Provider Availability and Network Sufficiency Access Standards

Background and Specifications

Data for this measure is derived from PHP's annually report GeoAccess reports. Per contract, PHP must maintain an adequate network of providers and practitioners to serve its members. Furthermore, providers and practitioners must be geographically accessible to members and have adequate appointment availability to meet members' needs. GeoAccess standards require that there must be at least one PCP available within 30 miles for members residing in an urban area (Jefferson County), and within 45 miles for members residing in a rural area (the remaining 15 counties served by PHP). At least one specialist must be located within 45 miles for members residing in both urban and rural areas.

Data is derived from Geo-Access reports submitted annually by PHP to the Department of Medicaid Services. DMS validates the information presented in PHP's report against its own data.

Outcome Goals

100% of the membership fell within the standard for distance to at least one PCP location and one specialist.

Results

PHP has been very successful in developing a provider network sufficient to meet member access needs in Region 3. In 2008 the longest average distance to a PCP for urban members was 9.1 miles and this distance increased in 2009 and 2010 to 14.1 miles. In 2012 the longest average distance to a PCP in urban areas was 8.7 miles. Longest average distance to a rural PCP ranged from a low of 4 miles in 2011 and then a high of 8.4 miles in 2012. One hundred percent of members fell within the standard distance.

For specialty providers the longest average distance for an urban member to travel to a specialty provider was between 7.8 miles in 2009 and as high as 12.5 miles in 2011. For members to access a specialty provider in rural areas, the longest average distance to one provider was 3.9 miles in 2009 and 2010, falling to 2.9 miles in 2012. In all years, 100% of the membership fell within the standard for distance to one specialty provider.

Table 18. Longest Average Distance to One PCP and to One Specialty Provider

	Primary Care Providers[1]			Specialty Providers[1]		
Year	Urban Longest Average Distance to PCP[2,3]	Rural Longest Average Distance to PCP[2,3]	Geographic Areas Compliant	Urban Longest Average Distance to Specialist[2]	Rural Longest Average Distance to Specialist[2]	Geographic Areas Compliant
2008	9.1	5.4	100%	NA[3]	NA[3]	NA[3]
2009	14.1	4.3	100%	7.8	3.9	100%
2010	14.1	4.3	100%	9.9	3.9	100%
2011	22.4	4.0	100%	12.5	2.8	100%
2012	8.7	8.4	100%	8.2	2.9	100%

Source: Annual Accessibility Reports

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

[1] Includes urban and rural, from 2008 to 2012.

[2] Distances are reported in miles.

[3] PCP: primary care provider; NA: specialty provider data was not available in the 2008 Annual Accessibility Report.

Interventions and initiatives taken to sustain rates for Provider Availability and Network Sufficiency included the following activities:

- Continued monitoring provider Geo-Access related to established standards;
- As a result of findings from the Provider Satisfaction Survey, PHP identified and implemented recruitment efforts for other needed specialists such as neurosurgeons and pain management specialists.

Practitioner Performance Access Standards

- **Routine Visit within 30 Days;**
- **Urgent Visit within 48 Hours**

Background and Specifications

PHP members should receive needed care within an appropriate timeframe, and in accordance with standards established by the PHP contract and the MCO. This contributes to both member satisfaction and overall good health outcomes. This measure evaluates whether primary care and specialty providers have appointments available in compliance with established standards. Data for this measure is derived from provider site visits conducted at primary care and specialty care provider offices. Appointment availability is accessed via direct observation of the appointment schedule. The standards are routine visits must be available within 30 days, and urgent appointments within 48 hours. This is a state-specific measure, and as such, no benchmarks exist.

Outcome Goals

For each year of the measurement period, all providers surveyed (100%) were offering visits within 30 days for routine care and visits within 48 hours for urgent care.

Results

PHP routinely surveys provider sites for credentialing and re-credentialing. While on-site, the reviewers examine appointment schedules to determine if the provider meets the access standard of a routine appointment within 30 days and an urgent care appointment within 48 hours. On-site surveys include PCP and specialty office. Throughout the entire waiver period 2008–2012, 1,282 sites were surveyed and in all instances, 100% of the sites were in compliance with appointment availability standards thus achieving the outcome goal each year.

Table 19. Appointment Availability Surveys Conducted and Provider Compliance with Access Standards

Year	Number of Sites Surveyed[1]	Percent Compliant with Access Standards
2008	459	100%
2009	240	100%
2010	306	100%
2011	171	100%
2012	106	100%

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.
Source: PHP's Annual Quality Improvement Evaluations
[1] Number includes PCP and specialist site visits conducted.

No specific interventions or initiatives were taken to sustain Provider Appointment Availability. PHP continually monitors provider appointment availability related to established standards during on-site visits for credentialing and re-credentialing. Provider education regarding the access standards occurs during this on-site visit as well as during the annual compliance review conducted by the EQRO. Any deviations from the standards are immediately addressed by the plan.

Out of Network Utilization

Background and Specifications

To determine the adequacy of the vision and dental provider network(s), vision and dental providers are profiled by population category to ascertain the percentage of enrollees who receive services at network providers versus non-network providers. When reviewing this data, it is important to note that members who are foster children may obtain care from any Medicaid provider, and this may be out of the MCO region; and SSI with Medicare members may seek care from Medicare providers in addition to those offered through PHP and its vision and dental subcontractors. Additionally, in July 2009, PHP changed its dental subcontractor.

All enrolled members who had either a vision or dental visit are included in this administrative measure. Active and enrolled Medicaid providers located within the Passport Region 3 (Jefferson and the 15 surrounding counties) who accept and participate with PHP provide services and those outside of the Passport region are considered out-of-network or non-par providers for PHP.

This is a state-specific measure, and as such, no benchmarks exist.

Outcome Goals

The goal for both dental and vision visits is to decrease by 5% the number of out of network visits.

Table 20. Outcome Goals for Visits with Eye Care and Dental Providers

Provider Type	Visits with Participating	Visits with Non-Participating	Total Visits	% Out of Network	Goal (Reduce Out of Network Visits by 5%)
Dental Providers	95,963	10,541	106,504	9.9%	9.41%
Eye Care Providers	33,758	13,800	47,558	29.0%	27.57%

Results

PHP has done exceptionally well in reducing the proportion of ambulatory visits to non-participating dental and eye care providers over the waiver period. From a 2007 baseline of 9.9% of total dental visits out of network, the proportion of out of network visits declined over the four years of data to less than 1% in 2010 and 2011 and met the goal in each of the four years.

For eye care providers, the proportion of visits to non-participating providers exceeded the outcome goal of 27.57% each year between 2008 and 2011, but the rate fluctuated from a low

of 4.5% in 2008, spiking to 10.7% in 2009, dropping to 7.5% in 2010 and increasing again in 2011 to 10.4%.

Table 21. Ambulatory Care Visits by Provider Type (2008–2011)

Year	Visits w with Participating	Visits with Non-Participating	Total Visits	% Visits Non-Participating
Dental Providers				
2008	107,796	9,916	117,712	8.4%
2009	145,846	8,489	154,335	5.5%
2010	164,825	101	164,926	0.1%
2011	171,300	56	171,356	0.03%
Eye Care Providers				
2008	50,133	2,382	52,515	4.5%
2009	53,656	6,413	60,069	10.7%
2010	63,935	5,225	69,160	7.5%
2011	67,237	7,809	75,046	10.4%
All Other Providers				
2008	703,124	22,808	725,932	3.1%
2009	807,297	14,639	821,936	1.8%
2010	828,818	11,929	840,747	1.4%
2011	848,027	5,942	853,969	0.7%

A blue shaded cell indicates that a measure rate met or exceeded the outcome goal
Source: PHP Quarterly Reports – Utilization Report 6 (submitted 2008–2011; not submitted for 2012)

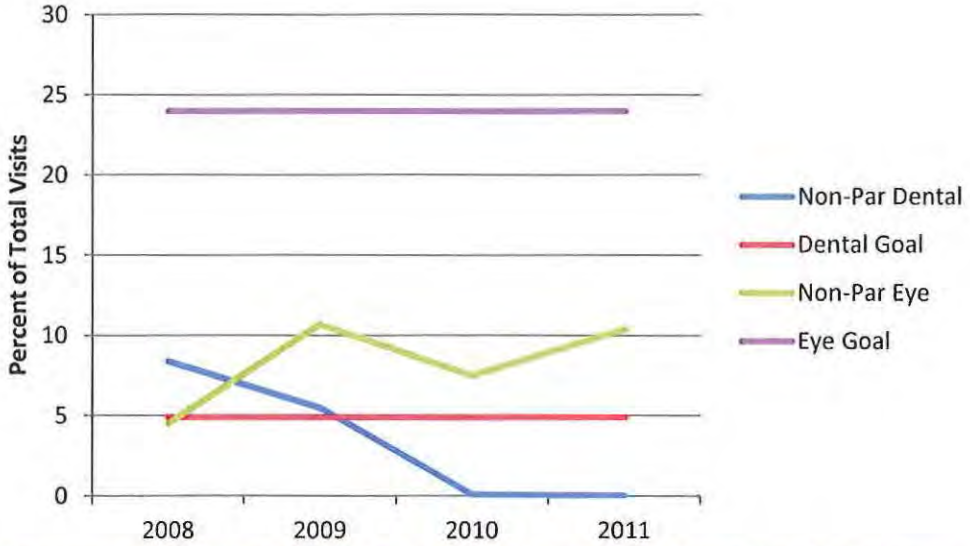

Figure 12. Comparison of Rate of Ambulatory Visits with Dental and Eye Care Providers to Outcome Goals. Reported rates (%) for Ambulatory Visits with Non-Participating (Non-Par) Dental and Eye Care Providers by PHP compared to outcome goals (2008–2011).

No specific interventions or initiatives to achieve the stated goals were described in either the PHP QI Work Plans or Annual QI Evaluations for the reporting period. These services are provided by subcontracted vendors, and access is assessed as part of annual and routine monitoring. When issues are identified, PHP directs the delegates to take actions and report resolution.

III. Domain – Satisfaction

Goal/Objective

Provider and member satisfaction with the Medicaid program/services will increase as a result of being enrolled/participating in the managed care Partnership program (PHP).

Hypothesis

1. Will mandatory enrollment in a managed care program administered by the Partnership, increase member satisfaction?
2. Will a managed care program administered by the Partnership, increase provider satisfaction?

Data Sources

Provider Satisfaction Survey, CAHPS® 4.0 Adult Medicaid Survey, Grievance Logs and Reports, Network Reports

Analysis Plan[10]

1. Comparison of baseline (2007 rates) CAHPS®, Practitioner Satisfaction, and Grievance trends annually. The CAHPS® 4.0 survey was administered annually on behalf of PHP by an NCQA-certified vendor. In addition, administration of the annual CAHPS® survey is required by the Department, and is a requirement for NCQA accreditation. PHP is required to submit its CAHPS® report(s) to the Department annually. Rates for each submission period will be compared against the baseline.
2. The PHP Practitioner Satisfaction Survey is approved by the Department and administered annually. PHP is required to submit the final report to the Department. Grievance data for providers and members is required quarterly, via statutory reports.
3. Compare rates of performance with state and national benchmarks. Benchmark data, such as NCQA's *Quality Compass* will be utilized to assess performance levels, where applicable.

[10] *Outcome goals may be adjusted based on re-measurement relative to baseline rates.*

Number/Type of Provider Grievances

Background and Specifications

This measure calculates provider grievances by category to determine areas for improvement. Data for this measure is derived from quarterly statutory reports submitted by PHP to the Department. The data was compiled for the 2011 Annual External Quality Review Technical Reports for PHP prepared by IPRO for fiscal years 2008, 2009 and 2010. Data was also obtained from PHP's quarterly reports to DMS. All grievances formally filed by providers in PHP's network in calendar years 2008–2012 are included in this analysis. If multiple grievances were filed by an individual provider, each specific complaint is counted as an individual occurrence.

This is a state-specific measure, and as such, no benchmarks exist. Results should be viewed with caution, as only the raw number of grievances is displayed. The number of network providers is not considered in this metric.

Outcome Goals

Decrease by 5% the number of provider grievances annually.

Results

After a high of 15,932 provider grievances in 2009, the number of provider grievances has steadily decreased to 3,843 reported in 2012, a 76% decrease since 2009. The most common reason for a grievance over the waiver period was coordination of benefits and third party liability, followed by payment or denial incorrect, claims denied for no referral or no authorization and disagreement with the billing policy. PHP exceeded the outcome goal for a 5% annual decrease in provider grievances in 2008, 2011 and 2012.

Table 22. Outcome Goals for Provider Grievances (2007–2012)

Year	Total Provider Grievances	Outcome Goal[1]
2007	10,927	**baseline**
2008	8,944	**10,381**
2009	15,932	**9,862**
2010	9,655	**9,369**
2011	7,331	**8,900**
2012	3,843	**8,455**

[1] A lower number of provider grievances is preferable.
A shaded cell, if any, indicates that a measure met or exceeded (was lower than) the outcome goal.

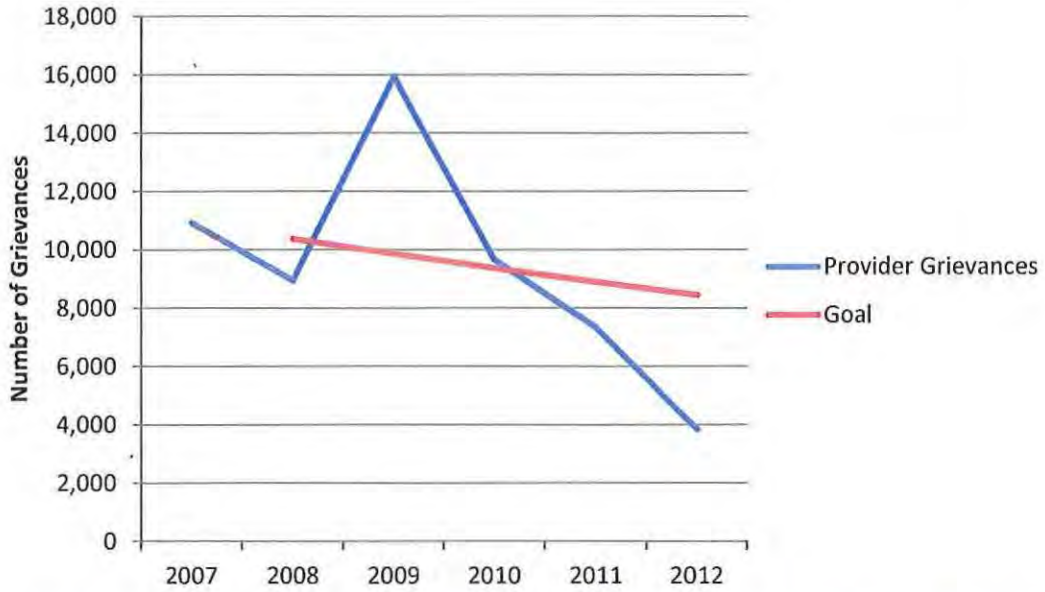

Figure 13. Comparison of Number of Provider Grievances to Outcome Goals. Reported number of provider grievances by PHP compared to outcome goals (2007 baseline; 2008–2012).

Table 23. Provider Grievances by Most Common Reasons

Grievance Description	2008	2009	2010	2011	2012
Coordination of Benefits, TPL[1] (subrogation)	2,252	4,464	3,522	2,057	876
Disagrees with Billing Policy	565	2,867	2,334	435	64
Claims Denied – no referral/no authorization	1,939	3,538	1,977	1,280	954
Payment/Denial Incorrect	3,073	3,113	1,228	3,295	1,856
Delayed>30 Days	503	661	403	0	0
Dissatisfaction with Information/Service Provided	389	955	100	0	10
Objects to Fee Schedule	157	322	84	3	52
All Other	66	12	7	261	31
Total	**8,944**	**15,932**	**9,655**	**7,331**	**3,843**

[1] TPL: third party liability

Interventions and initiatives taken to lower the number of Provider Grievances included the following activities:

- Conducted an analysis of the findings and developed targeted interventions;
- Provided additional and ongoing training for Provider Services representatives and Claims Processors;
- Increased Provider Relations representatives contacts with providers, conducted outreach visits;
- Conducted reviews of claims logs and provided focused education to Claims Processors;

- Held regular meetings to review the Claims Processing System and implement programming corrections;
- Convened a Workgroup to address Third Party Liability (TPL) issues;
- Expanded PCP Roundtable meetings to include specialists;
- Provided additional education regarding PHP programs for members;
- Educated providers regarding claims submission procedures;
- Enhanced and expanded E-services for claims processing, UM reviews, etc.;
- Conduct annual Provider Satisfaction Survey to assess provider satisfaction and areas for improvement.

Number/Type of Member Grievances

Background and Specifications

This measure calculates member grievances, by category, to determine areas for improvement. Data for this measure is derived from quarterly statutory reports submitted by PHP to the Department. The data was compiled for the 2011 Annual External Quality Review Technical Reports for PHP prepared by IPRO for fiscal years 2008, 2009 and 2010. Data was also obtained from PHP's quarterly reports to DMS. All grievances reported by members to PHP in calendar years 2008–2012 are included in this analysis. If multiple grievances were reported by an individual member, each specific complaint is counted as an individual occurrence.

This is a state-specific measure, and as such, no benchmarks exist. Results should be viewed with caution, as only the raw number of grievances is displayed. The number of members enrolled is not considered in this metric.

Outcome Goals

Decrease by 5% the number of member grievances annually.

Results

PHP has done an exceptional job in decreasing the total number of member grievances over the waiver period even as enrollment in the plan has steadily increased. In the baseline year, the total number of member grievances was the highest at 3,847 and continued to decline each year to a 2012 total of 1,060, a 72% decrease. The most common reason for member grievances was dissatisfaction with auto-assignment, followed by denial or reduction of services, coordination of benefits and third party liability and diagnosis or treatment slow, incomplete or unclear. PHP exceeded (had a lower amount than) the outcome goal for all five years of the waiver period 2008–2012.

Table 24. Outcome Goals for Member Grievances

Year	Total Member Grievances	Outcome Goal[1]
2007	3,847	**baseline**
2008	2,634	**3,655**
2009	1,390	**3,472**
2010	1,330	**3,298**
2011	1,023	**3,133**
2012	1,060	**2,977**

[1] A lower number of grievances is preferable.

A shaded cell, if any, indicates that a measure met or exceeded (was lower than) the outcome goal.

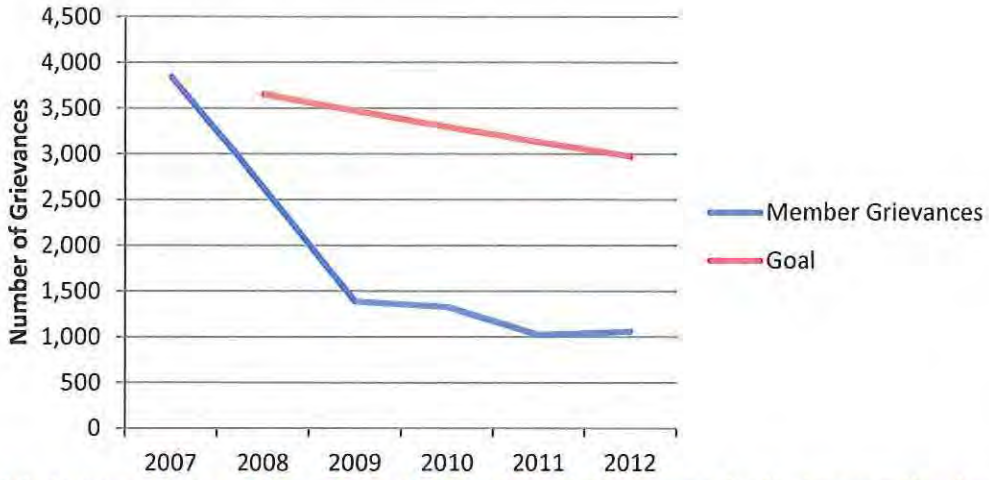

Figure 14. Comparison of Number of Member Grievances to Outcome Goals. Reported number of member grievances by PHP compared to outcome goals (2007 baseline; 2008–2012).

Table 25. Member Grievances by Most Common Reasons

Grievance Description	2008	2009	2010	2011	2012
Dissatisfied with Auto-Assignment	1,116	797	754	539	613
Coordination of Benefits/TPL[1] Pharmacy	105	154	221	138	111
Diagnosis-Treatment Slow/Incomplete/Unclear	181	102	116	90	93
Denial or Reduction of Services	448	53	94	82	75
Unprofessional Communication	43	33	41	53	54
All Other Categories	741	251	104	121	114
Total	2,634	1,390	1,330	1,023	1,060

[1] TPL: third party liability

Interventions and initiatives taken to lower the number of Member Grievances included the following activities:

- Evaluated the PCP auto-assignment process;
- Conducted provider and member education to decrease pharmacy denials;
- Published information regarding steps being taken to enhance satisfaction in the provider and member newsletters;
- Reviewed weekly and quarterly reports for tracking call reasons. Continuous training will be provided to ensure that first call resolution is being completed. PHP goal is to assist members on the first call which eliminates unnecessary callbacks;
- Revised the welcome call process to address member questions before they call plan. Use this call to review with new members their benefits, assign their PCP, answer any questions and complete a PIF (personal information form);
- The decrease in calls is a direct result of the Rapid Response team. When members have medical questions they are being referred to Rapid Response while Member Services will handle eligibility calls, Third Party Liability updates, PCP changes, ID

card requests, and demographic updates, etc. As the Rapid Response team is fully operational medical calls will shift to Rapid Response appropriately which in turn decreases inappropriate calls to Member Services.

Practitioner Satisfaction – Overall Satisfaction

Background and Specifications

This measure tracks overall provider satisfaction with the MCO. Data for this measure is derived from the annual Practitioner Satisfaction Survey required by DMS, and administered and reported to DMS by PHP. The data is derived from the ratings reported for providers' overall satisfaction with the health plan. PHP is required to report their survey methodology, including total surveys fielded and response rates. The survey instrument is approved by DMS annually.

The data presented are results for the survey question "Overall, how satisfied or dissatisfied are you with Passport Health Plan?" Response options were as follows: "Very Satisfied", "Somewhat Satisfied", "Neither ssatisfied nor Dissatisfied", "Somewhat Dissatisfied", or "Very Dissatisfied." Ratings of "Very Satisfied" or "Somewhat Satisfied" are considered as meeting the requirements for this measure.

This is a state-specific measure, and therefore, no benchmarks exist.

Outcome Goals

Increase by 5% the percentage of practitioners who indicate very satisfied/somewhat satisfied on overall satisfaction survey question by 2010.
Calendar year 2007 baseline rate = 75.40%.
Outcome goal by 2010 = 79.17%.

Results

Results from the Practitioner Surveys show a high level of overall satisfaction as measured by a total of "Very Satisfied" and "Somewhat Satisfied" responses. In 2008, 81% of practitioners were very – somewhat satisfied and by 2012 this rate increased by six percentage points to 87%. The overall satisfaction for practitioners exceeded the outcome goal in 2008, 2009, 2011 and 2012. Other measures showing improvement over the waiver period included satisfaction with availability of specialists, availability of Provider Relations Representative and Claim Payment Accuracy. Timeliness of the Utilization Management Process steadily increased from 2008–2010/2011 but then declined by 10 percentage points between 2011 and 2012. The Ease of Referral Submission and Ease of Pharmacy Prior Authorization also experienced declining rates of satisfaction over the waiver period.

Table 26. Practitioner Satisfaction Survey Results by Percent of Providers Surveyed

Year	MY 2008[1]	MY 2009[1]	MY 2010[1]	MY 2011[1]	MY 2012[1]	Percentage Point Change '08-'12
Overall Practitioner Satisfaction	81	87	75	84	87	+6
Timeliness of the UM Process	79	82	88	87	77	-2
Ease of Referral Submission	89	95	100	94	83	-6
Availability of Specialists	67	75	85	64	72	+5
Availability of Provider Relations Representative	82	85	86	83	83	+1
Claim Payment Accuracy	80	90	85	83	82	+2
Ease of the Pharmacy Prior Authorization Process	72	64	69	76	70	-2

A shaded cell, if any, indicates that a measure rate met or exceeded the outcome goal.
Only overall practitioner satisfaction had goals established.
Source: 2011 Annual External Quality Review Technical Report for PHP and PHP Quarterly Reports: PHP Annual Practitioner Survey Results 2011 and 2012
[1] MY: measurement year

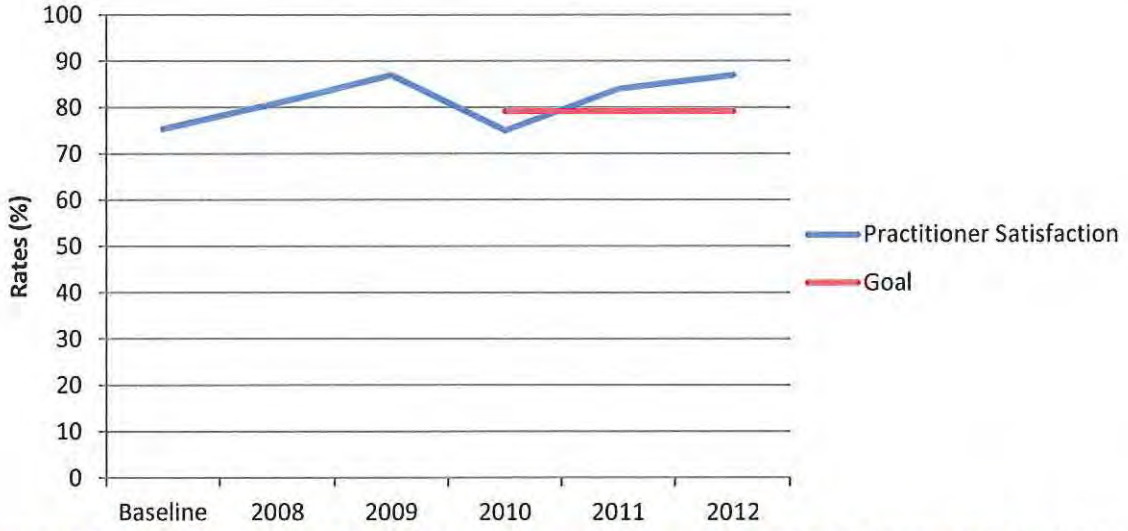

Figure 15. Comparison of Practitioner Satisfaction Rates to Outcome Goals. Reported rate (%) of overall practitioner satisfaction by PHP compared to outcome goals (2007 baseline; 2008–2012).

Practitioner Satisfaction – Number and Rate of Providers Leaving the Network

Background and Specifications

This measure assesses the stability of the PHP provider network. The original measure was based upon the HEDIS® measure Practitioner Turnover which was retired after reporting year 2006, resulting in no data being available past the baseline year of 2005. The Evaluation Design was revised, and data submitted by PHP in their quarterly reports was used to assess the numbers and reasons for providers leaving the PHP network.

This is a state-specific measure, and therefore, no benchmarks exist.

Outcome Goals

Due to the change in this measure's data source, no baseline data is available and no outcome goal has been determined for this measure.

Results

Satisfaction of providers can be discerned by their stability and longevity in the provider network. The number and rate of providers who voluntarily leave the network can indicate a level of dissatisfaction that should be addressed. Based on the quarterly report data submitted by PHP, the number of provider terminations has varied over the waiver period. While it is expected that providers will terminate when they move out of the service area, close their practice, retire or die, other reasons such as voluntary termination, a participating provider leaving to join a non-participating practice or a provider who leaves because he/she believes the capitation fees are too low may indicate their level of dissatisfaction with the plan or the managed care model. Between 2008 and 2012, there were 672 provider terminations. Thirty-eight percent of this total can be attributed to voluntary terminations, leaving a participating practice or leaving because the capitation rates are too low. Without a benchmark for this measure, the results are somewhat inconclusive.

Table 27. Provider Terminations by Reason

Reason	2008	2009	2010	2011	2012	Total
Voluntary termination/requested by provider	26	47	42	50	14	**179**
Par provider left to join non-par group	31	16	10	8	10	**75**
Cap fees and/or rates too low	0	0	1	2	0	**3**
Does not meet credential criteria[1]/other quality issue	3	1	8	12	90	**114**
All other[2]	21	16	32	70	162	**301**
Total	81	80	93	142	276	**672**

[1] In 2012, PerformRx, PHP's pharmacy benefits manager, underwent a national contracting process and during the review, it was determined that none of the pharmacies reported as terminated had a signed contract with PerformRx. It was also determined that none of these pharmacies processed any claims for PHP.

[2] All other not related to satisfaction or quality includes: moved out of area, location closed, retired, and deceased.

Source: PHP Quarterly Reports

Member Satisfaction

Background and Specifications

This measure assesses the overall satisfaction of members with the Partnership/PHP. Data for this measure is derived from PHP's reported CAHPS® results for MYs 2008–2012. Benchmarks are derived from NCQA's Quality Compass 2012. This measure is based on several Medicaid Adult CAHPS® 4.0 survey questions and composites. The CAHPS® survey is administered annually by an NCQA-certified survey vendor, on behalf of PHP. The survey is a PHP contract requirement and an NCQA-accreditation requirement.

Outcome Goals

Increase by 5% the percentage of members who indicate overall satisfaction in selected survey questions by 2010.

Table 28. Outcome Goals for Member Satisfaction

Measure	2007 Baseline Percent	2010 Goal Percent
Overall Ratings		
Health Plan Overall	79	82.95
Healthcare Overall	70	73.50
Personal Doctor Overall	76	79.80
Specialist Overall	80	84.00
Composite Score Percentages		
Getting Needed Care	84	88.20
Getting Care Quickly	84	88.20
How Well Doctors Communicate	87	91.35
Courteous & Helpful Office Staff	NR[1]	
Customer Service	89	93.45

[1] NR: not reported

Results

The rates displayed in the table below indicate a high level of overall satisfaction for adult members of PHP throughout the waiver period. Measure rates increased between 2008–2012 for all the selected measures with the highest increases evident for satisfaction with customer service (+13 percentage points), satisfaction for health plan overall (+7 percentage points), satisfaction with specialist overall (+7 percentage points), satisfaction with personal doctor (+6 percentage points) and satisfaction with how well doctors communicate (+6 percentage points). In MY 2012, all selected measures exceeded the HEDIS®2012 national average and as the number of stars indicate, there were many measure rates above the HEDIS®2012 national Medicaid benchmark in 2008, 2009, 2010 and 2011 as well.

Three measures met or exceeded the outcome goal showing 5% or more improvement over the 2007 baseline rate, and these were satisfaction with health plan overall, satisfaction with personal doctor and satisfaction with specialist overall.

Table 29. Member Satisfaction – Medicaid Adult CAHPS® 4.0

Year	HEDIS® 2009 MY 2008	HEDIS® 2010 MY 2009	HEDIS® 2011 MY 2010	HEDIS® 2012 MY 2011	HEDIS® 2013 MY 2012	Percent-age Point Change '08-'12	HEDIS® 2012 Nat'l Bench
Health Plan Overall	★77	★78	★78	★78	★84	+7	73.46
Healthcare Overall	68	★73	67	★70	★72	+4	69.88
Personal Doctor	76	★80	73	★81	★82	+6	77.08
Specialist Overall	★79	★79	★78	★83	★86	+7	77.66
Getting Needed Care	★84	★80	★82	★85	★87	+3	75.50
Getting Care Quickly	★83	★83	★83	★84	★86	+3	80.33
How Well Doctors Communicate	83	87	83	87	★89	+6	87.81
Customer Services	79	★85	★82	★85	★92	+13	80.42

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.

Interventions and initiatives taken to improve and sustain Member Satisfaction included the following activities:

- Member Services Department reviews member call reports weekly and quarterly and provides continuous training directed at "first call resolution," with a goal of resolving issues at the time of the first call;
- Data regarding grievances, PCP transfers and satisfaction with PCPs and specialty providers, and communication barriers are regularly reviewed and addressed as needed;
- Member satisfaction results are one of the scoring metrics for the PCP Provider Recognition Program – a monetary incentive program for physicians;
- Welcome calls are conducted within one week of enrollment to review benefits;
- An additional 800 toll free line was added to allow easy movement throughout phone system;
- Continued education is provided to members through New Member Packet, member newsletters and member webpage;
- Conduct education for both members and staff on prior authorization process;
- Increased collaboration between DMS, Kentucky Medicaid Management Information System and PHP to resolve issues regarding member eligibility;

- Monitored member complaints against PCPs and specialists with semi-annual complaint reports and conduct outreach to providers who do not meet Plan standards;
- Distributed a training tool for practitioners and office staff on ways to improve member satisfaction;
- Educated PCPs and specialists regarding member satisfaction via new provider orientations, site visits, provider workshops and roundtable meetings;
- Utilized the Rapid Response Outreach Team, of case manager technicians and case managers to discuss with members their urgent medical needs and help with scheduling appointments and finding needed services;
- Increased member awareness regarding the importance of selecting a PCP through distributing member materials and phone contact in member services;
- Conducted bi-weekly Customer Services training designed to develop and refine staff customer service skills and increase knowledge regarding plan benefits;
- Collaborated with Kentucky Department of Community Based Services (DCBS) to understand the member's experience from both PHP and DCBS;
- Assessed and monitored appointment access and availability during provider site visits.

Summary of Findings

The Evaluation Design for the Kentucky Partnership Plan 1115 (A) Waiver for the period November 1, 2008 to December 31, 2012 provided a comprehensive overview of Passport Health Plan's performance in quality of care (utilization and outcomes), access and member and provider satisfaction. Selected measures were tracked over the waiver period and compared to Medicaid MCO performance across the nation. The Partnership/PHP's performance was also assessed by their success in meeting or exceeding the outcome goal set for each measure.

The Partnership/PHP quarterly reports documented extensive community outreach and collaboration initiatives and a wide variety of both provider and member focused interventions for each quality initiative. PHP conducted both targeted and pro-active efforts such as physician office academic detailing and performance feedback, risk stratification and interventions for members with chronic diseases as well as broad-based educational activities to improve quality.

Overall, there were forty-five (45) measures addressed in this evaluation; two measures did not have an outcome goal, 15 did not have a national Medicaid benchmark rate and four could not be trended over time. Table 30 summarizes the Waiver evaluation findings by rate trend, national benchmarks and outcome goals for 2008–2012.

Table 30. Summary of Findings

Domain	Measures[1]	Improving Trend	MY 2012 Better than Nat'l Benchmark	Met or Exceeded Outcome Goal
Quality of Care: Utilization	Childhood Immunizations Combo 2	★	★	
	Childhood Immunizations Combo 3	★	★	
	Breast Cancer Screening	★	★	
	Appropriate Medication for Asthma		★	
	CDC[2] : HbA1c Testing		★	
	CDC: HbA1c Poor Control >9%		★	★
	CDC: HbA1c Control <8%		★	NA
	CDC: HbA1c Control <7%	★	★	★
	CDC: Eye Exam			
	CDC: LDL-C Screening		★	
	CDC: LDL-C Level Control <100mg/dL	★	★	★
	CDC: Medical Attention for Nephropathy	★	★	★
	CDC: Blood Pressure Controlled <130/80 mmHg	★	★	★

Domain	Measures[1]	Improving Trend	MY 2012 Better than Nat'l Benchmark	Met or Exceeded Outcome Goal
	CDC: Blood Pressure Controlled <140/90 mm/Hg		★	
	Normal Body Weight for Height for Adults Height and Weight Documented	★	NA	★
	Normal Body Weight for Height for Children Height and Weight Documented	★	NA	
	Lead Screening in Children	★	★	
	Persistence of Beta-Blocker Treatment After a Heart Attack			★
Quality of Care: Outcomes	Adult Access to Preventive/Ambulatory Services Ages 20–44	★	★	
	Children and Adolescents Access to Primary Care Providers – 12–24 mo.		★	★
	Children and Adolescents Access to Primary Care Providers – 24 mo.-6 yrs.		★	
	Children and Adolescents Access to Primary Care Providers – 7–11 yrs.	★	★	
	Children and Adolescents Access to Primary Care Providers – 12–19 yrs.	★	★	
	EPSDT Participation	★	NA	
	EPSDT Screening		NA	
	Annual Dental Visits	★	★	★
	Ambulatory Care – Outpatient Visits	★	NA	
	Ambulatory Care – ED Visits		NA	
Access	Access Standards: To PCP	NA	NA	★
	Access Standards: To Specialist	NA	NA	★
	Access Standards: Appointment Availability	NA	NA	★
	Out-of-Network: Dental Providers	★	NA	★
	Out-of-Network: Eye Care Providers		NA	★
Satisfac-tion	Number/Type of Provider Grievances	★	NA	★
	Number/Type of Member Grievances	★	NA	★
	Practitioner Satisfaction Overall	★	NA	★
	Practitioner Satisfaction: Terminations	NA	NA	NA
	CAHPS®[3] Health Plan Overall	★	★	★
	CAHPS® Healthcare Overall	★	★	

Domain	Measures[1]	Improving Trend	MY 2012 Better than Nat'l Benchmark	Met or Exceeded Outcome Goal
	CAHPS® Personal Doctor	★	★	★
	CAHPS® Specialist	★	★	★
	CAHPS® Getting Care Needed	★	★	
	CAHPS® Getting Care Quickly	★	★	
	CAHPS® How Well Doctors Communicate	★	★	
	CAHPS® Customer Service	★	★	

[1] Waiver evaluation measures by rate trend, national benchmarks and outcome goals for 2008–2012 are shown. A star (★) indicates positive measure finding. NA – Not applicable

[2]CDC – Comprehensive Diabetes Care

[3]CAHPS® Consumer Assessment of Healthcare Providers and Systems – Member Satisfaction

Recommendations

The EQRO will continue to work with the Department of Medicaid Services to continually evaluate the measures and performance relative to the Evaluation Design.

General recommendations include:

- Review the measure set and domains with regard to retiring measures, revising measures and adding new measures that may have been developed since the most recent Evaluation Design was prepared;
- Include comparisons to Medicaid Fee-for-Service, where feasible and appropriate;
- Consider adding measure(s) related to perinatal care;
- Re-evaluate goal setting for measures based on historical trends and national Medicaid averages. Consider using national Medicaid benchmark performance for Evaluation Design goals, where available and appropriate;
- Continue or enhance interventions to achieve improved performance particularly for those measures that did not meet the outcome goals, were not better than the Medicaid national average benchmark and/or did not have an improving trend.

Table 31 outlines areas of recommendation for each measure, where applicable.

Table 31. Recommendations

Domain	Measures	Data Source(s)	Revise Measurement Methodology	Re-Evaluate Goal(s)	Continue or Enhance Interventions
Quality of Care: Utilization	Childhood Immunizations	HEDIS®		X	X
	Breast Cancer Screening	HEDIS®		X	X
	Appropriate Medication for	HEDIS®		X	X

Domain	Measures	Data Source(s)	Revise Measurement Methodology	Re-Evaluate Goal(s)	Continue or Enhance Interventions
	Asthma				
	Comprehensive Diabetes Care	HEDIS®		X	X
	Normal Body Weight for Adults	State-specific			X
	Normal Body Weight for Children	State-specific			X
	Lead Screening in Children	HEDIS®		X	X
	Persistence of Beta-Blocker Treatment After a Heart Attack	HEDIS®		X	X
Quality of Care	Adult Access to Preventive/Ambulatory Services	HEDIS®		X	X
	Children and Adolescents Access to Primary Care Providers	HEDIS®		X	X
	EPSDT	State-specific		X	X
	Dental Visits	HEDIS®		X	X
	Ambulatory Care	HEDIS®	X	X	X
Access	Access Standards: Provider and Practitioner Availability and Network Sufficiency	State-specific			
	Access Standards: Practitioner Performance Against Access Standards	State-specific	X		
	Out-of-Network	State-specific	X	X	
Satisfaction	Number/Type of Provider Grievances	State-specific		X	X
	Number/Type of Member Grievances	State-specific		X	X
	Practitioner Satisfaction	State-specific	X	X	
	Provider Satisfaction	State-specific		X	
	Member Satisfaction	CAHPS®		X	X