

MAC Binder Section 9 – Provider Communications

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Located online at <http://chfs.ky.gov/dms/mac.htm>

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The MCO's Submit good news stories to DMS on a monthly basis. These stories reflect the positive impact of managed care and demonstrate the diligence of the MCO's effort at the improved and continued health care for Kentucky Medicaid Members.

2-Good News_Oct2015

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September 2015 MCO Good News Reports

MCOs Going Above and Beyond

All MCO staff and members' names have been removed to protect member privacy.



Anthem

An Anthem Case Manager has been working with a teenage member with a serious medical condition whose mother suddenly passed away over the summer. His primary caregiver is now his elderly grandfather who is very concerned about him being able to manage his own care should anything happen to him.

The case manager has helped to transition his care closer to home so that he no longer has to drive long distances each month for his medical appointments. She has also been talking to him about his chewing tobacco habit and has been working with him to quit.

She has engaged him in a plan to work toward learning about his medications. His grandfather has also been given information regarding advanced directives and living will and has been encouraged to look into having a transition plan to another caregiver, if needed.



An Anthem Case Manager has been working with member and her Social Worker since the summer when she was readmitted for having a stroke. Upon returning home, she felt overwhelmed with managing her care and communicating with her providers. She also needed assistance with transportation to her appointments.

The case manager assisted her and her husband with understanding how to schedule transportation services. She is now able to manage this on her own.

The Social Worker also assisted her with receiving a 30 day extension to avoid discontinued electricity service. She educated them on budget billing with the utility company as well.



Anthem Behavioral Health Case Manager has been working with a member who has a history of over twenty years of alcohol and substance addiction. He recently entered treatment voluntarily for help. He is now engaged in his treatment and is making plans to work with others to fight their addictions.

He stated he now feels like he has a purpose. He has also recently reconnected with family and is clean for the first time in two years.



Anthem Community Relations Representative recently spoke to an advocate who works with members in a variety of different capacities. She also serves on the boards of several non-profit organizations. She discussed with the community relations representative the difficulty many enrollees are having when trying to locate a provider who will accept members of the Burmese population due to the language barrier.

The community relations representative explained to her that Anthem's interpreter services are provided to members at no cost to either the member or the provider and provided her with the contact information to inquire about these services.

The community relations representative also informed her that Anthem can work with any provider to educate them on accessing these services. She was very happy to receive this information.



CoventryCares

Member is a 22 year old female with type 1 diabetes along with migraines, depression, anxiety, and obesity. Member is currently managing her diabetes with the use of an insulin pump. Member started working with a CoventryCares RN when she was identified for case management from a recent hospitalization.

While working with the, RN, it was identified that the Member had issues with poor compliance with seeing her doctor and following recommended diet suggestions.

The RN, was able to locate a program called PACT – Projects Affecting Care Transitions which assists members get the right care, at the right place, at the right time. This program offers face to face visits with the member as well as assistance with transportation.

During their initial visit with the member, the PACT resource navigator found out additional information that the member had not shared with the RN. The PACT navigator shared with the RN that the Member was involved in an abusive relationship. The RN was able to assist in getting the Member to a safe place and an appointment for counseling.

Positive Outcomes:

- Collaboration between member and case manager
- Collaboration between case manager and local resource to assist member



Member was referred to case management from a resent admission due to her diabetes. It was found during the admission that Member has been managing her diabetes very poorly. As a result of this, Member has a non-healing sore on her foot that requires dressing changes.

The RN enrolled Member in case management to assist with education on her diabetes. It was discovered that Member is hearing impaired and needed assistance in locating an interpreter service to assist her when home health came to the house for education and performing the dressing changes.

The RN was able to locate an interpreter with Northern KY Services for the Deaf to assist with Member's needs. As a result of locating this interpreter, member was able to communicate with the home health nurses and able to independently perform the dressing changes.

The RN discussed self-management and preventative care with Member. Member was encouraged by the RN to discuss having a routine Pap smear and mammogram with her PCP. Member had both a Pap smear and mammogram completed. The results of the Pap smear were positive for abnormal changes with the possibility of cancer.

The RN encouraged Member to discuss these results with her gynecologist and has been scheduled for total hysterectomy due to the grade of changes.

Positive Outcomes:

- Collaboration between member and case manager
- Encouragement of member to receive preventative care
- Early detection of possible cancer



Humana

A Humana – CareSource (HCS) member was referred to a HCS Case Manager, by a provider who thought the member might need assistance. When the HCS first contacted the member, he had been diagnosed with cancer and was having a very difficult time complying with his diabetes treatment because he did not understand all the medications he was taking.

The HCS was able to convince him to meet her at a Primary Care Provider's office for a visit to help him understand his condition. After working regularly with the HCS, he became compliant with his medication. He was also able to get an operation to address his cancer which has left him cancer free.

Now that he has a better handle on his condition, he checks his blood sugar twice a day and has drastically changed his diet. As a result he now takes substantially less medication and his condition is improving. Due to the HCS's insistence that he meet her at his doctor's office to ensure that he understood his conditions, his medications, and his choices, his health and standard of living has drastically improved.



An elderly Humana – CareSource (HCS) member, was diagnosed with several serious medical conditions and needed assistance coping with her diagnoses. An HCS High Risk Case Manager, had been working with her throughout her time as an patient at a hospital and when it was time to discharge, worked with her to help her understand her discharge plan including follow up appointments and medications.

The HCS discussed the benefits available to her through HCS. She mentioned that she was missing her HCS ID Card and was having trouble making appointments with several specialists. The HCS ensured that a new card was sent to her right away and scheduled an appointment with the providers she requested to see.

The HCS will continue to follow up with her throughout her treatment to make sure that she is on schedule during her recovery.



Passport

A Kentucky Department for Community Based Services (DCBS) worker recently approached Passport Out-of-Home Placement Manager to discuss a concern with a teenage female foster care member who has Passport. She was moved to another location for her own safety after witnessing violence in the community and having to testify against the accused.

The DCBS worker stated the member's foster care agency had given a two week notice stating the member needed to move to a new placement. When asked for more information, the agency stated she has a "bad attitude." The DCBS worker had contacted her foster parent, who said she was willing to keep her if she could get more help. At that time the local agency was only providing individual therapy for her twice per month. The agency told the DCBS worker they were unable to provide additional services for her, even though they had put additional therapy services in place for other children in the same home.

The manager worked with the DCBS worker and the DCBS Central Office to gain these additional services and find a provider in that area who could intervene with the member and her foster parent. By working together, Passport and DCBS were able to find a collaborative way to meet this member's needs when the foster care agency was unable to remove barriers to care and treatment.

A few days later, the DCBS worker emailed Stephanie saying "Thanks so much! We were able to save this placement!"

"We know that the more placement moves children in foster care have, the poorer their short and long-term health outcomes are," says the manager. "We are proud to have helped to maintain this child in her foster home, at least for the time being, which will improve her chances of success now and long-term." This member is one of 1,423 foster care members served by Passport in August 2015.



Fifteen year old Passport member gave birth and was attempting to get an electric breast pump with help from her state social worker. Unfortunately she had lost the original prescription that her OB provider had given her at the time of discharge.

The state social worker called the Passport Foster Care Liaison to determine how she could receive the breast pump. The Liaison contacted her OB provider, who agreed to fax a new prescription to the local supplier.



WellCare

A WellCare of Kentucky Field Service Coordinator was referred to a 63-year-old WellCare of Kentucky Medicaid member who had been recently diagnosed with Lewy body dementia – a form of dementia in the elderly affecting an estimated 1.4 million individuals and their families in the United States. The disease had already caused the member to have difficulty with mobility, incontinence and memory loss. It was also making it very challenging for the daughter to serve as the mother's primary caregiver.

With the goal of keeping the member at home, the field service coordinator referred Hospice Care Plus to provide palliative care. She then educated the daughter on what to expect as the disease progresses and provided her with ways to adapt to the member's changing physical and mental capabilities.

Additionally, the coordinator learned that the daughter did not have a way to check the member's blood pressure, so she ordered her a blood pressure monitor and educated the daughter on the importance of using it daily. She also ordered a bedside commode and incontinence supplies.

The field service coordinator then turned to WellCare's HealthConnections Referral Tracker (HCRT), which includes a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. She started with Kentucky Vision and helped the daughter fill

out an application for glasses for the mother. The daughter was also given a list of local resources for food and utility assistance, and was provided with local medical transportation assistance to help the member get to her medical appointments.

The field service coordinator educated the daughter about additional benefits available to the member, including a behavioral crisis line and a 24-hour nurse line.

Through the field service coordinator's efforts, the daughter now has the proper medical equipment, and access to food and financial resources to ensure the member's dignity and safety. Further, palliative care services will assist the member's daughter with the member's care and allow her to transition into hospice when appropriate. These efforts are allowing the member to stay at home with her family for as long as possible.



A 50-year-old WellCare of Kentucky Medicaid member, who had been admitted into a hospital for alcohol detoxification, was recently discharged into an inpatient alcohol treatment facility. The member, not feeling safe at that particular inpatient facility, stayed only one night and refused to return to that program.

A WellCare of Kentucky field service coordinator met with the member and learned she was in otherwise good health and was very open to getting help for her addiction. The member had a good career as a nurse, but was now unemployed due to her substance abuse issues.

The field service coordinator provided the member with several options for treatment and encouraged her to contact him with questions and when she needed encouragement. In order to address the potential stresses that could trigger a relapse, the coordinator also checked WellCare's HealthConnections Referral Tracker (HCRT), a database with approximately 9,000 Kentucky-based community organizations that WellCare refers its members to for social services support.

Through Lowell's efforts, the member was able to receive the needed social services to allow her to focus on her recovery. As a result, the member has taken initiative in her treatment at an outpatient alcohol treatment facility and has made an appointment with her psychologist. The member has kept in contact with the field services coordinator and shared that she is committed to her treatment to get her life back on track. She also said that she appreciates his concern for her well-being and that she will soon be attending cosmetology school.



October 2015 MCO Good News Reports

MCOs Going Above and Beyond

All MCO staff and members' names have been removed to protect member privacy.



CoventryCares

Member is a 26 year old referred to case management due to her chronic disease needing an expensive treatment. The member was enrolled in case management with a Case Manager Registered Nurse (RN) who provided education regarding the member's chronic disease and treatment. A prior authorization was submitted to pharmacy prior authorization and the medication was approved.

At the time that the member was to receive her education and start her treatment, she was admitted for gall bladder disease so everything had to be placed on hold. The RN worked with the provider's office to get the member rescheduled to start her treatment. An appointment was made but the member had to cancel due to financial issues.

The RN identified that the member met the qualifications for travel reimbursement from the Department of Medicaid Services and was able to secure prior approval for travel reimbursement. The RN provided instructions to the member for submitting her receipts for reimbursement.

The RN was able to reschedule the member's appointment to start her therapy. The member was able to keep her appointment to start her treatment for her chronic disease.

Positive Outcomes:

- Collaboration between member and case manager
- Additional resources located for compliance of treatment
- Successful start of needed treatment



Member was referred to case management from a recent admission due to her diabetes. It was found during the admission that the member has been managing her diabetes very poorly. As a result of this, the member has a non-healing sore on her foot that requires dressing changes.

The RN enrolled the member in case management to assist with education on her diabetes. It was discovered that the member is hearing impaired and needed assistance in locating an interpreter service to assist her when home health came to the house for education and performing the dressing changes.

The RN was able to locate an interpreter with Northern KY Services for the Deaf to assist with the member's needs. As a result of locating this interpreter, the member was able to communicate with the home health nurses and able to perform the dressing changes independently.

The RN discussed self-management and preventative care with the member. She was encouraged by the RN to discuss having a routine PAP smear and mammogram with her PCP. The member had both a PAP smear and mammogram completed. The results of the PAP smear were positive for abnormal changes with the possibility of cancer. The RN encouraged the member to discuss these results with her gynecologist and has been scheduled for total hysterectomy due to the grade of changes.

Positive Outcomes:

- Collaboration between member and case manager
- Encouragement of member to receive preventative care
- Early detection of possible cancer



Humana

The member has a history of preterm delivery and was pregnant. She engaged in Case Management with her Humana CareSource (HCS) Case Manager. She had received an eviction notice and needed to find a place for her family to move. The case manager coordinated efforts with a Social Worker and (HCS) behavioral health vendor because the member also reported that she was depressed.

The Social Worker was able to assist her in finding affordable housing and she did not become homeless. She was also able to utilize (HCS) Behavioral Health services. Through the case manager's coordinated efforts she was able to assist the member throughout her pregnancy and she delivered a healthy baby boy.



A (HCS) Case Manager identified a member based on a report of members that have been to the Emergency Room four or more times in one year. The case manager reached out to the member and he agreed to engage in High Risk Case Management. Through their conversation, the case manager determined that he had been in a serious accident, but he did not have a Primary care physician (PCP) for follow up care from the hospital.

The case manager called five different providers offices in a ten mile radius of his home and verified that the providers were accepting (HCS) and new patients. The member chose one of the providers and became an established patient with the provider one week after first speaking to the case manager.

The case manager was also able to assist him in coordinating efforts with HCS Behavioral Health Vendor to assist in treatment for his behavioral health needs. He is now engaged with both the case manager and with the behavioral health vendor.



Passport

When Passport Embedded Case Manager went into the primary care provider's (PCP) office to speak with a Passport member, she was expecting to discuss the member's 9-month old baby girl. The member had no additional questions for the case manager, but expressed concern about her 3-year old son, (even though it wasn't his appointment).

The member's son was getting ready to start in a "regular" preschool classroom, despite the fact that he was completely nonverbal, developmentally delayed, and had a possible diagnosis of Autism that was not being treated. She stated that the PCP had sent a referral to the Weisskopf Center, but as of that day she had not heard from them and did not know what to do. She was worried that what tiny amount of progress her son had made would be lost very quickly if he was placed into an unfamiliar setting with so many other people.

Having recently attended a professional clinical training at Passport from the University of Louisville (U of L) Autism Center, the case manager was able to educate the mother about a wonderful program through (U of L) that is available to help children and the parents of children with Autism. She explained that her son might qualify for additional speech therapy, assistance with his developmental delays, and an Independent Education Plan (IEP) with his school to help individualize his education.

While the mother waited, the case manager contacted the Weisskopf Center to investigate the status of her son's referral. The case manager discovered the referral was never processed due to wrong information that was entered on their end, and was given instructions on how to help the mother initiate a packet of information to make an appointment and start treatment. The case manager also spoke with the son's PCP, who agreed to make all necessary referrals and fill out IEP forms.

When the case manager told the mother the news, the mother burst into tears because she was so overwhelmed by the support Passport offered her. She stated that without an embedded case manager in the office, she would never have known about any of the services and her son probably would never have been treated. She felt as though she and her son's father were the only ones who had been supporting him, and she never knew that an insurance company could care so much about its members. She said she would be forever grateful for our support.

"I believe that we are all here to help people," says the case manager. "To touch someone's life with such an impact that the mother cried about it is a moment that will stick with me for the rest of my life. The

mom called me an angel and hugged me and said that I saved her child. Granted I think that the referral may have eventually been caught, but the mother was unaware of the additional resources available to her, not from us, but those in the community that can possibly change this child's life for the better. We have improved the care of this member in a way that will affect him for the rest of his life.”

The member is one of 1,072 members served by Passport’s Embedded Case Management program during 2nd quarter 2015.



A Passport member needed oxygen tubing to treat her Chronic Obstructive Pulmonary Disease (COPD), but she was allergic to the tubing provided by her durable medical equipment (DME) provider. Every time she tried to use their tubing, her lungs tightened and she ended up in the hospital. As a result, she had been using her funds to purchase her own tubing due to a misunderstanding with the DME Company.

When a Passport Embedded Case Manager learned of the member’s predicament, she contacted the DME company to ask if they could order tubing that she was not allergic to. The case manager researched tubing options and gave the DME company an alternative non-allergenic product name and identification number. Next, she checked with Passport’s Utilization Management staff and learned that Passport would cover different tubing due to allergy with a prior authorization. Armed with this knowledge, the case manager contacted the member’s primary care provider (PCP) office to request a change in tubing and possible prior authorization.

As a result, the member received the special tubing. She no longer needs to pay out-of-pocket for the tubing and has not been admitted to the hospital for related allergic reactions.

She is one of 1,072 members served by Passport’s Embedded Case Management program during 2nd quarter 2015.



WellCare

A WellCare of Kentucky Field Service Coordinator was referred to a 36-year-old WellCare of Kentucky Medicaid member who is a single mother with three children. The member suffers from multiple medical conditions including asthma, migraines and hypertension exacerbated by depression.

During the initial assessment, the field service coordinator learned that the member’s chronic depression intensified significantly after her husband left her. The member shared that she started experiencing suicidal thoughts. The member also said that she was sleeping up to 20 hours a day and had lost 25 pounds because she was not eating.

The member’s oldest daughter, age 17, was taking care of the two younger children and ensuring they went to school. The member, through her primary care physician, was prescribed antidepressants, but was not seeing any positive results from the medication, potentially due to missing doses. She was also not actively monitoring her hypertension and missing follow up appointments with her doctor. The member also smokes, which has contributed to her asthma.

The field service coordinator assisted the member in scheduling an appointment with her doctor and she also made a referral for a behavioral health visit. She assisted the member in scheduling an appointment for mental health counseling and educated her on depression and coping techniques. She also informed the member about additional benefits available, including a behavioral crisis line and a 24-hour nurse line.

The field service coordinator then turned to WellCare’s HealthConnections Referral Tracker (HCRT), which includes a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. She started with Kentucky Vision and helped her fill out an application for glasses. She was also provided with a list of local resources for food banks and was encouraged to enroll in Quit Now Kentucky to help her stop smoking.

The member is currently receiving mental health support and is seeing her doctor to address her medical needs. The community resources are helping the member get the resources needed for her and her family. Thanks to the intervention of the field services coordinator, the member’s mental state and physical health are improving, and she is now able to cope and care for her family.



A WellCare of Kentucky Field Service Coordinator was referred to a 55-year-old WellCare of Kentucky Medicaid member who had recently been discharged from the hospital after having a stroke due to severe and uncontrolled hypertension.

During the initial assessment, the field services coordinator learned that the member had not been prescribed medication or given a follow up appointment with a doctor to address his hypertension. Since discharge, the member was suffering from chronic headaches and his blood pressure was significantly elevated, which was discovered by a routine check at a pharmacy.

The field service coordinator immediately contacted the member's cardiologist and was able to get him evaluated on the same day, which enabled the member to receive needed medication to better control his hypertension. She also assisted the member in scheduling an appointment with a new primary care physician within two weeks from the initial call. The member was further educated on hypertension, the need to monitor blood pressure and the importance of maintaining a health log to share with his cardiologist and doctor. The field service coordinator also provided the member with information about other benefits, including a behavioral crisis line and a 24-hour nurse line.

The field service coordinator then turned to WellCare's HealthConnections Referral Tracker (HCRT), which includes a database with more than 9,000 Kentucky-based community organizations that WellCare can refer its members to for social services support. She started with Kentucky Vision and helped him fill out an application for his broken glasses. She also encouraged the member to enroll in Quit Now Kentucky to help him stop smoking.

By helping the member to quickly get evaluated by a cardiologist and receive needed medications, the field services coordinator was able to get his blood pressure controlled, decreasing his risk of having another stroke.



Anthem

An Anthem Case Manager had the opportunity to work with one of their members, who needed a specialty MD consult. His treating physician referred him to an out of state specialist; however, due to his current condition, this was not feasible. The case manager began the research to find a local specialist to see him. A specialist was found and an appointment was scheduled, along with transportation assistance, in case he needed it.

Since Anthem Employees go the extra mile, the case manager will be meeting the member at his specialist appointment, to provide any additional support that he may need. He is optimistic that his new doctor will help him heal, so that he can get back to his normal life. He is appreciative of the case manager's assistance, and even called her Manager to express his gratitude. He said, "I had no idea an insurance company could care so much!"



A couple of weeks ago, a Community Outreach representative at Anthem received a call from a gentleman who had been given her information from one of the family resource coordinators in their territory. He was inquiring about healthcare coverage options for his son's family and asked her to speak to his son.

The community outreach representative came to learn this young man had recently been laid-off from an employer he had had for a number of years. He was forced to claim unemployment benefits to support his wife and three children. After a stressful transitional period, the gentleman found another job that paid significantly less than his prior position. He was undeterred and thrilled to be working again.

While filling out his new hire information online, he was prompted to select a type of health insurance coverage. Since his estimated annual income in his new position was about \$23,000, he was unsure about which plan to choose. He was advised by a human resource representative to choose a "Family" plan, and after weighing his options he decided that almost \$300 a month for coverage was reasonable. It wasn't until a few weeks later, when he received his first paycheck, that he found his nearly \$300 contribution was deducted per pay period (biweekly). He was shocked and worried he would be unable to provide for his family after taxes were deducted.

As the community outreach representative spoke with the gentleman, she felt sad and frustrated that he had received such misguided advice. The community outreach representative let him know there was better coverage options available based on his family size. She discussed expanded Medicaid and KCHIP eligibility guidelines in the state, and advised him to make an appointment at his local DCBS office. He reiterated he was happy to receive his personal healthcare coverage provided his employer, since "single" plan coverage would be paid in full and require no employee contribution. He just desperately needed more options for his family in order to sufficiently provide for them.

In the end, the gentleman found affordable coverage for his family through managed care. He was very appreciative for the help and support he received.



A Case Manager was assigned to assist a member after an inpatient hospital stay for heart surgery. He is living with multiple health issues, which require that he take several medications. When the case manager began her assessment of him, she noted that he was missing some medications he was supposed to be taking. He had not realized that he was missing any medications, as most were prescribed once he was discharged. The case manager realized that after he was discharged, he did not have his inhaler. She contacted the pharmacy and determined that the inhaler prescription had been filled, but inadvertently left out of the bag. He was grateful that he could simply return to the pharmacy and pick up his inhaler.

The case manager worked with him, his providers and the Anthem Pharmacy Team, to obtain all of his necessary medications. She also helped him to understand how to use his medications correctly.

Through the case manager's intervention, He has a better understanding how to obtain and utilize his medications, and is now able to manage the process himself.

