating coalition activities. Enrolled over 17,000 additional children in Medicaid or KCHIP.
- Provided **quarterly member education classes to newly resettled refugees**. Classes averaged 70 persons representing 7 languages.
- Conducted **member education classes to 11 homeless shelters** within the PHP region.

PHP Plan Updates

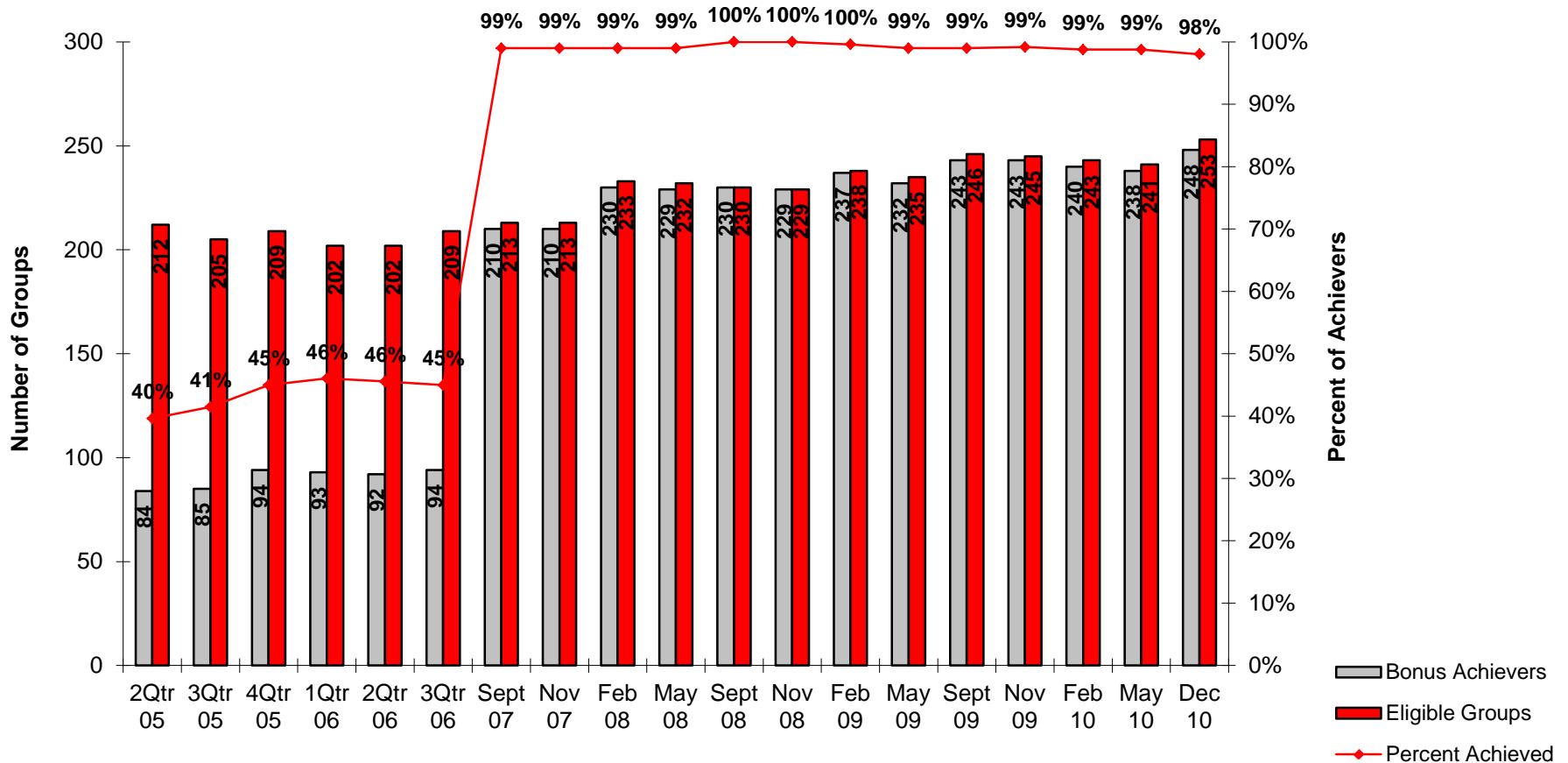
PCP Provider Recognition Program

The **PCP Provider Recognition Program** rewards providers who demonstrate improvement and/or excellence in performance in the following measures:

- PCP Profile
- EPSDT Screening Rate
- EPSDT Participation Rate
- Breast Cancer Screening
- Cervical Cancer Screening
- Chlamydia Screening
- ER Utilization
- Member Satisfaction

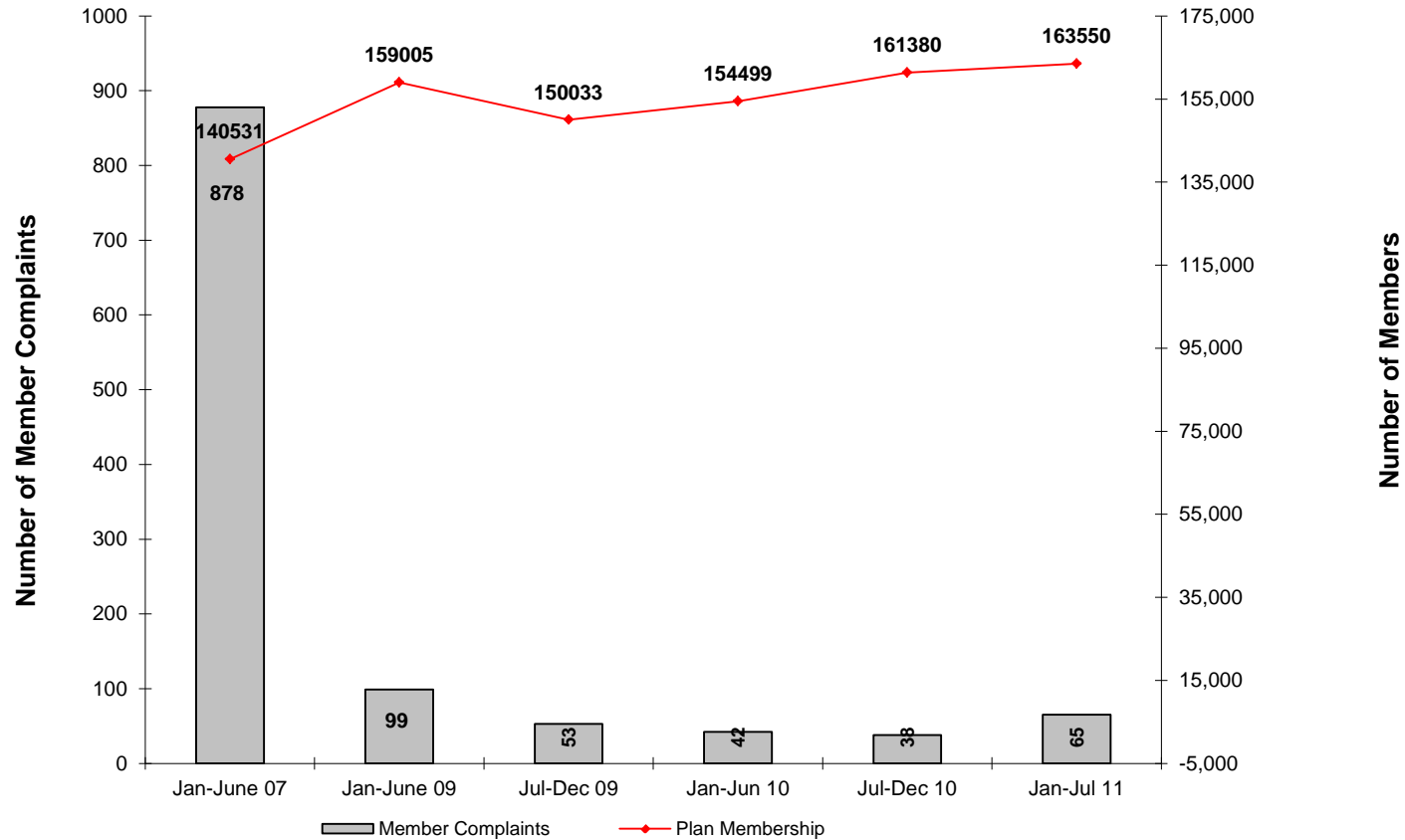
PCP PRP Results: 5-Year Overview

Overall Eligible Groups and Bonus Achievers



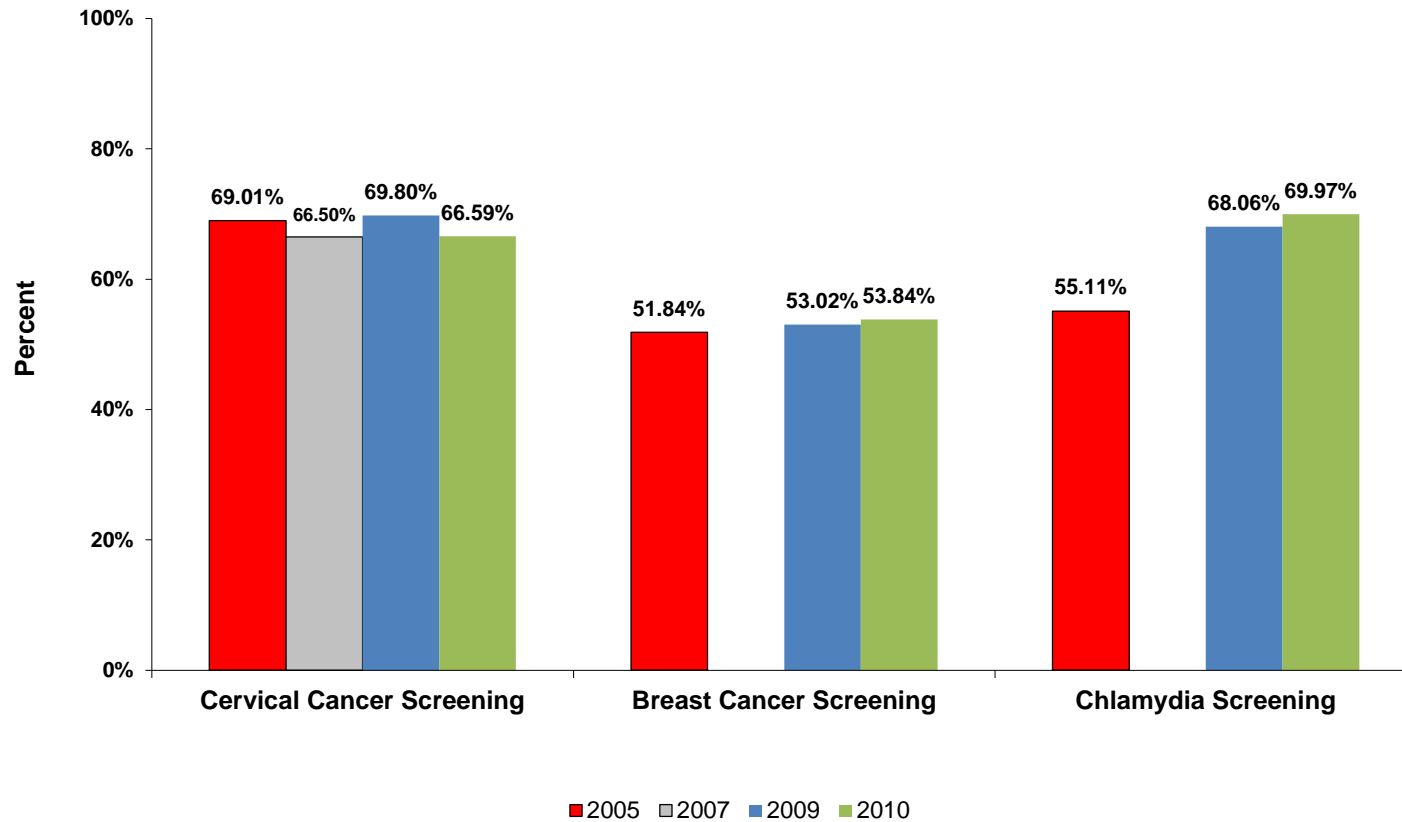
PCP Provider Recognition Program

Member Complaints Against PCPs and Plan Membership



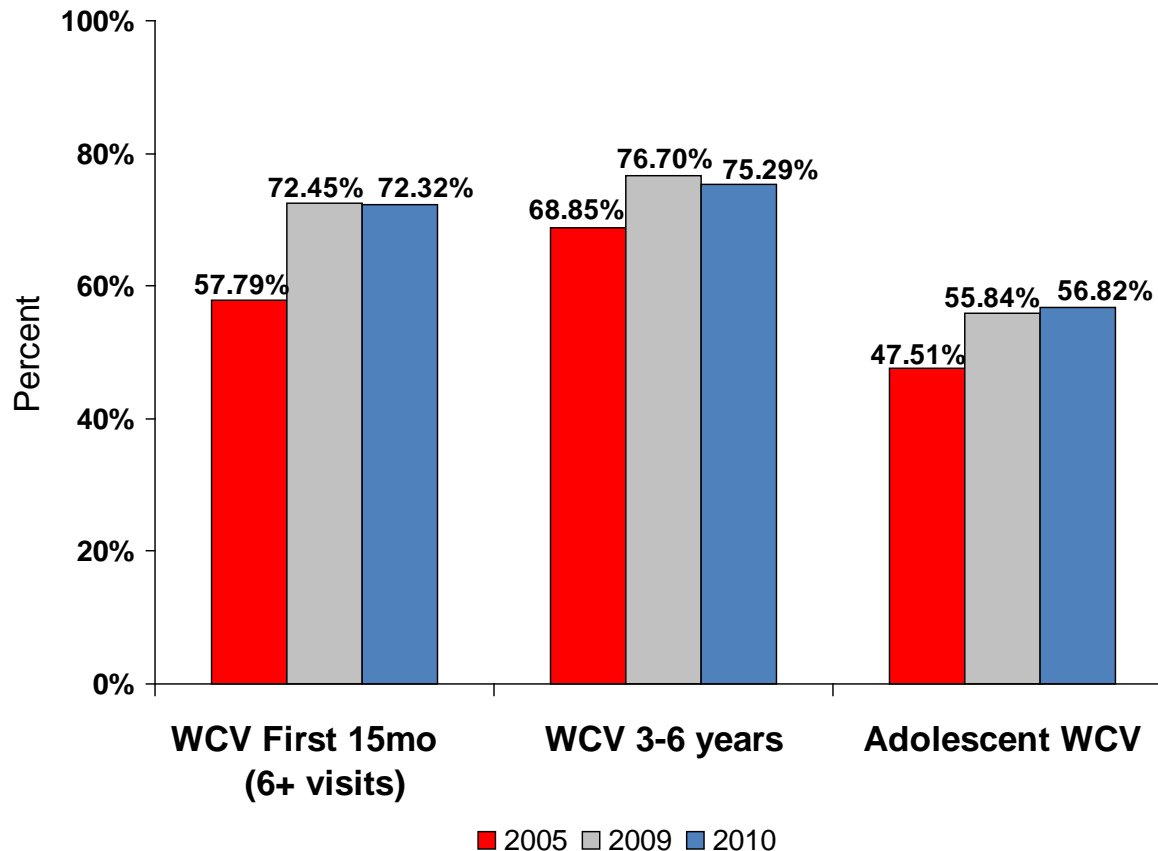
PCP Provider Recognition Program

Women's Health Outcomes have been fairly consistent since the inception of the program



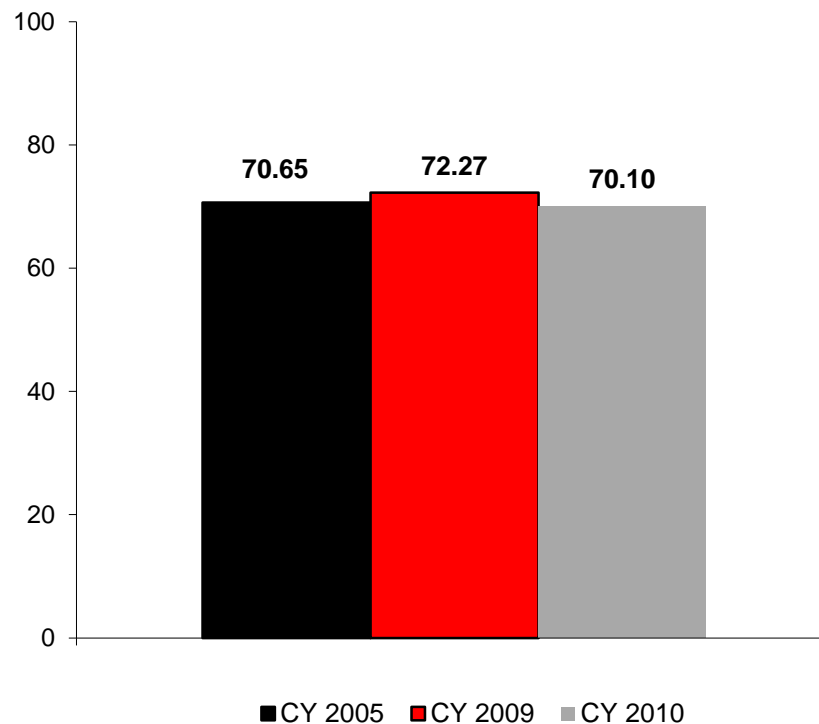
PCP Provider Recognition Program

Well Child Visits (WCV) have been consistent, with slight increases over time, since the inception of the program



PCP Provider Recognition Program

Impact on ER Utilization Plan rates per 1000/member months



PCP Provider Recognition Program

Guiding Principles of the Program

The PCP Provider Recognition Program steadily maintains its guiding principles:

1. Annual evaluation
2. Consideration of future measures
3. Provider partnership
4. Clinically relevant
5. Improve the health and quality of life of our members

For More Information or to Request a Training:

Call: your Provider Relations representative or the Provider Relations department at **(502) 585-7943**.

PCP Provider Recognition Program

- ❖ Watch for upcoming details about changes to the Recognition Program for 2012.

Goals for the 2012 Recognition Program:

- Shorten the window between the measurement period and the payout.
- Simplify program calculations.
- Remove and redesign ineffective measures.
- Allow more time for reconsiderations (medical record submissions).
- Incorporate new measures that are important to the Plan and to our membership.

EPSDT Changes

- The Plan historically required PCPs to submit an Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Form for reimbursement for these services.
- To ease the administrative burdens and improve the process, the EPSDT Screening Form was no longer required effective October 1, 2010.
- All EPSDT services will now be submitted as part of the standard electronic (837) or paper (CMS-1500) claims submission process.
- The Plan will conduct annual audits of submitted EPSDT claims to verify all elements of an EPSDT exam are completed and documented in the member's medical record.
- Our preliminary audit results indicate an increased need for awareness of EPSDT documentation requirements in the areas of growth charts, hearing and vision screens, and BMI calculation.

EPSDT Billing Requirements

- You must use comprehensive history and physical exam codes, 99381-99385* and 99391-99395** with an “EP” modifier to show all components of the appropriate EPSDT screening interval have been completed and documented in the member’s medical record.
*(New Patient Series) **(Established Patient Series)
- Also, you should render the following health evaluation services (according to the member’s age) and submit to the Plan using CPT Category II codes:
 - 3008F – to confirm a BMI has been performed and documented (ages two years and above).
 - 2014F – to confirm the member’s mental status has been assessed and documented (ages nine years and above).

Additional EPSDT Information

All other components of the EPSDT program remain unaffected by this claims processing change, including eligibility status and the EPSDT Periodicity Schedule.

Health Management Overviews

- Case Management
 - Pharmacy

Case Management Overview

- The Plan added a new program in late 2010 called “**Care Connectors.**”
- Designed to assist both members and providers. Examples of assistance:
 - Connect member with disease and case management programs
 - Connect members to special programs such as **Yes, You Can!** Smoking cessation or *Mommy & Me*
 - Answer members health questions
 - Schedule provider visits
 - Assist with scheduling transportation to medical appointments as needed
 - Remind members of upcoming medical appointments
 - Outreach to members after an Emergency Room Visit
 - Remind members about preventative health screenings such as Mammography and Cervical Cancer Screening
 - Assist with pharmacy problems such as prescription refills and prior authorizations
 - Assist members with finding available resources in their area
 - Evaluate barriers to care and working to eliminate the barrier
- The Care Connectors are available Monday – Friday, 8 a.m. to 6 p.m. at 1-877-903-0082.

Case Management Overview

- Case Management is available for members with complex medical conditions.
- Services include:
 - Comprehensive assessment of the member's physical and behavioral health;
 - Determination of available benefits and resources;
 - Identification/elimination of barriers to care; and
 - Development and implementation of a care management plan with performance goals, monitoring and follow-up.
- Developed in conjunction with the provider's treatment plan.
- To make a referral to Case Management, call 1-877-903-0082.

HEDIS® 2010 Results

Opportunities for improvement in the following measures:

- **Assessment of BMI in children and adolescents**
 - Must have a BMI **percentile** documented for children **up to age 15**
 - Must have BMI **value** documented for children **16 years of age and older**
- **Counseling for nutrition and physical activity for children, adolescents and adults**
 - Document all counseling in the medical record
- **Counseling for smoking, alcohol use, substance use, sexual activity, and mental health assessment for adolescents 12 years of age and older**
 - Document all counseling in the medical record
- **Testing for children with pharyngitis**
 - Perform group A streptococcus test and bill with specific streptococcus test CPT coding

HEDIS® 2010 Results

Opportunities for improvement in the following measures:

- Diabetes care
 - At least annual HbA1c testing
 - Good HbA1c control (<8%)
 - Annual dilated retinal exam
 - At least annual LDL-C testing
 - Good LDL-C control (<100 mg/dL)
 - Medical attention for nephropathy
 - Good blood pressure control (<140/90 mm Hg)

2011 HEDIS®

Well Child Exams for Ages 3 to 6

During our annual chart review process, we often identify instances in which child health exams were performed but not reported to the Plan via claim submission. Specifically, we observed the following:

- Situations in which a well child exam occurred in conjunction with a sick visit; however, the claim submitted contained only the diagnosis for the sick visit;
- Situations in which a well child exam occurred outside of the Plan's EPSDT periodicity schedule and as a result, no claim was submitted;
- Situations in which a well child exam occurred and primary carrier was billed for services rendered, but claim not submitted to PHP as secondary payer.

Well Child Exams are included in EPSDT bonus calculations for the Provider Recognition Program.

Pharmacy Overview

Passport Health Plan Outpatient Pharmacy Program

- Provides access to Medicaid-covered drugs and select diabetic supplies
- Medications may have step therapy, prior authorization, or ICD-9 requirements
- Emergency supply override for pharmacies
- Online Searchable Formulary
- Low or no copay for members

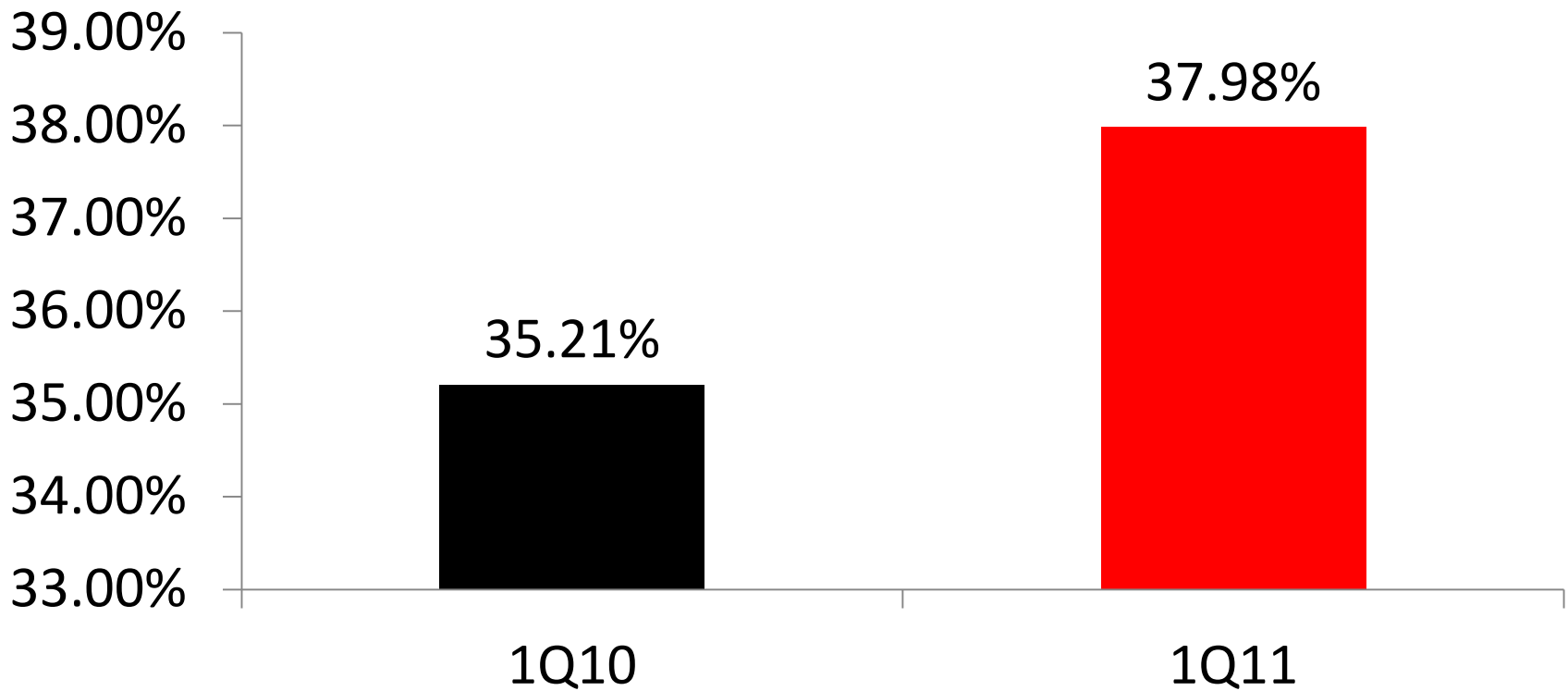
Pharmacy Overview

Passport Health Plan Pharmacy Utilization

- About 38% of PHP members use pharmacy benefits
- Average number of prescriptions pmpm = 1.2
- Generic use rate = 81.3%
- Pharmacy expenditures for 1Q11 have increased by 13.4% compared to 1Q10

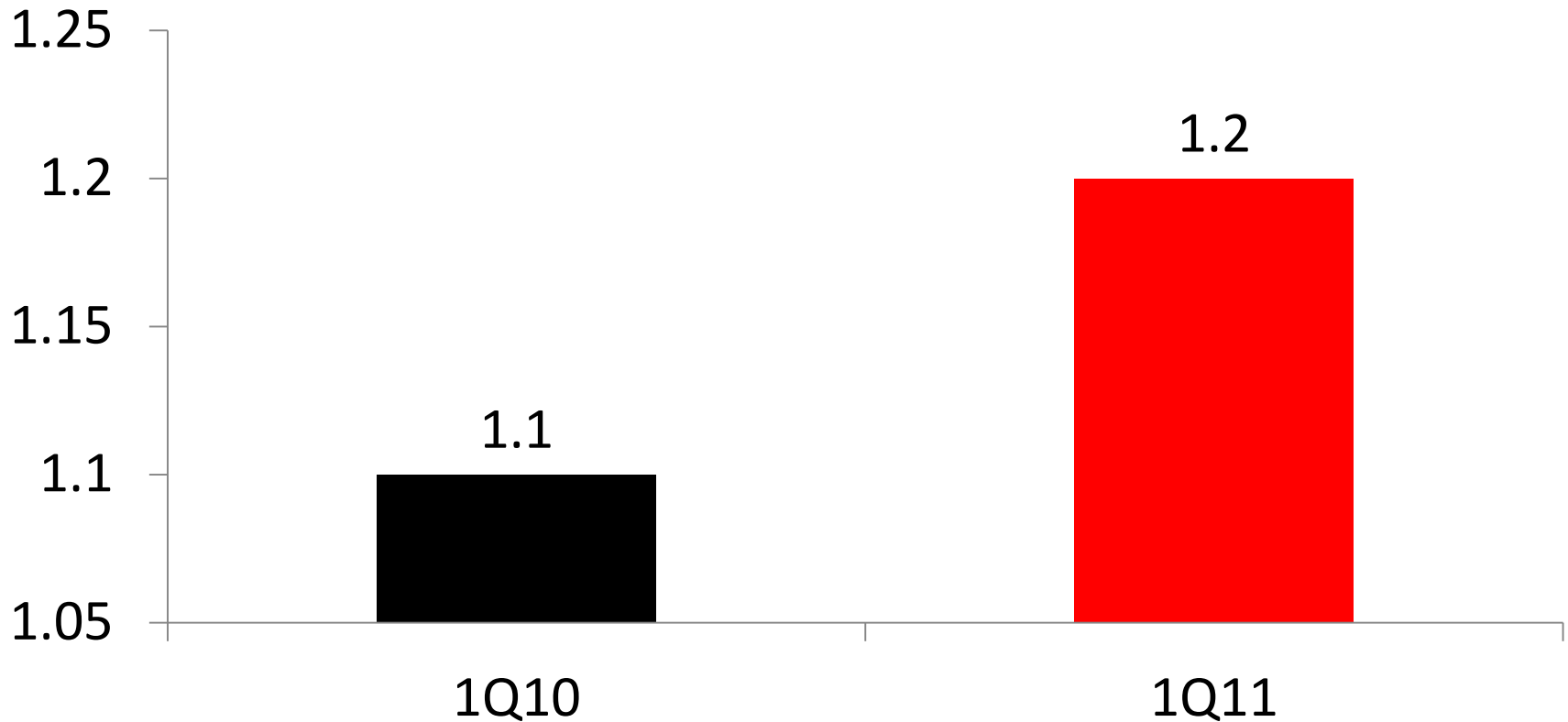
Pharmacy Overview

Members Using the Pharmacy Benefit



Pharmacy Overview

Average Number of Prescriptions PMPM



Pharmacy Overview

Factors influencing Pharmacy Trend

- Brand drug pricing increases
- Extremely high/unanticipated use of “allergy/flu” medications during 1Q2011
- Increased number of members using the prescription drug benefit
- New pharmacologic treatment options

Pharmacy Overview

Top Drugs by Cost

- Abilify
- Adderall XR
- Advair Diskus
- Concerta
- Ventolin HFA
- Genotropin
- Lipitor
- Nasonex
- Plavix
- Pulmicort ampules (generic)
- Seroquel , Seroquel XR
- Singulair
- Vyvanse
- Zyprexa

Pharmacy Overview

Pharmacy Management Strategies

- CHOICES Program
- Formulary Management
- Generic Drug Mandate
- Provider Interventions

Pharmacy Overview

CHOICES

healthcare quality through pharmaceutical options

A PASSPORT HEALTH PLAN PROGRAM

Choices in prescribing

Health comparisons

Outcomes

Information, ideas, and
improvements

Collaboration

Education and empowerment

Success for you and your
patients

In late 2004, a pharmacy medical utilization review program was initiated. The purpose of the program is to assist practitioners in attaining higher quality and better outcomes through prescribing practice.

Prescribers are presented with combined pharmacy and medical services data to be used by individual prescribers for comparative purposes and knowledge of bonus opportunity under the pay-for-performance program.

Pharmacy Overview

Formulary Management

- Formulary decisions are made by committee of external practitioners
- Pharmacy & Therapeutics (P&T) Committee meets at least 4 times per year
- Preferred drugs selected based on clinical evidence, safety, and cost
- Formulary changes are communicated to providers via Pharmacy News bulletin

Pharmacy Overview

Pharmacy Prior Authorizations (PA)

- Required for medications that are:
 - Non-preferred;
 - Outside the recommended age, dose or gender limits;
 - New to the market and not yet reviewed by the Plan's P&T Committee; or
 - Prescribed off-label.
- To facilitate review, complete the PA form legibly and completely.
- You should receive a response in 48 hours for standard requests and 24 hours for expedited requests.
- Your office must have the area code programmed into your fax machine with a Called Subscriber Identification (CSID) number in order to receive fax confirmation of PA receipt.
- Prior Authorization forms are available online at www.passporthealthplan.com/pharmacy.

Pharmacy Overview

Recent Changes to Pharmacy Program

- Lipitor removed from PHP Preferred Drug Listing
- Smoking cessation drugs are a covered prescription drug benefit
- 90-day supply for select generic medications

Pharmacy Overview

Provider Interventions

- Therapeutic Substitution Requests
- Clinical Advisory Letters
 - Drug Recalls
 - Drug Warnings/Advisories
 - Polypharmacy
- Pharmacy Care Gaps
 - Diabetics with no ACE/ARBs
 - Late refill reports
- Provider Resources
 - High Risk Medication Pocket Guides

Pharmacy Overview

Pharmacy Online Resources

- Online Searchable Formulary
- Prior Authorization Forms
- Pharmacy News
- OTC Drug Listing

Pharmacy Overview

The Passport Health Plan Lock-in Program

- The Lock-In Program is a requirement of the Kentucky Department for Medicaid Services (DMS).
- The program is designed to address unnecessary overuse of Medicaid Services.
- Inappropriate use or abuse of services may include:
 - Excessive emergency room or practitioner office visits;
 - Multiple prescriptions from different prescribers and/or pharmacies;
 - Reports of fraud, abuse, or misuse from law enforcement agencies, OIG, practitioners, pharmacies, and Plan staff.

Pharmacy Overview

Member Restrictions under Lock-In

- *One PCP*
- *One Prescriber* for Controlled substances
- *One Pharmacy*
- *One Designated Hospital* for non-emergency services (*new requirement*)

At least annually, members placed in lock-in will be reviewed to determine whether to maintain lock-in status for another 12 month period.

Pharmacy Overview

Lock-In Criteria

Members must satisfy the following in past 12 months:

- At least 4 hospital ER visits; or
- Services from at least 3 different hospital ERs for a non-emergency medical condition.
- Services from at least five (5) different providers;
- At least ten (10) different prescription drugs;
- Prescriptions from three (3) or more pharmacies.

Pharmacy Overview

Members Exempt from Lock-In

Members are exempt from the PHP Lock-In Program if they:

- Reside in a long-term care facility or personal care home;
- Are under the age of 18;
- Receive Medicare benefits;
- Receive hospice services;
- Use services which are necessary to treat complex health conditions, as determined by the PHP Lock-In Committee.

Pharmacy Overview

Lock-In Member Responsibility

- Members who receive services from a non-designated or non-referred provider (i.e. via PCP) and are informed of the financial responsibility before the service is provided will be responsible for payment.
- Members who receive services provided in the emergency department of a hospital for a condition that is not determined to be an emergency will also be responsible for payment.

Pharmacy Overview

Provider Responsibility

- Verify that you have admitting privileges to members designated hospital listed on the lock-in notification letter.
- If the designated hospital needs to be changed, contact the Lock-In Coordinator at (502) 585-7930.
- Whenever possible, do not refer the member to the ER for non-emergent services.

Pharmacy Overview

How to Refer PHP Members to Lock-In

- To refer a member, to determine if a member is part of the Lock-In program, or for general questions about the program, contact our Lock-In Coordinator at (502) 585-7930 or write to:

Passport Health Plan

Attn: Lock-In Coordinator

Passport Health Plan

5100 Commerce Crossings

Louisville, KY 40229

PCP Encounter Submissions

State Requirements

The Commonwealth of Kentucky *requires* complete, accurate, and timely encounter data.

Why?

- To effectively assess the availability and costs of services rendered to Medicaid members.
- Encounter data is used to fulfill Federal reporting requirements.

How PHP Uses Encounter Data

PHP uses encounter data to:

- Analyze physician reimbursement for fee-for-service and capitation models.
- Support provider recognition program analysis and bonus payments.

Provider Requirements for Encounter Submissions

Providers **must** report all member encounters by claim submission either electronically or by mail. For claim filing instructions, please refer to Section 18 of the *PHP Provider Manual* on our website, www.passporthealthplan.com/provider.

- Encounters **must** be submitted even when PHP is not the primary payer. Submit all encounters to PHP as secondary, tertiary, etc.

NOTE: The encounter bonus (\$1 per eligible claim) is paid for claims submitted that result in a \$0 payment for capitated and secondary claims.

- Please ensure your practice management system and automated billing vendor allows for the submission of claims with zero dollar balances.

(Some systems/vendors automatically strip off these claims prior to 837 transmission.)

- Though capitated services are not reimbursed on a fee-for-service basis, it is important to include exact service charges on the claim as you would when billing any other carrier.

Reporting Health Status Information

We also encourage all providers to submit CPT Category II codes to describe and report important health status information. Examples include:

- **1035F** – Current Smokeless Tobacco User
- **1039F** – Intermittent Asthma
- **1000F** – Tobacco Use Assessed (CAD, CAP, COPD, PV, DM)
- **4004F** – Patient Screened for Tobacco Use and Received Tobacco Cessation Counseling (if identified as a tobacco user).

2011 Member Satisfaction Survey Results

2011 Member Satisfaction Survey Results

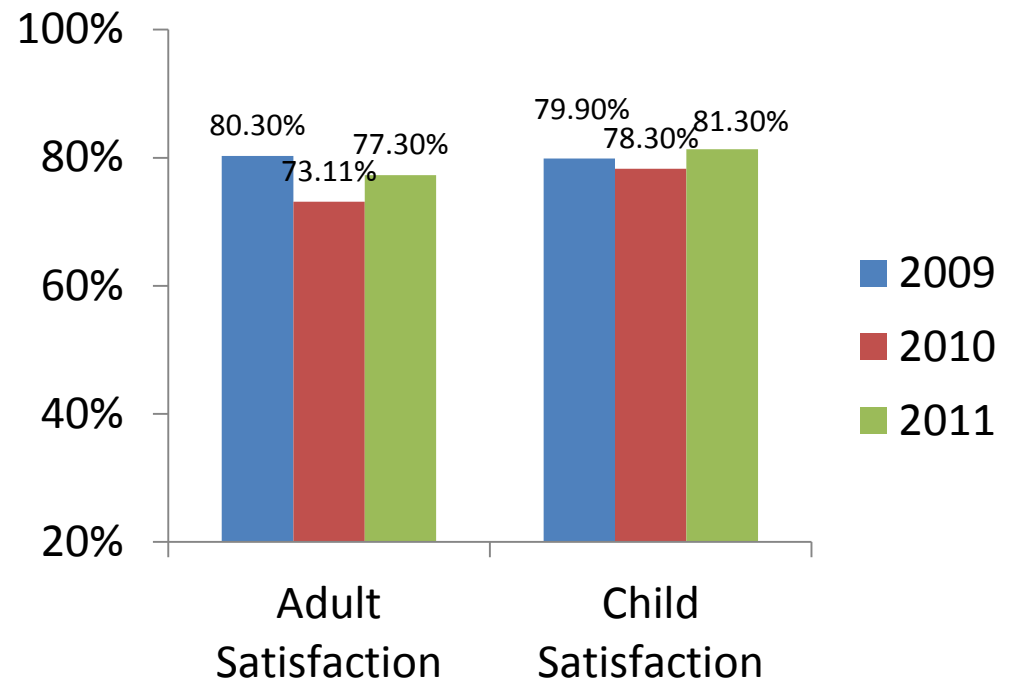
Each year the Plan contracts with an NCQA certified survey vendor to conduct a member satisfaction survey assessing members' satisfaction with the health plan as well as care and services provided by participating providers. Two surveys are conducted, one for the adult population and one for the child and adolescent population.

- Ratings measure how Plan members feel about major areas of their health care:
 - Health Plan
 - Specialist
 - Personal Doctor or Nurse
 - Health Care
- Composite scores measure how well the Plan meets members' satisfaction in key areas and include:
 - Getting Needed Care
 - Getting Care Quickly
 - How Well Doctors Communicate
 - Customer Service
 - Shared Decision Making

2011 Member Satisfaction Survey Results

Satisfaction with Personal Doctor:

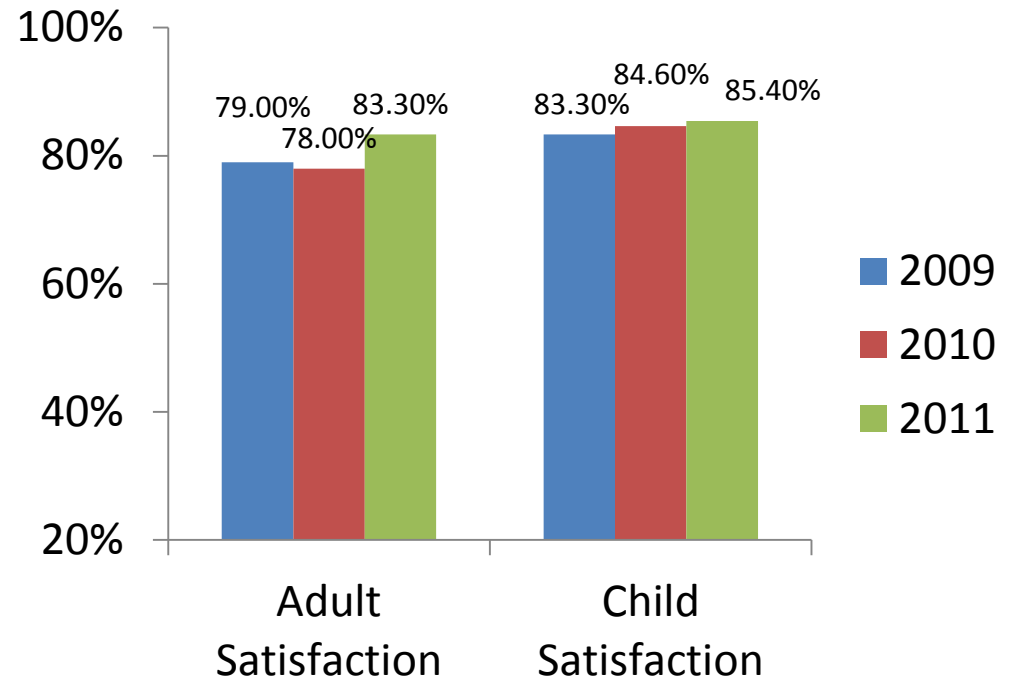
- One question that gives members the opportunity to rate their personal doctor using a 0 to 10 point scale with '10' being the highest.



2011 Member Satisfaction Survey Results

Rating of Specialist:

- One question that gives members the opportunity to rate the specialist they saw most often using a 0 to 10 point scale with '10' being the highest.

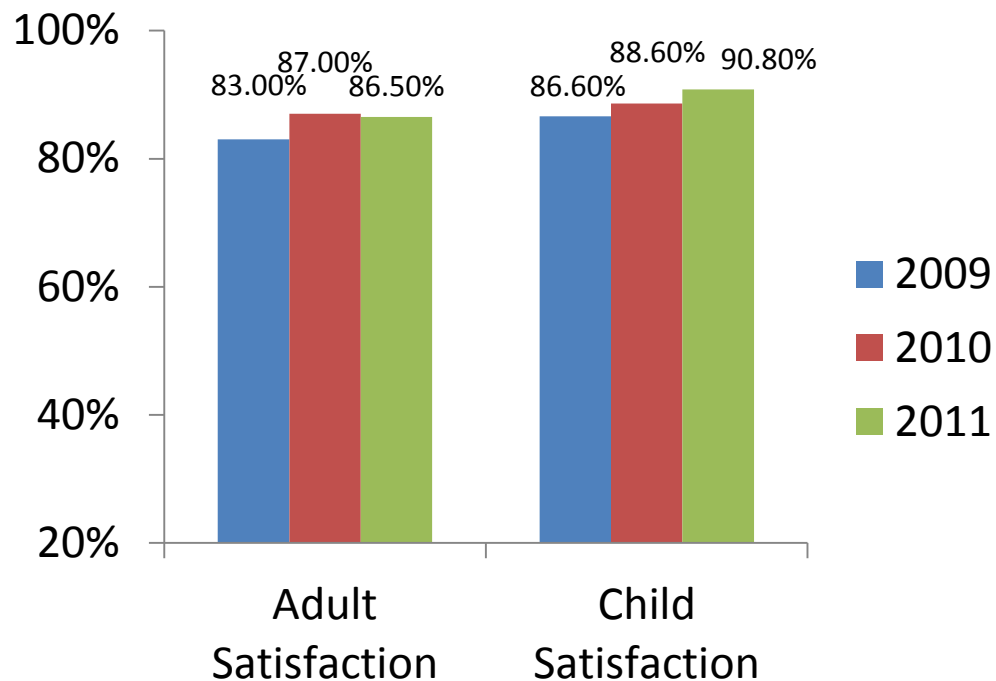


2011 Member Satisfaction Survey Results

How Well Doctors Communicate:

Comprised of four questions and calculated by the number of “always,” “usually,” “sometimes,” and “never” responses.

- Provider explained things in a way you could understand
- Providers listened carefully
- Provider demonstrated respect for what you had to say
- Provider spent enough time with you

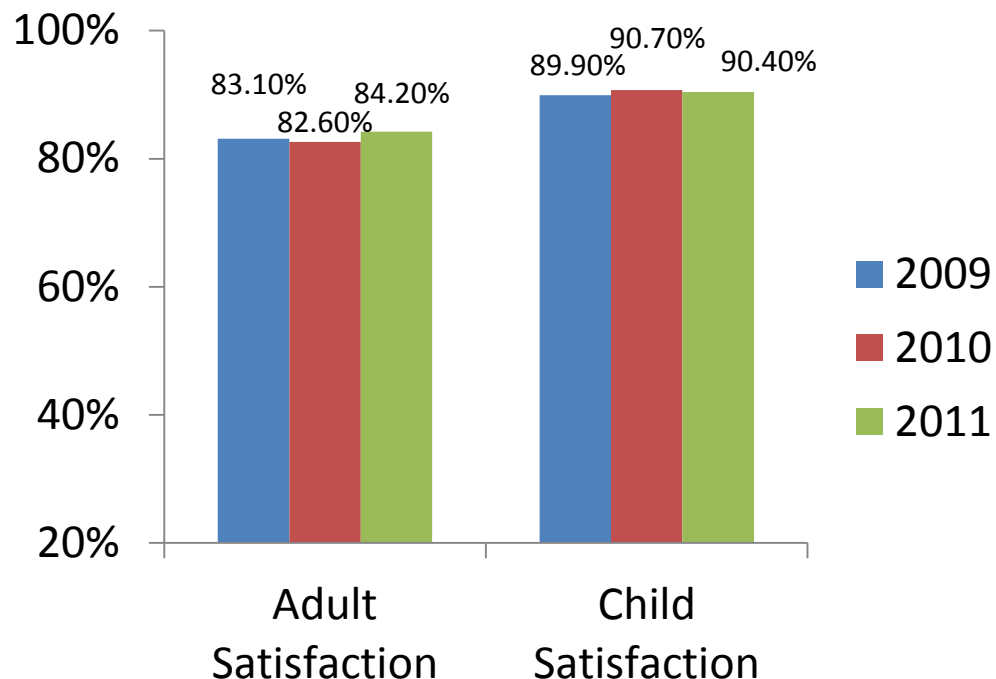


2011 Member Satisfaction Survey Results

Getting Care Quickly:

Comprised of two questions and calculated by the number of “always,” “usually,” “sometimes,” and “never” responses.

- Getting care as soon as need when care was needed right away
- Getting regular/routine appointment as soon as needed

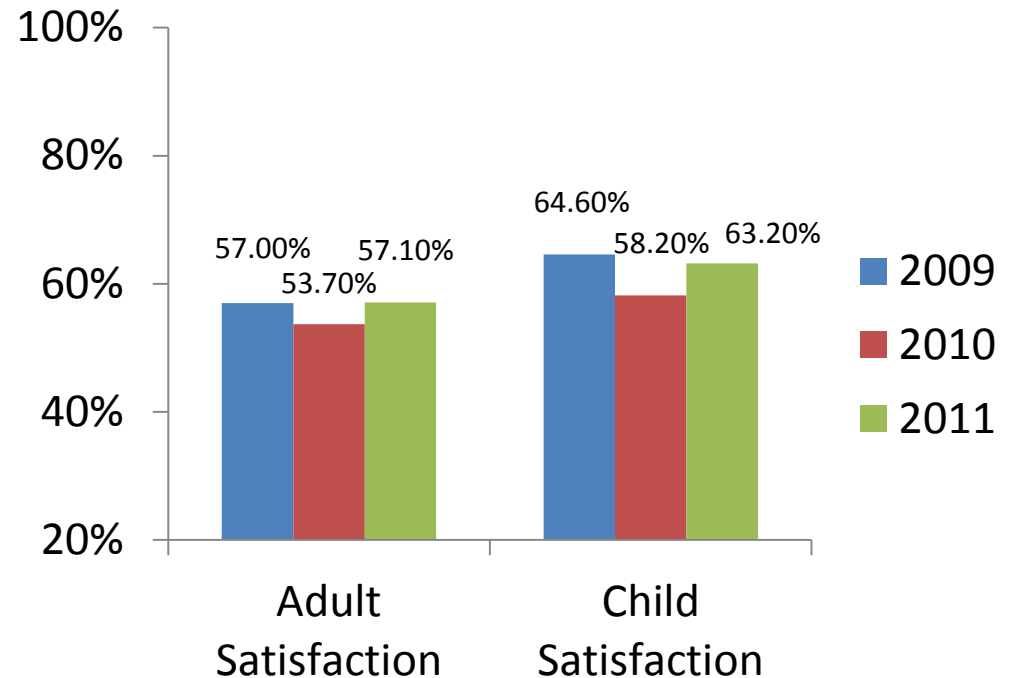


2011 Member Satisfaction Survey Results

Shared Decision Making:

Comprised of two questions and calculated by the number of “definitely yes,” “somewhat yes,” “definitely no,” and “somewhat no” responses.

- Doctor talked about pros and cons of each choice
- Doctor asked which choice was best for the member



Provider Responsibilities / Opportunities

Fraud, Waste & Abuse

Provider Responsibilities/Opportunities

Fraud, Waste & Abuse Training

- According to the Federal False Claims Act and Federal Administrative Remedies for False Claims and Statements Act in Section 6032 of the Deficit Reduction Act (DRA), civil penalties and damages apply to anyone who knowingly submits, causes the submission, or presents a false claim to any US employee or agency for payment or approval.
- The Kentucky Department for Medicaid Services (DMS) requires annual staff training for all PHP providers. Please keep in-office training records with dates and signatures.
- The Plan also strongly encourages all PAD providers to conduct and maintain records of annual FWA training as well.

Provider Responsibilities/Opportunities

Fraud, Waste & Abuse Training

- A training tool has been included for your review and use within your office.
 - The tool may also be accessed on the Passport Health Plan website under Provider References.
- Effective 7/1/11, a new compliance hotline number is in effect for both Passport Health Plan and Passport Advantage - **1-855-512-8500**.
 - This number should be used to report compliance matters, including fraud, waste, or abuse issues.

Advance Directives

Provider Responsibilities/Opportunities

Advance Directives

- Living will, living will directive, advance directive, and directive are all terms used to describe a document that provides directions regarding health care to be provided to the person executing the document. In Kentucky, advance directives are governed by the Kentucky Living Will Directive Act codified in KRS 311.621 to 311.643, and as otherwise defined in 42CFR, 489.100.

Provider

Responsibilities/Opportunities

Advance Directives

- A member who is 18 years of age or older and who is of sound mind may make a written living directive that does any or all of the following:
 - Directs the withholding or withdrawal of life-prolonging treatment
 - Directs the withholding or withdrawal of artificially provided nutrition or hydration.
 - Designates one or more adults as a surrogate or successor surrogate to make health care decisions on his or her behalf.
 - Directs the giving of all or any part of his or her body upon death for any of the following reasons: medical or dental education, research, advancement of medical or dental science, therapy, or transplantation.

Provider

Responsibilities/Opportunities

Advance Directives

- A form of a living will is included in KRS 311.625.
- The form may be reviewed at www.lrc.state.ky.us/KRS/311-00/625.PDF.
- Advance directives may be revoked in writing, by an oral statement, or by tearing up the written living will. The revocation is effective immediately.

Provider

Responsibilities/Opportunities

Advance Directives

- In addition to reviewing the Kentucky Living Will Directives Act, providers should:
 - On the first visit, as well as during routine office visits when appropriate, **discuss the member's wishes** regarding advance directives for care and treatment;
 - **Document in the member's medical record** the discussion and whether the member has executed an advance directive;
 - If asked, **provide the member with information** about advance directives;
 - Upon receipt of an advance directive from the member, **file the advance directive** in the member's record;
 - **Do not discriminate** against a member because he or she has or has not executed an advance directive; and,
 - **Communicate any conscientious objections** to the advance directive (if any) to the member, as indicated above.

Cultural & Linguistic Services

Provider Responsibilities/Opportunities

Cultural & Linguistic Services Program

- Title VI of the Civil Rights Act of 1964 is Federal legislation that requires any organization receiving direct or indirect Federal financial assistance to provide services to all beneficiaries without exclusion based on race, color, or national origin.

Provider

Responsibilities/Opportunities

Cultural & Linguistic Services Program

- Required CLAS Standards under Title VI:
 - Provide written and oral language assistance at no cost to member.
 - Provide members verbal or written notice.
 - Post and offer easy-to-read signage and materials in the languages of the common cultural groups.

Provider Responsibilities/Opportunities

Cultural & Linguistic Services Program

- Family and Friends as Interpreters Under Title VI
 - The assistance of friends or family is not considered competent, quality interpretation.
 - Using friends or family for interpretation may negatively impact your practice and/or the care you provide.
 - If a member chooses his or her own interpreter, providers are encouraged to ask members to sign a waiver.

Provider

Responsibilities/Opportunities

Cultural & Linguistic Services Program

Bilingual Staff Under Title VI

- Using employees who are not trained or “qualified” is not advisable.

“Qualified” interpretation must be evaluated by testing and should include:

- Proficiency in and ability to communicate information accurately in both English and the other language; and,
- Knowledge in both languages of any specialized terms, concepts, vocabulary, and/or phraseology.

Provider

Responsibilities/Opportunities

Cultural & Linguistic Services Program

Potential Consequences for Non-Compliance with Title VI Include:

- Federal fines and fees.
- Loss of federal and state funding, including future funding (i.e. prohibited from Medicaid/Medicare participation and/or incentive program participation).
- Legal action against you from the DHHS, legal service organizations, and private individuals.
- “Informed consent” issues which may also lead to medical malpractice charges.

Provider

Responsibilities/Opportunities

Cultural & Linguistic Services Program

Title VI and Plan Resources

- Onsite training by the Cultural and Linguistics Services Program (CLSP) Coordinator, including interactive presentations and a Provider Toolkit.
- Provider office signage to assist with Title VI compliance, available online or by request.
- Member materials translated into other languages and alternative formats such as Braille, audio, and large type.
- Discounts for telephonic and video interpretation from Language Services Associates (LSA).

For more information about Title VI and Plan resources, or to request a training, **please contact the CLSP Coordinator at (502) 585-7303.**

HIPAA 5010

Provider

Responsibilities/Opportunities

Preparing for HIPAA 5010 Transactions

- The January 1, 2012 deadline to be in compliance with HIPAA 5010 is fast approaching. The updated standards will result in a number of data reporting changes which will require you to use a different format in collecting and reporting data.
- Avoid any interruptions in the transaction process or fines for non-compliance by understanding these changes and being proactive now in your efforts to comply.
- Please reference the Medical Office Notes – *Preparing for HIPAA 5010 Transactions – Changes You Can Make Now!* - August 2011 for details on data reporting changes.

Provider Responsibilities/Opportunities

Preparing for HIPAA 5010 Transactions

- ✓ **Address Fields Explained:**
 - Some items are not changes but clarifications in the Centers for Medicare and Medicaid Services (CMS) requirements.
 - Please be aware of the following clarifications:
 - **Service Facility Location (Box 32) (Loop 2310D)** - The address listed in this box should be the address where services are performed. If services were performed at the primary location, this information will be the same as the information entered in Box 33. If services were performed in a location other than the primary service location (i.e. services performed in a hospital), this information will be different from Box 33. P.O. Boxes are unacceptable in this address location.
 - **Billing Provider Name and Address (Box 33) (2010AA)** – The address listed in this box should be the primary service location of the provider.
 - **Pay to Provider Address (will not be reflected on CMS-1500 paper claim) (2010AB)** – This address box is commonly referred to as the “Remit Address.” P.O. Boxes are acceptable in this address location.
- ✓ **Resources:**
 - The Workgroup for Electronic Data Interchange (WEDI) has played a major role in promoting and implementing the standardization of health care data. Their “White Paper” provides help with the 5010 implementation process, and is available on their website at: www.wedi.org/snip.

HIPAA ICD-10

Provider Responsibilities/Opportunities

HIPAA ICD-10 Transition – Prepare Now to Achieve Compliance

- ✓ **What is ICD-10 and why is it important?**
 - The Health Care Insurance Portability and Accountability Act (HIPAA) requires the Secretary, U.S. Department of Health and Human Services (HHS) to adopt standards for all covered entities to use when conducting certain health care administrative transactions electronically.
 - Effective **October 1, 2013**, the HHS will require all providers to implement the International Classification of Diseases, 10th Edition, Clinical Modification and Procedure Coding System (ICD-10-CM and ICD-10-PCS).
 - The compliance dates are firm and not subject to change.
 - There will be **no** delays.
 - There will be **no** grace period for implementation.

Provider Responsibilities/Opportunities

HIPAA ICD-10 Transition – Prepare Now to Achieve Compliance

✓ Who will need to transition?

- ICD-10 will affect diagnosis and inpatient procedure coding for everyone covered by HIPAA, not just those who submit Medicare or Medicaid claims.
- The following entities must be prepared to comply with ICD-10 transitions:
 - Kentucky Medicaid providers,
 - clearinghouses,
 - billing services, and
 - software vendors.

Provider Responsibilities/Opportunities

HIPAA ICD-10 Transition – Prepare Now to Achieve Compliance

✓ Important Reminder

- To accommodate the ICD-10 code structure, providers must upgrade their transaction standards used for electronic health care claims Version 4010/4010A to Version 5010 by January 1, 2012.
- For more information about HIPAA 5010, please view the communications on our web site.

Provider Responsibilities/Opportunities

HIPAA ICD-10 Transition – Prepare Now to Achieve Compliance

Important Dates to Remember

- **December 31, 2011**
 - External testing of Version 5010 for electronic claims must be complete to achieve Level II Version 5010 compliance.
- **January 1, 2012**
 - All electronic claims must use Version 5010.
 - Version 4010 claims are no longer accepted.
- **October 1, 2013**
 - Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures.

Medical Record Standards

Provider

Responsibilities/Opportunities

Medical Record Standards

- Passport Health Plan has adopted the following medical-record-keeping standards:
 - Confidentiality
 - Organization
 - Documentation
 - Access
 - Availability of records.
- Determined by the National Committee for Quality Assurance (NCQA) and the Department for Medicaid Services (DMS) and may be revised as needed to conform to new NCQA or DMS recommendations.
- Compliance with these standards will be audited by periodic on-site review of practitioners' offices and chart samplings.
- Practitioners must achieve an average score of 80% or higher on the medical records review. Passport Health Plan will assist practitioners' scoring less than 80% through corrective action plans and re-evaluation.

Provider

Responsibilities/Opportunities

Medical Record Standards

Confidentiality of Records

- Medical records are maintained in an area that is only accessible to practitioner office staff.

Organization of Records

- There is only one medical record per patient
- The medical record is bound or pages fastened to prevent loss of medical information.
- Each and every page in the record contains the member's name or ID number.
- The medical record is organized in chronological order with the most recent information appearing first. The record includes separate sections for progress notes, lab results, x-ray and other imaging studies, hospital records (ER report and discharge summaries), home health nursing reports, physical therapy reports, etc.
- All charts contain flow sheets for health maintenance.

Provider

Responsibilities/Opportunities

Medical Record Standards

Documentation

- The record is legible.
- Personal data includes date of birth, age, height, gender, home and work addresses, employer, home and work telephone numbers, marital status, emergency contact information, school name and telephone numbers (if no phone contact name and number), race, ethnicity, guardianship/custodial arrangements, and identifies preferred language.
- Entries are done in non-smearable, non-erasable ink.
- Medication allergies, adverse reactions, and no known allergies are prominently noted in the record.
- There is a completed immunization record in all pediatric records and/or appropriate history in all adult records.
- All charts contain a problem list, a medication list, and treatment plan. Significant illnesses and medical conditions are indicated on the problem list, including working diagnoses.
- Medical history (for members seen three or more times) is easily identified and includes medical, surgical, obstetric histories, and serious accidents. For children and adolescents (18 years of age and younger), medical history includes prenatal care, birth, operations, and childhood illnesses. Documentation includes weight recorded at each regular visit.
- All entries in the medical record are signed or initialed and dated and all providers are identified by name.

Provider

Responsibilities/Opportunities

Medical Record Standards

Documentation

- Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
- Documentation will reflect assessment of and counseling for tobacco, alcohol, substance abuse, and risk of sexually transmitted diseases.
- If a consultation is requested, there is a note from the consultant in the record.
- Consultation, lab, and x-ray reports filed in the chart are initialed by the practitioner to indicate review. Consultation and abnormal lab and imaging study results have a specific notation in the record of follow-up plans.
- Emergency care provided is documented in the medical record, as well as follow-up visits provided secondary to reports of emergency room care.
- Evidence of reportable diseases and conditions are documented and reported appropriately to local or state health departments.
- There is evidence that preventive screenings and services are offered in accordance with Passport Health Plan's Clinical Practice Guidelines. Use of risk assessments, disease maintenance, and preventive health sheets are encouraged (see Section 19, "Forms and Documents," for samples).
- Copies of consent forms, when applicable, are maintained in the record.
- The medical record also contains an indication of whether an adult (over 18 years old) member has executed an advance directive and the member's advance directive as applicable.
- Written denials for service and the reason for the denial are documented in the medical record.
- Hospital discharge summaries are included in the medical record.

Provider Responsibilities/Opportunities

Medical Record Standards

Access and Availability of Records

- Provider permits Passport Health Plan, on request, access to member medical records to inspect, review, and copy within five working days of receipt of request.
- Members have the right to all information contained in the medical record as required by law. Medical records must be made available to a member upon request.
- When a member changes PCP, the medical records or copies of medical records shall be forwarded to the new PCP within ten (10) business days from receipt of request.
- When releasing records to an entity other than the Plan, providers are first required to obtain written consent from the member.

Opportunities for Improvement

- One time documentation of members' race, ethnicity, and language spoken
- Documented directions for use of medications
- Documentation of adult immunizations record
- Documentation of assessment/counseling for nicotine, alcohol, substance use, and risk for sexually transmitted diseases
- Documentation of advanced medical directives
- Reminder: If it's not documented, it is not considered complete.

Appointment Scheduling Standards

Provider Responsibilities/Opportunities

Appointment Scheduling Standards / Access Standards

Providers must adhere to the following appointment scheduling standards to assure timely access to medical care as required by the Department for Medicaid Services (DMS). Compliance with these standards will be audited by periodic on-site review of provider offices and chart sampling.

- ✓ Appointments with primary care providers (PCP) and specialists must be scheduled within 30 days for routine care and preventive care visits.

Other appointment standards are as follows:

- ✓ Appointments for urgent care services must be scheduled within 48 hours.
- ✓ Appointments for emergency care must be immediately provided.
- ✓ Pregnant women in their first trimester are to be provided preventive care visits within 14 days of request.
- ✓ Pregnant women in their second trimester are to be provided preventive care visits within seven days of request.
- ✓ Pregnant women in their third trimester are to be provided preventive care visits within three days of request.
- ✓ Appointments for laboratory and radiology services must be scheduled within 30 days for routine care and 48 hours for urgent care.
- ✓ Providers should provide care for conditions that are non-urgent but require attention within seven days.

After Hours Coverage

Provider Responsibilities/Opportunities

After Hours Coverage

A PCP's office telephone must be answered in a way that the member can reach the PCP or another medical practitioner whom the practitioner has designated. Their telephone must be:

- ✓ Answered by an answering service that can contact the PCP or another designated medical practitioner who can return the call within a maximum of 30 minutes; OR
- ✓ Answered by a recording directing the member to call another number to reach the PCP or another medical practitioner whom the practitioner has designated to return the call within a maximum of 30 minutes; OR
- ✓ Transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner who will return the call within a maximum of 30 minutes.

Electronic Health Records (EHR)

Provider

Responsibilities/Opportunities

Electronic Health Records (EHR)

- Under Title XIII of the Health Information Technology (HITECH) section of the American Recovery and Reinvestment Act (ARRA) of 2009, eligible healthcare professionals and hospitals have the potential to receive incentive payments from Medicare and/or Medicaid for demonstrating **meaningful use** of a **certified electronic health record (EHR) technology**. The government's EHR incentive payment program is not mandatory, however, penalties for non-participants will begin in 2015.
- Please reference our webpage link for additional information.
www.passporthealthplan.com/provider/resources/references/ehr

NaviNet

Provider Responsibilities/Opportunities

NaviNet Implementation

Passport Health Plan will soon be shutting down the Secured Services portion of our web site. On **October 1, 2011**, the following services will ONLY be offered via NaviNet:

- Eligibility inquiries
- Information on patient third party liability (TPL)
- Claims status inquiry
- Electronic copies of your remittance advice
- Care Gap Alerts and Member Clinical Summaries (NaviNet only features)
- Links to other important sites
- Referral submission and inquiry
- PCP Panel Reports (*coming soon*)

*Note: The enhanced Secured Services which included the online claims editing feature will not be transitioned to NaviNet, and will no longer be available as of October 1, 2011. IVR services for claim status and eligibility inquiries will still be available.

Provider

Responsibilities/Opportunities

NaviNet Implementation

- **NaviNet registration may take 7 – 10 days, so REGISTER NOW!** To avoid disruption of these important services, please contact the NaviNet Customer Care line at 1-888-482-8057 or go to <https://navinet.navimedix.com/Main.aspx>.
- NaviNet is committed to the ideals of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Security and privacy safeguards are in place to ensure that NaviNet is HIPAA-compliant, such as encryption technology, session time-outs and NaviNet Security Officers.
- There will be at least one Security Officer designated for every provider office. Security Officers are responsible for adding new NaviNet Users and granting them access to NaviNet services.
- To learn more about NaviNet, visit www.aboutnavinet.com.

Provider Responsibilities/Opportunities

NaviNet Implementation

- Care Gap Alerts and Member Clinical Summaries may be new features to many of our providers. These tools have been exclusively available via NaviNet.
- **Care Gap Alerts**
With Member Care Gaps via NaviNet, each eligibility transaction will automatically display a pop-up notification if the respective member is due to receive one of the following preventive care services:
 - Nephropathy/Microalbumin Screening
 - Cervical Cancer Screening
 - Breast Cancer Screening
 - Chlamydia Screening
 - Annual Dental Exam
 - Eye Exam
 - Well Child Visit (ages three to six years)
 - Adolescent Well Care Visit (ages 12 to 21 years)
 - HbA1c/Glycated Hemoglobin
 - Lipid Test

Provider Responsibilities/Opportunities

NaviNet Implementation

- **Member Clinical Summaries**

In our continuing effort to help our network providers improve patients' clinical outcomes, we are pleased to provide our exclusive Member Clinical Summary Report (MCS) in a printable PDF format. The Member Clinical Summary Report can be accessed via NaviNet and includes the following claim based data:

- Demographic Information (member and PCP information)
- Medications (filled within the past six months)
- Chronic Conditions
- Gaps in Care (based upon diagnosis compared to clinical recommendations)
- ER Visits (within the past six months)
- Inpatient Admissions (within the past twelve months)
- Office Visits (within the past twelve months)

Note: State and federal health privacy laws preclude the inclusion of information related to any behavioral health, HIV-related and/or drug and alcohol addiction medications and treatments in this clinical summary.

Provider Responsibilities/Opportunities

NaviNet Implementation

Member Clinical Summaries

- With this new tool, practitioners, hospitals and ancillary providers can capture the most relevant demographic and clinical facts about a Passport Health Plan member's healthcare in a user-friendly format that is timely, accurate and complete. The valuable information returned in these reports represents a tremendous opportunity for improving both quality and continuity of care.
- To get started using this exceptional tool for your practice, your NaviNet Security Officer must grant security access to users.

We encourage you to continue to monitor the PHP website, POIS communications, Provider Alerts, and the NaviNet Plan Central page over the coming months for news and updates about NaviNet services.

Passport Advantage Plan Updates

PAD Model of Care

Patient-Centered Care

In 2011 Passport Advantage:

- Requires members to select a PCP
- Requires members to use in-network providers
- Implemented a Provider Recognition Program for contracted PCP providers

Increased focus on care coordination and preventive services is expected to improve member health and lower overall cost.

Collaborating with Providers to Achieve Goals

- Staff development of Plan of Care for physician input & agreement
- Provider Relations offers best practices & outreach efforts
- Member clinical care gaps reporting – started August 2010
- Case manager assigned to high volume offices
- Integrate discharge planning with PCP offices to schedule visits post-discharge from hospital
- Provider education & communication (provider site visits, workshops, Passport Online Information Service (POIS) notices, Medical Office Notes, etc.)

Key Components of the Passport Advantage Model

Key Components:

- Health Risk Assessment
- Plan of Care
- PAD Transition Triage Team

Health Risk Assessment Components

Health Risk Assessment:

- Conducted by Plan staff with each newly enrolled member within 90 days of enrollment.
- Conducted annually by Plan staff for existing members during their birth month.
- Facilitates better understanding of the medical, functional, cognitive and psychosocial health status of each member.
- Reviewed and utilized by Plan staff to recommend the member for care coordination and shared with the PCP as appropriate.

Plan of Care Components

Plan of Care:

- Initiated by Plan staff using HRA information and sent to the PCP for review and input.
- Reflects input from an interdisciplinary team which includes the member, member's support system, PCP, and specialists, as feasible.
- Contains member specific information, including medications, diagnoses, and treatment plan with measurable goals and objectives.
- Reviewed and updated annually, at minimum, and may be updated as frequently as the member experiences a change in health status, or transition of care.

Care Coordination and Transitions of Care

Role of the PCP in the transition process:

- Discuss the updated Plan of Care with the admitting provider.
- Review, provide input to, and document the updated Plan of Care.
- Maintain a copy of the revised Plan of Care in the member's medical record.

Passport Advantage 2012

Provider Resources

Recent Communications

- Please reference your workshop packet for copies of recently distributed provider communications, including Provider Alerts, Letters, and Medical Office Notes.
- These provider communications may also be found on our website – www.passporthealthplan.com

Website Resources

- Provider Directories (PDF and real-time search function)
- Subscribe to POIS – Passport Online Information Service
- Register and access NaviNet for Secured Services such as eligibility and claim inquiries
- Preferred Drug Formularies
- Provider Manual
- ERA/EFT Information
- And much more!

www.passporthealthplan.com/provider

Additional Information

- The Provider Satisfaction Survey will be issued in October 2011.
- An electronic communications survey will be issued during the first quarter of 2012.
- The 4th annual provider practice management seminar with national consultant Elizabeth Woodcock will be held on October 26, 2011 at the University Club in Louisville. Invitations will be mailed.
- We are in need of Credentialing Committee physician participants.
 - ❖ The committee meets once a month on the 3rd Tuesday evening of the month.
 - ❖ Meeting duration is approximately one hour and dinner is provided.
 - ❖ If interested, please contact Kathleen Burke, Credentialing Supervisor, at 502/585-7327 or Kathleen.Burke@passporthealthplan.com

QUESTIONS??