

MAC Binder Section 9 – Good News Stories

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

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The MCOs 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 MCOs efforts at the improved and continued health care for KY Medicaid members.

2 – Good News June 2015:

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May 2015 MCO Good News Reports

MCOs Going Above and Beyond

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



CoventryCares

A member is a 33-year-old man with a history of chronic hepatitis C. He was referred to case management to assist with education. A CoventryCares RN was able to enroll him in case management. Member's doctor wanted him to start on a new FDA-approved medication as he has severe liver disease.

The RN educated member on how the liver works and what happens when it gets sick. She assisted him with getting additional therapy for his depression and anxiety.

Medication was approved for 12 weeks of treatment and member successfully started on the new medication. After 4 weeks of treatment, his blood test came back undetected for the virus in his blood. With continued support by the RN, he continued on therapy.

As the 8th week of treatment neared, the RN started looking for a paid claim in the pharmacy system. Seeing none, she started reaching out to the member. After multiple unsuccessful attempts to reach him, she contacted the physician's office only to find out that member had been arrested and was in the local jail.

With the assistance of a CoventryCares social worker, a contact at the local jail was obtained and a medical release was obtained from member for the RN to be able to assist in getting his treatment. The RN and social worker worked diligently with the medical staff at the jail as well as the specialty pharmacy in order for him to be able to complete his treatment without a lapse.

Positive Outcomes:

- Collaboration between member and case manager
- Successful completion and compliance with therapy



A member is a 21 year old expectant mother enrolled in CoventryCare's Crib program. Our RN has been telephonically working with her throughout her pregnancy and she delivered a healthy baby 4 weeks early. The RN called member for her post-delivery follow-up, and mother and baby are both doing well. During the conversation, the new mom told the RN that she had cancelled her post-delivery check-up due to transportation issues. The RN assisted her with contacting the state transportation services and arranging for transportation for a rescheduled appointment.

As the member was actively participating in the Crib program, the RN completed the referral and request for a portable crib. The member explained to the RN that this was greatly appreciated as there were no other sleeping resources available for the newborn.

Positive Outcomes:

- Collaboration between member and case manager
- Successful completion of Crib program with delivery of healthy baby and portable crib.



Humana

An infant member was identified for Case Management through a routine postpartum follow up call. The member's parents informed the Humana – CareSource (HCS) Case Manager, that their child has several conditions that make it impossible for her to drink generic formula or breast milk. Due to her condition, the child's primary care provider regularly switched the prescription for different formulas to find the one that worked best. Each time there was a change to the prescription, her parents contacted WIC (Women Infants and Children) to see if the prescription was covered. Ultimately, the case manager responded most favorably to one particular brand that was not covered by WIC. The child's parents resorted to paying for the formula out of pocket, ultimately borrowing several hundred dollars over the course of a few months. Upon learning this

information, the case manager informed the member's parents that the formula the baby required was covered under HCS with a Prior Authorization. She coordinated with the baby's parents, provider, pharmacy, and HCS Utilization Management Department to ensure that the necessary paperwork was processed correctly and quickly.

The case manager's work on behalf of the infant was able to save her parents hundreds of dollars and ensure that she was able to get the formula she needed in a timely fashion. The HEDIS measures related to this interaction are Postpartum Care and Well Child Care.



A Humana – CareSource (HCS) Case Manager contacted a member to discuss prenatal care, member benefits, and local resources. The member previously had two emergency room visits within the past sixty days and did not have an Obstetrics (OB) provider associated with her records. The member informed the case manager that she has a history of difficult pregnancies and confirmed that she had not seen an OB during this pregnancy and was unsure of her due date. The member also expressed that she has had difficulty getting a job due to a lack of reliable child care and transportation.

The case manager informed her of the importance of prenatal care, especially with her prenatal history. She agreed to allow the case manager to schedule an appointment on her behalf with an in-network OB provider. The case manager followed up after her appointments and confirmed that the member had been able to make it to her appointments without incident. The case manager will continue to follow up on a weekly basis to assist Jessica with her transportation and childcare needs.



Passport

For the past several years a Case Manager interacted telephonically with a Passport member in medically fragile foster care and her foster family. The case manager completed assessments and made ongoing contacts to provide resources and education.

Last month, the case manager was invited to attend a foster care home visit and personally interact with the member, foster parents, commission nurse and state worker. As a result, she obtained more in-depth knowledge and understanding of the member and the struggles her foster parents faced in caring for her.

"This is the first member/foster family I was able to meet in person," says the case manager. "Being able to interact with the child and the foster parents along with the commission nurse and state worker made this more of a team collaboration with everyone's goal of helping the member to be as healthy and have the best quality of life possible."

Shortly after this meeting, the member's foster care parents attended a medically fragile foster parent conference and met the Passport Out of Home Placements Manager. The foster mom told the placements manager that the case manager is "the nicest person." She complimented her for being well-informed of Passport's benefits and how to access care/treatment for her foster child. She that she couldn't be happier working with the case manager, and that she wishes all of her foster kids could have Passport.

This foster child is one of 231 Passport members served by our complex case management program during the 1st quarter of 2015.



An embedded Case Manager recently identified that a Passport Pharmacy Lock-In member was forgetting to refill her medications and having difficulty getting to the pharmacy. The case manager was able to work with our Lock-In program to have her pharmacy changed to one that would deliver her medications and even pick up her physical narcotic strips when dropping off other medications or when in her area as needed. They also set the member up on automatic delivery so that forgetting to call in refills was no longer an issue.

The member expressed sincere gratitude for the assistance. Over the past few months since this interaction, she has been compliant with taking her medications and the case manager has received fewer calls from her about her symptoms related to her diagnosis.

This member is one of 1,225 Passport members contacted by an embedded case manager during the 1st quarter 2015.



A teenage Passport member and foster care child was moving to a different behavioral health facility. The Department for Community Based Services (DCBS) arranged for her to be transported via the sheriff's department. On the day of the scheduled transport, DCBS received word from the sheriff's office that they would be unable to transport the member due to a lack of resources. The local ambulance service was also unable to provide the transportation because the child was a flight risk. The DCBS worker contacted Passport's Out-of-Home Placements Manager to inform her of the situation and ask for help. She was afraid the member would lose placement at the new behavioral facility if she didn't make it there on this day.

The Placements Manager immediately involved a team of seven folks from Passport including: Utilization Management, Care Coordination, and Provider Network Management areas for assistance locating other ambulance services. She also contacted someone in the DCBS Central Office and Children's Review Program for assistance brainstorming solutions. The Passport Rapid Response Team Lead located 2 local ambulance companies in Passport's network. A Passport team member called the new behavioral facility to talk with them about other transportation options. The Placements Manager asked the DCBS worker to call the receiving hospital to see if their ambulance company would assist.

As a result of these fast efforts, we were able to locate an ambulance which agreed to provide transportation for the member. "We sometimes receive urgent calls for matters that have to be dealt with right away," says the Placements Manager. "It feels good to know this member is heading toward the treatment that's been identified as the best fit for her at this time. She didn't lose her spot in the program, and the DCBS worker feels more educated and empowered regarding arranging transportation."

The member is one of approximately 1,418 members served by Passport's Out-of-Home Placements program during 1st quarter 2015.



A young Passport member was having continued asthma symptoms. Though they were mild and have never required admission to a hospital, his mom was very open to additional education and resources since she had seen her child struggle sometimes to breathe and miss school days because of it.

After our Embedded Case Manager presented his standard face-to-face educational asthma power point with the family, the mother described learning a lot about signs, symptoms, and treatment of asthma among other things. She was shocked to learn that her constant use of aerosol-based products such as hairspray, air fresheners, perfumes, burning candles, and strong cleaning agents could be a potential trigger for her child's asthma. Empowered with this new knowledge, she stated she would immediately cut out much of the unnecessary use of these products. When they are absolutely needed, she will limit their use to when the member and his brother are not around (such as during school). After their discussion the mother had a better understanding on what to watch for, early warnings, and how to assess a situation based on the severity of her son's symptoms.

The member is one of 1,225 members served by Passport's Embedded Case Management program in 1st quarter 2015.



When husband and wife non-English speaking Passport members had questions about their co-pays and letters they'd received in the mail, they sought clarification from a Passport Embedded Case Manager on a day he was located at their primary care provider.

Through the use of an interpreter, the case manager educated the couple on their benefits and explained why they would have co-pays for some medications and not others. He helped sort through their medical-related mail for information they did and did not need. He also connected them to a community refugee center so that they would have another resource available to explain materials mailed to them in English. Lastly, he helped connect them to their Medicare Advantage carrier, who was able to answer their Medicare-specific questions.

The couple left with all of their questions answered and a better understanding of what cards they needed to show to whom. They are two of 1,225 members served by Passport's Embedded Case Management program in 1st quarter 2015.



When a Passport member began experiencing issues with his CPAP machine, a Passport Case Manager contacted an Embedded Case Manager for assistance, knowing he had extensive experience as a respiratory therapist. Together, over a conference call, they were able to identify the member's concerns to treatment and barriers to compliance. The embedded case manager offered suggestions to the member on how he could approach his provider and equipment supplier about fine tuning adjustments to improve his compliance. He also educated the member on self-management tools, over-the-counter items, and other products to discuss with his provider.

Thanks to this unique interaction, the member was empowered to speak with his provider on ways to improve compliance with his treatment plan. Passport's complex case managers served 231 members during 1st quarter 2015.



WellCare

A 63-year-old WellCare of Kentucky Medicaid member who has anxiety and depression reached out to WellCare's behavioral health crisis line for assistance handling family stress.

A field service coordinator for WellCare of Kentucky visited the member at her home to check on her and ensure she had follow-up behavioral health appointments scheduled. During their conversation, the member told the service coordinator that the food stamps she receives do not provide her with enough food each month. In addition, the member shared that because she doesn't drive, she cannot access local food banks.

The service coordinator immediately 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. She located a home meal delivery service that would deliver one hot meal to the member each day. Together, the service coordinator and the member called the meal service to get more information and to apply.

Due to the coordinator's efforts, the member now has reliable access to enough food through her food stamps and food delivery to provide better overall nutrition and improve her health. The member told her how much she loves the meals and the staff who delivers them.



A 49-year-old WellCare of Kentucky Medicaid member with coronary artery disease, chronic obstructive pulmonary disease (COPD) and diabetes had just been discharged from the hospital where an abdominal scan revealed he also had a type of cancer.

A field service coordinator for WellCare of Kentucky conducted an in-home visit to follow up with the member. During their conversation, the member told her that he was saving money to purchase a car, but did not currently have any reliable transportation to get to his medical appointments. The member would walk eight miles to see his primary care doctor. He occasionally missed these appointments when his COPD prevented him from making the walk. In fact, the member told her that since his hospital stay, his lack of transportation had prevented him from getting any of the follow-up care needed to treat for his cancer.

The field service coordinator immediately checked WellCare's HCRT for social services support. She located a Community Action Agency which provides non-emergency medical transportation to Medicaid members. When the coordinator mentioned the agency to the member, he said they had previously denied him assistance because there was a vehicle registered in his name. He told her that the vehicle had been stolen a number of years ago.

The field service coordinator called the agency and determined that to authorize his transportation, the member would first need to fax them a copy of the police report. An agency representative also asked that the member have his name removed from the car title. The coordinator explained the severity of the member's health conditions and was able to arrange temporary transportation to allow him adequate time to have his name removed from the car title.

Due to the coordinator's efforts, the member was able to obtain reliable transportation to his medical appointments and is now getting the ongoing treatment he needs to manage his COPD. He also got treatment for his cancer, which doctors were able to remove. The member phoned the field service coordinator to thank her for her assistance and to let her know that he was able to purchase a car, which is allowing him to maintain

his independence, keep his medical appointments and more easily manage his overall health. Without her intervention, the member may not have had the support he needed to get back on his feet.



Anthem

A member was in urgent need of hyperbaric oxygen therapy for a diabetic foot wound. The hyperbaric center was very concerned about getting the service approved as soon as possible. The member was in case management and also had transportation issues. They were able to schedule transportation but were concerned about the difficulties of rescheduling if the therapy could not be approved immediately. Anthem reviewed the request and approved it within a day. The member was able to start treatment within two days of the approval. The provider was surprised with the amount of assistance and follow up they received and called to express their appreciation. They had not received this much assistance from other plans and were sure it would take two weeks or more for the review to be completed.



An Anthem R.N. Case Manager had a recent opportunity to reach out to a member following a hospital stay for her breathing problems. The member was still smoking cigarettes at that time and undecided if she wanted to quit. She also has high blood pressure, which had caused chronic kidney failure due to the condition being untreated. After her next hospital stay, the case manager spoke with the member at length. Over the following weeks, she told her Case Manager that she decided to quit smoking, switch primary care providers, schedule with a specialist for care of her kidneys, and monitor her blood pressure. The case manager educated the member on what Anthem covers for smoking cessation, and she chose the nicotine replacement patches. The case manager assisted the member to get a prescription for the patches from her provider. They also discussed the normal ranges for blood pressure, and what to do if it rises over 140/90. The member agreed to call her doctor in that event. She also verbalized to the case manager that she understood that the steroids she needs for her breathing can raise her blood pressure, so smoking cessation can benefit her in many ways. Finally, the member shared that she had been feeling very sad due to the recent death of family members. The case manager, using integrated case management methods, encouraged her to vent her feelings and provided a listening ear. The member agreed to a behavioral health referral in order to get counseling and possibly medication.

As of today, the member has not had another hospital admission and remains on the right track to a healthier lifestyle.

It is satisfying to see a member start to take better care of herself, ask questions, and take positive, healthy steps in the right direction!



June 2015 MCO Good News Reports

MCOs Going Above and Beyond

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



Humana

A Humana – CareSource (HCS) Case Manager contacted a HCS member in response to a disenrollment request. The member requested a disenrollment because his dentist was no longer accepting KY Medicaid insurance. He did not realize at the time that this included all KY Medicaid MCOs, not just HCS. As a result the case manager found five other dentists in his area that were accepting new HCS members and scheduled an appointment for the provider of his choice.

Rather than stopping once she had solved the member's initial problem, the case manager inquired about any additional medical needs he might have. The member stated that he has a history of depression and sleep apnea, both of which had gone untreated for several months. The case manager immediately scheduled him an appointment with a provider capable of treating his depression and a pulmonologist to treat his sleep apnea.

The member is now enrolled in High Risk Case Management (HRCM) and is in regular contact with his case manager. He informs her if he is having any medical issues, including trouble making an appointment or finding a provider that he needs. Because the case manager did not stop trying to help once she had addressed his initial problem, she was able to uncover additional areas where she could help improve his standard of living and comfort.



A Humana – CareSource (HCS) member who suffers from a Traumatic Brain Injury (TBI) has her mother drive her just over an hour, one way, to a facility that specializes in TBI. While her mother has access to a car, she also has a job which prevents her from being able to provide transportation for her daughter as frequently as is required.

In addition, the member was having difficulties getting a prior authorization (PA) for the care she needed. It was for this reason that she initially reached out to HCS. She was put in touch with one of HCS's Case Managers to assist her. He investigated and discovered that the PA was not being authorized because the provider was not correctly submitting the necessary paperwork. The provider was notified of the issue and the correct documentation was submitted and approved.

Given the member and her mother's situation, the case manager subsequently offered to enroll the member in High Risk Case Management (HRCM) in order to provide further assistance. She accepted and her mother expressed concern about personally transporting her daughter such a long distance on a regular basis. The case manager explained that there is a transportation service in their area that is capable of providing the needed transportation, but additional steps are required to authorize the use of this service because the member has access to a car. After several phone calls coordinating with the state, the providers, and the transportation service, the case manager was able to guide the mother through the process required to obtain the transportation services her daughter needs. Her daughter will now be able to utilize this service on her next visit.

As a result of the case manager's dedication to obtaining the best possible care for the young member, he was able to lighten the burden on this family that has already overcome so much adversity. He will continue to follow up with mother and daughter on a regular basis to ensure that the latter continues to receive the care that she needs, assist them in any way possible, and provide support to this family in their time of need.



Passport

Like many people with Autism disorders, a Passport youth has texture issues and does not eat a wide variety of foods. This limited diet has led to his obesity. When Passport's SCORE** Program Disease Manager reached out to the member's mother, she was thrilled. She was desperately worried that her son might become diagnosed with diabetes (which runs in his family), and didn't know what to do.

The Passport manager worked with the mother to help her understand how to add the healthy foods her son enjoys, but just provide him with the proper portions for his age. She also introduced her to our recipe finder on the Passport Health Plan website. The mother was very excited to learn about different ways to prepare healthy foods for her son. The manager also referred the youth to behavioral health services for further resources for his depression symptoms. His mother has been very motivated to help him and reports he has lost "a few pounds." She said he is also trying new foods and has decreased his screen time. He is even going out of his comfort zone to get healthier, and signed up to walk in his first 5K at his school!

This youth is one of 18 high risk members served by our SCORE program in 2nd Quarter 2015.



A Passport member uses a special Bilevel Positive Airway Pressure (BiPAP) machine for her sleep apnea. Recently, her device started growing very hot after about six hours of use. She became increasingly fearful that it might overheat and catch her home on fire. The Durable Medical Equipment (DME) company who provided the device tested it, but didn't find anything wrong with its function. Still feeling unsafe, Anita didn't know what to do. She contacted a Passport Embedded Case Manager to help with her dilemma.

The case manager discovered that she was due for a new device in November. After speaking with the DME company and Passport's Utilization Management team, he instructed the DME company to submit a request to replace the device. The DME company submitted the paperwork, the equipment was approved, and within a week of the notification to the Embedded CM, the member had a new machine. Now, she is compliant with her treatment and no longer has fears about fire issues with the equipment while she is sleeping.

This member is one of 1,072 served by our Embedded Case Management program during 2nd Quarter 2015.



WellCare

A field service coordinator for WellCare of Kentucky conducted an in-home visit with a 50-year-old WellCare of Kentucky Medicaid member who has diabetes and hypertension. She was referred to the member because his doctors reported that he had not been monitoring his blood pressure or glucose levels. During their conversation, the member told her that he had not had a vision screening, because he knew he couldn't afford the glasses he knew he needed.

The field service coordinator educated the member on the importance of monitoring and recording both his blood sugar and blood pressure so he could share the results with his doctors. She explained how lifestyle changes could reduce the health risks associated with both diseases.

She also scheduled the member an appointment with an eye doctor. Then, she 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. She provided him with information about the Kentucky Vision Project and showed him how to fill out the application once his eye exam was complete.

During a subsequent follow up, the field service coordinator discovered that the member had taken her advice and had made positive changes in both his diet and lifestyle. In addition, because he started monitoring his blood pressure and sugar levels, he was able to report some abnormal findings to his doctor. His doctor used that information to change the member's medications, which brought his results back to normal.

Through the field service coordinator's efforts, the member's risk of complications related to his diabetes and hypertension had decreased. He also had his eyes examined and received new glasses through Kentucky Vision. This helped reduce the likelihood of blindness resulting from his diabetes. The member was able to become more independent, which improved his quality of life and his chances of experiencing a long-term positive health outcome.



A 52-year-old WellCare of Kentucky Medicaid member with hypertension and coronary artery disease had just been discharged from the hospital where he had an aortic valve replacement and triple bypass surgery.

A field service coordinator for WellCare of Kentucky conducted an in-home visit to follow up with the member. She found that he lived alone and did not have reliable transportation. During their conversation, the member told her that he was frustrated because he didn't know when he needed to see his cardiologist again. He also expressed confusion about the dosage and timing of his prescribed medications. Adding to his frustration was his inability to work, which made it hard for him to pay for food, utilities and rent.

The field service coordinator immediately contacted the cardiologist's office and learned that the member had an upcoming appointment with the doctor, as well as a cardiac rehabilitation appointment. She developed a calendar with both his medication schedule and upcoming medical appointments to help the member to follow through with his care plan. Then, she checked WellCare's HealthConnections Referral Tracker (HCRT). She located Federated Transportation, which provides non-emergency medical transportation to Medicaid members. She secured the service for all of his scheduled appointments.

The field service coordinator also used the HCRT to locate local organizations that could help the member pay for rent and utilities. Additionally, she connected the member to a local food bank that could help the member with his nutritional needs.

Through the field service coordinator's efforts, the member is able to keep his medication and appointment schedule organized, and get the care he needs with the assistance of safe and reliable transportation. Assistance with food, rent and utilities helps the member to remain in his home throughout his recovery and improves his quality of life. The member said that field service coordinator's help meant a lot to him because it removed his frustration and showed him that someone cared about his well-being.



Anthem

Case Management Services opened a member's case in February 2015 to help him manage his diabetes and other related complications, including blindness and two cornea transplants. His main concerns were lack of transportation, as his son could no longer provide this, and the onset of depression from loss of vision and ability to function independently in his home.

The member reached out to an Anthem case manager, for help as he had several times in the past. With her guidance, he agreed to contact his Primary Care Provider to discuss his depression and was also referred to LifeSkills for additional treatment, if needed. The member was placed on medication that he now states is helping. He also has the Anthem Crisis line number to call for help if a behavioral health crisis develops.

The case manager investigated other resources and called the local Community Action Center and was able to coordinate help through the Disability Resource Initiative (DRI). They provided the member with a homemaker in his home and assistance with local transportation in his area. The DRI also worked to connect him with his local Blind Club which offers monthly support groups with lunch and will pick him up to take him to these meetings. The Blind Club will also help him arrange out of county transportation, when needed, and transportation around his local area to their support group meetings and non-medical needs. The case manager also helped him get connected with the state transportation broker for his medical transportation needs.

He expressed great appreciation for the support the case manager provided. Thanks to the resources Anthem arranged, the member stated that his mental health has greatly improved. He continues to work to manage his vision loss by improving his diabetes control with the help of a diabetic specialist and hopes to eventually have another cornea transplant and some vision improvement down the road.



A member had been experiencing severe pain caused by his lack of preventative oral healthcare. He spoke with staff at the local health department who put him in contact with an Anthem Community Relations Representative. She was able to work with our dental vendor, DentaQuest, who has a contact at a dental clinic near the member's home. Although they were not accepting new patients at the time, the provider made an exception for him and he was able to finally schedule a visit to the dentist. The member was extremely grateful that Anthem went the extra mile to help him with his dental health.



CoventryCares

Member is an 18 year old referred to case management by customer service. She has multiple birth defects that include cerebral palsy and seizures. She is not able to take any food by mouth and relies completely on receiving feedings by a G-tube. She had been receiving formula, but the order had expired and her primary doctor had closed his practice.

A CoventryCares Registered Nurse (RN) contacted the member's mother to investigate the issue further. Upon review and enrollment in case management, the RN saw that the authorization on file for the formula had just expired so she collaborated with our pediatric medical director to get the authorization extended to cover the formula needed.

The RN assisted the member's mother in locating a new provider and making an appointment as well as working with the provider to obtain the formula.

Positive Outcomes:

- Collaboration between member, case manager, and medical director
- Successful continuation of therapy



A member was referred to case management from concurrent review due to multiple admissions. She had four admissions in two weeks due to multiple chronic issues that include asthma and heart failure as well as other issues. A CoventryCares social worker (SW) was consulted about the care of the member in their home.

During the review, the SW noted that the member's caregiver is her son, who had been in jail for a few weeks. The member was concerned about being able to return home once discharged from the hospital. The SW worked with her in identifying additional support as well as getting home health services, as she did not want to go into a skilled nursing facility.

The SW worked with a CoventryCares registered nurse (RN) to get the member enrolled in case management, as well as having all the things needed for discharge available at home. The member's son was to be released a few days prior to her discharge, but the son's girlfriend was available to assist with care in the interim.

Prior to the SW and RN's involvement, it was planned for the member to stay in the hospital until a facility could be found to accept her. With their involvement, she was able to be discharged to her home, to the care of her son and his girlfriend, with a reduction of days spent in the hospital by five days.

Positive Outcomes:

- Collaboration between member and case manager—both social worker and nurse
- Successful discharge to home with caregivers

