Passport Health Plan Quality Improvement

2018 Evaluation

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Introduction

Annually, University Health Care dba Passport Health Plan ("Passport") completes an evaluation of all quality improvement activities across the organization. Passport is pleased to release its 2018 Quality Improvement (QI) Program Evaluation. Passport's QI Program was established to provide the infrastructure for the continuous monitoring, evaluation and improvement in care, safety, and service. Annually, our goals are measured by the following objectives included in the QI Program:

- To continuously monitor and analyze key clinical and service indicators.
- To coordinate disease and health management programs.
- To conduct outreach and health education activities.
- To develop programs for populations with special needs.
- To conduct intervention studies in clinical and service areas which were selected based on review of data.
- To perform appropriate oversight of delegated activities.
- To conduct satisfaction surveys for members and providers/practitioners.
- To coordinate activities across functional areas to improve care and service.
- To foster an environment that assists practitioners and providers with improving the safety of their practice.
- To conduct oversight of risk management.
- To evaluate the effectiveness of the QI Program.

The QI Program Evaluation first discusses the structure of the organization throughout 2018. The evaluation then considers network management activities and Passport credentialing and re-credentialing activities, followed by clinical and service activities, and concluding with an overall assessment of effectiveness and opportunities for 2018.

This evaluation is not meant to take the place of other detailed program evaluations or reports such as annual evaluations for disease, health, or utilization management programs. However, it will provide a high-level overview of outcomes across all areas of Passport.

QI Staff and Resources

The Chief Medical Officer in conjunction with the Director of Quality and Performance have been granted approval by the CEO of University Health Care to implement the QI Program. The Director oversees the day-to-day operations of the Quality Improvement Department. At the end of 2018, there were ten QI staff members, who performed the QI Department responsibilities, which included but were not limited to:

- Providing staff support to quality improvement and subcommittees.
- Developing initial drafts of QI program documents for review and approval by the CMO, QMMC, and Partnership Council.
- Developing the QI Work Plan and identifying responsible Plan staff to facilitate QI program implementation.
- Reviewing and evaluating quarterly departmental reports and QI Work Plan updates that support the QI Program.
- Participating in the initial evaluation of potential delegates, reviewing and evaluating delegates' reports, and performing annual on-site reviews of delegates.

- Assisting in data collection for selected components of contractual reporting requirements for accrediting bodies and external review agencies.
- Developing and implementing systematic data collection methodologies.
- Monitoring the QI program to assure compliance with regulatory and accrediting agency requirements.
- Developing Passport Health Plan policies and procedures related to quality improvement.
- Conducting medical record reviews against documentation standards and Continuity and Coordination of Care standards.
- Assessing and promoting patient safety through use of the Annual Member Safety Plan.
- Collaborating with internal resources to conduct satisfaction surveys.
- Designing and implementing clinical and service studies to include appropriate methodologies and sample sizes.
- Performing qualitative and quantitative analysis for QI studies.
- Facilitating National Committee of Quality Assurance (NCQA) Accreditation, The Healthcare Effectiveness Data and Information Set (HEDIS®[1]) reporting and Consumer Assessment of Healthcare Providers and Systems (CAHPS®[2]).
- Reviewing and responding to external quality review organization's recommendations.

Additional resources were utilized during the year as follows:

Central HEDIS team to administer collection, review and submission of HEDIS performance measures.

Participating providers contributed recommendations for the QI Program throughout 2018 by involvement in the clinical quality improvement and credentialing committees.

Committee Structure

Committees under the Quality Improvement structure in 2018 included:

- Quality Medical Management Committee (QMMC)
- Credentialing Committee
- Delegation Oversight Committee
- Behavioral Health Joint Committee
- Quality Member Advisory Committee
- Pharmacy and Therapeutics Committee

All committees met the required number of times to meet program objectives during 2018 and were represented at the QMMC.

Quality and Performance Improvement Activities

Quality is comprised of several components across the organization. Performance improvement activities focus on HEDIS®, CAHPS and measures set by the Commonwealth of Kentucky. Quality improvement activities are conducted across the organization which include the performance improvement numbers as well as other measurement sources.

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[1] *HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).*
[2] *CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).*

Healthcare Effectiveness Data and Information Set (HEDIS®)

HEDIS® results reported were obtained though medical record reviews or by using administrative claims data. For those results identified by medical record review, a notation is included reflecting the sample size along with the measure's eligible population. Administrative claims data reflects all claims that meet HEDIS® requirements for each measure. Annual results are based on data from the previous measurement year.

EFFECTIVENESS OF CARE

The following measures are part of the HEDIS Effectiveness of Care domain:

- Prevention and Screening
  - Adult BMI Assessment (ABA)
  - Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC)
  - Childhood Immunization Status (CIS)
  - Immunizations for Adolescents (IMA)
  - Lead Screening in Children (LSC)
  - Breast Cancer Screening (BCS)
  - Cervical Cancer Screening (CCS)
  - Chlamydia Screening in Women (CHL)
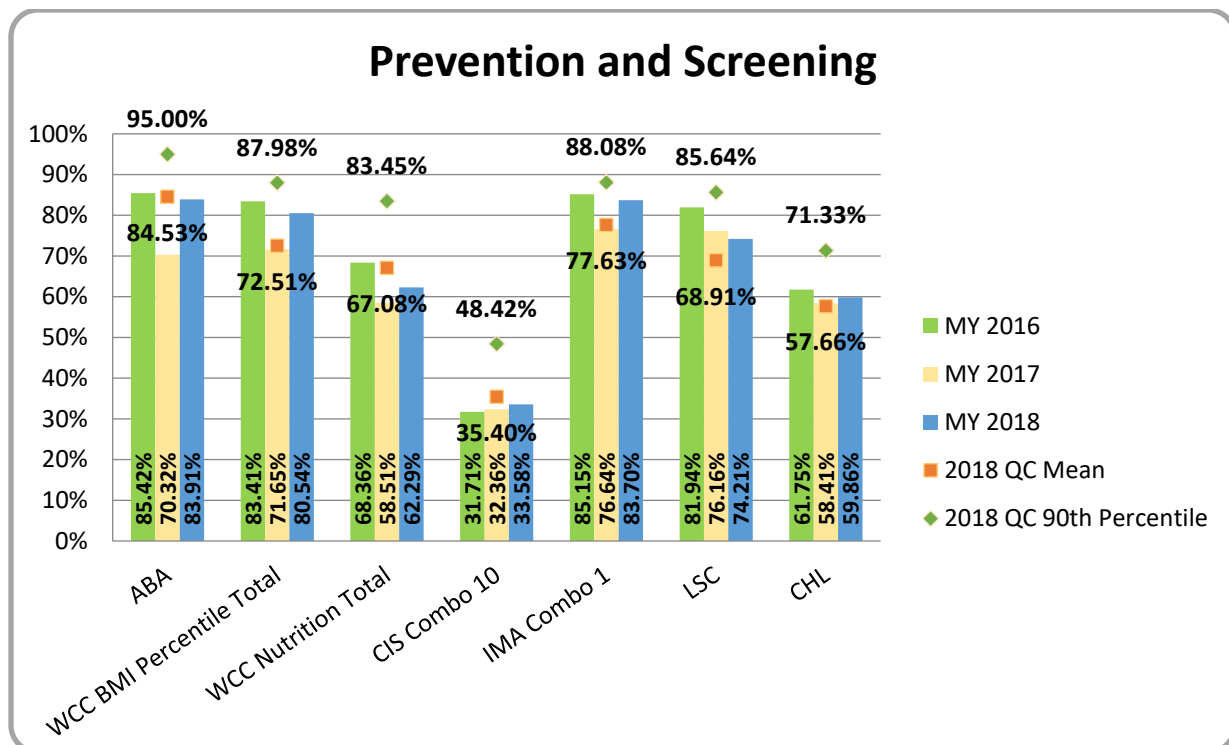
- Respiratory Conditions
  - Appropriate Testing for Children with Pharyngitis (CWP)
  - Use of Spirometry Testing in the Assessment and Diagnosis of COPD (SPR)
  - Pharmacotherapy Management of COPD Exacerbation
  - Medication Management for People with Asthma
  - Asthma Medication Ratio (AMR)

Respiratory Conditions

	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
CWP	86.12%	87.45%	89.96%	78.29%	90.53%
SPR	40.74%	34.93%	30.48%	31.53%	42.19%
COPD Corticosteroid	67.39%	65.86%	52.61%	68.28%	80.61%
COPD Bronchodilator	78.49%	79.70%	64.72%	81.63%	89.66%
MMA 50% Compliance Total	56.12%	61.23%	60.70%		
MMA 75% Compliance Total	29.13%	37.44%	37.06%	36.80%	51.22%
AMR Total	71.38%	65.76%	68.52%	61.35%	71.93%
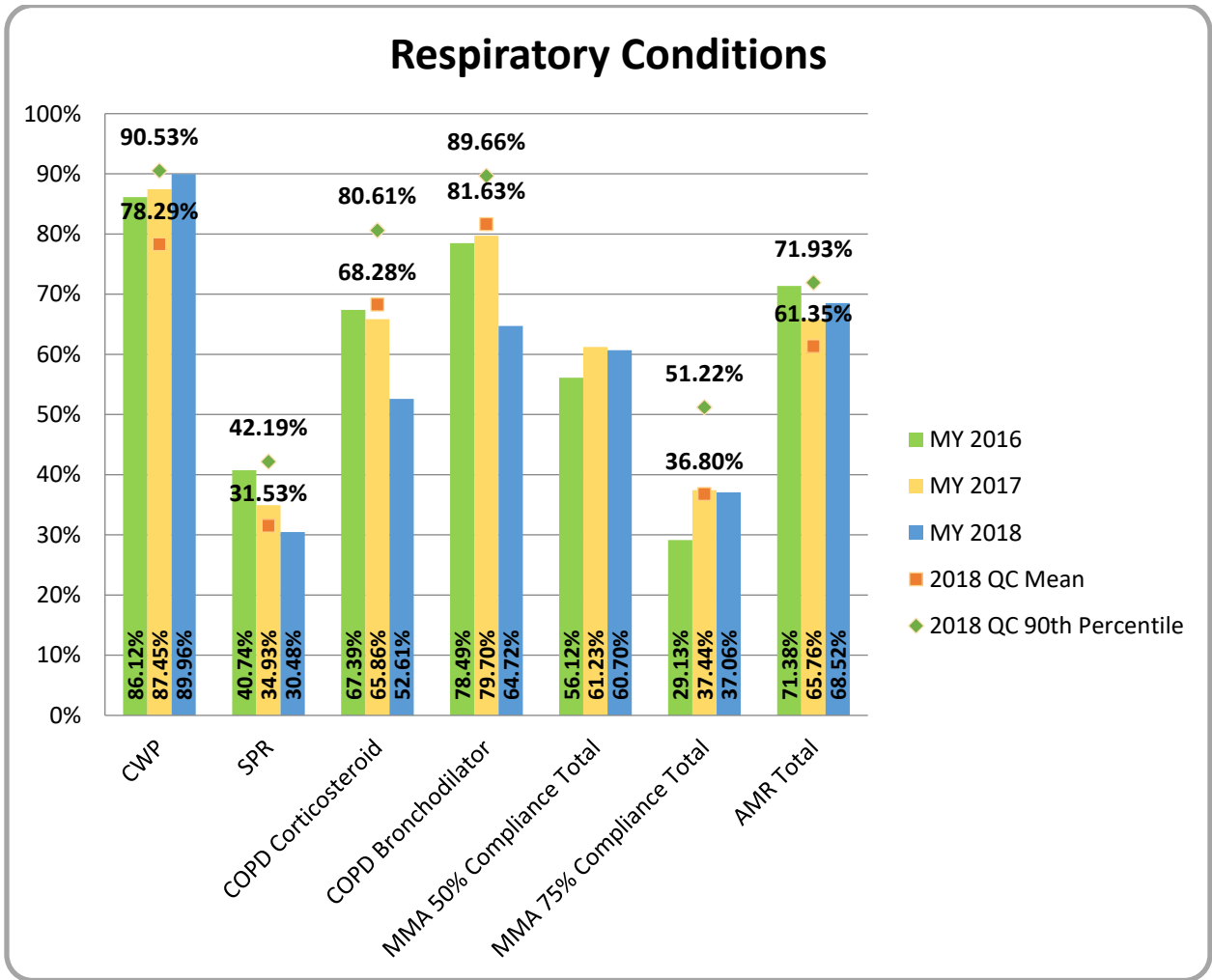
- Cardiovascular Conditions
  - Controlling High Blood Pressure (CBP)
  - Persistence of Beta-Blocker Treatment After a Heart Attack (PBH)
  - Statin Therapy for Patients with Cardiovascular Disease (SPC)

Cardiovascular Conditions
*2015 New Measure

Measure	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
CBP	59.95%	56.86%	48.18%		71.04%
PBH	69.41%	78.39%	73.70%		88.75%
SPC Received Total*	75.32%	76.11%	65.21%		83.75%
SPC Adherence Total*	47.15%	62.88%	60.02%		74.03%
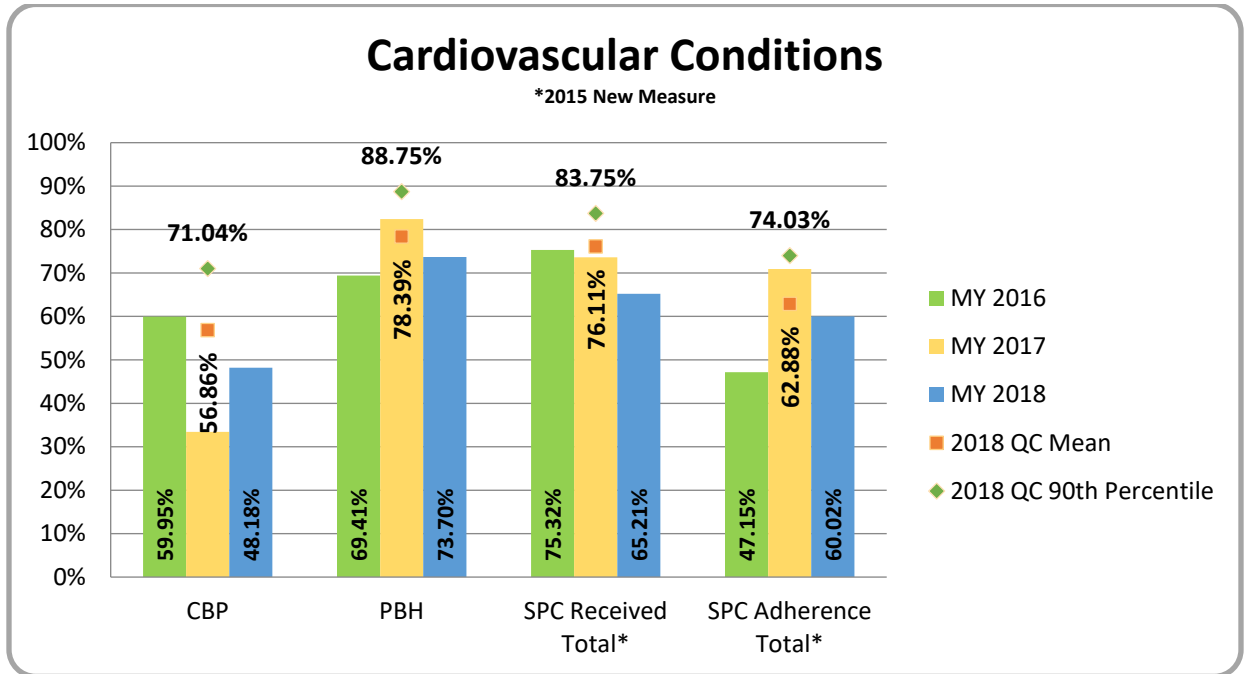
- Diabetes
  - Comprehensive Diabetes Care (CDC)
  - Statin Therapy for Patients with Diabetes (SPD)

Diabetes
2015 New Measure

Legend:
- MY 2016
- MY 2017
- MY 2018
- 2018 QC Mean
- 2018 QC 90th Percentile

Measure	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
CDC HbA1c Testing	86.73%	86.31%	87.96%	87.54%	92.70%
CDC HbA1c Poor Control...	37.15%	56.93%	58.58%	40.55%	29.68%
CDC HbA1c Control <8%	50.91%	34.67%	33.58%	49.34%	59.49%
CDC Hba1c Good Control...	38.70%	23.98%	24.32%	34.53%	42.69%
CDC Eye Exams	42.62%	44.53%	40.69%	57.13%	68.61%
CDC Nephropathy	90.05%	89.78%	88.50%	90.12%	93.43%
CDC Blood Pressure <140/90	65.01%	52.37%	52.37%	62.65%	77.50%
SPD Received*	59.76%	59.68%	53.32%	61.39%	68.78%
SPD Adherence*	46.46%	66.75%	58.05%	58.90%	72.03%

- Musculoskeletal Conditions
  - Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis (ART)

Musculoskeletal Conditions

Legend:
- MY 2016
- MY 2017
- MY 2018
- 2018 QC Mean
- 2018 QC 90th Percentile

Data values:
- 2018 QC 90th Percentile: 84.65%
- 2018 QC Mean: 73.88%
- MY 2016: 69.66%
- MY 2017: 63.31%
- MY 2018: 57.89%

X-axis: ART
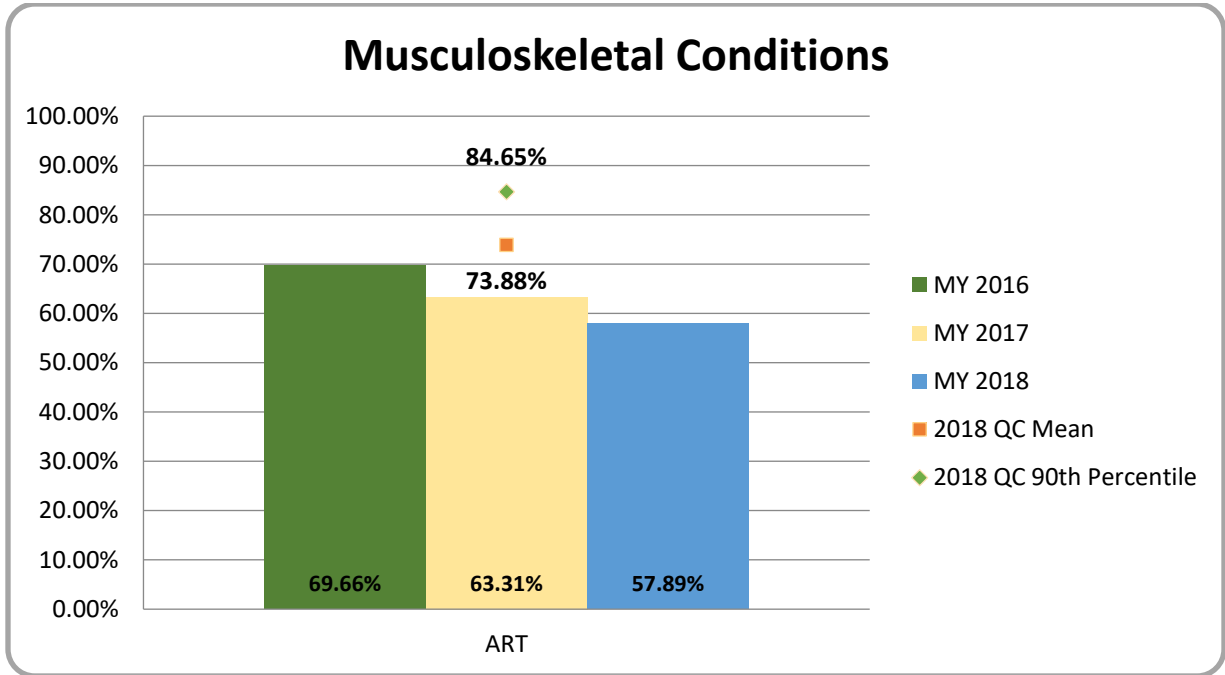
- Behavioral Health
    - Antidepressant Medication Management (AMM)
    - Follow-Up Care for Children Prescribed ADHD Medication (ADD)
    - Follow-Up After Hospitalization for Mental Illness (FUH)
    - Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications (SSD)
    - Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)
    - Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia (SMC)
    - Adherence to Antipsychotic Medications for Individuals with Schizophrenia (SAA)
    - Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM)

Behavioral Health Care Management

	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
AMM Acute	50.10%	52.84%	50.47%	53.82%	64.72%
AMM Continuation	33.72%	41.66%	33.45%	38.51%	49.24%
ADD Initial	56.86%	42.88%	40.85%	44.63%	55.91%
ADD Continuation	67.51%	49.90%	52.12%	54.95%	69.14%
FUH 7 Days	66.79%	24.54%	23.92%	37.01%	54.13%
FUH 30 Days	77.01%	49.08%	46.36%	57.95%	74.17%
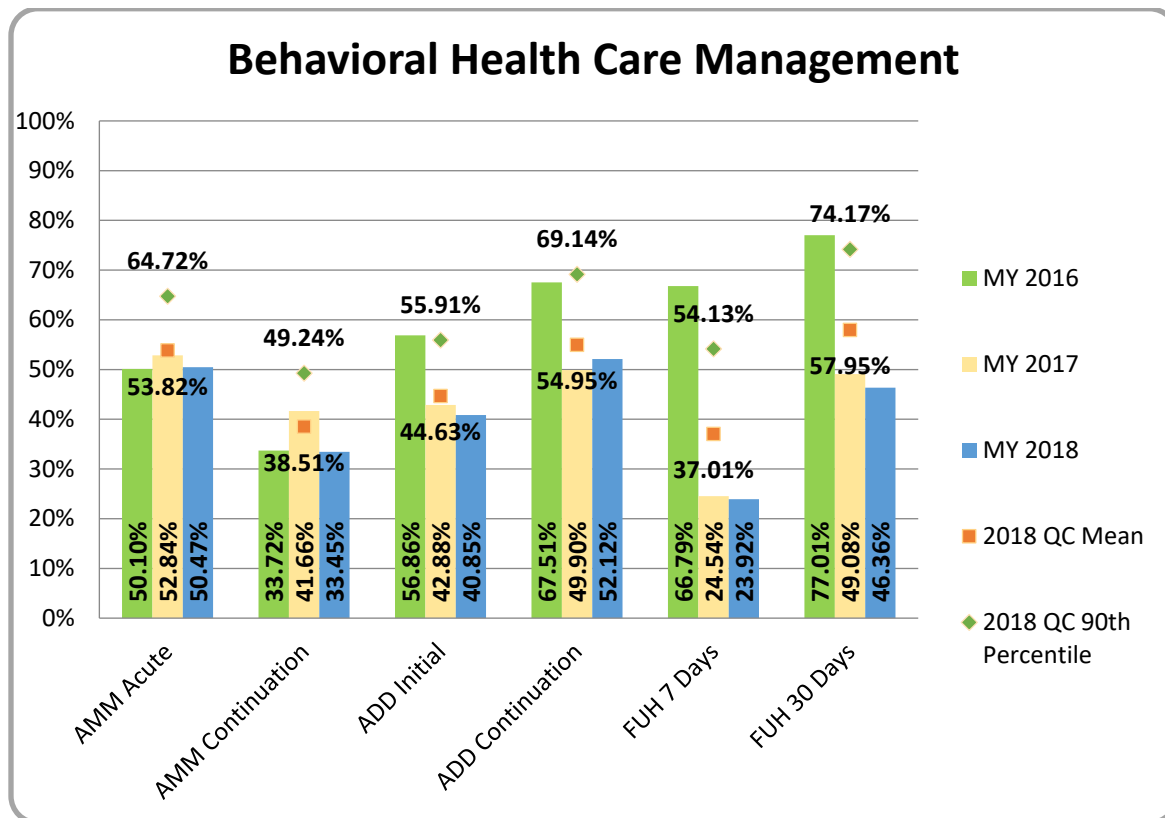
Medical Management of Members with Behavioral Health Conditions

	SSD	SMD	SMC	SAA	APM Total
MY 2016	84.17%	63.46%	100.00%	35.45%	38.73%
MY 2017	83.13%	68.87%	82.76%	48.15%	33.96%
MY 2018	84.69%	73.14%	67.27%	52.88%	35.65%
2018 QC Mean	80.80%	70.42%	78.81%	58.96%	34.64%
2018 QC 90th Percentile	87.44%	80.38%	88.71%	71.74%	50.85%
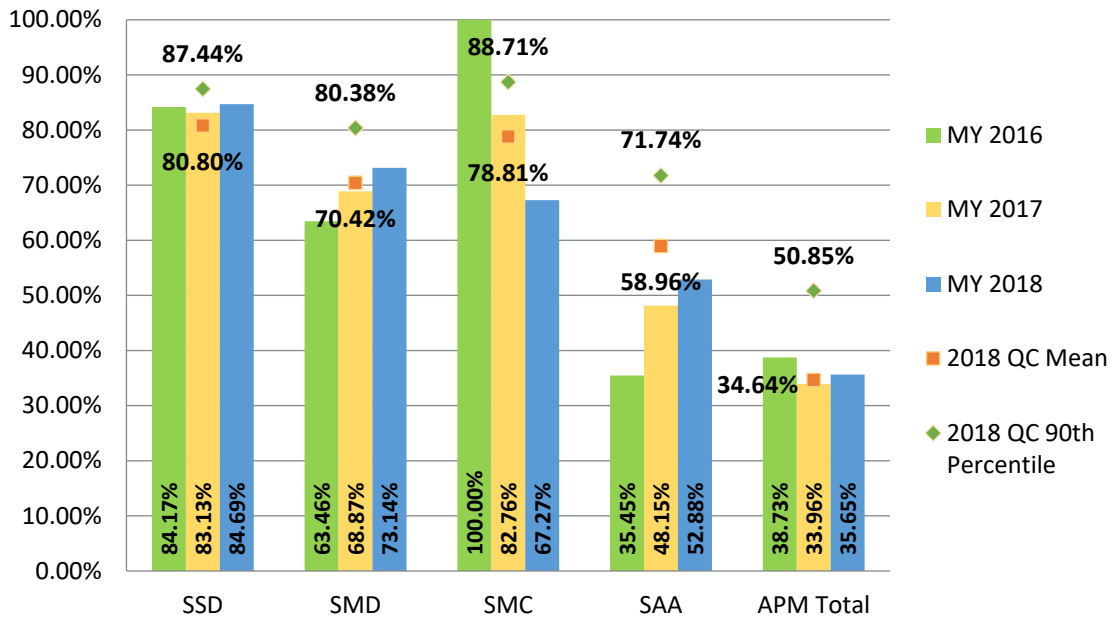
- Medication Management
  - Annual Monitoring for Patients on Persistent Medications

Medication Management

Category	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
MPM ACE/ARB	89.22%	82.29%	91.03%	88.23%	92.87%
MPM Diuretics	90.02%	89.44%	90.85%	88.31%	92.90%
MPM Total	89.48%	89.35%	90.95%	88.22%	92.76%
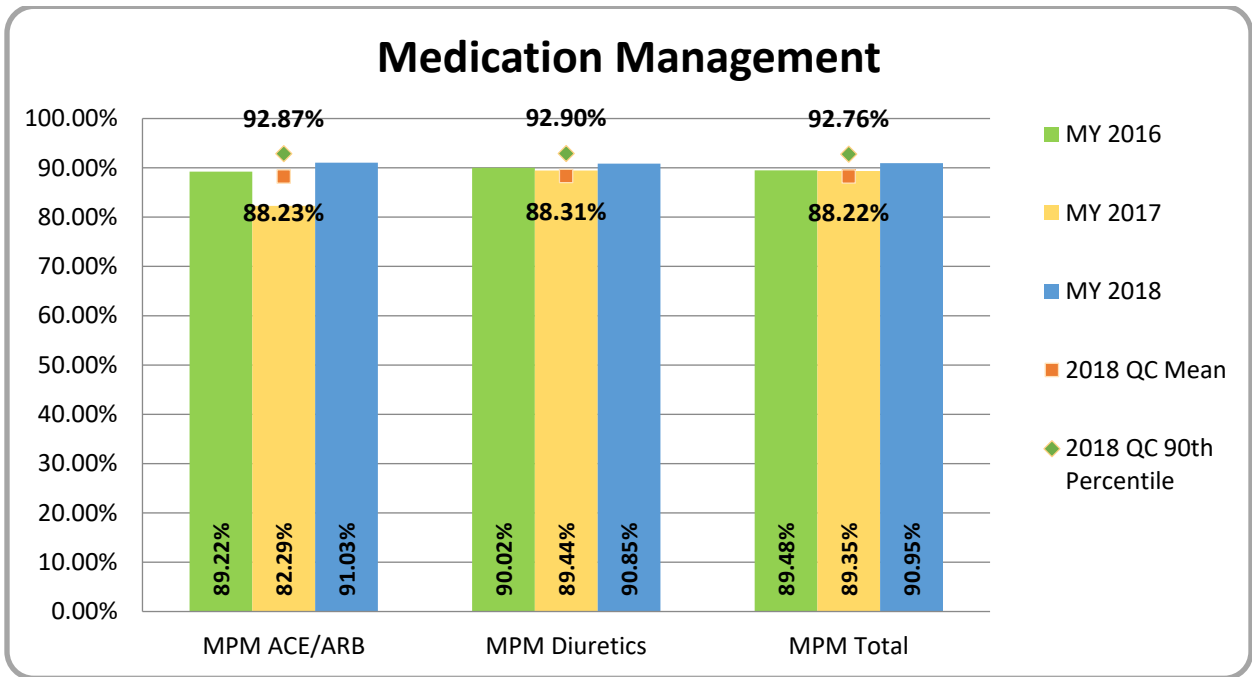
- Overuse/Appropriateness
  - Non-Recommended Cervical Cancer Screening in Adolescent Females (NCS)
  - Appropriate Treatment for Children with Upper Respiratory Infection (URI)
  - Avoidance of Antibiotics in Adults with Acute Bronchitis (AAB)
  - Use of Imaging Studies for Low Back Pain (LBP)
  - Use of Multiple Concurrent Antipsychotics in Children and Adolescents (APC)

Overuse/Appropriateness
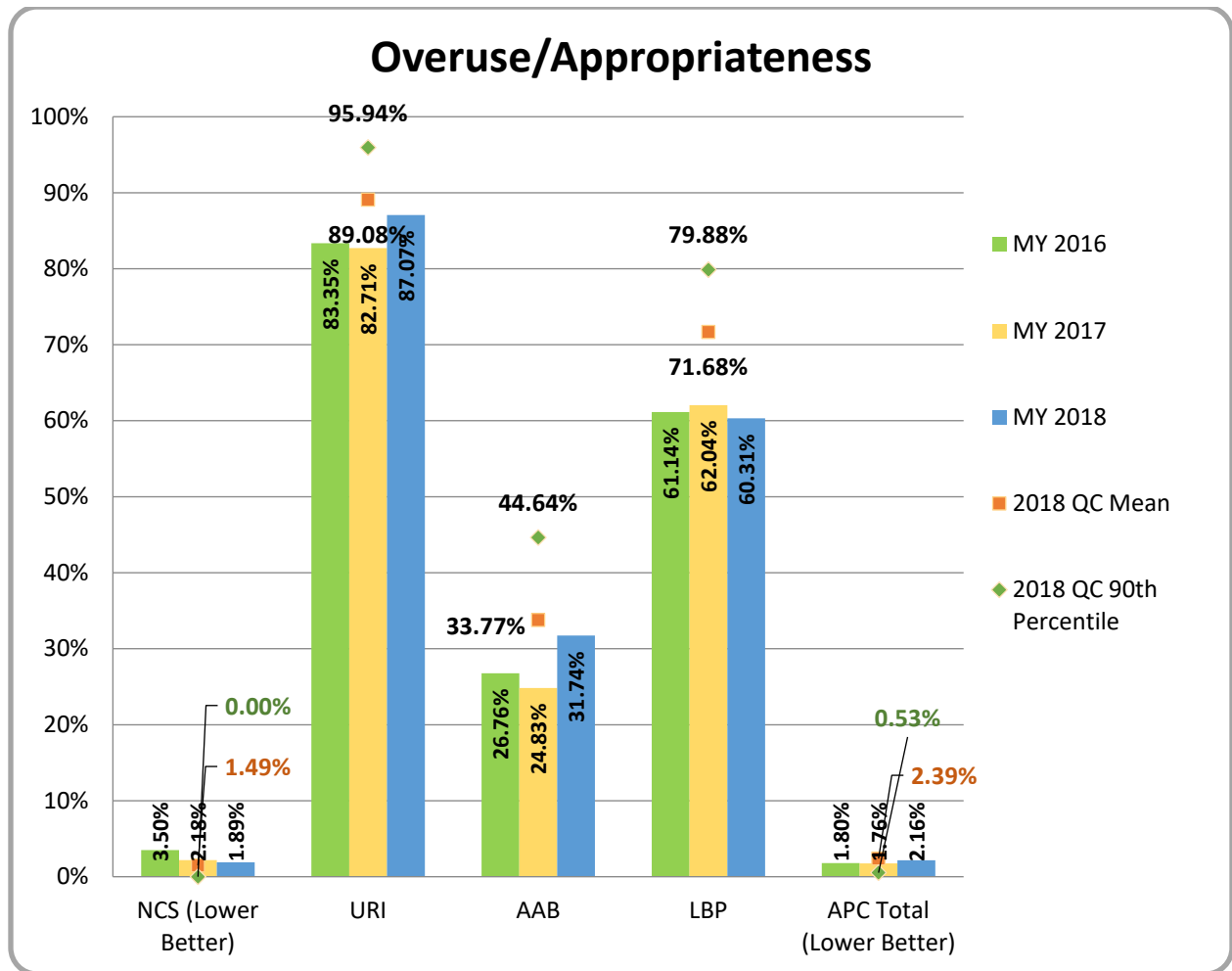
- Access/Availability of Care
  - Adults' Access to Preventive/Ambulatory Health Services (AAP)
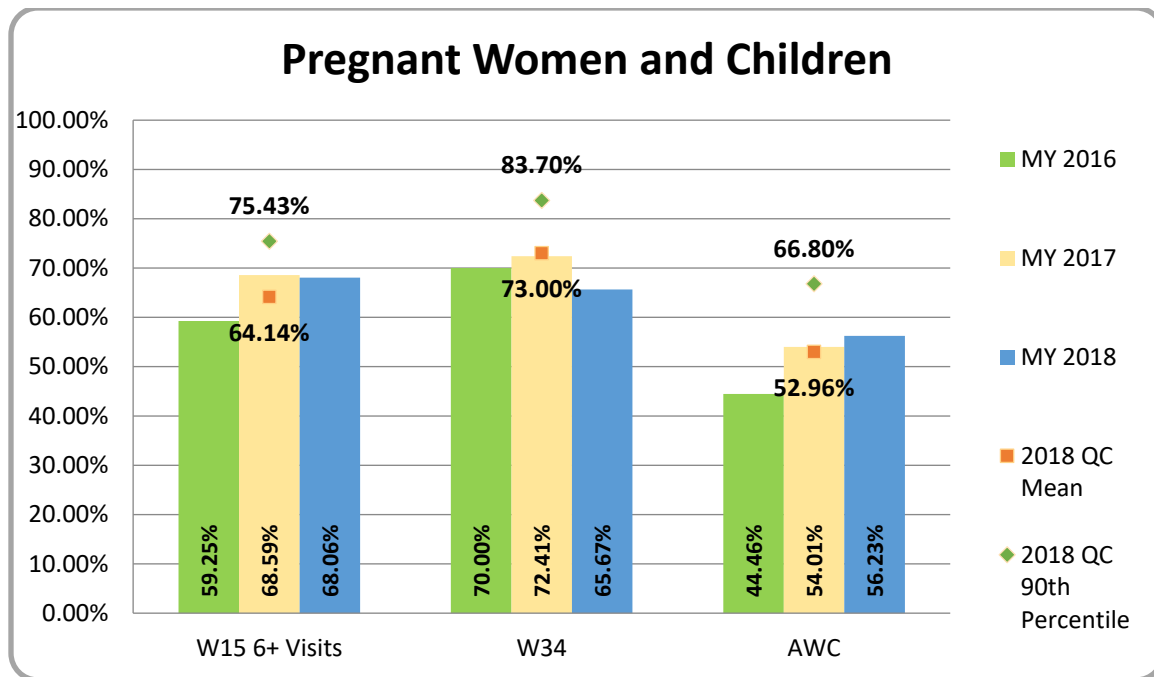 - Children and Adolescents' Access to Primary Care Practitioners (CAP)
  - Annual Dental Visit (ADV)
  - Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (IET)
  - Prenatal and Postpartum Care (PPC)
  - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP)

Access/Availability of Care

Legend:
- MY 2016
- MY 2017
- MY 2018
- 2018 QC Mean
- 2018 QC 90th Percentile

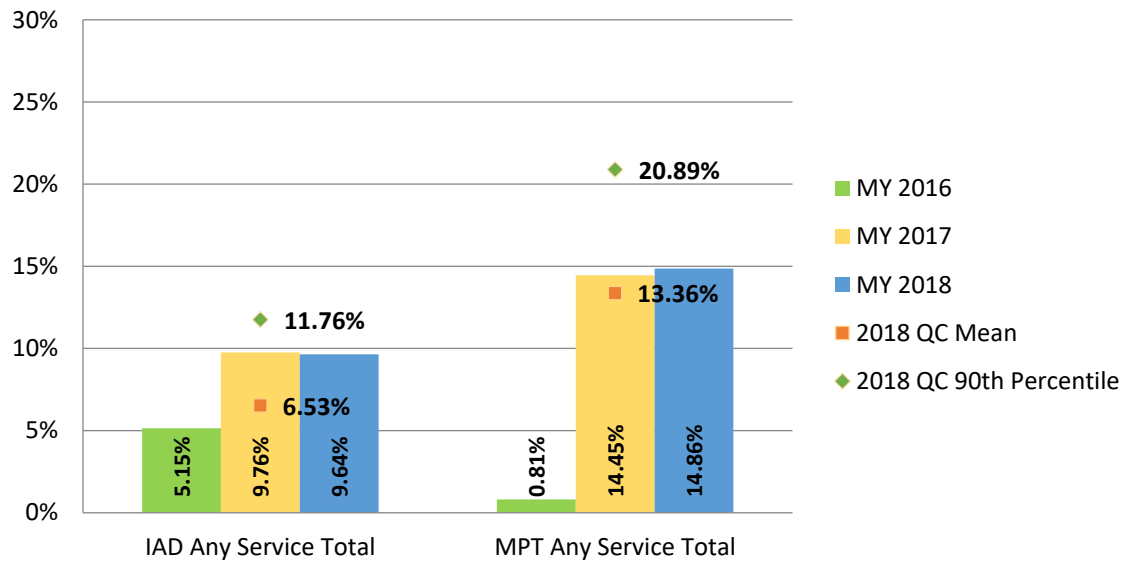| Category	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
AAP Total	79.08%	78.33%	78.34%	79.80%	87.70%
CAP Total	91.60%	90.83%	91.71%		
ADV Total	60.60%	60.15%	57.46%	54.13%	67.09%
IET Initiation Total	32.64%	36.25%	42.44%	42.29%	50.20%
IET Engagement Total	14.32%	18.16%	20.68%	13.47%	21.37%
PPC Timeliness	81.00%	71.28%	77.89%	81.13%	90.75%
PPC Postpartum	64.39%	55.59%	63.39%	64.35%	73.97%
APP Total	67.65%	66.13%	65.10%	59.55%	72.67%

The following measures are part of the HEDIS Utilization and Risk Adjusted Utilization domain:

- Utilization
    - Frequency of Ongoing Prenatal Care (FPC)
    - Well-Child Visits in the First 15 Months of Life (W15)
    - Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)
    - Adolescent Well Care Visits (AWC)
    - Ambulatory Care (AMB)
    - Identification of Alcohol and Other Drug Services (IAD)
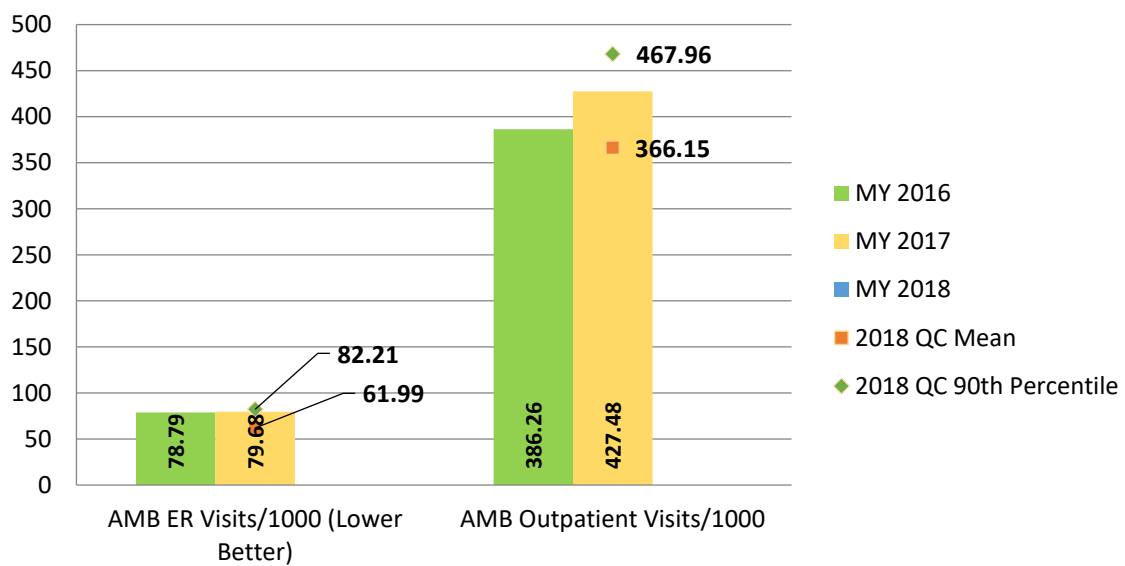   - Mental Health Utilization (MPT)

Pregnant Women and Children

Substance Abuse and Mental Health

Bar chart showing IAD Any Service Total and MPT Any Service Total across MY 2016, MY 2017, MY 2018, with 2018 QC Mean and 2018 QC 90th Percentile markers.

- IAD Any Service Total: MY 2016 = 5.15%, MY 2017 = 9.76%, MY 2018 = 9.64%, 2018 QC Mean = 6.53%, 2018 QC 90th Percentile = 11.76%
- MPT Any Service Total: MY 2016 = 0.81%, MY 2017 = 14.45%, MY 2018 = 14.86%, 2018 QC Mean = 13.36%, 2018 QC 90th Percentile = 20.89%

Ambulatory Care

Bar chart showing AMB ER Visits/1000 (Lower Better) and AMB Outpatient Visits/1000 across MY 2016, MY 2017, MY 2018, with 2018 QC Mean and 2018 QC 90th Percentile markers.

- AMB ER Visits/1000 (Lower Better): MY 2016 = 78.79, MY 2017 = 79.68, 2018 QC Mean = 61.99, 2018 QC 90th Percentile = 82.21
- AMB Outpatient Visits/1000: MY 2016 = 386.26, MY 2017 = 427.48, 2018 QC Mean = 366.15, 2018 QC 90th Percentile = 467.96

Kentucky Medicaid Managed Care Performance Measures

Identify select health outcomes measures in collaboration with DMS and EQRO, a contracted external peer review organization, for improvement.
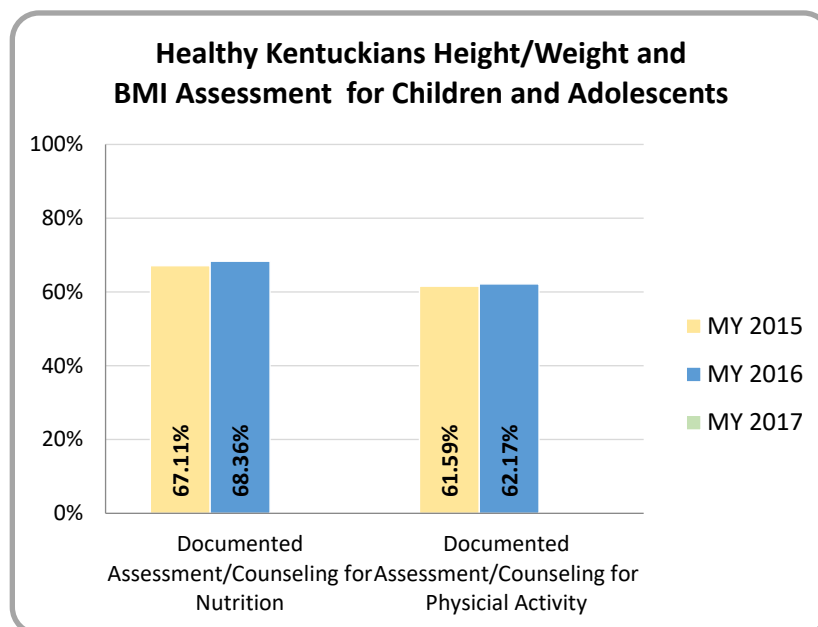
GOAL

Maintain or improve select health outcomes, identify barriers and implement actions as appropriate.
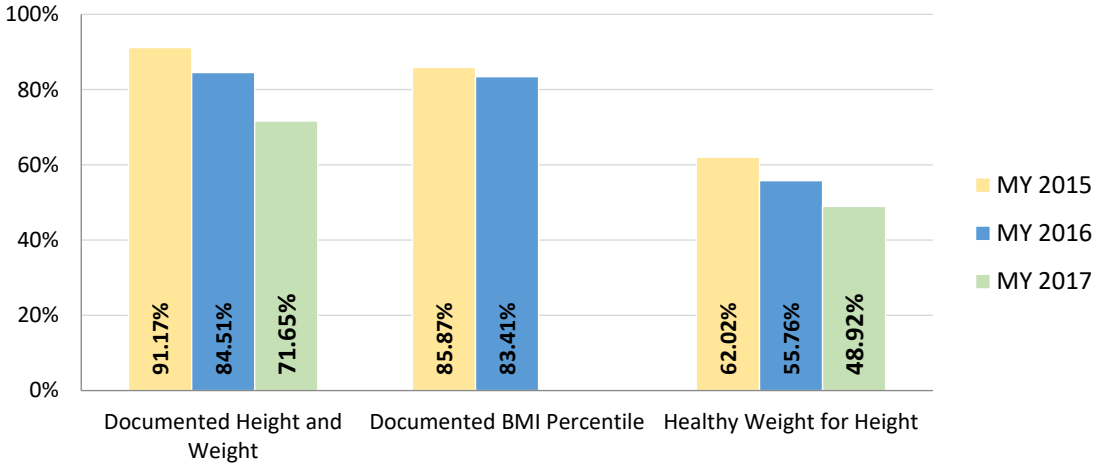
MEASUREMENT

Overall effectiveness is measured annually through audited HEDIS® results and medical record review. Results based on data from the previous calendar year.
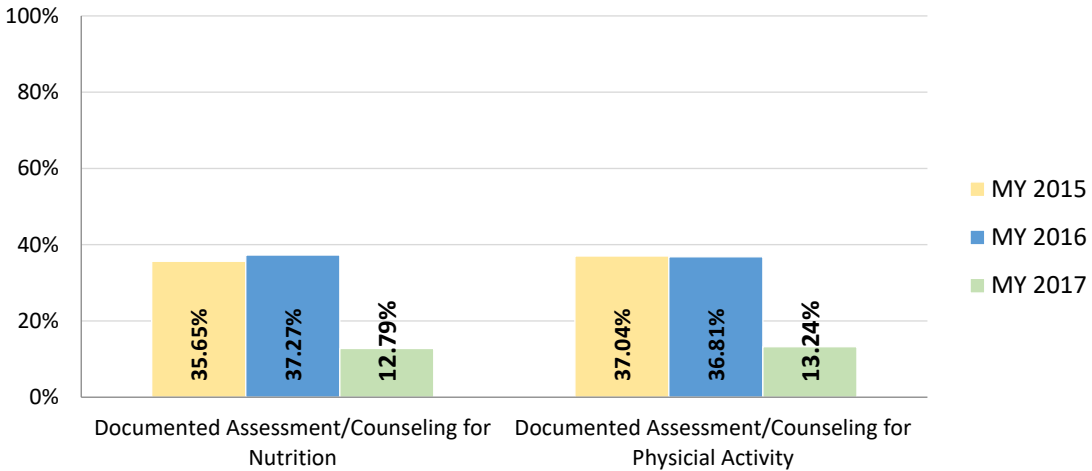
FINDINGS

The 2017 measurement year for the Healthy Kentuckian report was impacted by the technology change implemented in late 2016. While the technology change was much needed update to the previous system for collected and reporting performance data, the impact was visible with the results. With the implementation complete, the 2017 measurement year's data will be re-run in 2019 to internally validate the reported findings. The expectation is that the system and process for pulling the data inaccurately reported several of the measures. For the 2018 measurement year, the administration and collection of the Healthy Kentuckian is being performed by the vendor to produce consistent results.

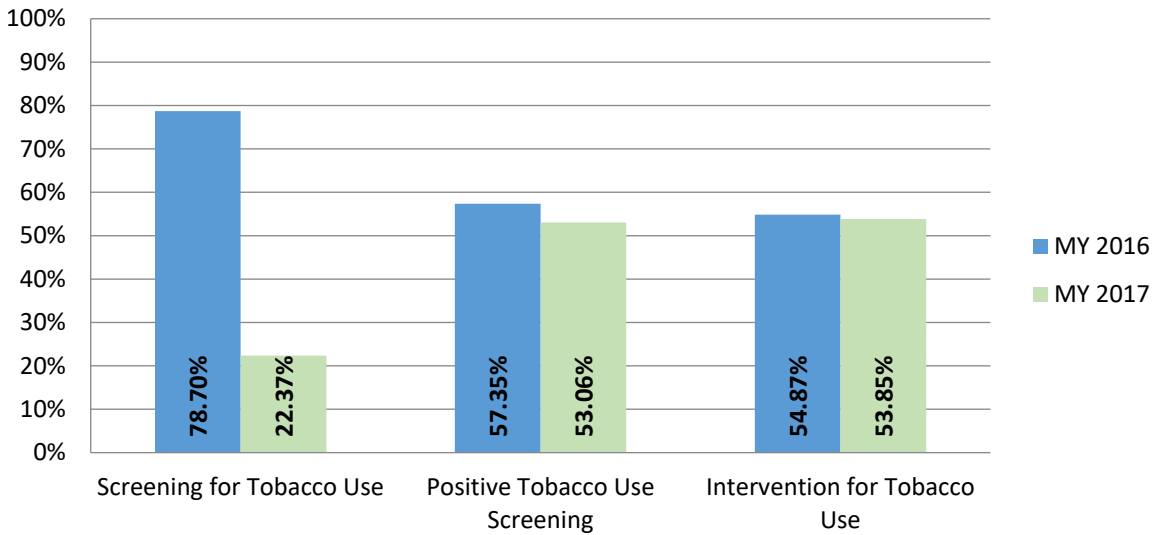**Healthy Kentuckians Height/Weight and BMI Assessment for Children and Adolescents**

	Documented Assessment/Counseling for Nutrition	Documented Assessment/Counseling for Physical Activity
MY 2015	67.11%	61.59%
MY 2016	68.36%	62.17%
MY 2017		

Healthy Kentuckians Height/Weight and BMI Assessment for Children and Adolescents

Bar chart legend: MY 2015 (yellow), MY 2016 (blue), MY 2017 (green)

Category	MY 2015	MY 2016	MY 2017
Documented Height and Weight	91.17%	84.51%	71.65%
Documented BMI Percentile	85.87%	83.41%	
Healthy Weight for Height	62.02%	55.76%	48.92%

Healthy Kentuckians Height/Weight and BMI Assessment for Adults

Bar chart legend: MY 2015 (yellow), MY 2016 (blue), MY 2017 (green)

Category	MY 2015	MY 2016	MY 2017
Documented Assessment/Counseling for Nutrition	35.65%	37.27%	12.79%
Documented Assessment/Counseling for Physical Activity	37.04%	36.81%	13.24%

Healthy Kentuckians Height/Weight and BMI Assessment for Adults

Category	MY 2015	MY 2016	MY 2017
Documented Height and Weight	81.48%	77.78%	70.32%
Documented BMI Percentile/Value	90.28%	85.42%	
Healthy Weight for Height	29.44%	28.27%	45.45%

Healthy Kentuckians Adult Tobacco Screening and Intervention

Category	MY 2016	MY 2017
Screening for Tobacco Use	78.70%	22.37%
Positive Tobacco Use Screening	57.35%	53.06%
Intervention for Tobacco Use	54.87%	53.85%

Healthy Kentuckians Adolescent Screening / Counseling

Category	MY 2015	MY 2016	MY 2017
Tobacco	71.70%	78.62%	77.94%
Alcohol/Substance Use	63.52%	60.38%	70.59%
Sexual Activity	49.69%	44.03%	56.62%
Depression Assessment/Screening	39.62%	40.88%	46.32%
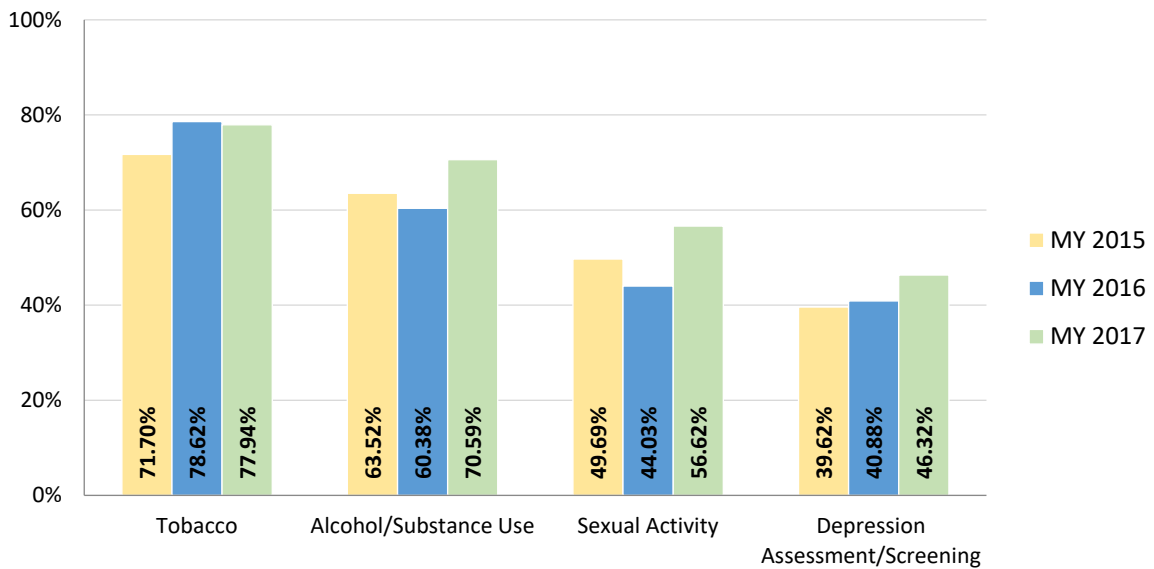
Healthy Kentuckians Cholesterol Screening for Adults

Bar chart showing Cholesterol Screening percentages: MY 2015 = 75.95%, MY 2016 = 77.52%, MY 2017 = 80.05%.

Healthy Kentuckians Perinatal Screening & Counseling

Chart showing screening and counseling percentages for MY 2015, MY 2016, MY 2017:

Category	MY 2015	MY 2016	MY 2017
Screened for Tobacco Use	84.81%	79.19%	78.26%
Positive Tobacco Screening	32.57%	33.71%	42.86%
Received Tobacco Intervention	61.00%	64.71%	62.96%
Screened for Alcohol Use	81.77%	76.70%	90.06%
Positive Alcohol Screening	8.11%	8.55%	9.66%
Received Alcohol Intervention	33.33%	27.59%	42.86%
Screened for Drug Use	82.04%	75.34%	89.44%
Positive Drug Screening	12.12%	13.81%	18.06%
Received Drug Intervention	52.78%	52.17%	46.15%
Nutrition...	44.75%	48.19%	38.51%
OTC/Rx Medication...	27.62%	30.54%	44.10%
Domestic Violence Screening	42.27%	47.06%	37.27%
Prenatal Depression Screening	82.32%	55.43%	44.10%
Postpartum Depression...	82.86%	67.25%	65.22%

BARRIERS

▪ Lack of provider compliance with the clinical practice guidelines related to child and adolescent and adult preventive health.

KEY 2018 INTERVENTIONS

▪ Continue to provide BMI measurement tools for both child/adolescent and adults, reading a food label, and My Plate on the web site.
▪ Community collaboration on obesity and nutrition for all members.
▪ Utilize the Shrinking Childhood Obesity with Real Expectations (SCORE) and Healthier Options for People Everyday (HOPE) Programs to provide education regarding the importance of evaluating BMI, BMI percentile, nutrition and physical activity.
▪ Continue EPSDT audits and provider education to promote adolescent screening and counseling.
▪ Counseling regarding cholesterol screening provided to members through various avenues, including but not limited to: Healthy Heart Disease Management Program, member newsletters, and Soundcare messages.
▪ Prenatal and postpartum education and care coordination provided to pregnant members through Mommy Steps and Stork Care.
▪ Member incentives available to members for receiving regular prenatal care and attending postpartum visits.

Kentucky Medicaid Performance Improvement Projects (PIP)

Performance improvement projects are developed in collaboration with DMS and EQRO. PIP reporting activity that occurred during 2018:

- Healthy Smiles – Final Status
- SMI- Final Status
- Prenatal Smoking- Interim Status
- EPSDT Screening and Participation- Interim Status

Annually, a performance improvement project report for each selected PIP is completed by Passport and submitted by September first to DMS and EQRO for review and recommendations.

GOAL (HEALTH SMILES PIP)

The project focus is aligned with the priorities formalized by the KYHealthNow goals, as well as those of the Quality Branch of the Division of Program Quality and Outcomes which oversees the health services provided by MCOs to Kentucky residents. It also has logical synergies with Passport's participation in the Children's Health and Dental Technical Advisory Committee (TAC) meetings. This project aims to increase the number of members that take advantage of the preventive dental services available through the plan.

Early prioritization of dental health that is sustained through adulthood will require increased utilization of preventive dental services that, although covered by the plan, are underutilized by Passport members in all age groups. This project will frame additional focus by Passport to deepen our understanding of barriers to our members' receiving the dental services available to them and additional strategies we implement and evaluate to decrease them.

MEASUREMENT

This PIP is measured by ADV HEDIS rate and fluoride and dental sealant rates.

FINDINGS

The following performance indicator results from the baseline to the interim year are as follows:
- Indicator #1a: Increase the proportion of members' ages 0-20 years (enrolled for at least 90 days) who were continuously enrolled who received at least one fluoride service during the measurement year by a dental provider by 10 percentage points. In MY 2015, the Plan's rate was 49%. In MY 2017, the Plan's rate increased to 49.4% which is a .4%-point increase from MY 2015.
- Indicator #1b: Increase the proportion of members' ages 0-20 years (enrolled for at least 90 days) who were continuously enrolled who received two or more fluoride services on different dates during the measurement year by a dental provider. In MY 2015, the Plan's rate was 17.6%. In MY 2017, the Plan's rate increased to 19.2% which is an 8% increase from MY 2015.

- Indicator #2a: Increase the proportion of members ages 0-20 years (enrolled for at least 90 days) who were continuously enrolled who received at least one fluoride service during the measurement year by a primary care provider to 80%. In MY 2015, the Plan's rate was 2.3%. In MY 2018, the Plan's rate decreased to 2.2% or remained flat from MY 2015.
- Indicator #2b: Increase the proportion of members' ages 0-20 years who were continuously enrolled who received at least one fluoride service during the measurement year by a primary care provider to 50%. In MY 2015, the Plan's rate was 0.4%. In MY 2017, the Plan's rate remained flat at 0.4% from MY 2015.
- Indicator #3: Increase the proportion of members ages 6-9 years who are continuously enrolled who received a sealant service (as defined by a CPT code of D1351) from a dental provider (as defined by taxonomy code) by 10 percentage points. In MY 2015, the Plan's rate was 17,5%. In MY 2017, the Plan's rate increased to 18.8% which is a 1.3%-point increase from MY 2015.
- Indicator #4: Increase the proportion of members ages 2-20 years who are continuously enrolled who received a preventative service (as defined by a CPT code of D1000-D1999) to the HEDIS® Annual Dental Visit rate to 66.8% (2014 Quality Compass®- Medicaid 90th percentile). In MY 2015, the Plan's rate was 42.2% and was incorrectly measured to include 0-1 year-olds. In MY 2017, the 0-1 year-olds were not included in the rate calculation at 23.5% which is well below the stated goal of 66.8%. However, more research is needed into the numerator on this measure as it does not align with the Passport's overall 2017 HEDIS rate of 60%.
- Indicator #5: Increase by 10 percent (KYHealthNow 2019 Goal) adult (over 20 years of age) who are continuously enrolled who received a preventative service in the measurement year to a goal of 14.8%. In MY 2015, the Plan's rate was 13.5%. In MY 2017, the Plan's rate was is a 14.0% which is a .5%-point increase from MY 2015.
- Indicator #6: Decrease the unmet dental need for non-traumatic dental ED visits among adults over the age of 20 years (KMDS) by 10 percent to a goal of 1.8%. In MY 2015, the Plan's rate was 2.0%. In MY 2017, the Plan's rate was 1.6% which is a 20% improvement. The goal rate was achieved and was revised to 1.6% in August 2017.
- With Avesis (Passport's dental vendor) the Plan assessed the effectiveness of provider education performed to determine the need to revise intervention. Avesis provides ongoing provider education pieces through their portal, newsletter and through visits through Provider Relations representatives. These education and outreach efforts are intended to inform both members and providers with the need for preventative dental care, fluoride and sealant treatments, and provider coding for proper HEDIS results.

GOAL (SMI PIP)

The goal of this PIP is to increase collaboration between Behavioral Health and Primary Care to improve the primary care services for members with severe mental illness (SMI). Through improved care coordination and collaboration between primary care and behavioral health, providers will work with members to achieve improved health outcomes for members with SMI.

MEASUREMENT

Measurements for this PIP include a collection of access, medical, and tobacco measures including: SMI access to PCP, BMI, blood pressure, cholesterol, and tobacco use and cessation measures.

This PIP focuses on the prevention of physical health risks for members with SMI. By improving communication between Behavioral Health and Primary Care Providers, members with SMI experience integrated care resulting in the utilization of preventative care services and improved health outcomes. The PIP was also focused on a new value-based incentive program/pilot conducted between June and August of 2017.

All but two indicators #1 and #2) demonstrated percentage point increases. Intervention #3 yielded positive outcomes. The results data for intervention #3 shows that for telephonic outreach to members with SMI ages 18-20 years with a gap in care of HbA1c or LDL, there is a positive effect on member engagement. Twenty-five percent (25%) of attempted contacts for HbA1c were successful, and of those contacted 14.3% resulted in a screening. Twenty-two percent (22%) of attempted contacts for LDL were successful, and of those 8% resulted in a screening. Although the percentages of screenings were low, the number of successful contacts was 35 out of 140 for HbA1c and 25 out of 113 for LDL. Members responded positively with this intervention. The Plan will continue this intervention and include behavior health provider education to members during care management.

The following performance indicator results from the baseline to the interim year are as follows:

- Indicator #1 for Access to preventative/ambulatory health services for adults with schizophrenia and bipolar disorder shows a decline from MY 2015 to MY 2017 of 2.5 percentage points.

- Indicator #2: Body Mass Index screening for people with schizophrenia or bipolar disorder shows a positive rate change from 22.3% in MY 2015 to 21.8% in MY 2017. It is possible that the smaller denominator (411 in MY 2016 to 285 in MY 2017) influenced the decrease in rate.

- Indicator #3: Blood Pressure assessment for people with schizophrenia or bipolar disorder shows a 36.7% percentage difference from 4.9% in MY 2015 to 7.1% in MY 2016.

- Indicator #4: Cholesterol screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications showed an insignificant change from MY 2015 to MY 2017.

- Indicators #5 a,b,c,d (Tobacco Screening): #5a demonstrated nearly a 4 point jump closer to target from MY 2016 to MY 2017. #5c demonstrated a significant change in nearly 20 points from MY 2015 to MY 2017. Note that the dominator is much small in MY 2017 compared to MY 2015. #5d also demonstrated a significant jump over 15 points from MY 2015 to MY 2017.

- Indicator #6: HEDIS ® Diabetes Screening for People with Schizophrenia and Bipolar Disorder Who are Using Antipsychotic Medications (SSD)shows a positive rate change from 82.25% in MY 2015 to 83.9% in MY 2017. This is a 1.5 percentage point increase.

The Affordable Care Act (ACA) requires Medicaid coverage for counseling and pharmacotherapy for cessation of tobacco use by pregnant women, in accordance with the Public Health Service (PHS) guidelines. The vast majority (90%) of pregnant smokers in the KY MMC population had neither a pharmaceutical claim nor a counseling smoking cessation claim (IPRO/KDMS, 2016). The IPRO/KDMS focused study showed that risk factors for non-receipt of smoking cessation benefits included adolescent age, urban residence, healthy women, and insufficient prenatal care (IPRO/KDMS, 2016). The U.S. Preventive Services Task Force (USPSTF, 2015) recommends clinicians ask all pregnant women about tobacco use, citing strong evidence that augmented, pregnancy-tailored counseling is of benefit for pregnant women who smoke. ACOG (2010) recommends the following set of interventions, sometimes referred to as "the 5 A's", for smoking cessation during pregnancy. The goal of this project is to implement a robust set of member, provider, community and plan interventions to improve prenatal screening for tobacco use and interventions for tobacco use rates and to increase the prenatal smoking abstinence rate.

MEASUREMENT

Measurements for this PIP include: percentage of pregnant women assessed for smoking status at the first or second prenatal visit, percentage of pregnant women screened for tobacco use with a positive screen, percentage of prenatal smokers who received cessation intervention, percentage of prenatal smokers who received cessation Intervention and who abstained through delivery, and percentage of prenatal smokers who received cessation intervention with smoking status monitored at one or more follow-up prenatal visit.

FINDINGS

Performance Indicator	Baseline Period- Measurement Year: 2016	Interim Period- Measurement Year: 2017	Goal/ Target Rate
Indicator #1: **The percentage of pregnant women assessed for smoking status at the first or second prenatal visit.**	Numerator: 358 Denominator:456 Rate: 78.51% 95% CI: 74.74%-82.28%	Numerator:383 Denominator:418 Rate:91.62%	Rate: 86.4%
Indicator #2: **The percentage of pregnant women screened for tobacco use with a positive screen.**	Numerator: 120 Denominator:456 Rate: 26.32% 95% CI: 22.29%-30.36%	Numerator: 117 Denominator: 383 Rate: 30.5%	Rate: 21.1%

Indicator #3: **The percentage of prenatal smokers who received cessation intervention.**	Numerator: 78 Denominator:120 Rate: 65% 95% CI: 56.47%-73.53%	Numerator: 77 Denominator: 117 Rate: 65.81%	Rate: 73.54%
Indicator #4: **The percentage of prenatal smokers who received cessation Intervention and who abstained through delivery.**	Numerator: 8 Denominator: 78 Rate: 10.26% 95% CI: 3.53% - 16.99%	Numerator: 1 Denominator: 77 Rate: 1.2%	Rate: 20%
Indicator #5: **The percentage of prenatal smokers who received cessation intervention with smoking status monitored at one or more follow-up prenatal visits.**	Numerator:29 Denominator:78 Rate:37.18% 95% CI: 26.45%-47.91%	Numerator: 5 Denominator: 77 Rate: 6.4%	Rate: 47.92%

BARRIERS

- Members not having a desire to quit smoking
- Unable to reach members to initiate NRT efforts and or gain obtain quit status
- Providers do not always notify the plan when a member is pregnant
- Provider does not always assess and counsel the member regarding smoking and cessation opportunities

2018 ACTIVITIES

- Outreach and education to pregnant member who smoke. Specific outreach and tracking in regions 6,7,8 were planned and on-going.
- Outreach and education to pregnant member who smoke and have a diagnosis of Asthma/COPD. Specific outreach and tracking in regions 6,7,8 were planned and on-going.
- Work with and educate providers to improve prenatal identification and treatment of smokers
- Educate providers to recommend referrals to Quit Now tobacco cessation resource
- Outreach and engage members who smoke in smoking cessation benefits/programs

GOAL (EPSDT PIP)

The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is designed to provide a comprehensive preventive health care package to members from birth to age 21 and the early diagnosis and treatment of medical conditions which, if undetected, could result in serious medical conditions and/or costly medical care. Interventions are focused on the member, the clinician, and the community.

EPSDT is a federally mandated program that entitles children and adolescents (from birth to age 21) covered under Medicaid and Kentucky Children's Health Insurance Program (KCHIP) to a broad package of health care benefits, administered with an emphasis on prevention and aggressive outreach to bring

children and adolescents in for care. Approximately 45% of the Passport Health Plan (Passport) membership is under the age of 21, making this a vital program for the health and welfare of the Passport's children.

This project's goal is to increase the EPSDT screening and participation rates for all eligible plan members. The Plan would seek to identify and implement new and robust interventions aimed at increasing the number of unique individuals who receive age appropriate screenings (screening rate) and at least one screen annually (participation rate).

MEASUREMENT

Measures for this PIP include well-care, dental, medical, immunizations, telephonic outreach, home health visits, screening and participation rates.

FINDINGS

Performance Improvement Goals

Project Element	HEDIS 2016	HEDIS 2017	HEDIS 2018	Trend (2016–2018)	Goal (2017 QC 90th Percentile) Met	Q1	Q2	Q3	Q4
								2018 Status	
LSC	77.26%	81.94%	76.16%		86.37%			76.16%	
CIS Combo 10	33.64%	31.71%	32.36%		48.47%			32.36%	
W15	66.32%	59.25%	68.59%		72.46%			68.59%	
W34	71.57%	70.00%	72.41%		82.77%			72.41%	
AWC	45.18%	44.46%	54.01%		68.06%			54.01%	
IMA Combo 1	87.41%	85.15%	76.64%		86.81%			76.64%	
HPV	30.63%	25.29%	33.09%		32.87%			33.09%	
ADV Total	42.23%	60.60%	60.15%		66.86%			60.15%	

Process and Performance Indicators

Project Element		Trend	2018 Goal	Q12018	Q22018	Q32018	Q42018
					2018 Status		
Screening Rate			80%	89%	93%	81%	83%
Participation Rate			80%	61%	61%	54%	54%
Telephonic outreach & education indicated by successful/attempted	Successful		Baseline Year for Goal Setting	163	972	2104	10,448
	Attempted		Baseline Year for Goal Setting	387	1678	3378	18,027
Number of Department of Health (DOH) provided home visit outreach (Contact only) for EPSDT and Dental education	Successful			74	263	52	85
	Attempted			310	1,406	538	1,190
Postcards mailed to EPSDT/Postpartum members regarding EPSDT & Dental Services			N/A	820	752	557	330
Community collaboration and outreach events where EPSDT & Dental Information was distributed			N/A	Yes	Yes	Yes	Yes
Member Incentives Adolescent/Well-Child Screens Completed			N/A	1,192	1157	2577	965
Member Newsletters regarding EPSDT & Dental Services			N/A	yes	yes	yes	Yes
SoundCare Messages regarding EPSDT & Dental Services			N/A	Yes	Yes	Yes	Yes
Automated call outreach			N/A	5,520	10,901	25,639	519

BARRIERS

- Department of health / PCP communications regarding department of health home visits.
- Immunizations not completed at PCP offices.
- Provider education regarding EPSDT screening requirements and billing configurations.
- Provider and specialist care collaboration.
- OBGYN's ability to perform the screening and code properly for billing claims.
- Members not showing for appointments due to transportation issues, lack of knowledge regarding the importance of well care visits versus sick visits.

2018 ACTIVITIES

- Ongoing education to clinicians through site visits, telephonic outreach, and written notifications. Education includes: distributing the EPSDT training tool for each required

encounter form, Reviewing the most common denial patterns identified through the monthly claims review, periodicity schedule and the target days, days calculator based on the members' birthday and designed to assist clinicians in determining the age interval screen the child is due to receive.

- EPSDT Orientation Packet distributed with numbers for Member Services, Provider Services, Provider Network Account Manager and Care Connector Team.
- Conducted on-site EPSDT outreach visits to EPSDT clinicians.
- Posted updates on the Passport Provider website at www.passporthealthplan.com to support efforts to increase EPSDT participation and compliance rates and identified health outcomes.
- Conducted EPSDT claims audits.
- Member telephonic outreach to encourage and help schedule missing EPSDT screenings
- Department of Health Home visits if unable to reach via telephonic campaign or unable to contact letter

Quality of Clinical Care
Care Management Programs for Population with Chronic Complex Conditions

FOCUS

Passport develops and implements new programs and policies with disease specific approaches, as identified through review of data, to improve the management of members' chronic medical conditions, and the health and quality of life of Passport's special needs population.

GOALS

Each program has specific goals that are listed in the program evaluations for 2018. All Care

Management Programs have the general goals listed below:

- Provide for the collaborative process in assessing, planning, implementing, coordinating, monitoring, and evaluating the options and services needed to meet the needs of members with special needs.
- Decrease unnecessary hospitalizations and ER visits.
- Improve member self-management skills and self-advocacy.
- Provide coordination of care and services to members who have experienced a critical event or diagnosis needing the extensive use of resources and who need assistance navigating the health care system.

MEASUREMENT

- Formal measurements are performed annually through the HEDIS® reviews using HEDIS® methodology. Results of the evaluation are utilized to revise the program and set the program goals for the following year. More frequent barrier analyses are performed on an ongoing basis and adjustments to the disease management programs are made accordingly.
- Decreased unnecessary hospitalizations and ER visits.
- Improved member self-management skills and self-advocacy.

- Continued coordination of care and services to members who have experienced a critical event or diagnosis needing the extensive use of resources and who need assistance navigating the health care system.

PROGRAMS

Below are Care Management programs currently in place to assist those with chronic health conditions.

Additional information related to Passport's Case Management Program can be found in the 2018 Case and Disease Management Program Evaluations and 2019 Case and Disease Management Program Descriptions.

Program	Activity
Complex Care	Complex Care is focused on addressing the needs of the highest risk patients who have been diagnosed with more than one chronic disease which could include the following health conditions; Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes Mellitus (DM), and Congestive Heart Failure (CHF). These patients, based on identified risks, are most likely to incur a disease-specific adverse event. This program's purpose is to systematically and comprehensively assess, monitor, measure, evaluate and implement strategies to improve the quality of care and healthcare services delivered. Evidence-based medicine and a provider-led team approach are used to: empower patients, support behavior change, reduce the incidence of complications, improve physical functioning, and improve emotional well-being. An emphasis is placed on the use of clinical practice guidelines in an effort to prevent exacerbations and condition-related complications, with a goal of improving overall health and self-management
Catastrophic Care	Catastrophic care is an individualized care management program focused on addressing the needs of members with potential life-threatening conditions, trauma, and intensive diagnoses. Patients that have had 10 or more inpatient days in the last 12 months as well as severe comorbidities may be eligible for Catastrophic Care. In addition, patients with a total medical spend of greater than $100k are also part of Catastrophic Care. A Care Advisor assesses and coordinates care and resources for members in the Catastrophic Care program, as well as educates them on disease processes and empowers them to improve their health.
Condition Care	Condition Care is a care advising program with a focus on addressing the needs of the medium risk patients who have been diagnosed with one of the following health Conditions; Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes Mellitus (DM), and Congestive Heart Failure (CHF). There is a separate Condition Care program for each of the targeted Conditions listed. Evidence-based medicine and a provider-led team approach are used to: empower patients, support behavior change, reduce the

Program	Activity
	incidence of complications, improve physical functioning, and improve emotional well-being. An emphasis is placed on the use of clinical practice guidelines in an effort to prevent exacerbations and condition-related complications, with a goal of improving overall health and self-management
Behavioral Health	The Behavioral Health Case Management Program is a comprehensive process focusing on improving a member's quality of life whereby an individual's catastrophic or chronic behavioral health problem is evaluated, and a case management plan is developed in collaboration with the member, member's providers, PCP, family members and/or caregivers, and state agencies to meet the member's needs. Elders, adults, and children at clinical risk because of the mental health, psychosocial, and/or co-morbid problems are accepted into the program. The case manager works collaboratively with the member to advocate for and assist with linkage to necessary supports and services.
Mommy Steps	Mommy Steps Program Care Managers work with pregnant members and OB/GYN providers to improve prenatal, infant, and maternal outcomes. Perinatal Management is the process of coordinating health care interventions and communications for pregnant members in which patient self-care efforts are significant; supporting OB clinician/member relationships and the plan of care; emphasizing prevention of complications; patient empowerment strategies; and evaluating clinical, humanistic and economic outcomes on an ongoing basis with the goal of improving overall health.

BARRIERS

- Difficulty maintaining member contact due to mobility of the population.
- Member unwilling to comply with treatment plan and its completion.
- Limited member response to the program surveys

KEY 2018 INTERVENTIONS

- Exhaust all avenues to contact members including CM telephonic outreach attempts, mailing "unable to contact" letters, contacting provider offices and pharmacies to obtain updated demographic information, and utilizing EXP system to locate most recent phone numbers for members.
- Continue to educate member on goals of program and the importance of self-management of healthcare
- Coordinate with Providers to help encourage member participation
- Prioritize outreach efforts using stratification tools.
- Continue to evaluate for new programs to identify populations in need of coordination of care.

RESULTS

- Overall the Care Management Programs noted increased membership, increased high risk engaged members, and overall improvements in 2018, helping to decrease hospital admissions, readmissions, and ER visits for those involved in the program. Based upon the 2018 evaluation,

Passport developed new initiatives to strive towards the overall goal of improving the health and quality of life for our members with chronic medical conditions.

EPSDT

The EPSDT Program is designed to provide to members from birth to age twenty-one a comprehensive preventive health care package plus early diagnosis and treatment of medical conditions which, if undetected, could result in serious medical conditions and/or costly medical care.

- Improve CMS-416 Screening and Participation rates.
- Increase HEDIS and Healthy Kentuckian rates related to EPSDT and the pediatric population.
- Educate and ensure provider compliance with the Bright Futures/American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Care's age-appropriate periodicity schedule.
- Promote member and provider compliance with the Center for Disease Control's (CDC) immunization schedule.

- The CMS-416 is completed annually on the federal fiscal year.
- HEDIS and Healthy Kentuckians are collected and reported on an annual basis.
- EPSDT compliance audits are completed on ongoing basis.

For more information about the EPSDT Program, please see the 2018 EPSDT Program Evaluation and the 2019 EPSDT Program Description.

2018 FFY EPSDT Screening and Participation Rates

Bar chart showing Screening, 77% and Participation, 62% (y-axis 0% to 100%)
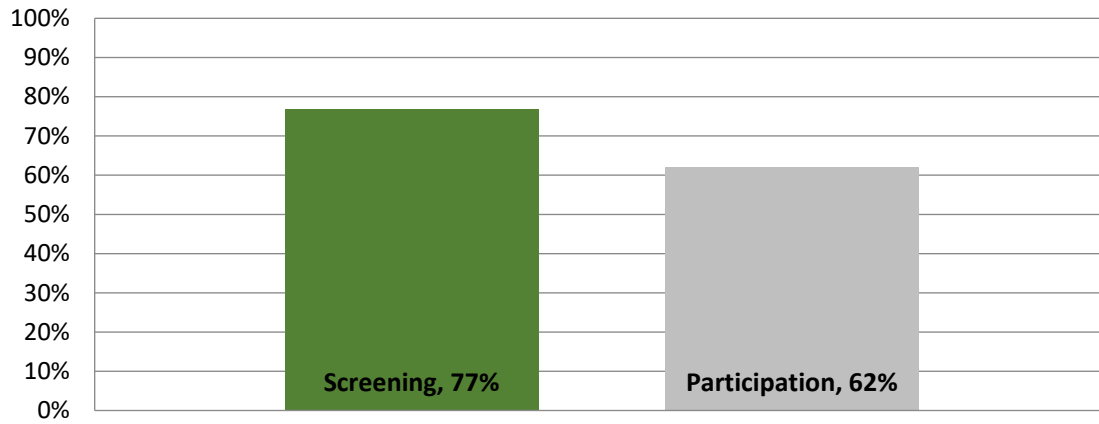
2018 EPSDT Compliance Audit Criteria	Regional Glance	Total Number of Providers Audited	90-99%	80-89%	70-79%	60-69%	50-59%
Primary Care providers selected for review are pulled by group and meet the following criteria: a) 50 or more well-child claims in the calendar year b) Have a primary address within the state of Kentucky c) Participating PCP agreement during the entire measurement year being reviewed. d) PCP not assessed previous 2 years (unless scored below 90%) Audits were performed utilizing NCQA's 8/30 sampling rules. If the overall score was 90% or above, the review was complete. If after 8 charts the overall score was below 90%, an additional 22 charts were reviewed for a total of 30.	Region 1	2 delete the	2	0	0	0	0
	Region 2	3 delete the	2	1	0	0	0
	Region 3	13	12	0	1	0	0
	Region 4	8 delete the	8	0	0	0	0
	Region 5	13	11	1	1	0	0
	Region 6	1	1	0	0	0	0
	Region 7	6	6	0	0	0	0
	Region 8	7	7	0	0	0	0
	Total	53	49	2	2 delete the	0	0

- Limited time and resources in provider offices to identify children due for screenings.
- In areas outside Region 3, a lack of provider awareness was noted regarding knowledge of the EPSDT Medicaid program and Kentucky EPSDT regulation (KAR11:034)
- Clinician lack of knowledge of all required age appropriate elements of an EPSDT screen. Top 10 opportunities are:

  1. Lead Risk Assessment (CDC and AAP minimum recommended 6, 9, 18 month, 3, 4, 5 and 6 yrs old)
  2. STI Risk Assessment (11 yrs and above)
  3. Hearing/audiometry testing (APP minimum recommended 4-6, 8, 10, once between 11 and 14, once between 15 and 17 and once between 18 and 21 years of age
  4. Visual acuity screening (AAP minimum 3-6, 8, 10, 12 and 15 yrs of age
  5. Immunizations (proof of immunizations or note stating up to date on immunizations)
  6. Alcohol and Drug use assessment (AAP recommended minimum 11 yrs and above
  7. Depression Screening (AAP recommended minimum 12 yrs and above
  8. Physical activity assessment/counseling (ages 3 yrs and above
  9. Dental/Oral health assessments
  10. Measurements for infants (Weight, Length, Weight for Length and Head Circumference-growth charts or %

- Member lack of knowledge and compliance with the EPSDT periodicity schedule and the AAP bright futures guidelines and recommendations.

KEY 2018 INTERVENTIONS

- Ongoing provider education through eNews, Provider website, Annual Provider Workshops, on-site education visits, telephonic education and EPSDT Orientation (upon request) to review screening requirements.
- Developed an all-inclusive data application that records, tracks, and reports on all member inquiries and activity as well as outreach to members referred for special services.
- Live and automated telephonic outreach to members.
- Home visits by the Department of Health on behalf of the health plan for non-compliant members.
- Promoted member utilization by offering member incentives for certain EPSDT screens and elements.
- EPSDT Performance Improvement Project (PIP)

Pharmacy

FOCUS

The Pharmacy Program is designed to support Passport Health Plan's mission to improve the health and quality of life of our members by providing access, direction, and monitoring of the quality and cost-effectiveness of pharmaceutical care and ensure appropriate use of medications for Passport Health Plan members. The Pharmacy Program is a coordinated effort between Passport Health Plan,

Evolent Health and CVS Caremark. The Pharmacy Program's primary functions include but are not limited to:

1. Maintain a point-of-sale claim system with drug utilization review (DUR) functionality and a network of contracted pharmacies that complies with DMS requirements.
2. Development and distribution of the preferred drug list (PDL) to providers and members.
3. Supporting the Pharmacy & Therapeutics Committee with reviews and recommendations for inclusion of new drugs or new indications on the preferred drug list.
4. Development and revision of drug prior authorizations or other utilization management criteria.
5. Monitor patterns of drug prescribing and utilization to identify areas for benefit design improvement, clinical intervention, or utilization management.
6. Develop and manage clinical pharmacy programs that improve quality or achieve cost savings.
7. Serving as a resource for plan staff, pharmacies, members, and providers.

Annually, an evaluation of the Pharmacy Program is conducted. Goals and objectives were reviewed and achieved.

GOALS

- Manage Drug Spend: Ensure that drug spend adheres to budgeted amounts by activity managing the formulary and associated utilization management programs. The Pharmacy Program actively communicates with the Plan's finance leaders.

- Formulary Management: Ongoing efforts to evaluate new drug products, align rebate opportunities and leverage generic categories to achieve lowest net cost in every drug category.

- Utilization Management: This program compliments the formulary initiatives by identifying the health conditions necessary to gain approval for managed or non-preferred products. The utilization management program also operationalizes the intake, review and notification processes.

MEASUREMENT

Overall effectiveness of activities is measured through:

- Pharmacy Trends: Monitor the utilization of pharmaceutical services to identify trends, assess contributing external and internal factors, and determine the budgetary impact to the Program and Plan. The Pharmacy Program will implement changes to the formulary or utilization management processes to address unfavorable trends when appropriate.

- Formulary Management: Use evidence-based indicators for selection of medications considered for formulary placement. Review new drugs and expanded indications for existing drugs for inclusion on the preferred drug list. Develop the preferred drug list for providers and members. Develop and revise drug prior authorization criteria and other utilization management strategies.

- Review Pharmacy Programs: To review patterns of drug prescribing, utilization, safety, and appropriateness to identify areas for benefit design improvement, clinical intervention, or utilization management. Where appropriate, communication will be designed and provided to providers alerting them of potential opportunities for improvement with drug use.

- Quality Intervention: Actively participate in quality measurements in a collaborative manner to optimize drug use and access, improve quality of life, and promote favorable outcomes.

- Provider Communication: Assure prescribing providers and members are informed of which drug products are available through the plan and provide information on their cost-effective use. In addition, continue to educate providers regarding any new and upcoming pharmacy program changes.

BARRIERS

Pharmacy Trends

- In 2018, the FDA approved 59 novel drug products. (Source: https://www.fda.gov/Drugs/DevelopmentApprovalProcess/DrugInnovation/ucm592464.htm) This was an increase compared to 2017 (46 approvals). More than half of the approvals were for rare diseases and are often classified as specialty products.
- In 2018, the FDA approved 820 generic products with 99 being the first generic alternatives to a brand-name product. (Source: https://www.fda.gov/Drugs/DevelopmentApprovalProcess/HowDrugsareDevelopedandApproved/DruganddBiologicApprovalReports/ANDAGenericDrugApprovals/ucm629378.htm)

- Formulary Management

  o Factors that inhibit formulary adherence include members being stabilized on non-formulary products, provider experience with or preference for a non-formulary products and unique clinical circumstances. The Pharmacy Program factors these considerations along with financial impacts when making formulary decisions.

- Pharmacy Programs

  o Changing prescribing patterns can be met with resistance from providers and members. In 2018, the Pharmacy Program continued efforts on direct provider outreach with improved analytics and a focus on targeted savings initiatives.

- Member Interventions

  o Evolent pharmacists provide care management to Passport members through telephonic outreach. The program is supported end-to-end by the Evolent Identifi platform. This platform applies claim history and demographic factors to target members for outreach for Safety Related or Savings Related Interventions. Passport has an established program to gather input and share plan information with providers. Provider outreach visits are one of the key vehicles for this important commitment.

2018 Outreach Provider Visits		2018 Member Interventions	
Pharmacy Provider	382	**Total Savings Related Interventions**	8,517
Prescribing Provider	1,486	**Total Safety Related Interventions**	14,038
Total Provider Visits (Offices)	1,868	**Total Interventions**	22,555

- Provider Communication

  Volume of communications providers must assimilate continues to be challenge. In 2018, the Pharmacy Program continued to post its newsletter to the website to make accessible to all providers.

KEY 2018 ACTIVITIES

- For 2018, despite a significant increase in spend due to state-mandated changes, the Medicaid year-end net pharmacy spend met the annual budgeted amount.

- In the spring of 2018, KY DMS mandated all MCO's to open access to HCV drugs by removing all limitations based on disease severity. Due to this, spend for HCV alone tripled, adding $6 PMPM to net spend after the changes were implemented.

- In July 2018, KY DMS mandated an additional $2 dispensing fee for all pharmacies as directed by Senate Bill 5. This additional fee caused an increase of $2.62 PMPM to pharmacy net spend.

- The generic dispensing rate (GDR) improved 1.01% in 2018 compared to 2017.

- In 2018, 901 members were added to the lock in program, bringing the total lock in enrollment to 1,906 by the end of the year. The end-of-year enrollment was lower than in 2017 as many members were enrolled in 2016 and began hitting their two-year anniversary date, therefore released from the program.

- There were 1,486 total provider visits in 2018 for the CHOICES Program. Additionally, 382 pharmacies were targeted to provide education and claims processing resources.

- There were 22,555 total member interventions to address saving or safety opportunities.

- Throughout 2018, notifications were sent to providers and members informing them of formulary or utilization management changes and drug recalls.

- Throughout 2018 pharmacy worked to increase collaboration around fraud waste and abuse (FWA) activities between Passport, Evolent, and CVS. Pilot program to address inappropriate use of controlled substance also launched in 2018 for Passport.

- Another focus of 2018 was to decrease pharmacy visits and concentrate on providers with specific drug initiative strategy. In 2018, there was also increased telephonic and electronic communication where appropriate to increase effectiveness.

Clinical Practice Guidelines

FOCUS

Adopt, maintain, and implement clinical practice guidelines (CPG) that support clinical management of acute and chronic conditions relevant to Passport's membership.

FINDINGS

Passport's quality committees adopted and approved clinical practice guidelines for the following conditions:

- Abdominal Aortic Aneurysm
- Adult US Preventative Services Task Force (USPSTF) Preventative Health Clinical Practice Guidelines and CDC 2018 Adult Immunization Schedule (including Influenza, Shingles, Pneumonia)
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Acute Bronchitis
- Breast Cancer
- Cardiovascular risk factors and Coronary Artery Disease (CAD) (including Aspirin use)
- Care of the Older Adult
- Cervical Cancer
- Child & Adolescent Preventative Health Clinical Practice Guidelines/EPSDT Periodicity Schedule, 2018 Center for Disease Control Immunization Schedule 0-18 years and Child Catch-Up Schedule, and USPSTF Recommendations for Preventative Pediatric Health Care
- Cholesterol Management
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease (CKD)
- Congenital Hypothyroidism
- Congestive Heart Failure (CHF)
- Colon Cancer
- Depression- Adolescent, and Adult
- Diabetes Standards of Care - Child, Adolescent, and Adult
- Fluoride
- Folic Acid
- Heart Failure
- Hepatitis B
- High Blood Pressure
- HIV
- Gonococcal Ophthalmia Neonatorum
- Gonorrhea and Chlamydia
- Lead Screening and Testing for Childhood and Prenatal Lead Poisoning
- Lifestyle Management to Reduce Cardiovascular Risk
- Low back pain
- Lung Cancer
- 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults, Overview & Key Points of ACC Full Guideline 2017 for the Management of Hypertension (HTN)Obesity – Child, Adolescent, and Adult
- Osteoporosis
- Otitis Media
- Perinatal and Prenatal Care
- Acute Pharyngitis
- PKU
- Sexually Transmitted Infections
- Schizophrenia
- Skin Cancer (Child, Adolescent)
- Sickle Cell Disease

- Substance Abuse Disorder (including Opioid Medication Assisted Training (MAT)), Adolescent, and Adult
- Syphilis
- Tobacco- Child, Adolescent, Adult
- Use of Atypical Antipsychotic Medications in Children and Adolescents
- Viral Upper Respiratory Infection
- Vision Screening

All clinical practice guidelines updates were made on the Passport website. Notification of Clinical Practice Guidelines updates were sent via Passport eNews, the Provider Newsletter available on the PassportHealthPlan.com website, email notification, and postcard mailings. Hard copies of the guidelines were mailed to providers upon request.

BARRIERS

- No barriers are identified at this time.

KEY 2018 INTERVENTIONS

- Continue to review and update Clinical practice guidelines at a minimum of every two years or when new information/updates are received.

Clinical Practice Guidelines Adoption Compliance

FOCUS

Adopt, maintain, and implement clinical practice guidelines (CPG) that support clinical management of acute and chronic conditions relevant to Passport's membership.

FINDINGS

Passport's quality committees adopted and approved clinical practice guidelines for the following conditions:

- Adult US Preventative Services Task Force (USPSTF) Preventative Health Clinical Practice Guidelines and CDC 2018 Adult Immunization Schedule
- Anxiety/Panic Disorder
- Asthma
- Attention Deficit Hyperactivity Disorder (ADHD)
- Acute Bronchitis
- Cardiovascular risk factors and Coronary Artery Disease (CAD)
- Care of the Older Adult
- Child & Adolescent Preventative Health Clinical Practice Guidelines/EPSDT Periodicity Schedule, 2018 Center for Disease Control Immunization Schedule 0-18 years and Child Catch-Up Schedule, and USPSTF Recommendations for Preventative Pediatric Health Care
- Cholesterol Management
- Chronic Obstructive Pulmonary Disease (COPD)
- Chronic Kidney Disease (CKD)
- Congestive Heart Failure (CHF)
- Depression

- Diabetes Standards of Care - Child, Adolescent, and Adult
- Heart Failure
- Lead Screening and Testing for Childhood and Prenatal Lead Poisoning
- Low back pain
- Management of Hypertension (HTN)
- Obesity – Adult and Child/Adolescent
- Osteoporosis
- Otitis Media
- Perinatal Care
- Acute Pharyngitis
- Schizophrenia
- Sickle Cell Disease
- Substance Abuse Disorder (including Opioid Medication Assisted Training (MAT))
- Use of Atypical Antipsychotic Medications in Children and Adolescents
- Viral Upper Respiratory Infection

All clinical practice guidelines updates were made on the Passport website. Notification of Clinical Practice Guidelines updates were sent via Passport eNews (email) and postcard mailings. Hard copies of the guidelines were mailed to providers upon request.

BARRIERS

- No barriers are identified at this time.

KEY 2018 INTERVENTIONS

- Continue to review and update Clinical practice guidelines at a minimum of every two years or when new information/updates are received.
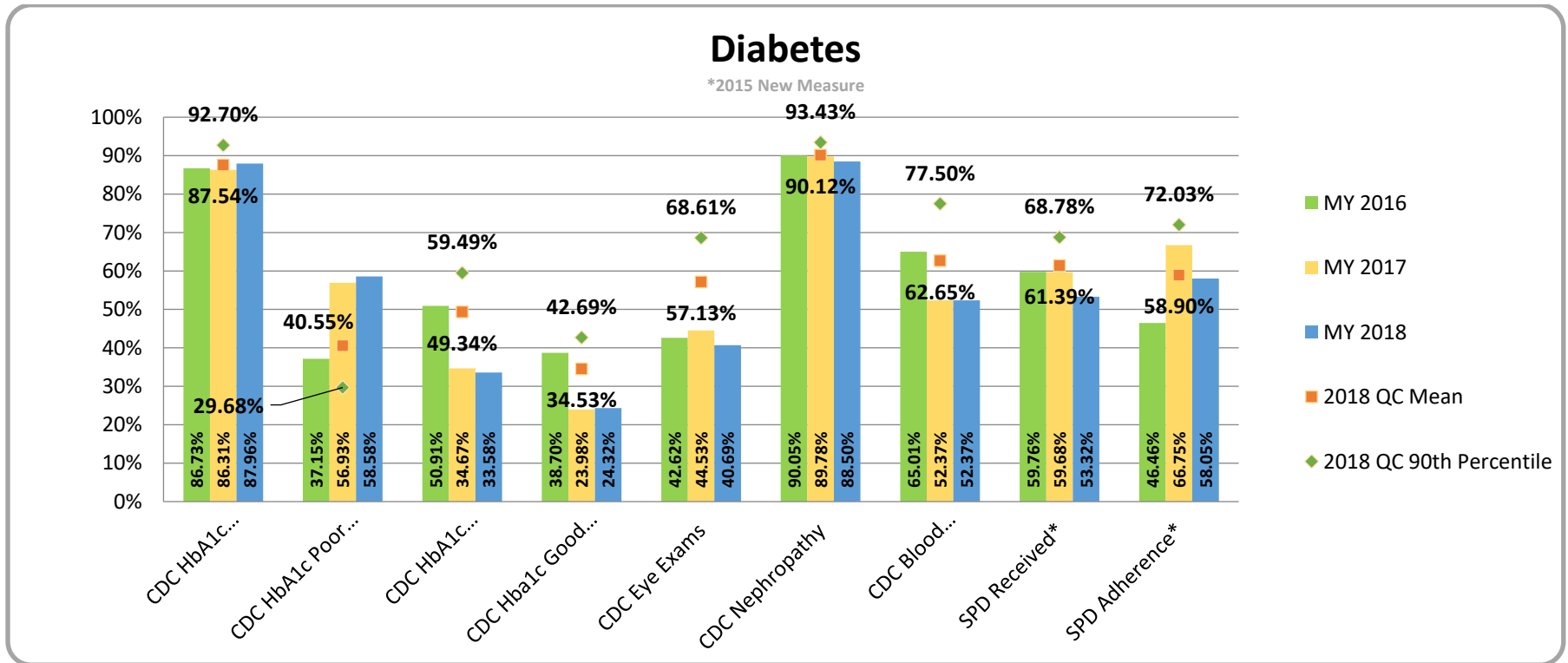
Clinical Practice Guidelines Compliance

In 2018, Clinical Practice Guideline (CPG) Compliance transitioned from medical record review to HEDIS rate monitoring. HEDIS® results reviewed and trended to assess practitioner compliance with adopted clinical practice guideline standards. Six guidelines were identified for compliance review: two each for medical acute/chronic conditions, two behavioral health guidelines that included one each for adult and pediatric populations, and two preventative care guidelines. Reviews of HEDIS® results were conducted for compliance with the following guidelines:

- Diabetes Standards of Care
- Hypertension
- Perinatal and Postpartum Care
- Child and Adolescent Preventive Care
- Attention Deficit Hyperactivity Disorder
- Depression

Diabetes Standards of Care

The HEDIS® measures Comprehensive Diabetes Care (CDC) and Statin Therapy for Patients with Diabetes (SPD) were reviewed to assess compliance with the diabetes guidelines and results are as follows:

Diabetes bar chart (*2015 New Measure). Values by measure:

Measure	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
CDC HbA1c...	86.73%	86.31%	87.96%	87.54%	92.70%
CDC HbA1c Poor...	37.15%	56.93%	58.58%	40.55%	29.68%
CDC HbA1c...	50.91%	34.67%	33.58%	49.34%	59.49%
CDC Hba1c Good...	38.70%	23.98%	24.32%	34.53%	42.69%
CDC Eye Exams	42.62%	44.53%	40.69%	57.13%	68.61%
CDC Nephropathy	90.05%	89.78%	88.50%	90.12%	93.43%
CDC Blood...	65.01%	52.37%	52.37%	62.65%	77.50%
SPD Received*	59.76%	59.68%	53.32%	61.39%	68.78%
SPD Adherence*	46.46%	66.75%	58.05%	58.90%	72.03%

Goals:

Passport has established our goal for each HEDIS measure to increase 2 percentage points from the previous year and meet the Quality Compass 50th percentile. One of the nine diabetes measures improved at least 2 percentage points from measurement year MY 2017 to MY 2018.
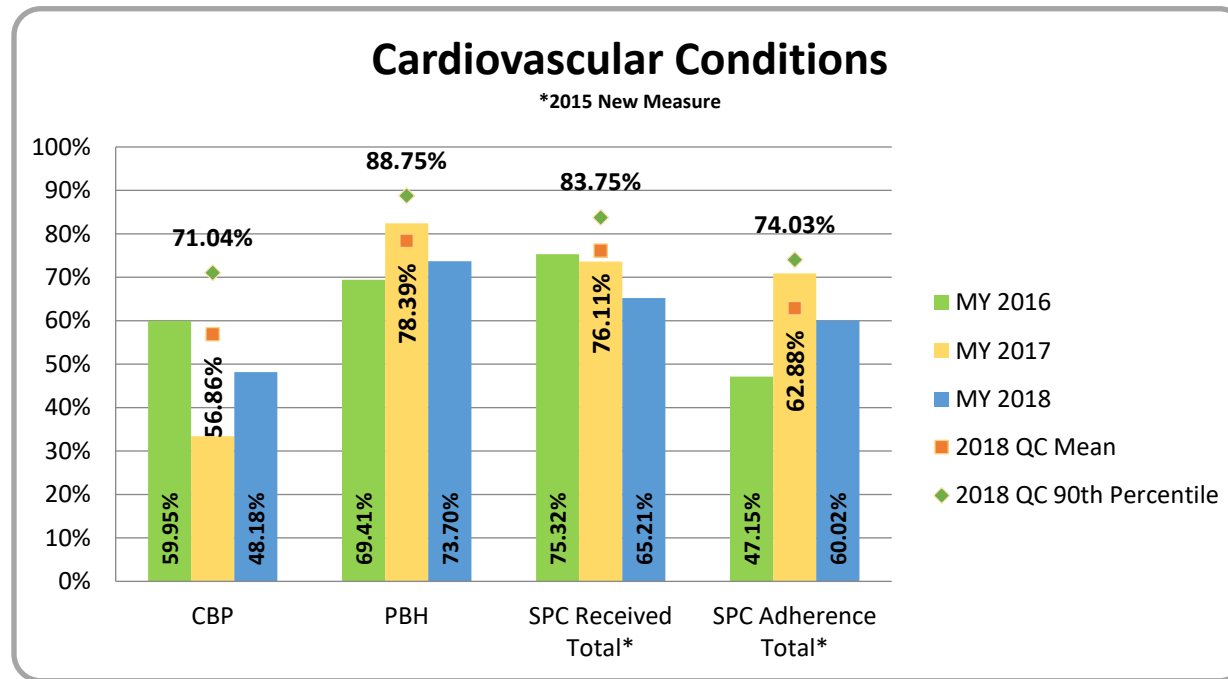
Barriers:

- o Lack of member compliance with the prescribed treatment regimen.
- o Inaccurate member demographic information encountered during phone call and mail campaigns.
- o Delays in ability to review claims and distribute care gap reports due to TPA transition.

2018 Interventions:

- o Promotion of the diabetes guideline to providers through various channels, including but not limited to the provider visits by Provider Network and Population Health Management staff, provider website, eNews, and care management conferences.
- o Targeted mailings and call campaigns from the health plan to members to facilitate provider visits for diabetes care.
- o Care gap reporting to providers to increase HbA1c screenings, eye exams, and attention for nephropathy.
- o Pharmacy adherence calls from health plan to members to assist providers with medication adherence.
- o Member incentive.
- o Inclusion of the Comprehensive Diabetes Care measure (DRE and nephropathy) in value based contracting efforts.

Hypertension

The HEDIS® measures Controlling High Blood Pressure (CBP), Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) and Statin Therapy for Patients with Cardiovascular Disease (SPC) were reviewed to assess compliance with the hypertension guideline and results are as follows:

Cardiovascular Conditions
*2015 New Measure

Measure	MY 2016	MY 2017	MY 2018	2018 QC Mean	2018 QC 90th Percentile
CBP	59.95%	56.86%	48.18%		71.04%
PBH	69.41%	78.39%	73.70%		88.75%
SPC Received Total*	75.32%	76.11%	65.21%		83.75%
SPC Adherence Total*	47.15%	62.88%	60.02%		74.03%

Goals:

Passport has established our goal for each HEDIS measure to increase 2 percentage points from the previous year and meet the Quality Compass 50th percentile.

Barriers:

- o Changes in staffing and stratification of members in cardiovascular condition care program.
- o Lack of member compliance with the prescribed treatment regimen.

42

2018 Interventions:

o Promotion of the hypertension guideline to providers through various channels, including but not limited to the provider visits by Provider Network and Population Health Management staff, provider website, eNews, and care management conferences.

Perinatal and Postpartum Care

The HEDIS® measures Frequency of Ongoing Prenatal Care - >81% (FPC) and Prenatal and Postpartum Care (PPC) were reviewed to assess compliance with the Perinatal and Postpartum Care guidelines and results are as follows:
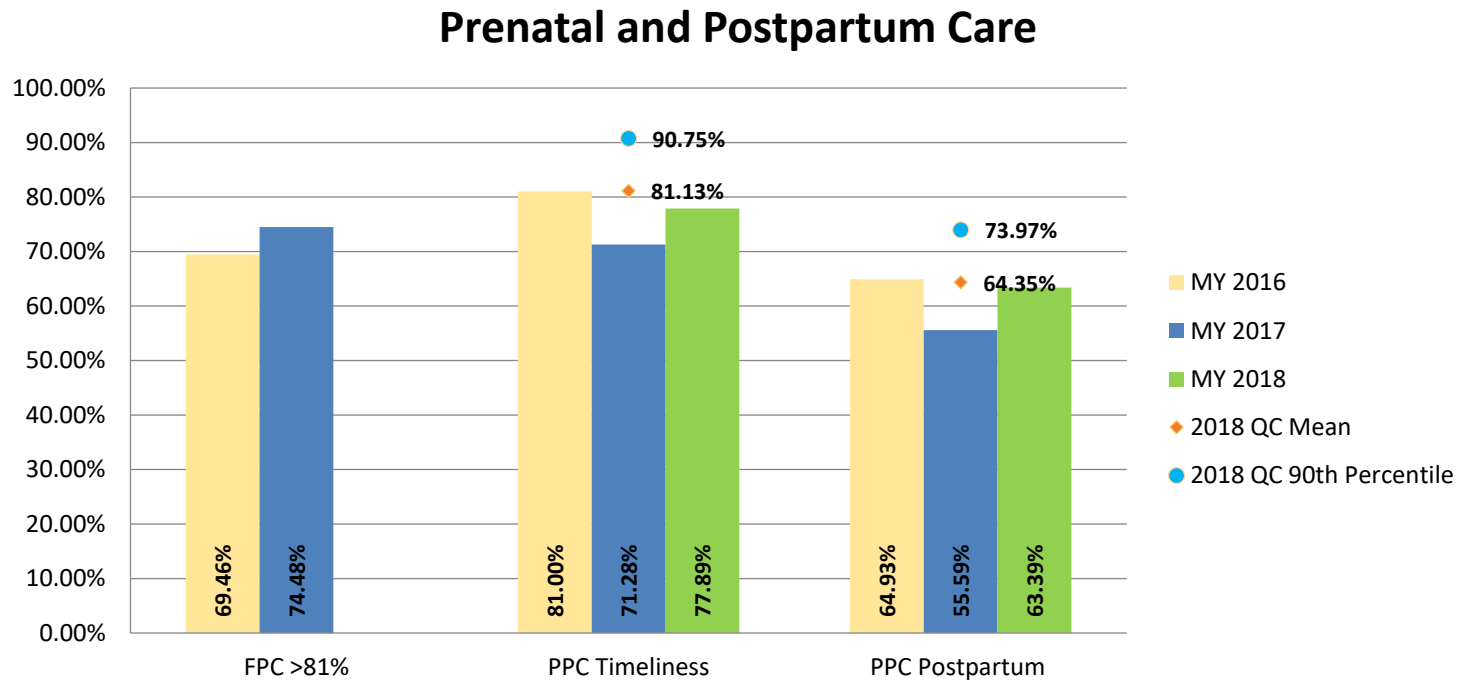
Prenatal and Postpartum Care

Goals:

Passport has established our goal for each HEDIS measure to increase 2 percentage points from the previous year and meet the Quality Compass 50th percentile. Both PPC measures improved at least 2 percentage points from measurement year MY 2017 to MY 2018.

Barriers:

- o Lack of member knowledge of need for early prenatal care.
- o Lack of member compliance with routine obstetrical care.
- o Delayed or no notification of pregnancy to the health plan.
- o Members' lack of transportation to scheduled appointments.

2018 Interventions:

- o Promotion of perinatal and postpartum care guidelines to providers through various channels, including but not limited to the provider visits by Provider Network and Population Health Management staff, provider website, eNews, and care management conferences.
- o Robust maternity care management program with new documentation platform.
- o Member incentives.
- o Member education regarding need for ongoing, routine prenatal and postpartum care.
- o Facilitation of transportation benefits.
- o Prenatal smoking performance improvement project (PIP).

Child and Adolescent Preventive Care

The HEDIS® measures Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents (WCC), Well-Child Visits in the First 15 Months of Life (W15), Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34), and Adolescent Well-Care Visits (AWC) were reviewed to assess compliance with the child and adolescent preventive care guideline and results are as follows:

Child and Adolescent Preventive Care
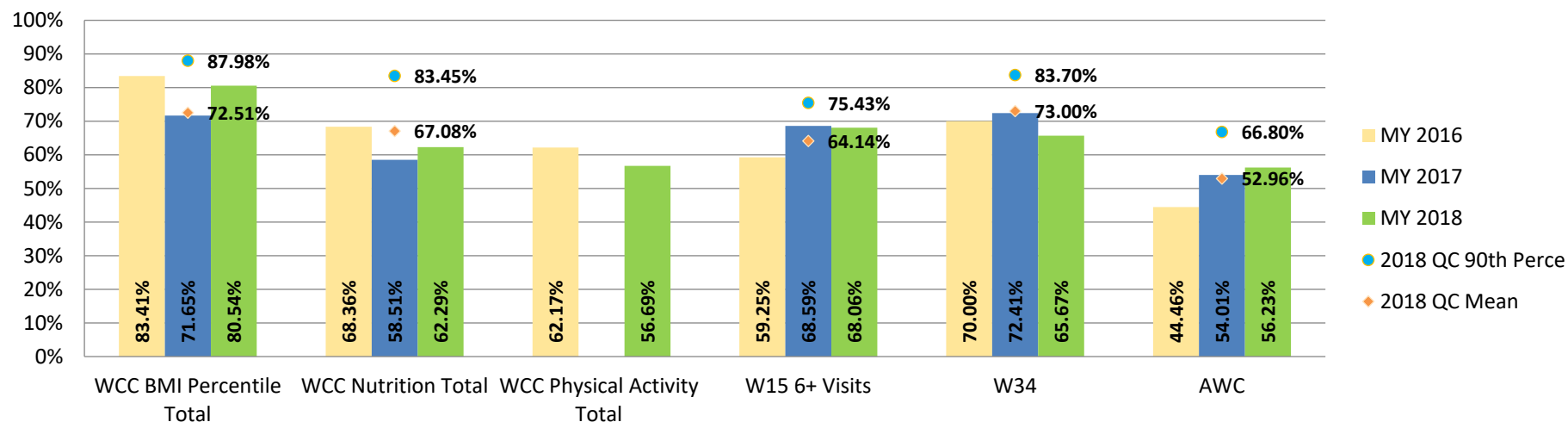
Goals:

Passport has established our goal for each HEDIS measure to increase 2 percentage points from the previous year and meet the Quality Compass 50th percentile. Three of these measures WCC BMI, WCC Nutrition, and AWC improved at least 2 percentage points from measurement year MY 2017 to MY 2018.

Barriers:

- o   Lack of member compliance with attending routine well-care visits.
- o   Member transportation to appointments.
- o   Provider confusion regarding coding and use of the EP modifier.
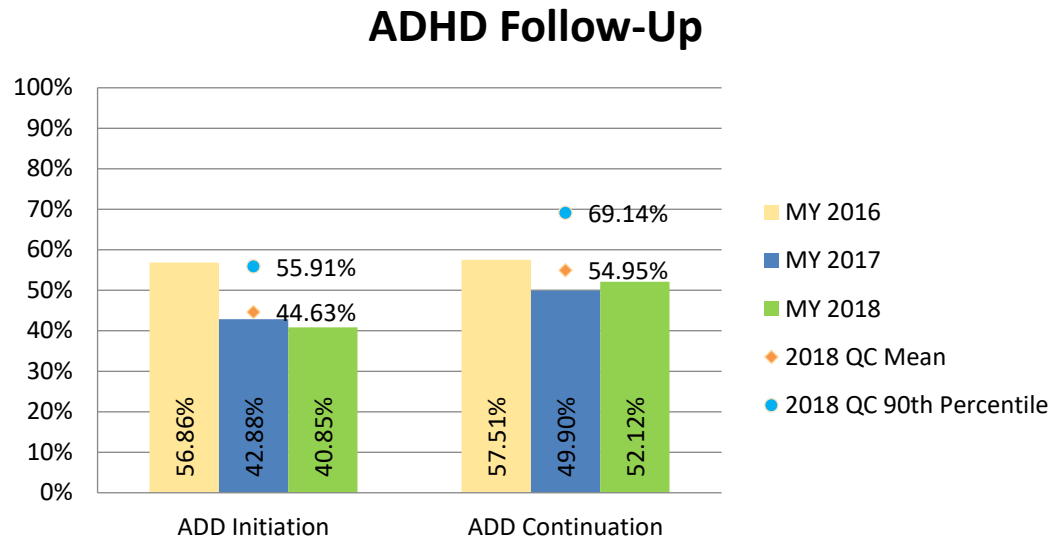- o   EMRs correctly capturing BMI percentile and HIM staff pulling the correct BMI percentile documentation.

2018 Interventions:

- o Promotion of child and adolescent preventive care guidelines to providers through various channels, including but not limited to the provider visits by Provider Network and Population Health Management staff, provider website, eNews, the EPSDT program, and care management conferences.
- o Growing and restructuring the health plan's EPSDT program.
- o Care gap reporting for EPSDT screens due.
- o EPSDT PIP in progress to increase EPSDT screening and participation rates.
- o Member incentive.
- o Inclusion of well-child visits in value based contracting efforts.
- o Use hybrid methodology to collect W15, W34, and AWC during HEDIS 2018 to evaluate if administrative methodology is less effective in recording all visits.

Attention Deficit Hyperactivity Disorder

The HEDIS® measure Follow-Up Care for Children Prescribed ADHD Medication (ADD) was reviewed to assess compliance with the ADHD guideline and results are as follows:

ADHD Follow-Up

	ADD Initiation	ADD Continuation
MY 2016	56.86%	57.51%
MY 2017	42.88%	49.90%
MY 2018	40.85%	52.12%
2018 QC Mean	44.63%	54.95%
2018 QC 90th Percentile	55.91%	69.14%

Goals:

Passport has established our goal for each HEDIS measure to increase 2 percentage points from the previous year and meet the Quality Compass 50th percentile. The ADD Continuation measure improved at least 2 percentage points from measurement year MY 2017 to MY 2018.
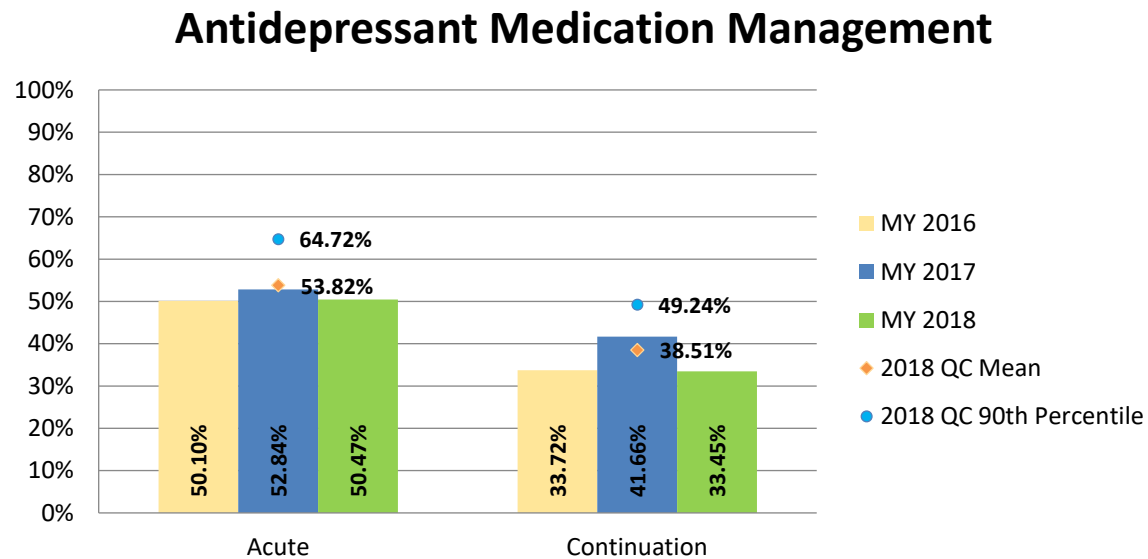
Barriers:

- o   Member transportation is an ongoing issue for some members.

2018 Interventions:

- o   Promotion of ADHD care guidelines to providers through various channels, including but not limited to the provider visits by Provider Network and Population Health Management staff, provider website, eNews, the EPSDT program, and care management conferences.
- o   Continued collaboration with Beacon, Passport's behavioral health vendor.

Depression

The HEDIS® measure Antidepressant Medication Management (AMM) was reviewed to assess compliance with the Depression guideline and results are as follows:

Antidepressant Medication Management

Chart legend:
- MY 2016
- MY 2017
- MY 2018
- 2018 QC Mean
- 2018 QC 90th Percentile

Acute: 50.10% (MY 2016), 52.84% (MY 2017), 50.47% (MY 2018), 53.82% (2018 QC Mean), 64.72% (2018 QC 90th Percentile)

Continuation: 33.72% (MY 2016), 41.66% (MY 2017), 33.45% (MY 2018), 38.51% (2018 QC Mean), 49.24% (2018 QC 90th Percentile)

Goals:

Passport has established our goal for each HEDIS measure to increase 2 percentage points from the previous year and meet the Quality Compass 50th percentile. Neither the acute or continuation phases met the established goals.

Barriers:

- o Members discontinuing medication due to negative side effects (weight gain, libido change, increase in suicidal ideation, feel tired, feeling numb, suppressed creativity)
- o Members discontinuing medication due to feeling better
- o Stigma associated with being on an antidepressant

2018 Interventions:

- o Promotion of the depression guideline to providers through various channels, including but not limited to the provider visits by Provider Network and Population Health Management staff, provider website, eNews, and care management conferences.
- o Continued collaboration with Beacon, Passport's behavioral health vendor.
- o Member incentive.
- o Member education on coping with side effects
- o Pharmacy adherence calls from health plan to members to assist providers with medication adherence.
- o Inclusion of the AMM Acute measure in value based contracting efforts.

2019 Activities:

For 2019, there will be a reintroduction of a process to perform Medical Record Review if the compliance threshold is not met. If the compliance threshold is not met for the provider, medical records will be requested. Upon completion, if documentation or process gaps are identified, education will be provided to the practitioner and monitoring will reoccur at six- and twelve-month intervals.

2018 Medical Record Documentation and Continuity and Coordination of Care

Assess compliance with medical-record-keeping standards and monitor the processes and procedures physician offices use to facilitate the delivery of continuous and coordinated care. Address trends or deficiencies via corrective action plans and Plan-wide trends or deficiencies as deemed appropriate by the Quality Medical Management Committee (QMMC).

GOAL

Passport Health Plan requires all provider groups to achieve an overall compliance score of 80 percent with medical record documentation standards.

MEASUREMENT

Annually, records are reviewed to assess PCP and ER/Hospital compliance using adopted medical record documentation and continuity and coordination of care standards. Sites reviewed include both rural and urban practices.

SAMPLE SELECTION CRITERIA

Passport collaborated with DMS and the EQRO to ensure that each PCP and ER/Hospital is assessed for compliance with medical record documentation standards once every three years.

Primary Care Providers (PCP's) selected for review must meet the following criteria:

- Participating PCP agreement during the entire measurement year (2017).
- Panel count of 50 or more members.
- PCP primary address within the state of Kentucky.
- Have at least 40 members with three or more visits during the measurement year.
- A specific DOS will be pulled from the sample based on the claims and will represent the 3rd visit.
- PCP was not assessed the previous three years unless they received a score below 80 percent.

ER/Hospitals selected for review must meet the following criteria:

- Participating facility agreement during the entire measurement year (2017).
- ER/Hospital primary address within the state of Kentucky.
- Have at least 40 members with three or more ER visits, one of which resulted in an inpatient stay at the same hospital during the measurement year.
- A specific DOS will be pulled from the sample based on the claims and will represent the 3rd visit.
- ER/Hospital was not assessed the previous three years unless they received a score below 80 percent.

Mental Hospital Reviews

- Reviews were performed per third party administrator quality review procedure.

- The review will be performed via delegation oversight.

Dental Reviews

- Reviews were performed per third party administrator quality review procedure.
- The review will be performed via delegation oversight.

FINDINGS

The Quality Department has adopted and applied the NCQA 8/30 sampling technique to improve efficiency of the audit process and ensure consistent methodology was utilized to support the contractual requirements defined by DMS. The number of charts reviewed per provider was eight, with the opportunity to expand the audit to 30 charts if the provider is noncompliant within the initial 8 chart sample. In addition to PCP's, ER/Hospitals were included in the Medical Record Review Audit. The 2018 overall compliance score for all audit types is 86%.

- Seven provider groups fell below PHP's compliance standard of 80%. These audits were in regions 3, 5 & 8.
- Six provider groups fell below 80% and chose to keep the score of their initial audit; therefore, they did not expand.
- Two provider group did not submit any documentation.

PCP COMPLIANCE

Thirty-seven elements were assessed for compliance in 2018 for PCP (Primary Care Providers). These elements are directly outlined in Passport's state contract, Passport's Provider Manual, and/or the NCQA Accreditation Manual.

Results are as follows:

- One hundred and twenty-nine PCP's were reviewed, representing 1022 members.
- The overall score for PCP's in 2017 is 86%. This is a decrease of 1% from 2017.

The following top 10 elements did not reach the 80% compliance standard:

- Documentation of whether a member has executed an Advance Medical Directive. (ADULTS ONLY-18 and older)
- If a consultation is requested, there is a note from the consultant in the medical record or documentation that the note has been requested, the patient was a no show, etc.
- An immunization record for children AGES 10 AND YOUNGER is up to date or an appropriate history has been made in the medical record (for adults).
- Documentation of an assessment or counseling regarding at risk sexual behaviors for members 22 years of age and older.
- Documentation of an assessment or counseling regarding substance abuse for members 22 years of age and older.

- Documentation of an assessment or counseling regarding alcohol use for members 22 years of age and older.
- Significant illness and medical conditions are indicated on problem list.
- Name and telephone numbers of emergency contact are documented.
- Past medical history is easily identified and includes serious accidents, operations, and illness. For children and adolescents (18 years and younger) past medical history relates to prenatal care, birth, operations, and childhood illnesses.
- Consults, labs, and imaging reports are reviewed and initialed by the ordering physician. Consultation and abnormal laboratory and imaging study results have an explicit notation in the record of follow up plans.

PCP VARIATIONS AND BARRIERS OBSERVED IN 2018

- o 3rd year audit expansion outside of region 3.
- o Seventy groups reviewed for PCPs were outside of region 3. All regions had overall score of 80% or higher.
- o One provider who had scored below the 80% pass threshold for two consecutive years was re-reviewed this year and scored 99% which is well above the passing percentile.
- o Certain providers were uncomfortable discussing topics such as assessment/ counseling regarding at risk sexual behaviors**.**
- o Several providers voiced difficulty in obtaining the member's emergency contact name and number.
- o When providing audit results and information to providers or appropriate office staff, several providers indicated they had not been addressing Advance Medical Directive in the past. Most have incorporated this information into the   paperwork the members update annually.

ER/HOSPITAL COMPLIANCE

No hospitals were reviewed for 2018.

Figure 1. illustrates the number of audits performed in each region, as well as the average.

Medical Record Reviews Completed in 2018	Regions							
	1	2	3	4	5	6	7	8
Number of PCP MRR completed	5	6	59	15	28	1	1	14
-Overall PCP average	85%	88%	85%	87%	88%	85%	82%	86%
Number of ER/Hospital Reviews completed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
-Overall ER/Hospital average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of ER/Hospital Reviews completed	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
-Overall ER/Hospital average	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Number of Offices with Score Below 80%	N/A	N/A	5	N/A	1	N/A	N/A	1

- Educate providers on the importance of updating demographic information, problem lists and medication lists.
- Provider education is completed at the end of each audit and the Office/Hospital/ER receives a copy of the results.
- Meet with the Provider Relations Specialists and provide education on the Medical Record Review Audit Process. This will allow them a better understanding of the process and lead to increased provider adherence of the MRR audit process.
- Notify Provider Relations Specialist when providers receive a second request for documentation letter, so they can assist in getting the records.
- Notify Provider Relations Specialist when providers score below 80% for two consecutive years to assist with provider education.
- Reassess PCP/ER/Hospital in 2019, for those with a score below 80%, to determine if improvements have been implemented. If the score is below 80% for two consecutive years, they must submit a Corrective Action Plan and will continue in the audit cycle until their score is 80% or greater.
- Monitor three-year cycle trends for those Medical Record Review Audits falling below 80% and refer appropriately to the Credentialing Committee at the time of their re-credentialing in support of policy QM 5.0 Medical Record Standards and Review.
- Solicit feedback and direction from QMMC regarding intervention activities.

Patient Safety

FOCUS

Review all sentinel/adverse events and member concerns for quality of care and determine if standards of care were met. Cases reviewed include both inpatient and outpatient settings. All outcomes are trended and analyzed on a quarterly basis with reports provided to the QMMC annually for oversight.

GOALS

- Foster an environment that assists providers with improving the safety of their practices through identifying safety and quality of care concerns, providing feedback, requesting corrective action as appropriate, and acting according to Passport's policies.

- Update Passport's Safety Initiatives quarterly and present it to QMMC for annual review.

MEASUREMENT

All member concerns are investigated per Policy QI.026.E.KY *Quality of Care Review for Member Concerns*. All sentinel events are investigated per Policy QI.025.E.KY *Quality of Care Review for Sentinel Events*

FINDINGS

All member concern cases and sentinel event/adverse event cases were reviewed by a Quality Improvement Nurse and a Passport Medical Director. Cases were referred to the Quality Medical Management Committee (QMMC) for additional review as appropriate.
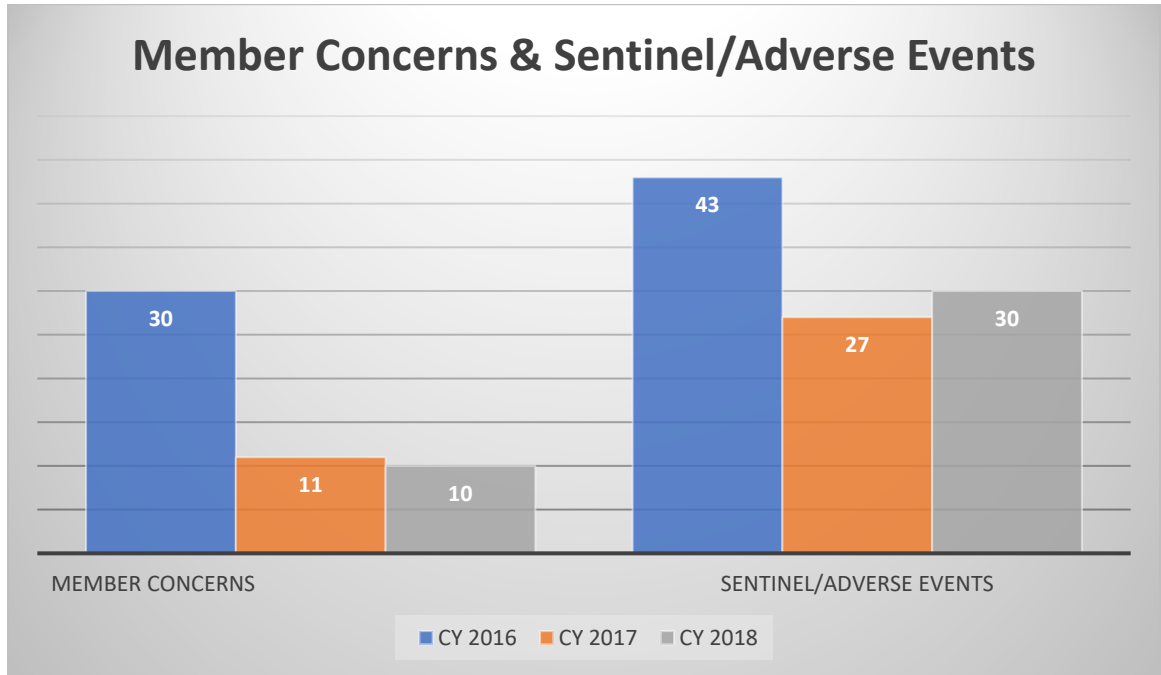
The following outcomes were noted:

SENTINEL/ADVERSE EVENTS	
Numbers of Cases	Outcome Codes
6	*0 – No Quality of Care Concerns (No potential or actual adverse outcome as result of care provided. Care meets standards).*
2	*1 – Quality of Care and/or Documentation Concern*
1	*2 – Quality of Care and/or Documentation concern with Potential for Adverse Outcome*
0	*3 – Quality of Care Concern Resulting in a Temporary Adverse outcome.* It is important to note that the members recovered from the adverse outcome in each of these cases
0	4 – Quality of Care concern resulting in permanent adverse outcome
0	5 – Quality of Car Concern resulting in mortality.

1	U – Quality of Care and/or Documentation Concern(s) is/are present but the Plan is unable to determine if the provider's action/inaction and/or documentation or lack thereof directly or indirectly impacted the outcome of the case.
0	F – Failure to Comply with Review Process
MEMBER CONCERNS	
24	*0 – No Quality of Care Concerns (No potential or actual adverse outcome as result of care provided. Care meets standards).*
2	*1 - Quality of Care Concern (Care or documentation does not meet standards but there is no adverse outcome or potential for adverse outcome).*
3	*2 – Quality of Care Concern with Potential for Adverse Outcome (Patient placed at risk for adverse outcome due to care that does not meet standards).*
0	*3 – Quality of Care Concern Resulting in a Temporary Adverse outcome. It is important to note that the members recovered from the adverse outcome in each of these cases.*
0	*4 – Quality of Care Concern resulting in permanent adverse outcome*
0	*5 – Quality of Care Concern resulting in a mortality*
1	*U – Quality of Care and/or Documentation Concern is present but Passport is unable to determine if the provider's action/inaction and/or documentation or lack thereof directly or indirectly impacted the outcome of the case.*
0	*F – Failure to Comply with Review process*

*There were no site visits conducted in 2018

BARRIERS

- Providers' failure to comply with the review process by not submitting the requested medical records in a timely manner.

KEY 2018 INTERVENTIONS

- All member concerns and sentinel/adverse events reviewed by both a Quality Review Nurse and a Medical Director.

- Provider Relations notified on all cases when a second request for medical records was sent for outreach and assistance in obtaining records.

Quality of Service

Information related to Passport's administrative and medical necessity appeals can be found in the 2016 Utilization Management Program Evaluation and 2017 Utilization Management Program Description.

Service Indicators

Member Services Performance Standards

FOCUS

Monitor and improve performance as necessary in support of Plan goals and member expectations for member services.

GOAL

- Increase the number of calls answered by a live voice within 30 seconds.
- Meet or exceed the average speed of answer (ASA) goal of 30 seconds and the abandonment rate (AR) goal of five percent.
- Improve satisfaction rate as assessed through CAHPS® Satisfaction Survey for the customer service composite. This composite of questions include:
  - Got information or help needed
 - Treated you with courtesy and respect

FINDINGS

Additional information related to Passport's Member Services indicators can be found in the 2018 Member Satisfaction Annual Evaluation.

During 2018, Passport's Member Services department had a total call volume of 462,613 HEDIS measure, Call Answer Timeliness, results show 64% of calls received were answered within 30 seconds.

Call Answer Timeliness
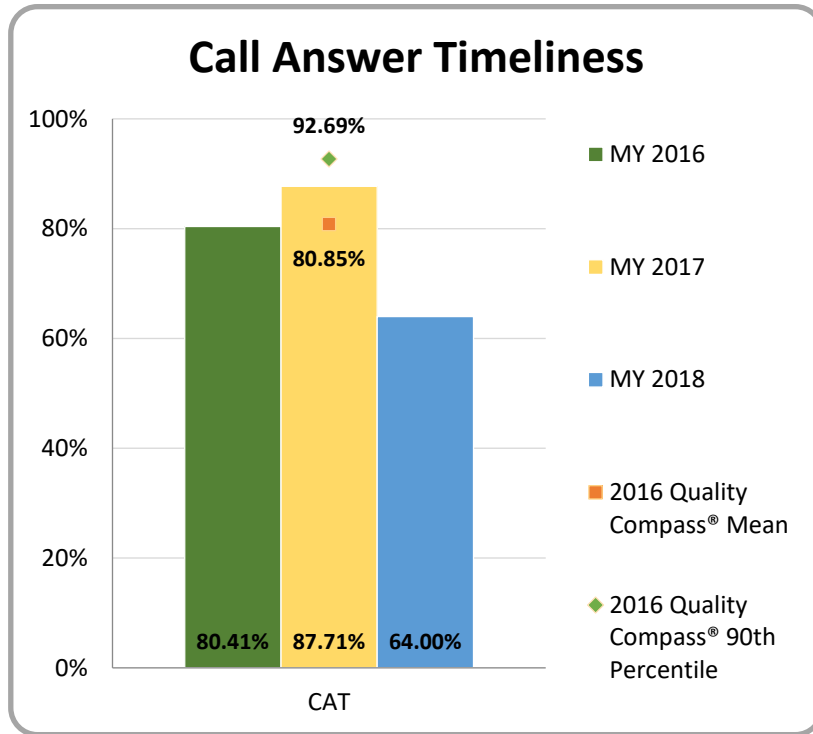
The AR goal is 5 percent or less in 2018 Passport achieved the AR goal by 5.0 percent. Passport did not achieve the ASA goal of 30 seconds or less Passport end with a 1 minute and 49 seconds ASA.
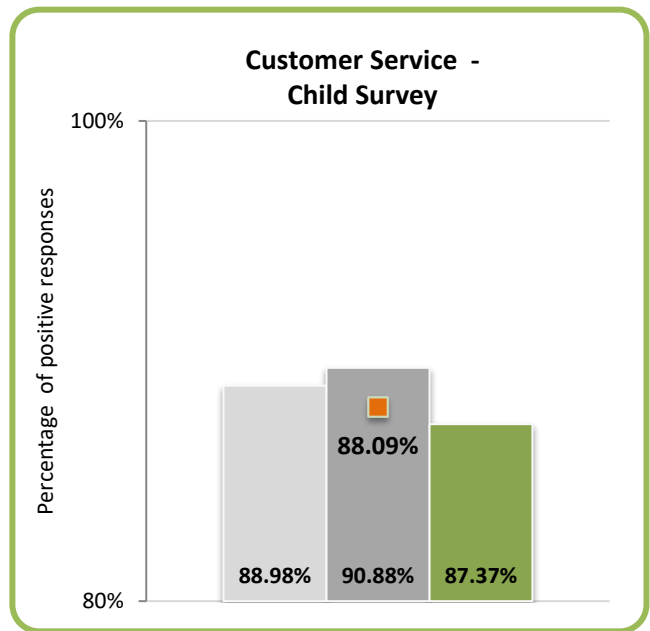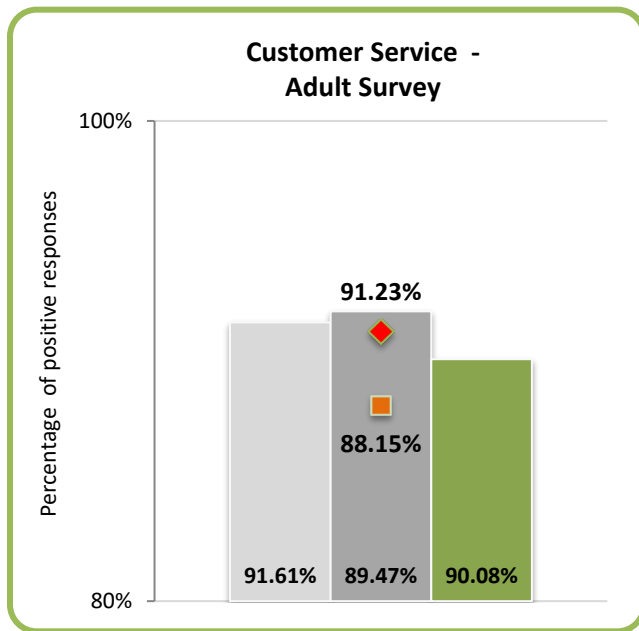
Customer Service - Adult Survey

Customer Service - Child Survey

BARRIERS

- No barriers were identified.

KEY 2018 INTERVENTIONS

- Continued to increase member awareness of the Plan's benefits, mission, and programs through:
  - Continued education to members through the New Member Packets and updates via the member newsletters and the member web site.
  - Increase Member Service staff due to call volume.
  - Utilize Auditor position to monitor calls.
  - Conduct ongoing training classes for staff.
  - Focused efforts on improving how well do doctors communicate.

Provider Service Performance Standards

FOCUS

Monitor and improve performance as necessary in support of Plan goals and customer expectations for provider services.
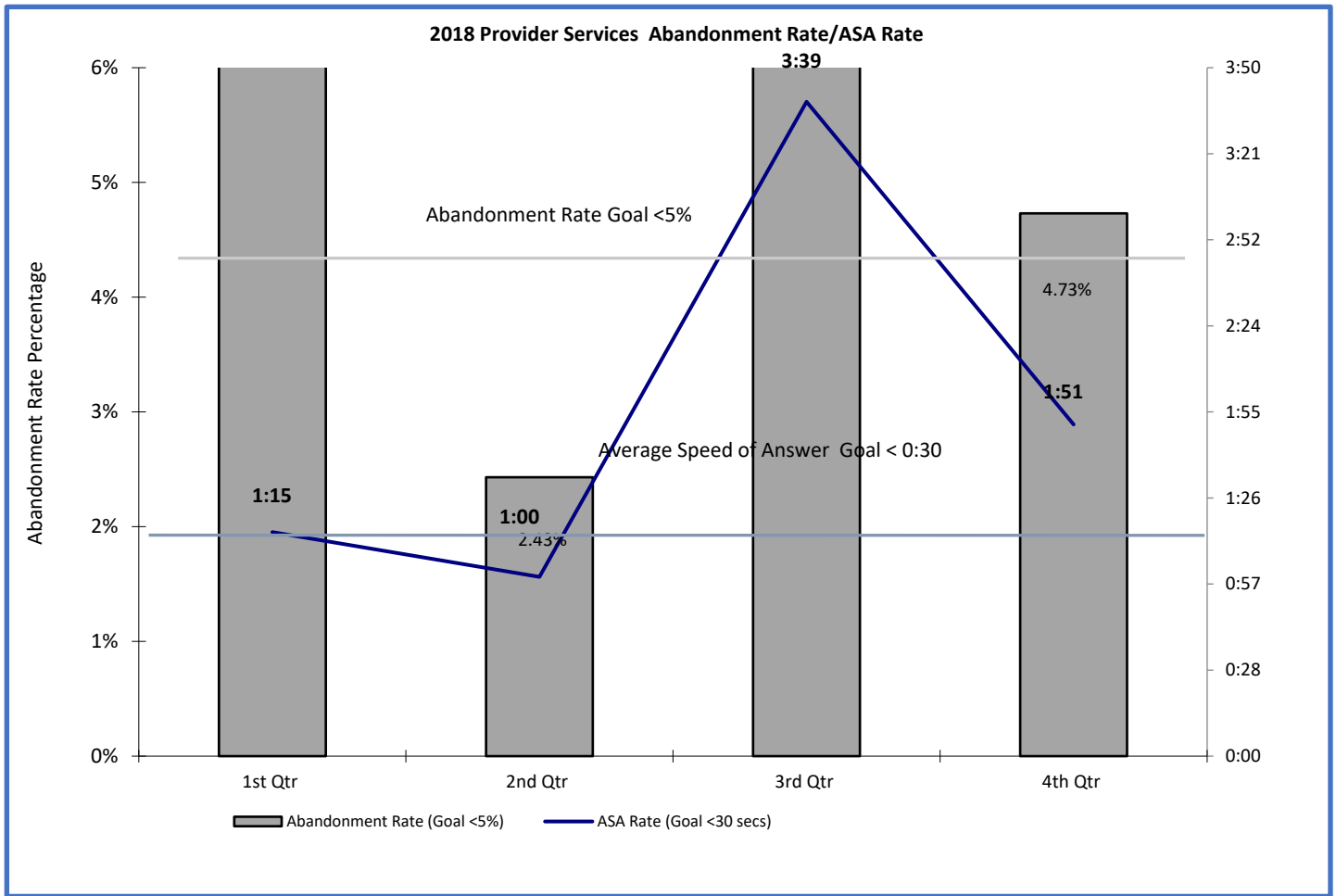
GOAL

Meet or exceed the ASA goal of 30 seconds and the AR goal of 5 percent.

MEASUREMENT

Overall effectiveness for ASA and AR is measured through reporting from the call center telephone system.

2018 Provider Services Abandonment Rate/ASA Rate

During 2018, Passport's Provider Call Center accepted 347,988 calls. The Provider Services Call Center achieved the AR goal of less than 5% and ASA goal of 30 seconds or less throughout 2018.

BARRIERS

Increased call volume in part due to implementation of a new claims system along with staffing shortages.

KEY 2018 INTERVENTIONS

▪ Increased staff so SLA goals can be met for the upcoming year.

Claims Processing Performance Standards

Monitor and improve performance as necessary in support of Plan goals and customer expectations for claim processing services.

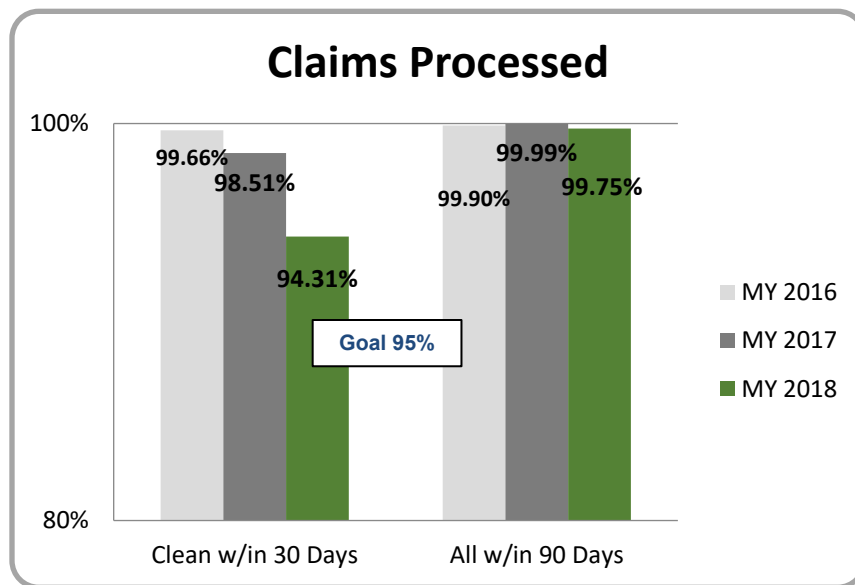## GOAL

- Process 95 percent of clean paper and EDI claims within 30 days and 99 percent of all claims clean/unclean within 90 days of receipt.
- Process 95 percent of claims accurately in accordance with financial (FAR) and procedural (PAR) policies.
- Improve provider satisfaction with the timeliness and accuracy of claims payment.

MEASUREMENT

Overall effectiveness is measured through claim processing reports and via Passport's annual provider satisfaction survey.

FINDINGS

Claims Processed

	Clean w/in 30 Days	All w/in 90 Days
MY 2016	99.66%	99.90%
MY 2017	98.51%	99.99%
MY 2018	94.31%	99.75%

Goal 95%

Financial & Procedural Accuracy Rates

During 2018, a total of 5,582,998 claims were received. All other claims processing and accuracy rate goals were met or exceeded.

BARRIERS

- Delay in crossover files from Medicare developing delays in SLAs/Claims Processing
- Allocation of claims inventory through Excel worksheet to claims adjusters.
- Brought TPA operations in house from TPA and working out of new claims systems.
- A number of new processes and enhancements were written for Aldera, there was a training curve for employees and developing. Caused some small QA errors.
- Bandwidth issues and system slowness that had to be worked out with the transition developing delays in SLAs/claim processing.

KEY 2018 INTERVENTIONS

- Transitioned to new WFM allocation tool in December 2018. WFM tool systematically allocated claims to assigned claims adjusters on a first in first out basis.
- Continue to explore opportunities to improve overall performance standards, auto adjudication and provider satisfaction.
- Key improvements made to pre-authorization Aldera logic and automation.
- Improve overall claim accuracy by seeking opportunities to reduce front end errors and improve provider satisfaction. Weekly meetings with QA leadership to
- Identify additional claim queues that could be sent through Rational Robot.
- Bi-weekly meetings with the Claim Processing staff to ensure full understanding of updates and Claim Processing rules.
- Continue to monitor claim work queues daily to ensure time-to-pay standards are met.
- Continue to assess staffing needs monthly and provide additional training sessions.

Member Satisfaction

Member Grievance Trends

FOCUS

Monitor and improve performance as necessary in support of Plan goals and member expectations for member services.
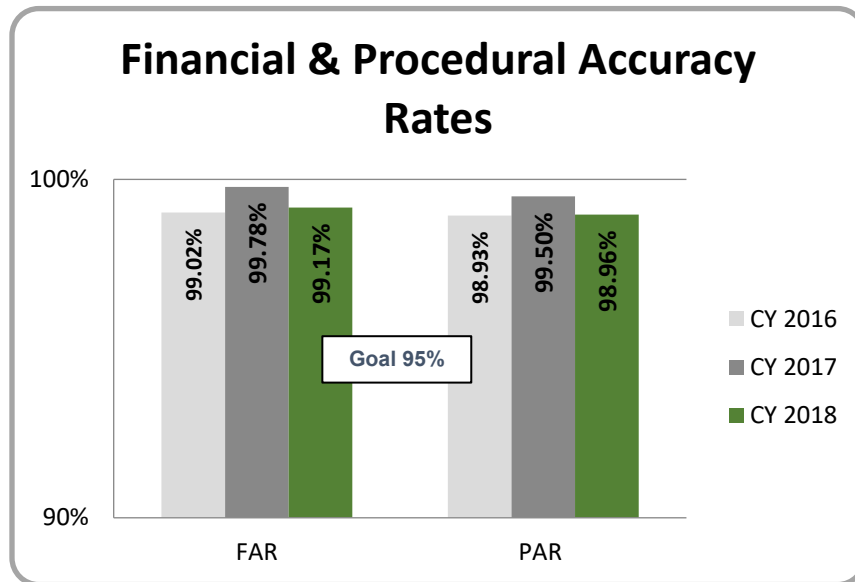
GOAL

Reduce and/or eliminate the top reasons for member complaints and grievances.

MEASUREMENT

All complaint data is collected and logged into an electronic documentation system. The complaints are grouped into the following five categories:

Quality of Care
Inadequate/inaccurate dispensing
PCP not following Advanced Directives
Verbal Abuse
Physical Abuse
Sexual Abuse/Harassment

Access
Denial/Reduction of Services
Appointment not timely
Excessive Wait Time
Phone No Answer/Busy/Hold time/Disconnect
PCP Access Availability Network
Inconvenient Hours of Operation
Specialist Availability Network

Attitude/Service
Communication Barrier
Diagnosis Treatment Slow/Incomplete/Unclear
Unprofessional communication
Office Staff Unprofessional
Communication Unclear/untimely
Discrimination

Billing/Financial
Par Provider Billing Member
Non-Par Provider Billing Member
HIPPA Violation
Potential Fraud/Abuse

Quality of Practitioner Office Site
Office Environment Unsafe
Environment Dirty/Offensive

Enrollment/Eligibility
PHP Enrollment Issues
DMS Eligibility Issue
Pharmacy Eligibility
Dental Eligibility
Vision Eligibility

Pharmacy
PA Not Submitted
Non-Formulary
TPL-Pharmacy
Duplicate Therapy
Step Therapy
Quantity/Plan Limits
Change Dosage
Lost/Stolen Meds-Expired Authorization

Plan Administration (Mgd Care)
Grievance/Appeal Process
Dissatisfied with Information provided
Dissatisfied with auto assignment
COB/TPL Medical
ID card
Parental Discrepancy

FINDINGS

Additional information regarding member grievances can be found in the 2018 Member Satisfaction Evaluation.

Grievances By Catagory

Category	CY 2016	CY 2017	CY 2018
Quality of Care	8	8	34
Access	85	46	39
Attitude & Service	106	42	52
Billing & Financial Issues	4	1	6
Quality of Practitioner Office...	4	3	
Enrollment			1
Pharmacy			9
Plan Adminstration			1
Other	1	0	1
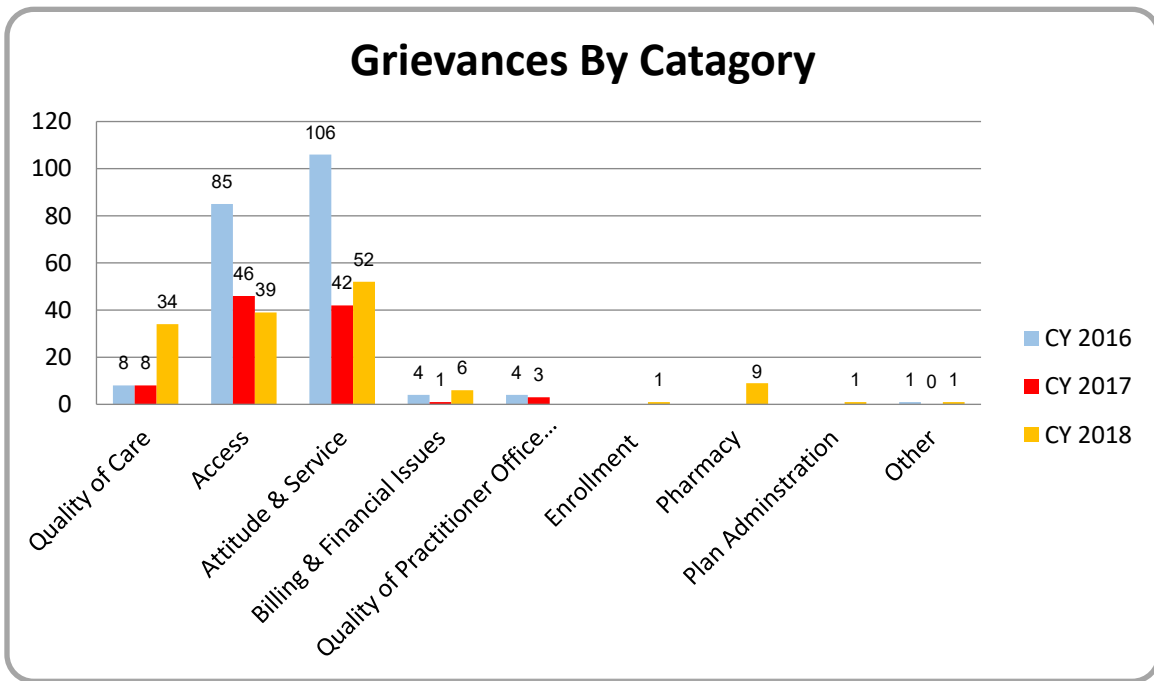
There were 143 grievances received in 2018. Results identified the top member grievances as:

- Attitude/Service
- Access
- Quality of Care

BARRIERS

- No major barriers were noted during 2018.

KEY 2018 INTERVENTIONS

- No major interventions were noted during 2018.

Member Satisfaction Survey (CAHPS®)

FOCUS

Assess and identify opportunities to improve member satisfaction.

GOAL

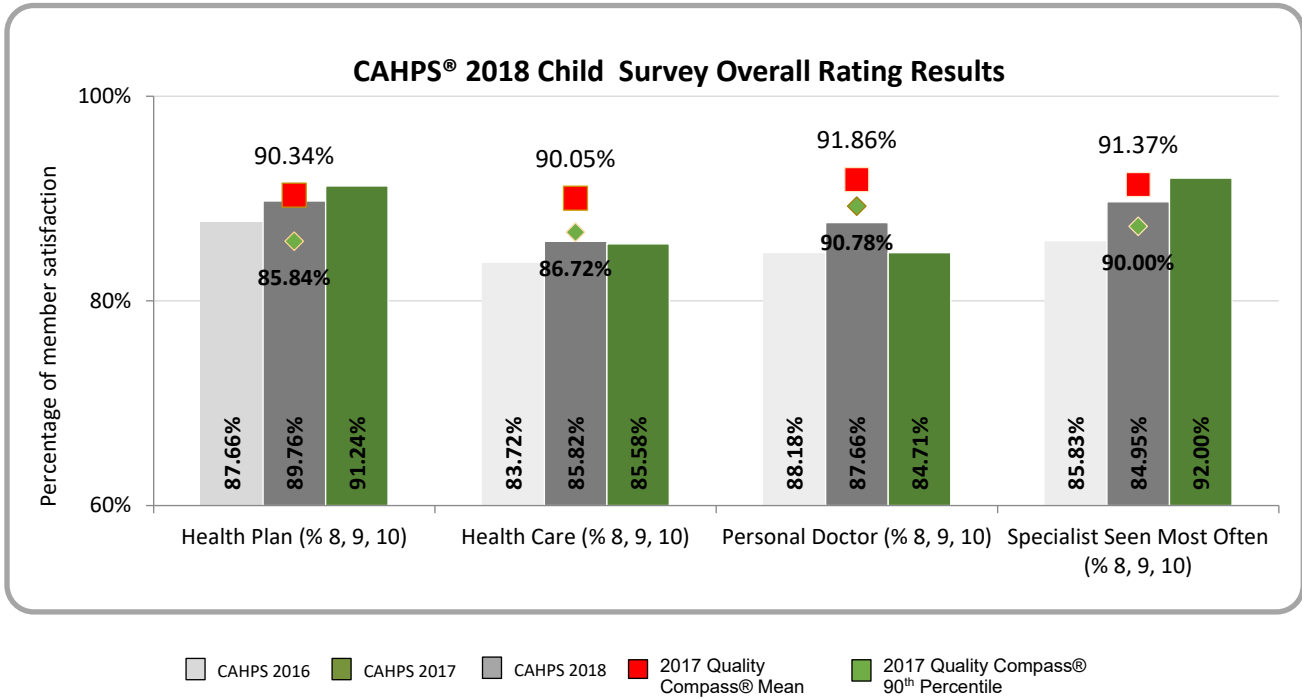Maintain or improve satisfaction rates for both adults and children.

MEASUREMENT

Overall effectiveness is measured through the annual member satisfaction survey.
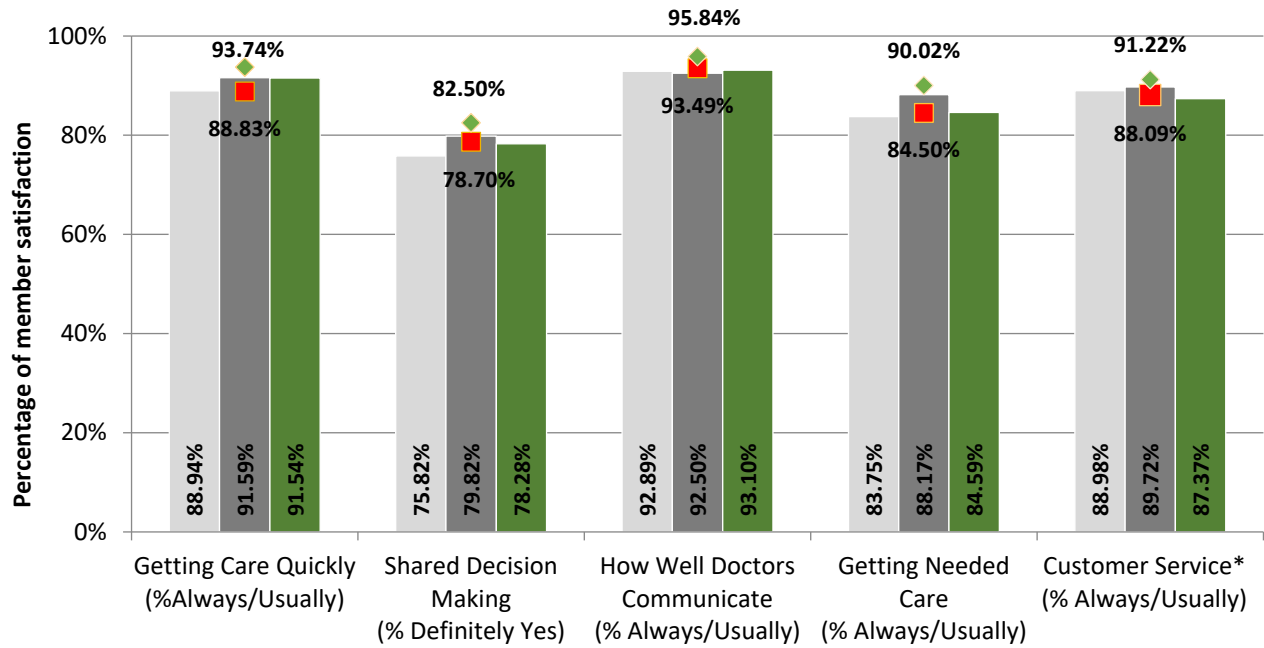
The 2018 CAHPS® 5.0H Child Medicaid Survey (MY 2017) was sent to a random selection of 2,145 members. A total of 563 child surveys were completed, taking into account, ineligible members, the adjusted response rate was 26.67 percent.

The 2018 CAHPS® 5.0H Adult Medicaid Survey (MY 2017) was sent to a random selection of 1,552 members. A total of 408 adult surveys were completed, taking into account, ineligible members, the adjusted response rate was 26.51 percent.

CAHPS® 2018 Child Survey Overall Rating Results

Category	CAHPS 2016	CAHPS 2017	CAHPS 2018	2017 QC Mean	2017 QC 90th Percentile
Health Plan (% 8, 9, 10)	87.66%	89.76%	91.24%	90.34%	85.84%
Health Care (% 8, 9, 10)	83.72%	85.82%	85.58%	90.05%	86.72%
Personal Doctor (% 8, 9, 10)	88.18%	87.66%	84.71%	91.86%	90.78%
Specialist Seen Most Often (% 8, 9, 10)	85.83%	84.95%	92.00%	91.37%	90.00%

Legend: CAHPS 2016, CAHPS 2017, CAHPS 2018, 2017 Quality Compass® Mean, 2017 Quality Compass® 90th Percentile

CAHPS® 2018 Child Survey Composite Results

Percentage of member satisfaction

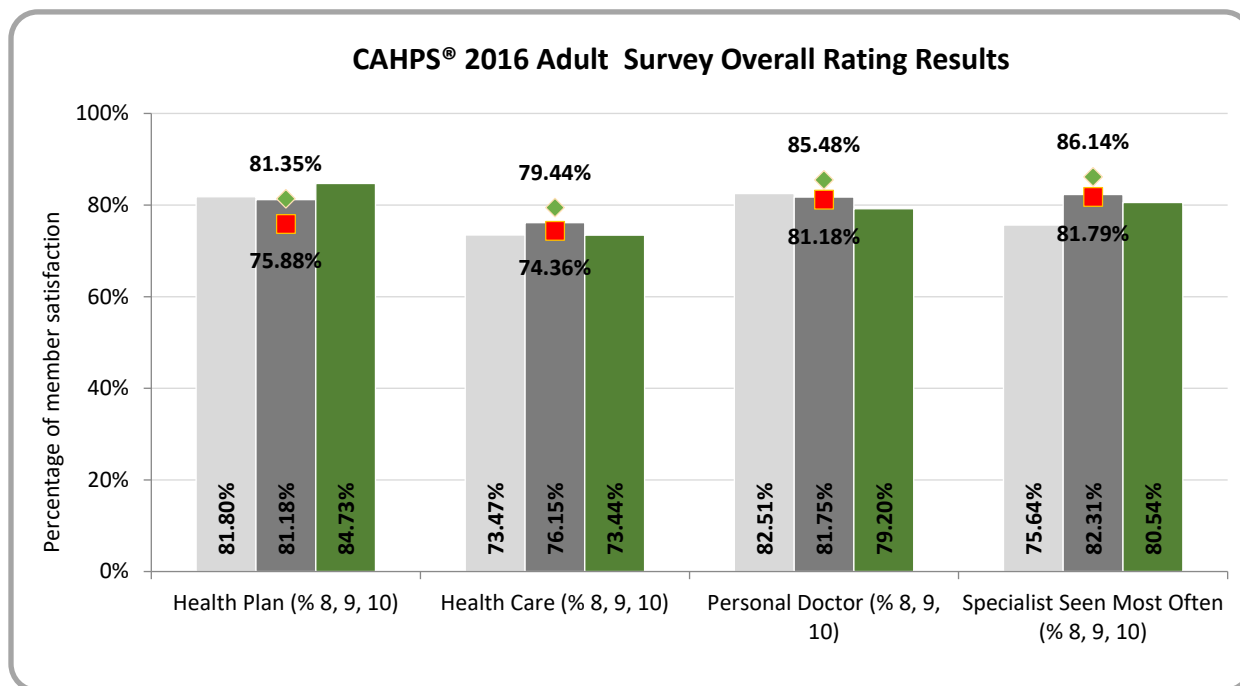| Category	CAHPS 2016	CAHPS 2017	CAHPS 2018	2017 Quality Compass Mean	2017 Quality Compass 90th Percentile
Getting Care Quickly (%Always/Usually)	88.94%	91.59%	91.54%	93.74%	88.83%
Shared Decision Making (% Definitely Yes)	75.82%	79.82%	78.28%	82.50%	78.70%
How Well Doctors Communicate (% Always/Usually)	92.89%	92.50%	93.10%	95.84%	93.49%
Getting Needed Care (% Always/Usually)	83.75%	88.17%	84.59%	90.02%	84.50%
Customer Service* (% Always/Usually)	88.98%	89.72%	87.37%	91.22%	88.09%

Legend: CAHPS 2016, CAHPS 2017, CAHPS 2018, 2017 Quality Compass® Mean, 2017 Quality Compass® 90th Percentile

CAHPS® 2018 Adult Survey Composite Results

Percentage of member satisfaction

Category	CAHPS 2016	CAHPS 2017	CAHPS 2018	2017 Quality Compass Mean	2017 Quality Compass 90th Percentile
Getting Care Quickly (%Always/Usually)	82.07%	82.99%	85.55%	86.64%	81.83%
Shared Decision Making (% A lot / Yes)	79.41%	79.61%	79.39%	83.40%	79.76%
How Well Doctors Communicate (% Always/Usually)	90.75%	92.02%	90.63%	93.90%	91.38%
Getting Needed Care (% Always/Usually)	82.02%	83.73%	80.66%	85.56%	81.98%
Customer Service (% Always/Usually)	91.61%	92.07%	90.08%	91.23%	88.15%

Legend: CAHPS 2016, CAHPS 2017, CAHPS 2018, 2017 Quality Compass® Mean, 2017 Quality Compass® 90th Percentile

CAHPS® 2016 Adult Survey Overall Rating Results

Chart: Percentage of member satisfaction

Category	2016	2017	2018	Labels above
Health Plan (% 8, 9, 10)	81.80%	81.18%	84.73%	81.35% / 75.88%
Health Care (% 8, 9, 10)	73.47%	76.15%	73.44%	79.44% / 74.36%
Personal Doctor (% 8, 9, 10)	82.51%	81.75%	79.20%	85.48% / 81.18%
Specialist Seen Most Often (% 8, 9, 10)	75.64%	82.31%	80.54%	86.14% / 81.79%

Legend: CAHPS 2016 ▪ CAHPS 2017 ▪ CAHPS 2018 ▪ 2017 Quality Compass® Mean ▪ 2017 Quality Compass® 90th Percentile

BARRIERS

▪ Decreased response rates for both child and adult surveys.

KEY 2018 INTERVENTIONS

▪ Sent pre-survey notification postcards.

Provider Satisfaction

Provider Claims Complaint

FOCUS

To work with the configuration area to correct the issues with the way the claims are being paid.

GOAL

▪ Reduce the number of appeals that a provider is submitting and to improve provider satisfaction.

MEASUREMENT

Overall effectiveness is measured through reporting trends. Methods for tracking and categorizing provider grievances, complaints, and appeals have remained consistent since 2014.

PROVIDER GRIEVANCES AND APPEALS			
	MY 2016	**MY 2017**	**MY 2018**
GRIEVANCES / COMPLAINTS	1	100	15
APPEALS	14,220	20,068	36,182

BARRIERS

No barriers were identified.

KEY 2018 INTERVENTIONS

- Continue to work with configuration to ensure the system is paying all claims correctly.

Provider Satisfaction Survey

FOCUS

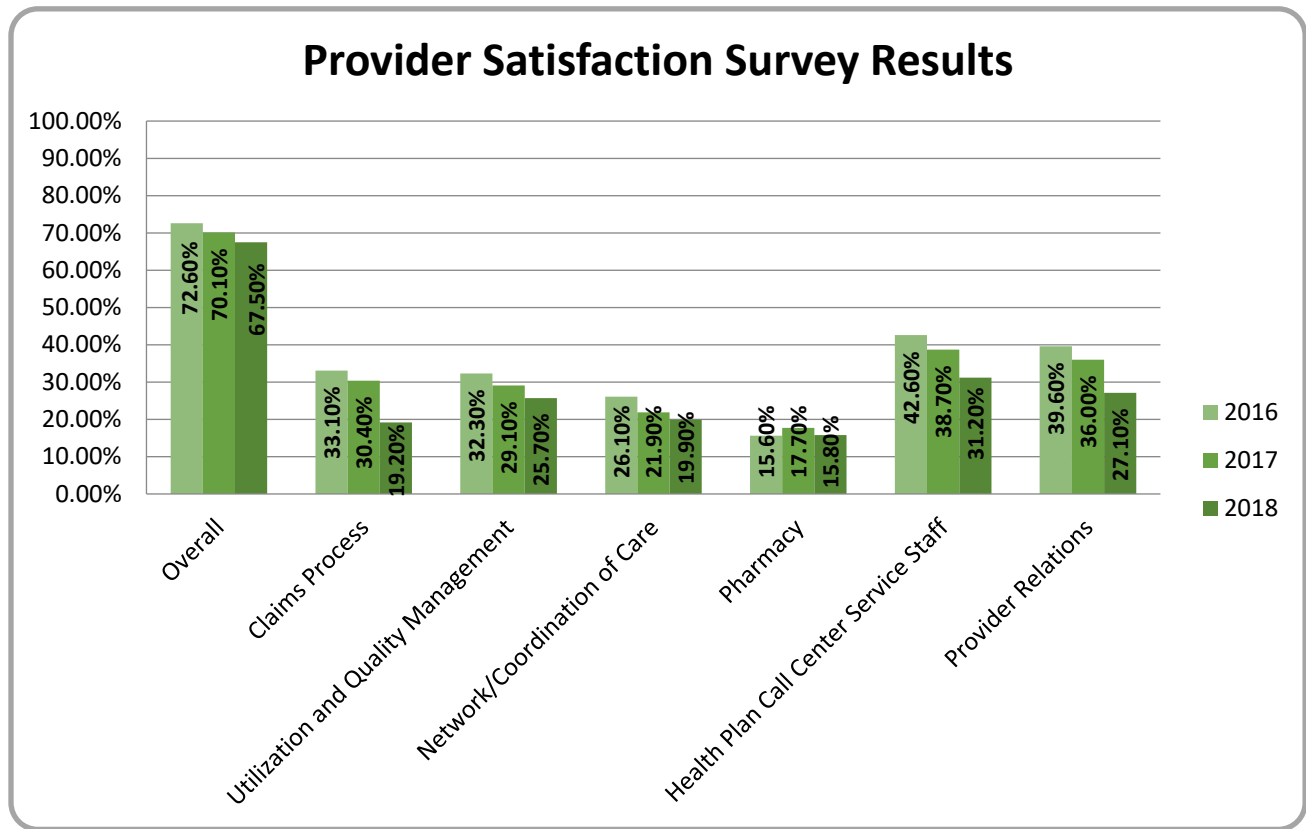Assess and identify opportunities to improve provider satisfaction.

GOAL

Maintain or improve satisfaction rates for services provided by Passport.

MEASUREMENT

Overall effectiveness is measured through the annual provider satisfaction survey. Passport Health Plan began outsourcing the Provider Satisfaction Survey in 2014 to enhance data collection and to more accurately identify areas which will further strengthen our service to our provider community. This established new baselines for Passport's Provider Satisfaction Survey results.

Provider Satisfaction Survey Results

Chart data (2016, 2017, 2018):

Category	2016	2017	2018
Overall	72.60%	70.10%	67.50%
Claims Process	33.10%	30.40%	19.20%
Utilization and Quality Management	32.30%	29.10%	25.70%
Network/Coordination of Care	26.10%	21.90%	19.90%
Pharmacy	15.60%	17.70%	15.80%
Health Plan Call Center Service Staff	42.60%	38.70%	31.20%
Provider Relations	39.60%	36.00%	27.10%

Mail/Internet Response Rate:

$$\frac{89 \text{ (mail)} + 35 \text{ (internet)}}{5{,}000 \text{ (sample)} - 485 \text{ (ineligible)}} = 2.7\%$$

Phone Response Rate:

$$\frac{379 \text{ (phone)}}{2{,}781 \text{ (sample)} - 792 \text{ (ineligible)}} = 19.1\%$$

BARRIERS

No barriers were identified.

KEY 2018 INTERVENTIONS

- Focus on process improvements and provider education to improve member and provider satisfaction.
- Continue to meet department timeliness standards for provider inquiries.
- Continue to use and improve collaboration with internal departments to address practitioner issues as they are identified through the Provider Payment Inquiry tracking tool.

- Identify and act upon staff training and educational opportunities.
- Continue to conduct site visits and provider outreach.
- Continue to conduct consistency reviews with department staff to increase knowledge and awareness of Plan policies and programs.
- Continue to conduct targeted site visit evaluations to identify and address practitioner concerns and opportunities in a timely manner.
- Conduct analysis of available specialties and initiate recruitment efforts.
- Ensure that a Medical Director is available in the event a peer-to-peer review is requested.
- Conduct training workshops and webinars for Kentucky HEALTH.
- Conduct site visits to providers offices to address complaints from members and to ensure member safety.

Marketing and Community Engagement

FOCUS

Our vision is to position Passport as the #1 Health Plan in the Commonwealth and support the growth of the MCOE.

GOALS

- **Growth:** Employ Marketing, Communications, Government Relations and Community Engagement strategies to achieve 25.5% market share in Medicaid and 2,400 enrolled Medicare members
- **Financial**: Ensure fiscal responsibility and assist in Medical Loss Ratio (MLR) reduction strategy
- **Culture:** Support MCOE culture initiatives and continue to be mission driven in our activities
- **Quality:** Help Kentuckians live healthier lives through collaborative partnerships, member engagement and marketing initiatives
- **Health Plan Satisfaction:** To be the #1 ranked Medicaid health plan in the Commonwealth based on member and provider satisfaction
- **Implement Kentucky Health Waiver**

MEASUREMENT

Overall effectiveness of activities is measured through membership growth, community relationships and member, provider and customer satisfaction.

BARRIERS

- Lack of diversified products
- New administration policies, focus & new waiver
- Lack of detailed and accurate information from DMS, as well as inconsistencies in their policies
- Lack of integration & alignment between Passport & Evolent (i.e. systems, leadership, culture)

The Marketing and Community Engagement Department consists of the following areas: Marketing, Community Engagement including Health Equity, Communications including Health Education, and Government Relations including local, state and federal government. Below are the core deliverables for these areas:

Core Deliverables for 2018:

a. Marketing and Community Engagement Administration
   i. Support team efforts to realize the Mission, Vision and Values of Passport Health Plan as well as the Vision Statement and Core Values of the MACE department
   ii. Ensure Philanthropic direction is aligned with the Mission, Vision and Values of Passport Health Plan
   iii. Monitor and certify that all regulatory and compliance requirements are met

b. Advertising & Marketing
   i. Develop and execute annual Marketing Plans for both Medicaid and Medicare (PAD)
   ii. Execute and expand "Better Health Together" brand strategy
   iii. Support communications and messaging
   iv. Establish and implement PHP and PAD Member retention strategies

c. Community Engagement
   i. Develop and execute member education & outreach strategy for growth & retention
   ii. Develop and execute advocate strategy
   iii. Support strategies around social determinants in health
   iv. Develop and execute a health equity strategy

d. Communications
   i. Expand Passport's external communications capabilities
   ii. Expand Passport's internal communications capabilities
   iii. Execute Health Education partnerships (internally and externally)
   iv. Support strategies around social determinants in health

e. Government Relations
   i. Foster positive relationships with elected officials and staff at all levels and in all branches of government
   ii. Keep PHP leadership informed of political landscape and legislative issues and develop plan to navigate challenges facing PHP
   iii. Strengthen and nurture relationships between PHP and advocacy agencies
   iv. Be recognized by elected officials, government agencies and staff as the leading resource regarding issues facing Medicaid and its members

Utilization Management

The purpose of the Passport Utilization (UM) Program is to safeguard against unnecessary and inappropriate medical care and to develop programs and initiatives to address population management. The programs allow Passport to review patient care from perspectives of medical necessity, quality of care, appropriateness of decision-making, place of service and length of hospital stay.

Utilization Management includes or involves the evaluation of the medical necessity and the appropriateness and efficiency of the use of healthcare services, procedures and facilities under the provisions of the benefit plan. The UM Department implements comprehensive processes to monitor and control the utilization of health care resources. These programs assist in ensuring services are available in a timely manner, provided in the appropriate settings, and services are planned, individualized and evaluated for effectiveness.

GOALS

The goals of the UM Department are to:

- Ensure Contractual Service Level Agreements are met on a consistent basis
- Ensure regulatory compliance
- Evaluate the appropriateness, medical need and efficiency of healthcare services according to established criteria and policies
- Monitor and report practice patterns of participating providers
- Evaluate for program modification based upon data and health care trends
- Ensure consistency amongst reviewers and Medical Director's aptitude at applying criteria and protocols in a consistent manner through auditing
- Evaluate provider satisfaction with the Utilization Management program
- Evaluate subcontracted activities as it relates to Utilization Management
- Implement training initiatives
- Facilitate integration and communication between all departments within Passport

MEASUREMENT

Overall effectiveness of Utilization Management is measured through:

- Clinical reviews
    - Prospective/prior authorization review
    - Precertification review
    - Concurrent review
    - Retrospective review
- Appeals
- Internal auditing
- Inter-rater reliability/consistency review testing and reporting
- Policies and procedures
- Evaluate, test and implement medical management systems
- Develop clinical initiatives

- Conduct data analysis for potential over-and under-utilization and provider trending
- Evaluate satisfaction with the UM Program using member and provider input
- Approve and monitor subcontracted activities
- Evaluate for program effectiveness

<u>BARRIERS</u>

- Providers failing to submit requests within required time frames
- Placement of member requiring long term care and treatment for infection related to IV Drug use
- Low member reach rate for ER lock in program
- Changes to DMS requirements for ER lock in prohibit balance billing the member resulting and claims denial based on diagnosis resulting in significant reduction of savings

<u>KEY 2018 ACTIVITIES</u>

- Medical Policy:
  - 3 internal Passport medical polices were reviewed and approved during 2018.
    - Induction of Labor
    - Enteral Feedings
    - Metabolic Foods and Formula

- New Technology:
  - During 2018, the MPC discussed a variety of new treatments and testing. All were approved with the exception of one treatment device.

New Technology	Definition	Committee Decision
Liquid Embolic System	For the treatment of intracranial aneurysms	Approve
Neurolink	Evaluates structural, chemical, and emotional aspects of health using manual muscle testing	Approve
Abicort Implantable Replacement Heart	Totally implantable heart	Approve
Aneurysm Treatment System (cPax)	Used to treat large, giant and wide-neck cerebral aneurysms	Approve
APO-E Genetic Test	Genetic testing for Alzheimer's	Approve
Breast Cancer Index	Analyzes the activity of seven genes to help predict the risk of node-negative	Approve
PhotoKymography	Noninvasive method of detecting ischemic segmental myocardial wall motion abnormalities.	Approve
Wingspan Stent System	Flexible, trackable delivery system designed to facilitate	Not Approved

New Technology	Definition	Committee Decision
	access through challenging neurovascular anatomy	Not recommended as initiate treatment
Surgimend Collagen Matrix	Dermal matrix derived from fetal and neonatal bovine	Approve
Activa Dystonia Therapy	Aid in the management of chronic, intractable (drug refractory) primary dystonia,	Approve
Epifix	Bioactive tissue matrix allograft	Approve
Stem cell transplant for MS	Stem cell transplant for Multiple Sclerosis	Approve
Bone Marrow Aspirate	Bone marrow aspirate for bone heling	Approve
Mist Therapy	Low energy ultrasound-generated mist used to promote wound healing	Approve
Ovation Wound Cover Cellular repair matrix	Cellular repair matrix specifically for diabetic plantar ulcers	Approve
Fetal RhD genotype detection	Determine if there is an increased risk of Rh blood type incompatibility	Approve
LINX	Prevents reflux from the stomach into the esophagus.	Approve
Collagen Meniscus Implants	Used to reinforce and repair a meniscus injury	Approve
IDET	Treat patients with chronic low back pain	Approve
BSD-2000 Hyperthermia System	Delivers localized therapeutic heating (hyperthermia) to solid tumors by applying radiofrequency	Approve
Repose System	Tongue base suspension	Approve
Cancer Type ID Test	Standardized, objective molecular test based on the differential expression of 92 genes that classifies tumors	Approve
Corus CAD Gene Expression test	Blood test that: Integrates your age, sex, and gene expression to calculate a score.	Approve
Cardiac Velocity Flow	MR technique for quantifying flowing blood	Approve
Electro Sleep Therapy	Treatment for insomnia that avoids polypharmacy interactions for pain patients taking medications while	Approve

New Technology	Definition	Committee Decision
	simultaneously reducing anxiety, depression, and pain	
MERCI Clot Retriever	Medical device designed to treat Ischemic Strokes.	Approve
Partial Ventriculectomy	Treat patients with irreversible (end-stage) heart failure secondary to dilated or hypertrophic cardiomyopathy, valvular disease, or Chagas' disease	Approve

- Clinical Criteria Requests:

During 2018 there were 2 provider clinical requests and no member request for criteria.

Date	Criteria	Sent to:	Provider:
Feb - 2018	MM 9.10 / Enteral Feedings Bolus/Gravity/Pump/Oral	Sherie Gower	Discount Medical
May - 2018	MM 48.0E Prescribed Pediatric Extended Care	Debbie Hunt	Kidz Club

Quality
- The initial average for nurse reviewers for 2018 (30 out of 30) was 94.81%. Targeted education was provided to each nurse reviewer scoring less than 90% cumulative for all ten (10) test scores combined. Each reviewer scoring less than 90% from those compiled scores were required to be re-trained and re-tested utilizing a new test. The average score after education and final retesting for those taking the end-of-year additional tests (4 out of 4) was 97.5%.

Training and Education:

The UM Department conducted 7 educational forums during 2018. Educational forums provided Continuing Education (CE) Credits to our clinical staff.
1) IQCI Train the Trainer
2) InterQual
3) New Health Plan Training
4) Appeals Training
5) Documentation, NCQA, IPRO training
6) Aldera (Claims System) and DRG Calculator
7) CCSI Portal Training

**Response Standards and Service Level Agreements:**

- The goal ASA of 2 minutes or less was met for all four quarters of 2018 with an ASA of 7.0 seconds.
- The goal AR of 10% or less was met for all four quarters of 2018 with an average AR of 1.30%.
- Total call volume for 2018 was 33,994 inbound calls with a monthly average of 2,832 inbound calls. This is a 19.5% increase in total call volume from 2017.

| Metric	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	2018
Total Inbound call volume	3,213	3,213	3,041	3,085	2,839	2,817	2,746	2,982	2,526	2,620	2,512	2,400	33,994
Average Speed of Answer (ASA) (in seconds)	6	6	6	9	9	7	7	8	8	6	5	5	7
Call Abandonment Rate	1.50%	1.50%	1.80%	2.00%	1.41%	1.35%	1.93%	0.91%	1.15%	0.61%	0.84%	0.79%	1.30%

Utilization Analysis:

- There was an overall downward trend in medical admissions per 1,000 members from the prior year. Days per 1,000 and ALOS saw a slight upward overall trend from the prior.
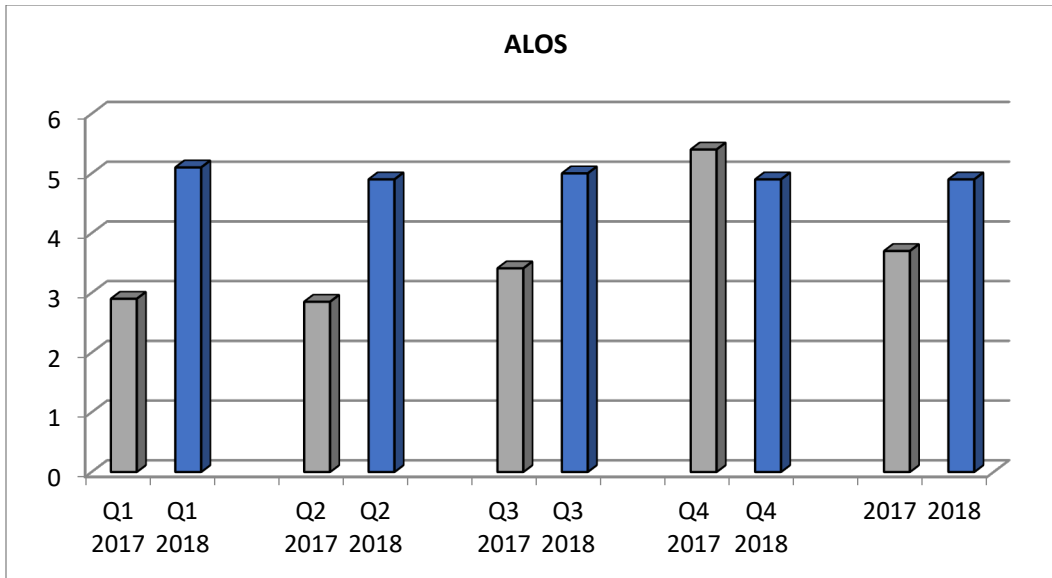
Admits per 1,000

Days per 1,000

ALOS
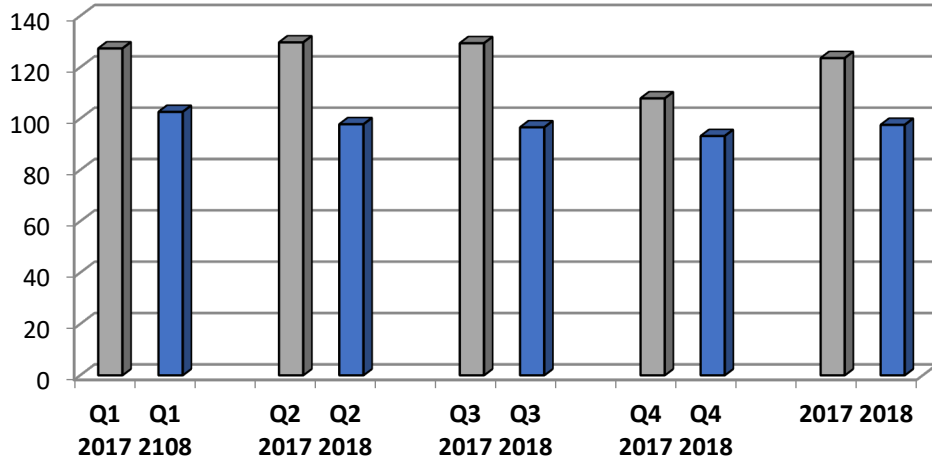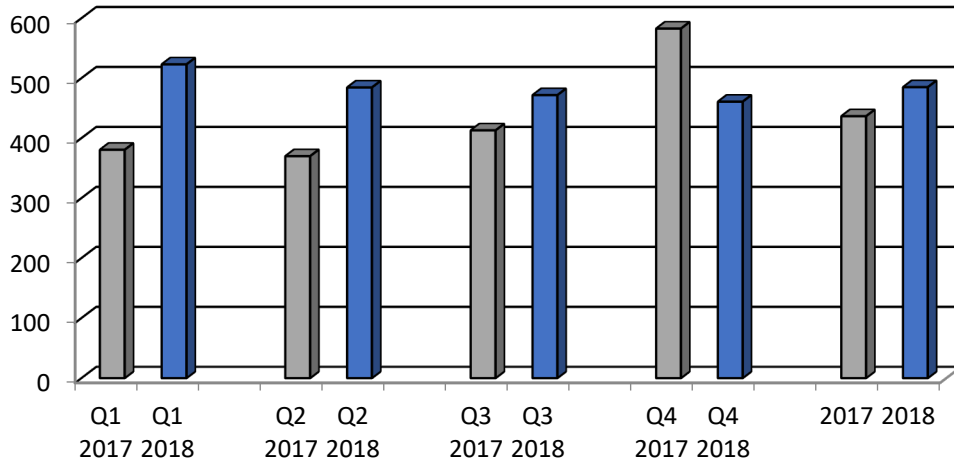
All case turnaround times were met during 2018:

	Q1	Q2	Q3	Q4
Standard Request	96.80%	98.90%	98.00%	95.00%
Goal	95% will be complete within TAT			
Urgent Requests	96.80%	99.90%	99.20%	96.90%
Goal	95% will be complete within TAT			

- 33% - 35% of the total outpatient requests were for advanced radiology services (CT, MRI, PET and NCI).

- The UM department also had 3 key clinical initiatives during 2018:
  - Review of 1 and 2 data hospital lengths of stay for appropriateness of observation resulting in a decrease in acute admissions.
  - 100% Medical Director referral of all LTAC (Long Term Acute Care) admissions resulting in trending of short term stay for IV antibiotics for IV drug users; ongoing discussion continue in 2019 for placement of these members outside LTAC.
  - Revisions to the outpatient authorization list resulting in elimination of authorization requirements for services approved 100%.

Denials:

- For inpatient requests that do not meet clinical criteria, the request is referred to the Medical Director for review.
- Outpatient high tech services, administered in partnership with eviCore, had the overall highest denial rate at 11 – 15%.

- An increase in denials was noted during August and September; the 1- and 2-day inpatient to observation was initiated during these months resulting in an increase in acute inpatient admissions.

	Total	Approved	Denied	% Denied
Jan	7,360	7,276	84	1%
Feb	6,690	6,605	85	1%
Mar	7,483	7,409	74	1%
Apr	7,876	7,763	113	1%
May	8,879	8,733	146	2%
Jun	8,350	8,204	146	2%
Jul	8,661	8,475	186	2%
Aug	9,765	9,464	301	3%
Sept	7,739	7,338	401	5%
Oct	8,923	8,713	219	2%
Nov	8,436	8,238	198	2%
Dec	8,332	8,169	163	2%
2018	**98,494**	**96,387**	**2116**	**2%**

Appeals

- A total of 438 medical appeals were completed during 2018 for all medical services.
- 100% of standard appeal requests were completed within the 30 day time frame with an average completion time of 22 days and 100% of expedited appeals were complete within 3 days.
- 37% of appeal requests were for provider administrative appeals whereas a denial was issued for untimely notification; 92% were upheld.

State Administrative Hearing:

Once all appeals have been exhausted with Passport, the member has a right to a State Hearing. Passport Health Plan is to attend all State Hearings requested by our members and to have legal representation at those Hearings.

- Passport received notice from the DMS Administrative Hearing Office that a total of 33 members requested a State Hearing during 2018.
  - 2 were dismissed as the member did not complete the Passport appeals processed and 2 were dismissed as the member failed to attend the hearing.
  - 21 requests were overturned, and the request was approved. 16 of the 21 were pharmacy requests that were re-reviewed prior to a Hearing date being set and the drug request was approved. 2 requests were upheld.
  - 8 requests are pending or DMS has not notified the Plan of the determination

Clinical Initiatives:

Emergency Room

Three Emergency Room Initiatives continued during 2018:

- Emergency Room Lock-in Program
- Emergency Room Coordinator Program
- Emergency Room Navigator Program

Program highlights:

- 816 members were placed in the ER Lock in program
- Navigators met with 985 members
- Conducted 3,748 follow up telephone calls
- Referred 186 members to specialty programs (Case / Disease Management)

Tiny Tots

The Tiny Tots program assists members with the transition of detained newborns from the hospital to home after the newborn's medical condition has been stabilized. A Detained Newborn is an infant in the first 28 days of life that remained hospitalized after birth mother has been discharged.

The Tiny Tots nurse objectives are to:

- Identify and educate members on the importance of follow up care
- Ensure a secure and healthy transition of the detained newborn from hospital to home
- Ensure compliance with follow-up visits for detained newborns

The Tiny Tots Nurses managed 300 detained newborns in 2018.

99.3% of the infants managed under the Tiny Tots program saw the Pediatrician within 30 days post DC; of those, 91.3 % saw the pediatrician 1 to 7 days post inpatient discharge.

Provider Experience with UM Process:

The 2018 provider survey evaluates numerous areas including experience with the Utilization Management process.

The overall provider experience score for 2018 in the areas related to Utilization Management indicated that 90.2% of providers felt services related to the Utilization Management experience was average to well above average.

Well Above Average	Somewhat Above Average	Average	Well / Somewhat Below Average
10.5%	15.8%	63.8%	11.8%

Network and Provider Management
Network Adequacy and Expansion

To assess Passport's provider and practitioner network against adopted access standards on a quarterly basis. Adjust the network, and access to the network, as necessary to address the needs of the membership.

GOAL

- Meet or exceed GeoAccess standards for primary care providers (PCPs) (30 miles urban and 45 miles rural).
- Meet or exceed GeoAccess standards for high volume specialists* (30 miles urban and 45 miles rural).
- Meet and/or exceed Provider access standards of 1 PCP to 1,500 members
- Meet and/or exceed High-volume Specialist* access standards of 1 SCP to 5,000 members
- Conduct analysis of services rendered by providers outside of Passport's network and adjust the network as appropriate.
- Identify opportunities and implement actions as appropriate to address the cultural, ethnic, racial, and linguistic needs of the membership.

*High-volume specialist includes cardiologist, obstetrics and gynecologist (OB/GYN), general surgeons, and community mental health centers (CMHC).

MEASUREMENT

Overall effectiveness of network adequacy and expansion is measured through GeoAccess reports and language line usage with monitoring provided by the Marketing and Community Engagement department.

FINDINGS

Accessibility to PCPs and SCPs met all Geo/Access standards during 2018.

Primary Care Providers: All counties meet or exceed Passport's required access standards of 1:1500
- Urban membership - the ratio is 1 PCP for every 8 members, exceeding the goal of 1 PCP for every 1500 members.
- All members living in urban counties have access to a PCP and/or high volume SCP* within 30 miles or minutes of their home.
- Rural membership - the ratio is 1 PCP for every 8 members, exceeding the goal of 1 PCP for every 1500 members.
- All members living in rural counties have access to a PCP and/or high volume SCP* within 45 miles or minutes of their home.

High Volume Specialists: All counties exceed Passport's required access standards of 30 minutes or miles in urban areas and 45 minutes or miles in rural areas.

- Cardiology: 100% of membership has access to a Cardiologist within the Plan standard.
- OB/GYN: 100% of membership has access to an OB/GYN provider within the Plan standard.
- Surgery: 100% of membership has access to a surgeon with the Plan standard.

Behavioral Health Specialists: All counties meet or exceed Passport's required access standards of a behavioral health specialist within 60 miles (urban and rural).
- 100% of both urban and rural membership has access to a behavioral health specialist within the Plan standard.

The total amount paid to non-participating providers is estimated at $94,827,008.26 during 2018. This accounts for about 8.7% of total payments made to providers. Hospital-based medical physicians, labs, diagnostic radiology, air transport, dialysis centers, and hospital/multi-specialty groups were high contributors to this amount.

The Provider Network Management department continues to establish contact with physicians who have non-par set-ups within the service area for potential participation as well as perform network analysis to identify contracting opportunities.

BARRIERS

- Murray Calloway Hospital and Medical Associates, a large health provider termed with Passport in November of 2018. Passport worked to ensure all members had access to a PCP and SCP in their area.

KEY 2018 INTERVENTIONS

- Visited out of network substance abuse providers in Kentucky in an attempt to increase network adequacy.
- Hosted education training sessions on Kentucky HEALTH program that was due to be implemented by the state of Kentucky and DMS.
- Ongoing statewide contracting efforts to build the network.
- Continual network analysis to identify contracting opportunities including an evaluation of eligible providers vs. contracted providers.
- Initiate additional contracting as a result of ongoing analysis of member complaints against providers for availability issues.

Accessibility of Services

FOCUS

Assess practitioner compliance against adopted access standards and implement corrective actions as necessary to maintain and/or increase compliance.

GOALS

- Assess 5 percent of PCP and SCP network for accessibility compliance.
- Assess 5 percent of BH network for accessibility compliance.
- Maintain PCP compliance in providing coverage for Passport members 24 hours a day, seven days a week.

- Maintain compliance with phone answering standards by an answering service that can contact the PCP or designee who can return the call within 30 minutes.

Adherence to Passport standards for appointment availability is monitored through site visits and telephonic surveys conducted by provider relations representatives. The representative reviews the provider's appointment book/computer system for compliance.

During 2018, 772 PCP and SCP site visits were conducted. Accessibility standards were assessed at each site visit. During 2018, PCP and SCP compliance was 100%.

377 Behavioral Health site visits were made during 2018. Accessibility standards were assessed at each site visit. Overall compliance with accessibility standards was 99%.

- Ensuring that all provider data is accurate post transition to new system so that network adequacy is properly evaluated.
- In some rural areas there could possibly be only one provider of a particular specialty, so it is vital that those type providers remain in network.
- Member perceptions of expected timeframes for appointments.

- Improve member satisfaction with getting care quickly through:
- Assess and monitor appointment access and availability along with specialists' availability during provider site visits and Passport's annual practitioner satisfaction survey.
- Provide targeted education, as appropriate, to those specialties identified via the practitioner satisfaction survey as not accessible for education as appropriate.
- Utilize the Case Management team to coordinate care for members when a provider group terminates from the Plan
- Conduct site visits to meet or exceed standards based on new account manager roles.
- Analyze the Network monthly to ensure that accessibility needs are being met across the state and locate potential provider recruitment opportunities.
- Outreach to providers being paid out of network.

Qualified Providers and Practitioners

Credential and re-credential all eligible provider types in accordance with NCQA Standards and Guidelines, State, Regulatory requirements and Health Plan policies.

GOALS

- Initial credentialing and re-credentialing of providers, practitioners, and organizations in accordance with health plan policy.
- Credential 95% of new practitioners within ninety (90) days from receipt of a completed application or within forty-five (45) days if the practitioner is providing substance use disorder services.
- The ninety (90) day for practitioners or forty-five (45) days for substance use disorder providers are state required turnaround times (TATs).
  - Aperture is our Credentials Verification Organization (CVO); contractual SLAs with Aperture are:

SLA - PSV004 Rate <u><</u>10%	**<u><</u>10%**
SLA - PSV005 Rate <u><</u>10%	**<u><</u>10%**
SLA - Initials Completes <u><</u>30d	**<u>></u>97%**
SLA - Initials Completes <u><</u>45d	**100%**

- Recredentialing providers within thirty-six (36) months of last credential date.
- Average TAT for processing credentialing and recredentialing applications is less than sixty (60) days.
- Enroll 95% of new practitioners within ten (10) calendar days of receipt of a complete paper application, if credentialing is not required, or from Credentials Committee approval. (Note: the ten (10) calendar day provider enrollment timeframe is the state required TAT)
- Identify and act on quality and safety issues in a timely manner between credentialing and recredentialing cycles.

MEASUREMENT

Overall, effectiveness of the Credentialing Program is measured through monthly TAT reports and credentialing quality performance data.

FINDINGS

All credentialing and recredentialing activities comply with regulatory requirements. However, Aperture did not consistently and successfully comply with contractual service level agreements (SLAs).

Initial credentialing reviews were completed for 2,458 practitioners and 201 organizational practitioners. Not all initial Credentialing Applications, which met clean file criteria, were completed within Passport's goal of sixty (60) calendar days. The average 2018 TAT for processing of an initial Credentialing Application, which met clean file criteria, was twenty (20) calendar days. During 2018, 2,958 Recredentialing Applications were processed and completed.

Failure to meet Passport Health Plan contractual TAT SLAs for five (5) consecutive months in 2018.

During EVH inventory management review in April 2019, Credentialing management team determined that more than one hundred (100) providers with a current CAQH attestation were not appropriately bridged to primary source verification (PSV) status by Aperture within the standard two to three business day average.

ROOT CAUSE

Aperture accepted credentialing volume from EVH for three (3) additional EVH client partners in July 2018. Aperture used the same resources for all EVH client partners. Each EVH client partner was negatively impacted by Aperture's failure to meet TAT SLAs. EVH client partner provider files were not processed timely, resulting in failure to meet established TAT SLAs for credentialing and recredentialing, and with performance expectations for successful collection of CAQH applications and/or documents required to move providers to PSV status.

KEY 2018 INTERVENTIONS

- Aperture is currently on a formal Corrective Action Plan (CAP).
- The EVH and Aperture teams have collaborated on SLA/TAT failures and Aperture successfully resolved providers artificially held in a CAQH review status in April 2019. Additionally, EVH management team performed daily inventory management of CAQH status through review of daily Work in Progress (WIP) reports to identify significant deficiencies, which have been successfully addressed in real time.

Member Cultural Needs and Preferences

FOCUS

Passport Health Plan must assess the Cultural needs of the membership to ensure that the network standards are met and membership preferences are satisfied. Passport educates its associates, health providers and advocates on Title VI of the Civil Rights Act of 1964, Culturally and Linguistically Appropriate Services in Healthcare (CLAS) standards, Section 1557 of the Affordable Care Act (ACA), and the Americans with Disabilities Act (ADA). Though education the Plan assists providers to eliminate communication issues and cultural barriers to provide quality care to all members.

GOALS

- Monitor and evaluate local, regional, and national data to determine the most common languages spoken by Passport members, including languages that meet the 5% threshold for interpretation of materials beyond vital documents.
- Monitor member access to interpreters and other language access services.
- Test competency of bilingual staff.

- Train Member Services and Care Management staff on how to collect and record member self-identified race, language, and ethnicity.
- Upon request, facilitate on-site education and training for participating providers.
- Facilitate on-going training for new and existing associates.
- Work collaboratively with Provider Network Management to maintain a practitioner and provider network that meets the cultural and linguistic needs of our members
- Coordinate the translation of significant member documents into preferred languages and alternative formats, such as large type, Braille, and audio.
- Educate providers who have denied language services or other accommodations during a medical encounter.
- Use member race/ethnicity and language data to improve services and reduce disparities.
- Verify accuracy of Spanish translated materials.
- Build relationships and collaborate with agencies and organizations that serve immigrants and refugees to better evaluate membership/communities' needs.
- Build relationships and collaborate with agencies and organizations that advocate on behalf of sensory impaired and disabled members.
- Create and mail culturally- appropriate member communications.

MEASUREMENT

- Information on member language is included in the eligibility file that Passport receives from the Department for Medicaid Services on a daily basis, but it is not complete. It is not possible for the Plan to determine if this language data is volunteered by the member, presumed by the intake worker, or not requested during the application process. According to records received from the Department of Medicaid Member eligibility file 834 less than one third of the total membership has a language-spoken identifier. The language found in the file is not always accurate.

- The Plan also collects self-identified preferred language, race, and ethnicity directly from members during calls for the collection of Health Risk Assessment information by the Care Coordination department. This number is not very large.

- The information in the charts below is from the Interpreter Language Line. It identifies the top 10 language the Passport staff use to speak with members. These are grouped by language for all departments. The department that uses the language line most often is Care Coordination followed by the Member Services department (graphs below). Spanish has been the predominant Language used for all the Plan's years.

FINDINGS

Using State Refugee Resettlement, interpreter line and KY Department of education language reports Passport annually identifies the top ten languages and cultural groups in the Commonwealth. These sources are used due to the lack of member Race, Ethnicity and Language data received in the eligibility file. According to records received from the Department of Medicaid Member eligibility file 834 less than one quarter of the total membership has a language-spoken identifier. The information below is used to inform associate education as well as the translation of significant and educational documents for members. The assessment is also used to assess the adequacy of the provider network.

Practitioner/Member Count by Language Region (excluding English)

Practitioner/Member Count by Language Region (excluding English)			
Language	PCP Practitioners	Specialist Practitioners	Members
Region 1			
American Sign Language for the Deaf	2	4	1
Spanish	61	80	1
Cambodian	0	0	1
Region 2			
Degalo	0	0	1
Spanish	65	122	8
Region 3			
Spanish	125	792	4123
Arabic	4	51	235
Swahili	0	2	66
Vietnamese	5	5	51
Russian	2	14	52
Bosnian	3	2	49
Afrikaans	2	7	45
French	9	32	44
Karen	0	0	19
American Sign Lang. for Deaf	7	11	17
Region 4			
Spanish	169	325	14
Egyptian	0	0	1
Mandarin	0	0	1
Region 5			
Spanish	315	833	24
Russian	2	5	2
Albanian	5	1	1
Egyptian	0	0	2

American Sign Lang. for Deaf	6	19	1
Ethiopian	0	0	1
Region 6			
Spanish	84	138	15
Region 7			
Spanish	42	101	4
Region 8			
American Sign Lang. for Deaf	0	2	1

BARRIERS

- Providers choosing not to provide interpreter services to members.
- Using State and National data due to not having accurate data on membership race, ethnicity and language.
- The number of newly resettled refugees and immigrants in the service area continues to grow creating the need to provide continuous culture-specific training and education.

2018 ACTIVITIES

- Introduction to Cultural Humility training to new associates during onboarding.
- Monthly ongoing education to associates on cultural topics.
- Annual and ongoing with Provider Network Management provided training and support to the network to meet the cultural and linguistic needs of the members at their offices.
- Coordinated the translation of documents into threshold hold language, other top languages and alternative formats, such as large type, Braille, and audio.
- Continued to build the library of translated health education materials.
- Continued to build relationships and to collaborate with agencies and organizations that serve African American, immigrant, refugee and LGBTQ communities to better evaluate community needs.
- Continued to collaborate with agencies and organizations that advocate on behalf of sensory impaired and disabled members.
- Created and mailed culturally- appropriate member communications.
- Worked with resettlement agencies to identify health cultural preferences of newly resettled refuges in order to provide accurate and appropriate services for this population.
- Monitored member language access needs.
- When reported, offered appropriate feedback and education to provider sites on their level of compliance with Tittle VI and CLAS Standards when a language access.
- Provider Management Representatives provided drop by site visit and education session when a concern about Title VI compliance or cultural insensitivity.
- Translated the Pediatric HRA into Spanish.

- Translated hanging notice of visit for use during EPSDT non-participation visits to Spanish speaking children and their families.

These are some of the 2018 initiatives/activities for Passport Health Plan will use to mitigate the deficiency in the Provider Network:

- Introduce Cultural Humility training to new associates during onboarding.
- Provide ongoing education to associates on member's cultural diversity.
- Annually and ongoing with Provider Network Management provide training and support to the network to meet the cultural and linguistic needs of the members at their offices.
- Schedule and hold member outreach at key advocate sites.
- Establish process to begin collecting REL data. (Information repository will be in test mode in April)
- Collect Race, Ethnicity and Language of members receiving care coordination.
- Using National data on most common chronic diseases that affect Health Disparities work with Medical programs to choose best educational material for translations.
- Collaborate with community organizations hold one on one information sessions, member education, member outreach, and participate in community events.
- Develop and execute strategy for LEP population including development of materials and translation of documents
- Attend committee meetings (Human Trafficking Task Force, Health Equity Network, Foster Parent Support, LGBTQ etc.) to find opportunities to partner
- Invite LGBTQ community advocates to form a Health Interagency group in Jefferson Co.
- Collect and report data for QI Workplan goals.
- Reconvene the CLAS committee to guide the work in addressing disparities for Passport Health Plan and Advantage Members
- Assess the cultural needs and characteristics of members and determine whether the contracted provider network adequately meets those needs
- In collaboration with Quality, identify non-English Speaking children that are not participating in EPSDT and develop an execute interventions.
- Evaluate and Measure Effectiveness of member education sessions

Regulatory and Compliance
Delegation Oversight

Conduct oversight for delegated activities via review by the Delegation Oversight Committee (DOC). Continue to enhance relationships between Passport Health Plan and the delegates to foster an environment of collaborative quality improvement for delegated services.

The DOC reviews Quality Improvement and Utilization Management program descriptions, annual work plans, evaluations and related administrative policies for compliance with applicable QI/UM protocols, UHC contract requirements, and regulatory and accrediting body compliance. The DOC also reviews policies and performance reports related to quality improvement/management, utilization management, credentialing, member services, provider services, and/or claims operations as appropriate. The DOC assures that pre-delegation visits, quarterly reviews, and annual on-site visits/reviews occur to assess subcontractor performance against predetermined indicators and report findings.

MEASUREMENT

Overall effectiveness of each delegate is measured through quarterly reports. Annual site visits or reviews are also conducted as part of delegated/ subcontractor monitoring activities. These visits/ reviews assess delegates' compliance with Plan contracts, the Kentucky State Medicaid contract and NCQA standards.

DELEGATION/CONTRACT ARRANGEMENTS

The following delegation and/or contract arrangements were in place during 2018:

Subcontractor	Delegated/Contracted Activities	Effective Date	Certification / Accreditation
Avesis Third Party Administrators	Dental benefits manager responsible for member services, claims, quality, credentialing/re-credentialing, and utilization management for dental services.	October 2012	None
Beacon Health Strategies	Behavioral Health benefits manager responsible for network development and management, credentialing, utilization management, processing of appeals and claims processing for behavioral health services.	January 2013	NCQA, URAC
CareEnroll *KyHealth	Member Billing and Payment Processing Services	August 2017	None
Superior Vision, Inc. (*formerly Block Vision)	Vision benefits manager responsible for network development and management, credentialing, utilization management, processing of appeals and claims processing for general vision services only.	October 1997	None
Axis Point Health (*formerly McKession)	Health Information Line responsible for providing 24-hour nurse line services.	September 2012	NCQA, URAC
eviCore (*formerly MedSolutions, Inc.)	High dollar radiology service manager responsible for radiology utilization management.	October 2012	NCQA, URAC
Optum Insight	Fraud, Waste & Abuse	July 2013	NCQA

Subcontractor	Delegated/Contracted Activities	Effective Date	Certification / Accreditation
Conduent (*formerly Xerox Recovery Services)	Subrogation services responsible for investigation, payment collection, and inquiry response.	May 2013	None
Aperture CVO	Credentialing Verification Organization	July 2013	NCQA, URAC
CVS Pharmacy	Pharmacy benefits manager responsible for network management, credentialing, and claims processing for pharmacy services.	September 2016	URAC
Evolent Health	Operations partnership with delegated services including quality, UM/CM/DM, credentialing, customer service.	February 2016	NCQA

Delegation Entity agreements transitioned to Evolent Health in 2016:

Subcontractor	Last Passport Audit Date
Aperture CVO	8/2016
eviCore (*formerly MedSolutions, Inc.)	6/2016
Optum Insight	7/2016

FINDINGS

Subcontractor Name	Annual Evaluation Completed	Onsite Visit	Evaluation Tool Complete	# Follow-Up Items	File Review	Overall Score
Conduent	12/2018	10/3/2018	Yes	N/A	Yes	Met Full Compliance
Avesis	Pending	Pending	N/A	N/A	N/A	TBD
Beacon Health Strategies	2/2019	11/29/2018	Yes	N/A	Complete	Met Full Compliance
Superior Vision	10/2018	7/26/2018	Yes	N/A	Complete	Met Full Compliance
CVS	Pending	12/20/2018	Yes	TBD	TBD	Pending
AxisPoint McKesson	6/2018	4/17/2018	Yes	N/A	N/A	Met Full Compliance
Care Enroll *pre-delegation	6/2018	6/11/2018	Yes	N/A	N/A	Met Full Compliance

- Determining roles and responsibilities with our Evolent partnership.
- Beacon and Superior continue to work through Encounter submission issues

KEY 2018 INTERVENTIONS

- Continue to monitor delegated activities through the Delegated Oversight Committee.
- TPA services transitioned to Evolent in October 2018- continued issues with eligibility files and provider enrollment processing
- Update Delegate Contracts with Delegation Grids
- Propose changes to Delegation Oversight Committee charter and metric review cycle (quarterly to monthly)

INTERVENTIONS PLANNED FOR 2019

- Continue to monitor delegated activities through the Delegated Oversight Committee, annual audits and quarterly reporting.
- Quarterly delegated entity metric audits

Delegation Oversight summary to be presented to Compliance Committee and the Board Compliance Committee.

External Quality Review Organization (EQRO) Annual Evaluation

In conjunction with the EQRO, PHP Quality Program evaluation and activities include linkage of activities and processes across departments, with objectives that include continuously monitoring and analyzing clinical, safety and service indicators. In addition, PHP has a teleconference calls with DMS and EQRO to discuss selected health outcome measures as appropriate. The 2018 Annual Compliance Review was completed with a result of the QAPI overall compliance determination as substantial.

EQRO has completed their annual evaluation of the health plan in October 2018. Final results indicated no corrective action plans.

2018 NCQA Accreditation Scoring

Passport stands at an *Accredited* Accreditation status based on the 2018 NCQA Standards and Guidelines plus HEDIS® 2018 and 2018 CAHPS® Medicaid Child Survey. Based on NCQA's Health Plan Insurance Plan Ratings in 2018, Passport Health Plan stands at a 3.0 rating.

Passport continues to maintain NCQA accreditation requirements during the three-year renewal cycle through continual communication of updates and annual changes to stakeholders through monthly NCQA meetings and applicable *Lunch and Learn* sessions.

Program Impact

The 2018 QI Program was considered effective in that Passport achieved all its QI Program Objectives. Interventions were implemented in clinical, safety, and service areas; and improvements were noted in each of those areas.

According to NCQA's Medicaid Health Insurance Plan Ratings 2016-2018, Passport Health Plan received a score of 3.0 out of 5 for their HMO product. Passport maintains an "Accredited" Accreditation status with NCQA.

Recommendations for 2019

Areas of the QI Program not meeting goals were analyzed and activities directed towards identified barriers have been integrated in the 2019 QI Work Plan.

Targeted areas of focus for 2019 will include:
- Implementation of the Quality Strategy that focuses on a coordinated approach to performance improvement involving member and provider engagement through innovative strategies.
- Accelerate quality actions on 2018 Performance Improvement Projects to include: at least achieve meets requirement score of 60 or above for 2 open Performance Improvement Projects. PIP submission end of August 2019.
- Drive and monitor movement of 27 strategic HEDIS measures:
- Drive and monitor key Health Plus provider value-based HEDIS measures and provide QI support for this new strategic project (7 HEDIS measures include: CDC-N, AMM, MMA, LSC, LBP, URI, W34, AWC)
- Create and establish a new quality and reporting analysis team to monitoring QI metrics through newly created dashboards. Monthly, create enhanced quarterly and annual report outs of key QI metrics.
- Drive and support member and provider satisfaction workgroups assisting in developing strategies moving satisfaction scores to at least 50 percentile benchmarks plus create interim satisfaction tools/measures to monitor progress
- Further expand the Quality program across the organization through Process development, Process Improvement, Process Management, Project Management, and stakeholder satisfaction:
- Collaborate with DMS to improve shared accountabilities.
- Increase health plan rating by improvement in HEDIS® and CAHPS® results.
- Assess medical management effectiveness and identify opportunities for process improvement.
- Enhance configuration and testing capabilities to assure accurate provider contract administration.
- Continue to enhance data management effectiveness.
- Close NCQA quality accreditation gaps during 2018 lookback analysis and gap closure project

Acknowledgements and Approval

This Quality Improvement Program Evaluation is submitted by:

(signature)   09/17/2019
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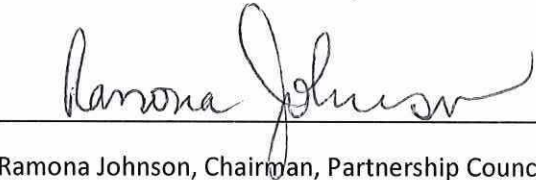
Betsy Simpson, Director, Quality Improvement   Date

Approvals:

(signature)   9/17/2019
_____   _____

Steve Houghland, MD, Chief Medical Officer   Date

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Ramona Johnson, Chairman, Partnership Council   Date

(signature)   9/17/2019
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Scott Bowers, Chief Executive Officer, Passport Health Plan   Date