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A Note from the Chief Medical Officer

Dear Valued Provider:

As you know, Passport Health Plan’s mission is to improve the health and quality of life of our members. One of the methods we are going to begin using to assist in achieving this goal is care gap reporting. Care gap reporting is vital to help identify and address gaps in care for your patients. By focusing on these gaps in care, we can move closer to fulfilling our mission of healthier communities.

You will begin regularly receiving reports to help your practice monitor performance on key indicators of quality at the patient level. Metrics for these reports are derived from HEDIS® standards, NCQA, and STARs, among others that are all based on clinical evidence. Patients, for whom specific elements of care are indicated, based upon their conditions, but who have not received those elements of care, have “care gaps.”

In order to maximize the benefits of care gap reporting, we are asking you to help us by submitting timely and accurately coded claims and encounter data, as well as appropriately documenting care in the medical record. Once received, care gap reports and gap closure should be integrated into practice workflow. The member’s medical record should be reviewed to verify if the gap exists or not. Primary care physicians, along with Passport’s Case and Disease Managers, attempt to close gaps in care by regularly connecting with patients. If the gap is already closed or does not exist, then claims or medical record documentation should be submitted to Passport.

We want you to know that Passport is providing hands-on support for you and your practice through our Quality, Care Coordination, and Provider Network Management teams. The following training guide will also be available on Passport’s provider website. Our staff will work diligently to meet with any providers desiring further assistance in implementing care gap initiatives in your office.

If you have questions about care gaps or other topics, please contact Provider Services at 1-800-578-0775. Your cooperation in this process is always appreciated, as is your commitment to our members and continued participation in the Passport network of providers.

Sincerely,

Steven Houghland, MD
Vice President and Chief Medical Officer
Passport Health Plan
Introduction to Reporting for Primary Care Practices

Care gap reporting is a coordinated approach to providing quality healthcare, increasing patient engagement, and improving provider and patient experience. These reports support you with data to close gaps in care, as indicated by discrepancies between the care that has been rendered (claims data) and evidence-based best practices. Care gap reports are a tool that enables you to treat patients based on their complete health profile, not just the relevant conditions of the day.

**Point of Care Report Suggested Implementation**

- Passport distributes reports by mail
- Office reviews the report and medical record
- Gap exists
- If there is documentation that the gap has already been closed, medical record documentation is submitted to Passport
- Passport Quality staff reviews the documentation to close the gap
- Check appointment data to see if member is scheduled
- If scheduled, address gap at that next visit
- If not scheduled, outreach to member via phone, mail, etc.
- Close gap by submitting timely and accurate claims
- Schedule member for for visit

**Care Gap Reporting Frequently Asked Questions**

**Q: What are care gap reports?**  
**A:** Care gap reports are reports that Passport Health Plan distributes to practices to help them monitor their performance on key indicators of quality at the patient level. Patients, for whom specific elements of care are indicated, based on their conditions, but who have not received these elements of care, have “care gaps.” Primary Care Physicians, along with Case Managers, attempt to address care gaps by regularly connecting with patients. This can include regular phone calls, an action plan for improving health, or routine visits.

**Q: What drives the indicators of quality we are measured against?**  
**A:** Metrics derived from HEDIS standards, STARS metrics, and NCQA, among others – all based on clinical evidence - are used as indicators of quality.
**How will I know if one of my patients has a care gap?**

A: Practices will receive reports showing all your assigned patients who have gaps in care.

**How does Passport get data to generate care gap reports?**

A: We collect data in two ways:

1. Much of the data is claims-based. However, since claims have several limitations in the degree to which they reflect the care provided, we enhance that data using additional data sources.
2. Passport staff will work closely with your practice to review and collect clinical data in your EMR.

**PCP Assignment**

The following points are important to consider when determining how members are assigned to you as a Primary Care Provider (PCP), and thus appear on your reports:

- Members can call and choose any PCP meeting age and gender requirements with an open panel at any time.
- Providers can call and ask for a member to be assigned to them at any time.
- If a member is new to the plan, or has been off the plan for a year or more, they will be auto-assigned to a new PCP with considerations of family link, geography, etc., within 30 days. SSI members have 90 days to be auto-assigned. This is within a couple of days due to the DMS requirements for mailing new member material and they are considered new for this reason after 60 days.
- If a member has been on the plan in the prior year, the member is auto-assigned to their previous PCP unless there are age or gender limitations that disallow that auto-assignment. The system will then look for a family link, if age and gender are appropriate. If there is no assignment after previous PCP or family link, the member is auto-assigned based on address (within 30 miles or 45 miles for rural areas).
- Some members are never assigned a PCP – Medicare Primary, disabled children, and foster children.
- Once a member is assigned, the PCP needs to show cause in order to remove the member from their panel. There are instructions in the provider manual explaining reasons PCPs may remove members from their panel and steps that need to be taken to do so.

**How to Close Care Gaps**

1. Practices should review the Care Gap Report and their records to determine if a gap exists.
2. If so, then attempts should be made to close the gap. Consider appointment data to see if the member is already scheduled for a visit or determine if additional outreach efforts are needed.
3. If the gap has already been closed, then practices should close the gap by submitting claims, as appropriate, or submitting supporting medical record documentation. Medical records may be submitted to Passport’s Quality Improvement Department.
Medical Record Documentation Needed for Care Gap Closure

<table>
<thead>
<tr>
<th>Measure</th>
<th>Documentation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wellness/preventive visit in the past 12 months</td>
<td>Adult Medicaid members should have at least one ambulatory / preventive care visit annually.</td>
</tr>
</tbody>
</table>
| Cervical Cancer Screening (HEDIS)      | Screening  
- Pap smear within the past three (3) years or Pap smear with HPV co-testing for women ages 30-64 every five (5) years.  
- A note indicating the date when the test was performed, and the result or finding.  
- For women ages 30-64, reflex testing does not meet the criteria for HPV co-testing. Both tests must be ordered. In co-testing, both cytology and HPV are ordered. HPV testing based on Pap smear results is considered reflex testing and does not count towards the HPV co-testing HEDIS measure.  
- Lab results that explicitly state the sample was inadequate or that “no cervical cells were present” do not count; this is not considered appropriate screening.  
- Biopsies do not count because they are diagnostic and therapeutic only and are not valid for primary cervical cancer screening.  

Exclusion  
Documentation must include a note indicating a hysterectomy with no residual cervix by December 31st of the measurement year.  
- Complete, Total or Radical abdominal or vaginal hysterectomy meets criteria for hysterectomy with no residual cervix.  
- Documentation of a Vaginal Pap Smear in conjunction with documentation of Hysterectomy meets exclusion criteria.  
- Documentation of hysterectomy in combination with documentation that the patient no longer needs pap testing/cervical cancer screening  
- Documentation of hysterectomy alone does not meet criteria because it does not indicate that the cervix was removed. |
| Breast cancer screening (HEDIS)        | Screening  
Mammogram in the past two years. Documentation may include the radiology report or a note indicating the date and result.  
Exclusion |
| **Chlamydia screening (HEDIS)** | Bilateral or two single mastectomies any time in the member’s history. Women, ages 16-24, identified as sexually active via pharmacy or claims/encounter data should have at least one test for chlamydia during the measurement year. |
| **Diabetes HbA1c Test (HEDIS) in the past 12 months** | Documentation in the medical record must include a note indicating the most recent date when the HbA1c test was performed and the result or finding. |
| **Diabetes nephropathy screening (HEDIS) in the past 12 months** | **A urine test for albumin or protein.** At a minimum, documentation must include a note indicating the date when a urine test was performed, and the result or finding. Any of the following meet the criteria:  
  - 24-hour urine for albumin or protein.  
  - Timed urine for albumin or protein.  
  - Spot urine for albumin or protein.  
  - Urine for albumin/creatinine ratio.  
  - 24-hour urine for total protein.  
  - Random urine for protein/creatinine ratio.  
  - **Documentation of a visit to a nephrologist.**  
  - **Documentation of a renal transplant.**  
  - **Documentation of medical attention for any of the following (no restriction on provider type):**  
    - Diabetic nephropathy.  
    - ESRD.  
    - CRF.  
    - Chronic kidney disease (CKD).  
    - Renal insufficiency.  
    - Proteinuria.  
    - Albuminuria.  
    - Renal dysfunction.  
    - Acute renal failure (ARF).  
    - Dialysis, hemodialysis or peritoneal.  
  - **Evidence of ACE inhibitor/ARB therapy.** Documentation in the medical record must include, at minimum, a note indicating that the member received an ambulatory prescription for ACE inhibitors/ARBs in the measurement year. |
| **Diabetic Eye Exam** | Dilated or retinal exam by an eye care professional (optometrist or ophthalmologist).  
  - A note or letter prepared by an ophthalmologist, optometrist, PCP or other health care professional indicating that an ophthalmoscopic exam was completed by an eye care professional (optometrist or ophthalmologist), the date when the procedure was performed and the results.  
  - A chart or photograph of retinal abnormalities indicating the date when the fundus photography was performed and evidence that an eye care professional (optometrist or ophthalmologist) |
reviewed the results. Alternatively, results may be read by a qualified reading center that operates under the direction of a medical director who is a retinal specialist.

- Documentation of a negative retinal or dilated exam by an eye care professional (optometrist or ophthalmologist) in the year prior to the measurement year, where results indicate retinopathy was not present (e.g., documentation of normal findings for a dilated or retinal eye exam performed by an eye care professional -optometrist or ophthalmologist- meets criteria).
- Documentation does not specifically have to state "no diabetic retinopathy" to be considered negative for retinopathy; however, it must be clear that the patient had a dilated or retinal eye exam by an eye care professional (optometrist or ophthalmologist) and that retinopathy was not present. Notation limited to a statement that indicates "diabetes without complications" does not meet criteria.

<table>
<thead>
<tr>
<th>Adolescent Immunization: Tdap (HEDIS)</th>
<th>Note or immunization certificate with name of vaccine and date of administration. One Tdap should be given between the member’s 10th and 13th birthdays.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescent Immunization: Meningococcal (HEDIS)</td>
<td>Note or immunization certificate with name of vaccine and date of administration. One meningococcal should be given between the member’s 11th and 13th birthdays.</td>
</tr>
<tr>
<td>HPV Vaccine for Adolescents (HEDIS)</td>
<td>Note or immunization certificate with name of vaccine and date of administration. Three (3) doses should be given between the member’s 9th and 13th birthdays.</td>
</tr>
</tbody>
</table>
| Childhood Immunization Status (HEDIS) | Note or immunization certificate with name of vaccine and date of administration. The member should have the following by their 2nd birthday:  
  - 4 DTaP  
  - 3 IPV  
  - 1 MMR  
  - 3 Hib  
  - 3 Hep B  
  - 1 VZV  
  - 4 PCV  
  - 1 Hep A  
  - 2 Rotarix or 3 Rotateq  
  - 2 influenza |
| Lead screening in children (HEDIS) | Members should have at least one (1) lead test before their 2nd birthday. Documentation in the medical record must include:  
  - Lab report of lead screening test, or  
  - A note indicating the date the test was performed, and the result or finding |
| EPSDT | Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) uses a Periodicity Schedule based on the AAP/Bright Futures |
Standards of Care and state guidelines. Members should have an EPSDT visit at the following ages:

<table>
<thead>
<tr>
<th>Age</th>
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<tbody>
<tr>
<td>Birth to 1 month</td>
</tr>
<tr>
<td>2 months</td>
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<tr>
<td>4 months</td>
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<tr>
<td>6 months</td>
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<tr>
<td>9 months</td>
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<td>12 months</td>
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<tr>
<td>18 months</td>
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<tr>
<td>24 months</td>
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<tr>
<td>30 months</td>
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<tr>
<td>3 years and every year after through age 20</td>
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</tbody>
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**Provider Resources**

**Provider Services**

Provider Services
Monday – Friday
8:00 am – 6:00 pm (EST)
(800) 578-0775

**Member Services**

Member Services
Monday – Friday
7:00 am – 7:00 pm (EST)
(800) 578-0603

**Claims**

(800) 578-0775 option 2

**Care Connectors**

(877) 903-0082

**Passport Provider Website**

[www.passporthealthplan.com/providers](http://www.passporthealthplan.com/providers)

**Where to submit medical record documentation to close care gaps:**

**FAX:** 502-585-8206

Attn: Quality Care Gaps

**MAIL:** Passport Health Plan

Attn: Quality Care Gaps

5100 Commerce Crossings Dr.

Louisville, KY 40229