

Passport Advantage Special Needs Plan (SNP) Model of Care for Dual Eligible Members

Attachment A

1. Goals and Objectives

a. List the goals and objectives of the model of care that drive service delivery under your dual-eligible SNP.

Section §231 of the 2003 Medicare Modernization Act created the opportunity for Passport Advantage to focus on services to our "special needs members," i.e., members who reside in nursing facilities who were dually eligible for both Medicare and Medicaid, or who had severe and disabling chronic conditions. The goal for Passport Advantage is to address the needs and challenges of our growing member population with chronic illnesses and disabilities, while simultaneously minimizing problems arising from care systems that are fragmented through the coordination of Medicare and Medicaid finances, benefits, and services. The result is a comprehensive, integrated model of care.

Responding to the needs and challenges of our special needs members (those members with high rates of chronic illnesses and disabilities) has involved the coordination of services for acute and long-term care, as well as for referrals for community care/services. In partnership with our providers, Passport Advantage strives to be the member's advocate as well as the facilitator for services/care for our members.

Passport Advantage utilizes the talents and knowledge of our associates and our community provider partners to provide our members with the highest quality of healthcare.

Passport Advantage's mission is "to improve the health and quality of life of our members." This is accomplished through the incorporation of our core organizational values into each aspect of our model of care, which are:

Compassion: The principle that directs us to be kind, caring, concerned, and empathetic;

Dignity: The recognition of the inherent worth of each person;

Diversity: The commitment to an environment that values understanding, acceptance, and respect of individuals and their multicultural richness;

Stewardship: The wise and responsible use of all resources, human, financial, and material, for the greater good; and

Hospitality: The knowledge, skills, and ability to provide quality care and service.

The goals and objectives of the model of care for the Passport Advantage dual-eligible SNP are:

- To improve the health status/outcomes and quality of life of members, through coordination of care and services.
- To provide coordination of care and services to members who have experienced a critical event or diagnosis requiring the extensive use of resources.

- To seamlessly coordinate benefits between the dual eligible member's Medicare and Medicaid benefits.
- To assist members in navigating the health care system.
- To provide member assessment and intervention prior to a major high-cost event.
- To increase emphasis on member access to care.
- To break down social barriers and eliminate healthcare disparities.
- To identify and address environmental barriers to care.
- To better manage health care costs.
- To improve clinical and quality of life outcomes through compliance with nationally-recognized and accepted guidelines for treatment of chronic conditions.
- To improve timely access to primary care and specialty care services for initial and ongoing monitoring and treatment of chronic illness.
- To increase the length of time between, and reduce the number of hospitalizations and emergency room visits for treatment of chronic illness and associate complications.
- To empower members to accept responsibility for their ongoing healthcare needs.
- To empower members via education and advocacy to establish goals of care.
- To establish treatment options congruent with the values, beliefs and wishes of the patient/family.
- To educate members regarding end-of-life issues, including advanced directives and hospice care options.
- To identify and assess the need for care coordination through early identification of behavioral health, chronic, and/or long-term needs.
- To promote appropriate interventions and alternatives as behavioral health care services are rendered.
- To assure necessity and appropriateness of behavioral health care services.
- To continually monitor, evaluate, and optimize use of behavioral health care resources.
- To promote collaborative practice among all disciplines to assure continuity of care and high quality services.
- To ensure equitable access to care for members.
- To monitor practice patterns of participating practitioners.
- To promote behavioral health care in accordance with local, state, and national standards.

b. Address the goals and objectives specific to each of the following subpopulations: frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

i. Frail/disabled beneficiaries –

- To improve the health status/outcomes and quality of life of members.
- To proactively provide coordination of care and services.
- To seamlessly coordinate benefits between the dual eligible member's Medicare and Medicaid benefits.
- To assist members to navigate the health care system.
- To identify and address environmental barriers to care.
- To break down social barriers and eliminate healthcare disparities.

ii. Beneficiaries with multiple chronic illnesses –

- To improve the health status/outcomes and quality of life of members.
- To proactively provide coordination of care and services.
- To seamlessly coordinate benefits between the dual eligible member’s Medicare and Medicaid benefits.
- To assist members in navigating the health care system.
- To identify and address environmental barriers to care.
- To break down social barriers and eliminate healthcare disparities.
- To increase the length of time between, and reduce the number of, hospitalizations and emergency room visits for treatment of chronic illness and complications of chronic illness.
- To improve clinical and quality of life outcomes through compliance with nationally-recognized and accepted guidelines for treatment of chronic conditions.
- To improve timely access to primary care and specialty care services for initial and ongoing monitoring and treatment of chronic illness.
- To assist members to learn self-management skills related to their chronic conditions.
- To empower members via education and advocacy to establish goals of care.
- To establish treatments options congruent with the values, beliefs and wishes of the patient/family.
- To promote collaborative practice among all disciplines to assure continuity of care and high quality services.
- To ensure equitable access to care for members.

iii. Beneficiaries near end of life -

- To seamlessly coordinate benefits between the dual eligible member’s Medicare and Medicaid benefits.
- To empower members via education and advocacy to establish goals of care.
- To establish treatments options congruent with the values, beliefs and wishes of the patient/family.
- To evaluate and establish a plan of care which will address pain and symptom management.
- To educate members regarding end-of-life issues, including advanced directives and option of hospice care.
- To promote collaborative practice among all disciplines to assure continuity of care and high quality services.
- To ensure equitable access to care for members

2. Organization of Staff

- a. Describe the specific organization of staff (e.g. employees, community service workers, nurse practitioners, and case managers) that interacts with dual-eligible individuals to provide the specialized services available under the model of care.**

There are three components of the Model of Care for dual eligible members:

- i. **The Case Management/Care Coordination Team** – This team is comprised of registered nurses, social workers, case management intake specialists, clinical pharmacists, and physical and behavioral health Plan Medical Directors. Registered nurses and social workers are required to obtain their case management certification within two years of employment with the Plan. Members of the team have both physical and behavioral health expertise. In addition to generalized case managers, within the department are specialized case managers who focus on special needs of the dual eligible population, these include (but are not limited to):
- Physical rehabilitation
 - HIV/AIDS
 - Palliative Care
 - Solid organ and bone marrow transplants
 - Chronic Obstructive Pulmonary Disease (COPD)
 - Diabetes

Members of the team work with the member's Primary Care Provider (PCP) or designated medical home, specialists, member, and caregiver, parent or guardian. The team works to meet the member's needs at all levels in a proactive manner designed to prevent adverse outcomes and avoidable episodes of care.

One example of specialized services is Palliative Care. Due to the complexity of most Palliative Care cases, a team approach is often most helpful. Members appropriate for Palliative Care have unique needs requiring a collaborative effort of assessment, planning, facilitation, and advocacy. The Palliative Care program assists in coordinating the physical, psychological, social, spiritual and existential needs of our members facing an incurable, progressive disease. The goal is to achieve the best possible quality of life for our members through the relief of suffering, control of symptoms, and the restoration of functional capacity, while remaining sensitive to the personal, cultural and religious values, beliefs and practices of our diverse population.

The integration of Palliative Care into traditional Case Management optimizes the care of our chronically-ill members by providing a comprehensive disease-specific care coordination, education on disease trajectory, treatment options, and potential symptoms, while promoting advocacy and allowing for psychosocial and spiritual support to our members and their families, caregivers and/or significant others.

- ii. **The Behavioral Health Care Coordination Team** - This team is comprised of Registered Nurses, a Licensed Clinical Social Worker, Clinical Pharmacist, and Physical and Behavioral Health Plan Medical Directors all with clinical experience and expertise in Behavioral Health.

Members of this team work with the members Primary Care Provider (PCP)/ designated medical home, Behavioral Health Practitioners, Behavioral Health Facilities, community partners, member and caregiver, and parent or guardian. Care Coordination functions to incorporate the needs of the member, ranging from those with minor behavioral health illnesses who live functional, independent lives within the community, to those with severe mental illnesses or severe emotional disabilities requiring ongoing individual supervision at all times.

Team members assist members in obtaining and coordinating needed medical and social services. The team serves as the primary link between the member and the providers concerning Passport Advantage policies and procedures and network/community resources.

Management of the member's care (where and when appropriate) is conducted according to the identified medical necessity need and clinical criteria. The team's efforts supplement any services already provided by the member's provider and incorporate available community resources. Care Coordination efforts include active and ongoing participation and involvement of the member and family members (where and when appropriate) including adults where consent is given by the adult member for involvement in the development and management of the treatment plan and overall plan of care. Ongoing collaboration and cooperation (where and when appropriate) occurs among the various entities and agencies involved in the member's care.

iii. The Health and Disease Management Care Coordination Team – This team is comprised of Registered Nurses and Health Outcomes Coordinators. Members of this team work with members in one-on-one disease management as well as all aspects of preventive health services. The team coordinates efforts to prevent or decrease the exacerbation of an illness through the utilization of comprehensive, integrated approaches to care. This is accomplished through program-specific provider and member interventions intended to complement and assist the care given by the provider. Clinical and non-clinical interventions are based on established and nationally-recognized guidelines specific to each program, and updated at least once every two years. Registered Nurses in the Disease Management Programs have experience and expertise in the specific disease states that the program supports. Dual eligible members with the following conditions are automatically enrolled in a Disease Management Program:

- Coronary Artery and other Vascular Diseases
- Diabetes
- Chronic Obstructive Pulmonary Disease

Members enrolled in these programs are stratified by severity of illness and intensity of service. Those members at the highest level of stratification receive one-on-one intervention with a Registered Nurse as well as all other interventions in the program.

Health Outcomes Nurses and Health Outcomes Coordinators are dedicated to providing education to members regarding prevention of illness/disease and assisting members to obtain preventive health services available in the Plan.

These services include:

- The *Yes, You Can!* Smoking Cessation Program
- Preventive health education regarding vaccines, mammography, cervical cancer screenings, colorectal screenings, and others

The Coronary Artery and other Vascular Diseases (CAD) Program strives to improve the health status of adult members with CAD through improved member and provider compliance with the American Heart Association and the American College of Cardiology Guidelines for the prevention of heart attack and death in members with atherosclerotic cardiovascular disease by:

- Increasing provider and member adherence to screening of LDL levels for members with known CAD;
- Increasing provider adherence to CAD guidelines regarding the use of appropriate lipid management treatment;
- Increasing provider adherence to guidelines regarding the use of lipid lowering medications in those members with known coronary artery disease;
- Increasing provider adherence to guidelines regarding the use of ACE inhibitors post MI in those members with known coronary artery disease;
- Increasing provider adherence to guidelines regarding beta-blocker use in post MI and acute ischemic members unless contraindicated;
- Increasing member adherence to the use of lipid lowering and anti-hypertensive drug therapy;
- Increasing member awareness of those risk factors that increase the risk of CAD; and
- Promoting healthy lifestyles through diet and nutrition, weight loss, physical activity, and smoking cessation.

The Diabetes Management Program attempts to improve the health status of our adult members with diabetes through improved member and provider compliance with the American Diabetes Association (ADA) standards of care by:

- Increasing provider and member adherence to the American Diabetes Association (ADA) Guidelines regarding HbA1c, LDL-C, dilated retinal exam (DRE) tests, medical attention for nephropathy, and blood pressure control.
- Increasing the administration of flu and pneumonia vaccinations to members; and
- Promoting healthy lifestyles through exercising, avoiding cigarette smoke and other air pollutants, and eating well.

The Chronic Obstructive Pulmonary Disease (COPD) Management Program endeavors to improve the health status of adult members, while decreasing complications through improved member and provider compliance with the National Heart, Lung and Blood Institute standards of care by:

- Increasing the use of spirometry testing for new diagnosis and the newly active Chronic Obstructive Pulmonary Disease to confirm the diagnosis;
- Increasing provider adherence to Global Initiative for Chronic Obstructive Lung Disease Report (GOLD) from the national Institutes of Health and the National Heart, Lung and Blood Institute (NHLBI) guidelines regarding the use of bronchodilator medications;
- Increasing provider adherence to GOLD guidelines regarding the use of inhaled glucocorticosteroid medications;
- Increasing the administration of flu and pneumonia vaccinations to members; and
- Promoting healthy lifestyles through exercising, avoiding cigarette smoke and other air pollutants, and eating well.

b. Specify the role for each position described above.

i. The Case Management/Care Coordination Team

- **Nurse Case Managers** (RN) – Case Managers complete a comprehensive assessment, determine available benefits and resources, and work with members and practitioners, including specialists, to develop and implement the case management treatment plan. This plan includes establishing performance goals both long and short, identification of barriers to meeting goals, monitoring for compliance, and follow-up. Periodic assessments of progress against plans and goals are conducted and modifications to the plan are made as needed.
- **Licensed Clinical Social Workers** (LCSW) – LCSW Case Managers work in conjunction with RN Case Managers to assist dual eligible members with psychosocial issues and to address care needs. These needs may include shelter, utilities, food, and clothing. LCSW case managers also connect members to community resources that address a myriad of needs and concerns in the community.
- **Case Management Intake Specialists** (CMIS) – CMIS's outreach to members to complete the Health Risk Assessment. They coordinate CM referrals to ensure that the referral is directed to the appropriate case manager/care coordinator.
- **Clinical Pharmacist** – The Clinical Pharmacist conducts medication profiles and monitors for persistent medications, drug interactions, and drugs to avoid in the elderly. The pharmacist is available to provide education to the staff regarding certain pharmaceuticals.
- **Physical Health and Behavioral Health Medical Directors** – The Medical Directors provide consultation to staff and practitioners regarding program components and member specific interventions.

ii. The Behavioral Health Care Coordination Team

- **Registered Nurses** (RN) – RN's provide Care Coordination for those members identified as having ongoing behavioral health needs. They complete the health risk assessment to identify risk factors, prior authorize all behavioral health and substance abuse inpatient admissions, and all behavioral health home health services.
- **Licensed Clinical Social Worker** (LCSW) – The LCSW provides on-site review of inpatient admissions to the behavioral health facilities. He assists with discharge planning and the transition of care back to the outpatient providers and is a liaison between the facilities and the Plan's behavioral health care coordinators.
- **Clinical Pharmacist** - The Clinical Pharmacist conducts medication profiles and monitors for persistent medications, drug interactions, and drugs to avoid in the elderly. The pharmacist is available to provide education to the staff regarding certain pharmaceuticals.
- **Physical Health and Behavioral Health Medical Directors** – The Medical Directors Serve as consultants to the behavioral health care coordination team, actively participate in staff development, perform individual case review, conduct denials as necessary, are available as a peer reviewer to practitioners to discuss potential denials, review and make recommendations regarding potential quality of care issues.

iii. **The Health and Disease Management Care Coordination Team**

- **Registered Nurses** (RN) – RN’s in Disease Management Programs assesses the member’s needs including a disease specific assessment and develop an individualized plan of care with the member. They coordinate care with the provider(s) involved in the member’s care and ensure follow-up with a specialist, if appropriate. They provide the member with additional written and/or verbal information targeted to the member’s specific needs, arrange home health visit(s) as needed, maintain ongoing follow-up contact with the member to evaluate and revise the plan of care as needed.
- **The Health Outcomes RN** monitors members for preventive health screenings for breast and cervical cancer, colorectal cancer, influenza and pneumonia vaccinations, as well as others.
- **Health Outcomes Coordinators** – Coordinators assist the RN’s to coordinate activities with members, internal staff, and community partners to promote improved health outcomes.
- **Clinical Pharmacist** – The Clinical Pharmacist conducts medication profiles and is available to provide education and consultation to the staff regarding certain pharmaceuticals.
- **Physical Health and Behavioral Health Medical Directors** – The Medical Directors provide consultation to staff and practitioners regarding program components and member specific interventions.

3. **Describe the lines of communication and accountability between the SNP and the care delivery staff**

Communication and accountability between the SNP and the care delivery staff is accomplished through the following mechanisms:

- Provider Newsletters
- Pharmacy News
- Medical Office Notes
- Medical criteria policies
- Passport Advantage Provider Manual
- Clinical practice guidelines
- Provider workshop presentations
- Information on compliance with HIPAA and Title VI of the Civil Rights Act of 1964
- Provider letters
- Passport Online Information Service (POIS) –plan list serve
- Electronic Provider Alerts
- Online Provider Directory

Plan communications providing important information on billing, program updates, new programs, etc. are available to view electronically on our web page, www.passportadvantage.org.

Additionally, providers in the health plan are notified of all three components of care coordination by the following:

- Welcome packet to new participating providers with information regarding how the Complex Case Managers, Disease Managers, and Behavioral Health Care Coordinators work with members and instructions on how to access the programs
- The Passport Advantage Provider Manual
- Articles in the provider newsletter
- The Passport Advantage Provider Website (www.passportadvantage.org)

Also, each component of the model has provider interactions specifically regarding the dual eligible members they serve.

The Case Management/Care Coordination Team

- Primary Care Provider (PCP)/medical home receives written notification regarding their patients' participation in Case Management.
- Written notification of member's goals is provided to the PCP/medical home.
- Contact with the member's PCP/medical home and/or specialist continues as needed for continuity and coordination of care throughout the time the member remains in Case Management.
- An additional notification letter is sent to the PCP/medical home at the time the member is discharged from Case Management.

The Behavioral Health Care Coordination Team

- Primary Care Provider (PCP)/medical home receive written notification regarding their patients' participation in Behavioral Health Care Coordination.
- Written notification of member's goals is provided to the PCP/medical home.
- Contact with the member's PCP/medical home and/or specialist continues as needed for continuity and coordination of care throughout the time the member remains in Behavioral Health Care Coordination.
- A notification letter is sent to the PCP/medical home at the time the member is discharged from Case Management.
- Additionally, with member consent, a coordination of care letter is sent to the PCP/medical home and the behavioral health practitioner to assist in coordination of physical and behavioral health care.

The Health and Disease Management Care Coordination Team

All providers treating identified members in Disease Management receive:

- Quarterly reports detailing their eligible members and including the status of recommended testing, medications member is taking, and member comorbidities.
- Provider outreach visits by the Disease Manager
- Notification of high-risk members enrolled in one-on-one Disease Management.
- Notification of high-risk members discharged from one-on-one disease management.

4. Describe the specific steps the SNP takes (e.g. written protocols and training) to ensure that the staff understands how the model of care works and how to function in accordance with the model of care.

This team approach involves the dissemination of information for a coordinated effort of services. **Passport Advantage accomplishes this through:**

i. The development and maintenance of a company website

(www.passportadvantage.org) to provide information for our members, providers, and associates. The website is updated as changes are implemented.

ii. The development of policies and procedures for consistent delivery of healthcare.

- **UM 2.01 (PAD)** Medical Criteria, Guidelines, Policy and Protocol Development, Review and Adoption
- **CM 4.06 (PAD)** Case Management Processes and Scope of Services

iii. The ongoing training of Medical Management associates whenever policy changes are instituted with annual consistency evaluations.

- **UM 6.01 (PAD)** Annual Consistency Reviews for all Associates Involved in Medical Necessary Reviews
- **UM 10.01 (PAD)** Nurse Reviewer Consistency Review
- **BH 10.01 (PAD)** Nurse Reviewer Consistency Review for Behavioral Health

iv. The use of clinical practice guidelines.

Passport Advantage's mission is to improve the health and quality of life of our members. Passport Advantage has adopted the following Clinical Practice Guidelines to support our providers in the care and education of our members and to reduce variation in diagnosis and treatment. Passport Advantage has made every effort to ensure current scientific data and expert opinion is the basis for each guideline. Each guideline is evaluated as new data becomes available or at a minimum of every two years. Passport Advantage monitors provider compliance and member outcomes related to these clinical guidelines for quality improvement initiatives and recertification efforts. These guidelines are intended to assist the provider in clinical decision-making and attempt to define clinical practices that apply to most members in most circumstances. The treating physician should make the ultimate judgment regarding the care of a particular member.

- **Diabetes**

Based on the American Diabetes Association Standards of Medical Care in Diabetes - 2006, published in Diabetes Care, Volume 30, Supplement 1, January 2007.

- **Adult Preventive Health**

Based on the *U.S. Preventive Services Task Force, Guide to Clinical Preventive Services 2005; Morbidity and Mortality Weekly Report (MMWR)*, **Notice to Readers:** Updated Recommendations of the Advisory Committee on Immunization Practices (ACIP) for the Control and Elimination of Mumps, June 1, 2006; the CDC, Recommended Adult Immunization Schedule – United States, October 2006-September 2007. MMWR 2006; 55Q1-Q4 and CA A Cancer Journal for Clinicians, American Cancer Society for the Early Detection of Cancer, 2006, Volume 56, Number 1, January/February 2006.

- **Risk Reduction for Coronary and Other Vascular Disease**

Based on the American Heart Association/American College of Cardiology Guidelines for Preventing Heart Attack and Death in Patients with Atherosclerotic Cardiovascular Disease: 2001.

AHA/ACC Guidelines for Secondary Prevention for Patients with Coronary and Other Atherosclerotic Vascular Disease: 2006 Update

- **Hypertension**

Based on the 7th Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7), December 2003, and ICSI Hypertension Diagnosis and Treatment, Eleventh Edition, October 2006.

- **Major Depression in Adults in Primary Care Clinical Practice Guideline**

The MacArthur Initiative on Depression & Primary Care www.depression-primarycare.org

Based on The MacArthur Initiative on Depression & Primary Care at Dartmouth & Duke, Depression Management Tool Kit, Volume 1.3, June 7, 2004 and the Institute for Clinical Systems Improvement Health Care Guideline: Major Depression in Adults in Primary Care, Eighth Edition, May 2004.

Hamilton M. "Development of a rating scale for primary depressive illness."

Br J Soc Clin Psychol. 1967; 6:278-296

www.stanford.edu/ yesavage A series provided by The Hartford Institute for Geriatric Nursing (hartford.ign@nyu.edu) www.hartfordign.org

- **Anxiety Disorders in Adults in Primary Care Clinical Practice Guideline**

Based on National Institute of Clinical Excellence, Anxiety, management of anxiety (panic disorder, with or without agoraphobia, and generalized anxiety disorder) in adults in primary, secondary, and community care, Clinical Guideline 22, December 2004; National Institute of Mental Health, Anxiety Disorders, NIH Publication No. 02-3879, Reprinted 2002; and Va/Dod Clinical Practice Guideline for the Management of Post Traumatic Stress, December 2003. National Institute of Mental Health (NIMH) Anxiety Disorders, website www.nimh.nih.gov; and Hamilton Anxiety Rating Scale (HAM-A) at www.cnsforum.com .

- **COPD Clinical Practice Guidelines**

Based on Global Initiative for Chronic Obstructive Lung Disease, Executive Summary, Updated 2006 and Institute for Clinical Systems Improvement, Chronic Obstructive Pulmonary Disease, Sixth Edition, January 2007.

- v. **Weekly, bi-weekly, or monthly departmental staff meetings for policy and procedure updates.**
- vi. **Use of technology, i.e., E-Mail, for communication to all associates.**
- vii. **Periodic inservices to keep associates informed of the latest services and medical care available.**
- viii. **CP 10.02 (PAD) Continuing Education for Medical Management Staff.**
- ix. **New hires are provided orientation/mentoring sessions.**
- x. **Policies and procedures for acute inpatient care, long-term acute care (LTAC), skilled nursing care (SNF), behavioral health, on-site review, Disease Management, Case Management, discharge planning, and community resources.**
 - **UM 9.01 (PAD) Discharge Planning**
 - **CM 4.02 (PAD) Assessment of Case Management Needs**
 - **CM 20.01 (PAD) Transition and Continuity of Care**
 - **CM 22.01 (PAD) Reporting of Abuse, Neglect or Violence**
 - **BH 9.01 (PAD) Discharge Planning for Behavioral Health Care Coordination Services**
 - **BH 20.01 (PAD) Transition and Continuity of Care for Passport Advantage Members**
 - **HM 1.01 (PAD) Health and Disease Management Programs**
 - **HM 3.01 (PAD) Chronic Conditions for Disease Management**
- xi. **Policies and procedures for referral and coordination of services between departments within Medical Management.**
 - **UM 31.01 (PAD) Referrals to Case Management for Coordination of Care**
 - **CM 4.05 (PAD) Identification of Members for Case Management**
 - **CM 16.02 (PAD) Coordination of Care Between Case Management**
 - **CM 19.01 (PAD) Referral to Individual Disease Management**
 - **CM 26.01 (PAD) Co-Management of Coordination of Cases with Behavioral Health Care Coordination Services**
 - **BH 14.02 (PAD) Referral of Members to Behavioral Health Care Coordination**
 - **BH 19.01 (PAD) Referral from Behavioral Health Care Coordination Services to Individual Disease Management**

5. Specific Needs of dual-eligible beneficiaries

a. State how this model of care identifies and meets the specialized needs of dual-eligible beneficiaries.

The needs of the dual eligible population are met through the following program components: initial health risk assessments, program explanation, consent to participate, comprehensive assessments, Quality of Life Survey (QOL) (SF-12), one-on-one disease process education, member disease specific educational materials, assessment of treatment adherence, nutritional education, preventive health education, vaccines (to include influenza and pneumococcal), screenings, Pap smear for sexually active females, Tuberculosis (TB), education on transmission prevention, explanation of benefits, routine follow-up by staff and access to 24/7 Nurse Line.

- i. Initial outreach is conducted to members at time of enrollment for completion of health risk assessment. Screening criteria are used to determine members who are at risk (either physical or behavioral or both). For those members identified at risk, a referral is made to the physical/behavioral health Case Manager/Care Coordinator.
- ii. The Case Management Intake Specialist reviews the referral and assigns the member to an appropriate Case Manager/Care Coordinator. This could be a Behavioral Health Care Coordinator, Palliative Care Case Manager, HIV/AIDS Case Manager, Sickle Cell Case Manager, Diabetes Case Manager, COPD Case Manager, Transplant Case Manager, or general Adult/Child Case Manager.
- iii. The Case Manager/Care Coordinator outreaches to the member to conduct a more comprehensive assessment to determine both short and long-term goals. In addition to the comprehensive assessment, a quality of life survey is conducted. During both the initial assessment as well as the comprehensive assessment, any immediate needs are addressed. If through this process it is identified that the member would also benefit from a disease specific Care Manager, a referral is also made for those services and the member may be co-managed in order to meet the complex needs of that member. Disease specific management includes complex diabetes, COPD, and coronary artery disease. The disease specific Care Coordinator co-manage this member's complex condition with the Case Manager/Care Coordinator.
- iv. The member and the Case Manager/Care Coordinator jointly develop a plan of care. The plan of care is shared with the member's Primary Care Provider and/or specialist. The plan of care includes preventive health measures, management of complex/chronic conditions, clinical interventions, addressing environmental barriers, accessing services, empowerment of the member, and improving outcomes and quality of life.
- v. Case Managers/Care Coordinators coordinate care and address various issues including but not limited to:
 - Pharmacy
 - DME

- Assistance with transportation
- Identification of and access to Specialists
- Referral and coordination with other community resources

b. State whether the model of care specifically addresses the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

The Passport Advantage Model of Care addresses the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life. The frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life are identified upon completion of health risk assessments and referred for further care coordination to any of the three components of the Passport Advantage model of care; dual eligible members may be co-managed in any combination of these programs. Through coordination with the Primary Care Provider/designated medical home/specialist the needs of the member are included in the plan of care for that member and short and long-term goals are established. Physical health and behavioral health Case Management staff/Care Coordinators were trained in the principles of palliative care and the model incorporates those principles into the process. Additionally, one case manager is a certified hospice and palliative care nurse.

6. Extra Benefits and Services

a. List and explain extra benefits and services that are provided to meet the needs of dual-eligible beneficiaries.

Extra Benefits – The only benefit provided by the Plan that exceeds the Medicare benefit deals with the Skilled Nursing Facility benefit. The member pays the coinsurance on days 23-100 on the Skilled Nursing Facility benefit.

Services – In addition to assisting the member with medical/behavioral health access and coordination of care, the care managers/care coordinators teach the members how to understand and utilize their health care benefits and assist the member in accessing needed community resources.

b. List and explain extra benefits and services that are provided to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

See response for 2(a) for specialized services that address the needs of the dual eligible population in the Plan.

7. Outcome Measures

a. State what specific process and outcome measures are used to evaluate performance of the model of care for dual-eligible beneficiaries.

Evaluation of the specific process and outcome measures used to evaluate performance of the model of care for dual-eligible beneficiaries includes:

i. Case Management/Care Coordination Process Measures

- Analysis of enrollment in Case Management/Care Coordination by diagnosis is completed quarterly to determine if the need exist for expansion of areas of focus as subpopulations are identified
- Reasons for discharge from Case Management - Review results quarterly to identify trends and take actions as necessary
- Goals met or unmet is reported quarterly and tracks the percentage of members completing, partially completing, or not completing their treatment plan goals
- Variances for goals not me are reported quarterly and identifies reasons why goals where not met
- Member satisfaction with the Case Management process and services is evaluated on a quarterly basis
- Evaluation of member self-reported improvements in quality of life is evaluated on a quarterly basis

Outcomes Measures

HEDIS® measures are utilized on an annual basis to assess clinical outcomes. These include:

- Colorectal Cancer Screening
- Breast Cancer Screening
- Osteoporosis Management in Women who have had a fracture
- Controlling high blood pressure
- Beta-blocker treatment after a heart attack
- Persistence of beta-blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive diabetes care
- Use of spirometry testing in the assessment and diagnosis of COPD
- Glaucoma screening in older adults
- Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis
- Annual monitoring for patients on persistent medication
- Drugs to be avoided in the elderly
- Potentially harmful drug-disease interactions in the elderly
- Adults' access to preventive/ambulatory health services

ii. Behavioral Health Care Coordination Process Measures

- **Inpatient Utilization Report** – evaluated quarterly to monitor for over and underutilization of inpatient behavioral health services
- **Diagnosis Report** – quarterly report to track and trend primary admitting behavioral health diagnosis
- **Readmissions to inpatient psychiatric hospital within 30 days or less** - evaluated quarterly to monitor for over and underutilization of inpatient behavioral health services.

- **Referrals to Behavioral Health Care Coordination** – quarterly review of number of member referred, number accepted, number co-managed with case management, number of members unable to contact.
- **Goals met or unmet** - reported quarterly and tracks the percentage of members completing, partially completing, or not completing their treatment plan goals
- **Variances for goals not met** - reported quarterly and identifies reasons why goals where not met
- **Member satisfaction with the Case Management process and services** - evaluated on a quarterly basis

Outcomes Measures

HEDIS® measures are utilized on an annual basis to assess clinical outcomes. These include:

- Follow-up after hospitalization for mental illness
- Antidepressant medication management
- Initiation and engagement of alcohol and other drug dependence treatment

iii. Health and Disease Management Care Coordination Process Measures

- **Quarterly reports for Disease Management Program including:**
 - Number of dual eligibles in each program
 - Rate per 1000 for each disease state (CAD, COPD, Diabetes)
 - % of program membership on appropriate medication for condition
 - % of program membership with appropriate testing for condition
 - % of program membership with ER visits in a rolling 12 months
 - % of program membership with IP admissions in a rolling 12 months
 - % of program membership with certain comorbidities

Outcomes Measures

HEDIS® measures are utilized on an annual basis to assess clinical outcomes. These include:

- Colorectal Cancer Screening
- Breast Cancer Screening
- Controlling high blood pressure
- Beta-blocker treatment after a heart attack
- Persistence of beta-blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive diabetes care
- Use of spirometry testing in the assessment and diagnosis of COPD

b. Address the specific process and outcome measures the plan used to evaluate performance of the model of care for frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

Frail/disabled beneficiaries

- Goals met or unmet is reported quarterly and tracks the percentage of members completing, partially completing, or not completing their treatment plan goals
- Variances for goals not met is reported quarterly and identifies reasons why goals were not met
- Member satisfaction with the Case Management process and services is evaluated on a quarterly basis.
- Evaluation of member self-reported improvements in quality of life is evaluated on a quarterly basis.
- Glaucoma screening in older adults
- Disease modifying anti-rheumatic drug therapy in rheumatoid arthritis
- Annual monitoring for patients on persistent medication
- Drugs to be avoided in the elderly
- Potentially harmful drug-disease interactions in the elderly
- Adults' access to preventive/ambulatory health services
- Colorectal Cancer Screening
- Breast Cancer Screening
- Osteoporosis Management in Women who have had a fracture.
- Controlling high blood pressure

Beneficiaries with multiple chronic illnesses

- % of program membership on appropriate medication for condition
- % of program membership with appropriate testing for condition
- % of program membership with ER visits in a rolling 12 months
- % of program membership with IP admissions in a rolling 12 months
- % of program membership with certain comorbidities
- Beta-blocker treatment after a heart attack
- Persistence of beta-blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive diabetes care
- Use of spirometry testing in the assessment and diagnosis of COPD

Beneficiaries near the end of life

- Goals met or unmet is reported quarterly and tracks the percentage of members completing, partially completing, or not completing their treatment plan goals
- Variances for goals not met are reported quarterly and identifies reasons why goals were not met
- Member satisfaction with the Case Management process and services is evaluated on a quarterly basis
- Evaluation of member self-reported improvements in quality of life is evaluated on a quarterly basis

- Controlling high blood pressure
- Persistence of beta-blocker treatment after a heart attack
- Cholesterol management for patients with cardiovascular conditions
- Comprehensive diabetes care
- Use of spirometry testing in the assessment and diagnosis of COPD
- Annual monitoring for patients on persistent medication
- Drugs to be avoided in the elderly
- Potentially harmful drug-disease interactions in the elderly
- Adults' access to preventive/ambulatory health services

State whether the SNP provider and pharmacy networks are different than the networks for the MAOs other Medicare coordinated care plans (CCP) plans in the same service area under this contract.

The Medicare Advantage Plan, Passport Advantage, operates in a sixteen county region in Kentucky. This specific region comprises the entire service area. Further, there are no other Medicare Advantage Plans sponsored by University Health Care, Inc.

Clinical Expertise

- Describe the pertinent clinical expertise used in the provider network to meet the special needs of the dual-eligible population.**

In order to meet the special needs of the dual eligible population, the Passport Advantage provider network includes specialties which are pertinent to the needs of this population. These specialties include physicians with expertise in chronic conditions, specialties addressing issues related to frail/disabled and those beneficiaries near the end of life. These specialties include:

Provider specialties:

Specialty
Allergy
Anesthesiology
Audiology
Cardiology
Cardiovascular
Critical Care
Cardiothoracic Surgery
Chiropractor
Comprehensive Inpatient Rehab
Community Medical Health Ctr
Certified Nurse Midwife
Comprehensive Outpatient Rehab
Cert Reg Nurse Anes CRNA
Cert Reg Nurse Practitioner
Cert Reg Nurse Pract OBGY

Specialty
Neurophysiology
Neuro-Ophthalmology
Nurse Practitioner
Neurological Surgery
Nuclear Medicine
Nutritionist
Obstetrics
OB/Gynecology
Occupational Medicine
Ophthalmology - Cornea
Oculo Plast Reconst Surg
Occupational Therapist
Ocularist
Ophthalmology - Glaucoma
Oncology

Specialty
Physical Medicine & Rehab
Pediatrics, Nephrology
Pediatrics, Nurse Practitioner
Pediatrics, Ophthalmology
Pediatrics, Orthopedic Surgery
Pediatrics
Otorhinolaryngology
Pediatrics, Pathology
Preventative Medicine
Emergency Room Physician
Prosthodontics
Prosthetics & Orthotics
Pediatrics, Rheumatology
Preventative Medicine
Psychiatry, Child
Psychologist

Diabetes Educator
Oral and Maxillofacial Surgeon
Dermatology
Developmental Rehab
Diabetology
Dialysis Center
Durable Medical Supplier
Podiatry
Dermopathology
Endocrinology
Ears/Nose/Throat
Federally Funded Health Clinic
Family Practice
FP, Maternal & Child Health
Federally Qualified Health Ctr
Gastroenterology
Geriatrics
General Practice
Gynecology
Hematology
Hematology & Oncology
Surgery, Hand
Home Health Agency
Hospital - Infusion Therapy
Home Infusion
Hospital
Immunology
Infusion Center
Infectious Disease
Internal Medicine
Laboratory
Lithotripsy/Kidney
Long Term Care Facility
Midwife
Mental/Rehab Clinic
Multiple Specialty Group
Neonatology
Nephrology
Neurology

Gynecologic Oncology
Optician
Ophthalmology-Plastic Recon
Optical Supply
Optometry
Ophthalmology
Ophthalmology - Retina
Orthodontics
Orthotics & Prosthetics
Orthopaedics
Osteopathy
Oral Surgery
Otorhinolaryngology
Pain Management
Pathology, Clinical
Hospital Pathology
Pediatric Anesthesiology
Pathology
Pediatric Critical Care
Pediatrics, Allergy
Pediatrics, Cardiology
Pediatrics, Developmental
Pediatrics, Endocrinology
Pediatrics, Gastroenterology
Pediatrics, Infectious Disease
Private Duty Nursing
Pediatrics, Hem/Onc
Pediatrics, Oncology
Pediatrics, Pulmonology
Pediatrics, Radiology
Pediatrics, Neurosurgery
Pediatrics, Neurology
Pediatrics
Pediatrics, Emergency Medicine
Periodontics
Perinatology
Physician Assistant
Pediatrics, Internal Medicine
Private Mental Health

Psychiatry, Neurology
Psych Rehab-Subst Abuse
Pediatric Surgery
Plastic Surgery
Psychiatry
Physical Therapy
Pulmonary Disease
Pediatrics, Urology
Radiology
Radiation Oncology
Radiology, Diagnostic
Res Substance Abuse Treat Ctr
Radiology, Therapeutic
Rural Health Clinic
Rheumatology
Res Psych Treatment Center
Surgery, Cardiovascular
Surgery, Colon and Rectal
Sleep Disorders
Skilled Nursing Facility
Surgery, Oncology
Social Worker
Surgery, Pathology
Surgery, Pediatric
Surgery, Plastic, Facial
Surgery, Plast. Maxillofacial
Surgery, Orthopedic
Speech Pathology
Speech Therapy
Surgery, Thoracic
Surgery, Transplant
Surgery, Urological
General Surgery
Urogynecology
Urology
Vitreoretinal Surg
Vascular Medicine
Vascular Surgery
Xray

b. Address the pertinent clinical expertise used to meet the needs of frail/disabled beneficiaries, beneficiaries with multiple chronic illnesses, and beneficiaries near the end of life.

i. Frail/disabled

Specialty
Allergy
Anesthesiology
Audiology
Cardiology

Specialty
Neurophysiology
Neuro-Ophthalmology
Nurse Practitioner
Neurological Surgery

Specialty
Physical Medicine & Rehab
Pediatrics, Nephrology
Pediatrics, Nurse Practitioner
Pediatrics, Ophthalmology

Cardiovascular
Critical Care
Cardiothoracic Surgery
Chiropractor
Comprehensive Inpatient Rehab
Community Medical Health Ctr
Certified Nurse Midwife
Comprehensive Outpatient Rehab
Cert Reg Nurse Anes CRNA
Cert Reg Nurse Practitioner
Cert Reg Nurse Pract OBGY
Diabetes Educator
Oral and Maxillofacial Surgeon
Dermatology
Developmental Rehab
Diabetology
Dialysis Center
Durable Medical Supplier
Podiatry
Dermopathology
Endocrinology
Ears/Nose/Throat
Federally Funded Health Clinic
Family Practice
FP, Maternal & Child Health
Federally Qualified Health Ctr
Gastroenterology
Geriatrics
General Practice
Gynecology
Hematology
Hematology & Oncology
Surgery, Hand
Home Health Agency
Hospital - Infusion Therapy
Home Infusion
Hospital
Immunology
Infusion Center
Infectious Disease
Internal Medicine
Laboratory
Lithotripsy/Kidney
Long Term Care Facility
Midwife
Mental/Rehab Clinic
Multiple Specialty Group
Neonatology
Nephrology
Neurology

Nuclear Medicine
Nutritionist
Obstetrics
OB/Gynecology
Occupational Medicine
Ophthalmology - Cornea
Occulo Plast Reconst Surg
Occupational Therapist
Occularist
Ophthalmology - Glaucoma
Oncology
Gynecologic Oncology
Optician
Ophthalmology-Plastic Recon
Optical Supply
Optometry
Ophthalmology
Ophthalmology - Retina
Orthodontics
Orthotics & Prosthetics
Orthopaedics
Osteopathy
Oral Surgery
Otorhinolaryngology
Pain Management
Pathology, Clinical
Hospital Pathology
Pediatric Anesthesiology
Pathology
Pediatric Critical Care
Pediatrics, Allergy
Pediatrics, Cardiology
Pediatrics, Developmental
Pediatrics, Endocrinology
Pediatrics, Gastroenterology
Pediatrics, Infectious Disease
Private Duty Nursing
Pediatrics, Hem/Onc
Pediatrics, Oncology
Pediatrics, Pulmonology
Pediatrics, Radiology
Pediatrics, Neurosurgery
Pediatrics, Neurology
Pediatrics
Pediatrics, Emergency Medicine
Periodontics
Perinatology
Physician Assistant
Pediatrics, Internal Medicine
Private Mental Health

Pediatrics, Orthopedic Surgery
Pediatrics
Otorhinolaryngology
Pediatrics, Pathology
Preventative Medicine
Emergency Room Physician
Prosthodontics
Prosthetics & Orthotics
Pediatrics, Rheumatology
Preventative Medicine
Psychiatry, Child
Psychologist
Psychiatry, Neurology
Psych Rehab-Subst Abuse
Pediatric Surgery
Plastic Surgery
Psychiatry
Physical Therapy
Pulmonary Disease
Pediatrics, Urology
Radiology
Radiation Oncology
Radiology, Diagnostic
Res Substance Abuse Treat Ctr
Radiology, Therapeutic
Rural Health Clinic
Rheumatology
Res Psych Treatment Center
Surgery, Cardiovascular
Surgery, Colon and Rectal
Sleep Disorders
Skilled Nursing Facility
Surgery, Oncology
Social Worker
Surgery, Pathology
Surgery, Pediatric
Surgery, Plastic, Facial
Surgery, Plast. Maxillofacial
Surgery, Orthopedic
Speech Pathology
Speech Therapy
Surgery, Thoracic
Surgery, Transplant
Surgery, Urological
General Surgery
Urogynecology
Urology
Vitreoretinal Surg
Vascular Medicine
Vascular Surgery
Xray

ii. Chronic Illness

Specialty
Allergy
Anesthesiology
Audiology
Cardiology
Cardiovascular
Critical Care
Cardiothoracic Surgery
Chiropractor
Comprehensive Inpatient Rehab
Community Medical Health Ctr
Certified Nurse Midwife
Comprehensive Outpatient Rehab
Cert Reg Nurse Anes CRNA
Cert Reg Nurse Practitioner
Cert Reg Nurse Pract OBGY
Diabetes Educator
Oral and Maxillofacial Surgeon
Dermatology
Developmental Rehab
Diabetology
Dialysis Center
Durable Medical Supplier
Podiatry
Dermopathology
Endocrinology
Ears/Nose/Throat
Federally Funded Health Clinic
Family Practice
FP, Maternal & Child Health
Federally Qualified Health Ctr
Gastroenterology
Geriatrics
General Practice
Gynecology
Hematology
Hematology & Oncology
Surgery, Hand
Home Health Agency
Hospital - Infusion Therapy
Home Infusion
Hospital
Immunology

Specialty
Neurophysiology
Neuro-Ophthalmology
Nurse Practitioner
Neurological Surgery
Nuclear Medicine
Nutritionist
Obstetrics
OB/Gynecology
Occupational Medicine
Ophthalmology - Cornea
Occulo Plast Reconst Surg
Occupational Therapist
Occularist
Ophthalmology - Glaucoma
Oncology
Gynecologic Oncology
Optician
Ophthalmology-Plastic Recon
Optical Supply
Optometry
Ophthalmology
Ophthalmology - Retina
Orthodontics
Orthotics & Prosthetics
Orthopaedics
Osteopathy
Oral Surgery
Otorhinolaryngology
Pain Management
Pathology, Clinical
Hospital Pathology
Pediatric Anesthesiology
Pathology
Pediatric Critical Care
Pediatrics, Allergy
Pediatrics, Cardiology
Pediatrics, Developmental
Pediatrics, Endocrinology
Pediatrics, Gastroenterology
Pediatrics, Infectious Disease
Private Duty Nursing
Pediatrics, Hem/Onc

Specialty
Physical Medicine & Rehab
Pediatrics, Nephrology
Pediatrics, Nurse Practitioner
Pediatrics, Ophthalmology
Pediatrics, Orthopedic Surgery
Pediatrics
Otorhinolaryngology
Pediatrics, Pathology
Preventative Medicine
Emergency Room Physician
Prosthodontics
Prosthetics & Orthotics
Pediatrics, Rheumatology
Preventative Medicine
Psychiatry, Child
Psychologist
Psychiatry, Neurology
Psych Rehab-Subst Abuse
Pediatric Surgery
Plastic Surgery
Psychiatry
Physical Therapy
Pulmonary Disease
Pediatrics, Urology
Radiology
Radiation Oncology
Radiology, Diagnostic
Res Substance Abuse Treat Ctr
Radiology, Therapeutic
Rural Health Clinic
Rheumatology
Res Psych Treatment Center
Surgery, Cardiovascular
Surgery, Colon and Rectal
Sleep Disorders
Skilled Nursing Facility
Surgery, Oncology
Social Worker
Surgery, Pathology
Surgery, Pediatric
Surgery, Plastic, Facial
Surgery, Plast. Maxillofacial
Surgery, Orthopedic

Infusion Center
Infectious Disease
Internal Medicine
Laboratory
Lithotripsy/Kidney
Long Term Care Facility
Midwife
Mental/Rehab Clinic
Multiple Specialty Group
Neonatology
Nephrology
Neurology

Pediatrics, Oncology
Pediatrics, Pulmonology
Pediatrics, Radiology
Pediatrics, Neurosurgery
Pediatrics, Neurology
Pediatrics
Pediatrics, Emergency Medicine
Periodontics
Perinatology
Physician Assistant
Pediatrics, Internal Medicine
Private Mental Health

Speech Pathology
Speech Therapy
Surgery, Thoracic
Surgery, Transplant
Surgery, Urological
General Surgery
Urogynecology
Urology
Vitreoretinal Surg
Vascular Medicine
Vascular Surgery
Xray

iii. Beneficiaries Near the End of Life

Specialty
Allergy
Anesthesiology
Audiology
Cardiology
Cardiovascular
Critical Care
Cardiothoracic Surgery
Chiropractor
Comprehensive Inpatient Rehab
Community Medical Health Ctr
Certified Nurse Midwife
Comprehensive Outpatient Rehab
Cert Reg Nurse Anes CRNA
Cert Reg Nurse Practitioner
Cert Reg Nurse Pract OBGY
Diabetes Educator
Oral and Maxillofacial Surgeon
Dermatology
Developmental Rehab
Diabetology
Dialysis Center
Durable Medical Supplier
Podiatry
Dermopathology
Endocrinology
Ears/Nose/Throat
Federally Funded Health Clinic
Family Practice
FP, Maternal & Child Health
Federally Qualified Health Ctr
Gastroenterology
Geriatrics

Specialty
Neurophysiology
Neuro-Ophthalmology
Nurse Practitioner
Neurological Surgery
Nuclear Medicine
Nutritionist
Obstetrics
OB/Gynecology
Occupational Medicine
Ophthalmology - Cornea
Oculo Plast Reconst Surg
Occupational Therapist
Ocularist
Ophthalmology - Glaucoma
Oncology
Gynecologic Oncology
Optician
Ophthalmology-Plastic Recon
Optical Supply
Optometry
Ophthalmology
Ophthalmology - Retina
Orthodontics
Orthotics & Prosthetics
Orthopaedics
Osteopathy
Oral Surgery
Otorhinolaryngology
Pain Management
Pathology, Clinical
Hospital Pathology
Pediatric Anesthesiology

Specialty
Physical Medicine & Rehab
Pediatrics, Nephrology
Pediatrics, Nurse Practitioner
Pediatrics, Ophthalmology
Pediatrics, Orthopedic Surgery
Pediatrics Otorhinolaryngology
Pediatrics, Pathology
Preventative Medicine
Emergency Room Physician
Prosthodontics
Prosthetics & Orthotics
Pediatrics, Rheumatology
Preventative Medicine
Psychiatry, Child
Psychologist
Psychiatry, Neurology
Psych Rehab-Subst Abuse
Pediatric Surgery
Plastic Surgery
Psychiatry
Physical Therapy
Pulmonary Disease
Pediatrics, Urology
Radiology
Radiation Oncology
Radiology, Diagnostic
Res Substance Abuse Treat Ctr
Radiology, Therapeutic
Rural Health Clinic
Rheumatology
Res Psych Treatment Center
Surgery, Cardiovascular

General Practice	Pathology	Surgery, Colon and Rectal
Gynecology	Pediatric Critical Care	Sleep Disorders
Hematology	Pediatrics, Allergy	Skilled Nursing Facility
Hematology & Oncology	Pediatrics, Cardiology	Surgery, Oncology
Surgery, Hand	Pediatrics, Developmental	Social Worker
Home Health Agency	Pediatrics, Endocrinology	Surgery, Pathology
Hospital - Infusion Therapy	Pediatrics, Gastroenterology	Surgery, Pediatric
Home Infusion	Pediatrics, Infectious Disease	Surgery, Plastic, Facial
Hospital	Private Duty Nursing	Surgery, Plast. Maxillofacial
Immunology	Pediatrics, Hem/Onc	Surgery, Orthopedic
Infusion Center	Pediatrics, Oncology	Speech Pathology
Infectious Disease	Pediatrics, Pulmonology	Speech Therapy
Internal Medicine	Pediatrics, Radiology	Surgery, Thoracic
Laboratory	Pediatrics, Neurosurgery	Surgery, Transplant
Lithotripsy/Kidney	Pediatrics, Neurology	Surgery, Urological
Long Term Care Facility	Pediatrics	General Surgery
Midwife	Pediatrics, Emergency Medicine	Urogynecology
Mental/Rehab Clinic	Periodontics	Urology
Multiple Specialty Group	Perinatology	Vitreoretinal Surg
Neonatology	Physician Assistant	Vascular Medicine
Nephrology	Pediatrics, Internal Medicine	Vascular Surgery
Neurology	Private Mental Health	Xray

10. If the existing network does not include sufficient specialists to fully meet the special needs of the target population, describe the policies and procedures used to arrange access to non-contracted specialists.

Passport Advantage establishes standards for availability to medical care for primary and specialty care providers. Monitoring mechanisms are developed and implemented to assure the accessibility of primary care services, specialist care services and hospital services. (See PR 13.0 (PAD))

If a deficiency is identified in the measurement of the provider network, the following is required of Provider contracting:

- Identify providers in the geographic area who would satisfy network access needs.
- If no providers exist in the needed specialty, document that no providers are available to meet the access standards and indicate the closest available physician who is contracted.
- If providers are available, attempt to contract with the providers.
- If a provider refuses, the refusal of contract must be documented in the Contracts File with an explanation for the refusal.
- Providers who accept Medicare assignment but who are non-contracted with Passport Advantage may provide services to Passport Advantage members and be reimbursed by the Plan.