HPP Care Coordination Support for your Patients

Medicaid and CHIP Programs

PartnerUp Health Partners Plans HPP

Agenda

- Clinical Programs Overview
  - Clinical Connections—Manager, Molly Skalina
  - Baby Partners Program—Manager, Libby Cohen
  - Healthy Kids Program—Manager, Shatara Bowman
  - Special Needs Unit—Manager, Leah French
  - Care Coordination Program—Manager, Debbie Smith
- Important phone numbers

Clinical Programs Overview

- Designed to address needs of members across the life continuum
- Staffed by licensed and non-licensed staff
- Critical components for all programs:
  - Collaboration with member, family/caregivers, health care providers and community agencies, as appropriate
  - Member-centric/whole-person focus
  - Voluntary with the ability to opt out at any time by calling HPP Member Relations or discussing with the HPP Care Coordinator
  - Telephonic, face to face, email, social media, in the community and in provider offices
  - Use of HPP Aunt Bertha to identify SDoH resources
  - Member Rewards for completing important health screenings

Clinical Programs Overview (continued)

- **Program objectives:**
  - Support provider's treatment plan and health care goals
  - Reduce or eliminate barriers to care—such as social and behavioral health needs

Services Provided

- Complete assessment of physical, behavioral and social needs
- Food resources including medically tailored meals and dietary counseling
- Coordination with community resources using Aunt Bertha platform
- Appointment scheduling and transportation assistance
- Disease education

Services Provided
(continued)

- Medication adherence tips
- Behavioral health and substance abuse referrals, as needed
- Collaborative care plan with behavioral health MCO
- Discharge assessment attempted within two days of discharge to ensure needs are in place as well as follow-up appointments are scheduled

Utilizing Telehealth to Improve Patient Access

HPP encourages all Providers to utilize telehealth when appropriate to improve and expand patient access to care.

- **Why use Telehealth:**
  - Covered reimbursable service
  - Reduces patient barrier to accessing timely care for non-emergent or routine care
  - Increases patient ability to access primary care, specialists and behavioral health visits for chronic conditions and medication management
  - Improves your ability to monitor clinical signs for certain chronic medical conditions (e.g. blood pressure, blood glucose, weight gain)
  - Increases patient compliance with needed after hospitalization follow up visits
  - Improves your no show rates

- **Challenges:**
  - Not all HPP members have a phone therefore limiting their access to Telehealth

HPP Can Help Qualified Members Access a Phone Service through Pennsylvania's Life Line Program

- Life Line is available for free to qualifying low-income households
- Your patient will qualify if they are receiving Medicaid coverage, this does include Medicare Dual Special Needs members

We can help your HPP qualified patients access these State funded phones and increase your office visit compliance by having your office contact our Provider Service Helpline at 1-888-991-9023. Members can call the number on the back of their ID cards too.

Clinical Connections

Door to all teams

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Clinical Connections

- Triage provider and member referrals to assign the member to the appropriate team
- Post-hospitalization discharge follow-up for members not in active case management
- Health Risk Assessment (HRA)/Health Survey follow-up
- Disease-specific education

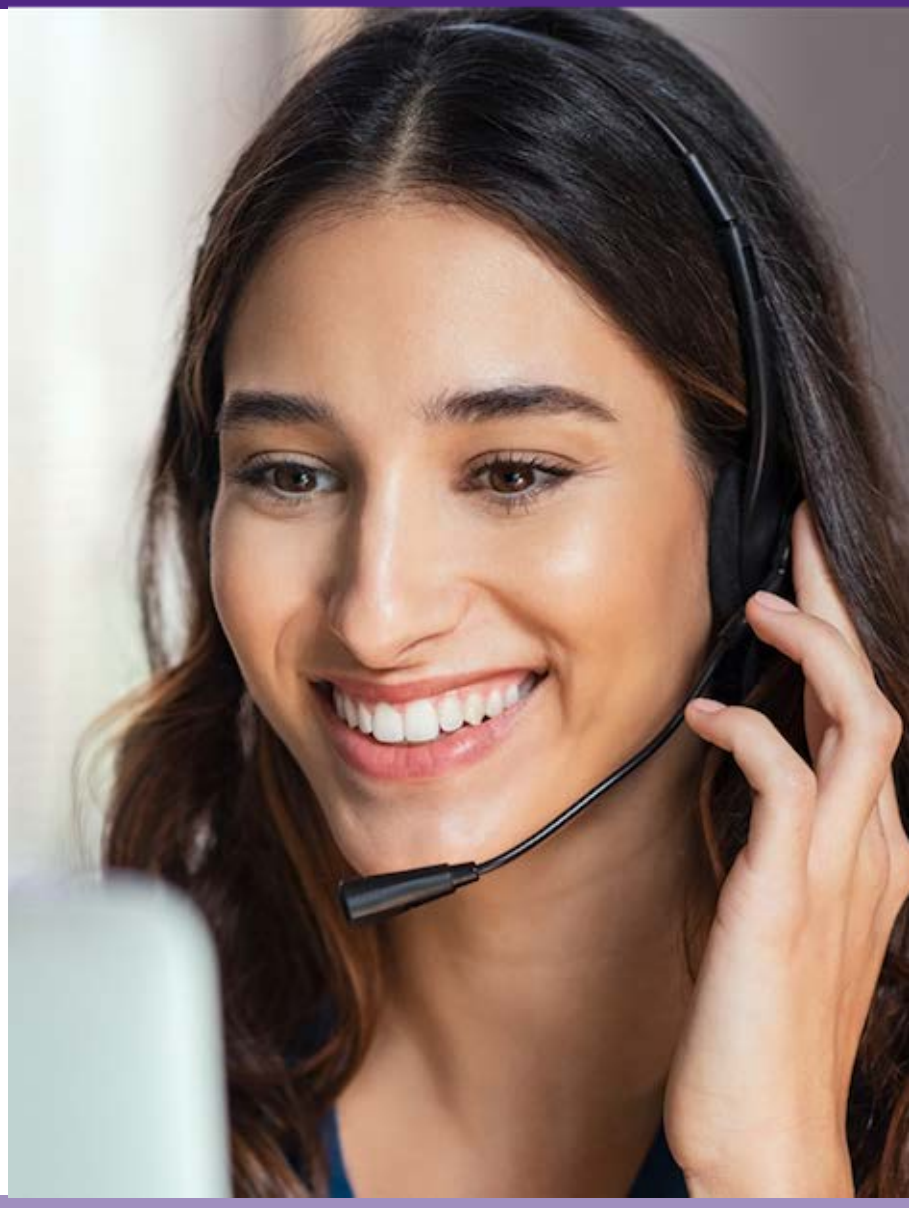
Clinical Connections

Referrals Made Easy

Provider Referral Line: 215-845-4797

ClinicalConnections@HPplans.com

Fax: 215-845-4181



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Baby Partners

Mom and Baby Program

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Baby Partners Builds Relationships

- **Target Population:** Pregnant members with their newborns until 84 days postpartum
- How HPP identifies our pregnant members:
  - ONAF forms
  - New member outreach based on DHS files
- Outreach to members within 5 business days of notification includes:
  - Complete assessment of member's needs, connect to OB care
  - Notice to assigned OB provider – describe the program with assigned HPP staff contact information
  - Single point of member contact
  - Ongoing outreach according to the member's risk schedule

We Go the Extra Mile

Ongoing efforts:

- For members lost to follow up or unreachable
  - Letter is sent to the member letting them know we are available
  - Coordinate with the OB provider and pharmacy for better contact information
  - Partner with HPP UM staff for delivery notification or other inpatient activity
  - Members are eligible for rewards, details at www.healthpartnersplans.com/rewardslist
    - Timeliness of prenatal care
    - Postpartum visit
    - First outpatient well baby visit

Baby Partners

Provider Incentives

- **The Maternity Quality Care Plus (MQCP) program** provides individualized support and targeted feedback to providers and office staff.
- Incentives include:
  - ONAF submission through Optum portal https://obcare.optum.com
  - Selected HEDIS measure impact
- For more details about MQCP visit https://www.healthpartnersplans.com/providers/clinical-resources/pay-for-performance

Healthy Kids

Spreading the word about
EPSDT and Bright Future

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Healthy Kids

- Healthy Kids collaborates with members and providers to increase awareness of all the **EPSDT (Medicaid)** and **Bright Future (CHIP)** periodicity schedule requirements that promote holistic well care
- Proactive outreach and case management for members with the following indicators:
  - Developmental diagnoses
  - Lead exposure
  - Children in Substitute Care (CSC)
  - Neonatal Intensive Care Unit (NICU)
  - Asthma
  - Diabetes
  - Behavioral Health (BH)
- Accepts referrals from parents/guardians, PCPs, hospital and any agency/community organization

Healthy Kids and their Families

- Although the team's primary focus is members up to age 21, we work with the entire family to meet goals and ensure optimal health and well-being of the child including:
  - Preventive services
  - Dental care
  - Behavioral health
  - Developmental and specialty services
  - Social determinants of health

EPSDT/Bright Future Benefits

- The ESPDT/Bright Future benefit provides comprehensive and preventive health care services for children ages 0-21 for Medicaid and ages 0-19 for CHIP
- **Screening services:**
  - Comprehensive health and developmental history
  - Comprehensive unclothed physical exam
  - Appropriate immunizations (according to the Advisory Committee on Immunization Practices)
  - Laboratory tests (including lead toxicity screenings)
  - Health education (anticipatory guidance, including child development, healthy lifestyles and accident and disease prevention)

EPSDT/Bright Future Benefits (continued)

- **Vision Services**
  - At a minimum, diagnosis and treatment (including eyeglasses) for vision defects. Vision services must be provided according to a distinct periodicity schedule developed by the state and at other intervals as medically necessary.
- **Dental Services**
  - At a minimum, dental services include relief of pain and infections, restoration of teeth and maintenance. Dental services may not be limited to emergency services. Each state is required to develop a dental periodicity schedule in consultation with recognized dental organizations involved in child health.
- **Hearing Services**
  - At a minimum, hearing services include diagnosis and treatment for defects in hearing, including hearing aids.

EPSDT/Bright Future Periodicity Schedules

- The EPSDT Periodicity Schedule and Bright Future Periodicity Schedule are located on our website: https://www.healthpartnersplans.com/providers/clinical-resources/epsdtbright-futures

- The Clinical Resources (under Providers) section provides important information related to preventive screenings, such as lead, developmental, hearing and vision.

Adult Case Management

Helping members with chronic, complex needs through Care Coordination and Special Needs Units (SNU)

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Adult Members

How are members identified for proactive care coordination?

- Stratification model based on:
  - Claims
  - Care gaps
  - SDOH needs
  - SPMI indicators
  - Special needs
  - Predictive modeling
- Referrals from HPP internal departments, HRA scores, providers and outside agencies such as BH MCOs

Complex Children

Including shift care members

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Shift Care Members

- Coordination with HPP UM team as well as identified provider, home care agency or medical day care, in collaboration with the family or care giver and assigned school as needed
- Managed by Special Needs Unit specialized team

Shift Care and Medical Day Care

Shift Care Services

- RN or home health aid
- Services can be provided in the home or at school
- Covered under EPSDT until age 21
- Services transition to Office of Developmental Programs or Community HealthChoices at age 21

Medical Day Care

- Day care services for children with special health care needs that preclude them from attending traditional day care settings
- Services up to age 12

Important Phone Numbers

- Refer your patients, our members, through Clinical Connections: **215-548-4797**
- **Together we can improve health care!**