



State of Georgia
Department of Community Health

2020 External Quality Review
Annual Report

April 2020

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1. Executive Summary

Overview of 2019 External Quality Review

Title XIX of the Social Security Act (SSA), Section 1932(c)(2)(A) requires states that operate Medicaid managed care plans to “provide for an annual external independent review conducted by a qualified independent entity of the quality and timeliness of, and access to, the items and services for which the organization is responsible under the contract.”¹⁻¹ According to the 42nd Code of Federal Regulations (CFR) §438.350, states with capitated Medicaid managed care delivery systems that contract with managed care entities (MCEs) are required to arrange for the provision of an annual external quality review (EQR) for each Medicaid managed care contractor.

The external quality review organization (EQRO) must annually provide an assessment of each MCE’s performance related to the quality and timeliness of, and access to care and services provided by each MCE and produce the results in an annual EQR technical report (42 CFR §438.364). The annual technical report must also describe how data from activities were collected, and in accordance with the CFR, were aggregated and analyzed. To meet this requirement, the Georgia Department of Community Health (DCH) has contracted with Health Services Advisory Group, Inc. (HSAG), to perform an EQR of the Georgia Care Management Organizations (CMOs) and produce this EQR technical report.

The DCH contracted with HSAG to conduct EQR and review activities completed during the period of July 1, 2018, through June 30, 2019. HSAG used the U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services’ (CMS’) December 2018 update of its External Quality Review Toolkit for States when preparing this report.¹⁻²

The DCH is responsible for administering the Medicaid program and the Children’s Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. Both programs include fee-for-service (FFS) and managed care components. The DCH contracts with four privately owned managed care organizations, referred to by the State as CMOs, to deliver services to members who are enrolled in the State’s Medicaid and CHIP programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in

The GF and the GF 360° programs provide Medicaid services to approximately 1.9 million members

¹⁻¹ Social Security Administration. Compilation of the Security Laws: Provisions Related to Managed Care. Available at: https://www.ssa.gov/OP_Home/ssact/title19/1932.htm. Accessed on: Jan 8, 2020.

¹⁻² The Centers for Medicare & Medicaid Services. CMS External Quality Review (EQR) Protocols, December 2018. Available at: <https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing-Items/CMS-R-305.html>. Accessed on: June 27, 2019.

the Georgia Families[®] 360[°] (GF 360[°]) managed care program. This program serves all other Medicaid and CHIP managed care members not enrolled in the GF 360[°] program. Approximately 1.985 million members are enrolled in the GF program, approximately 141,000 children are enrolled in the PeachCare for Kids[®] program, and approximately 29,327 members are enrolled in the GF 360[°] program.¹⁻³ The DCH provides Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH is dedicated to a healthy Georgia. The goal of the GF care management program is to maintain a successful partnership with care management organizations to provide care to members while focusing on continual quality improvement (QI). The Georgia-enrolled member population encompasses Low-Income Medicaid (LIM), Transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees, women with breast or cervical cancer, women participating in the Planning for Healthy Babies[®] (P4HB[®]) program, as well as the CHIP population.

The DCH contracted with the following CMOs to provide services to the GF population for the 2018–2019 contract year, which covers the time span of July 1, 2018, through June 30, 2019: Amerigroup Community Care (Amerigroup), CareSource, Peach State Health Plan (Peach State), and WellCare of Georgia, Inc. (WellCare). Amerigroup also has a contract with DCH to provide services to the GF 360[°] population, and in these instances, Amerigroup is referred to as Amerigroup 360[°]. For ease of reporting information relevant to both the GF and GF 360[°] populations, HSAG uses the term “CMOs” in the remainder of this report to refer to Amerigroup, CareSource, Peach State, WellCare, and Amerigroup 360[°] results collectively.

Care Management Organizations

The DCH held contracts with five CMOs during the review period for this annual report. Each CMO provides for the delivery of healthcare services to enrolled GF members. Table 1-1 provides a brief description of each CMO.

Table 1-1—Care Management Organization Profiles

CMO	Year Operations Began in Georgia as a Medicaid CMO	Profile Description	CMO National Committee for Quality Assurance (NCQA) Accreditation Status
Amerigroup	2006	Amerigroup Community Care is a subsidiary of Amerigroup Corporation. Amerigroup is a wholly owned subsidiary of Anthem, Inc., founded in 2004 with the merger of Anthem and WellPoint Health Networks. Product lines include Medicaid, Medicare commercial, federal employees, and specialty services.	Commendable* 11/14/2019

¹⁻³ Georgia Department of Community Health. Medicaid Management Information System.

CMO	Year Operations Began in Georgia as a Medicaid CMO	Profile Description	CMO National Committee for Quality Assurance (NCQA) Accreditation Status
Amerigroup 360°	2014	Amerigroup 360° is a subsidiary of Amerigroup Corporation. Amerigroup is a wholly owned subsidiary of Anthem, Inc., founded in 2004 with the merger of Anthem and WellPoint Health Networks. Product lines include Medicaid, Medicare commercial, federal employees, and specialty services.	Not accredited separately from Amerigroup.
CareSource	2017	CareSource was founded in 1989 and is a nonprofit model of managed care. CareSource product lines include Medicaid, Marketplace and Medicare Advantage programs.	Accredited** 3/1/2022
Peach State	2006	Peach State Health Plan is a subsidiary of the Centene Corporation. Centene was founded in 1984. Product lines include Medicaid, Medicare, and the Exchange plans in some states.	Commendable 6/5/2020
WellCare	2006	WellCare of Georgia is a subsidiary of WellCare Health Plans, Inc. WellCare was founded in 1985. Product lines include Medicaid, Medicare Advantage, Medicare Prescription Drug Plans, State Children's Health Insurance Programs, and others.	Commendable 8/1/2020

* Commendable: The National Committee for Quality Assurance has awarded an accreditation status of Commendable for service and clinical quality that meet NCQA's rigorous requirements for consumer protection and quality improvement.

** Accredited: The National Committee for Quality Assurance has awarded an accreditation status of Accredited for service and clinical quality that meet the basic requirements of NCQA's rigorous standards for consumer protection and quality improvement.¹⁻⁴

Mandatory Activities

As mandated by CFR §438.364 and in compliance with CMS' EQR Protocols and the External Quality Review Toolkit for States, this technical report:

- Describes how data from mandatory and optional EQR activities were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.

¹⁻⁴ The National Committee for Quality Assurance. Advertising and Marketing Guidelines: Health Plan Accreditation. Available at: https://www.ncqa.org/wp-content/uploads/2018/08/20180804_HPA_Advertising_and_Marketing_Guidelines.pdf. Accessed on: March 10, 2020.

- Assesses each CMO's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the CMOs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the CMOs, including recommendations for each individual CMO and recommendations for DCH to target the Georgia Quality Strategic Plan to improve the quality of care provided by the DCH managed care program overall.
- Contains methodological and comparative information for all CMOs.
- Assesses the degree to which each CMO has addressed the recommendations for QI made by the EQRO during the 2018 EQR.

How Conclusions Were Drawn From EQRO Activities

To draw conclusions about the quality of, timeliness of, and access to care provided by the CMOs, HSAG assigned each of the activities reviewed by the EQR to one or more of three domains. Assignment to these domains is depicted in Table 1-2.

Table 1-2—EQR Activities and Domains

Activity	Quality	Access	Timeliness
Healthcare Effectiveness Data and Information Set (HEDIS) Compliance Audit ^{TM,1-5}	✓	✓	
Performance Measure Validation (PMV)	✓	✓	✓
Aggregate Report	✓	✓	
Weighted Average Spreadsheet	✓	✓	
Performance Improvement Project (PIP) Validation	✓	✓	✓
Compliance Reviews	✓	✓	✓
Consumer Assessment of Healthcare Providers and Systems (CAHPS [®]) ¹⁻⁶	✓	✓	✓

¹⁻⁵ HEDIS Compliance AuditTM is a trademark of the NCQA.

¹⁻⁶ CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Aggregating and Analyzing Statewide Data

For each CMO, HSAG analyzed the results obtained from each EQR mandatory activity as well as those obtained from optional activities. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall quality of, access to, and timeliness of care and services to be drawn for each CMO independently and the overall statewide GF program. For a detailed, comprehensive discussion of the strengths, weaknesses, conclusions, and recommendations for each CMO, please refer to the results of each activity in Section 4 of this report.

Definitions

HSAG used the following definitions to evaluate and draw conclusions about CMO performance in each of the domains of quality of, access to, and timeliness of care and services.

Quality

CMS defines “quality” in the final rule at 42 CFR §438.320 as follows:

Quality, as it pertains to external quality review, means the degree to which an MCO or prepaid inpatient health plan (PIHP) increases the likelihood of desired health outcomes of its enrollees through its structural and operations characteristics, through the provision of services consistent with current professional evidence-based knowledge, and through interventions for performance improvement.¹⁻⁷

Access

CMS defines “access” in the final 2016 regulations at 42 CFR §438.320 as follows:

Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcomes information for the availability and timeliness elements defined under §438.68 (network adequacy standards) and §438.206 (availability of services).¹⁻⁸

¹⁻⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Volume 81, May 6, 2016.

¹⁻⁸ Ibid.

Timeliness

NCQA defines “timeliness” relative to utilization decisions as follows: “The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation.”¹⁻⁹ NCQA further states that the intent of this standard is to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require timely response by the MCO or MCO—e.g., processing appeals and providing timely care. In the final 2016 Federal Managed Care Regulations, CMS recognized the importance of timeliness of services by incorporating timeliness into the general rule at 42 CFR §438.206 (a) and by, at 42 CFR §438.68 (b), requiring states to develop both time and distance standards for network adequacy.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from contract year (CY) 2019 to assess the performance of Medicaid CMOs in providing quality, timely, and accessible healthcare services to Georgia Medicaid members. For each activity, HSAG provides the following summary of its overall key findings and conclusions based on each CMO’s performance. For CMO-specific findings, strengths, and recommendations for improvement for the activities conducted, refer to sections 5 through 9 of this report.

Compliance Monitoring

HSAG aggregated and analyzed results from the compliance monitoring reviews for the CMOs by organizing the State and federal Medicaid managed care requirements into the 15 performance areas referred to as standards. The DCH determined that a comprehensive compliance review would be conducted once in each three-year EQR cycle. HSAG completed the Compliance With Standards review during CY 2019. The overall scores are presented in Table 1-3 below.

Table 1-3—Summary of CMO Overall Compliance With Standards Scores

Compliance Monitoring Activity	Amerigroup	CareSource	Peach State	WellCare	Amerigroup 360°
Overall Compliance With Standards Score	93.75%	89.58%	95.31%	92.71%	94.79%

The CMOs’ overall scores ranged from a low of 89.58 percent to a high of 95.31 percent. The compliance scores demonstrate the CMOs’ strong application of federal and State access and availability of services and quality assessment and performance improvement program requirements.

¹⁻⁹ National Committee for Quality Assurance. *2013 Standards and Guidelines for MBHOs and MCOs*.

The DCH required that the CMOs report HEDIS measures to DCH for the GF and GF 360° populations. CMOs were required to contract with an NCQA-licensed audit organization and undergo an NCQA HEDIS Compliance Audit. Final audited HEDIS measure results from NCQA's Interactive Data Submission System (IDSS) were submitted to HSAG and provided to DCH.

The CMOs' HEDIS auditors found that the CMOs were fully compliant with all information system (IS) standards and determined that the CMOs submitted valid and reportable rates for all measures in the scope of the HEDIS audit.

HSAG validated the performance measures identified by DCH to evaluate their accuracy as reported by, or on behalf of, the CMOs. The DCH annually selects a set of performance measures to evaluate the quality of care and services delivered by its contracted CMOs to GF and GF 360° members. PMV determines the extent to which the CMOs followed specifications established by DCH for its performance measures when calculating the performance measure rates.

HEDIS Compliance Audits were conducted following the NCQA's HEDIS Compliance Audit timeline, from January 2019 through July 2019. The final PMV results generally reflected the measurement period of January 1, 2018, through December 31, 2018.

The CMOs submitted HEDIS IDSS files for HEDIS 2019. To assess CMO performance, HSAG compared the performance measure results to the NCQA's Quality Compass¹⁻¹⁰ national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018. The measures were grouped into the following three domains of care: Quality of Care, Stewardship, and Access to Care.

Table 1-4 shows the GF average performance on the HEDIS 2019 measure results that were comparable to national percentiles. The GF Average rates represent the average of four CMOs' (Amerigroup, CareSource, Peach State, and WellCare) measure rates weighted by the eligible population. Please refer to Section 4 for more information on performance measure results for the GF program.

Table 1-4—Summary of Scores for Reporting Year (RY) 2019 Measures With Percentile Comparisons for Georgia Families

Domain	Measures	At or Above the 50th Percentile	Percentage at or Above the 50th Percentile
Quality of Care	8	6	75.00%
Stewardship	3	3	100%
Access to Care	15	11	73.33%
All Domains	26	20	76.92%

Overall, the GF Average for HEDIS 2019 demonstrated strength, as 20 of 26 (76.9 percent) measure rates exceeded the 50th percentile. Of note, all three measure rates within the Stewardship domain exceeded the 50th percentile.

¹⁻¹⁰ Quality Compass® is a registered trademark of the NCQA.

Validation of Performance Measures—HEDIS Compliance Audits

For the GF and GF 360° populations, HSAG validated the CMOs' performance measure rates that DCH selected for validation, which originated from CMS' Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set),¹⁻¹¹ Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set),¹⁻¹² the NCQA's HEDIS, and the AHRQ's Quality Indicator measures. The measurement period was calendar year 2018 for all measures. Appendix A—Technical Methods of Data Collection and Analysis, includes the methodology used for validating the CMOs' performance measures.

Georgia Families Findings

Based on HSAG's validation of performance measures, HSAG did not identify concerns with the CMOs' data processing, integration, and measure production. HSAG determined that the CMOs followed the State's specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Georgia Families 360° Findings

Based on HSAG's validation of performance measures, HSAG had no concerns with Amerigroup 360°'s data processing, integration, and measure production. HSAG determined that Amerigroup 360° followed the State's specifications and produced reportable rates for all measures.

Validation of Performance Improvement Projects

In calendar year 2019, the CMOs continued using the rapid-cycle PIP approach. The CMOs selected one clinical and one nonclinical PIP topic which were approved by DCH. CareSource, Peach State, and Amerigroup 360° selected topics focused on improving mental healthcare for their members, including follow-up care after inpatient mental health hospitalization and antidepressant medication compliance. Amerigroup selected a clinical PIP topic to improve chronic disease management (diabetic eye exams), and WellCare selected a clinical PIP to improve prenatal care. The nonclinical PIP topics varied across CMOs with topics focused on improving provider and member satisfaction, and internal processes and systems to improve member services.

HSAG validated the CMOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and member

¹⁻¹¹ The Centers for Medicare & Medicaid Services. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, June 2016.

¹⁻¹² The Centers for Medicare & Medicaid Services. Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, June 2016.

satisfaction. HSAG reviews each PIP using CMS' *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012¹⁻¹³ to ensure that the CMOs design, conduct, and report PIPs in a methodologically sound manner and meet all State and federal requirements. HSAG's rapid-cycle PIP process places emphasis on applying QI science to the PIP process and using rapid-cycle evaluation through Plan-Do-Study-Act (PDSA) cycles to determine which interventions have the greatest impact and potential to bring about real improvement. Appendix A—Technical Methods of Data Collection and Analysis—CMOs, includes the methodology used for validating the CMOs' rapid-cycle PIPs.

SMART [Specific, Measurable, Attainable, Relevant, and Time-bound] Aim outcomes were not available at the time of this report. In calendar year 2019, the CMOs completed their PIPs through Module 3 (Intervention Determination) and submitted intervention plans (the "Plan" for each PDSA cycle) for each PIP topic. HSAG reviewed the intervention plans and provided written feedback and technical assistance to the CMOs. The CMOs tested interventions through the SMART Aim end date of October 31, 2019, and will submit Module 4 (Intervention Testing) and Module 5 (PIP Conclusions) in January 2020 for validation. The results for the annual validation of Module 4 and Module 5, as well as the SMART Aim outcomes for each PIP topic, will be included in the next annual EQR technical report.

Member Experience of Care Surveys—CAHPS

The CAHPS survey is nationally recognized as an industry standard for both commercial and public payers. Samples and data collection procedures promote standardized administration of survey instruments and comparability of results. The CAHPS survey asks enrollees to report on and evaluate their experiences with healthcare, covering topics important to members, such as accessibility and quality of services. The majority of CMOs experienced low response rates for the CAHPS adult and child populations compared to the national response rates reported by NCQA for 2018.

Similar to last year's results, the CMOs' rates for the majority of smoking measures (*Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*) were significantly (i.e., at least 5 percentage points) lower than the 2018 NCQA national averages. Overall, member experience scores for the CMOs' adult and child populations have fluctuated, either increasing or decreasing slightly, across years with few significant differences. Also, the scores for the CMOs' adult populations were not statistically significantly better or worse than the State average for all measures, and the CMOs' child population's scores were only statistically significantly different than the State average for one measure, *Rating of Health Plan*.

¹⁻¹³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf>. Accessed on: Sept. 4, 2019.

Weighted Average Spreadsheet and Aggregate Report

The DCH contracted with HSAG to calculate statewide weighted average rates based on the CMOs' performance measure rates (i.e., both HEDIS and non-HEDIS performance measures) and evaluate each CMO's current performance level, as well as the statewide performance, relative to national percentiles, where applicable. HSAG aggregated the results and produced a weighted averages spreadsheet and aggregate report for DCH as tools to review the quality of care provided to Medicaid managed care members across all domains of care with a focus on DCH's established pillars.

Summary of the DCH Quality and Timeliness of, and Access to Care Initiatives

The DCH's 2019 Annual Report describes key accomplishments achieved during fiscal year (FY) 2019. The following are examples of DCH initiatives that reflect the quality and timeliness of, and access to care for the Georgia Families, Georgia Families 360° and PeachCare for Kids® programs.¹⁻¹⁴

Patients First Act

On March 27, 2019, Governor Brian P. Kemp signed The Patients First Act into law. In December 2019, DCH submitted a waiver request aimed at developing a plan to restructure Georgia's Medicaid program to include partial Medicaid expansion. If approved, the 1115 Medicaid Expansion Waiver would allow approximately 200,000 single, low-income adults to qualify for Medicaid.

Medical Assistance Plans Organizing for Success Initiative

In FY 2019, the DCH Medical Assistance Plans (MAP) Division undertook the Organizing for Success initiative to build on its purpose to advance the health, wellness, and independence of those DCH serves by providing access to quality care and resources statewide. The DCH undertook this initiative in order to enhance MAP's long-term strategy and performance tracking; further the focus on professional development, training, and onboarding programs; and roll out new information technology (IT) systems and processes with a focus on integration and collaboration tools for employees.

Other Program Updates

Electronic Visit Verification (EVV): In accordance with the 21st Century Cures Act, DCH collaborated with member advocacy groups, provider associations, and stakeholders to ensure that a

¹⁻¹⁴ The Georgia Department of Community Health. 2019 Annual Report. Available at: <https://dch.georgia.gov/document/document/2019annualreportpdf/download>. Accessed on: Jan 27, 2020.

wide range of input and concerns was received and addressed prior to implementing an EVV system. The DCH continued conducting public forums throughout the Georgia during FY 2019. EVV technology will reduce gaps in long-term services and supports and also support DCH's goal to reduce and eliminate fraud, waste, and abuse in home care service delivery.

Implementation of the Home and Community-Based (HCBS) Settings Rule: CMS issued regulations in FY 2014 defining the characteristics and qualities of HCBS settings where services can be delivered, which included requirements for services to be provided in the most integrated setting and in the most community-inclusive manner. The DCH developed a Statewide Transition Plan (STP) that describes how the State would assure compliance with the HCBS Settings Final Rule by 2022. Based on CMS guidance, DCH is conducting inquiries of all HCBS providers and providing them with technical assistance to assist them in being compliant with the Rule.

Health Information Technology (Health IT or HIT): The Office of Information Technology continued its mission to advance the use of health information technology throughout Georgia to reduce healthcare disparities, improve health outcomes, increase the efficiency of healthcare delivery, and reduce overall healthcare costs.

Georgia Health Information Network (GaHIN): DCH continued its support of the GaHIN, which is Georgia's statewide health information exchange and the State-Designated Entity.

National Testing Experience and Functional Tools (TEFT): Health IT successfully completed five years of the TEFT grant. The TEFT grant tested the value of return from a survey, an electronic functional assessment tool, a personal health record mobile application, and a published Health Level 7 informative document for data exchange.

Rural Health Stabilization: The DCH State Office of Rural Health continued to focus on rural hospital stabilization; establishing and promoting the use of primary and specialty telemedicine; mental health and behavioral health services; care coordination; reduction in nonurgent and emergent use of hospital emergency department and emergency medical services (EMS); and identifying creative ways to ensure healthcare accessibility in Georgia's underserved and rural communities. At the close of FY 2019, 22 small rural and critical access hospitals (CAHs) had completed four phases of the stabilization program.

Summary of the Quality and Timeliness of, and Access to Care Furnished by CMOs

The following section provides a high-level overview of examples of the CMOs' performance related to the quality and timeliness of, and access to care furnished to members. The information is intended to be representative and should not be considered an all-inclusive list.

Quality

The CMOs demonstrated quality of care with all five CMOs receiving full compliance with Standard III—Coordination and Continuity of Care in the Compliance With Standards reviews.

The CMOs' total Compliance With Standards scores ranged from a low of 89.58 percent to a high of 95.31 percent, demonstrating quality and timeliness of, and access to care and services.

Two CMOs demonstrated quality of service with the highest performance among the CMOs, exceeding the 50th percentile for 20 of 26 (76.9 percent) and 19 of 25 (76.0 percent) performance measure rates, respectively.

In 2019, one CMO demonstrated the provision of quality of care and services with the child CAHPS survey scoring statistically significantly better than the Georgia CMO program average in *Rating of Health Plan*.

Overall, the CMOs and the GF performance measure average demonstrated quality of care for HEDIS 2019, with the GF average rate exceeding the 50th percentile for 20 of 26 (76.9 percent) performance measure rates that were comparable to benchmarks.

Access

The CMOs demonstrated access to care and services in the Compliance With Standards review with all five achieving full compliance for Standard II—Assurances of Adequate Capacity and Services and Standard III—Coordination and Continuity of Care.

Overall, the CMOs and the GF performance measure average rates demonstrated access to care for HEDIS 2019, with the GF Average exceeding the 50th percentile for 20 of 26 (76.9 percent) measure rates that were comparable to benchmarks.

Timeliness

The HEDIS 2019 performance measures *Well-Child Visits in the First 15 Months of Life* and *Percentage of Eligibles Who Received Preventive Dental Services* were determined to indicate high performance for the GF program (i.e., more than half of the reportable CMO measure rates and the GF Average exceeded the 50th percentile), demonstrating timeliness of care and services.

The CMOs generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, taking into account the urgency of the member's need for services. Overall, the CMOs' Compliance With Standards review results documented that the CMOs had policies, procedures, and programs which described their coverage and authorization of service activities and supported timely access to care and services.

Quality Strategy Recommendations for DCH

To comply with federal regulations, DCH developed and submitted its GF Quality Strategic Plan (plan) for CMS' review and approval, receiving CMS approval on the initial plan in 2008. Updates to the plan were completed in January 2010 and again in November 2011.¹⁻¹⁵

During 2015, in collaboration with numerous stakeholders, DCH prepared a new Quality Strategic Plan to coincide with the reprocurement of the GF and GF 360° managed care contracts. The 2016 Quality Strategic Plan¹⁻¹⁶ is consistent with CMS' guidance in the 2013 Quality Strategy Toolkit for States¹⁻¹⁷ and aligns with the Department of Health and Human Services National Quality Strategy Aims for better care, affordable care, and healthy people/healthy communities.¹⁻¹⁸

In 2016, DCH implemented the third edition of its comprehensive Medicaid quality strategic plan in accordance with 42 CFR §438.340. The DCH's goals are to improve the health status of Georgians by promoting healthy lifestyles, preventive care, disease management and disparity elimination; improve access to quality healthcare at an affordable price; ensure value in health care contracts; move health plans administered by DCH toward being financially solvent to meet the needs of the members; increase effectiveness and efficiency in the delivery of health care programs; and ensure DCH has enough workers with the necessary skills and competencies to meet the current and future demand.

The DCH goals for the GF 360° program are to enhance the coordination of care and access to services; improve health outcomes; develop and utilize meaningful and complete electronic medical records; and comply fully with regulatory reporting requirements. The DCH's Quality Strategic Plan promotes the identification of creative initiatives to continually monitor, assess, and improve access to care along with supporting the provision of quality, satisfaction, and timeliness of services for Georgia Medicaid and CHIP members.

Quality Strategic Plan Focus and Priorities

DCH's Quality Strategic Plan combined five of the DCH key goals into two focus areas:

- Improving the health status of Georgians
- Smarter spending of each Medicaid dollar

¹⁻¹⁵ Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: <https://dch.georgia.gov/medicaid-quality-reporting-archive>. Accessed on: Jan 24, 2019.

¹⁻¹⁶ Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: <https://dch.georgia.gov/medicaid-quality-reporting>. Accessed on: Jan 8, 2020.

¹⁻¹⁷ Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf>. Accessed on: Jan 24, 2019.

¹⁻¹⁸ Department of Health and Human Services, Agency for Healthcare Research and Quality. About the National Quality Strategy (NQS). Available at: <https://www.ahrq.gov/workingforquality/about.htm>. Accessed on: Jan 24, 2019.

The DCH 2016 Quality Strategic Plan prioritizes measures for continuous improvement, and the measures were selected based on the needs of the populations served and the favorable health outcomes that result when there is adherence to relevant clinical guidelines. The DCH also takes into consideration the availability and reliability of the data used in evaluating performance.

Strengths

Compliance With Standards

The CMOs' Compliance With Standards review total scores ranged from a low of 89.58 percent to a high of 95.31 percent, demonstrating strength in meeting federal and State Medicaid requirements.

The CMOs demonstrated a strength in addressing the social determinants of health (SDoH) by incorporating SDoH factors into outreach efforts such as using community health workers to reach members in the communities where they resided; addressing members' psychosocial needs; ensuring transportation to and from care appointments; completing follow-up on appointment calls; and ensuring members had access to available food sources in local communities that included fresh food sources and choices.

One CMO expanded assistance with SDoH beyond the member to include the member's family and others living in the member's home, even those individuals who were not GF members.

The CMOs demonstrated culturally competent service delivery through the addition of gender identity and sexual orientation questions during member intake and orientation processes. The gender identity and sexual orientation information was used by the care management and medical management teams to ensure culturally competent service delivery.

The CMOs strengthened access to care through implementation of initiatives such as using Zoom technology to ensure telehealth services were available anywhere, expanding telemedicine sites to include school-based clinics, and installing telehealth equipment in hospitals and local provider offices.

One CMO implemented a Life Services program that assisted members in identifying life goals, developing action plans; providing employment, education, and health coaching; offering assistance in GED preparation and testing; providing coaching on hiring and employment; and making afterschool resources and child care available.

To ensure members had resources to meet their needs, a CMO collaborated with judges who had insight into the foster program to develop a "bench book" that contained information on resources available for foster children.

Performance Measure Validation

The CMOs' results for more than half of the reportable CMO performance measure rates and for the GF Average exceeded the 50th percentile. The following HEDIS 2019 measures were determined to be indicators of high performance, demonstrating strength for the GF program:

- *Asthma Medication Ratio—5–11 Years, 12–18 Years, and 19–50 Years*
- *Heart Failure Admission Rate*
- *Ambulatory Care—Emergency Department Visits—Total*
- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*
- *Adolescent Well-Care Visits*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women—16–20 Years and 21–24 Years*
- *Cervical Cancer Screening*
- *Developmental Screening in the First Three Years of Life—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Percentage of Eligibles Who Received Preventive Dental Services*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*

For HEDIS 2019, the GF performance measure rate average exceeded the 50th percentile for 20 of 26 (76.9 percent) performance measure rates that were comparable to benchmarks, demonstrating CMO strength in the provision of quality care and ensuring access to care and services.

Two CMOs demonstrated high performance, exceeding the 50th percentile for 20 of 26 (76.9 percent) and 19 of 25 (76.0 percent) performance measure rates.

Recommendations for Opportunities for Improvement

HSAG recommends that DCH prioritize continuous improvement activities for the GF populations by focusing on the following areas:

- The CMOs' lowest-scoring standards in the Compliance With Standards reviews were Standard VI—Subcontractual Relationships and Delegation (80.00 percent) and Standard X—Grievance and Appeal Systems (86.67 percent). HSAG recommends that the CMOs focus QI efforts in areas that did not receive a score of *Met* during the Compliance With Standards reviews, including ensuring all requirements are included in subcontractor and vendor agreements and meeting the grievance notification and resolution timelines and the notice of adverse benefit determination (NABD) timelines.

- The following HEDIS 2019 measures were determined to indicate low performance for the GF program (i.e., the rates for one or fewer reportable CMO measures exceeded the 50th percentile and the GF average fell below the 50th percentile). HSAG recommends that the CMOs develop and implement interventions and activities aimed at improving rates for the following performance measures.
 - *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
 - *Percentage of Live Births Weighing Less than 2,500 Grams*
 - *Colorectal Cancer Screening*
 - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
 - *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*
- HSAG recommends that the CMOs also focus QI efforts on the performance measure scores that exhibited a substantial decrease from HEDIS 2018 to HEDIS 2019 and were at least 5 percentage points less than the NCQA adult or child Medicaid national 50th percentile.
- For the Child Medicaid Plan CAHPS Survey, the *Rating of Health Plan* measure score for one CMO exhibited a statistically significant decrease compared to the Georgia CMO program average. HSAG recommends that the CMO identify reasons for the low score and develop and implement interventions focused on improving the member's experience with the CMO to improve the *Rating of Health Plan* score.

Overall

HSAG recommends that CMO leadership be actively involved and demonstrate commitment to QI throughout the organization. HSAG recommends that the CMOs regularly review their data to identify opportunities for improvement early and implement interventions, using the small tests of change process used for PIPs. HSAG also recommends that CMOs include the members' perspectives whenever possible to gain a clear understanding of members' perceptions with care and service delivery and the challenges members encounter in receiving the CMOs' healthcare services. HSAG recommends that the CMOs use the information collected to develop and implement QI initiatives focused on quality of, access to, and timeliness of care and services.

2. Introduction to the Annual Technical Report

Purpose of Report

As required by CFR 42 §438.364,²⁻¹ DCH contracts with HSAG, an EQRO, to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access to, and timeliness and quality of care, including:

A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]).

For each EQR-related activity conducted in accordance with §438.358, the technical report includes:

- Objectives.
- Technical methods of data collection and analysis.
- Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii).
- Conclusions drawn from the data.
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.

²⁻¹ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431, 433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf>. Accessed on: Apr 11, 2019.

Methodology for Aggregating and Analyzing EQR Activity Results

For the 2019 EQR Technical Report, HSAG used findings from the EQR activities conducted from January 1, 2019, through December 31, 2019, to derive conclusions and make recommendations about the quality of, access to, and timeliness of care and services provided to the GF and GF 360° managed Medicaid members. From these analyses, HSAG determined which results were applicable to the domains of quality of, access to, and timeliness of care and services. To identify strengths and weaknesses and draw conclusions for each CMO, HSAG analyzed and evaluated all components of each EQR activity and resulting findings across the continuum of program areas and activities that comprise the GF program. The composite findings for each CMO were analyzed to identify overarching trends and focus areas for the CMOs.

Scope of External Quality Review (EQR) Activities

At the request of DCH, HSAG performed a set of mandatory and optional EQR activities, as described in 42 CFR §438.358. These activities are briefly described below. Refer to Appendix A—Technical Methods of Data Collection and Analysis for a detailed description of each activity’s methodology.

Mandatory Activities

Compliance Monitoring—HSAG conducts compliance monitoring activities at least once during each three-year EQR cycle. During 2019, HSAG conducted a comprehensive compliance review of each CMO for the GF and the GF 360° programs.

Validation of Performance Measures—The purpose of PMV is to assess the accuracy of performance measures reported by the CMOs and to determine the extent to which performance measures reported by the CMOs follow State specifications and reporting requirements.

The DCH contracted with HSAG to conduct the PMV activity for each CMO, validating the data collection and reporting processes used to calculate the performance measure rates. The DCH identified a set of performance measures that the CMOs are required to calculate and report. Measures are required to be reported following the specifications provided by DCH. The DCH identified the measurement period as January 1, 2018–December 31, 2018.

Validation of Performance Improvement Projects—The CMOs are required to conduct PIPs that have the potential to affect member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each CMO’s PIP Summary Forms. These forms provide detailed information about the PIPs related to the steps completed and validated by HSAG for the 2019 validation cycle. The results from the CY 2019 PIP validation are presented in this report.

Network Adequacy—With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and certification of CMO, PIHP, and

PAHP networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long-term services and supports programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); obstetricians/gynecologists; behavioral health; specialists (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. The DCH has implemented network standards in its contracts with the CMOs.

Optional Activities

CAHPS Survey—DSS Research administered the 2019 CAHPS surveys for Amerigroup and Amerigroup 360°. Morpace administered the 2019 CAHPS survey for Peach State, and SPH Analytics administered the 2019 CAHPS surveys for CareSource and WellCare. All three vendors were NCQA-certified vendors at the time of survey administration. Two populations were surveyed for Amerigroup, CareSource, Peach State, and WellCare: adult Medicaid and child Medicaid. One population was surveyed for Amerigroup 360°: children in State custody, children receiving adoption assistance, and certain children in the juvenile justice system.

Weighted Averages Spreadsheet and Aggregate Report—The DCH contracted with HSAG to calculate statewide weighted average rates based on the CMOs' rates (i.e., both HEDIS and non-HEDIS performance measures) and evaluate each CMO's current performance level, as well as the statewide performance, relative to national percentiles, where applicable. HSAG aggregated the results and produced a weighted averages spreadsheet and aggregate report for DCH as tools to review the quality of care provided to Medicaid managed care members across all domains of care with a focus on DCH's established pillars.

Organizational Structure of Report

Section 1—Executive Summary

This section of the report presents a summary of the EQR activities. The section also includes high-level findings and conclusions regarding the performance of each CMO.

Section 2—Introduction to the Annual Technical Report

This section of the report presents the scope of the EQR activities and provides a brief description of each section's content.

Section 3—Overview of Georgia’s Managed Care Program

This section of the report presents a brief description of the State’s managed care program, services, regions, and populations. This section also presents a brief description of the State’s quality initiatives.

Section 4—CMO Comparative Information

This section presents methodologically appropriate, comparative information about all CMOs by activity and consistent with the guidance provided in the CMS Protocols. This section includes recommendations for improvement to the quality of healthcare services furnished by the CMOs, including how the State can target goals and objectives in the Quality Strategic Plan to better support improvement in the quality of, timeliness of, and access to healthcare services furnished to members.

Section 5—CMO-Specific Summary—Amerigroup Community Care

This section presents Amerigroup-specific results and conclusions based on the data analysis for each of the mandatory and optional EQR activities. It includes an overall summary of Amerigroup’s strengths and recommendations for improvement, including the quality and timeliness of, and access to healthcare services furnished to members. Also included is an assessment of how effectively Amerigroup has addressed the recommendations for QI made by HSAG during the previous year.

Section 6—CMO-Specific Summary—CareSource

This section presents CareSource-specific results and conclusions based on the data analysis for each of the mandatory and optional EQR activities. It includes an overall summary of CareSource’s strengths and recommendations for improvement, including the quality and timeliness of, and access to healthcare services furnished to members. Also included is an assessment of how effectively CareSource has addressed the recommendations for QI made by HSAG during the previous year.

Section 7—CMO-Specific Summary—Peach State Health Plan

This section presents Peach State-specific results and conclusions based on the data analysis for each of the mandatory and optional EQR activities. It includes an overall summary of Peach State’s strengths and recommendations for improvement, including the quality and timeliness of, and access to healthcare services furnished to members. Also included is an assessment of how effectively Peach State has addressed the recommendations for QI made by HSAG during the previous year.

Section 8—CMO-Specific Summary—WellCare of Georgia, Inc.

This section presents WellCare-specific results and conclusions based on the data analysis for each of the mandatory and optional EQR activities. It includes an overall summary of WellCare’s strengths and recommendations for improvement, including the quality and timeliness of, and access to healthcare services furnished to members. Also included is an assessment of how effectively WellCare has addressed the recommendations for QI made by HSAG during the previous year.

Section 9—CMO-Specific Summary—Amerigroup Community Care for Georgia Families 360°

This section presents Amerigroup 360°-specific results and conclusions based on the data analysis for each of the mandatory and optional EQR activities. It includes an overall summary of Amerigroup 360°’s strengths and recommendations for improvement, including the quality and timeliness of, and access to healthcare services furnished to members. Also included is an assessment of how effectively Amerigroup 360° has addressed the recommendations for QI made by HSAG during the previous year.

Appendix A—Technical Methods of Data Collection and Analysis

This section of the report presents the objective(s), technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity including:

- Compliance With Standards Reviews Methodology.
- PMV Methodology.
- PIP Validation Methodology.
- CAHPS Survey Methodology.

3. Overview of Georgia's Managed Care Program

Medicaid Managed Care in the State of Georgia

Introduction

Medicaid and CHIP provide comprehensive health coverage to approximately 71 million Americans³⁻¹ including eligible low-income adults, children, pregnant women, elderly adults, and people with disabilities. Medicaid is administered by states according to federal requirements. The program is funded jointly by states and the federal government. CMS approves Section 1115 demonstrations and waiver authorities in Section 1915 of the Social Security Act as vehicles that states can use to test new or existing ways to deliver and pay for healthcare services in Medicaid and CHIP.

The Georgia Department of Community Health

The DCH is responsible for administering the Medicaid program and CHIP in the State of Georgia. The State refers to its standalone CHIP as PeachCare for Kids[®]. Both programs include FFS and managed care components. The DCH contracts with four privately owned managed care organizations, referred to by the State as CMOs, to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the GF 360° managed care program. The GF program serves all other Medicaid and CHIP managed care members not enrolled in the GF 360° program. On average, approximately 1.985 million members are enrolled in the GF program, approximately 141,000 children are enrolled in the PeachCare for Kids[®] program, and approximately 29,327 members are enrolled in the GF 360° program.³⁻²

As the largest DCH division, the Medical Assistance Plans Division administers the Medicaid program and CHIP. The Medicaid program provides healthcare for low-income families; refugees; pregnant women; children; women under 65 who have breast or cervical cancer; and those who are aging, blind, and disabled.

The DCH has administered an FFS model since the inception of Medicaid. The FFS model delivers services to Medicaid and some PeachCare for Kids[®] members through a statewide provider network. In addition to the FFS model, the State of Georgia introduced the GF managed care program in 2006 and contracts with

³⁻¹ Medicaid.gov. September 2019 Medicaid & CHIP Enrollment. Available at: <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>. Accessed on: Jan 9, 2020.

³⁻² Georgia Department of Community Health. Medicaid Management Information System.

private CMOs to deliver services to enrolled members. One of the contracted CMOs also provides care and services to the Amerigroup 360° program members.

Georgia Quality Strategy

The United States (U.S.) Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations, 42 CFR §438.340, require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of healthcare services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted MCOs and PIHPs must meet.

This section outlines the goals and objectives of the DCH 2016 quality strategy as well as the annual evaluation of the strategy for contract year 2019. The State conducts periodic reviews to examine the scope and content of its quality strategy, evaluates the strategy's effectiveness, and updates it as needed. The DCH quality strategy is consistent with CMS' guidance in the 2013 Quality Strategy Toolkit for States³⁻³ and aligns with the HHS National Quality Strategy Aims for better care, affordable care, and healthy people/healthy communities.

The DCH considers its quality strategy, referred to as the Quality Strategic Plan, to be its roadmap for the future. The DCH developed its Medicaid comprehensive Quality Strategic Plan to continually improve the delivery of quality healthcare to all Medicaid and CHIP recipients served by the Georgia Medicaid managed care and FFS programs. The DCH's Quality Strategic Plan provides the framework to accomplish its goals and objectives for the Georgia Medicaid and CHIP programs. The Quality Strategic Plan promotes the identification of creative initiatives to continually monitor, assess, and improve access to care, the quality of care and services, member satisfaction, and the timeliness of service delivery for Georgia Medicaid and CHIP members.

The DCH Quality Strategic Plan strives to ensure members receive high-quality care that is safe, efficient, patient-centered, timely, value and quality-based, data-driven, and equitable. The DCH conducts oversight of CMOs to promote accountability and transparency for improving health outcomes.

The Quality Strategic Plan is DCH's roadmap for developing a dynamic approach to assessing and improving the quality of healthcare and services furnished by the managed care and FFS CMOs and providers. The mechanisms for assessing quality of, timeliness of, and access to care vary across the Medicaid program in Georgia; therefore, the Quality Strategic Plan is tailored to incorporate these variances while ensuring an integrated strategy overall. The strategy requires a succession of incremental steps that DCH pursues to achieve these quality objectives. The Quality Strategic Plan establishes a strong foundation for quality governance and a comprehensive data analytics strategy.

³⁻³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf>. Accessed on: Jan 24, 2019.

The purpose of the Georgia Quality Strategic Plan is to establish and describe:

- Quality performance measures with targets for the CMOs related to access, utilization, service quality, and appropriateness.
- Value-based purchasing performance metrics for the GF program that align with some of the State's key focus areas for improved care and member outcomes (e.g., low birth weight, diabetes, and attention deficit hyperactivity disorder [ADHD]).
- DCH's processes for assessing, monitoring, and reporting on the CMOs' performance, progress, and outcomes related to the State's strategic goals and areas of focus.
- Adoption of innovative QI strategies, such as rapid-cycle performance improvement projects, and ensuring DCH and the CMOs are in tune with the latest advances in QI science through participation in QI trainings and technical assistance sessions sponsored by CMS and those hosted by the EQRO.
- Numerous collaborative efforts by DCH that include interagency coordination and participation of other key stakeholders, along with the CMOs and provider community, to leverage the talent and resources needed to address shared challenges that impede improved performance.

History

To comply with federal regulations, DCH developed and submitted its GF Quality Strategic Plan (strategy) for CMS' review and approval, receiving CMS approval on the initial strategy in 2008. Updates to the strategy were completed in January 2010 and again in November 2011.³⁻⁴

DCH's vision for quality extends beyond the content of the Quality Strategic Plan. The strategy serves as the blueprint for developing a dynamic approach to assessing and improving the quality of healthcare and services furnished by the managed care and FFS programs.

In July 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to concerns that the Patient Protection and Affordable Care Act, the national recession, and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high-quality care in a cost-effective manner. After the delivery of the comprehensive assessment and recommendations in 2012, DCH engaged several stakeholder groups to obtain feedback while considering Medicaid redesign options. The DCH compiled a table of stakeholder group comments and recommendations which covered such areas as DCH program administration, provider credentialing, copayments, claims, reimbursement, prior authorizations, benefits and services, care coordination, data collection, electronic medical records, data sharing, monitoring and oversight, provider networks, access to care, and QI.

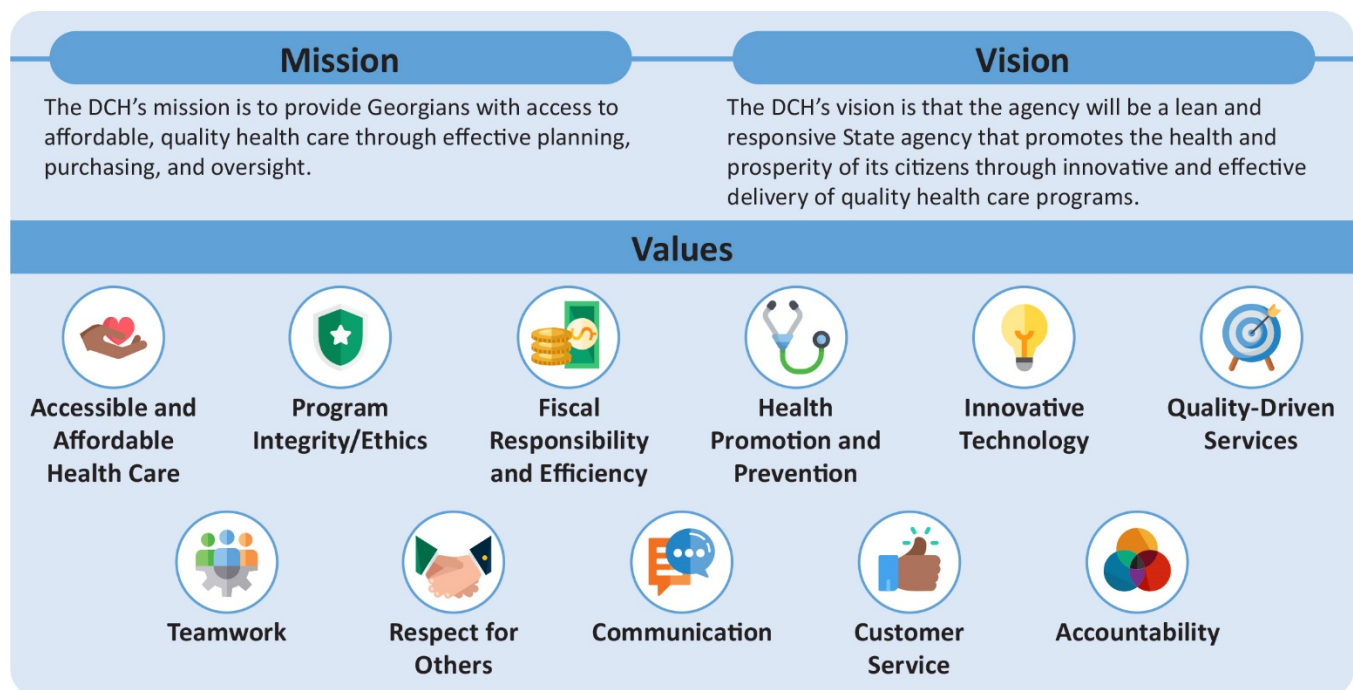
³⁻⁴ Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: <http://dch.georgia.gov/medicaid-quality-reporting>. Accessed on: Jan 24, 2019.

During 2015, in collaboration with numerous stakeholders, DCH prepared a new Quality Strategic Plan to coincide with the reprocurement of the GF and GF 360° managed care contracts. The strategy incorporated adopted recommendations from the comprehensive stakeholder assessment. The strategy was posted for public comment in December 2015 and was implemented as of February 2016, upon receiving CMS approval.

Data Analytics Strategy

The proactive identification and resolution of issues related to healthcare quality depend on complete, accurate, and timely data. The DCH's strategy for clinical data focuses on automation, connection, and information. Additionally, through contracting and increased oversight, DCH has worked to ensure that the participating CMOs and FFS providers submit accurate and timely administrative and clinical data.


Mission, Vision and Values




Quality Strategic Plan Goals, Objectives, and Strategies

The strategy describes DCH's mission, which is to provide Georgians with access to affordable, quality health care through effective planning, purchasing, and oversight. The DCH's vision is that the agency will be a lean and responsive State agency that promotes the health and prosperity of its citizens through innovative and effective delivery of quality health care programs. The DCH's program aims to accomplish the following goals and objectives:

Figure 3-1—DCH's Quality Strategic Plan Goals, Objectives, and Strategies Dashboard

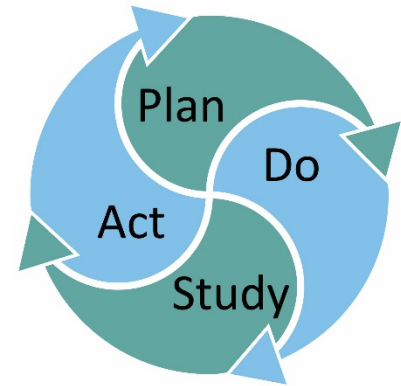
Aims	Goals	Objectives
 <p>Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members.</p>	Objective 1: Improve access to high quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.	Strategy 1: Increase and monitor access to health services for members.
	Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.	Strategy1: Increase preventive health and follow up care service utilization.
	Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.	Strategy 1: Improve care coordination programs.
		Strategy 2: Improve evidence-based practices.
		Strategy 3: Implement improvement activities focused on chronic conditions.
	Objective 4: Decrease the statewide low-birth weight (LBW) rate to 8.6 percent by December 2019 as reported in June 2020.	Strategy 1: Improve early access to prenatal care and perinatal case management.
		Strategy 2: Improve access to family planning and interpregnancy care and services.
		Strategy 3: Decrease non-medically necessary early elective inductions and deliveries and increase utilization of 17-P.
	Objective 5: Require CMOs' use of rapid-cycle process improvement/Plan-Do-Study-Act principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.	Strategy 1: Review quarterly utilization; prior authorization; case management; disease management; Early, Periodic, Screening, Diagnostic and Treatment (EPSDT); and P4HB® reports to ensure rapid-cycle process improvement principles are in use across all program areas and improving care management strategies. Strategy 2: Continue annual tracking of performance measure rates and comparisons with HEDIS percentiles to monitor improvements in preventive care, birth outcomes, and chronic disease management.

Aims	Goals	Objectives
		Strategy 3: Participate with CMS in the implementation of a new performance metric to monitor contraceptive utilization. Strategy 4: Conduct annual CMO and DCH CAHPS adult and child surveys and the annual DCH CAHPS survey of the PeachCare for Kids® (CHIP) members.
 Goal 2: Smarter Utilization of each Medicaid dollar.	Objective 1: Improve the member's appropriate utilization of services so that improvements will be documented in emergency room (ER) visit rates and utilization management (UM) rates for the adult and child populations compared with the contract year 2014 rates as reported in June 2020 based on contract year 2019 data.	Strategy 1: Reduce ER visits for ambulatory sensitive conditions.
		Strategy 2: Increase access to urgent care services.
		Strategy 3: Medical necessity determinations are made using evidence-based criteria.
	Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all-cause readmission rate for all Medicaid populations to 9 percent by the end of contract year 2019 as reported in June 2020.	Strategy 1: Improve the transition of care process.
		Strategy 2: Ensure effective concurrent review and discharge-planning processes are in place for CMO and FFS members.
	Objective 3: Continue payment denials for identified medically induced negative outcomes and measure effectiveness through claims auditing.	Strategy 1: Ensure hospitals do not receive payments for hospital-acquired conditions.
		Strategy 2: Ensure providers are not reimbursed for nonmedically necessary early elective deliveries.
	Objective 4: Improve access to healthcare information through collaboration with the Georgia Health Information Technology Extension Center and the Georgia Health Information Network (GaHIN) until 90 percent of all Georgia's providers are connected to an HIE and to the GaHIN.	Strategy 1: Increase the provider's use of technology.
		Strategy 2: Encourage members' access to personal health information available through their providers' electronic health records (EHRs).

Note: Each objective has targeted metrics to measure progress.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous QI efforts to improve a service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DCH encourages the CMOs to continually track and monitor the effectiveness of QI initiatives and interventions, using a PDSA cycle, to determine if the benefit of the intervention outweighs the effort and cost.



Another method used by DCH to promote best and emerging practices among the CMOs is to ensure that the State's contractual requirements for the CMOs are at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). The DCH actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which CMO performance is measured.

DCH Quality Initiatives Driving Improvement

The DCH is responsible for managing the quality oversight process including the monitoring of quality initiatives, tracking progress over time, and developing recommendations for improvement. The DCH actively collects and reviews all CMO monitoring and quality reports and organizes the results to support DCH's oversight activities through CMO-to-CMO comparisons and trending analyses.

The DCH uses monthly, quarterly, and annual reporting from the CMOs and HSAG EQRO mandatory and optional activity deliverables to monitor its success in meeting the key goals/measures of the Quality Strategic Plan. The DCH continues to make progress on implementing its quality initiatives through ongoing monitoring, assessments of progress toward meeting strategic goals, and evaluating the relevance of its Quality Strategic Plan. The DCH conducted the following activities to support progress in implementing the Quality Strategic Plan.

- The DCH regularly monitors the effectiveness of CMOs in achieving the goals and objectives through EQR activities and reports. The DCH has contracted with HSAG to perform both mandatory and optional activities for the State of Georgia Medicaid program: compliance monitoring and corrective action follow-up evaluation, PMV and HEDIS audits, and PIP validation.
- The DCH contractually requires the CMOs to conduct adult, child, and PeachCare for Kids[®] population CAHPS surveys.
- The DCH annually defines a set of performance measures to monitor progress in improving preventive care for women and children, healthcare for individuals who have chronic conditions, and

the provision of behavioral health services. In collaboration with the healthcare community, measures are reviewed and selected each year to support the measurement, tracking, and improvement of performance and outcomes. The DCH and HSAG also work to define additional measures to incorporate into monitoring processes that address access to and quality of care and service delivery.

- The DCH and HSAG continue to work with the CMOs to implement a rapid-cycle PIP framework to test and refine interventions through a series of PDSA cycles designed to facilitate more efficient and long-term sustained improvement. The CMOs continued to test and evaluate selected interventions.

Following are some of the initiatives DCH implemented during the review period that support the improvement of quality of care and services for GF and GF 360° members, as well as activities that supported the CMOs' QI efforts.

Commissioner Frank W. Berry describes a clear purpose for the DCH: *"Shaping the future of a Healthy Georgia by improving access and ensuring quality to strengthen the communities we serve."*³⁻⁵

The DCH's FY 2019 Annual Report describes key accomplishments achieved during FY 2019. The following are examples of DCH oversight and initiatives that reflect the quality and timeliness of, and access to care for the Georgia Families, Georgia Families 360°, and PeachCare for Kids® programs.

In FY 2019, the DCH Medical Assistance Plans (MAP) Division oversaw the Georgia Medicaid programs and PeachCare for Kids® (Georgia's CHIP population). The MAP Division provided management oversight of the Medicaid and PeachCare for Kids® programs by:

- Developing and implementing policies on allowable services and service delivery.
- Administering the Georgia Families 360° managed care program for children in foster care, children receiving adoption assistance, and select youth in the juvenile justice system.
- Overseeing member eligibility and enrollment in Medicaid, PeachCare for Kids®, and Planning for Health Babies® (P4HB®), and enrollment in the Georgia Families CMOs and the Georgia Families 360° CMO.
- Overseeing the five programs offering home- and community-based services (HCBS) alternatives to long-term institutional care.
- Collecting data and reporting the performance metrics for both the fee-for-service population and the managed care populations in Georgia Families and Georgia Families 360°. The State used HEDIS to measure performance on important dimensions of care and services.
- Implementing programs in Medicaid and PeachCare for Kids® promoting continuity of care, care coordination, and enhanced health outcomes, such as the rapid-cycle PIPs.

³⁻⁵ The Georgia Department of Community Health. 2019 Annual Report. Available at: <https://dch.georgia.gov/document/document/2019annualreportpdf/download>. Accessed on: Jan 27, 2020.

- Controlling expenditures and overseeing all categories of service including capitation payments, pharmacy, inpatient hospital, outpatient hospital, nursing, and long-term care facility and transportation.
- Addressing member needs through Medicaid and PeachCare for Kids[®] provider relations and claims resolution services.
- Evaluating opportunities to improve efficiency and effectiveness in Medicaid operations and implementing changes that streamline processes for providers as well as Medicaid and PeachCare for Kids[®] members.
- Managing performance of four CMOs responsible for providing medical services under the Georgia Families and Georgia Families 360° programs to approximately 1.4 million Medicaid, PeachCare for Kids[®], and P4HB[®] members.

The DCH highlighted the following 2019 initiatives for the Georgia Families, Georgia Families 360°, and PeachCare for Kids[®] programs.

Beyond the primary role of managing Medicaid, DCH focused on two major initiatives to further enhance the effectiveness and efficiency of healthcare services offered to members. In FY 2019, the MAP Division participated in or implemented the Patients First Act and the 1115 and 1332 waiver development processes and the Medical Assistance Plans Organizing for Success initiative.

Patients First Act

On March 27, 2019, Governor Brian P. Kemp signed The Patients First Act into law. The Act authorizes DCH to submit a Section 1115 Medicaid Waiver request to the CMS. The DCH submitted the 1115 Medicaid Waiver to CMS in late December 2019, following the State's 30-day public comment period. The waiver is aimed at developing a plan to restructure Georgia's Medicaid program to include partial Medicaid expansion. If approved, the Waiver would allow approximately 200,000 single, low-income adults to qualify for Medicaid.

Medical Assistance Plans Organizing for Success Initiative

In FY 2019, the DCH Medical Assistance Plans Division (MAP) undertook its Organizing for Success initiative to build on its purpose to advance the health, wellness, and independence of those DCH serves by providing access to quality care and resources statewide. The DCH undertook this initiative in order to enhance the MAP Division's long-term strategy, and performance tracking; further the focus on professional development, training, and onboarding programs; and roll out new IT systems and processes with a focus on integration and collaboration tools for employees.

Under the Organizing for Success initiative, a new MAP executive director was appointed and charged with overseeing four new offices:

- Eligibility and Enrollment Office

- Service Delivery and Administration Office
- Performance and Care Management Office
- Policy, Compliance and Operations Office

Other Program Updates

Electronic Visit Verification (EVV): In accordance with the 21st Century Cures Act, a request for proposals was issued seeking a single qualified supplier to provide EVV services. EVV is an automated process for home healthcare and personal care services that electronically verifies the date and time of services, the type of services performed, the individual providing the services, the location where the services were provided, and the individual receiving the services. EVV also provides real-time information and verification to ensure no gaps in care occur throughout the course of the member's service plan. The DCH collaborated with member advocacy groups, provider associations, and stakeholders to ensure that a wide range of input and concerns were received and addressed prior to implementing an EVV system. The DCH continued conducting public forums throughout Georgia during FY 2019 to educate the public, Medicaid and PeachCare for Kids[®] providers, and members. EVV technology will also support DCH's goal to reduce and eliminate fraud, waste, and abuse in home care service delivery.

Implementation of the Home and Community Based (HCBS) Settings Rule: CMS issued regulations in FY 2014 defining the characteristics and qualities of HCBS settings where services can be delivered, which included requirements for services to be provided in the most integrated setting and in the most community-inclusive manner. The DCH has developed a Statewide Transition Plan (STP) that describes how the State would assure compliance with rules for all HCBS providers certified as being in compliance by 2022. Georgia's work toward compliance includes:

- Engagement of a statewide task force.
- Public meetings.
- Preparation of four waiver-specific transition plans.

Based on CMS guidance, DCH is conducting inquiries of all HCBS providers and providing them with technical assistance to assist them in being compliant with the HCBS Settings Final Rule.

Non-Emergency Medical Transportation (NEMT): Through the NEMT program, DCH provided more than 3.8 million trips to Medicaid members who had no other means of transportation to receive healthcare services and treatment across Georgia in FY 2019.

Health Information Technology (Health IT or HIT): The Office of Information Technology continued its mission to advance the use of health information technology throughout Georgia to reduce healthcare disparities, improve health outcomes, increase the efficiency of health care delivery, and reduce overall healthcare costs. Administrative oversight continued of the Medicaid Promoting Interoperability (PI) Program (formerly the Medicaid Electronic Health Records [EHR] Incentive

Program) that determined eligibility, and included registration or the provider attestation for the distribution of incentive payments to eligible Medicaid providers that adopted, implemented, upgraded, or demonstrated meaningful use (MU) or certified EHR technology to improve patient care and reduce healthcare disparities.

National Testing Experience and Functional Assessment Tools (TEFT): Health IT successfully completed five years of the TEFT grant. The TEFT grant successfully benefited the DCH Medicaid waivers and members by testing the value of return from a waiver annual survey, an electronic functional assessment tool, personal health record mobile application, and a published Health Level 7 informative document for data exchange.

Georgia Health Information Network (GaHIN): DCH continued its support of the GaHIN, which is Georgia's statewide health information exchange and the State-Designated Entity.

Rural Health Stabilization: The DCH State Office of Rural Health continued to focus on rural hospital stabilization; establishing and promoting the use of primary and specialty telemedicine; mental health and behavioral health services; care coordination; reduction in nonurgent and emergent use of hospital emergency department and emergency medical services (EMS); and identifying creative ways to ensure healthcare accessibility in Georgia's underserved and rural communities. At the close of FY 2019, 22 small rural and critical access hospitals (CAHs) had completed four phases of the stabilization program.

CMO-Specific Quality Initiatives

The DCH requires each CMO to have a quality assurance and performance improvement (QAPI) program which meets contractual standards that are at least as stringent as those requirements specified in 42 CFR §438.236–438.242. The CMOs' ongoing programs objectively and systematically monitor and evaluate the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

The DCH also requires that the CMOs' QAPI programs be based on the latest available research around quality assurance and include a method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and overutilization of services). The following provides a non-all-inclusive sample of the quality initiatives the CMOs highlighted as their efforts toward achieving the DCH Quality Strategic Plan's goals and objectives.

Amerigroup

Amerigroup used traditional quality, patient safety, and UM approaches to identify activities that were relevant to the goals and objectives in the Georgia Quality Strategic Plan. Most often, Amerigroup identified initiatives through analysis of key indicators of care and service based on reliable data which indicated the need for improvement in a particular clinical or nonclinical area.

Amerigroup focused QI efforts on improving member and provider collaboration strategies, improving gaps in care reporting, and increasing provider engagement in health promotion and QI activities. The CMO described its quality initiatives that were focused on achieving DCH's Quality Strategic Plan goals and objectives which included:

DCH Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members

Objective 1: Improve access to high quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Amerigroup continued to encourage provider engagement through completing over 395 quality focused meetings with providers to discuss performance reports, missed opportunities, and the implementation of direct provider scheduling or clinic days to close care gaps.
 - Amerigroup self-reported member outreach efficiencies improvement from a 40 percent to a 42 percent reach rate.

Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Amerigroup increased utilization of automated short message service (SMS) text messaging as an additional way to close care gaps, engage members, and promote healthy outcomes.

Objective 4: Decrease the statewide low-birth weight (LBW) rate to 8.6 percent by December 2019 as reported in June 2020.

- Amerigroup continued to provide quality incentive programs to providers that allowed providers the opportunity to earn incentive payments by closing care gaps in areas such as preventive and pregnancy care.

Objective 5: Require CMOs' use of rapid-cycle process improvement/PDSA principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Amerigroup self-reported that it continued to meet an 80 percent EPSDT screening ratio for PeachCare for Kids® and Medicaid.

CareSource

CareSource aligned its quality goals and objectives with the DCH Quality Strategic Plan. Additionally, CareSource developed a Quality Improvement Work Plan based on both the NCQA standards and

DCH's Quality Strategic Plan. The CMO described its quality initiatives that were focused on achieving DCH's Quality Strategic Plan goals and objectives which included:

DCH Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members

Objective 1: Improve access to high-quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Network Development QI Initiatives
 - Each month, CareSource used the ratio of the number of members to the number of practitioners for each primary care specialty to evaluate the availability of primary care providers (PCPs) in its network. CareSource used the ratio of the number of members to the number of practitioners for high-volume specialists and for high-impact specialists to evaluate the availability of specialty care practitioners in the network.
 - CareSource contracted with large obstetrical/gynecological (OB/GYN) groups in metro Atlanta and the North Region.
 - CareSource provided telemedicine and nonemergency transportation to the closest provider if no specialty providers were located within close proximity to the member.
 - CareSource conducted in-office provider education for providers that did not meet the access standards for after-hours and routine care and performed subsequent audits.
 - The CMO developed an educational article for members on the CareSource accessibility standards that advised on the appropriate times and situations to make after-hours calls to practitioner offices.
 - CareSource performed an annual analysis to collect data and measure its performance against its standards for access to primary care for both regular and routine care appointments, urgent care appointments, and after-hours care. This analysis helped the CMO ensure members were receiving access to the care they needed in a timely manner.
- Telehealth QI Initiatives
 - CareSource implemented an “Adopt a School” telehealth initiative at a public Atlanta elementary school to improve access to healthcare, reduce emergency department (ED) visits, increase convenience for the parent/guardian who did not have time or paid time off to leave work and pick up a sick child, increase parent engagement, and increase school attendance rates. CareSource donated telehealth equipment to the school; sponsored parent engagement meetings to discuss telehealth; worked closely with the school nurse, teachers, and parents; and partnered with healthcare providers.
- Patient-Centered Medical Home (PCMH) Transformation Program QI Initiative
 - CareSource developed a Patient-Centered Medical Home Transformation Program that focused on training CareSource clinical and nonclinical staff in the area of PCMHs to serve as PCMH coaches for practices to transform from non-PCMH to NCQA PCMH-recognized providers. CareSource PCMH coaches were embedded within the practices to work with practice office

staff and practitioners weekly to provide them consultation to improve office operations, accessible services, comprehensive care, coordinated care, utilization, quality and safety, and patient satisfaction.

Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Planning for Healthy Babies (P4HB®) QI Initiatives
 - The CareSource care management team outreached to P4HB®-eligible women to provide education about the services and benefits of the program.
 - The CMO's care managers conducted member outreach through telephone calls to ED high-utilizers and all interpregnancy care and Right from the Start Medicaid members to provide education on the appropriate use of the ED and helped them identify a PCP, where applicable.
- Oral Health QI Initiatives
 - CareSource disseminated an annual dental newsletter from the CMO's dental director.
 - CareSource continued outreach efforts to provide education to new members and currently enrolled members about EPSDT services.
 - CareSource educated new and current members about EPSDT services and screenings during baby shower events, outbound calls, and community events.
 - The CMO gathered feedback from members serving on the Member Advisory Committee about how to increase the utilization of physical, behavioral health, and oral health services each quarter.
- Behavioral Health QI Initiatives
 - CareSource proactively recruited Applied Behavior Analysis (ABA) therapy providers into its network.
 - CareSource created, published, and distributed collateral material for providers that discussed how to partner with CareSource and how ABA prior authorizations were processed.
 - CareSource presented on ABA services at the Emory Autism Center via in-person visit and webinar. The audience included the Georgia Autism Assessment Collaborative.
 - The CMO developed behavioral health informational fliers for providers.
 - The CMO developed targeted webpages related to behavioral health services.
 - CareSource developed a behavioral health member flier based on feedback from the Member Advisory Committee.
 - CareSource collaborated with the DCH and the other Georgia CMOs to create the ABA policy manual outlining what constitutes ABA services, how the services are authorized and provided, and what tools/assessments are encouraged for diagnosis.

Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Care Management QI Initiatives

- CareSource developed a transitions of care team to improve timely follow-up with members transitioning between care settings (e.g., inpatient to home, inpatient to long-term care, crisis center to partial hospitalization).
- The CMO provided education to providers on proper discharge follow-up and provided education to the CareSource transition team to ensure discharge follow-up was completed and appointments were scheduled before discharge, if appropriate.
- The CMO developed a PCMH plan to actively support practitioners transforming into a medical home and provided practitioners the opportunity to receive incentives for achieving the NCQA PCMH recognition.
- Quarterly, the CMO determined provider adherence to the clinical practice guidelines for ADHD, asthma, and diabetes by conducting reviews of medical records to ensure, at a minimum, an 80 percent compliance rate for each indicator was achieved.
- CareSource implemented a home visiting program to improve blood pressure management.

Objective 4: Decrease the statewide low-birth weight (LBW) rate to 8.6 percent by December 2019 as reported in June 2020.

- Maternal and Prenatal Care QI Initiatives

- The CMO hosted baby shower events to provide pregnancy education and resources to pregnant women.
- CareSource partnered with seven community agencies to provide assistance with addressing pregnant members' needs and offered members an opportunity for participation on the Member Advisory Committee (MAC).
- The CMO assisted members in removing individual member barriers including addressing SDoH.
- CareSource offered the care management program to pregnant and recently delivered women so that they could be assessed by trained staff to identify any medical, behavioral, or social needs to maintain their health as well as their baby's health and well-being.
- The CMO offered the Georgia's Babies Can't Wait early intervention program for moms with newborn babies or children under 3 years of age with significant development delays or who may be at risk for delays due to a diagnosed medical condition.
- The CMO reviewed all Caesarian sections and determined whether they were medically necessary, according to the standards of care.
- CareSource implemented a "Get Our Moms Back to Work" campaign. Pregnant members and new moms were connected to meaningful employment opportunities.
- The CMO increased early identification of pregnancy by discussing with providers the importance of completing the notification of pregnancy (NOP) form and identifying claims with International Classification of Diseases, 10th Revision (ICD 10) codes specific to pregnancy.

- CareSource conducted population-specific outreach which included aggressive outreach to all members who were younger than 18 and pregnant, used tobacco, were pregnant with multiples, or had a history of preterm birth.
- CareSource improved the initiation of progesterone for high-risk women by providing information on early assessment for progesterone initiation, providing education to all pregnant members on receiving prenatal care, and providing education to members of child-bearing age on the importance of being healthy prior to pregnancy.

Objective 5: Require CMOs' use of rapid-cycle process improvement/ PDSA principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- The CMO implemented a PIP to improve follow-up after hospitalization for mental illness within seven days of discharge.
- CareSource implemented a PIP to improve the timeliness of UM decisions.

Peach State

Peach State adopted and is committed to achieving HHS' Triple Aim, developed by the Institute for Healthcare Improvement, which also supports the DCH's Quality Strategic Plan for GF goals and objectives. The CMO described its quality initiatives that were focused on achieving DCH's Quality Strategic Plan goals and objectives which included:

DCH Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members

Objective 1: Improve access to high-quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- For members discharged from a hospital with a mental health diagnosis, Peach State offered an incentive for members to keep their scheduled follow-up appointment.
- The CMO conducted quarterly geo-access evaluations to assure timeliness and geo-access standards were met.
- Peach State regularly reviewed member grievances to ensure any concerns regarding access to care were resolved.
- Peach State reviewed the 2019 CAHPS results to identify members' experience with care concerns and worked to resolve the concerns identified by implementing the use of personal advocates for care.
- The CMO worked with DCH on the pregnancy PIPs to improve the number of members who had a prenatal service within 42 days of enrollment or within the first trimester.

- Peach State conducted outbound calls to members who had not had a PCP visit in the previous 23 months.
 - In 2018 Peach State piloted a program of offering \$100 to members who had not had a PCP visit in two years and subsequently completed a visit after being contacted by Peach State. The pilot was a success and was expanded to a larger group of members in 2019 to encourage members to see their PCP for preventive services.
- Peach State regularly partnered with practitioners to provide community-based, school-based, and in-home services. In 2019, Peach State provided funds to allow Kids Doc on Wheels (KDOW) to purchase a second vehicle to take services to members.

Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Peach State provided assistance, including a financial consultant and a PCMH consultant, to work with providers to obtain NCQA PCMH status.
- A Peach State medical director reached out to practitioners identified as over-prescribing psychotropic medications to discuss the appropriate use of psychotropic medications as well as the clinical guidelines.
- Peach State conducted outbound calls to members reminding them to have their prescriptions filled and to stay on their medications.
- Peach State contacted behavioral health practitioners and ensured they were obtaining lab work for members who were prescribed an antipsychotic and offered assistance with coordinating care for the members.
- Peach State conducted quarterly audits of providers to ensure they were following clinical practice guidelines for treatment of ADHD, diabetes, and asthma.
- Peach State adopted an opioid-related clinical practice guideline.

Objective 4: Decrease the statewide low-birth weight (LBW) rate to 8.6 percent by December 2019 as reported in June 2020.

Peach State worked with providers that participate in the DCH pregnancy-centering pilot program at four sites: Upson, Grady, Southside, and Dougherty County. Peach State implemented its own independent centering incentive program that incentivizes participation in the centering meetings. Peach State has provided grants to providers to build out their centering facility. Peach State also worked with a federally qualified health center (FQHC) to onboard and build the pregnancy-centering program to achieve centering certification. The pregnancy-centering program groups are composed of women of different ages, races, and socioeconomic backgrounds who share the common experience of pregnancy, birth, and family care. Pregnancy-centering takes women out of exam rooms and into groups for their prenatal care. Groups meet regularly throughout the pregnancy and discuss health concerns and expectations in a supportive setting. Discussion topics may include nutrition, common discomforts,

stress management, labor and delivery, breastfeeding, and infant care. The groups promote the following:

- Better birth outcomes
- More provider and patient contact
- Patient empowerment and learning
- Self-care
- Support and friendship among group members

Objective 5: Require CMOs' use of rapid-cycle process improvement/ PDSA principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- In 2019, the CMO completed two formal PIPs (*Improving Behavioral Health—7-Day Follow-up* and *Provider Satisfaction*) using the rapid-cycle process.

WellCare

WellCare implemented its QI plan initiatives in support of the DCH Quality Strategic Plan for GF goals and objectives which included:

DCH Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members

Objective 1: Improve access to high-quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- WellCare continued its care gap coordinator (CGC) program which was used as an aid in making outreach calls regarding:
 - Medication adherence to increase medication compliance around diabetes, hypertension, and cholesterol.
 - HEDIS documentation management and chart retrieval.
 - Member outreach activities.
 - A year-end push to close care gaps for members.
- The CMO used its Patient Care Advocacy program to close member care gaps by embedding a WellCare associate (patient care advocate [PCA]) into select high-volume provider offices. The PCA was tasked with outreaching to members with care gaps and identifying and eliminating barriers to engage members in their healthcare.

Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- WellCare continued the Healthy Rewards Program which incentivized GF and PeachCare for Kids® members to complete health screenings and preventive services in a timely manner. Eligible members who completed a preventive health visit, such as well-child visits or prenatal visits, could earn a reloadable Visa debit card.
- The CMO continued mailings and periodicity letter campaigns to provide education to members on the importance of preventive and dental health visits, immunizations, and age-appropriate well-child visits. Educational material was also sent to members identified as having a health concern for follow-up care, such as asthma, diabetes, or positive lead screenings. Lists of members in need of preventive health visits were also sent to providers.
- The CMO's customer service inbound care gap program allowed customer service representatives to notify members of care gaps that were flagged in member accounts during member encounters. CMO representatives provided additional assistance including, but not limited to, scheduling appointments to fill care gaps, finding providers, arranging transportation to appointments, and reassigning PCPs. Members who continued to appear on the care gap reports received follow-up via a letter or telephone call.
- Avesis, the CMO's vendor leading the dental home program, established ongoing relationships with general and pediatric dental providers, and members younger than 21, to increase completion of preventive dental visits among members.
- MedTox, a CMO laboratory vendor, coordinated outreach and provided education to practitioners about elevated lead levels (five or more micrograms per deciliter of lead in blood) in children. MedTox also conducted initial blood lead screenings of members to determine the necessity for standard, whole-blood lead level testing. If a member's lead level was 10 µg/dL or greater, the member remained in the CMO's case management lead program until his or her lead level dropped below five micrograms or the member became ineligible with WellCare.
- WellCare's community relations outreach program events provided face-to-face educational interactions with all GF members at community events and WellCare member-focused activities across Georgia, impacting over 7,000 members in 2019. The CMO's community relations team led many activities and events, including over 200 informational table events, over 40 health fairs, over 45 HEDIS events, and over 20 school events.
- The CMO implemented a behavioral health HEDIS initiative for the *Follow-up after ADHD Medication (ADD)* measure. Quality practice advisors (QPAs) educated PCPs during face-to-face meetings, sent weekly faxes to prescribers of patients with new prescription fills of ADHD medications reminding them of the required follow up visits, and provided education to prescribers about writing initial prescriptions for only 10 days.
 - The CMO implemented a behavioral health HEDIS initiative for the *Antidepressant Medication Management (AMM)* measure. The CMO's QPAs educated PCPs during face-to-face meetings on AMM requirements, sent member and provider letters, and sent targeted member mailings on managing depression.

- The CMO implemented a behavioral health HEDIS initiative for *Follow-up after Hospitalization for Mental Illness (FUH)*. WellCare assigned telephonic discharge planners to three high-volume mental health facilities to assist with scheduling and following up on discharge appointments.
- The CMO's behavioral health case management (BHCM) team outreached to all members discharged from a behavioral health facility encouraging them to attend follow-up visits.

Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Avesis, the CMO's vendor leading the dental home program, established ongoing relationships with general and pediatric dental providers, and members younger than 21 to increase completion of preventive dental visits among members.
- The CMO's "Gold Card" program provided a process for preferential management for behavioral health inpatient facilities that achieved high levels of performance. This program benefited high-performing hospitals by lessening the requirements for approval of inpatient stays and focused instead on inpatient facilities that were not meeting quality and utilization goals. Three requirements of the program were (1) high patient volume of at least 30 inpatient admissions per quarter, (2) quality performance on the *Ambulatory Follow-Up after Hospitalization* HEDIS measure by achieving or exceeding the 90th percentile, and (3) efficient management of average length of stay (ALOS) of five days or less.

After an inpatient behavioral health facility had been deemed a "Gold Card" facility, only approvals for admissions were required. Concurrent reviews to establish medical necessity were no longer required during the time period of this designation, and the facility did not receive denials for inpatient days once the admission had been approved. In exchange for the relaxed requirements, the facility informed WellCare about discharge plans, and WellCare maintained the ability to interact with the facility for issues including member complaints, care coordination, case management, and other related activities.

- WellCare continued diabetes screening for people with schizophrenia or bipolar disorder who were using psychotropic medications. The CMO's behavioral health case manager conducted outreach to all members in the denominator, provided education about the required screening, and distributed a tip sheet that reminded prescribers of the required screening through posting information on the provider portal and distributing the information to prescribers during face-to-face visits.
- The CMO continued the PCMH model which was a person-centered approach to providing comprehensive primary care that facilitated partnerships between members and their providers. WellCare's PCMH incentive plan rewarded provider practices with PCMH recognition from NCQA. The program also included PCMH coaching assistance for practices working toward PCMH recognition through the Enhanced PCMH Program.
- The CMO implemented or continued the use of over 40 clinical practice guidelines (CPGs) relevant to behavioral health conditions, chronic diseases, and preventive health. The CMO conducted quarterly evaluations of provider compliance with CPGs for asthma, diabetes, and ADHD.

Objective 4: Decrease the statewide low-birth weight (LBW) rate to 8.6 percent by December 2019 as reported in June 2020.

- WellCare's BabyLine—Obstetrical Nurse Triage (case management) provided education to pregnant members. Caller concerns included topics such as prenatal visits and tests; symptoms (backache, nausea, cramping, etc.); pregnancy complications (diabetes, hypertension, pre-term labor, hyperemesis, rupture of membranes, etc.); body changes; bed rest; diet; and breastfeeding.
- Inter-pregnancy care services (IPC) were available for women who gave birth to a baby weighing less than three pounds, five ounces. Women could continue to receive up to five primary care office or outpatient visits per year, substance use treatment, case management services, limited dental services, and prescription drugs for the treatment of chronic diseases (non-family planning).
- WellCare's Resource Mother services offered support to mothers and provided them with information on parenting, nutrition, and healthy lifestyles.
- The CMO's Obstetrical (OB) Optimization Plan addressed the trend of premature births by adopting the 17P/Makena initiation, which is a treatment protocol recognized as the standard of care by the American College of Obstetricians and Gynecologists (ACOG) for the prevention of preterm delivery in asymptomatic patients at high-risk for preterm birth due to a prior preterm delivery.

Amerigroup 360°

Amerigroup 360° used traditional quality, patient safety, and UM approaches to identify activities that were relevant to the Georgia Quality Strategic Plan goals and objectives. Amerigroup 360° focused QI efforts on improving member and provider collaboration strategies, improving gaps in care reporting, and increasing provider engagement in health promotion and QI activities. The CMO described its quality initiatives that were focused on achieving DCH's Quality Strategic Plan goals and objectives which included:

DCH Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members

Objective 1: Improve access to high-quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Amerigroup 360° continued to encourage provider engagement through completing over 395 quality focused meetings with providers to discuss performance reports, missed opportunities, and implementation of direct provider scheduling or clinic days to close care gaps.

Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Amerigroup 360°'s care coordinators continued to co-manage members admitted to a psychiatric residential treatment facility in conjunction with the Georgia Division of Family and Children

Services (DFCS) clinical care coordinators. This partnership was designed to improve the transition from inpatient to community care for all members.

- Amerigroup 360° implemented an ED redirection pilot program in partnership with the Georgia Baptist Children's Homes and the Crescent Pines behavioral health inpatient facility. The goal of the program was to ensure members having a behavioral health crisis got to the right place for treatment at the right time resulting in reduced ED admissions for a behavioral health crisis.

Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- Continued to use video conferencing technology that was compliant with Health Insurance Portability and Accountability Act of 1996 (HIPAA) security and privacy standards to outreach to members.

Objective 4: Decrease the statewide low-birth weight (LBW) rate to 8.6 percent by December 2019 as reported in June 2020.

- Continued to provide quality incentive programs to providers that allowed providers the opportunity to earn incentive payments by closing care gaps in areas such as preventive and pregnancy care.

Objective 5: Require CMOs' use of rapid-cycle process improvement/ PDSA principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10 percent increase over contract year 2014 rates as reported in June of 2020 based on contract year 2019 data.

- The CMO stated that it continued to meet an 80 percent EPSDT screening ratio.

4. CMO Comparative Information

Comparative Analysis of the CMOs by Activity

In addition to performing a comprehensive assessment of the performance of each CMO, HSAG compared the performance findings and results across CMOs to assess the quality and timeliness of, and accessibility of the GF and GF 360° program.

Compliance With Standards

Table 4-1 provides information that compares the CMOs' performance in each of the standards reviewed in the Compliance With Standards review.

Table 4-1—Standards and Compliance Percentage Scores: CMO Comparison

Standard #	Standard Name	# of Elements*	Amerigroup		CareSource		Peach State		WellCare		Amerigroup 360°		Aggregate Score
			Met	Score**	Met	Score**	Met	Score**	Met	Score**	Met	Score**	
I	Availability of Services	15	15	100%	13	86.67%	14	93.3%	15	100%	15	100%	96.00%
II	Assurances of Adequate Capacity and Services	2	2	100%	2	100%	2	100%	2	100%	2	100%	100%
III	Coordination and Continuity of Care	19	19	100%	19	100%	19	100%	19	100%	19	100%	100%
IV	Coverage and Authorization of Services	12	12	100%	11	91.67%	12	100%	11	91.67%	11	91.67%	95%
V	Provider Selection	10	10	100%	9	90.00%	10	100%	7	70.00%	10	100%	92.00%
VI	Subcontractual Relationships and Delegation	4	3	75.00%	3	75.00%	4	100%	3	75.00%	3	75.00%	80.00%
VII	Member Rights and Protections	7	6	85.71%	7	100%	7	100%	7	100%	7	100%	97.14%
VIII	Confidentiality of Health Information	4	4	100%	4	100%	4	100%	3	75.00%	4	100%	95.00%

Standard #	Standard Name	# of Elements*	Amerigroup		CareSource		Peach State		WellCare		Amerigroup 360°		Aggregate Score
			Met	Score**	Met	Score**	Met	Score**	Met	Score**	Met	Score**	
IX	Enrollment and Disenrollment	12	12	100%	12	100%	11	91.67%	12	100%	12	100%	98.33%
X	Grievance and Appeal Systems	42	37	88.10%	33	78.57%	37	88.10%	36	85.71%	39	92.86%	86.67%
XI	Practice Guidelines	3	3	100%	2	66.67%	3	100%	3	100%	3	100%	93.33%
XII	Quality Assessment and Performance Improvement (QAPI)	12	11	91.67%	11	91.67%	11	91.67%	12	100%	11	91.67%	93.33%
XIII	Health Information Systems	8	6	75.00%	8	100%	8	100%	8	100%	6	75.00%	90.00%
XIV	Program Integrity	13	12	92.31%	12	92.31%	13	100%	13	100%	12	92.31%	95.38%
XV	Member Information	29	28	96.55%	26	89.66%	28	96.55%	27	93.10%	28	96.55%	94.48%
	Total Compliance Score	192	180	93.75%	172	89.58%	183	95.31%	178	92.71%	182	94.79%	93.23%
* Total # of Elements: The total number of elements in each standard.													
** Total Compliance Score: Elements that were <i>Met</i> were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.													

The CMOs' total compliance scores ranged from a low of 89.58 percent to a high of 95.31 percent. Additionally, the CMOs achieved full compliance for Standard II—Assurances of Adequate Capacity and Services and Standard III—Coordination and Continuity of Care.

The CMOs' lowest-scoring standards were Standard VI—Subcontractual Relationships and Delegation (80.00 percent) and Standard X—Grievance and Appeal Systems (86.67 percent). The review findings for the CMOs that did not receive a score of *Met* included:

- The CMOs did not consistently include all federal and state-specific requirements in their subcontract agreements with subcontractors and delegated entities.
- The CMOs did not consistently meet grievance notification and resolution timelines.
- The CMOs did not consistently meet notice of adverse benefit determination (NABD) timelines.
- The CMOs' NABD language was not consistently written in a manner that was easily understood.

Network Capacity Analysis

With the May 2016 release of revised federal regulations for managed care, CMS required states to set standards to ensure ongoing state assessment and certification of MCO, PIHP, and PAHP networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long-term services and supports programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric); obstetricians/gynecologists; behavioral health; specialist (adult and pediatric); hospital; pharmacy; pediatric dental; and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards. The DCH established time and distance standards and additional network capacity requirements in its contracts with the CMOs. The DCH receives regular CMO network files and conducts internal analysis to determine network adequacy and compliance with contractual network requirements.

Performance Measure Validation (PMV)—CMOs

Monitoring of performance measures allows for the assessment of quality of, access to, and timeliness of the care and services provided to Medicaid members. Validation of CMOs' performance measure rates reported to the State during the preceding 12 months is a mandatory EQR activity set forth in 42 CFR §438.358(b)(ii).

As part of performance measurement, the Georgia CMOs were required to submit performance measure data to the State. To ensure that rates were accurate and reliable, each CMO was required to undergo an EQR performance measure validation audit, which was conducted by HSAG, an NCQA-licensed organization (LO).

HSAG validated a set of performance measures identified by DCH that were calculated and reported by the CMOs for their GF population for CY 2018. All performance measures were selected from CMS' Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set),⁴⁻¹ Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set),⁴⁻² or the Agency for Healthcare Research and Quality's (AHRQ's) Quality Indicator measures. *Colorectal Cancer Screening*, a HEDIS non-Medicaid measure, was also included as part of HSAG's validation. HSAG reviewed the CMOs' performance measure data and information systems (IS) compliance tools. All CMOs were compliant with the reporting requirements for the Adult and Child Core Set measures. Three of the four CMOs had a designation of Report (R) for all the performance measures. For CareSource reporting, the *Colorectal Cancer Screening* performance measure received a designation of Small Denominator (NA).

⁴⁻¹ The Centers for Medicare & Medicaid Services. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, June 2016.

⁴⁻² The Centers for Medicare & Medicaid Services. Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, June 2016.

HSAG’s PMV activities included validation of the following measures:

- *Colorectal Cancer Screening*
- *Developmental Screening in the First Three Years of Life*
- *Diabetes Short-Term Complications Admission Rate*
- *Heart Failure Admission Rate*
- *Live Births Weighing Less Than 2,500 Grams*
- *Percentage of Eligibles Who Received Preventative Dental Services* (reported at the county level [159 counties])
- *Screening for Depression and Follow-Up Plan* (Ages 12–17)
- *Screening for Depression and Follow-Up Plan* (Ages 18 and Older)

Using the validation methodology and protocols described in Appendix A, HSAG determined results for each performance measure. The CMS EQRO PMV protocol identifies two possible validation finding designations for performance measures: Report (R)—Measure data were compliant with HEDIS and DCH specifications and the data were valid as reported, or Not Reported (NR)—Measure data were materially biased. Table 4-2 lists the performance measures that HSAG validated and displays the key review findings and final audit results for all CMOs for each performance measure rate.

Table 4-2—CMO Validation Results

	Performance Measure	Amerigroup	Amerigroup 360°	CareSource	Peach State	WellCare
1.	<i>Colorectal Cancer Screening*</i>	R		NA	R	R
2.	<i>Developmental Screening in the First Three Years of Life</i>	R	R	R	R	R
3	<i>Diabetes Short-Term Complications Admission Rate</i>	R	R	R	R	R
4.	<i>Heart Failure Admission Rate</i>	R		R	R	R
5	<i>Live Births Weighing Less Than 2,500 Grams</i>	R		R	R	R
6	<i>Percentage of Eligibles Who Received Preventative Dental Services</i> (reported at the county level [159 counties])	R	R	R	R	R
7	<i>Screening for Depression and Follow-Up Plan</i> (Ages 12–17)	R	R	R	R	R

	Performance Measure	Amerigroup	Amerigroup 360°	CareSource	Peach State	WellCare
8	Screening for Depression and Follow-Up Plan (Ages 18 and Older)	R	R	R	R	R

*CareSource continuous enrollment criteria not met.

Performance Measure Validation (PMV)—DCH

As part of performance measurement, DCH submitted HEDIS data to NCQA. The DCH contracted with DXC Technology (DXC) as its Medicaid Management Information System (MMIS) vendor. DXC was responsible for calculating performance measure rates for the 2018 calendar year for the Medicaid and PeachCare for Kids® programs for the following populations:

- FFS members
- PeachCare for Kids®: Children/members ages 18 and under (eligible until 19th birthday)
- Total Population—All Medicaid and Peach Care for Kids® (ALL) members

The DCH contracted with its EQRO, HSAG, to conduct the validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0 September 2012.⁴⁻³

HSAG validated rates for the following set of performance measures selected by DCH for validation. All performance measures were selected from the 2018 HEDIS measures developed by NCQA, CMS' Child Core Set⁴⁻⁴ and Adult Core Set,⁴⁻⁵ and AHRQ's Quality Indicator measures. *Colorectal Cancer Screening*, a HEDIS non-Medicaid measure, was also included as part of HSAG's validation.

HSAG's PMV activities included validation of the following measures:

- Adolescent Well-Care Visits
- Ambulatory Care—Emergency Department (ED) Visits
- Asthma Medication Ratio (Ages 5–18 and 19–64)

⁴⁻³ Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf>. Accessed on: Apr 25, 2019.

⁴⁻⁴ The Centers for Medicare & Medicaid Services. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, June 2016.

⁴⁻⁵ The Centers for Medicare & Medicaid Services. Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, June 2016.

- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Childhood Immunization Status*
- *Children and Adolescents' Access to Primary Care Practitioners*
- *Chlamydia Screening in Women (21–24 Years and 16–20 Years)*
- *Colorectal Cancer Screening*
- *Comprehensive Diabetes Care—HbA1c Good Control (< 8.0%)*
- *Developmental Screening in the First Three Years of Life*
- *Diabetes Short-Term Complications Admission Rate*
- *Heart Failure Admission Rate*
- *Immunizations for Adolescents*
- *Live Births Weighing Less Than 2,500 Grams (report as a percentage; not per live births)*
- *Percentage of Eligibles Who Received Preventive Dental Services*
- *Plan All-Cause Readmissions*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Screenings for Depression and Follow-Up Plan (Ages 12–17 and Ages 18 and older)*
- *Well-Child Visits in the First 15 Months of Life*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

The measurement period specified by DCH was calendar year 2018 for all measures. Table 4-3 lists the performance measures that HSAG validated for each of the audited populations and identifies the key review findings and final audit results.

Table 4-3—Key Review Findings and Audit Results for DCH FFS, PeachCare for Kids®, and All Populations

	Performance Measure	Populations		
		FFS	ALL	PeachCare for Kids®
1	<i>Adolescent Well-Care Visits</i>	R	R	R
2	<i>Ambulatory Care—Emergency Department (ED) Visits</i>	R	R	R
3	<i>Asthma Medication Ratio (Ages 5–18 and 19–64)</i>	R	R	R
4	<i>Breast Cancer Screening</i>	R	R	
5	<i>Cervical Cancer Screening</i>	R	R	
6	<i>Childhood Immunization Status</i>	R	R	R

	Performance Measure	Populations		
		FFS	ALL	PeachCare for Kids®
7	<i>Children and Adolescents' Access to Primary Care Practitioners</i>	R	R	R
8	<i>Chlamydia Screening in Women (Ages 21–24 and Ages 16–20)</i>	R	R	R
9	<i>Colorectal Cancer Screening</i>	R	R	
10	<i>Comprehensive Diabetes Care—HbA1c Control (< 8.0%)</i>	R	R	
11	<i>Developmental Screening in the First Three Years of Life</i>	R	R	R
12	<i>Diabetes Short-Term Complications Admission Rate</i>	R	R	
13	<i>Heart Failure Admission Rate</i>	R	R	
14	<i>Immunizations for Adolescents</i>	R	R	R
15	<i>Live Births Weighing Less Than 2,500 Grams (report as a percentage; not per live births)</i>	R	R	R
16	<i>Percentage of Eligibles Who Received Preventive Dental Services</i>	R	R	R
17	<i>Plan All-Cause Readmissions</i>	R	R	
18	<i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i>	R	R	R
19	<i>Screening for Depression and Follow-Up Plan (Ages 12–17 and Ages 18 and older)</i>	R	R	R
20	<i>Well-Child Visits in the First 15 Months of Life</i>	R	R	R
21	<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	R	R	R

Additionally, HSAG reviewed several aspects crucial to the calculation of performance measure data: data integration, data control, and documentation of performance measure calculations. Following are the highlights of HSAG's validation findings:

Data Integration—The steps used to combine various data sources (including claims and encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by DCH, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code,

production activity logs, and linking mechanisms. HSAG determined that the data integration processes for DCH were acceptable.

Data Control—DCH’s organizational infrastructure must support all necessary information systems; its quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data and to provide data protection in the event of a disaster. HSAG validated DCH’s data control processes and determined that the data control processes in place were acceptable.

Performance Measure Documentation—While interviews and system demonstrations provide supplementary information, most validation review findings were based on documentation provided by DCH. HSAG reviewed all related documentation, which included the completed roadmap, job logs, computer programming code, output files, workflow diagrams, narrative descriptions of performance measure calculations, and other related documentation. HSAG determined that the documentation of performance measure generation by DCH was acceptable.

CMO Comparative and Georgia Families Average Performance Measure Results

As part of performance measurement, the Georgia CMOs were required to submit HEDIS data to NCQA. To ensure that HEDIS rates are accurate and reliable, NCQA required each CMO to undergo an NCQA HEDIS Compliance Audit conducted by a certified independent auditor.

Each CMO contracted with an NCQA-LO to conduct the HEDIS audit. HSAG reviewed the CMO’s final audit reports (FARs), IS compliance tools, and the IDSS files approved by each CMO’s LO. HSAG found that all five of the CMO’s IS compliance tools and processes were compliant with the applicable IS standards. All CMOs were compliant with the HEDIS reporting requirements for the key GF Medicaid measures for HEDIS 2019.

Table 4-4 displays the CMO rates and GF averages for HEDIS 2019, along with the performance rating for NCQA’s HEDIS measure rate results compared to NCQA’s Quality Compass national Medicaid health maintenance organization (HMO) percentiles (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*), where available.⁴⁻⁶ Additionally, measure cells shaded gray indicate non-HEDIS rates that were compared to the Center for Medicaid & CHIP Services’ (CMCS’) national 50th percentile for the Federal Fiscal Year (FFY) 2018 Child and Adult Core Set measures as an indicator of performance, with measure rates shaded yellow indicating performance that met or exceeded the 50th percentile. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the 50th percentile are shaded yellow. Benchmarks were not available for comparisons to the *Screening for Depression and Follow-Up Plan* measure.

⁴⁻⁶ Quality Compass® is a registered trademark of NCQA.

Table 4-4—RY 2019 Results for GF CMOs

Measure	Amerigroup	CareSource	Peach State	WellCare	GF Average
Quality of Care					
<i>Asthma Medication Ratio</i>					
5–11 Years	78.72% ★★★★	NA	82.97% ★★★★★	78.30% ★★★★	79.94% ★★★★
12–18 Years	70.52% ★★★★	NA	78.62% ★★★★★	73.24% ★★★★★	74.32% ★★★★★
19–50 Years	46.75% ★	NA	58.72% ★★★★★	55.41% ★★★★	53.85% ★★★★
51–64 Years	54.55% ★★	NA	NA	70.00% ★★★★★	58.67% ★★★★
<i>Comprehensive Diabetes Care</i>					
Hemoglobin A1c (HbA1c) Control (<8.0%)	33.51% ★	27.92% ★	33.09% ★	39.60% ★	34.79% ★
<i>Diabetes Short-Term Complications Admission Rate^{*1}</i>					
Diabetes Short-Term Complications Admission Rate	11.56	17.39	12.97	17.53	14.84
<i>Heart Failure Admission Rate^{*1}</i>					
Heart Failure Admission Rate	4.67	12.09	5.16	9.16	7.56
<i>Percentage of Live Births Weighing Less Than 2,500 Grams^{*1}</i>					
Percentage of Live Births Weighing Less Than 2,500 Grams	9.36%	9.86%	9.74%	9.05%	9.45%
<i>Screening for Depression and Follow-Up Plan</i>					
12–17 Years	20.44% NC	21.97% NC	12.07% NC	16.00% NC	17.61% NC
18 Years and Older	11.19% NC	14.15% NC	13.70% NC	17.65% NC	14.06% NC
Stewardship					
<i>Ambulatory Care—Total</i>					
Emergency Department Visits—Total*	52.71 ★★★★	60.15 ★★★★	50.98 ★★★★	60.70 ★★	56.06 ★★★★
<i>Plan All-Cause Readmissions²</i>					
Index Total Stays—Observed Readmissions—Total*	10.82% ★★★★★	13.16% ★★★★	7.61% ★★★★★	12.38% ★★★★★	11.06% ★★★★★
Index Total Stays—Observed/Expected (O/E) Ratio—Total*	0.73 ★★★★	0.85 ★★	0.56 ★★★★★	0.84 ★★	0.76 ★★★★
Access to Care					
<i>Adolescent Well-Care Visits</i>					
Adolescent Well-Care Visits	59.90% ★★★★	47.20% ★★	56.93% ★★★★	60.85% ★★★★	57.71% ★★★★

Measure	Amerigroup	CareSource	Peach State	WellCare	GF Average
Breast Cancer Screening					
Breast Cancer Screening	60.56% ★★★	NA	63.98% ★★★	63.40% ★★★	62.64% ★★★
Childhood Immunization Status					
Combination 7	64.48% ★★★★★	36.98% ★	65.21% ★★★★★	57.91% ★★	59.56% ★★★
Chlamydia Screening in Women					
16–20 Years	63.99% ★★★★★	57.84% ★★★	63.44% ★★★★★	60.23% ★★★	61.58% ★★★
21–24 Years	68.07% ★★★	71.67% ★★★★★	70.00% ★★★★★	68.57% ★★★	69.27% ★★★
Colorectal Cancer Screening³					
Colorectal Cancer Screening	41.12% ★	NA	46.72% ★	46.96% ★	45.06% ★
Cervical Cancer Screening					
Cervical Cancer Screening	72.68% ★★★★★	56.69% ★★	69.13% ★★★★★	67.21% ★★★★★	67.45% ★★★★★
Developmental Screening in the First Three Years of Life¹					
Total	58.15%	45.26%	59.37%	54.26%	54.26%
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tetanus, Diphtheria Toxoids, and Acellular Pertussis [Tdap])	91.24% ★★★★★	74.70% ★★	87.59% ★★★★★	92.70% ★★★★★	89.27% ★★★★★
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	36.50% ★★★	24.33% ★	34.31% ★★★	36.01% ★★★	34.57% ★★★
Percentage of Eligibles Who Received Preventive Dental Services¹					
Percentage of Eligibles Who Received Preventive Dental Services	53.27%	30.80%	51.66%	56.41%	50.69%
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	77.62% ★★	70.32% ★	73.97% ★	83.04% ★★	77.28% ★★
Well-Child Visits in the First 15 Months of Life					
No Well-Child Visits*	0.73% ★★★★★	5.60% ★	1.29% ★★★	0.58% ★★★★★	0.96% ★★★★★
Six or More Well-Child Visits	66.42% ★★★	39.42% ★	64.43% ★★	66.37% ★★★	65.19% ★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life					
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.43% ★★★	63.26% ★	70.49% ★★	71.68% ★★	71.37% ★★

* A lower rate includes better performance for this measure.

¹ The rates for this measure were compared to CMCS' national 50th percentile for the FFY 2018 Child and Adult Core Set.

² Quality Compass benchmarks were not available for this measure; therefore, the rates for this measure were compared to NCQA's Audit Means and Percentiles national Medicaid benchmarks.

³ Quality Compass benchmarks for the Medicaid population were not available for this measure; therefore, the rates for this measure were compared to the Commercial benchmarks.

NC indicates comparisons to benchmarks for the RY 2019 rate was not available.

NA indicates the denominator for the measure is too small to report (<30); therefore, comparisons to benchmarks were not appropriate.

Gray shading indicates that the measure was compared to CMCS' national 50th percentile.

Yellow shading indicates that the performance measure rate for RY 2019 met or exceeded CMCS' national 50th percentile.

RY 2019 performance ratings for the HEDIS measures represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

The following HEDIS 2019 measures were determined to indicate high performance for the GF program (i.e., the performance for more than half of the reportable CMO measure rates and the GF average exceeded the 50th percentile):

- *Asthma Medication Ratio—5–11 Years, 12–18 Years, and 19–50 Years*
- *Heart Failure Admission Rate*
- *Ambulatory Care—Emergency Department Visits—Total*
- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*
- *Adolescent Well-Care Visits*
- *Breast Cancer Screening*
- *Chlamydia Screening in Women—16–20 Years and 21–24 Years*
- *Cervical Cancer Screening*
- *Developmental Screening in the First Three Years of Life—Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap) and Combination 2 (Meningococcal, Tdap, HPV)*
- *Percentage of Eligibles Who Received Preventive Dental Services*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*

The following HEDIS 2019 measures were determined to indicate low performance for the GF program (i.e., the performance for one or fewer reportable CMO measure rates exceeded the 50th percentile and the GF Average fell below the 50th percentile):

- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Percentage of Live Births Weighing Less than 2,500 Grams*
- *Colorectal Cancer Screening*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Overall, the CMOs and the GF Average demonstrated strength with quality of care, stewardship, and access to care for HEDIS 2019, with the GF Average exceeding the 50th percentile for 20 of 26 (76.9 percent) measure rates that were comparable to benchmarks. Amerigroup and Peach State demonstrated the highest performance among the CMOs, exceeding the 50th percentile for 20 of 26 (76.9 percent) and 19 of 25 (76.0 percent) measure rates, respectively. Conversely, CareSource demonstrated low performance compared to the other CMOs, with only six of 20 (30.0 percent) measure rates exceeding the 50th percentile.

CMO Comparative and Statewide Aggregate Performance Improvement Project Results

In calendar year 2019, each CMO continued with the one clinical PIP and one nonclinical PIP initiated in 2018. With the rapid-cycle PIP approach, each CMO may have the same overarching PIP topic; however, the selected narrowed focus and SMART Aim statements vary; therefore, a comparison of performance on the same topic cannot be made. Table 4-5 summarizes the PIP topics for each CMO. The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to care and services.

Table 4-5—CY 2019 PIP Topics

CMO	PIP Topics
Amerigroup	<i>Diabetes—Retinal Eye Exam</i>
	<i>Customer Satisfaction</i>
Amerigroup 360°	<i>Antidepressant</i>
	<i>Adoption Assistance—Member Contact Information</i>
CareSource	<i>Follow-up After Hospitalization for Mental Illness within 7 days of Discharge</i>
	<i>Improve the Timeliness of Utilization Management Decisions</i>
Peach State	<i>Improving Follow-up After Hospitalization for Mental Illness (7-Day)</i>
	<i>Improving Providers' Satisfaction</i>
WellCare	<i>Prenatal Birth Outcomes—17p Initiation</i>
	<i>Member Realignment</i>

Each CMO achieved the objective of completing Module 3 and testing interventions through the SMART Aim end date of October 31, 2019. SMART Aim outcomes were not available at the time of this report and will be included in the next annual EQR technical report.

CMO Comparative and Statewide Aggregate CAHPS Results

Adult Plan Comparisons

Table 4-6 shows the results of the CMO comparative analysis of the 2019 adult Medicaid CAHPS top-box scores.

Table 4-6—Adult Medicaid Plan Comparisons

	State Average	Amerigroup	CareSource	Peach State	WellCare
Composite Measures					
<i>Getting Needed Care</i>	80.50%	80.93% ↔	77.02% ↔	80.68% ↔	81.90% ↔
<i>Getting Care Quickly</i>	80.57%	76.28% ↔	80.64% ↔	82.50% ↔	82.00% ↔
<i>How Well Doctors Communicate</i>	92.02%	92.86% ↔	91.19% + ↔	90.17% ↔	92.99% ↔
<i>Customer Service</i>	88.46%	88.89% + ↔	88.71% + ↔	90.12% + ↔	87.04% ↔
<i>Shared Decision Making</i>	78.13%	75.64% + ↔	80.46% + ↔	77.35% + ↔	79.17% ↔
Global Ratings					
<i>Rating of All Health Care</i>	76.46%	81.29% ↔	73.47% ↔	73.13% ↔	76.98% ↔
<i>Rating of Personal Doctor</i>	82.82%	88.10% ↔	80.65% ↔	80.50% ↔	81.89% ↔
<i>Rating of Specialist Seen Most Often</i>	80.27%	83.72% + ↔	80.88% + ↔	79.75% + ↔	78.10% ↔
<i>Rating of Health Plan</i>	76.82%	79.92% ↔	71.36% ↔	76.59% ↔	78.06% ↔
Effectiveness of Care*					
<i>Advising Smokers and Tobacco Users to Quit</i>	71.01%	64.42% ↔	71.76% ↔	72.22% ↔	73.68% ↔
<i>Discussing Cessation Medications</i>	34.90%	25.24% ↔	37.69% ↔	37.38% ↔	37.06% ↔
<i>Discussing Cessation Strategies</i>	34.58%	32.04% ↔	35.16% ↔	36.45% ↔	34.52% ↔
<p>* These rates follow NCQA's methodology of calculating a rolling two-year average.</p> <p>+ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results.</p> <p>↑ Indicates the CMO's score is statistically significantly better than the State average.</p> <p>↔ Indicates the CMO's score is not statistically significantly different than the State average.</p> <p>↓ Indicates the CMO's score is statistically significantly worse than the State average.</p>					

Summary of Adult Medicaid Plan Comparisons Results

None of the CMOs' scores were statistically significantly better or worse than the Georgia CMO program average.

Child Plan Comparisons

Table 4-7 shows the results of the CMO comparative analysis of the 2019 child Medicaid CAHPS top-box scores.

Table 4-7—Child Medicaid Plan Comparisons

	State Average	Amerigroup	CareSource	Peach State	WellCare
Composite Measures					
<i>Getting Needed Care</i>	86.10%	83.19% ↔	83.43% ↔	89.16% ↔	88.82% ↔
<i>Getting Care Quickly</i>	90.65%	88.63% ↔	90.03% ↔	92.86% ↔	91.68% ↔
<i>How Well Doctors Communicate</i>	93.41%	91.90% ↔	93.57% ↔	94.70% ↔	94.07% ↔
<i>Customer Service</i>	88.31%	88.75% ↔	89.31% ↔	87.54% ↔	87.44% ↔
<i>Shared Decision Making</i>	78.43%	77.08% ↔	77.04% ⁺ ↔	78.32% ↔	81.87% ⁺ ↔
Global Ratings					
<i>Rating of All Health Care</i>	89.94%	90.80% ↔	88.30% ↔	89.41% ↔	91.22% ↔
<i>Rating of Personal Doctor</i>	91.81%	92.52% ↔	92.25% ↔	90.69% ↔	91.50% ↔
<i>Rating of Specialist Seen Most Often</i>	87.14%	84.25% ↔	86.21% ⁺ ↔	87.27% ↔	91.67% ⁺ ↔
<i>Rating of Health Plan</i>	88.25%	91.41% ↑	81.34% ↓	89.11% ↔	90.16% ↔
⁺ Indicates fewer than 100 responses. Caution should be exercised when evaluating these results. ↑ Indicates the CMO's score is statistically significantly better than the State average. ↔ Indicates the CMO's score is not statistically significantly different than the State average. ↓ Indicates the CMO's score is statistically significantly worse than the State average.					

Summary of Child Medicaid Plan Comparisons Results

One measure's scores, *Rating of Health Plan*, for two CMOs exhibited statistically significant differences compared to the Georgia CMO program average. Amerigroup's score was statistically significantly better than the Georgia CMO program average, while CareSource's score was statistically significantly worse than the Georgia CMO program average.

5. CMO-Specific Summary—Amerigroup Community Care

Activity-Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for Amerigroup. It provides a discussion of Amerigroup’s overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively Amerigroup addressed the recommendations for QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis.

Compliance With Standards Review

Review of Standards

Table 5-1 presents a summary of Amerigroup’s Compliance With Standards review results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements reviewed.

Table 5-1—Summary of Compliance With Standards Scores for Amerigroup

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
I	Availability of Services	15	15	15	0	0	100%
II	Assurances of Adequate Capacity and Services	2	2	2	0	0	100%
III	Coordination and Continuity of Care	19	19	19	0	0	100%
IV	Coverage and Authorization of Services	12	12	12	0	0	100%
V	Provider Selection	10	10	10	0	0	100%
VI	Subcontractual Relationships and Delegation	4	4	3	1	0	75.00%
VII	Member Rights and Protections	7	7	6	1	0	85.71%

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
VIII	Confidentiality of Health Information	4	4	4	0	0	100%
IX	Enrollment and Disenrollment	12	12	12	0	0	100%
X	Grievance and Appeal Systems	42	42	37	5	0	88.10%
XI	Practice Guidelines	3	3	3	0	0	100%
XII	Quality Assessment and Performance Improvement (QAPI)	12	12	11	1	0	91.67%
XIII	Health Information Systems	8	8	6	2	0	75.00%
XIV	Program Integrity	13	13	12	1	0	92.31%
XV	Member Information	29	29	28	1	0	96.55%
	Total Compliance Score	192	192	180	12	0	93.75%
* Total # of Elements: The total number of elements in each standard.							
** Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of <i>NA</i> .							
*** Total Compliance Score: Elements that were <i>Met</i> were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.							

Findings

Of the 192 applicable elements identified in Table 5-1, Amerigroup received *Met* scores for 180 elements, with a total compliance score of 93.75 percent. The findings suggest that Amerigroup developed the necessary policies, procedures, and processes to operationalize the required elements of its contract with DCH and demonstrated compliance with the contract. Interviews with Amerigroup staff identified that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the CMO employed to meet contractual requirements.

Of note, Amerigroup was fully compliant in eight of the 15 standards reviewed:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VIII—Confidentiality of Health Information
- Standard IX—Enrollment and Disenrollment
- Standard XI—Practice Guidelines

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to Amerigroup.

Strengths

Person-Centered Care and Services

- The CMO encouraged members diagnosed with chronic needs to use an action plan that related to their condition. The CMO interfaced the care plan with the care coordination team and the member's providers.
- The CMO documented noncovered services in the member's service plan and coordinated receipt of these services with community organizations.

Quality Improvement

- The CMO partnered with the University of Maryland to make available provider training on trauma informed care, and the University of Georgia in Atlanta to provide training regarding infant brain development to increase provider understanding of the needs of members diagnosed with intellectual or developmental delays.
- The CMO used information from quality of care concern trends, claims, and grievances and appeals to identify actionable areas of focus to improve the quality of care delivered and member outcomes. Quality trends were identified for individual providers, the system of care, and the overall program.
- The CMO described processes initiated at the corporate level that included case managers, specialty agencies, and other community partners to recruit providers to fill network gaps that supported gender identity; languages spoken by the CMO's members; and other niche needs identified by members, providers, and community partners.

Social Determinants of Health

- The CMO incorporated SDoH factors into its outreach efforts and used local community health workers to reach members in the communities where they resided. Community health workers addressed psychosocial needs, transportation, follow-up on appointments, and food sources.

Access to Care and Services

- The CMO's care managers maintained data regarding available behavioral health providers and PCPs that specialized in providing services to members with behavioral health conditions. The CMO's care managers assisted members diagnosed with behavioral health conditions in accessing needed care and services from providers who specialized in their unique care needs.
- The CMO implemented Zoom technology to ensure telehealth services were available anywhere, including from the member's mobile device, resulting in increased members' access to behavioral health services.
- The CMO expanded telemedicine sites which included school-based clinics to meet members "where they are."

Recommendations for Improvement

- HSAG recommends that the CMO review and update vendor agreements to consistently contain required contract language.
- HSAG recommends that the CMO review its adverse benefit determination process to consistently send members NABDs within the required time frame.
- HSAG recommends that the CMO review its grievance process to ensure that all grievances are resolved within 90 calendar days of receipt of the grievance.
- HSAG recommends that the CMO review its expedited appeals process to ensure that notices to affected parties are consistently provided within 72 clock hours.
- HSAG recommends that the CMO document processes used to screen and verify the accuracy, completeness, logic, consistency, and timeliness of claims or encounters submitted by providers or subcontractors.

Assessment of Follow-Up on Prior Recommendations

As contract year 2018 was the first year the Compliance With Standards review activity was completed for the CMOs contracted with DCH for the GF program that began in July 2017, there were no prior recommendations.

Validation of Performance Measures

Strengths

The following HEDIS 2019 measures were determined to be strengths for Amerigroup (i.e., exceeded the 75th percentile):

- *Asthma Medication Ratio—5–11 Years and 12–18 Years*

- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total and O/E Ratio—Total*
- *Childhood Immunization Status—Combination 7*
- *Chlamydia Screening in Women—16–20 Years*
- *Cervical Cancer Screening*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*

Recommendations for Improvement

The following HEDIS 2019 measures were determined to be opportunities for improvement for Amerigroup (i.e., below the 25th percentile):

- *Asthma Medication Ratio—19–50 Years*
- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Colorectal Cancer Screening*

Please refer to Section 4 for more information on performance measure results for Amerigroup.

Assessment of Follow-Up on Prior Recommendations

From the results of the 2018 PMV activity, Amerigroup received four recommendations. Table 5-2 presents the prior recommendations made during HEDIS 2018 as well as Amerigroup’s response to those recommendations.

Table 5-2—PMV—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2019)	Amerigroup’s Response to Recommendations
<p>HSAG recommended that Amerigroup focus QI efforts on the following measure rates related to care for behavioral health conditions. (The recommendations may not be listed according to the NCQA domain, and each bullet may include more than one measure or measurement set.)</p> <ul style="list-style-type: none"> • <i>Follow-Up After ED Visit for AOD Abuse or Dependence</i> • <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i> • <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—1–5 Years and 12–17 Years</i> 	<p>Amerigroup completed various QI efforts including:</p> <ul style="list-style-type: none"> • Implementing collaborative actions to improve coordination of care between behavioral health and physical health providers. • Conducting targeted outreach to members on antipsychotics. • Referring members on multiple antipsychotics to a CMO behavioral health medical director for review and triage. • Providing education to members to ensure an understanding of the potential side effects of antipsychotic medications which may impact their overall health. • Using an emergency department case management program that provided continued

Prior Recommendations (CY 2019)	Amerigroup's Response to Recommendations
<ul style="list-style-type: none"> <i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents—6–11 Years</i> 	<p>outreach and education to members and enhanced access and care coordination.</p> <ul style="list-style-type: none"> Focused on follow-up after hospital discharge and readmission/emergency department prevention by ensuring that the member's discharge plan was being followed upon leaving the emergency department setting. Behavioral health case managers continued to work with the necessary facility staff to prevent unnecessary readmissions by ensuring that the members had follow-up appointments within 30 days of discharge with a behavioral health clinician/agency prior to being discharged from the facility. Behavioral health case managers attempted to participate in the behavioral health facility's interdisciplinary rounds/treatment team meetings/discharge planning sessions to ensure that members with ongoing needs were appropriately transitioned to the appropriate level of step-down service.
<p>HSAG recommended that Amerigroup focus QI efforts on the following measure rates related to children's health:</p> <ul style="list-style-type: none"> <i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months and 12–19 Years</i> <i>Annual Dental Visit—19–20 Years</i> <i>Childhood Immunization Status—Combination 6 and Combination 10</i> 	<p>Amerigroup completed various QI efforts including:</p> <ul style="list-style-type: none"> Provided gap-in-care reports to providers with lists of members who had outstanding service needs. Conducted targeted member outreach call campaigns to schedule well-care and immunization appointments. Implemented a text message campaign to members who were identified as in need of immunizations. Implemented a text message campaign to members who were identified as in need of a dental visit.
<p>HSAG recommended that Amerigroup focus QI efforts on the following measure rates related to care for chronic conditions:</p> <ul style="list-style-type: none"> <i>Comprehensive Diabetes Care—HbA1c Control (<7.0%) and Blood Pressure Control (<140/90 mm Hg)</i> <i>Medication Management for People With Asthma—Medication Compliance 50%—Ages 12–18 Years and Medication Compliance 75%—Ages 12–18 Years</i> 	<p>Amerigroup completed various QI efforts including:</p> <ul style="list-style-type: none"> Provided gap-in-care reports to providers with lists of members who were in need of recommended care and services. Educated members and providers about Amerigroup's disease management program. Conducted targeted member outreach call campaigns to schedule appointments with PCPs for annual visits including HbA1c tests and/or follow-up visits with a provider for members

Prior Recommendations (CY 2019)	Amerigroup's Response to Recommendations
<ul style="list-style-type: none"> <i>Asthma Medication Ratio—19–50 Years</i> 	<p>whose lab results indicated that they had poor control.</p> <ul style="list-style-type: none"> Implemented a text message campaign for members identified as in need of recommended care and services. Members with gaps in care for HbA1c testing, in poor control, and/or members identified through claims with an elevated blood pressure were invited to a diabetes event to receive missing services. Provided education to providers on the utilization of Current Procedural Terminology (CPT) Category II codes to capture blood pressure and HbA1c test results. The CMO also collected medical records to review and determine the blood pressure readings and HbA1c test results.
<p>HSAG recommended that Amerigroup focus QI efforts on the following measure rates related to adults' health:</p> <ul style="list-style-type: none"> <i>Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total</i> <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> 	<p>Amerigroup completed various QI efforts including:</p> <ul style="list-style-type: none"> Implemented member outreach campaigns to provide assistance in scheduling members for their annual visit. Used a text message campaign to members identified as needing an annual exam. Conducted provider education sessions on utilization of CPT Category II codes for the prenatal and postpartum care timeliness measure. Conducted member outreach call campaigns to schedule members for their annual well visit.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Based on HSAG's validation of performance measures, HSAG identified no concerns with Amerigroup's data processing, integration, and measure production. HSAG determined that Amerigroup followed the State's measure specifications and produced reportable rates for all measures in the scope of the performance measure validations.

The Amerigroup HEDIS auditor found that the CMO was fully compliant with all IS standards and determined that the CMO submitted valid and reportable rates for all measures in the scope of the NCQA HEDIS Compliance Audit.

Validation of Performance Improvement Projects

For calendar year 2019, Amerigroup submitted two PIPs for validation. The PIPs were validated using HSAG’s rapid-cycle PIP validation process. Table 5-3 includes the PIP title and SMART Aim statement for each topic.

Table 5-3—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Diabetes—Retinal Eye Exam</i>	Improve the percentage of members 18–75 years of age at Choice Healthcare Network (CHN) who have had a diabetic retinal eye exam from 44.94% to 61%, by October 31, 2019.
<i>Customer Satisfaction</i>	Improve the percentage of member satisfaction with benefit inquiries Post Call Survey results by 5%* from baseline 92% to 97%.

* HSAG provided feedback to Amerigroup that the change from baseline to the goal in the *Customer Satisfaction* SMART Aim statement should be described as 5 percentage points, rather than 5 percent.

Findings

For the clinical PIP topic, *Diabetes Retinal Eye Exam*, the CMO achieved all validation criteria for Module 1 with the fifth submission, for Module 2 with the fourth submission, and Module 3 with the third submission. For the nonclinical PIP topic, *Customer Satisfaction*, all validation criteria were achieved for Module 1 with the third submission, for Module 2 with the fourth submission, and Module 3 with the third submission. Amerigroup collaborated within its PIP teams to prioritize the identified failure modes which were used to develop interventions that may be tested using PDSA cycles.

The following interventions were selected by the CMO to test in Module 4 for *Diabetes—Retinal Eye Exam*.

- Partner with Grady Health Eye Clinic to refer and schedule the dilated retinal exams (DREs) for Choice Health Care Network members.
- Have member education support staff call members from one of three healthcare networks and conference in an eye care provider to schedule diabetes retinal exams.
- Provider staff distribution of “AmeriTips: What is Diabetes” from one of three provider groups within the Choice Health Care Network during member office visits.

The following are interventions that the CMO selected to test in Module 4 for *Customer Satisfaction*.

- Implementation of a new training program to improve customer service skillsets for new employees with six months of service or less.
- Partner with network management to develop and test a training program focused on improving customer service agents’ provider query skills for new employees with six months of service or less.
- Monitor customer service recorded calls randomly from the morning shift to identify trends or patterns.

Recommendations for Improvement

- HSAG recommends that Amerigroup develop an internal process to discuss, support, and report PIP progression and outcomes, including methodology development and effective use of QI tools.
- HSAG recommends that Amerigroup apply lessons learned and knowledge gained from its efforts and HSAG’s feedback throughout the PIP process to final modules, future PIPs, and other QI activities.
- HSAG recommends that Amerigroup ensure it addresses all documentation requirements for each module. The CMO should use HSAG’s Rapid-Cycle PIP Reference Guide and the module-specific instructions within each module as modules are completed and the CMO progresses through the PIP process.

Assessment of Follow-Up on Prior Recommendations

Table 5-4 presents the prior recommendations made regarding the 2018 PIPs as well as Amerigroup’s response to those recommendations.

Table 5-4—PIP Validation—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2019)	Amerigroup’s Response to Recommendations
HSAG recommended that the CMO focus subsequent modules of the PIPs and support achieving the established goals for improving PIP outcomes in 2019.	Amerigroup committed to adhering to the PDSA methodology to improve current PIP processes. Amerigroup continued to seek technical assistance when barriers were identified.
HSAG recommended that the CMO take responsibility for ensuring adequate staffing, institutional knowledge, and resources are allocated for each project.	Each Amerigroup PIP team was composed of a leadership champion, a QI professional, a data analyst, and one consultant external to the CMO. The remainder of the team comprised individuals with subject matter expertise.

CAHPS Surveys

Table 5-5 shows Amerigroup’s 2018 and 2019 adult Medicaid CAHPS top-box scores. In 2019, a total of 1,755 adult members were administered a survey, of which 245 completed a survey. After ineligible members were excluded, the response rate was 14.2 percent. In 2018, the average NCQA response rate for the adult Medicaid population was 21.8 percent, greater than the Amerigroup 2019 response rate.

Table 5-5—Amerigroup Adult Medicaid CAHPS Results

	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	77.78%	80.93%
<i>Getting Care Quickly</i>	74.22%	76.28%

	2018 Top-Box Scores	2019 Top-Box Scores
<i>How Well Doctors Communicate</i>	91.24%	92.86%
<i>Customer Service</i>	89.81%	88.89% ⁺
<i>Shared Decision Making</i>	77.57% ⁺	75.64% ⁺
Global Ratings		
<i>Rating of All Health Care</i>	75.26%	81.29% ▲
<i>Rating of Personal Doctor</i>	82.56%	88.10% ▲
<i>Rating of Specialist Seen Most Often</i>	82.86%	83.72% ⁺
<i>Rating of Health Plan</i>	76.47%	79.92%
Effectiveness of Care*		
<i>Advising Smokers and Tobacco Users to Quit</i>	71.17%	64.42% ▼
<i>Discussing Cessation Medications</i>	34.55%	25.24% ▼
<i>Discussing Cessation Strategies</i>	36.36%	32.04%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

■ Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

■ Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

Amerigroup's top-box scores showed a substantial increase of 5 percentage points or more between 2018 and 2019 for two measures:

- *Rating of All Health Care* (6.03 percentage points)
- *Rating of Personal Doctor* (5.54 percentage points)

Amerigroup's 2019 top-box scores were at least 5 percentage points greater than the 2018 NCQA adult Medicaid national averages for two measures:

- *Rating of All Health Care*
- *Rating of Personal Doctor*

Recommendations for Improvement

Amerigroup's top-box scores showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for two measures:

- *Advising Smokers and Tobacco Users to Quit* (6.75 percentage points)
- *Discussing Cessation Medications* (9.31 percentage points)

Amerigroup's 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA adult Medicaid national averages for four measures:

- *Getting Care Quickly*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

HSAG recommends that Amerigroup focus QI efforts on the measure scores that exhibited a decrease from 2018 to 2019 and were lower than the NCQA adult Medicaid national averages. Amerigroup should conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that Amerigroup continue to monitor the measures to ensure there are no significant decreases in rates over time.

HSAG recommends that Amerigroup focus QI initiatives on the medical assistance it provides related to smoking and tobacco use cessation, since these scores fell below NCQA's 2018 adult Medicaid national averages by at least 5 percentage points. For those patients who smoke or use tobacco, Amerigroup should encourage providers to discuss strategies and possible medication options on how to quit smoking and tobacco use. Amerigroup may also identify opportunities to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns.



Table 5-6 shows Amerigroup's 2018 and 2019 child Medicaid CAHPS top-box scores. In 2019, a total of 2,640 child members were administered a survey, of which 699 completed a survey. After ineligible members were excluded, the response rate was 26.8 percent. In 2018, the average NCQA response rate for the child Medicaid population was 21.2 percent, less than the Amerigroup 2019 response rate.

Table 5-6—Amerigroup Child Medicaid CAHPS Results

	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	86.13%	83.19%
<i>Getting Care Quickly</i>	88.93%	88.63%
<i>How Well Doctors Communicate</i>	91.78%	91.90%
<i>Customer Service</i>	88.50%	88.75%
<i>Shared Decision Making</i>	74.81%	77.08%

	2018 Top-Box Scores	2019 Top-Box Scores
Global Ratings		
<i>Rating of All Health Care</i>	86.21%	90.80%
<i>Rating of Personal Doctor</i>	91.05%	92.52%
<i>Rating of Specialist Seen Most Often</i>	86.89%	84.25%
<i>Rating of Health Plan</i>	87.43%	91.41%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.
 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

Amerigroup’s 2019 top-box score was at least 5 percentage points greater than the 2018 NCQA child Medicaid national averages for one measure:

- *Rating of Health Plan*

None of Amerigroup’s top-box scores showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for any measure. None of Amerigroup’s 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA child Medicaid national averages for any measure.

Recommendations for Improvement

Amerigroup’s 2019 top-box scores for *Getting Needed Care*, *Getting Care Quickly*, and *Rating of Specialist Seen Most Often* decreased slightly from 2018; therefore, Amerigroup should focus on interventions targeted toward improving members’ access to care, getting the care needed quickly, and interactions with specialists to help improve these scores. In addition, HSAG recommends that Amerigroup continue to monitor the measures to ensure there are no significant decreases in rates over time.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2018 CAHPS Survey, Amerigroup received four recommendations. Table 5-7 presents the prior recommendations made by HSAG during CY 2019 as well as Amerigroup’s response to HSAG’s recommendations.

Table 5-7—CAHPS Survey—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2019)	Amerigroup’s Response to Recommendations
HSAG recommended that Amerigroup focus efforts on members’ access to care to improve the rate for <i>Getting Care Quickly</i> since it was lower than both the 2017 adult CAHPS top-box rate and the NCQA 2018 CAHPS adult Medicaid national average by at least 5 percentage points.	To ensure that members continued to have access to care, Amerigroup continued to annually monitor practitioner appointment accessibility, after-hour accessibility, and telephone accessibility. On an ongoing basis, Amerigroup continued to evaluate its partnerships with urgent care providers to ensure there was adequate access that supported network growth to meet members’ needs for urgent care services.
For the adult population, HSAG recommended that Amerigroup focus QI initiatives on medical assistance it provides related to smoking and tobacco use cessation (i.e., the effectiveness of care measures [<i>Advising Smokers and Tobacco Users to Quit</i> , <i>Discussing Cessation Medications</i> , and <i>Discussing Cessation Strategies</i>]) since these rates fell below NCQA’s 2018 CAHPS adult Medicaid national averages by at least 5 percentage points, with the <i>Discussing Cessation Medications</i> rate decreasing more than 5 percentage points from 2017 to 2018. For those patients who smoke or use tobacco, HSAG recommended that the CMO work with providers to discuss strategies with members and possible medication options on how to quit smoking and tobacco use. HSAG also recommended that Amerigroup identify opportunities to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns.	Amerigroup participated in the Georgia Department of Public Health smoking cessation workgroup. When a member was identified as a smoker, they were referred to the Georgia Tobacco Quit Line managed by the Georgia Department of Public Health. Members were also provided information for Aunt Bertha’s community-based programs for a smoking cessation program.
Amerigroup saw improvement in the 2018 composite measure rating for <i>Customer Service</i> as compared to 2017 (indicating that the CMO’s members were satisfied with its customer service); however, HSAG recommended that Amerigroup continue to focus QI efforts to improve members’ experience with the CMO and with access to timely care.	Amerigroup initiated a workgroup focused on customer service. Amerigroup implemented the following interventions focused on increasing CAHPS scores: <ul style="list-style-type: none"> Streamlined the process to access care from a PCP or specialist. Facilitated member access to lab, pharmacy, or treatment services. Ensured accurate and timely communication of CMO benefits, services, or updates to members and their providers. Conducted provider education to enhance provider communication skills. Implemented process improvement initiatives to facilitate access to specialists, tests, and treatment,

Prior Recommendations (CY 2019)	Amerigroup's Response to Recommendations
	<p>and provided easy access to care members received from other healthcare providers.</p> <p>To ensure that members continued to have access to timely care, Amerigroup continued to annually monitor practitioner appointment accessibility, after-hours accessibility, and telephone accessibility. On an ongoing basis, Amerigroup continued to evaluate its partnerships with urgent care providers to ensure that there was adequate access that supported network growth to meet members' needs for urgent care access.</p>
<p>For the child Medicaid population, HSAG recommended that Amerigroup focus on activities and initiatives targeted at improving the rates for the <i>Getting Care Quickly</i>, <i>How Well Doctors Communicate</i>, <i>Customer Service</i>, <i>Shared Decision Making</i>, <i>Rating of All Health Care</i>, and <i>Rating of Specialist Seen Most Often</i> measures since their rates all fell below the NCQA 2018 CAHPS child Medicaid national averages. Additionally, HSAG recommended that the CMO efforts focus on improving the <i>Rating of Health Plan</i> measure rate, as well as all of the measures that fell below the NCQA child Medicaid national averages, since all rates but <i>Customer Service</i> decreased between 2017 and 2018. HSAG identified that interventions targeted at the provider level and toward provider communication and interaction with Medicaid members most likely will have the greatest impact on these CAHPS measures. In addition, interventions targeted toward improving members' access to care and getting the care needed quickly will help improve rates.</p>	<p>Amerigroup initiated a workgroup focused on customer service. Amerigroup implemented the following interventions focused on increasing CAHPS scores:</p> <ul style="list-style-type: none"> • Streamlined the process to access care from a PCP or specialist. • Facilitated member access to lab, pharmacy, or treatment services. • Ensured accurate and timely communication of CMO benefits, services, or updates to members and their providers. • Conducted provider education to enhance provider communication skills. • Implemented process improvement initiatives to facilitate access to specialists, tests, and treatment, and provided easy access to care members received from other healthcare providers. <p>To ensure that members continued to have access to timely care, Amerigroup continued to annually monitor practitioner appointment accessibility, after-hours accessibility, and telephone accessibility. On an ongoing basis, Amerigroup continued to evaluate its partnerships with urgent care providers to ensure that there was adequate access that supported network growth to meet members' needs for urgent care access.</p>

6. CMO-Specific Summary—CareSource

Activity-Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for CareSource. It provides a discussion of CareSource’s overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively CareSource addressed the recommendations for QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix. A—Technical Methods of Data Collection and Analysis.

Compliance With Standards Monitoring

Review of Standards

Table 6-1 presents a summary of CareSource’s Compliance With Standards review results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements reviewed

Table 6-1—Summary of Compliance With Standards Scores for CareSource

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
I	Availability of Services	15	15	13	2	0	86.67%
II	Assurances of Adequate Capacity and Services	2	2	2	0	0	100%
III	Coordination and Continuity of Care	19	19	19	0	0	100%
IV	Coverage and Authorization of Services	12	12	11	1	0	91.67%
V	Provider Selection	10	10	9	1	0	90.00%
VI	Subcontractual Relationships and Delegation	4	4	3	1	0	75.00%
VII	Member Rights and Protections	7	7	7	0	0	100%

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
VIII	Confidentiality of Health Information	4	4	4	0	0	100%
IX	Enrollment and Disenrollment	12	12	12	0	0	100%
X	Grievance and Appeal Systems	42	42	33	9	0	78.57%
XI	Practice Guidelines	3	3	2	1	0	66.67%
XII	Quality Assessment and Performance Improvement (QAPI)	12	12	11	1	0	91.67%
XIII	Health Information Systems	8	8	8	0	0	100%
XIV	Program Integrity	13	13	12	1	0	92.31%
XV	Member Information	29	29	26	3	0	89.66%
	Total Compliance Score	192	192	172	20	0	89.58%

* **Total # of Elements:** The total number of elements in each standard.

** **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *N/A*.

*** **Total Compliance Score:** Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Findings

Of the 192 applicable elements identified in Table 6-1, CareSource received *Met* scores for 172 elements, with a total compliance score of 89.58 percent. The findings suggest that CareSource developed the necessary policies, procedures, and processes to operationalize the required elements of its contract with DCH and demonstrated compliance with the contract. Interviews with CareSource staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the CMO employed to meet contractual requirements.

Of note, CareSource was fully compliant in six of the 15 standards reviewed:

- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard VII—Member Rights and Protections
- Standard VIII—Confidentiality of Health Information
- Standard IX—Enrollment and Disenrollment
- Standard XIII—Health Information Systems

During the Compliance With Standards review process, HSAG identified strengths and opportunities for improvement specific to CareSource.

Strengths

Access to Care and Services

- The CMO used a team-based, member-centric approach to ensure member access to care. The CMO used community health workers, the CMO's Customer Advocacy Team, and care managers to conduct outreach, provide education, and connect members to faith-based organizations, community resources, and food banks to address unmet SDoH.
- The CMO used the Global Partnership for Telehealth to serve members in rural areas where there were limited network providers to deliver needed services. The CMO's provider directory included information for members on how to access telemedicine services and which providers offered telemedicine services.

Social Determinants of Health

- The CMO used community health workers who worked in the community in which they lived to address SDoH, giving members a unique perspective and information about their own community from someone who was a trusted insider.
- The CMO implemented the Care4U model, which considered the member's health needs, SDoH, neighborhood resources, pharmacy utilization, and provider referrals. The CMO used the Johns Hopkins adjusted clinical model to identify members with the greatest risks for purposes of care management with a special focus on pregnant women, children ages 0–5 years, and members with chronic or acute conditions.

Person-Centered Care and Services

- The CMO provided a Life Services program to help members identify goals and to develop an actionable plan to achieve them. These goals were specific to each member and included life coaching on employment, educational opportunities, and health. The CMO included parents of members under 21 years of age in the life-coaching sessions for members to serve as supportive partners.

- The CMO’s Life Services program information was listed in the member handbook and included a network of community partners that had expertise in General Education Diploma (GED) preparation, testing, and site locations; hiring and employment; after-school resources; and child care. The Life Services program also used community health workers to connect members with community-based resources.

Quality Improvement

- The CMO included executive leadership in regular reviews of quality metrics. Senior leaders participated in NCQA meetings to learn and understand the quality requirements. Quality was integrated, by senior leadership, throughout the organization.

Recommendations for Improvement

- HSAG recommends that the CMO review and update its process to ensure that oral appeals are followed by a written appeal, and that members approve appeals submitted by a provider on behalf of a member and the extension of an appeal time frame.
- HSAG recommends that the CMO review its administrative review/appeal process to ensure that all notices and all grievance acknowledgement letters are sent within the required time frames.
- HSAG recommends that the CMO implement a process to ensure the accuracy and completeness of grievance resolution letters.

Assessment of Follow-Up on Prior Recommendations

As contract year 2018 was the first year the Compliance With Standards review activity was completed for the CMOs contracted with DCH for the GF program that began in July 2017, there were no prior recommendations.

Validation of Performance Measures

Strengths

CareSource began operations in Georgia as a Medicaid CMO in 2017, and HEDIS 2019 is the first time performance measure results were reported by the CMO. Therefore, caution should be exercised when comparing CareSource’s rates to national benchmarks and to the other CMOs’ rates in this report.

The following HEDIS 2019 measure was determined to be a strength for CareSource (i.e., exceeded the 75th percentile):

- *Chlamydia Screening in Women—21–24 Years*

Recommendations for Improvement

The following HEDIS 2019 measures were determined to be opportunities for improvement for CareSource (i.e., below the 25th percentile):

- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Childhood Immunization Status—Combination 7*
- *Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits and Six or More Well-Child Visits*
- *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*

Please refer to Section 4 for more information on performance measure results for CareSource.

Assessment of Follow-Up on Prior Recommendations

As HEDIS 2019 was the first year the performance measure review activity was completed for the CMO, there were no prior recommendations.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Based on HSAG's validation of performance measures, HSAG identified no concerns with CareSource's data processing, integration, and measure production. HSAG determined that CareSource followed the State's specifications and produced reportable rates for all measures in the scope of performance measure validation. For CareSource reporting, the *Colorectal Cancer Screening* performance measure received a designation of Small Denominator (NA).

CareSource's HEDIS auditor found that the CMO was fully compliant with all IS standards and determined CareSource submitted valid and reportable rates for all measures in the scope of the NCQA HEDIS Compliance Audit.

Validation of Performance Improvement Projects

For calendar year 2019, CareSource submitted two PIPs for validation. The PIPs were validated using HSAG's rapid-cycle PIP validation process. Table 6-2 includes the PIP title and SMART Aim statement for each topic.

Table 6-2—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Improve the Timeliness of Utilization Management Decisions</i>	By October 31, 2019, increase the percent of medical outpatient prior authorization compliance rate of timely decision (within 3 business days of request) at Soft Touch Medical, LLC from 76.6 percent to 86.9 percent.
<i>Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge</i>	Increase the percent of members receiving a follow-up visit with a mental health clinician within seven days of discharge for acute inpatient mental health hospitalizations from Tanner Medical Center Villa Rica Hospital from 14.8 percent to 46.5 percent by October 31, 2019.

Findings

For the clinical PIP topic, *Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge*, the CMO achieved all validation criteria for Module 1 with the fourth submission, Module 2 with the fourth submission, and Module 3 with the third submission. For the nonclinical PIP topic, *Improve the Timeliness of Utilization Management Decisions*, all validation criteria were achieved for Module 1 with the second submission, Module 2 with the fourth submission, and Module 3 with the third submission. CareSource collaborated within its PIP workgroup to prioritize the identified failure modes which were used to develop interventions that may be tested using PDSA cycles in Module 4.

The following interventions were selected by the CMO to test in Module 4 for the clinical PIP topic, *Follow-up After Hospitalization for Mental Illness Within 7 Days of Discharge*.

- Develop a “Staff Point of Contact” list that identifies the CareSource care coordinators, and Tanner will develop a “Staff Point of Contact” list that identifies the Tanner Medical discharge planners. The list will be shared with all appropriate staff, and CareSource will contact the discharge planner for introductions.
- Provide training material to Tanner Medical Center staff on requirements for follow-up visits seven days after discharge. Tanner Medical Center will use the material to train discharge planning staff.
- Develop a behavioral health management queue and test it with Tanner Medical Center Villa Rica Hospital.

The following interventions were selected by the CMO to test for the nonclinical PIP topic, *Improve the Timeliness of Utilization Management Decisions*.

- Provide training material to Soft Touch Medical on submission of prior authorizations, turnaround time, and the difference between pre-authorization and retrospective review.
- Develop a document that identifies all the durable medical equipment (DME) that does not require prior authorization and disseminate the document to Soft Touch Medical in person or via email, fax, or the CareSource provider portal. This intervention will be tested with Soft Touch Medical.

- Develop a pre-recorded video training for Soft Touch Medical on the steps to successfully submit a prior authorization form through the provider portal.

Recommendations for Improvement

- HSAG recommends that CareSource apply lessons learned and knowledge gained from its QI efforts and HSAG’s feedback throughout the PIP process to final modules, future PIPs, and other QI activities.

HSAG recommends that CareSource ensure it addresses all documentation requirements for each module. The CMO should use HSAG’s Rapid-Cycle PIP Reference Guide and the module-specific instructions within each module as modules are completed and the CMO progresses through the PIP process.

Assessment of Follow-Up on Prior Recommendations

As calendar year 2019 was the first year the PIP activity was completed for the CMO, there were no prior recommendations.

CAHPS Surveys

Table 6-3 shows CareSource’s 2018 and 2019 adult Medicaid CAHPS top-box scores.⁶⁻¹ In 2019, a total of 2,025 adult members were administered a survey, of which 212 completed a survey. After ineligible members were excluded, the response rate was 10.7 percent. In 2018, the average NCQA response rate for the adult Medicaid population was 21.8 percent, greater than CareSource’s 2019 response rate.

Table 6-3—CareSource Adult Medicaid CAHPS Results


	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	78.06%	77.02%
<i>Getting Care Quickly</i>	76.53%	80.64%
<i>How Well Doctors Communicate</i>	91.08%	91.19% ⁺
<i>Customer Service</i>	88.24%	88.71% ⁺
<i>Shared Decision Making</i>	76.65% ⁺	80.46% ⁺
Global Ratings		
<i>Rating of All Health Care</i>	70.35%	73.47%


⁶⁻¹ The 2018 top-box scores for the Effectiveness of Care measures were calculated using 2018 data only, as 2017 data did not exist. Therefore, the 2018 Effectiveness of Care top-box scores were not calculated following NCQA’s methodology.

	2018 Top-Box Scores	2019 Top-Box Scores
<i>Rating of Personal Doctor</i>	78.45%	80.65%
<i>Rating of Specialist Seen Most Often</i>	85.39% ⁺	80.88% ⁺
<i>Rating of Health Plan</i>	70.72%	71.36%
Effectiveness of Care*		
<i>Advising Smokers and Tobacco Users to Quit</i>	71.62% ⁺	71.76%
<i>Discussing Cessation Medications</i>	37.84% ⁺	37.69%
<i>Discussing Cessation Strategies</i>	31.94% ⁺	35.16%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

None of CareSource's top-box scores showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for any measure.

Recommendations for Improvement

CareSource's 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA adult Medicaid national averages for five measures:

- *Getting Needed Care*
- *Rating of Health Plan*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

HSAG recommends that CareSource continue to monitor the measures to ensure there are no significant decreases in rates over time. Also, HSAG recommends that CareSource focus QI initiatives on the medical assistance it provides related to smoking and tobacco use cessation, since these scores fell below NCQA's 2018 adult Medicaid national averages by at least 5 percentage points. For those patients who smoke or use tobacco, CareSource should encourage providers to discuss strategies and possible medication options on how to quit smoking and tobacco use. CareSource may also identify opportunities to collaborate with public health and community organizations and their work related to smoking and


tobacco cessation campaigns. Along with smoking and tobacco cessation initiatives, the CMO should focus QI activities on members’ overall experience and access to care.


Table 6-4 shows CareSource’s 2018 and 2019 child Medicaid CAHPS top-box scores. In 2019, a total of 3,300 child members were administered a survey, of which 486 completed a survey. After ineligible members were excluded, the response rate was 15.4 percent. In 2018, the average NCQA response rate for the child Medicaid population was 21.2 percent, greater than CareSource’s 2019 response rate.

Table 6-4—CareSource Child Medicaid CAHPS Results

	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	83.36%	83.43%
<i>Getting Care Quickly</i>	89.55%	90.03%
<i>How Well Doctors Communicate</i>	93.45%	93.57%
<i>Customer Service</i>	85.31%	89.31%
<i>Shared Decision Making</i>	73.33%	77.04% ⁺
Global Ratings		
<i>Rating of All Health Care</i>	84.56%	88.30%
<i>Rating of Personal Doctor</i>	90.53%	92.25%
<i>Rating of Specialist Seen Most Often</i>	87.13%	86.21% ⁺
<i>Rating of Health Plan</i>	79.85%	81.34%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

None of CareSource’s top-box scores showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for any measures. In addition, none of CareSource’s 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA child Medicaid national averages for any measure.

Recommendations for Improvement

The CMO should focus QI activities on improving members’ positive experiences with CareSource and its contracted providers. CareSource’s 2019 top-box score for *Rating of Specialist Seen Most Often*

declined from 2018. HSAG recommends that CareSource conduct a root cause analysis on this area. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that CareSource continue to monitor the measures to ensure there are no significant decreases in rates over time.

Assessment of Follow-Up on Prior Recommendations

From the results of the calendar year 2018 CAHPS Survey, CareSource received three recommendations. Table 6-5 presents the prior recommendations made by HSAG during calendar year 2019 as well as CareSource’s responses to HSAG’s recommendation.

Table 6-5—CAHPS Survey—Prior Recommendations and CareSource’s Response

Prior Recommendations (CY 2019)	CareSource’s Response to Recommendations
For CareSource’s adult population, HSAG recommended, based on the Adult CAHPS results, that QI initiatives focus on medical assistance the CMO provides related to smoking and tobacco use cessation (i.e., the Effectiveness of Care measures— <i>Advising Smokers and Tobacco Users to Quit</i> , <i>Discussing Cessation Medications</i> , and <i>Discussing Cessation Strategies</i>) since all of these rates fell below NCQA’s 2018 CAHPS adult Medicaid national averages by at least 5 percentage points.	<ul style="list-style-type: none"> • CareSource proactively identified all smokers and tobacco users using a monthly report. • Pregnant members who were identified as smokers or tobacco users were called and informed of the “Quit 4 Two Program” and encouraged to enroll as soon as possible. • Nonpregnant smokers or tobacco users were referred to the “Georgia Quit Line.” • CareSource partnered with myStrength and offered a nicotine recovery program. This program allowed members to customize a cessation plan tailored to their specific needs.
All but one of CareSource’s CAHPS Adult Medicaid Population 2018 top-box rates fell below the NCQA 2018 adult Medicaid national averages, with <i>Getting Care Quickly</i> , <i>Rating of Health Plan</i> , <i>Advising Smokers and Tobacco Users to Quit</i> , <i>Discussing Cessation Medications</i> , and <i>Discussing Cessation Strategies</i> rates at least 5 percentage points less than the 2018 national averages. Along with smoking and tobacco cessation initiatives, HSAG recommended that the CMO focus QI activities on member experience, access to care, and provider relations.	<p>To directly impact member experience, access to care, and provider relations, the CMO initiated several targeted interventions:</p> <ul style="list-style-type: none"> • Member orientations were being held to reeducate and update members on their rights and responsibilities, CareSource’s Find-A-Doc resource, how members could obtain a provider directory, and the importance of well visits (child and adolescent). • The CMO’s customer advocacy group and QI and case management departments conducted outreach calls throughout the year to members during appropriate evening hours. These calls focused on satisfaction with CareSource, ensuring members were getting the care, tests, and/or treatment(s) they needed, and included assistance with scheduling appointments to specialists, as applicable. • CareSource performed an annual analysis to collect data and measure the CMO’s performance against its

Prior Recommendations (CY 2019)	CareSource's Response to Recommendations
	<p>standards for access to primary care for regular and routine care appointments, urgent care appointments, and after-hours care. This analysis helped the CMO ensure members were receiving access to the care they needed in a timely manner.</p> <ul style="list-style-type: none"> Phase II provider orientations were being held to educate providers on CareSource services and benefits. CareSource incorporated the feedback from providers serving on the Provider Advisory Committee (PAC) on services and programs offered by CareSource of which providers may not be aware. Providers were encouraged to communicate and share care information with all providers involved in a patient's care.
<p>Based on the 2018 CAHPS Child Medicaid population, HSAG recommended that CareSource focus on improving the rates for the <i>Getting Needed Care</i>, <i>How Well Doctors Communicate</i>, <i>Customer Service</i>, <i>Shared Decision Making</i>, <i>Rating of All Health Care</i>, and <i>Rating of Health Plan</i> measures since these rates all fell below the NCQA 2018 CAHPS child Medicaid national averages, with the <i>Rating of Health Plan</i> rate at least 5 percentage points less than the national average. HSAG also recommended that CareSource work with the State to adopt identified best practices and initiatives to support members' positive experiences with the CMO and its contracted providers.</p>	<p>To directly impact members' positive experiences with CareSource as well as its contracted providers, the CMO initiated several targeted interventions:</p> <ul style="list-style-type: none"> CareSource implemented member orientations in the community. The orientations reeducated members on their rights and responsibilities and CareSource services, and included on-site health screenings. Additionally, members were advised to obtain discharge summaries, medical records, and test results to share with other providers involved in their care. The CMO worked on updating its mobile application and website to better inform members about the CMO, tools, benefits, coverage, and costs. Phase II provider orientations were held to educate providers on CareSource services and benefits. Providers were encouraged to communicate and share care information with all providers involved in a patient's care. Member Advisory Committee (MAC) meetings were held on a recurring schedule to solicit input from members. Additionally, the CareSource Office of Ombudsman was present at the MAC meetings to offer immediate assistance with any concerns expressed by CMO members. PAC meetings were held with participating network physicians who provided quality input regarding members and CMO benefits/services.

7. CMO-Specific Summary—Peach State Health Plan

Activity-Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for Peach State. It provides a discussion of Peach State’s overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively Peach State has addressed the recommendations for QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis.

Compliance With Standards Monitoring

Review of Standards

Table 7-1 presents a summary of Peach State’s Compliance With Standards Review results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements reviewed.

Table 7-1—Summary of Compliance With Standards Scores for Peach State

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
I	Availability of Services	15	15	14	1	0	93.33%
II	Assurances of Adequate Capacity and Services	2	2	2	0	0	100%
III	Coordination and Continuity of Care	19	19	19	0	0	100%
IV	Coverage and Authorization of Services	12	12	12	0	0	100%
V	Provider Selection	10	10	10	0	0	100%
VI	Subcontractual Relationships and Delegation	4	4	4	0	0	100%
VII	Member Rights and Protections	7	7	7	0	0	100%

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
VIII	Confidentiality of Health Information	4	4	4	0	0	100%
IX	Enrollment and Disenrollment	12	12	11	1	0	91.67%
X	Grievance and Appeal Systems	42	42	37	5	0	88.10%
XI	Practice Guidelines	3	3	3	0	0	100%
XII	Quality Assessment and Performance Improvement (QAPI)	12	12	11	1	0	91.67%
XIII	Health Information Systems	8	8	8	0	0	100%
XIV	Program Integrity	13	13	13	0	0	100%
XV	Member Information	29	29	28	1	0	96.55%
	Total Compliance Score	192	192	183	9	0	95.31%
* Total # of Elements: The total number of elements in each standard.							
** Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of <i>N/A</i> .							
*** Total Compliance Score: Elements that were <i>Met</i> were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.							

Findings

Of the 192 applicable elements identified in Table 7-1, Peach State received *Met* scores for 183 elements, with a total compliance score of 95.31 percent. The findings suggest that Peach State developed the necessary policies, procedures, and processes to operationalize the required elements of its contract with DCH and demonstrated compliance with the contract. Interviews with Peach State staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the CMO employed to meet contractual requirements.

Of note, Peach State was fully compliant in 10 of the 15 standards reviewed:

- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VI—Subcontractual Relationships and Delegation
- Standard VII—Member Rights and Protections
- Standard VIII—Confidentiality of Health Information
- Standard XI—Practice Guidelines
- Standard XIII—Health Information Systems
- Standard XIV—Program Integrity

Strengths

Social Determinants of Health

- The CMO's case management staff coordinated with community resources for members over 21 years of age for needed noncovered services.
- The CMO developed and included a community resource guide on its website. The CMO's member-facing staff members used the community resource guide to assist members with addressing SDoH.
- The CMO's Member Advisory Committee meetings raised a member concern regarding the lack of availability of fresh produce in some communities where members lived. To address this concern, the CMO began offering a mobile produce van that brought healthy food into the affected communities.

Person-Centered Care and Services

- The CMO included a data field in its system that allowed for documenting a member's gender identity preference. The goal of adding this information was to assist members who needed support finding a culturally competent provider who could deliver services in an affirming way for members of the lesbian, gay, bisexual, transgender, queer or questioning, intersex, and asexual or allied (LGBTQIA) community and other gender minorities.

Access to Care and Services

- The CMO used telehealth, partnering with the Global Partners for Telehealth, to increase access to care and services for members, particularly in the rural areas of the State. If a provider gap was identified, the CMO supported the installation of telehealth equipment in a provider's office and actively promoted the access and availability of the telehealth equipment to members and providers throughout the region. The CMO sponsored telehealth equipment in hospitals, FQHCs, provider offices, and school-based clinics.

Quality Improvement

- The CMO conducted member orientation meetings in the community to assist members with accessing CMO benefits and services. During the orientation meetings, CMO staff members assisted members with registering on the CMO's member portal, which provided benefit information and information on how to access care and services.
- The CMO placed care coordination and discharge planning staff members on-site within 16 hospitals throughout the State to provide pre-discharge services such as setting up transportation, scheduling follow-up appointments, and conducting medication reconciliation. The CMO also conducted post-discharge follow-up calls with members to ensure that DME had been received, prescriptions had been filled, and that the member was attending follow-up appointments.
- The CMO partnered with a community provider to travel with the provider relations team during some office visits. The provider also worked with the providers from a peer-to-peer perspective to improve member outcomes.
- The CMO had two pharmacy representatives in the community who worked with providers on issues with medications and understanding the CMO's medication drug list or formulary.

Recommendations for Improvement

- HSAG recommends that the CMO review its appeals process to consistently resolve appeals within the state-specific time frame.
- HSAG recommends that the CMO review its process to ensure that it consistently sends acknowledgement letters within the required time frame.
- HSAG recommends that the CMO review its process to consistently implement the state-specific time frame for adverse benefit determination notifications.
- HSAG recommends that the CMO review its process to ensure that it consistently implements the grievance resolution notification requirements and provides a clear resolution of the member's grievance in the grievance resolution letter.

Assessment of Follow-Up on Prior Recommendations

As contract year 2018 was the first year the Compliance With Standards review activity was completed for the CMOs contracted with DCH for the GF program that began in July 2017, there were no prior recommendations.

Validation of Performance Measures

Strengths

The following HEDIS 2019 measures were determined to be strengths for Peach State (i.e., exceeded the 75th percentile):

- *Asthma Medication Ratio—5–11 Years, 12–18 Years, and 19–50 Years*
- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total and O/E Ratio—Total*
- *Childhood Immunization Status—Combination 7*
- *Chlamydia Screening in Women—16–20 Years and 21–24 Years*
- *Cervical Cancer Screening*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*

Recommendations for Improvement

The following HEDIS 2019 measures were determined to be opportunities for improvement for Peach State (i.e., below the 25th percentile):

- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Colorectal Cancer Screening*
- *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Please refer to Section 4 for more information on performance measure results for Peach State.

Assessment of Follow-Up on Prior Recommendations

From the results of the 2018 PMV activity, Peach State received four recommendations. Table 7-2 presents the prior recommendations made during calendar year 2019 as well as Peach State’s response to those recommendations.

Table 7-2—PMV—Prior Recommendations and Peach State’s Response

Prior Recommendations (CY 2019)	Peach State’s Response to Recommendations
<p>HSAG recommended that Peach State focus QI efforts on the following measure rates related to care for chronic conditions:</p> <ul style="list-style-type: none"> • <i>Comprehensive Diabetes Care—HbA1c Testing and Medical Attention for Nephropathy</i> • <i>Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total</i> • <i>Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years and Total, and Medication Compliance 75%—Ages 5–11 Years and Ages 12–18 Years</i> • <i>Annual Monitoring for Patients on Persistent Medications—Ace Inhibitors or ARBs and Diuretics</i> 	<p><i>Comprehensive Diabetes Care—HbA1c Testing and Medical Attention for Nephropathy</i></p> <ul style="list-style-type: none"> • Follow-up telephonic member outreach was conducted for members identified with gaps in diabetes care. • In-home test kits were sent to members with diabetes. Results were provided to the member’s PCP on record. <p><i>Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total</i></p> <ul style="list-style-type: none"> • To prevent a second cardiovascular event, Peach State Pharmacy used the American College of Cardiology/American Heart Association (ACC/AHA) guidelines, encouraging the use of statin therapy in members identified as previously

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
<ul style="list-style-type: none"> <i>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</i> 	<p>having cardiovascular disease. The Peach State pharmacy department actively engaged in provider outreach to recommend statin therapy, when appropriate.</p> <ul style="list-style-type: none"> The Pharmacy Statin Use in Cardiovascular Disease Program identified members who had cardiovascular disease and were not receiving statin therapy to evaluate the benefit of initiating statin therapy, encourage medication adherence, and conduct telephonic outreach to improve medication adherence. <p><i>Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years and Total, and Medication Compliance 75%—Ages 5–11 Years and Ages 12–18 Years</i></p> <ul style="list-style-type: none"> The CMO used Enroll People Care (EPC) Disease Management/Lifestyle Management (DM/LM) to employ health status evaluations, educate and coach members and caregivers, arrange and coordinate needed services to stabilize the member's health conditions, and thereby reduced member use of inappropriate or unnecessary inpatient admissions, readmissions, and emergency department visits, including those associated with under- and overutilization of medications. <p><i>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</i></p> <ul style="list-style-type: none"> Initiated disease modifying anti-rheumatic drug therapy in patients diagnosed with rheumatoid arthritis who were not dispensed at least one ambulatory prescription for a disease-modifying anti-rheumatic drug. Peach State's pharmacy department outreached to the providers of targeted members to clinically evaluate the use and benefit of starting disease-modifying anti-rheumatic drug therapy in patients diagnosed with rheumatoid arthritis.
<p>HSAG recommended that Peach State focus QI efforts on the following measure rates related to children's health:</p> <ul style="list-style-type: none"> <i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 7–11 Years, and 12–19 Years</i> 	<p><i>Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 7–11 Years, and 12–19 Years,</i></p> <p><i>Annual Dental Visit—19–20 Years</i></p> <p><i>Childhood Immunization Status—Combination 6 and Combination 10</i></p>

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
<ul style="list-style-type: none"> • <i>Annual Dental Visit—19–20 Years</i> • <i>Childhood Immunization Status—Combination 6 and Combination 10</i> • <i>Appropriate Treatment for Children With Upper Respiratory Infection</i> • <i>Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits</i> • <i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i> 	<p><i>Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits</i></p> <ul style="list-style-type: none"> • The CMO sent care reminders to members and providers when potential gaps in care were identified through claims, laboratory data, and other sources to create actionable opportunities to improve preventive health, chronic condition management, and HEDIS scores. • The CMO used automated interactive voice response (IVR) calls to educate members on the services they should have during the year and to offer assistance in scheduling appointments. • Follow-up IVR calls were made for identified campaigns. • Reminders calls were placed for members who were almost due for screenings/services. • Reminder calls were placed for members with a gap in dental or well-child visits with assistance provided to schedule appointments to close open gaps. • The Helping All Lives through Outreach (HALO) team conducted calls, offered DCH-approved incentives, and assisted with scheduling appointments and transportation. • Implemented new software allowing providers a real-time view of member care gaps during patient visits. • Educated members (parents/guardians) about the need to obtain timely EPSDT preventive health services via the following methods: mail, telephonic, in-person events, and Web portal alerts. • The Peach State community relations department hosted monthly member orientation sessions across the State to meet, connect with, and educate new members about Peach State Health Plan. • Assisted members with signing up for the secure member portal. • Demonstrated the CMO's website to assist new members with the website navigational process. • Informed members (parents/guardians) about the need to obtain an EPSDT visit within 60 days of

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
	<p>enrollment and according to the Bright Futures Guideline (schedule for periodicity).</p> <ul style="list-style-type: none"> • Due to utilization concerns, partnered with two providers in the Southeast Region to help increase the number of members who received EPSDT visits. • Hosted “The Celebration of Motherhood” in Macon, Georgia. The purpose of the event was to provide education to CMO members on benefits including dental, EPSDT, and maternal care while celebrating their pregnancy via games and door prizes. • The CMO conducted a formal focus study to identify barriers for members not receiving EPSDT preventive health visits. <p><i>Appropriate Treatment for Children With Upper Respiratory Infection</i></p> <ul style="list-style-type: none"> • Reviewed practitioners who were outliers; conducted Peach State medical director outreach to the provider to discuss the appropriate treatment for children with upper respiratory infections. <p><i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i></p> <ul style="list-style-type: none"> • Reviewed outlier practitioners, and a Peach State medical director conducted outreach to discuss the appropriate age range to conduct cervical screenings based on risk factors and clinical guidelines.
<p>HSAG recommended that Peach State focus QI efforts on the following measure rates related to care for behavioral health conditions:</p> <ul style="list-style-type: none"> • <i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i> • <i>Follow-Up After ED Visit for Mental Illness</i> • <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—6–11 Years, 12–17 Years, and Total</i> 	<p><i>Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications</i></p> <ul style="list-style-type: none"> • Established payment for in-office stat labs for behavioral health providers. • Developed and updated the HEDIS tool kit and the behavioral health HEDIS lab flyer with best practice guidelines for closing care gaps. • Reviewed requirements during quarterly joint operating committee meetings with psychiatric hospitals and medical and behavioral health providers, and encouraged hospitals to submit results to the CMO's pharmacy department.

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
	<ul style="list-style-type: none"> Conducted outreach to providers that prescribed antipsychotics to members and requested that they submit results to close the gap. Scheduled health clinic days in behavioral health providers' offices where labs could be drawn and assisted the provider in reaching out to members to schedule appointments. <p><i>Follow-Up After ED Visit for Mental Illness</i></p> <ul style="list-style-type: none"> Monitored mental health emergency department utilization. Outreached to members who were seen in the emergency department within the last 30 days and assisted the member with reducing barriers to attend a follow-up appointment with a provider including assistance with appointment scheduling, transportation, reduction of SDoH, and any coordinating care to close any other open care gaps. Provided education to medical and behavioral health providers on the importance of following up with members after a mental health emergency department visit. <p><i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—6–11 Years, 12–17 Years, and Total</i></p> <ul style="list-style-type: none"> Educated medical and behavioral health providers on best practices to close care gaps. Incentivized PCPs to close care gaps for this measure under the CMOs' provider incentive program.
<p>HSAG recommended that Peach State focus QI efforts on the following measure related to adults' health:</p> <ul style="list-style-type: none"> <i>Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total</i> <i>Prenatal and Postpartum Care—Postpartum Care</i> <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i> <i>Use of Imaging Studies for Low Back Pain</i> 	<p><i>Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and Total</i></p> <ul style="list-style-type: none"> Implemented a PCP medical home steerage intervention which provided outreach and care coordination for chronic/high-risk members who had been identified as using multiple PCPs and those who had no PCP utilization. Completed automated IVR calls to educate members on the services they should have during the year; offered assistance in scheduling appointments. Offered members incentives to schedule an appointment and complete a physical with their PCP.

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
	<p><i>Prenatal and Postpartum Care—Postpartum Care</i></p> <ul style="list-style-type: none"> • The Start Smart Case Management Program promoted the early identification and assessment of pregnant members; encouraged appropriate prenatal care and follow-up; educated members on the importance of prenatal and postpartum care; offered incentives for pregnant members to attend their prenatal and timely postpartum follow-up appointments. • The Start Smart for Your Baby case management program included the following: <ul style="list-style-type: none"> — Education and assistance with accessing needed medical, nutritional, social, educational, and other services, including coordination of referrals to appropriate specialists. — Member education on the importance of timely preventive visits and immunizations for the unborn/newborn child. — Special programs when indicated including High Risk OB (HROB), 17-P, and Puff Free Pregnancy Program (a smoking cessation program). — Incentives for accessing prenatal and postpartum care. — Utilizing innovative Start Smart mobile technology to help keep pregnant women connected and engaged. • Hosted Smart Baby Showers in the highly populated pregnancy regions of Atlanta, Central Region, and Southwest region to provide education to reduce low-birth weight and very-low-birth weight babies. • Provided a Smart Start packet after delivery that included an Edinburgh Depression scale for the member to mail back to the CMO. <p><i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i></p> <ul style="list-style-type: none"> • Reviewed outlier practitioners, and a Peach State medical director conducted provider outreach to discuss the appropriate treatment for adults with acute bronchitis.

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
	<p><i>Use of Imaging Studies for Low Back Pain</i></p> <ul style="list-style-type: none"> Reviewed outlier practitioners, and a Peach State medical director conducted provider outreach to discuss the appropriate treatment for low back pain.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Based on HSAG's validation of performance measures, HSAG identified no concerns with Peach State's data processing, integration, and measure production. HSAG determined that Peach State followed the State's specifications and produced reportable rates for all measures in the scope of the performance measure validation activity.

Peach State's HEDIS auditor found that the CMO was fully compliant with all IS standards and determined Peach State submitted valid and reportable rates for all measures in the scope of the NCQA HEDIS Compliance Audit.

Validation of Performance Improvement Projects

For calendar year 2019, Peach State submitted two PIPs for validation. The PIPs were validated using HSAG's rapid-cycle PIP validation process. Table 7-3 includes the PIP title and SMART Aim statement for each topic.

Table 7-3—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Improving Follow-Up After Hospitalization for Mental Illness (7-Day)</i>	By October 31, 2019, Peach State Health Plan will increase the <i>FUH 7</i> rate for Peachford Hospital from 47.53% to 57.53%
<i>Improving Providers' Satisfaction</i>	By October 31, 2019, the percentage of providers reporting that they are "very satisfied" at Snellville Pediatrics will increase from 58.8% to 80.6%.

Findings

For the clinical PIP topic, *Improving Follow-Up After Hospitalization for Mental Illness (7-Day)*, the CMO achieved all validation criteria for Module 1 with the second submission, Module 2 with the third submission, and Module 3 with the second submission. For the nonclinical PIP topic, *Improving Providers' Satisfaction*, all validation criteria were achieved for modules 1 through 3 with the second submission. Peach State collaborated within its PIP team and workgroup to prioritize the identified

failure modes which were used to develop interventions that may be tested using PDSA cycles in Module 4.

The following interventions were selected by the CMO to test in Module 4 for the clinical PIP topic, *Improving Follow-up After Hospitalization for Mental Illness (7 Day)*.

- Offer an incentive ($\leq \$100$) for completion of the 7-day follow-up appointment to a select group of members to offset the cost of transportation (gas/bus/Uber) and/or missed work.
- Incentivize providers near Peachford who are accepting new patients to have open access for members for 7-day follow-up after hospitalization for mental illness.
- Implement technologically focused outreach such as emails and/or electronic health record (EHR) alerts for a subset of members who have not responded to the CMO's initial post-discharge outreach.

The following interventions were selected by the CMO to test for the nonclinical PIP topic, *Improving Providers' Satisfaction*.

- Send welcome/introductory postcards to members from the CMO. The postcard will introduce the member to Snellville Pediatrics and ask the member to schedule an appointment or call Peach State if the member would like to change his or her PCP.
- Perform outreach calls and schedule members using the My Health Direct (MHD) tool. The CMO will use the reminder function of the MHD tool to send reminders once preventive visits are scheduled and the day before the scheduled appointment.
- Use incentives for completion of preventive visit appointments for a specific age range of Snellville Pediatric members who are contacted by Peach State and schedule and keep their appointment.

Recommendations for Improvement

- HSAG recommends that Peach State apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP process to final modules, future PIPs, and other QI activities.
- HSAG recommends that Peach State ensure it addresses all documentation requirements for each module. The CMO should use HSAG's Rapid-Cycle PIP Reference Guide and the module-specific instructions within each module as modules are completed and the CMO progresses through the PIP process.

Assessment of Follow-Up on Prior Recommendations

As calendar year 2018 was the first year the PIP activity was completed for the CMO under the new GF program that began in July 2017, there were no prior recommendations.

CAHPS Surveys

Table 7-4 shows Peach State’s 2018 and 2019 adult Medicaid CAHPS top-box scores. In 2019, a total of 2,727 adult members were administered a survey, of which 211 completed a survey. After ineligible members were excluded, the response rate was 7.8 percent. In 2018, the average NCQA response rate for the adult Medicaid population was 21.8 percent, greater than Peach State’s 2019 response rate.

Table 7-4—Peach State Adult Medicaid CAHPS Results

	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	81.95%	80.68%
<i>Getting Care Quickly</i>	83.22%	82.50%
<i>How Well Doctors Communicate</i>	92.20%	90.17%
<i>Customer Service</i>	86.82%	90.12% ⁺
<i>Shared Decision Making</i>	79.32%	77.35% ⁺
Global Ratings		
<i>Rating of All Health Care</i>	79.65%	73.13% ▼
<i>Rating of Personal Doctor</i>	84.52%	80.50%
<i>Rating of Specialist Seen Most Often</i>	77.23%	79.75% ⁺
<i>Rating of Health Plan</i>	80.50%	76.59%
Effectiveness of Care*		
<i>Advising Smokers and Tobacco Users to Quit</i>	73.10%	72.22%
<i>Discussing Cessation Medications</i>	36.69%	37.38%
<i>Discussing Cessation Strategies</i>	37.43%	36.45%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

* These rates follow NCQA’s methodology of calculating a rolling two-year average.

Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Recommendations for Improvement

Peach State’s top-box score showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for one measure:

- *Rating of All Health Care* (6.52 percentage points)

Peach State’s 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA adult Medicaid national averages for two measures:

- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

HSAG recommends that Peach State focus QI efforts on the measure scores that exhibited a substantial decrease from 2018 to 2019 and were at least 5 percentage points less than the NCQA adult Medicaid national averages. HSAG recommends that Peach State conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that Peach State continue to monitor the measures to ensure there are no significant decreases in rates over time.

HSAG recommends that Peach State focus QI initiatives on the medical assistance it provides related to smoking and tobacco use cessation, since these scores fell below NCQA’s 2018 adult Medicaid national averages by at least 5 percentage points. For those patients who smoke or use tobacco, Peach State should encourage providers to discuss strategies and possible medication options on how to quit smoking and tobacco use. HSAG recommends that Peach State also identify opportunities to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns.


Table 7-5 shows Peach State’s 2018 and 2019 child Medicaid CAHPS top-box scores. In 2019, a total of 3,218 child members were administered a survey, of which 510 completed a survey. After ineligible members were excluded, the response rate was 16.2 percent. In 2018, the average NCQA response rate for the child Medicaid population was 21.2 percent, greater than Peach State’s 2019 response rate.


Table 7-5—Peach State Child Medicaid CAHPS Results

	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	86.72%	89.16%
<i>Getting Care Quickly</i>	90.84%	92.86%
<i>How Well Doctors Communicate</i>	94.08%	94.70%
<i>Customer Service</i>	85.48%	87.54%

	2018 Top-Box Scores	2019 Top-Box Scores
<i>Shared Decision Making</i>	80.68%	78.32%
Global Ratings		
<i>Rating of All Health Care</i>	90.87%	89.41%
<i>Rating of Personal Doctor</i>	91.09%	90.69%
<i>Rating of Specialist Seen Most Often</i>	84.16%	87.27%
<i>Rating of Health Plan</i>	90.44%	89.11%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

None of Peach State’s top-box scores showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for any measure. In addition, none of Peach State’s 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA child Medicaid national averages for any measure.

Recommendations for Improvement

Peach State saw a decline in top-box scores for *Shared Decision Making*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Health Plan*. HSAG recommends that Peach State consider conducting root cause analyses on these areas. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that Peach State continue to monitor the measures to ensure there are no significant decreases in rates over time.

Assessment of Follow-Up on Prior Recommendations

From the results of the calendar year 2018 CAHPS Survey, Peach State received four recommendations. Table 7-6 presents the recommendation made by HSAG during calendar year 2019 as well as Peach State’s response to HSAG’s recommendation.

Table 7-6—CAHPS Survey—Prior Recommendations and Peach State’s Response

Prior Recommendations (CY 2019)	Peach State’s Response to Recommendations
Because members rated their personal doctor highly (i.e., rate greater than the national average and increased between 2017 and 2018), HSAG recommended that Peach State work with providers of smoking and tobacco-using members to discuss	<ul style="list-style-type: none"> Required all obstetrical providers to screen pregnant members for tobacco use during the first prenatal visit.

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
smoking cessation medications and strategies that may help their patients to quit smoking and tobacco use. HSAG also recommended that Peach State identify opportunities to collaborate with public health and community organization work related to smoking and tobacco cessation campaigns.	<ul style="list-style-type: none"> – Provided \$150 member incentives to pregnant members with verifiable tobacco cessation. The associated provider received a \$100 incentive. • Reminded providers of the Georgia Department of Public Health “Ready to Quit” program.
Based on the results of the 2018 CAHPS adult population results, HSAG recommended that Peach State continue to focus QI initiatives on providing medical assistance with smoking and tobacco use cessation (<i>Discussing Cessation Medications</i> and <i>Discussing Cessation Strategies</i>), since these rates fell below NCQA’s 2018 CAHPS adult Medicaid national averages by at least 5 percentage points.	<ul style="list-style-type: none"> • Required all obstetrical providers to screen pregnant members for tobacco use during the first prenatal visit. • Provided \$150 member incentives to pregnant members with verifiable tobacco cessation. The associated provider received a \$100 incentive. • Reminded providers of the Georgia Department of Public Health “Ready to Quit” program.
HSAG recommended that Peach State focus QI initiatives on enhancing members’ experiences with <i>Customer Service</i> , <i>How Well Doctors Communicate</i> , and <i>Rating of Specialist Seen Most Often</i> for the adult Medicaid population, since these rates were less than the 2017 adult CAHPS results and (except for <i>How Well Doctors Communicate</i>) also fell below NCQA’s 2018 CAHPS adult Medicaid national averages. The CMO should focus targeted efforts on member experience, as well as provider-member relations.	<ul style="list-style-type: none"> • Modified the quality monitoring and coaching process by focusing on the overall member experience, coaching to specific behaviors and building knowledge. • Implemented biweekly team huddles to provide real-time updates within the customer service department regarding impactful changes in process or procedures and reviewed trends discovered during quality observation. • Provided education to members on the importance of communicating and addressing member’s specific needs with their doctor. • Developed a checklist encouraging members to engage with their provider, including questions for their providers. • Conducted a cross-functional committee that met biweekly to collaborate on provider initiatives that will improve the overall member experience. • Provided education to providers on the CAHPS survey specifically discussing <i>Customer Service</i>, <i>How Well Doctors Communicate</i>, and <i>Rating of Specialist Seen Most Often</i>. <p><i>Customer Service</i></p> <ul style="list-style-type: none"> • Completed “What is CAHPS” training with the CMO’s customer service staff. • Conducted refresher customer service training classes regarding hold times.

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
	<ul style="list-style-type: none"> Implemented weekly tips and customer service representative coaching. Modified the call script to include specific questions to gauge the customer service representative's knowledge and helpfulness during call interactions. Sent get well cards to members who were inpatient or recently discharged from the hospital. Sent happy birthday cards to members. Assigned a member advocate to members for 60 days when the member was not satisfied with a customer service contact. Assessed and discussed pay rate increases for staff who demonstrated a high-level of proficiency and knowledge. Developed a mentoring program to allow staff to shadow and learn about other opportunities within the CMO. <p><i>How Well Doctors Communicate</i></p> <ul style="list-style-type: none"> Developed a checklist encouraging members to engage with their provider, including questions for their providers.
<p>For the child Medicaid population, HSAG recommended that Peach State focus on improving the <i>Customer Service</i> and <i>Rating of Specialist Seen Most Often</i> rates since they were less than the 2017 child CAHPS results and fell below NCQA's 2018 CAHPS child Medicaid national averages, with <i>Customer Service</i> decreasing more than 5 percentage points from 2017 to 2018. HSAG also recommended that Peach State look to improve the <i>Getting Care Quickly</i> measure rate by improving members' access to care since the rate also fell slightly below the 2017 CAHPS results.</p>	<ul style="list-style-type: none"> Modified the quality monitoring and coaching process to focus on the overall member experience; specifically, coaching to specific behaviors and building knowledge. Implemented biweekly team huddles to provide real-time updates within the customer service department regarding impactful changes in processes or procedures. Implemented a process to educate members on the importance of communicating and addressing member-specific needs including engagement between the member and his or her doctor. Developed a checklist encouraging members to engage with their provider, including questions for their providers. Conducted a cross-functional committee that met biweekly to collaborate on provider initiatives that will improve the overall member experience. Educated providers on the CAHPS survey specifically discussing <i>Customer Service</i>, <i>How</i>

Prior Recommendations (CY 2019)	Peach State's Response to Recommendations
	<p><i>Well Doctors Communicate, and Rating of Specialist.</i></p> <ul style="list-style-type: none"> Conducted quarterly timely access studies to ensure providers are following the established guidelines for waiting maximums and appointment requirements. <p><i>Customer Service</i></p> <ul style="list-style-type: none"> Completed “What is CAHPS” training with the CMO’s customer service staff. Conducted refresher customer service training classes regarding hold times. Implemented weekly tips and customer service representative coaching. Modified the call script to include specific questions to gauge the customer service representative’s knowledge and helpfulness during call interactions. Sent get well cards to members who were inpatient or recently discharged from the hospital. Sent happy birthday cards to members. Assigned a member advocate to members for 60 days when the member was not satisfied with the customer service contact. Assessed and discussed pay rate increases for staff who demonstrate a high level of proficiency and knowledge. Developed a mentoring program to allow staff to shadow and learn about other opportunities within the CMO. <p><i>Getting Care Quickly</i></p> <ul style="list-style-type: none"> Highlighted on the website provider offices with weekend/after-hours appointment availability. Provided information to members via the member newsletter on provider access and appointment standards. Conducted provider appointment availability and wait-times surveys by provider type.

8. CMO-Specific Summary—WellCare of Georgia, Inc.

Activity-Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for WellCare. It provides a discussion of WellCare’s overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively WellCare has addressed the recommendations for QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—Technical Methods of Data Collection and Analysis.

Compliance With Standards Monitoring

Review of Standards

Table 8-1 presents a summary of WellCare’s Compliance With Standards Review results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements reviewed.

Table 8-1—Summary of Compliance With Standards Scores for WellCare

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
I	Availability of Services	15	15	15	0	0	100%
II	Assurances of Adequate Capacity and Services	2	2	2	0	0	100%
III	Coordination and Continuity of Care	19	19	19	0	0	100%
IV	Coverage and Authorization of Services	12	12	11	1	0	91.67%
V	Provider Selection	10	10	7	3	0	70.00%
VI	Subcontractual Relationships and Delegation	4	4	3	1	0	75.00%
VII	Member Rights and Protections	7	7	7	0	0	100%

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
VIII	Confidentiality of Health Information	4	4	3	1	0	75.00%
IX	Enrollment and Disenrollment	12	12	12	0	0	100%
X	Grievance and Appeal Systems	42	42	36	6	0	85.71%
XI	Practice Guidelines	3	3	3	0	0	100%
XII	Quality Assessment and Performance Improvement (QAPI)	12	12	12	0	0	100%
XIII	Health Information Systems	8	8	8	0	0	100%
XIV	Program Integrity	13	13	13	0	0	100%
XV	Member Information	29	29	27	2	0	93.10%
	Total Compliance Score	192	192	178	14	0	92.71%
* Total # of Elements: The total number of elements in each standard.							
** Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of <i>NA</i> .							
*** Total Compliance Score: Elements that were <i>Met</i> were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.							

Findings

Of the 192 applicable elements identified in Table 8-1, WellCare received *Met* scores for 178 elements, with a total compliance score of 92.71 percent. The findings suggest that WellCare developed the necessary policies, procedures, and processes to operationalize the required elements of its contract with DCH and demonstrated compliance with the contract. Interviews with WellCare staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the CMO employed to meet contractual requirements.

Of note, WellCare was fully compliant in nine of the 15 standards reviewed:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard VII—Member Rights and Protections
- Standard IX—Enrollment and Disenrollment
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement
- Standard XIII—Health Information Systems
- Standard XIV—Program Integrity

Strengths

Social Determinants of Health

- The CMO's care management program identified the individual member's specific needs. For services not covered by the GF program, the CMO maintained a regional and local resource list to address unmet SDoH. The CMO's partner organizations coordinated with the CMO through the community assistance process, which included faith-based and other community organizations, to fulfill the noncovered care plan needs. The services were available for all occupants of a home, not exclusive to the CMO's members.
- The CMO's advocacy activities expanded beyond the member to include the member's family and others living in the member's home, even those who were not GF members. The CMO also maintained a community assistance line, which included over 12,000 local resources to assist members or community members.

Person-Centered Care and Services

- The CMO demonstrated culturally competent service delivery through the addition of gender identity and sexual orientation questions during its member intake and orientation processes. The member information obtained through the member's intake process was available in the system to both the care management and medical management teams. The CMO also provided transgender training to its provider network via the CMO's website.

Quality Improvement

- The CMO's community health workers were staff members with degrees in public health or similar areas of focus and lived in the communities in which they worked.
- The CMO used quality of care concern trends, claims, and grievances and appeals to identify actionable areas of focus to improve quality of care and member outcomes. Quality trends were identified for individual providers, the system of care, and for the program. Quality scores were assigned to identified trends after a review by the CMO's workgroups and committees.

Recommendations for Improvement

- HSAG recommends that the CMO review, update, and implement its policies and procedures to ensure consistent information regarding the time frames required for making standard authorization decisions.
- HSAG recommends that the CMO develop and implement a process to inform providers of the reason for nonselection when they are not selected for the CMO's provider network.
- HSAG recommends that the CMO review and update its processes to consistently implement the state-specific time frames for notifications and decisions of adverse benefit determinations. HSAG also recommends that the CMO implement processes to ensure that the member's grievance is addressed and resolved.
- HSAG recommends that the CMO implement processes to consistently send appeal resolution letters within the required time frame.

Assessment of Follow-Up on Prior Recommendations

As contract year 2018 was the first year the Compliance With Standards review activity was completed for the CMOs contracted with DCH for the GF program that began in July 2017, there are no prior recommendations.

Validation of Performance Measures

Strengths

The following HEDIS 2019 measures were determined to be strengths for WellCare (i.e., exceeded the 75th percentile):

- *Asthma Medication Ratio—12–18 Years and 51–64 Years*
- *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*
- *Cervical Cancer Screening*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Well-Child Visits in the First 15 Months of Life—No Well-Child Visits*

Recommendations for Improvement

The following HEDIS 2019 measures were determined to be opportunities for improvement for WellCare (i.e., below the 25th percentile):

- *Comprehensive Diabetes Care—HbA1c Control (<8.0%)*
- *Colorectal Cancer Screening*

Please refer to Section 4 for more information on performance measure results for WellCare.

Assessment of Follow-Up on Prior Recommendations

From the results of the 2018 PMV activity, WellCare received four recommendations. Table 8-2 presents the prior recommendations made during calendar year 2019 as well as WellCare's response to those recommendations.

Table 8-2—PMV—Prior Recommendations and WellCare's Response

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
<p>HSAG recommended that WellCare focus QI efforts on the following measure rates related to care for chronic conditions:</p> <ul style="list-style-type: none"> • <i>Comprehensive Diabetes Care—HbA1c Control (<8.0%)</i> • <i>Blood Pressure Control (<140/90 mm Hg)</i> • <i>Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total</i> • <i>Pharmacotherapy Management of COPD Exacerbation—Bronchodilator</i> • <i>Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years, Ages 12–18 Years, and Ages 19–50 Years</i> • <i>Medication Compliance 75%—Ages 5–11 Years, Ages 12–18 Years, and Ages 19–50 Years</i> • <i>Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis</i> 	<p>The CMO's efforts and interventions in 2018 and 2019 included:</p> <ul style="list-style-type: none"> • Reviewed care gap reports. • Discussion with providers on care gaps. • Implemented a model-of-care outreach program for members with diabetes mellitus. • Implemented a diabetes healthy rewards program member incentive program. • Conducted social media messaging with information on topics such as diabetes, weight management, tobacco use and cessation tips, farmers markets, heart disease, women's health, dental screenings, and immunizations. • Implemented a robust pharmacy program. • Conducted provider education and support programs using patient care advocates (PCAs), quality practice advisors (QPAs), and hospital and provider representatives at all levels on care gaps and quality measures. • Used the Georgia Health Information Network (GaHIN) to obtain available medical record information. • Implemented a model-of-care program for members with asthma. • Implemented a pay-for-quality (P4Q) program, provider incentive program focused on closing care gaps, helping to ensure members take prescribed medications, and updating the members' health history. • Paid quarterly incentives to providers and practices that achieved NCQA PCMH recognition.

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
<p>HSAG recommended that WellCare focus QI efforts on the following measure rates related to care for behavioral health conditions:</p> <ul style="list-style-type: none"> <i>Follow-Up After ED Visit for AOD Abuse or Dependence</i> <i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i> <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—1–5 Years and 12–17 Years</i> <i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i> <i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents—12–17 Years</i> 	<p>CMO efforts and interventions in 2018 and 2019 included:</p> <p><i>Follow-Up After ED Visit for AOD Abuse or Dependence</i></p> <p><i>Follow-Up After ED Visit for Mental Illness—30-Day Follow-Up</i></p> <ul style="list-style-type: none"> Attempted to engage the high-volume emergency departments for assistance with scheduling follow-up appointments for members presenting for behavioral issues. However, they declined participation as it did not include monetary gain. <p><i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—1–5 Years and 12–17 Years</i></p> <ul style="list-style-type: none"> Developed the Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM) tip sheet to educate prescribers on the required testing for children and adolescents on antipsychotics. Outreached to prescribers during the fourth quarter to notify them of members who were in need of metabolic testing. <p><i>Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics</i></p> <ul style="list-style-type: none"> Provided clinical practice guidelines for all behavioral health measures and encouraged psychosocial care in conjunction with any prescribed behavioral health medications. Reviewed care gap reports and discussed gaps for behavioral health measures. Conducted provider education and support programs using PCAs, QPAs, and hospital and provider representatives at all levels on care gaps and quality measures. Implemented a robust pharmacy program that included a one-year pharmacy and prescriber lock-in program to prevent the opioid epidemic and substance use. Implemented a pay-for-performance provider incentive program for closing behavioral health care gaps. Implemented an opioid care management program that included the following elements: <ul style="list-style-type: none"> Non-opioid alternatives

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
	<ul style="list-style-type: none"> – Member engagement – Safety education – Community and provider engagement: Connected members to psychosocial supports and/or substance abuse treatments, including medication-assisted treatment (MAT) providers. Included MAT pharmaceuticals in the 72-hour emergency fill process. – Overdose (OD) Prevention: Provided education on recognizing signs of overdose and correct use of naloxone. • Implemented a behavioral health home (BHH) program using Georgia Hope, which provided coordinated, integrated care to members with significant behavioral health and medical needs. • Used collaborative, cross-functional activities focused on behavioral health, the opioid epidemic, and substance use disorders (SUDs). • Developed a QI project focused on the behavioral health case management program. • Strengthened the discharge planning process which included a discharge plan that addressed member health needs, services, and supplies needed, and updated care plans. • Worked collaboratively with DCH, Department of Behavioral Health and Developmental Disabilities (DBHDD), the Georgia Health Policy Center at Georgia State University, the other CMOs, and community providers to evaluate the State's behavioral health delivery system. • Participated in the National Rx Drug Abuse and Heroin Summit held in Atlanta in April 2018 and sponsored Addiction Recovery Awareness Day at the Capitol in January 2018. • Increased SUD treatment options by adding DBHDD vetted narcotic treatment providers (NTPs) to the WellCare network. • Implemented social media campaigns on Facebook and Twitter on health topics that included influenza shots; immunizations; well-child visits and screenings; dental checkups; sickle cell disease; and mental health topics including depression, anxiety, and stress reduction.

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
	<ul style="list-style-type: none"> Completed in-depth analysis of members with behavioral health conditions, including those diagnosed with depression or attention deficit hyperactivity disorder (ADHD). <p><i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents—12–17 Years</i></p> <ul style="list-style-type: none"> Behavioral health care managers closely monitor use of antipsychotics in children. Potential quality of care (PQOC) issues are referred to the Georgia Quality department for review. Children on multiple concurrent antipsychotics are often referred to Case Management. The case manager has the ability to discuss the medication regime with the provider. The behavioral health medical director is consulted as needed. WellCare's robust pharmacy program monitors providers who are "outliers" with regard to prescribing multiple concurrent antipsychotics. Outreach is conducted by the pharmacy team to the prescriber as needed.
<p>HSAG recommended that WellCare focus QI efforts on the following measure rates related to children's health:</p> <ul style="list-style-type: none"> <i>Children and Adolescents' Access to Primary Care Practitioners—12–19 Years</i> <i>Appropriate Treatment for Children With Upper Respiratory Infection</i> <i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i> 	<p>CMO efforts and interventions in 2018 and 2019 included:</p> <ul style="list-style-type: none"> Reviewed care gap reports, including behavioral health measures. Completed discussions with providers regarding care gaps, including behavioral health measures. Conducted provider education and support programs using PCAs), QPAs, and hospital and provider representatives at all levels on care gaps and quality measures. Implemented social media campaigns on Facebook and Twitter on health topics that included influenza shots; immunizations; well-child visits and screenings; dental checkups; sickle cell disease; mental health topics including depression, anxiety, and stress reduction; weight management; tobacco use and cessation tips; farmers markets; heart disease; diabetes; and women's health. Developed interventions for decreasing parental refusal of immunizations for children and adolescents.

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
	<ul style="list-style-type: none"> Implemented a P4Q provider incentive program for closing care gaps, helping to ensure members took prescribed medication, and updating the members' health records. Implemented a Healthy Rewards member incentive program focused on receipt of primary care services such as well-child visits.
<p>HSAG recommended that WellCare focus QI efforts on the following measure rates related to adults' health:</p> <ul style="list-style-type: none"> <i>Adults' Access to Preventive/Ambulatory Health Services—Total</i> <i>Prenatal and Postpartum Care—Timeliness of Prenatal Care</i> <i>Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis</i> 	<p>CMO efforts and interventions in 2018 and 2019 included:</p> <ul style="list-style-type: none"> Reviewed care gap reports. Discussed care gaps with providers. Discussed behavioral health care gaps with providers. Conducted provider education and support programs using PCAs, QPAs, and hospital and provider representatives at all levels on care gaps and quality measures including behavioral health measures. Implemented a maternity education and rewards program. Implemented a Healthy Rewards member incentive program focused on prenatal and postpartum visits. Developed a P4Q provider incentive program that rewarded closed care gaps, helping to ensure members took prescribed medication, and by updating the members' health history. Implemented social media campaigns on Facebook and Twitter on health topics that included influenza shots; immunizations; well-child visits and screenings; dental checkups; sickle cell disease; mental health topics including depression, anxiety, and stress reduction; weight management; tobacco use and cessation tips; farmers markets; heart disease; diabetes; and women's health. Implemented a prenatal program that reduced the neonatal intensive care unit (NICU) rate for care management members. Implemented an in-home vendor postpartum outreach program that addressed postpartum assessments, including depression screening, contraception, and chlamydia screening.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Based on HSAG’s validation of performance measures, HSAG had no concerns with WellCare’s data processing, integration, and measure production. HSAG determined that WellCare followed the State’s specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Additionally, WellCare’s HEDIS auditor found that the CMO was fully compliant with all information system (IS) standards and determined WellCare submitted valid and reportable rates for all measures in the scope of the HEDIS Compliance Audit.

Validation of Performance Improvement Projects

For calendar year 2019, WellCare submitted two PIPs for validation. The PIPs were validated using HSAG’s rapid-cycle PIP validation process. Table 8-3 includes the PIP title and SMART Aim statement for each topic.

Table 8-3—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Member Realignment</i>	By October 31, 2019, decrease the rate of members receiving services from a primary care physician in which they are not assigned among TGS Management Corporation’s assigned members from 15.34% to 10.34%
<i>Prenatal Birth Outcomes—17p Initiation</i>	By October 31, 2019, increase the Optum service initiations of 17P protocol by 5 percentage points from the 2017 baseline of 77% to 82% to support the prolongation of pregnancy for clinically eligible Medicaid/PeachCare for Kids® pregnant women ages 17 and above.

Findings

For the clinical PIP topic, *Prenatal Birth Outcomes—17p Initiation*, the CMO achieved all validation criteria for Module 1 and Module 2 with the fourth submission and Module 3 with the third submission. For the nonclinical PIP topic, *Member Realignment*, all validation criteria were achieved for Module 1 with the second submission, Module 2 with the fourth submission, and Module 3 with the third submission. WellCare collaborated within its PIP teams to prioritize the identified failure modes which were used to develop interventions that may be tested using PDSA cycles.

The following interventions were selected by the CMO to test in Module 4 for the clinical PIP topic.

- Institute a 17p tag reconciliation tool that provides the information used to validate the member’s demographic details for initiation of 17p protocol.
- Create the OPTUM Home Health Care Coordination Variance Report on 17p protocol initiations.
- Educate obstetric providers on available options for 17p administration.

- Exactus Pharmacy will test a new Delivery Status Notification Report to inform WellCare Case Management and OPTUM Home Health of the 17p medication delivery confirmation to the member.

The following are the interventions the CMO selected to test for the nonclinical PIP topic.

- Phone call to members informing them of their currently assigned PCP.
- Automated process that would identify members that are assigned outside of the member's assigned PCP location. This intervention would include a notification via phone call to the member.
- Provide education to individual providers on timely closed panel notification requirements via regularly scheduled meetings. Track all closed panel requests via a centralized provider update mailbox and provider documentation system.

Recommendations for Improvement

- HSAG recommends that WellCare apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP process to final modules, future PIPs, and other QI activities.
- HSAG recommends that WellCare ensure it addresses all documentation requirements for each module. The CMO should use HSAG's Rapid-Cycle PIP Reference Guide and the module-specific instructions within each module as modules are completed and the CMO progresses through the PIP process.

Assessment of Follow-Up on Prior Recommendations

The CMO did not receive any recommendations for the PIP activity during 2019.

CAHPS Surveys

Table 8-4 shows WellCare's 2018 and 2019 adult Medicaid CAHPS top-box scores. In 2019, a total of 2,160 adult members were administered a survey, of which 361 completed a survey. After ineligible members were excluded, the response rate was 17.3 percent. In 2018, the average NCQA response rate for the adult Medicaid population was 21.8 percent, greater than WellCare's 2019 response rate.


Table 8-4—WellCare Adult Medicaid CAHPS Results


	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	81.39%	81.90%
<i>Getting Care Quickly</i>	81.67%	82.00%
<i>How Well Doctors Communicate</i>	92.57%	92.99%
<i>Customer Service</i>	88.24%	87.04%
<i>Shared Decision Making</i>	82.76%	79.17%

	2018 Top-Box Scores	2019 Top-Box Scores
Global Ratings		
<i>Rating of All Health Care</i>	77.55%	76.98%
<i>Rating of Personal Doctor</i>	83.04%	81.89%
<i>Rating of Specialist Seen Most Often</i>	84.00%	78.10% ▼
<i>Rating of Health Plan</i>	77.74%	78.06%
Effectiveness of Care*		
<i>Advising Smokers and Tobacco Users to Quit</i>	76.03%	73.68%
<i>Discussing Cessation Medications</i>	27.21%	37.06% ▲
<i>Discussing Cessation Strategies</i>	27.59%	34.52% ▲

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

* These rates follow NCQA's methodology of calculating a rolling two-year average.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

WellCare's top-box scores showed a substantial increase of 5 percentage points or more between 2018 and 2019 for two measures:

- *Discussing Cessation Medications* (9.85 percentage points)
- *Discussing Cessation Strategies* (6.93 percentage points)

Recommendations for Improvement

None of WellCare's 2019 top-box scores were at least 5 percentage points greater than the 2018 NCQA adult Medicaid national averages for any measure.

WellCare's top-box score showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for one measure:

- *Rating of Specialist Seen Most Often* (5.90 percentage points)

WellCare's 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA adult Medicaid national averages for two measures:

- *Discussing Cessation Medications*

- *Discussing Cessation Strategies*⁸⁻¹

HSAG recommends that WellCare focus QI efforts on the measure scores that exhibited a substantial decrease from 2018 to 2019 and were at least 5 percentage points less than the NCQA adult Medicaid national averages. HSAG recommends that WellCare conduct root cause analyses of study indicators that have been identified as areas of low performance. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that WellCare continue to monitor the measures to ensure there are no significant decreases in rates over time.

While WellCare's 2019 top-box scores increased by over 5 percentage points compared to 2018 for *Discussing Cessation Medications* and *Discussing Cessation Strategies*, HSAG recommends that WellCare still work with its providers to improve rates for the adult Effectiveness of Care measures. For those patients who smoke or use tobacco, WellCare should encourage providers to discuss strategies and possible medication options on how to quit smoking and tobacco use. WellCare may also identify opportunities to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns.

Table 8-5 shows WellCare's 2018 and 2019 child Medicaid CAHPS top-box scores. In 2019, a total of 1,980 child members were administered a survey, of which 399 completed a survey. After ineligible members were excluded, the response rate was 21.3 percent. In 2018, the average NCQA response rate for the child Medicaid population was 21.2 percent, slightly less than WellCare's 2019 response rate.


Table 8-5—WellCare Child Medicaid CAHPS Results


	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	84.37%	88.82%
<i>Getting Care Quickly</i>	91.23%	91.68%
<i>How Well Doctors Communicate</i>	92.46%	94.07%
<i>Customer Service</i>	90.42%	87.44%
<i>Shared Decision Making</i>	72.40% ⁺	81.87% ⁺ ▲
Global Ratings		
<i>Rating of All Health Care</i>	91.03%	91.22%
<i>Rating of Personal Doctor</i>	89.24%	91.50%

⁸⁻¹ While the top-box scores for *Discussing Cessation Medications* and *Discussing Cessation Strategies* did increase by 5 percentages point or more, which is noted under Strengths, the top-box scores are still below the national averages, which is noted in Recommendations for Improvement.

	2018 Top-Box Scores	2019 Top-Box Scores
<i>Rating of Specialist Seen Most Often</i>	85.14% ⁺	91.67% ⁺ ▲
<i>Rating of Health Plan</i>	90.24%	90.16%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

WellCare's top-box scores showed a substantial increase of 5 percentage points or more between 2018 and 2019 for two measures:

- *Shared Decision Making* (9.47 percentage points)
- *Rating of Specialist Seen Most Often* (6.53 percentage points)

None of WellCare's top-box scores showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for any measure. In addition, none of WellCare's 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA child Medicaid national averages for any measure.

Recommendations for Improvement

HSAG recommends that WellCare focus QI efforts on the *Customer Service* measure score that exhibited a decrease from 2018 to 2019. HSAG recommends that WellCare conduct a root cause analysis on this area. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that WellCare continue to monitor the measures to ensure there are no significant decreases in rates over time.

Assessment of Follow-Up on Prior Recommendations

From the results of the calendar year 2018 CAHPS survey, WellCare received four recommendations. Table 8-6 below presents the prior recommendation made by HSAG during calendar year 2019 as well as WellCare's response to HSAG's recommendation.

Table 8-6—CAHPS Survey—Prior Recommendations and WellCare's Response

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
HSAG recommended that WellCare focus QI efforts, for the adult Medicaid population, on the rates for <i>Getting Needed Care, Getting Care Quickly, Customer</i>	The CMO's QI efforts focused on care coordination continued to drive positive outcomes for the

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
<p><i>Service, Advising Smokers and Tobacco Users to Quit, Discussing Cessation Medication, and Discussing Cessation Strategies</i>, which fell below NCQA's 2018 CAHPS adult Medicaid national averages, with <i>Getting Care Quickly</i> decreasing more than 5 percentage points from 2017 to 2018. WellCare's rates for two of the adult Effectiveness of Care measures (<i>Discussing Cessation Medications</i> and <i>Discussing Cessation Strategies</i>) fell below the NCQA 2018 CAHPS adult Medicaid national averages by at least 5 percentage points.</p>	<p>following: <i>Getting Needed Care, Getting Care Quickly, and Customer Service</i> which included:</p> <ul style="list-style-type: none"> • Frequent communication for provider engagement and member education. • QPAs and provider relations representatives coached providers on Medicaid access and wait time standards. • Providing detailed educational material to inform providers about strategies to improve member perception of getting the care they needed when they needed it. <p>To encourage individuals who smoked or used tobacco to quit, the CMO offered various resources to members including:</p> <ul style="list-style-type: none"> • Over-the-counter benefits with coverage for nicotine gum (2mg and 4mg), and a smoking cessation product. • Offering educational material to pregnant members to quit smoking. • Providing methods to reduce stress. • Directing members to national resources such as the National Cancer Institute Smoking Quitline: 877-44U-QUIT.
<p>Since the global rating for <i>Rating of Specialist Seen Most Often</i> improved (indicating that the CMO's members were satisfied with their specialty providers' care) and members rated their personal doctor highly (i.e., rate greater than the national average), HSAG recommended that WellCare work with these providers to improve rates for the adult Effectiveness of Care measures. For those patients who smoke or use tobacco, providers could discuss strategies on how to quit smoking and tobacco use. HSAG also identified opportunities for WellCare to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns. HSAG also recommended that WellCare focus efforts on improving members' access to timely care, as well as members' experience with the CMO (<i>Getting Needed Care, Getting Care Quickly, and Customer Service</i>).</p>	<p>WellCare of Georgia implemented concerted efforts to drive continuous improvement in members' access to timely care. Efforts included:</p> <ul style="list-style-type: none"> • During visits to provider offices, provider relations representatives and QPAs reinforced the CMO's wait time standards and access standards (Medicaid). • PCAs engaged provider offices on-site. • Care gap coordinators conducted member outreach to help members get the care they needed as quickly as possible. • The CMO also remained dedicated to recruiting and retaining top-performing physicians and expanding its telemedicine strategy. <p>To encourage individuals who smoked or used tobacco to quit, the CMO offered various resources to members including:</p>

Prior Recommendations (CY 2019)	WellCare's Response to Recommendations
	<ul style="list-style-type: none"> Over-the-counter benefits with coverage for nicotine gum (2mg and 4mg), and a smoking cessation product. Educational material to pregnant members to quit smoking. Provided methods to reduce stress. Directed members to national resources such as the National Cancer Institute Smoking Quitline: 877-44U-QUIT.
<p>For the child Medicaid population, HSAG recommended that WellCare focus on improving the rate for the <i>Shared Decision Making</i> measure since the rate fell below NCQA's 2018 CAHPS child Medicaid national averages by at least 5 percentage points⁸⁻². WellCare could use member focus groups or targeted provider education to better understand and provide information to providers about involving members and their caregivers in decision making regarding the member's care and services. Including the member's voice in QI provides an opportunity for WellCare to target specific areas that may improve satisfaction with the specialist seen most often as well as ensuring members perceive that they participate in making healthcare decisions with their providers.</p>	<p>The CMO used targeted education to emphasize to providers the importance of involving members and their caregivers in decision making regarding the members' care. The CMO:</p> <ul style="list-style-type: none"> Distributed materials with coordination of care practices that included guidance for providers to: 1) encourage patients to ask questions and to express their needs and priorities; 2) assist patients in arranging care with other practitioners and services; and 3) follow up on referrals and discuss patients' current specialist care.
<p>HSAG recommended that WellCare focus efforts on improving the <i>Getting Needed Care</i>, <i>Getting Care Quickly</i>, <i>How Well Doctors Communicate</i>, <i>Customer Service</i>, and <i>Rating of Personal Doctor</i> rates for the child Medicaid population, since these rates were less than the 2017 child CAHPS results. Of these measures, <i>Getting Needed Care</i>, <i>How Well Doctors Communicate</i>, and <i>Rating of Personal Doctor</i> fell below NCQA's 2018 CAHPS child Medicaid national averages. HSAG recommended that WellCare consider conducting a root cause analysis of these areas of low performance and devise potential improvement strategies.</p>	<ul style="list-style-type: none"> The CMO executed surveys semiannually to identify providers who did not meet contractual obligations on standards for access and availability. Noncompliant providers were counseled to follow the required standards via letters, on-site visits, and the issuance of a corrective action plan. The CMO coached clinicians to use effective communication to ensure member understanding of health condition(s), treatment plans, and goals. Clinicians and support staff were reeducated in appropriate teach-back techniques when coaching members in self-care management.

⁸⁻² This CAHPS score had fewer than 100 respondents. Due to the low response rate, caution should be exercised when interpreting results for this measure.

9. CMO-Specific Summary—Amerigroup Community Care for Georgia Families 360°

Activity-Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for Amerigroup 360°. It provides a discussion of Amerigroups 360°’s overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively Amerigroup 360° addressed the recommendations for QI made by HSAG during the previous year. The methodology for each activity can be found in Appendix. A—Technical Methods of Data Collection and Analysis.

Compliance With Standards Monitoring

Review of Standards

Table 9-1 presents a summary of Amerigroup 360°’s Compliance With Standards review results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements reviewed.

Table 9-1—Summary of Compliance With Standards Scores for Amerigroup 360°

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
I	Availability of Services	15	15	15	0	0	100%
II	Assurances of Adequate Capacity and Services	2	2	2	0	0	100%
III	Coordination and Continuity of Care	19	19	19	0	0	100%
IV	Coverage and Authorization of Services	12	12	11	1	0	91.67%
V	Provider Selection	10	10	10	0	0	100%
VI	Subcontractual Relationships and Delegation	4	4	3	1	0	75.00%

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Not Met	# Not Applicable	Total Compliance Score***
VII	Member Rights and Protections	7	7	7	0	0	100%
VIII	Confidentiality of Health Information	4	4	4	0	0	100%
IX	Enrollment and Disenrollment	12	12	12	0	0	100%
X	Grievance and Appeal Systems	42	42	39	3	0	92.86%
XI	Practice Guidelines	3	3	3	0	0	100%
XII	Quality Assessment and Performance Improvement (QAPI)	12	12	11	1	0	91.67%
XIII	Health Information Systems	8	8	6	2	0	75.00%
XIV	Program Integrity	13	13	12	1	0	92.31%
XV	Member Information	29	29	28	1	0	96.55%
	Total Compliance Score	192	192	182	10	0	94.79%
* Total # of Elements: The total number of elements in each standard.							
** Total # of Applicable Elements: The total number of elements within each standard minus any elements that received a designation of <i>N/A</i> .							
*** Total Compliance Score: Elements that were <i>Met</i> were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.							

Findings

Of the 192 applicable elements identified in Table 9-1, Amerigroup 360° received *Met* scores for 182 elements, with a total compliance score of 94.79 percent. The findings suggest that Amerigroup 360° developed the necessary policies, procedures, and processes to operationalize the required elements of its contract with DCH and demonstrated compliance with the contract. Interviews with Amerigroup 360° staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the CMO employed to meet contractual requirements.

Of note, Amerigroup 360° was fully compliant in eight of the 15 standards reviewed:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard V—Provider Selection
- Standard VII—Member Rights and Protections
- Standard VIII—Confidentiality of Health Information
- Standard IX—Enrollment and Disenrollment
- Standard XI—Practice Guidelines

Strengths

Access to Care and Services

- The CMO implemented a process to complete behavioral health visits using Zoom technology for members without an originating telehealth site. Zoom technology was available anywhere from the member's mobile device and increased members' access to behavioral health services.
- Telemedicine services were available to all members. The CMO continued to expand telehealth capabilities as opportunities were identified through its work with the Global Partnership for Telehealth.
- Amerigroup 360° included school-based clinics in its provider network for member and foster family convenience. The CMO provided training to the school-based clinics and the local education agencies (LEAs) regarding Medicaid, covered services, and claims and billing requirements. Children were able to receive behavioral, oral, and physical healthcare to meet members "where they are."
- The CMO's Member Advisory Committee included a judge that presided over child welfare cases. The CMO used information from the Member Advisory Committee meetings to sponsor an innovative solution for foster children to receive preventive and needed healthcare services through a court-based, full-service clinic. The courthouse clinic was championed by the judge who sat on the Member Advisory Committee. The courthouse clinic included a full array of services including EPSDT services, oral health, and behavioral health services.

Quality Improvement

- The CMO offered training to providers to assist them in working with members who had high rates of engagement with law enforcement. The trainings included minimizing risk and mental health first aid.
- The CMO implemented a GF 360° steering committee whose membership included foster youth, providers, foster parents, other State agencies, and community partners. The steering committee's work resulted in the development of a "bench book" that judges with insight into foster care cases

were able to use to ensure that members had resources to meet their needs, as well as the development of webinars on topics such as psychotropic medication guidance.

- To ensure a smooth transition from foster children into adulthood, the CMO developed a transition plan, in coordination with partners providing services to the foster children's population, six months prior to a foster child's 18th birthday. The CMO provided enhanced care coordination to assist in the transition. The CMO used virtual care connections from any mobile device which allowed members, their foster families, case managers, and providers to enhance participation in care planning and transition activities.
- The CMO offered an apprenticeship program within Anthem (Amerigroup's parent company) for foster children aging into adulthood to receive information technology (IT) and programming training and also to receive on-the-job IT experience. Foster children were sometimes offered employment opportunities within Anthem after successful completion of the apprenticeship program. The CMO also offered foster children financial literacy and personal development training opportunities.
- The CMO's staff included licensed clinical social workers, nurses, and child welfare specialists, often having previous work experience in state government positions. Staff were licensed and trained in the development of care plans, person-centered planning, trauma-informed care, mental health first aid, and integrated care management. The CMO partnered with the University of Maryland, which provided training on trauma-informed care, and the University of Georgia in Atlanta, which provided training regarding infant brain development to increase the understanding of providers that serve members diagnosed with intellectual or developmental delays.

Social Determinants of Health

- The CMO incorporated SDoH factors into its outreach efforts and used community health workers to reach members in the communities where they resided. Community health workers addressed psychosocial needs, transportation, follow-up on appointments, and food sources.

Person-Centered Care and Services

- The CMO approached the development of the care plan and service authorizations from the perspective of the member, not the member's diagnosis. The CMO made care plan decisions based on medical necessity.
- The Amerigroup 360° program conducted behavioral health rounds that addressed unique member challenges, addressed gaps in care, and developed high-touch wrap-around services for members.

Recommendations for Improvement

- HSAG recommends that the CMO update its GF policies and procedures to include the CMO's coverage of:
 - The ability for a member to achieve age-appropriate growth and development.
 - The ability for a member to attain, maintain, or regain functional capacity.

- HSAG recommends that the CMO review its process for sending acknowledgement letters consistently to members within the required time frame.
- HSAG recommends that the CMO review its grievance process to consistently send grievance acknowledgement letters that accurately address the member's concerns.
- HSAG recommends that the CMO review its adverse benefit determination process to consistently send notices to members within the required time frame.
- HSAG recommends that the CMO review its expedited appeal process to consistently provide notice to affected parties within the required time frame.

Assessment of Follow-Up on Prior Recommendations

As contract year 2018 was the first year the Compliance With Standards review activity was completed for the CMOs contracted with DCH for the GF program that began in July 2017, there were no prior recommendations.

Validation of Performance Measures

Table 9-2 displays the GF 360° rates for HEDIS 2019, along with the performance rating for NCQA's HEDIS measure rate results compared to NCQA's Quality Compass national Medicaid HMO percentiles (from ★ representing *Poor Performance* to ★★★★★ representing *Excellent Performance*), where available. Additionally, measure cells shaded gray indicate non-HEDIS rates that were compared to CMCS' national 50th percentile for the FFY 2018 Child Core Set measures as an indicator of performance, with measure rates shaded yellow indicating performance that met or exceeded the 50th percentile. Of note, measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, rates that fall at or below the 50th percentile are shaded yellow. Benchmarks were not available for comparisons to the *Screening for Depression and Follow-Up Plan* measure.

Table 9-2—HEDIS 2019 Results for Amerigroup 360°

Measure	Amerigroup 360°
Quality of Care	
<i>Asthma Medication Ratio</i>	
5–11 Years	91.67% ★★★★★
12–18 Years	70.83% ★★★★★
<i>Diabetes Short-Term Complications Admission Rate*¹</i>	
Diabetes Short-Term Complications Admission Rate	39.93
Screening for Depression and Follow-Up Plan	
12–17 Years	18.98% NC

Measure	Amerigroup 360°
<i>18 and Older</i>	8.27% NC
Stewardship	
<i>Ambulatory Care—Total</i>	
<i>Emergency Department Visits—Total*</i>	35.13 ★★★★★
Access to Care	
<i>Adolescent Well-Care Visits</i>	
<i>Adolescent Well-Care Visits</i>	60.51% ★★★
<i>Childhood Immunization Status</i>	
<i>Combination 7</i>	60.10% ★★★
<i>Chlamydia Screening in Women</i>	
<i>16–20 Years</i>	66.89% ★★★★
<i>21–24 Years</i>	74.34% ★★★★★
<i>Developmental Screening in the First Three Years of Life¹</i>	
<i>Total</i>	71.78%
<i>Immunizations for Adolescents</i>	
<i>Combination 1 (Meningococcal, Tdap)</i>	86.62% ★★★★
<i>Combination 2 (Meningococcal, Tdap, HPV)</i>	37.96% ★★★★
<i>Percentage of Eligibles Who Received Preventive Dental Services¹</i>	
<i>Percentage of Eligibles Who Received Preventive Dental Services</i>	63.82%
<i>Prenatal and Postpartum Care</i>	
<i>Timeliness of Prenatal Care</i>	62.14% ★
<i>Well-Child Visits in the First 15 Months of Life</i>	
<i>No Well-Child Visits*</i>	0.49% ★★★★★
<i>Six or More Well-Child Visits</i>	67.64% ★★★
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	80.35% ★★★★

* A lower rate includes better performance for this measure.

¹ The rates for this measure were compared to CMCS' national 50th percentile for the FFY 2018 Child and Adult Core Set.

NC indicates comparisons to benchmarks for the RY 2019 rate was not available.

NA indicates the denominator for the measure is too small to report (<30); therefore, comparisons to benchmarks were not appropriate.

Gray shading indicates that the measure was compared to CMCS' national 50th percentile.

Yellow shading indicates that the performance measure rate for RY 2019 met or exceeded CMCS' national 50th percentile.

RY 2019 performance ratings for the HEDIS measures represent the following percentile comparisons:

★★★★★ = 90th percentile and above

★★★★ = 75th to 89th percentile

★★★ = 50th to 74th percentile

★★ = 25th to 49th percentile

★ = Below 25th percentile

Strengths

Overall, GF 360° demonstrated strength with quality of care, stewardship, and access to care for HEDIS 2019, exceeding the 50th percentile for 14 of 16 (87.5 percent) measure rates that were comparable to benchmarks. Of note, nine of 13 (69.2 percent) HEDIS measure rates were above the 75th percentile, with four of these rates (30.8 percent) exceeding the 90th percentile. The *Developmental Screening in the First Three Years of Life* and *Percentage of Eligibles Who Received Preventive Dental Services* measure rates exceeded the CMCS' national 50th percentile, further demonstrating strength.

Recommendations for Improvement

The GF 360° performance for the *Diabetes Short-Term Complications Admission Rate* measure fell below the 50th percentile; however, caution should be exercised when interpreting this result because the 50th percentile is based on admissions for ages 18 to 64, whereas the GF 360° program only includes members up to age 21. Additionally, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rate fell below the 25th percentile, demonstrating opportunities to ensure women receive care during their pregnancies.

Assessment of Follow-Up on Prior Recommendations

From the results of the 2018 PMV activity, Amerigroup 360° received two recommendations. Table 9-3 presents the prior recommendations made during calendar year 2019 as well as Amerigroup 360°'s response to those recommendations.

Table 9-3—PMV—Prior Recommendations and Amerigroup 360°'s Response

Prior Recommendations (CY 2019)	Amerigroup 360°'s Response to Recommendations
<p>HSAG recommended that Amerigroup 360° focus QI efforts on the following measure rates related to care for behavioral health conditions:</p> <ul style="list-style-type: none"> <i>Metabolic Monitoring for Children and Adolescents on Antipsychotics—1–5 Years and 6–11 Years</i> 	<ul style="list-style-type: none"> Amerigroup 360° continued to work with providers to ensure appropriate monitoring for children and youth on antipsychotics. Amerigroup 360° continued use of the psych medication tool, which is completed when a

Prior Recommendations (CY 2019)	Amerigroup 360°'s Response to Recommendations
<ul style="list-style-type: none"> <i>Use of Multiple Concurrent Antipsychotics in Children and Adolescents—6–11 Years</i> 	<p>member is on one or more medications and is monitored by the CMO's medical director.</p> <ul style="list-style-type: none"> Amerigroup 360° continued to strategize regarding identification of members who were on two or more antipsychotics.
<p>HSAG recommended that Amerigroup 360° focus QI efforts on the following measure rates related to children's health:</p> <ul style="list-style-type: none"> <i>Appropriate Treatment for Children With Upper Respiratory Infection</i> <i>Non-Recommended Cervical Cancer Screening in Adolescent Females</i> 	<ul style="list-style-type: none"> Amerigroup 360° continued to work with providers to ensure appropriate treatment for children with upper respiratory infections and provided education on not prescribing antibiotics for children diagnosed with upper respiratory infections. Amerigroup 360° also provided education to providers on unnecessary screening for cervical cancer for adolescent females.

Validation of Performance Measures—NCQA HEDIS Compliance Audit

Based on HSAG's validation of performance measures, HSAG had no concerns with Amerigroup 360°'s data processing, integration, and measure production. HSAG determined that Amerigroup 360° followed the State's specifications and produced reportable rates for all measures in the scope of the validation of performance measures.

Additionally, Amerigroup 360°'s HEDIS auditor found that the CMO was fully compliant with all IS standards and determined Amerigroup 360° submitted valid and reportable rates for all measures in the scope of the HEDIS Compliance Audit.

Validation of Performance Improvement Projects

For calendar year 2019, Amerigroup 360° submitted two PIPs for validation. The PIPs were validated using HSAG's rapid-cycle PIP validation process. Table 9-4 includes the PIP title and SMART Aim statement for each topic.

Table 9-4—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
<i>Antidepressant Adherence During Continuation Phase of Treatment</i>	To increase the number of GF 360° members, ages 18–26, who live in Bibb, DeKalb, Fulton, Gwinnett, and Rockdale counties and are diagnosed with major depression, who are compliant with taking an antidepressant for at least 180 days following the first fill. This PIP should increase the compliance rate across counties by 20 percentage points from the average baseline rate of 0% to 20% by October 31, 2019.

PIP Title	SMART Aim Statement
<i>AA Member Contact Information and Care Coordination Services</i>	To increase the number of GF 360° newly enrolled AA members who have phone numbers. This PIP should increase the combined rate of phone numbers in the 5 identified counties by 5 percentage points from 47.68% to 52.68% by October 31, 2019.

Findings

Both PIP topics achieved all validation criteria for Module 1 and Module 2 with the fourth submission. For the clinical PIP topic, *Antidepressant Adherence During Continuation Phase of Treatment*, the CMO achieved all validation criteria for Module 3 with the fourth submission. For the nonclinical PIP topic, *AA Member Contact Information and Care Coordination Services*, all validation criteria were achieved for Module 3 with the third submission. Amerigroup 360° collaborated within its PIP team and workgroup to prioritize the identified failure modes which were used to develop interventions that may be tested using PDSA cycles.

The following intervention was selected by the CMO to test in Module 4 for the clinical topic, *Antidepressant Adherence During Continuation Phase of Treatment*.

- Partner with core services providers to ensure members are educated on the importance of medication compliance. Amerigroup 360° will provide a list of eligible members and educational material to the core provider. Care coordinators will collaborate with the individual service provider (i.e., therapist) to provide additional identified supports.

The following interventions were selected by the CMO to test in Module 4 for the nonclinical topic, *AA Member Contact Information and Care Coordination Services*.

- Identify potential adoptions through the Department of Family and Children's Services (DFCS) case manager and/or DFCS Discharge Report and request new/updated contact information to update the CMO's medical record system.
- Update the Release of Information letter to state that requests for member information follow the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rule for covered entities, such as the CMO. The updated document will also include the member's pre- and post-adoptive names and Medicaid ID numbers to help link medical records from foster care to adoptions.

Recommendations for Improvement

- HSAG recommends that Amerigroup 360° develop an internal process to discuss, support, and report PIP progression and outcomes, including methodology development and the effective use of QI tools.
- HSAG recommends that Amerigroup 360° key staff complete training related to rapid-cycle improvement efforts and/or QI science methods to ensure understanding of the PIP process.

- HSAG recommends that Amerigroup 360° develop cross-functional PIP teams and select champions and subject matter experts appropriate for each PIP topic.
- HSAG recommends that Amerigroup 360° apply lessons learned and knowledge gained from its efforts and HSAG’s feedback throughout the PIP to final modules, future PIPs, and other QI activities.
- HSAG recommends that Amerigroup 360° ensure it addresses all documentation requirements for each module. HSAG recommends that the CMO use HSAG’s Rapid-Cycle PIP Reference Guide and the module-specific instructions within each module as modules are completed and the CMO progresses through the PIP process.

Assessment of Follow-Up on Prior Recommendations

From the results of the calendar year 2018 PIP validation activity, Amerigroup 360° received two recommendations. Table 9-5 presents the prior recommendations made during calendar year 2018 as well as Amerigroup 360°’s response.

Table 9-5—PIP Validation—Prior Recommendations and Amerigroup 360°’s Response

Prior Recommendations (CY 2019)	Amerigroup 360°’s Response to Recommendations
HSAG recommended that the CMO focus subsequent modules of the PIPs and support achieving the established goals for improving PIP outcomes in 2019.	<ul style="list-style-type: none"> • Amerigroup 360° committed to adhering to PDSA methodology to improve current PIP processes. • Amerigroup 360° continued to seek technical assistance when barriers were identified.
HSAG recommended that the CMO take responsibility for ensuring adequate staffing, institutional knowledge, and resources are allocated for each project.	<ul style="list-style-type: none"> • Each Amerigroup 360° PIP team was composed of a leadership champion, a QI professional, a data analyst, and one consultant external to the CMO. The remainder of the team comprised individuals with subject matter expertise.

CAHPS Surveys


Table 9-6 shows the Amerigroup 360° program’s 2018 and 2019 child Medicaid CAHPS top-box scores. In 2019, a total of 2,640 child members were administered a survey, of which 580 completed a survey. After ineligible members were excluded, the response rate was 22.1 percent. In 2018, the average NCQA response rate for the child Medicaid population was 21.2 percent, less than the Amerigroup 360° program’s 2018 response rate.


Table 9-6—Amerigroup 360° Program Child Medicaid CAHPS Results

	2018 Top-Box Scores	2019 Top-Box Scores
Composite Measures		
<i>Getting Needed Care</i>	86.77%	89.45%

	2018 Top-Box Scores	2019 Top-Box Scores
<i>Getting Care Quickly</i>	95.64%	98.21%
<i>How Well Doctors Communicate</i>	97.42%	96.92%
<i>Customer Service</i>	88.98%	91.15%
<i>Shared Decision Making</i>	84.28%	77.90% ▼
Global Ratings		
<i>Rating of All Health Care</i>	87.65%	87.31%
<i>Rating of Personal Doctor</i>	93.69%	93.42%
<i>Rating of Specialist Seen Most Often</i>	85.20%	92.05% ▲
<i>Rating of Health Plan</i>	81.09%	82.48%

+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.

 Indicates the 2019 score is at least 5 percentage points greater than the 2018 national average.

 Indicates the 2019 score is at least 5 percentage points less than the 2018 national average.

▲ Indicates the 2019 score is at least 5 percentage points higher than the 2018 score.

▼ Indicates the 2019 score is at least 5 percentage points lower than the 2018 score.

Strengths

Amerigroup 360°'s top-box score showed a substantial increase of 5 percentage points or more between 2018 and 2019 for one measure:

- *Rating of Specialist Seen Most Often* (6.85 percentage points)

Amerigroup 360°'s 2019 top-box scores were at least 5 percentage points greater than the 2018 NCQA child Medicaid national averages for two measures:

- *Getting Care Quickly*
- *Rating of Specialist Seen Most Often*

None of Amerigroup 360°'s 2019 top-box scores were at least 5 percentage points less than the 2018 NCQA child Medicaid national averages for any measure.

Recommendations for Improvement

Amerigroup 360°'s top-box score showed a substantial decrease of 5 percentage points or more between 2018 and 2019 for one measure:

- *Shared Decision Making* (6.38 percentage points)

HSAG recommends that Amerigroup 360° focus QI efforts on the measure score that exhibited a substantial decrease from 2018 to 2019 (*Shared Decision Making*). HSAG recommends that Amerigroup 360° conduct a root cause analysis on this area. This type of analysis is typically conducted to investigate process deficiencies and unexplained outcomes to identify causes and devise potential improvement strategies. In addition, HSAG recommends that Amerigroup 360° continue to monitor the measures to ensure there are no significant decreases in rates over time.

Assessment of Follow-Up on Prior Recommendations

From the results of the calendar year 2018 CAHPS Survey, Amerigroup 360° received three recommendations. Table 9-7 below presents the prior recommendations made by HSAG during calendar year 2019 as well as Amerigroup 360°'s response to HSAG's recommendations.

Table 9-7—CAHPS Survey—Prior Recommendations and Amerigroup 360°'s Response

Prior Recommendations (CY 2019)	Amerigroup 360°'s Response to Recommendations
The CAHPS rates for Amerigroup 360°'s GF 360° composite measures <i>Getting Care Quickly</i> and <i>Shared Decision Making</i> were at least 5 percentage points greater than the 2018 national averages. HSAG recommended that Amerigroup 360° review and determine which best practices (e.g., network, providers maintaining same-day appointment schedules) have resulted in members perceiving that they receive care quickly.	<ul style="list-style-type: none"> To ensure that members continued to have access to care, Amerigroup 360° continued to annually monitor practitioner appointment accessibility, after-hour accessibility, and telephone accessibility. On an ongoing basis, Amerigroup 360° continued to evaluate its partnerships with urgent care providers to ensure that there was adequate access which supported network growth to meet members' needs for urgent care. The CMO's care coordinators continued to conduct outreach to members and members' guardians to provide education on how to communicate with PCPs when tasked with making decisions. Care coordinators and outreach staff continued to provide transition age youth with a booklet, <i>Taking Charge of My Health Care</i>, which included information on how members should talk with their physician.
For the GF 360° Medicaid population, Amerigroup 360°, HSAG recommended that the CMO focus on improving the <i>Rating of Health Plan</i> measure rate since the rate for this measure was at least 5 percentage points less than NCQA's 2018 CAHPS child Medicaid national average.	<ul style="list-style-type: none"> Amerigroup 360° initiated a workgroup focused on customer service. Amerigroup 360° implemented the following interventions focused on increasing CAHPS scores: <ul style="list-style-type: none"> Streamlined the process to access care from a PCP or specialist.

Prior Recommendations (CY 2019)	Amerigroup 360°'s Response to Recommendations
	<ul style="list-style-type: none"> – Facilitated member access to lab, pharmacy, or treatment services. – Ensured accurate and timely communication of CMO benefits, services, or updates to members and their providers. – Conducted provider education to enhance provider communication skills. – Implemented a process improvement to facilitate access to specialists, tests and treatment, and provided easy access to care members received from other healthcare providers. • To ensure that members continued to have access to timely care, Amerigroup 360° continued to annually monitor practitioner appointment accessibility, after-hours accessibility, and telephone accessibility. • On an ongoing basis, Amerigroup 360° continued to evaluate its partnerships with urgent care providers to ensure there was adequate access that supported network growth to meet members' needs for urgent care access.
<p>HSAG recommended that the CMO's efforts focus on improving the <i>Rating of Specialist Seen Most Often</i> measure rate since it was also lower than NCQA's 2018 CAHPS child Medicaid national average and decreased from 2017 to 2018. It was recommended that Amerigroup 360° conduct a root cause analysis of indicators identified as areas of low performance and devise potential improvement strategies.</p>	<ul style="list-style-type: none"> • Amerigroup 360° initiated a workgroup focused on customer service. • Amerigroup 360° implemented the following interventions focused on increasing CAHPS scores: <ul style="list-style-type: none"> – Streamlined the process to access care from a PCP or specialist. – Facilitated member access to lab, pharmacy, or treatment services. – Ensured accurate and timely communication of CMO benefits, services, or updates to members and their providers. – Conducted provider education to enhance provider communication skills. – Implemented a process improvement to facilitate access to specialists, tests, and treatment, and provided easy access to care members received from other healthcare providers.

Appendix A. Technical Methods of Data Collection and Analysis

Compliance with Standards Review Methodology

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR §438.358—the external quality review of Compliance with Standards activity for the DCH GF program CMOs addresses HSAG's:

- Objective for conducting the reviews.
- Activities in conducting the reviews.
- Technical methods of collecting the data, including a description of the data obtained.
- Data aggregation and analysis processes.
- Processes for preparing the draft and final reports of findings.

HSAG followed standardized processes in conducting the review of the CMOs' performance.

Objective of Conducting the Review of Compliance with Standards

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMO regarding compliance with State and federal requirements. HSAG assembled a team to:

- Collaborate with DCH to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, on-site review activities schedules, and the on-site review agenda.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare a report related to the findings.

To accomplish the objective and based on the results of collaborative planning with DCH, HSAG developed and used a data collection tool to assess and document the CMO's compliance with certain federal Medicaid managed care regulations and the associated DCH CMO contractual requirements. The review tool included requirements that addressed the following performance areas:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care

- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Selection
- Standard VI—Subcontractual Relationships and Delegation
- Standard VII—Member Rights and Protections
- Standard VIII—Confidentiality of Health Information
- Standard IX—Enrollment and Disenrollment
- Standard X—Grievance and Appeal System
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement (QAPI)
- Standard XIII—Health Information Systems
- Standard XIV—Program Integrity
- Standard XV—Member Information

The DCH and the CMO will use the information and findings that resulted from HSAG’s review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

The review was the first year of the three-year compliance review cycle of the CMOs.

HSAG’s Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal regulations and on the associated requirements set forth in the contract between DCH and the CMO, as they related to the scope of the review. HSAG also followed the guidelines set forth in CMS’ *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012^{A-1} for the following activities:

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the CMO a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for the desk review.

^{A-1} Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: <https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Jan 16, 2019.

- Conducting a kick-off webinar call with the CMOs to explain the review process and provide information about the scope of the review.
- Scheduling the on-site reviews.
- Developing the agenda for the two-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMO to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of key documents and other information obtained from DCH, and of documents and sample cases that HSAG selected that the CMO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMO's operations, identify areas needing clarification, and begin compiling information before the on-site review.

On-site review activities: HSAG reviewers conducted an on-site review of the CMO, which included:

- An opening session, with introductions and a review of the agenda and logistics for HSAG's two-day on-site review activities.
- A review of the documents HSAG requested that the CMO have available on-site.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference session during which HSAG reviewers summarized their preliminary findings.

HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the CMO's performance into compliance for those requirements that HSAG assessed as *Not Met*.

Description of Data Obtained

To assess the CMO's compliance with federal regulations, and DCH contract requirements, HSAG obtained information from a wide range of written documents produced by the CMO, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written member informational materials
- Case files/records
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMO's key staff members.

Table A-1 lists the major data sources HSAG used in determining the CMO's performance in complying with requirements and the time period to which the data applied.

Table A-1—Description of the CMO's Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 1, 2017–June 30, 2018
Information obtained through interviews	May 17, 2019—the last day of the CMO's on-site review
Information obtained from a review of a sample of the CMO's case files	July 1, 2017–June 30, 2018

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the CMO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

Met indicates full compliance defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.
- No documentation is present and/or staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores HSAG assigned for each of the requirements, a total percentage-of-compliance score was calculated for each of the standards and an overall percentage-of-compliance score across the

standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to, care and services the CMO provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the CMO's performance in complying with each of the requirements.
- Scores assigned to the CMO's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to DCH and to the CMO for their review and comment prior to issuing a final report.

Performance Measure Validation Methodology

CMS requires that states, through their contracts with managed care organizations (MCOs), measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of performance measures is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) described in the Code of Federal Regulations (CFR) at 42 CFR §438.358(b)(2) requires state Medicaid agencies to perform.

The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by CMOs and to determine the extent to which performance measures reported by the CMOs follow state specifications and reporting requirements. According to CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012, the mandatory PMV activity may be performed by the State Medicaid agency, an agent that is not a CMO, or an external quality review organization (EQRO).

HSAG validated a set of performance measures identified by DCH that were reported by the CMOs for their Medicaid and CHIP populations. HSAG conducted the validation in accordance with CMS' PMV protocol mentioned above and cited in Section 1.

The DCH requires the CMOs to submit performance measurement data as part of their QAPI programs for the GF and GF 360° populations. Validating the CMOs' performance measures is one of the federally required EQR activities described in 42 CFRs §438.330(c) and §438.358(b)(2).

To comply with this requirement, DCH contracted with HSAG to conduct performance measure validation activities for a set of select measures, and DCH required that the CMOs contract with an NCQA-licensed audit organization and undergo an NCQA HEDIS Compliance Audit for an additional set of measures. These audits focused on the CMOs' ability to process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data accurately. As part of the audits, HSAG also explored the completeness of claims and encounter data to improve rates for the performance measures.

The following sections provide summary information from HSAG's performance measure validation activities and the NCQA HEDIS Compliance Audits that were conducted for Amerigroup, Peach State, WellCare, and Amerigroup 360°.

Objectives

The objectives of the validation of performance measures activities conducted by HSAG and the CMOs' NCQA-licensed audit organizations were to assess the accuracy of performance measure rates reported by the CMOs and to determine the extent to which performance measures calculated by the CMO followed the technical specifications and reporting requirements. The audits included a detailed assessment of the CMOs' information systems capabilities for collecting, analyzing, and reporting

performance measure information. Additionally, the auditors reviewed the specific reporting methods used for performance measures, including databases and files used to store measure information, medical record abstraction tools and abstraction procedures used, certified measure status when applicable, and any manual processes employed in performance measure data production and reporting. The audits included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the CMOs' oversight of these outsourced functions. The auditors also evaluated the strengths and weaknesses of the CMOs in achieving compliance with performance measures.

Audited Populations

Georgia Families (GF)—the GF population consisted of Medicaid and PeachCare for Kids® members excluded from the GF 360° program and enrolled in one of the three contracted GF CMOs during the measurement year:^{A-2} Amerigroup, Peach State, and WellCare. To be included in the GF rates, a member

^{A-2} The DCH required its CMOs to contract with an NCQA-licensed audit organization to undergo an NCQA HEDIS Compliance Audit. To validate the rates calculated for the non-HEDIS measures, DCH contracted HSAG to perform an independent performance measure validation for each CMO. Results for these validations are presented in each CMO-specific PMV report.

had to be continuously enrolled in GF but could have switched CMOs during the measurement period. The GF rates excluded members who were simultaneously enrolled in Medicare and Medicaid (referred to as dual-eligible members).

Georgia Families 360° program (GF 360° program)—On March 3, 2014, DCH launched the Georgia Families 360° program. This program’s population consisted of children, youth, and young adults in foster care; children and youth receiving adoption assistance; and select youth involved in the juvenile justice system. The DCH contracted with Amerigroup to provide services to improve care coordination and continuity of care, and to provide better health outcomes for these members. To be included in the GF 360° program rates, a member had to be enrolled in the GF 360° program at some point during contract year 2017.

Description of Validation Activities

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities, HSAG obtained a list of the performance measures that were selected by DCH for validation.

HSAG then prepared a document request letter that was submitted to the CMOs outlining the steps in the PMV process. The document request letter included:

1. A request for the source code for each performance measure.
2. A completed HEDIS 2019 Record of Administration, Data Management, and Processes (Roadmap).
3. A completed Information Systems Capabilities Assessment Tool (ISCAT).
4. Any additional supporting documentation necessary to complete the audit.
5. A timetable for completion.
6. Instructions for submission.

HSAG also forwarded a letter that included requested documentation needed to complete the medical record review validation (MRRV) process. HSAG responded to any audit-related questions received directly from the CMOs during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided the CMOs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with the CMOs to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from CMOs.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed these data:

- **NCQA's HEDIS 2019 Roadmap:** The CMOs completed and submitted the required and relevant portions of its Roadmap for HSAG's review of the required HEDIS measures. HSAG used responses from the Roadmap to complete the pre-on-site assessment of information systems.
- **Information Systems Capabilities Assessment Tool (ISCAT):** The CMOs completed and submitted an ISCAT for HSAG's review of the required DCH-developed measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** CMOs that calculated the performance measures using source code were required to submit the source code used to generate each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DCH. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). CMOs that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures.
- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

On-Site Activities

HSAG conducted an on-site visit with the CMOs. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key CMO staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT and Roadmap documentation:** This session was designed to be interactive with key CMO staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and Roadmap and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of enrollment, eligibility, and claims systems and processes:** The evaluation included a review of the information systems, focusing on the processing of claims, and processing of enrollment and disenrollment data. HSAG conducted interviews with key staff familiar with the processing, monitoring, reporting, and calculating of the performance measures. Key staff included executive leadership, enrollment specialists, business analysts, customer operations staff, data analytics staff, and other front-line staff familiar with the processing, monitoring, and generating of the performance measure.

- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG performed PSV to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each CMO provided a listing of the data that it had reported to DCH to HSAG, from which HSAG selected a sample. These data included numerator positive records for HEDIS measures and a subset of requested claims data for the claim processing timeliness measure.

HSAG selected a random sample from the submitted data and requested that the CMO provide proof of service documents or system screen shots that allowed for validation against the source data in the system. These data were also reviewed live in the CMO's systems during the on-site review for verification, which provided the CMO an opportunity to explain its processes as needed for any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the CMO.

Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the CMOs have system documentation which supports that the CMO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT and the on-site visit, and revisited the documentation requirements for any post-on-site activities.

Post-On-Site Activities

After the on-site visit, HSAG reviewed any final performance measure data submitted by the CMOs and followed up with each CMO on any outstanding issues identified during the documentation review and/or during the on-site visits. Any issues identified from the rate review were communicated to the CMOs as a corrective action as soon as possible so that the data could be revised before the PMV report was issued. HSAG worked closely with DCH and the CMOs if corrected measure data were required.

HSAG prepared a PMV report for each CMO, documenting the validation findings. Based on all validation activities, HSAG determined the validation result for each performance measure. The CMS

PMV Protocol identifies possible validation results for performance measures, which are defined in the table below.

Table A-2—Validation Results and Definitions for Performance Measures

Report (R)	Measure data were compliant with DCH specifications and the data, as reported, were valid.
Not Reported (NR)	Measure data were materially biased.

According to the CMS protocol, the validation result for each performance measure is determined by the magnitude of errors detected for the audit elements, not by the number of audit elements determined to be “Not Reported” (NR). It is possible for a single audit element to receive a validation result of NR when the impact of the error associated with that element biased the reported performance measure rate by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to an audit result of “Report” (R).

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure as “NR.”

Performance Improvement Projects Validation Methodology

For the PIPs initiated in CY 2018, DCH instructed each CMO to select one clinical PIP topic and one non-clinical PIP topic. The CMO selected the topics and DCH approved each topic. Table A-3 summarizes the PIP topics for each CMO.

Table A-3—CY 2018–2019 PIP Topics

CMO	PIP Topics
Amerigroup	<i>Diabetes—Retinal Eye Exam</i>
	<i>Customer Satisfaction</i>
Amerigroup 360°	<i>Antidepressant</i>
	<i>Adoption Assistance – Member Contact Information</i>
CareSource	<i>Follow-up After Hospitalization for Mental Illness within 7 days of Discharge</i>
	<i>Improve the Timeliness of Utilization Management Decisions</i>
Peach State	<i>Improving Follow-up After Hospitalization for Mental Illness (7-Day)</i>
	<i>Improving Providers’ Satisfaction</i>
WellCare	<i>Prenatal Birth Outcomes—17p Initiation</i>
	<i>Member Realignment</i>

PIP Components and Process

The key concepts of the rapid-cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of PDSA cycles, and applying rapid-cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability.

HSAG developed five modules with an accompanying reference guide. Prior to issuing each module, HSAG held training webinars and technical assistance sessions with the CMOs to educate them on the requirements of each module. The five modules are defined as follows:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a core PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the CMO summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

Approach to PIP Validation

For the PIPs validated in CY 2019, HSAG obtained the data needed to conduct the PIP validation from the CMO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in each module.

The CMOs submitted modules 1 through 3 for each PIP throughout CY 2019. The CMOs initially submitted Module 1 and Module 2, received feedback and technical assistance from HSAG, and resubmitted these modules until all validation criteria were met. The CMOs followed the same process for Module 3. Once Module 3 was approved, the CMOs initiated intervention testing for each PIP in Module 4, which continued through October 31, 2019. The CMOs will submit Module 4 and Module 5 to HSAG for annual validation in January 2020.

The goal of HSAG's PIP validation is to ensure that the DCH and key stakeholders can have confidence that any reported improvement is related to, and can be directly linked to, the quality improvement strategies and activities the CMO conducted during the PIP. HSAG's scoring methodology evaluates whether the CMO executed a methodologically sound improvement project and confirms that any achieved improvement can be clearly linked to the quality improvement strategies implemented by the CMO.

PIP Validation Scoring

HSAG assigned a score of Achieved or Not Achieved for each of the criteria in modules 1 through 3. Any validation criteria not applicable (N/A) were not scored. Using a standardized scoring methodology, HSAG will assign a level of confidence and report the overall validity and reliability of the findings, upon validation of Module 4 and Module 5, as one of the following:

- **High confidence** = The PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes conducted and intervention(s) tested.
- **Confidence** = The PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- **Low confidence** = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- **Reported PIP results were not credible** = The PIP methodology was not executed as approved.

CAHPS Survey Methodology

Two populations were surveyed for Amerigroup, CareSource, Peach State, and WellCare: adult Medicaid and child Medicaid. One population was surveyed for Amerigroup 360°: children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system. DSS Research administered the 2019 CAHPS surveys for Amerigroup and Amerigroup 360°. Morpace administered the 2019 CAHPS surveys for Peach State, and SPH Analytics administered the 2019 CAHPS surveys for CareSource and WellCare. All three vendors were NCQA-certified vendors at the time of survey administration.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (without the children with chronic conditions [CCC] measurement set) to the child Medicaid population. Amerigroup, WellCare, and Amerigroup 360° used a mixed-mode methodology (i.e., mailed surveys followed by telephone interviews of non-respondents) for data collection. CareSource and Peach State

used a mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents) for data collection. Respondents were given the option of completing the survey in Spanish for all CMOs. Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2018; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2018.

The survey questions were categorized into various measures of experience. These measures included four global ratings, five composite measures, and three effectiveness of care measures.^{A-3} The global ratings reflected patients' overall experience with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The effectiveness of care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation in the adult population. When a minimum of 100 responses for a measure was not achieved, the result is denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (a response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a top-box response rate or top-box score. For each of the five composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box score for the composites was defined as a response of Usually/Always or Yes. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator.

CMO Comparisons

The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. For each CMO, the 2019 adult and child CAHPS scores were compared to their corresponding 2018 CAHPS scores. Scores that were at least 5 percentage points higher in 2019 than in 2018 are noted with upward (▲) triangles. Scores that were at least 5 percentage points lower in 2019 than in 2018 are noted with downward (▼) triangles. Scores in 2019 that were not at least 5 percentage points different from scores in 2018 are not noted with triangles. Additionally, each CMO's 2019 adult and child CAHPS scores were compared to the 2018 NCQA adult and child Medicaid national averages, respectively.^{A-4} Substantial differences are noted with colors. A cell was highlighted in green if the score was at least 5 percentage points greater than the national average. However, if the score was at least 5 percentage points less than the national average, then a cell was highlighted in red.

To identify performance differences in member experience between the four CMOs, the results for Amerigroup, CareSource, Peach State, and WellCare were compared to the Georgia CMO program

^{A-3} Effectiveness of Care measures related to smoking cessation were only included for the adult surveys.

^{A-4} Quality Compass® 2018 data serve as the source for the 2018 NCQA adult and child Medicaid national averages.

average using standard tests for statistical significance.^{A-5} For this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among CMOs. Results for the CMOs were case-mix adjusted for the member's general health status, respondent educational level, and respondent age.^{A-6} Given that differences in case-mix can result in differences in ratings between CMOs that are not due to differences in quality, the data were adjusted to account for disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level (or top-box) responses a score of 1, with all other responses receiving a score of 0. After applying this scoring methodology, the percentage of top-level responses was calculated to determine the question summary rates and global proportions. For additional detail, please refer to NCQA's *HEDIS 2019 Volume 3: Specifications for Survey Measures*.

Statistically significant differences are noted in the tables by arrows. A measure rate that is statistically significantly better than the Georgia CMO program average is denoted with an upward (↑) arrow. Conversely, a measure rate that is statistically significantly worse than the Georgia CMO program average is denoted with a downward (↓) arrow. A measure rate that is not statistically significantly different than the Georgia CMO program average is denoted with a horizontal (↔) arrow.

For this report, CAHPS scores are reported for measures even when NCQA's minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

^{A-5} Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

^{A-6} Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.