

Normal Body Weight for Height for Adults – Height and Weight Documented

Background and Specifications

This measure is part of the Healthy Kentuckians 2010 initiative, the State's response to the national Healthy People 2010 initiative. The two common goals of the Healthy People 2010 initiative are to increase the quality and years of healthy life and eliminate health disparities. Overweight and obesity are major contributors to many preventable causes of death. Starting in reporting year 2009, this measure used hybrid (both administrative and medical record) data to calculate the number and percentage of members 18–74 years of age who had an outpatient visit and whose medical record contained evidence of documentation of height and weight during the measurement year or the year prior to the measurement year. Additional data regarding documentation of BMI, healthy weight for height and assessment/counseling for nutrition and documentation of assessment/counseling for physical activity were also collected. This measure's specification is a combination of the HEDIS® Adult BMI Assessment (ABA) measure (introduced in 2009) and the Healthy Kentuckians measure(s) Adult Appropriate Weight for Height; Physical Activity Assessment/Counseling; and Nutritional Assessment/Counseling introduced in Kentucky in 2005.

For reporting years 2007 and 2008 (and prior years), the measure specification differed as the eligible population/denominator were comprised of all members included in the HEDIS® hybrid samples for Cholesterol Management, Comprehensive Diabetes Care and Controlling High Blood Pressure. This represented only members with chronic conditions; therefore, the Department worked with the EQRO and PHP to devise a measure that would evaluate a group more representative of the general membership.

Due to the change in specifications, the rates are not comparable from HEDIS 2008® and therefore, the rates cannot be trended from the baseline. Also, no benchmarks are available as this is a state-specific measure.

The data is derived from Healthy Kentuckians Clinical Outcomes Performance measure rates reported by PHP and validated by the EQRO.

Outcome Goals

Increase to 68% the percentage of adult members with documented weight and height in their medical chart by 2010.

Results

The trend for this Healthy Kentuckians measure increased over the waiver period to a high of 74.61% in MY 2010 and then declined slightly to 71.90% in MY 2012. PHP exceeded the outcome goal for this measure in all four years reported from 2009 through 2012.

Table 7. Normal Body Weight and Height Adults – Adult Height and Weight Documented (%)

Measure	2007 Baseline	2009 ¹	2010 ¹	2011 ¹	2012 ¹	Percentage Point Change
Normal Body Weight for Adults – Height and Weight Documented	66.40	72.50	74.61	68.99	71.90	+5.50

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

¹ Rates for height and weight documented for reporting years (RYs) 2009–2012.

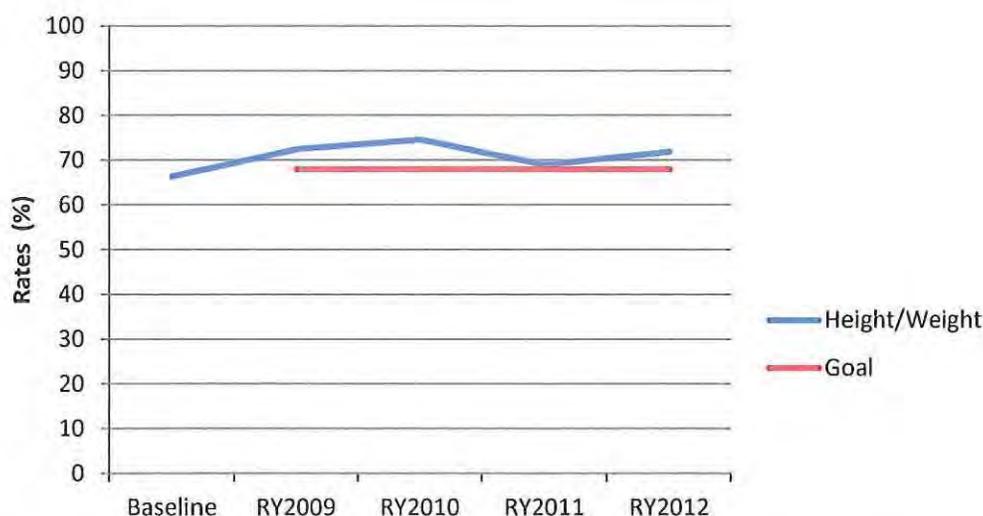


Figure 4. Comparison of Adult Height and Weight Documented Rates to Outcome Goals. Reported rates for Adult Height and Weight Documented by PHP compared to outcome goals for reporting years (RYs) 2009–2012.

Interventions and initiatives taken to improve rates of Normal Body Weight for Adults – Height and Weight Documented included the following activities:

- Quarterly Multi-measure reports were sent to providers. The Multi-measure report is a listing of members on a provider’s panel who are due for annual screenings, testing, and/or monitoring;
- Information regarding nutrition and physical activity is posted on the Member Page of the PHP website, including: how to read food labels, food pyramid, vitamins, ways to enhance activity and nutrition, and exercise. Distributed Mommy and Me Basics booklets to members that include information on exercise and developing good eating habits;
- Distributed educational literature to members via mailings, community events; PHP-sponsored events;

- Conducted outreach visits to provider offices to provide education on counseling members on nutrition and physical activity;
- Posted educational materials for members and providers on the PHP website;
- Published member and provider newsletter articles;
- Participated in community events to promote healthy nutrition and physical activity.

Normal Body Weight for Height for Children – Height and Weight Documented

Background and Specifications

This measure is part of the Healthy Kentuckians 2010 initiative, the state's response to the national Healthy People 2010 initiative. The two common goals of the Healthy People 2010 initiative are to increase the quality and years of healthy life and eliminate health disparities. For reporting year 2009, this measure used hybrid (both administrative and medical record) data to calculate the number and percentage of members 3 -17 years of age who had an outpatient visit with a PCP and/or OB/GYN and whose medical record contained evidence of documentation of height and weight in the measurement year or the year prior to the measurement year. Additional data regarding documentation of BMI percentile, healthy weight for height and assessment/counseling for nutrition and documentation of assessment/counseling for physical activity were also collected. This measure's specification is a combination of the HEDIS® Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measure introduced in 2009 and the Healthy Kentuckians measure(s) Child/Adolescent Appropriate Weight for Height; Physical Activity Assessment/Counseling; and Nutritional Assessment/Counseling introduced in Kentucky in 2005.

For reporting years 2007 and 2008 (and prior years), the measure specification differed as the eligible population/denominator was comprised of all members included in the Childhood Immunization Status and Adolescent Immunization Status. This represented only members who turned age 2 or 14 during the measurement year. The Department worked with the EQRO and PHP to devise a measure that would evaluate a group more representative of the general membership, adopting some of the criteria from the HEDIS® measure when it was introduced in HEDIS® 2009.

Due to the changes in HEDIS specifications, from HEDIS®2008 to HEDIS® 2009, this measure cannot be trended from the baseline. Also, no benchmarks are available as this is a state-specific measure.

The data is derived from Healthy Kentuckian Clinical Outcomes Performance measure rates reported by PHP and validated by the EQRO.

Outcome Goals

Increase to 92% the percentage of children and adolescent members who had weight and height documented in the medical record by 2010.

Results

The trend for this measure peaked in 2010 with a rate of 88.71% of children and adolescent members who had weight and height documented in their medical record. By the 2012

reporting year, the rate had fallen to 83.22%. The outcome goal for this measure, of 92%, was not met during the waiver period.

Table 8. Normal Body Weight and Height Children - Height and Weight Documented (%)

Measure	2007 Baseline	2009 ¹	2010 ¹	2011 ¹	2012 ¹	Percentage Point Change
Normal Body Weight for Children – Height and Weight Documented	80.10	87.58	88.71	81.90	83.22	+3.12

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

¹ Rates for height and weight documented for reporting years (RYs) 2009–2012.

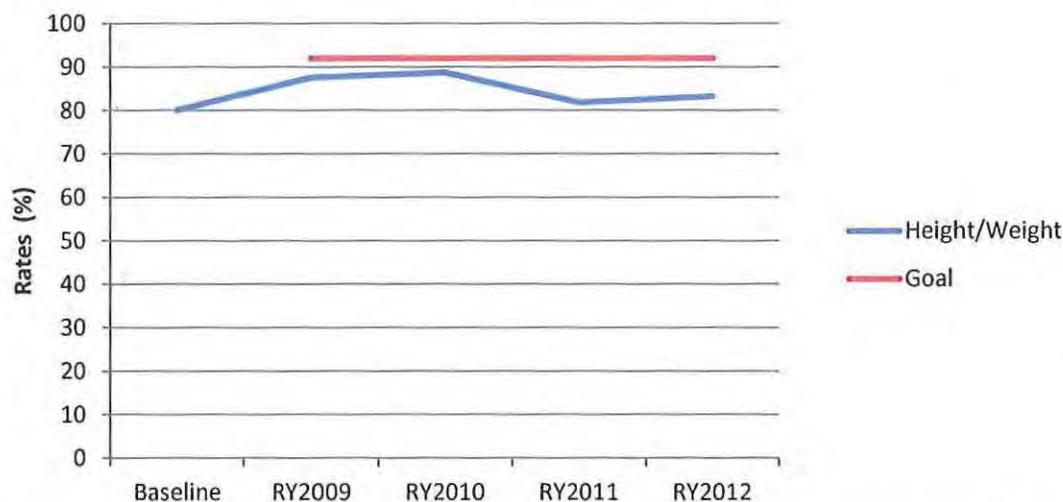


Figure 5. Comparison of Children’s Height and Weight Documented Rate to Outcome Goals. Reported rates for Children’s Height and Weight Documented by PHP compared to outcome goals for reporting years (RYs) 2009–2012.

Interventions and initiatives taken to improve rates of Normal Body Weight for Children – Height and Weight Documented included the following activities:

- Initiated a 2010 PIP to reduce the prevalence of childhood obesity among PHP’s child and adolescent members. Interventions were comprehensive and targeted to both providers and members and included:
 - Development of a toolkit for primary care providers;
 - Publishing member and provider newsletter articles regarding BMI percentiles and nutrition and physical activity;
 - Posting information on PHP’s member webpage and mailing information regarding a comprehensive pediatric obesity evaluation and treatment center to primary care providers;

- Quarterly Multi-measure reports were sent to providers. The Multi-measure report is a listing of members on a provider's panel who are due for annual screenings, testing, and/or monitoring;
- Initiated the S.C.O.R.E (Shrinking Childhood Obesity with Real Expectations) Program for overweight children and teens. Working with an Obesity Disease Manager, members receive written informational materials and access to information on the PHP website;
- Information regarding nutrition and physical activity is posted on the Member Page of the PHP website, including: how to read food labels, food pyramid, vitamins, ways to enhance children's activity and nutrition, and exercise;
- Distributed Mommy and Me Basics booklets to members, and Spanish Mommy and Me Basics informational materials to Spanish speaking members. These materials include information on exercise and developing good eating habits;
- Coordinated PHP's Louisville Youth Training Center Childhood Obesity Program (LYTC COP), which is a program providing fitness and nutrition training;
- Providers were mailed postcard notification of the updates of the Child and Adolescent Obesity Clinical Practice Guidelines;
- Distributed educational literature to members via mailings, community events; and other PHP-sponsored events;
- Conducted outreach visits to provider offices to provide education on counseling members on nutrition and physical activity;
- Posted educational materials for members and providers on the PHP website;
- Participated in community events to promote healthy nutrition and physical activity.

Lead Screening in Children

Background and Specifications

This measure is based upon the HEDIS® Effectiveness of Care measure: Lead Screening in Children. The measure uses hybrid (administrative and medical record) data to calculate the percentage of children 1–2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday. The member must be continuously enrolled 12 months prior to the second birthday, with no more than one gap in enrollment of up to 45 days during the 12 months prior to the second birthday. Benchmarks are derived from NCQA’s Quality Compass 2012. Data for this measure is derived from PHP’s reported HEDIS® rates beginning with HEDIS®2009 (for MY 2008); thus, the baseline for this measure is HEDIS®2008.

The data reported by PHP was audited and found reportable by an NCQA licensed HEDIS® audit organization.

Outcome Goals

Increase to 85% the percentage of child members who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday by 2010.

Results

Beginning with a first year (HEDIS®2008) rate for Lead Screening in Children of 77.70%, PHP’s results steadily increased to a high of 83.22% in MY 2009 and then decreased slightly over the next three years to a rate of 82.3% in MY 2012. The MY 2012 rate represents a +4.6 percentage point increase over the HEDIS®2008 baseline rate. While PHP’s rates for Lead Screening in Children never met the outcome goal of 85% during the waiver years, the MY 2012 rate exceeded the HEDIS®2012 Medicaid national average thus indicating above average performance on this measure compared to other Medicaid MCOs nationally.

Table 9. Lead Screening in Children (%)

Measure	HEDIS® 2008 Baseline ⁷	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent- age Point Change	HEDIS® 2012 Nat’l Ave.
Lead Screening in Children	77.70	80.13	★83.22	★83.19	★83.00	★82.3	+4.6	80.49

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.

⁷ This measure was introduced in HEDIS®2008.

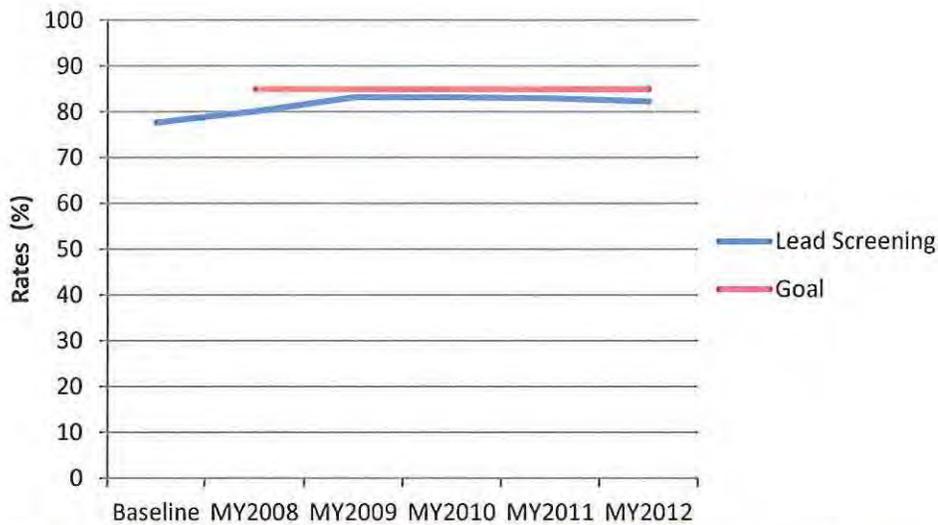


Figure 6. Comparison of Lead Screening in Children Rates to Outcome Goals. Reported rates (%) for Lead Screening in children by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve rates of Lead Screening in Children included the following activities:

- Clinical practice guideline for Lead Screening was updated and approved by the Quality Medical Management Committee (QMMC). The guideline was communicated to providers via the POISE alerts system, in Pharmacy News and placed on PHP’s website and updated in the Provider Manual;
- Monitored monthly administrative data;
- Published articles in provider newsletter regarding Lead Screening guidelines;
- Published articles in member newsletter regarding lead poisoning and lead screening;

Persistence of Beta-Blocker Treatment after a Heart Attack

Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on the HEDIS® Effectiveness of Care Measure: Persistence of Beta Blocker Treatment after a Heart Attack. This measure uses administrative data to calculate the percentage of members 18 years of age and older during the measurement year who were hospitalized and discharged alive from July 1 of the year prior to June 30 of the measurement year with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge. The member must be continuously enrolled from discharge through 180 days after discharge, with no more than one gap in enrollment of up to 45 days within the 180 day period.

The data reported by PHP was audited and found reportable by an NCQA licensed HEDIS® audit organization.

Outcome Goals

Increase to 70% the percentage of the adult members who were hospitalized and discharged alive from July 1 of the year prior to the MY to June 30 of the MY with a diagnosis of acute myocardial infarction (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Results

The reported rate for this measure dropped dramatically in MY 2008 from the baseline measurement of 76.74% but then continued to improve through the waiver period to a high of 73.42% in MY 2012. The MY 2012 rate exceeded the outcome goal of 70% but was below the HEDIS® 2012 national Medicaid average of 80.49%.

Table 10. Persistence of Beta-Blocker Treatment after a Heart Attack (%)

Measure	HEDIS® 2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent- age Point Change	HEDIS® 2012 Nat'l Ave.
Persistence of Beta-Blocker Treatment after a Heart Attack	76.74	53.66	59.65	65.67	65.00	73.42	-3.32	80.49

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.

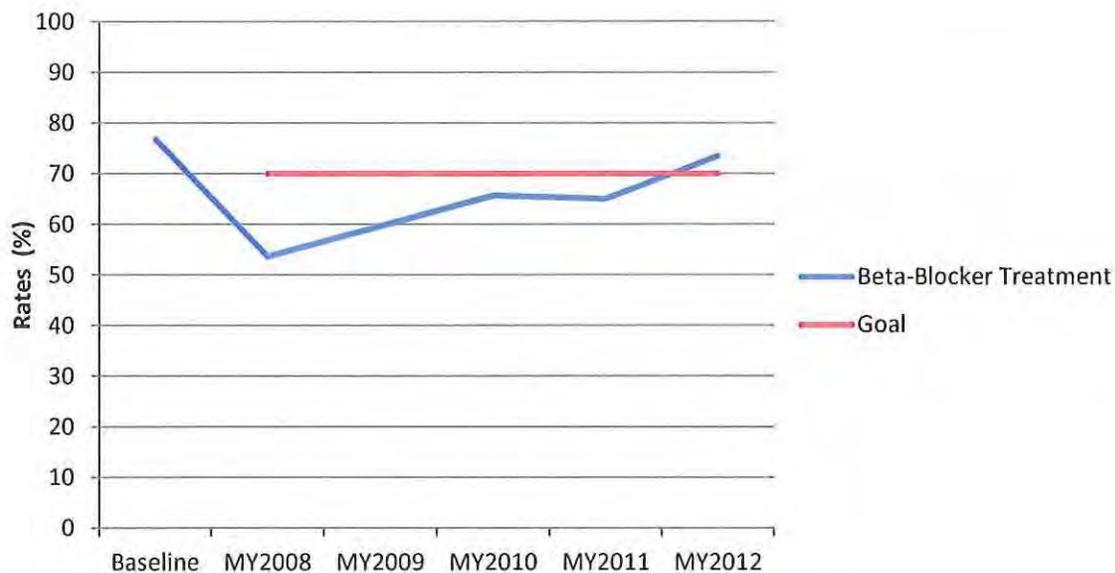


Figure 7. Comparison of Persistence of Beta-Blocker Treatment after a Heart Attack Rates to Outcome Goals. Reported rates (%) for Persistence of Beta-Blocker Treatment after a Heart Attack by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve rates for Persistence of Beta-Blocker Treatment after a Heart Attack included the following activities:

- Providers were mailed postcard notification of the updates to the Cardiovascular Clinical Practice Guidelines;
- Guidelines were posted on PHP’s website under the Providers’ Center;
- Reminder postcards were sent to providers regarding the updated guidelines.
- PHP conducted provider education during on-site visits.

II. Domain – Quality of Care – Outcomes

Goal/Objective

The demonstration project, through the healthcare Partnership (PHP), will increase the use of primary care and preventive services by Partnership (PHP) members.

Hypothesis

1. Will utilization of medical services, mainly primary and preventive care, improve/increase as a result of the demonstration project?
2. Will usage of the emergency room for non-emergent care decrease as a result of the demonstration project?

Data Sources

PHP-reported HEDIS® Results, CMS 416 EPSDT Results, and Statutory Reports of Utilization

Analysis Plan⁸

- Comparison of HEDIS and CMS 416 EPSDT baseline (2007 rates) and annually for selected measures.
Subsequent to the MCO's annual HEDIS Compliance Audit, PHP is required to submit the Final Audit Report (FAR), which lists the auditor's determination regarding which measure rates are reportable (i.e., were calculated in accordance with HEDIS Technical Specifications), and if not reportable, the reason. The CMS 416 EPSDT rates are calculated per CMS-defined specifications and have been reviewed by the EQRO.
- Compare rates of performance with national benchmarks.
NCQA's *Quality Compass 2012* is utilized to assess performance levels against Medicaid means.

⁸ Note: Outcome goals may be adjusted based on re-measurement relative to the baseline rates.

Adult Access to Preventive/Ambulatory Services

Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on the HEDIS® Access/Availability of Care: Adults' Access to Preventive/Ambulatory Health Services. This measure uses administrative data to calculate the percentage of members 20 years and older who had an ambulatory or preventive care visit during the measurement year. Rates are reported for three age stratifications: 20–44 years; 45–64 years; 65 years and older. Members must be continuously enrolled the measurement year and have no more than one gap in enrollment of up to 45 days during the year.

The data reported by PHP was audited and found reportable by an NCQA licensed HEDIS® audit organization.

Outcome Goals

Increase to 93% the percentage of adults 20–44 years of age who accessed preventive/ambulatory health services by 2009 with sustained results in 2010.

Results

The reported rates for adult access to preventive/ambulatory services increased for all age groups during the waiver period with the largest increase (of +2.19 percentage points) for the 45–64 year group. PHP's reported HEDIS®2013 rates for all adult age groups exceeded the HEDIS®2012 national benchmark, indicating above average performance compared to other Medicaid MCOs in the nation. The outcome goal for the 20–44 year age group was not achieved during the waiver period.

Table 11. Adult Access to Preventive/Ambulatory Services (%)

Measure	HEDIS® 2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent- age Point Change	HEDIS 2012® Nat'l Bench
Adult Access to Preventive/Ambulatory Services								
Total	NA	★87.56	★87.49	★87.15	★85.37	★88.22	+0.66	81.92
20–44 years	★83.80	★84.95	★84.82	★84.03	★81.61	★85.12	+1.32	80.04
45–64 years	★88.49	★89.12	★89.30	★89.22	★88.16	★90.68	+2.19	86.05
65 + years	★91.16	★91.30	★90.69	★91.59	★91.37	★92.07	+0.91	83.47

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.

Only age group 20-44 years had an established goal.

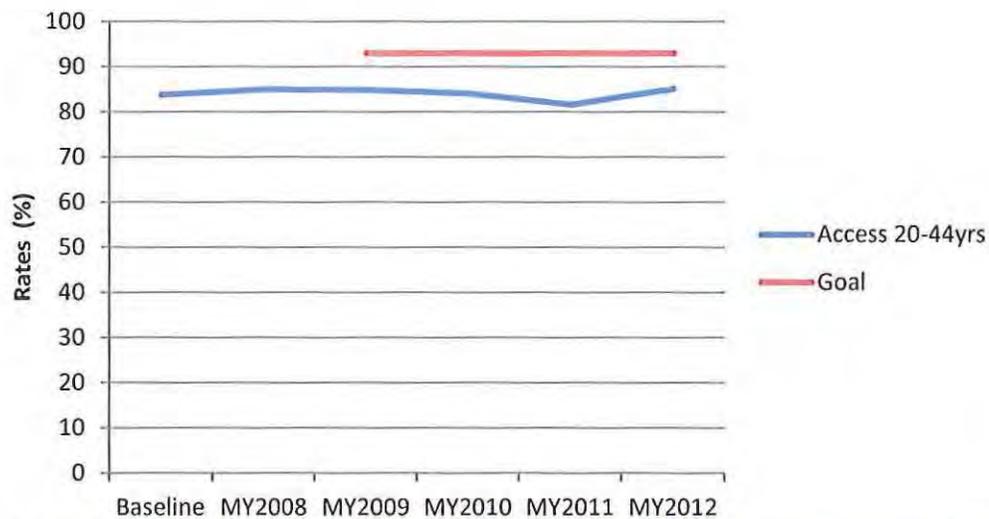


Figure 8. Comparison of Adult Access to Preventive/Ambulatory Services Rates (Age Group 20–44 Years) to Outcome Goals. Reported rates (%) for Adult Access to Preventive/Ambulatory Services for age group 20–44 years by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve rates for Adult Access to Preventive/Ambulatory Services included the following activities:

- Monitored monthly administrative data;
- Reviewed quarterly Geo-access reports for PCP and health center panel accessibility;
- Used on-hold messaging to encourage preventive health visits;
- Posted preventive health and wellness information on the PHP website for members.

Children and Adolescents Access to Primary Care Providers

Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on the HEDIS® Access/Availability of Care: Children and Adolescents' Access to Primary Care Practitioners. The measure uses administrative data to calculate the percentage of members 12 months–19 years of age who had a visit with a Primary Care Provider. Rates are reported for four age stratifications: 12–24 months; 25 months–6 years; 7–11 years; and 12–19 years. Members ages 12–24 months and 25 months–6 years must be continuously enrolled and have at least one PCP visit within the measurement year. Members ages 7–11 years and 12–19 years must be continuously enrolled and have at least one PCP visit within the measurement year or the year prior to the measurement year.

The data reported by PHP was audited and found reportable by an NCQA licensed HEDIS® audit organization.

Outcome Goals

Increase to 98% the percentage of children and adolescents of all ages who accessed PCPs by 2009 with sustained results in 2010.

Results

PHP's reported rates for Children and Adolescents Access to PCPs tended to be at the 90 percentage level throughout the waiver period with highs of 98+% in MYs 2008, 2009 and 2010 for the 12–24 month olds and lows just under 90% for the 25 months–6 years old age group. All four age groups each had MY 2012 rates above the HEDIS®2012 national benchmark, indicating above average performance for all ages when compared to national Medicaid MCOs. While none of the age groups met the outcome goal in the 2012 MY, the goal was exceeded in MYs 2008, 2009 and 2010 for the 12–24 months age group.

Table 12. Children’s and Adolescents’ Access to Primary Care Providers (%)

Measure	HEDIS® 2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percentage Point Change	HEDIS® 2012 Nat'l Bench
Children’s and Adolescents’ Access to Primary Care Providers								
12–24 months	★97.92	★98.52	★98.05	★98.25	96.02	★97.85	-0.07	96.07
25 months–6 years	★88.56	★89.99	★90.92	★90.61	86.64	★89.37	-0.62	88.19
7–11 years	★90.10	★91.66	★92.28	★92.87	★91.00	★91.95	+0.29	89.54
12–19 years	★88.69	★90.17	★89.53	★91.34	★90.11	★91.64	+1.47	87.89

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure is better than the national average benchmark.

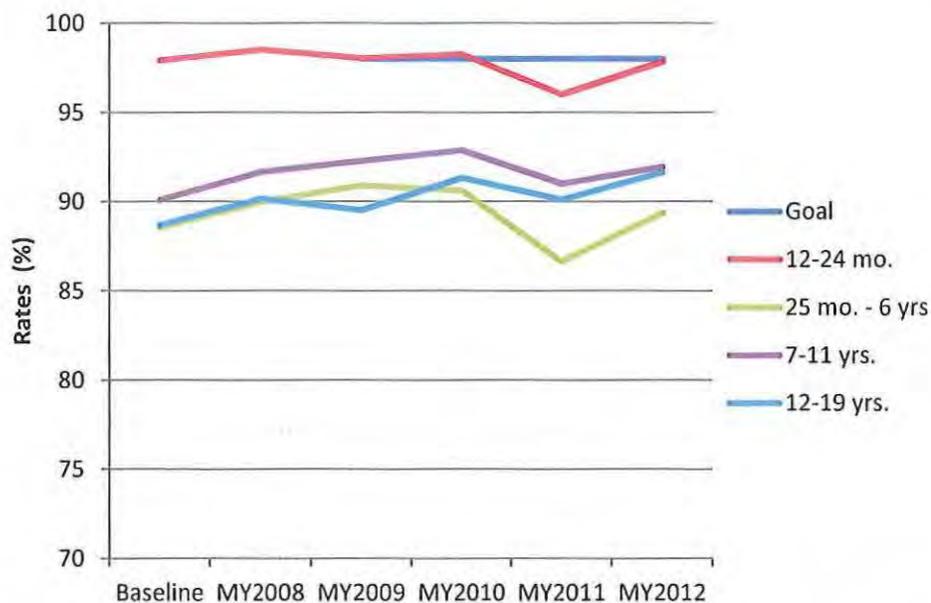


Figure 9. Comparison of Children’s and Adolescents’ Access to PCPs Rates to Outcome Goals. Reported rates (%) for Children’s and Adolescents’ Access to PCPs by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve rates for Children and Adolescents Access to PCPs included the following activities:

- Monitored monthly administrative data;
- Reminder postcards distributed to parent/guardians, reminding them to select a PCP and schedule Well-Child/EPSDT exam for their newborn babies;
- On-hold SoundCare messages included the importance of regular well-child screens and age-appropriate immunizations;

- Conducted telephonic outreach to parents of children in need of preventive care visits;
- Issued performance feedback and lists of members in need of visits to PCPs;
- Published various member and provider newsletter articles;
- Posted preventive health and wellness information on the PHP website for members including immunization schedules;
- Participated and sponsored community events.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Background and Specifications

The goal of the EPSDT program is to provide routine physicals and other related health services to children at specified ages. In addition to routine physicals, other types of services included are growth assessments, immunizations and hearing, vision and dental services. Data for this measure is derived from PHP's CMS 416 EPSDT rates, which are reported quarterly to the Department, and evaluated by the EQRO. There are two measures: EPSDT Participation Rate and EPSDT Screening Rate. There are no benchmarks for these measures, although CMS has established goals of 80% for EPSDT Participation and 80% for EPSDT Screening. The eligible population for both measures includes all members who are between ages 0 to 21, and who are less than 22 years old. These measures use administrative data to calculate the proportion of children who access EPSDT services. The EPSDT Participation rate is comprised of children who receive any initial and periodic EPSDT screening services during the reporting year. The EPSDT Screening rate is comprised of children who receive the age-expected initial or periodic EPSDT screenings, according to the state-specific periodicity table

Outcome Goals

Increase the EPSDT participation rate to 77% by 2009 with sustained results in 2010; and maintain the EPSDT screening rate at or above 96% by 2010.

Results

From the baseline, PHP's participation rate in the EPSDT program increased from 70% to a high of 76% in 2009 and 2010 and ended the waiver period with a participation rate of 72%, a 2 percentage point increase over baseline but below the outcome goal of 77% by 2009. PHP's screening rate increased from a baseline of 91% to a high of 95% in 2009. The screening rate fell dramatically in 2010 to 81% and then began to increase again to 90% in 2012, one percentage point lower than the baseline. PHP's screening rate failed to meet or exceed the outcome goal of 96% by 2010.

Table 13. Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Measures	2007 Baseline	2008	2009	2010	2011	2012	Percent- age Point Change '07-'12
EPSDT Participation Rate (%)	70	71	76	76	71	72	+2
EPSDT Screening Rate (%)	91	93	95	81	89	90	-1

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal

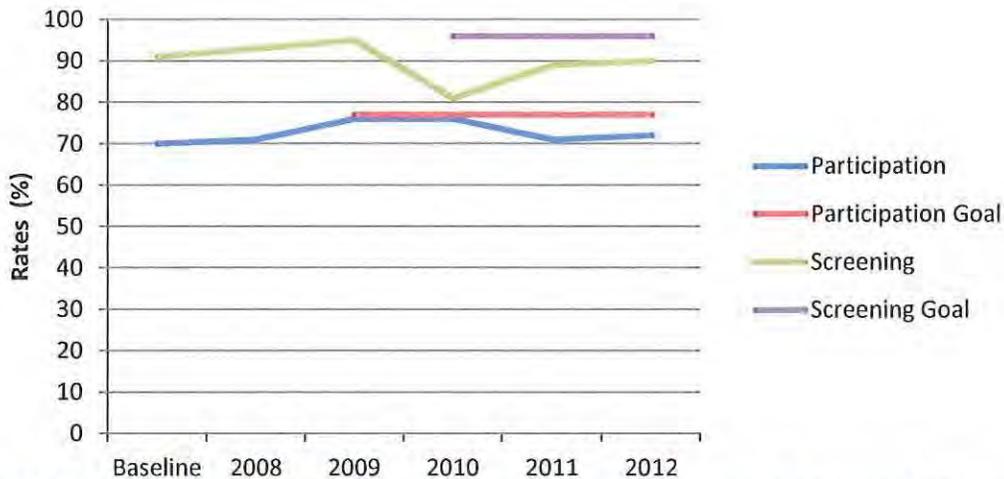


Figure 10. Comparison of EPSDT Participation and Screening Rates to Outcome Goals. Reported rates (%) for EPSDT Participation and Screening by PHP compared to outcome goals for this measure for MYs 2008–2012.

Interventions and initiatives taken to improve rates for EPSDT participation and screening included the following activities:

- In 2007–2010 PHP conducted a Performance Improvement Project (PIP) to increase the EPSDT participation rate. PHP collaborated with the Department of Health, Head Start and other community groups. Ongoing interventions included a robust EPSDT tracking program, a member reminder/outreach program, and inclusion of the EPSDT measures in PHP’s Provider Recognition Program;
- PHP provided real-time information technology to assist PCPs in identifying members in need of EPSDT screenings and collaborated with the Jefferson County Head Start program to assist members in scheduling appointments;
- PHP continued to provide EPSDT/well-child reminders via on-hold SoundCare messages;
- Non-participating members by age group were identified for targeted outreach;
- Reminder postcards were distributed to parent/guardians reminding them to select a PCP and to schedule a well-child/EPSDT exam for newborn babies;
- Identified members in Head Start program and outreached to parents to encourage EPSDT visits and immunizations;
- Monitored monthly administrative data;
- Identified non-participating members by age-category via the EPSDT tracking database for targeted outreach;
- Staff provided telephonic outreach and education to identified delinquent members;
- Referred members to Healthy Start program;
- Mommy Steps Program Representative conducted postpartum visits with new moms to deliver postpartum packets and assist in scheduling EPSDT appointments. The Mommy Steps Program is a special program for pregnant women. For more information: <http://www.passporthealthplan.com/member/eng/health/pregnancy/index.aspx#.UyCgE-D9ZQ>;
- Care Coordination staff participated in events where EPSDT material was distributed and outreach/education provided;

Annual Dental Visits

Background and Specifications

Annual Dental Visits is both a HEDIS® measure, and a Healthy Kentuckians Clinical Outcomes Performance Measure. Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based upon the HEDIS® Access/Availability of Care Measure: Annual Dental Visit. The measure uses administrative data to calculate the proportion of child and adolescent members between 2–21 years of age who had at least one dental visit during the measurement year. Members must be continuously enrolled during the measurement year, with no more than one gap in enrollment of up to 45 days.

The data is derived from HEDIS® rates reported by PHP and audited and found reportable by an NCQA-licensed HEDIS® audit organization.

Outcome Goals

Increase the proportion of children and adolescents screened for dental caries to 54% by 2010.

Results

From a baseline rate of 46.69% in HEDIS®2007, PHP's reported rates for Annual Dental Visits increased to a high rate of 61.02% in MY 2010 and finished the waiver period with a rate of 60.95% for MY 2012, an increase of +14.26 percentage points from the baseline. The MY 2012 rate of 60.95% was also above the HEDIS®2012 Medicaid national benchmark of 45.42%. Reported rates in MY 2010, 2011 and 2012 all exceeded the outcome goal of 54% by 2010.

Table 14. Annual Dental Visits (%)

Measure	HEDIS® 2007	HEDIS® 2009	HEDIS® 2010	HEDIS® 2011	HEDIS® 2012	HEDIS® 2013	Percent- age Point Change	HEDIS® 2012 Nat'l Bench
	Baseline	MY 2008	MY 2009	MY 2010	MY 2011	MY 2012		
Annual Dental Visits	★46.69	★53.15	★57.95	★61.02	★60.01	★60.95	+14.26	45.42

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

A star (★) indicates that a HEDIS® measure rate is better than the national average benchmark.

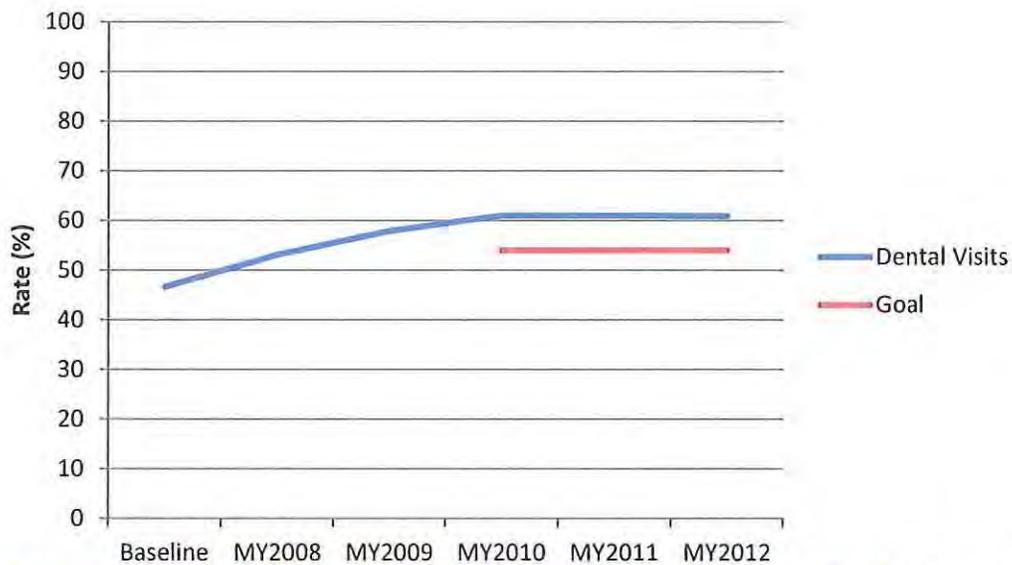


Figure 11. Comparison of Annual Dental Visit Rates to Outcome Goals. Reported rates (%) for Annual Dental Visits by PHP compared to outcome goals for this measure for HEDIS® 2009–2013 (MY 2008–2012).

Interventions and initiatives taken to improve rates for Annual Dental Visits included the following activities:

- In 2011, PHP began a Performance Improvement Project (PIP) to improve dental care in children with special healthcare needs;
- Conducted telephonic and written outreach for members with special healthcare needs who were missing a dental visit;
- Incorporated preventive dental care in treatment plans for those children with special healthcare needs who are enrolled in care coordination;
- Conducted telephonic outreach stressing the importance of routine dental care to all families with eligible children;
- Monitored monthly administrative data;
- Conducted home visits to educate members about the importance of routine dental care, in collaboration with local Departments of Health (DOH);
- Distribute educational materials on the availability of dental services while conducting provider site visits;
- Used on-hold messages regarding the importance of preventive dental care;
- Published articles stressing the importance routine dental care in provider and member newsletters.

Ambulatory Care

Background and Specifications

Data for this measure is derived from PHP's reported HEDIS® rates for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based upon the HEDIS® Use of Services Measure: Ambulatory Care. The measure categorizes Ambulatory Care into four categories: outpatient visits, emergency department (ED) visits, ambulatory surgery/procedures, and observation room stays and utilizes administrative data to calculate a rate per 1,000 members enrolled per month⁹ by age groupings and in total for each category.

Data was derived from HEDIS® rates reported by PHP and audited and found reportable by an NCQA licensed HEDIS audit organization.

Outcome Goals

Increase the rate of outpatient/ambulatory services for all age groups as shown by a decrease in emergency department (ED) visits for non-emergent services/diagnosis by 5% reduction in ED Visits/1,000 member months (MM).

Table 15. Outpatient and Emergency Department (ED) Visits and ED Visit Goals

HEDIS®2007 Baseline Outpatient Visits		HEDIS®2007 Baseline ED Visits		Goal ED Visits
Age	Visits/1,000 Member Months	Age	Visits/1,000 Member Months	Visits/1,000 Member Months
<1	896.58	<1	115.97	110.17
1–9	321.00	1–9	51.75	49.16
10–19	264.50	10–19	43.15	40.99
20–44	489.71	20–44	109.56	104.08
45–64	431.00	45–64	87.10	82.75
65–74	128.57	65–74	43.14	40.98
75–84	108.92	75–84	36.14	34.33
85 +	119.44	85 +	41.60	39.52
Unknown	-	Unknown	-	
Total	366.20	Total	65.56	62.28

⁹ For an explanation on the calculation of member months, see HEDIS® Volume 2: Technical Specifications.

Results

Total outpatient visits/1,000 member months declined from the baseline rate of 366.2 to a low of 240.58/1,000 member months in MY 2010. For the remaining two years of the waiver period, total outpatient visits increased to a high of 469.38 in MY 2012 with an overall increase of 103.18 visits/1,000 member months from baseline. Outpatient visits/1,000 member months increased for all age groups with the largest increases evident for the older age groups of 65–74 and 75–84 years of age.

Total ED visits/1,000 member months increased from a baseline of 65.56 to 81.30 visits/1,000 member months in MY 2012 with increases evident for every age group. The 20–44 year group had the largest increase of 28.7 visits/1,000 member months followed by the 65–74 year group which increased by 28.3 visits/1,000 member months.

The outcome goal for this measure was partially realized by an increase in outpatient visits/1,000 member months, but unfortunately, this did not result in a decrease in ED visits/1,000 member months for any of the age groups.

Table 16. Outpatient Visits and Emergency Department Visits

Measures	HEDIS® 2007 Baseline	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Change from Baseline to MY 2012
Total Outpatient Visits/1,000 MM ²	366.2	276.98	262.15	240.58	417.91	469.38	+103.18
Total ED ¹ Visits/1,000 MM ²	65.56	65.00	72.27	70.35	74.89	81.30	+15.74

¹ MM: member months; ED: emergency department

Table 17. Comparison of Outpatient Visits and Emergency Department Visits by Age Group to Outcome Goals

HEDIS®2007 Baseline Outpatient Visits		HEDIS®2007 Baseline ED ¹ Visits		HEDIS®2013 Outpatient Visits		HEDIS®2013 ED ¹ Visits		Goal
Age	Visits/ 1,000 MM ¹	Age	Visits/ 1,000 MM ¹	Age	Visits/ 1,000 MM ¹	Age	Visits/ 1,000 MM ¹	Visits/ 1,000 MM ¹
<1	896.58	<1	115.97	<1	899.39	<1	134.76	110.17
1–9	321.00	1–9	51.75	1–9	404.49	1–9	66.97	49.16
10–19	264.50	10–19	43.15	10–19	353.81	10–19	52.15	40.99
20–44	489.71	20–44	109.56	20–44	613.05	20–44	138.28	104.08
45–64	431.00	45–64	87.10	45–64	652.37	45–64	111.93	82.75
65–74	128.57	65–74	43.14	65–74	404.78	65–74	71.41	40.98
75–84	108.92	75–84	36.14	75–84	422.62	75–84	61.38	34.33
85 +	119.44	85 +	41.60	85 +	420.36	85 +	65.00	39.52
Total	366.20	Total	65.56	Total	469.38	Total	81.30	62.28

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.

¹ MM: member months; ED: emergency department

PHP continues to implement ongoing efforts to examine and address ED utilization. Specifically, actions targeted at reducing ED visits and increasing use of primary care services have been implemented. Interventions and initiatives taken to improve utilization of outpatient services while decreasing use of hospital EDs included the following activities:

- ED utilization rate is a measure in PHP's Provider Recognition/Incentive Program for PCPs;
- An internal committee and a PCP Workgroup review ED data on a quarterly basis;
- High utilizers of ED services are identified and referred to case management;
- Physicians are sent letters identifying panel members with eight or more ED visits. Letters include suggestions for alternative options to ED visits for those members identified;
- PHP staff reviews data from hospital emergency departments and refers members with disease-specific diagnoses to the appropriate disease manager;
- ED utilization reports are reviewed on a quarterly basis to evaluate the effectiveness of case management and health management interventions related to ED utilization and to identify additional members who may be in need of case management and/or disease management assistance. Referrals are made to these programs as appropriate;
- The Mommy & Me onsite nurse visits postpartum members in high volume facilities to assist with scheduling six-week postpartum visits and first newborn PCP/EPSTDT visit;
- The Tiny Tot Nurse Care Managers follow NICU newborns that cannot be discharged home after delivery due to medical problems. Upon discharge, the Tiny Tot Nurse Care Manager acts as a liaison for home care services, physicians, and facilities;

- PHP monitors monthly administrative data;
- Letters were mailed to members identified as high-utilizers of ER services at University of Louisville Hospital. The letter recommends visits to the PCP and/or a participating urgent care center as a more appropriate source of care when there is not an emergent need;
- Letters were mailed to members identified as having an ER visit with a diagnosis of asthma;
- Care coordination telephonic outreach to members and/or caregivers of members seen in the ER at Hardin Memorial Hospital, University of Louisville Hospital, and Kosair Children's Hospital for non-emergent symptoms advising member to schedule an appointment with their PCP for follow-up care;
- Staff reviews quarterly report data and performs outreach to those members identified as having a significant increase in ER utilization from the previous quarter in an effort to identify barriers to care and offer case management services.

III. Domain – Access

Goal/Objective

Access to healthcare and needed services, through stability and continuity of care, will improve as a result of the Demonstration project.

Hypothesis

1. Will all needed healthcare and related services be available and accessible via the managed care Partnership network?
2. Is the Partnership network sufficient to meet or exceed access standards established by the Department?

Data Sources

- GeoAccess Reports and Mapping
- Statutory Reports: Results of PHP assessment of appointment availability
- Statutory Reports: Reports of In-Network and Out-of-Network Utilization

Analysis Plan

- **GeoAccess Mapping:** Evaluate for each of the reporting years, whether PHP's provider network met or exceeded the standards for geographic accessibility for members residing in urban and rural areas.
PHP is required to provide the Department with a Network Geo- Access report annually. The specifications for the report are contained in the PHP contract. The report is produced using GeoAccess software and provides maps and charts that detail the locations of PHP's network providers and facilities, number of providers and facilities within the required distance standards, and greatest distance from member location(s) to the providers and facilities. Analysis of the capacity of the MCO to serve all categories of members in all geographic areas served by PHP is conducted and network sufficiency is assessed. The minimum standards for geographic accessibility are as follows:
 - Urban (Jefferson County) – PCPs: one provider within 30 miles, Specialists: one provider within 45 miles.
 - Rural (15 remaining counties served by PHP) – PCPs: one provider within 45 miles, Specialists: one provider within 45 miles.
- **Provider Access and Availability:** Evaluate for each of the reporting years, whether PHP's PCP and specialty providers met appointment availability standards for routine and urgent appointments.
PHP is required to assess appointment availability for routine and urgent appointments with both PCPs and specialists and report this quarterly to the Department. Appointment availability is assessed by Provider Relations Associates via onsite visits,

where the appointment schedule is viewed to determine if routine and urgent appointment slots are available within the required timeframes. The required timeframes for appointment availability are:

- Routine Appointment: appointment available within 30 days.
- Urgent Appointment: appointment available within 48 hours.