State of Georgia

Department of Community Health (DCH)

2008–2009
External Quality Review Annual Report
for
Georgia Families
Care Management Organizations (CMOs)

March 2009

HSAG Health Services Advisory Group

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HSAG HEALTH SERVICES ADVISORY GROUP

CONTENTS

Overview of the 2008–2009 External Quality Review Activities

The Balanced Budget Act of 1997 (BBA) added Section 1932 to the Social Security Act (the Act), which pertains to Medicaid managed care. Section 1932(c) of the Act requires state Medicaid agencies to provide for an external, independent review each year of the quality and timeliness of, and access to, services covered under each managed care organization (MCO) and prepaid inpatient health plan (PIHP) contract. The Code of Federal Regulations (CFR) outlines BBA requirements for external quality review (EQR) activities.

The CFR describes three activities that are mandatory and activities that are optional at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, §438.358(b) and (c). The three mandatory activities are: (1) validating performance improvement projects (PIPs), (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the State to comply with the requirements of 42 CFR §438.204(g). According to 42 CFR §438.358(a), "the State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities."

The BBA requires states to provide for an annual technical report that describes the manner in which data from activities conducted in accordance with 42 CFR §438.358 were aggregated and analyzed. The report must describe how conclusions were drawn as to the quality and timeliness of, and access to, care furnished by the states' MCOs and PIHPs. The report of results must also contain an assessment of the strengths and weaknesses of the plans regarding health care quality, timeliness, and access, and must make recommendations for improvement. Finally, the report must assess the degree to which the MCOs and PIHPs addressed any previous recommendations. To meet this requirement, the State of Georgia Department of Community Health (DCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to:

- Conduct the three mandatory activities for its Georgia Families Care Management Organizations (CMOs), which are MCOs under contract with DCH to provide physical health and behavioral health services to the State's Medicaid managed care-enrolled members.
- Use the data it collected from conducting the activities to prepare this 2008–2009 EQR annual report of findings, conclusions, and recommendations.

This is the first year that DCH contracted with an EQRO to conduct the mandatory activities and prepare the annual technical report of findings, conclusions, and recommendations. By producing and delivering this 2008–2009 External Quality Review Annual Report, DCH has complied with 42 CFR §438.364.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.354(b) and (c). HSAG has extensive experience and expertise in both conducting the mandatory activities and in using the information that either HSAG derived from directly conducting the activities or that a state derived from conducting the activities. HSAG uses the

information and data to draw conclusions and make recommendations about the quality and timeliness of, and access to, care and services the state's MCOs and PIHPs provide.

This EQR annual report describes the methodology HSAG used to conduct the three mandatory activities, the results it obtained, and recommendations to improve the CMOs' performance in providing accessible, timely, and quality care and services to members enrolled in Georgia Families Medicaid managed care. As set forth in 42 CFR §438.358(b), the State, its agent that is not an MCO or PIHP, or an EQRO must perform the following three activities for each contracted Medicaid managed care MCO and PIHP:

- **Conduct a review and evaluation of compliance with federal Medicaid managed care regulations and the associated State contract requirements.** As required by 42 CFR §438.358(b)(3), the review must be conducted within the previous three-year period to determine the MCO's or PIHP's compliance with standards—except with respect to standards under §438(240)(b)(1) and (2) for the conduct of PIPs and the calculation of performance measures, respectively—established by the State to comply with the requirements of §438.204(g). The §438.204(g) citation requires each state Medicaid agency to include in its written quality strategy standards at least as stringent as those described in 42 CFR §438.206–242 related to access to care, structure and operations, and measurement and improvement standards.
- **Validate performance measures.** As required by §438.358(b)(2), State-required performance measures reported by the MCOs/PIHPs or calculated by the State during the preceding 12 months must be validated. As a result, validating performance measures is required annually.
- **Validate performance improvement projects (PIPs).** As required by §438.358(b)(1), the State-selected PIPs that MCOs/PIHPs had underway during the preceding 12 months must be validated. As a result, validating PIPs is required annually.

For each of the three activities it conducted, HSAG prepared and submitted to DCH and the CMOs individual CMO-specific reports that included the results HSAG obtained from conducting each activity. HSAG's findings, conclusions, and recommendations to improve the CMOs' performance are summarized in this section and described in detail in Sections 6–8 of this report (i.e., Review of Compliance With Operational Standards, Validating Performance Measures, and Validating Performance Improvement Projects, respectively).

This Executive Summary includes an overview of HSAG's 2008–2009 EQR activities and a high-level summary of the results. The results include a description of HSAG's findings with respect to the three CMOs' performance in complying with select federal Medicaid managed care regulations and the associated DCH contract requirements, calculating and reporting performance results for DCH-selected measures, and conducting valid and effective DCH-required PIPs. This section also includes a summary of HSAG's overall findings, conclusions, and recommendations across the three performance areas for each CMO and statewide across the CMOs. The 2008–2009 annual report has these sections, as well:

- Section 2 (Background)—An overview of the history of the DCH Georgia Families Medicaid managed care program and a summary of its quality assessment and performance improvement (QAPI) strategy goals and objectives

- Section 3 (Description of EQRO Activities)—A description of the 2008–2009 EQR activities that HSAG conducted
- Section 4 (Quality Initiatives)—An overview of DCH's statewide quality initiatives across its CMOs
- Section 5 (CMO Best and Emerging Practices)—An overview of the CMOs' best and emerging practices
- Sections 6–8 (Organizational Assessment and Structure Performance, Performance Measure Performance, and Performance Improvement Project Performance, respectively)—A detailed description of each of the three mandatory activities that includes:
  1. HSAG's objectives for conducting each required activity, aggregating and analyzing the data, and preparing this report of findings and recommendations.
  2. HSAG's methodologies for conducting each activity and for using the data to prepare this annual report, including the technical methods of data collection and analysis, a description of the data obtained, and how HSAG drew conclusions from the data.
  3. CMO-specific results and statewide comparative results across CMOs, including an assessment of CMO strengths and opportunities for improvement.
  4. HSAG's recommendations for improving quality outcomes and the timeliness of, and access to, care and services the CMOs provide to members.

As this was the first year that DCH contracted with an EQRO to conduct the mandatory activities and prepare the EQR annual report required by the U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS), there were no prior-year EQR recommendations to improve CMO performance. The EQR Annual Report for 2009–2010 will include an assessment of the degree to which the CMOs addressed HSAG's recommendations included in this report.

For its Georgia Families Medicaid managed care program DCH contracts with three privately-owned CMOs—i.e., AMERIGROUP Community Care (AMERIGROUP), Peach State Health Plan (Peach State), and WellCare of Georgia, Inc. (WellCare). Each of the three Georgia-based CMOs is a subsidiary of a national parent company, with staff and other resources at both its Georgia office and its parent company's office to administer the Georgia Families Medicaid program.

This EQR annual report focuses on the three activities that HSAG conducted for each of the CMOs:

- *Evaluation of compliance with federal Medicaid managed care regulations and the associated State contract requirements***.** HSAG designed and conducted a review of the CMOs' performance to assess their compliance with select federal Medicaid managed care regulations and the associated DCH contract requirements. For the first year of a three-year cycle of compliance reviews, HSAG conducted the review of performance in six compliance areas (i.e., standards) associated with the federal Medicaid managed care access standards cited at 42 CFR 438.206–438.210.
- *Validation of performance measures.* For each CMO, HSAG validated and reported on two-DCH-specified performance measures—from among those the CMOs were required to report to DCH—to evaluate the accuracy of the performance measures reported by the CMOs. The validation also determined the extent to which Medicaid-specific performance measures calculated by the CMOs followed the DCH-established specifications.

- *Validation of PIPs*. HSAG reviewed and validated three DCH-specified PIPs—from among those DCH required the CMOs to conduct—to ensure that the CMOs designed, conducted, and reported on the projects in a methodologically sound manner, allowing real improvements in care and services and giving confidence in the reported improvements.

For each of the three activities it conducted, HSAG followed standardized evaluation methodologies across the CMOs that were consistent with the following published CMS protocols for conducting each of the activities:

- *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations*, Final Protocol, Version 1.0, February 11, 2003, at 42 CFR, Parts 400, 430, et al
- *Validating Performance Measures: A Protocol for Use in Conducting Medicaid External Review Activities,* Final Protocol, Version 1.0, May 1, 2002
- *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities:* Final Protocol, Version 1.0, May 1, 2002

Definitions

The BBA states that "each contract with a Medicaid managed care organization must provide for an annual external independent review conducted by a qualified independent entity of the quality outcomes and timeliness of, and access to, the items and services for which the organization is responsible."[1-1] CMS chose the domains of quality, access, and timeliness as key to evaluating MCO/PIHP performance. HSAG used the following definitions as guidelines to evaluate and draw conclusions about the CMOs' performance in each of these domains.

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 PIHP increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge."[1-2]

Timeliness

The National Committee for Quality Assurance (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."[1-3] It further discusses the intent of this standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness

[1-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*
[1-2] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*. *Code of Federal Regulations*. Title 42, Volume 3, October 1, 2005.
[1-3] National Committee on Quality Assurance. 2006 Standards and Guidelines for MBHOs and MCOs.

to include other managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals, and providing timely follow-up care.

Access

In the preamble to the BBA Rules and Regulations,[1-4] CMS discusses access and availability of services to Medicaid enrollees as the degree to which MCOs/PIHPs implement the standards set forth by the State to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP.

Findings, Conclusions, and Recommendations About Timeliness, Access, and Quality of Care

HSAG has summarized its findings from conducting each of the three mandatory activities for the CMOs during the first year of its EQRO contract with DCH, which started in July 2008. HSAG's findings, conclusions, and recommendations for each CMO, and comparatively across the CMOs, are described in detail in Section 6—Organizational Assessment and Structure Performance, Section 7—Performance Measure Performance, and Section 8—Performance Improvement Project Performance.

Operational Standards

The review of compliance with Medicaid managed care regulations and the DCH associated contract requirements was the first year of a three-year cycle of external quality reviews conducted for the Georgia Families CMOs. HSAG evaluated the degree to which the CMOs complied with the federal Medicaid managed care regulations and the associated DCH contract requirements in six performance categories (i.e., standards). The six standards included requirements associated with Medicaid managed care access standards found at 42 CFR §438.206–§438.210. DCH selected the access standards for the first year of the three-year cycle of reviews. The six standards contained requirements addressing availability of services, furnishing of services, cultural competence, coordination and continuity of care, coverage and authorization of services, and emergency and poststabilization services.

HSAG has described in detail in Section 6 of this report—Review of Compliance With Operational Standards—its methodology for conducting the review of the CMOs' compliance with the requirements, evaluating and scoring the CMOs' performance, and calculating the percentage-of-compliance scores for each standard and across the six standards. Table 1-1 presents the CMO-specific and the statewide results from HSAG's review showing the compliance scores for each of the standards and the overall compliance scores.

[1-4] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

Table 1-1—Individual CMO and Statewide Compliance Scores					
Standard #	**Standard Name**	**AMERIGROUP Community Care**	**Peach State Health Plan**	**WellCare of Georgia**	**Statewide Scores**
I	Availability of Services	**100%**	**100%**	**100%**	**100%**
II	Furnishing of Services	**100%**	**100%**	**100%**	**100%**
III	Cultural Competence	**100%**	**96%**	**100%**	**99%**
IV	Coordination and Continuity of Care	**100%**	**100%**	**100%**	**100%**
V	Coverage and Authorization of Services	**68%**	**76%**	**100%**	**81%**
VI	Emergency and Poststabilization Services	**95%**	**100%**	**95%**	**97%**
	Overall Compliance Rating	**92%**	**94%**	**99%**	**95%**

Scores ranging from 95 to 100 percent reflected *Excellent* CMO performance, scores ranging from 85 to 94 percent reflected *Good* performance, scores ranging from 75 to 84 percent reflected *Average* performance, and scores of 74 percent and lower reflected relatively *Poor* performance.

As presented in Table 1-1, the overall statewide CMO performance in complying with the requirements across all six standards was 95 percent, reflecting excellent performance. Individual CMO overall percentage-of-compliance scores across the six standards ranged from a high of 99 percent for WellCare to a low of 92 percent for AMERIGROUP.

Statewide performance for the individual standards ranged from a high of 100 percent for three of the standards (Availability of Services, Furnishing of Services, and Coordination and Continuity of Care) to a low of 81 percent for the Coverage and Authorization of Services standard. The score of 81 percent was heavily weighted by the low scores of 68 percent and 76 percent for AMERIGROUP and Peach State, respectively. In contrast, WellCare's percentage-of-compliance score for this standard was 100 percent

All CMOs demonstrated excellent performance for five of the six standards. Statewide performance was the strongest for the Availability of Services, Furnishing of Services, and Coordination of Care standards for which all three CMOs' percentage-of-compliance scores were 100 percent. The statewide percentage-of-compliance score of 99 percent for the Cultural Competence standard reflected the scores of 100 percent for both AMERIGROUP and WellCare and a score of 96 percent for Peach State. The statewide percentage-of-compliance score of 97 percent for the Emergency and Poststabilization standard reflected scores that ranged from a high of 100 percent for Peach State to a low of 95 percent for both AMERIGROUP and WellCare.

While each CMO's performance was not equally strong across the six standards, all three CMOs demonstrated some strength for each of the six standards, which HSAG has summarized at a high level on the following pages. Detailed descriptions of each CMO's strengths and opportunities for improvement are contained in Section 6 of this report.

- **Standard I—Availability of Services**: All CMOs had policies and procedures to ensure that they used multiple data sources to develop and continually evaluate the adequacy of the provider network. Members had direct access to services from primary care providers (PCPs) and to services from most specialists. Female members had unrestricted, direct access to obstetrician/gynecologists (OB/GYNs) in addition to their PCPs. Members also had direct access to a second opinion by in-network providers, and if needed, the CMOs authorized services by out-of-network providers when an appropriately qualified in-network provider was not available. Providers were not allowed to balance bill members and were required to accept the CMOs' contracted or negotiated rate as payment in full.
- **Standard II—Furnishing of Services**: All CMOs used the provider and delegate contracts and the provider manual to communicate to providers and delegates the standards for providing timely appointments. While methods varied among the CMOs, each had processes for frequently reminding providers about the standards. CMOs also had robust processes for regularly monitoring and evaluating provider performance in meeting the timely access standards and required from, and worked with, providers to implement corrective actions when performance was not satisfactory. The CMOs used GeoAccess or similar software to regularly assess and report to DCH their performance in meeting standards for providing geographically accessible care to members. In general, all CMOs demonstrated strong performance in meeting standards for ensuring geographic access to services as measured against the DCH standards for drive time or miles. While varied somewhat among the CMOs, each CMO implemented aggressive and creative approaches for recruiting additional in-network providers and/or engaging providers willing to provide out-of-network services to its members (by entering into single-case agreements with the CMOs for specific members) as one of the primary mechanisms for improving performance.
- **Standard III—Cultural Competence**: All CMOs had written cultural competency plans that provided an overview of their commitment to, and philosophy about, the importance of cultural competency and their goals and values related to providing culturally competent and responsive services to members. The CMOs provided education/training to staff and providers regarding the demographic characteristics and cultural needs of their members and informed and educated them about the importance of providing culturally competent and responsive services. Member informational materials, including the member handbooks, were written in both English and Spanish and in language that was easy to understand. The CMOs provided free access for members to interpreter and TTY services, and when requested, written information in alternative formats (large print, audio, Braille, etc.). The CMOs regularly reviewed member grievances and responses to satisfaction surveys to identify any deficiencies in staff, provider, or overall CMO performance related to providing culturally competent and responsive services. The CMOs also used member grievances and satisfaction responses to ensure that providers did not discriminate against members based on the federally prohibited member characteristics (e.g., race, color, disability, religion, etc.) or treat Georgia Families Medicaid members differently than other patients with regard to office or appointment wait times, appointment times (days of the week, hours), and the professionalism of the office staff and providers when interacting with members.
- **Standard IV—Coordination and Continuity of Care**: All CMOs used provider manuals and contracts to communicate with providers with regard to their expectations for the PCP's role in coordinating care. They used the member handbooks to inform members about the PCP's role and the importance of selecting and making/keeping appointments with their PCP. In addition,

all CMOs used medical record audits to monitor provider compliance with documentation and coordination-of-care requirements and required provider corrective action plans from those not meeting them. While there was variation among the CMOs, each had robust processes for coordinating and case managing the care of members needing more intensive care coordination/case management services (e.g., using stratification methods to identify members with the greatest need for care coordination, data mining to identify members with complex conditions or long-term care needs, a trigger list of diagnoses, referrals from PCPs, and training staff to identify the members). For these members, the CMOs conducted comprehensive assessments and developed detailed care plans. HSAG considered WellCare's electronic system for documenting administrative data as a best practice because the system provided staff members in multiple areas of the company with real-time data about a member's treatment, services requested, services provided, and authorization history to facilitate care coordination.

- **Standard V—Coverage and Authorization of Services**: As noted in Table 1-1 and the individual CMO findings in Section 6, the CMOs' performance for this standard varied considerably from a high of 100 percent to a low of 68 percent, and required several corrective action plans for two of the CMOs. However, all CMOs did have written definitions of medical necessity that were consistent with the federal Medicaid managed care regulations' and DCH's definitions. Each CMO also had a utilization management (UM) system in place to ensure members received medically necessary services in the amount, duration, and scope needed. Utilization determinations were based on medical necessity and nationally accepted criteria such as the McKesson/InterQual index. The CMOs also used extensive training and interrater reliability (IRR) testing to ensure that reviewers were consistent in applying the criteria. While there was variation among the CMOs, each had an impressive and very sophisticated management information system for managing (not merely tracking) requests for services, authorization or denial decisions by the CMO, and the related paperwork and actions taken to meet the associated requirements. HSAG considered each of the systems a best practice model.
- **Standard VI—Emergency and Poststabilization Services**: All CMOs used a definition of emergency medical condition that was consistent with the Medicaid managed care regulations' and DCH's definitions. While the information varied in the quality, sufficiency, and ease of understanding among the CMOs, for the most part, the CMOs communicated accurate information to providers and members about emergency, urgent care, and poststabilization services. Documentation in policies/procedures and claims submitted and paid demonstrated that the CMOs: (1) were compliant with the regulations prohibiting them from requiring prior authorization for these services and (2) paid provider claims for these services as required by contract, State statutes, and Medicaid managed care regulations.

While the CMOs' performance reflected numerous strengths and best practices for five of the six standards as summarized above and described in detail in Section 6, HSAG also identified significant opportunities for performance improvement for two of the CMOs (AMERIGROUP and Peach State) regarding performance for the Coverage and Authorization of Services standard. The percentage-of-compliance scores of 68 percent and 76 percent, respectively, reflected relatively poor or just average performance for these two CMOs, in contrast to WellCare's excellent performance of 100 percent. Recommendations and required corrective actions for AMERIGROUP and Peach State focused on ensuring that the two CMOs have the following:

- Complete and accurate written policies and procedures, and consistency across them, that address all applicable Medicaid managed care regulations and the associated DCH contract requirements for the coverage and authorization/denial of services
- Activities and actions/decisions that comply with the written policies and procedures

HSAG described a limited number of additional CMO-specific recommendations and required corrective actions to bring performance into full compliance in Section 6 in the subparts describing each CMO's strengths and opportunities for improvement. These sections also include additional HSAG recommendations to further improve already strong and compliant performance related to several of the standards.

Performance Measures

HSAG designed the validation of performance measures activity to ensure the accuracy of the performance indicator results reported by the CMOs to DCH. To determine that the results were valid and accurate, HSAG evaluated the CMOs' data collection and calculation processes.

HSAG validated two performance measures for each CMO for compliance with technical requirements, specifications, and construction. HSAG scored the performance measures as *Fully Compliant* (the CMO followed the specifications without any deviation), *Substantially Compliant* (some deviation was noted, but the reported rate was not significantly biased), or *Not Valid* (significant deviation from the specifications that results in a +/- bias of greater than 5 percent in the final reported rate). HSAG scored all the measures *Fully Compliant*. Table 1-2 displays CMO results for the two performance measures. Variation of performance among CMOs was wide. For the *Members with Diabetes that had at Least One HbA1c Test* measure, the difference between the high-performing and low-performing CMOs was 13.7 percentage points. For the *Members with Asthma Receiving Appropriate Medications* measure, the difference was 22 percentage points.

Table 1-2—CMO Performance Measure Results—Percentage Scores

CMO	Percent of members with diabetes who had at least one HbA1c test	Percent of members with asthma receiving appropriate medications
AMERIGROUP Community Care	59.3%	95.7%
Peach State Health Plan	73.0%	80.1%
WellCare of Georgia	65.7%	73.7%
Statewide Rate	**64.6%**	**85.8%**

Both performance measures reported for this year were related to quality and no measures were related to the access and timeliness domains. For the *Members with Asthma Receiving Appropriate Medications* measure, Georgia's overall performance (85.8 percent) was above the national 2007 HEDIS Medicaid 10th percentile (81.5 percent). More specifically, two of the three CMOs performed below the 10th percentile, suggesting room for improvement. Because the rate for the *Members with Diabetes who had at Least One HbA1c Test* measure was reported using administrative data only, comparison with the national 2007 HEDIS Medicaid benchmarks would not be meaningful since this is a hybrid measure.

Performance Improvement Projects (PIPs)

Performance improvement projects (PIPs) are designed to assess health care processes, implement process improvements, and improve outcomes of care. In 2008–2009, HSAG validated three PIPs for each CMO that were under way during the 12 months preceding fiscal year (FY) 2008–2009. HSAG's validation of the nine PIPs was consistent with the CMS protocol for validating PIPs.

Overall, the total percentage of all evaluation elements receiving a score of *Met* was 77 percent, demonstrating a high level of success for the CMOs' efforts on their first-year submissions. Three PIPs received a *Met* validation status, with four receiving a *Partially Met* and two a *Not Met* status. The CMOs demonstrated statewide strengths in fulfilling the requirements related to selecting and documenting an appropriate study topic (Activity I) and identifying appropriate improvement strategies (Activity VII). HSAG refers to "activities" when discussing conducting PIPs and CMS' Protocol for Conducting PIPs.

Table 1-3 presents a statewide summary of the CMOs' PIP validation results for each of the CMS PIP protocol activities. HSAG refers to "steps" when discussing the PIP validation process and CMS' protocol for validating PIPs. As directed by DCH, HSAG only validated Steps I through VII for each of the nine PIPs. For three of the seven validated steps, 100 percent of the critical elements received a *Met* score, suggesting that in general the CMOs met the fundamental PIP documentation requirements for defining the study topics, identifying appropriate data collection processes, and designing and implementing improvement strategies. However, since only slightly more than three quarters of the critical elements (77 percent) received a *Met* score, room for improvement existed especially in Step II—Review the Study Question(s). Steps I, IV, and VII received a *Met* score for all critical elements, while only step VII achieved 100 percent for both evaluation and critical elements. These findings indicated that although the majority of the PIPs did not have a fundamental flaw in the study design, there was significant opportunity for improvement in conducting and documenting a successful PIP.

Table 1-3—Summary of Data from Validation of Performance Improvement Projects

Steps HSAG Reviewed		Percentage of Evaluation Elements Receiving A *Met* Score	Percentage of Critical Elements Receiving A *Met* Score
I.	Review the Selected Study Topic(s)	88%	100%
II.	Review the Study Question(s)	56%	56%
III.	Review the Selected Study Indicator(s)	83%	78%
IV.	Review the Identified Study Population	70%	72%
V.	Review Sampling Methods*	83%	50%
VI.	Review Data Collection Procedures	67%	100%
VII.	Assess Improvement Strategies	100%	100%
VIII.	Review Data Analysis and Study Results	--	--
IX.	Assess for Real Improvement	--	--
X.	Assess for Sustained Improvement	--	--
	Total percentage of elements scored as Met	77%	77%

*Only two of the nine PIPs used sampling methodology.

Table 1-4 presents the CMO results of the 2008–2009 PIP validation. Experience in conducting and documenting PIPs varied widely across CMOs and PIP topics. One CMO achieved a *Met* validation status for all of its PIPs whereas the other two CMOs did not attain a *Met* validation status for any of its PIPs. In addition, the *Provider Satisfaction* PIPs tended to show better performance than the other two HEDIS-related PIPs.

Table 1-4—CMOs' PIP Validation Results

CMO-PIP	% of All Elements *Met*	% of All Critical Elements *Met*	Validation Status
AMERIGROUP			
Improving Childhood Lead Rates	50%	44%	*Not Met*
Provider Satisfaction	79%	91%	*Partially Met*
Well-Child Visits	50%	44%	*Not Met*
Peach State			
Improving Childhood Lead Rates	79%	44%	*Partially Met*
Provider Satisfaction	73%	100%	*Partially Met*
Well-Child Visits	79%	56%	*Partially Met*
WellCare			
Improving Childhood Lead Rates	96%	100%	*Met*
Provider Satisfaction	91%	100%	*Met*
Well-Child Visits	96%	100%	*Met*

All the PIP topics submitted for this year's validation provided an opportunity to improve the quality of care. In addition, the focus of two PIP topics, *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits*, was to improve access to care. However, the EQR activities themselves related to these PIPs were designed to evaluate the validity and quality of each CMO's processes for conducting valid PIPs. Therefore, the summary assessment of the CMOs' PIP validation results related to the domain of quality.

Overall Findings, Conclusions, and Recommendations

Categorizing Results

Once HSAG identified the data sources it would use to assess the CMOs' performance, it reviewed the data and, using the definitions included earlier in this executive summary, determined whether the CMOs' performance results related to the quality and/or timeliness of and/or access to the health care services the CMOs provided to Georgia Families Medicaid members. HSAG used these determinations to draw conclusions and make recommendations about the quality and timeliness of, and access to, the care and services the CMOs provided.

- **Review of Compliance with Standards**: For the review of the CMOs' compliance with operational standards, based on the focus of the requirements within each standard, HSAG determined that the CMOs' performance for the standard reflected one or more dimensions of providing care and services (i.e., quality and/or timeliness and/or access). HSAG did not

separately assign requirements within a standard. Table 1-5 displays for each standard the dimensions of care and services reflected in the CMO's performance for the standard.

Table 1-5—Standards By Dimensions of Care Assessed

Standard		Quality	Timeliness	Access
I.	Availability of Services	X		X
II.	Furnishing of Services		X	X
III.	Cultural Competence	X		X
IV.	Coordination and Continuity of Care	X		X
V.	Coverage and Authorization of Services		X	X
VI.	Emergency and Poststabilization Services		X	X

- **Performance Measures:** All of the performance measures HSAG validated were related to quality and no measures were related to the access and timeliness domains.
- **Performance Improvement Projects:** All three PIPs provided an opportunity to improve the quality of care the CMOs' provide to their members. In addition, the focus of two PIPs, *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits*, was to improve quality of care and access to care. However, the EQR activities themselves were designed to evaluate the validity and quality of the CMOs' processes for conducting valid PIPs. Therefore, the summary assessment of the CMOs' PIP validation results related to the domain of quality.

The following is a high-level summary of conclusions drawn from the findings of the EQR activities, including HSAG's recommendations with respect to quality, timeliness, and access. Detailed descriptions of each CMO's performance and overall strengths and opportunities for improvement, as well as HSAG's recommendations, are contained in the following sections of this report: Section 6—*Review of Compliance With Operational Standards*, Section 7—*Validating Performance Measures*, and Section 8—*Validating Performance Improvement Projects*.

Quality

Table 1-6 displays the statewide scores and the lowest and highest scores among the CMOs for measures assessing the **quality** of care and services the CMOs provided.

Table 1-6—Measures Assessing Quality			
Measure	**Statewide Score**	**CMO Low Score**	**CMO High Score**
Compliance Review Standards			
Standard I. Availability of Services	100%	100%	100%
Standard III. Cultural Competence	98%	96%	100%
Standard IV. Coordination and Continuity of Care	100%	100%	100%
Performance Measure Indicators			
Performance Measure: Percent of members with diabetes who had at least one HbA1c test	64.6%	59.3%	73.0%
Performance Measure: Percent of members with asthma receiving appropriate medications	85.8%	73.7%	95.7%
Performance Improvement Projects			
Performance Improvement Project: *Improving Childhood Lead Rates (Medicaid)*			
All evaluation elements *Met*	75%	50%	96%
Critical elements *Met*	63%	44%	100%
Performance Improvement Project: *Provider Satisfaction*			
All evaluation elements *Met*	81%	73%	91%
Critical elements *Met*	97%	91%	100%
Performance Improvement Project: *Well-Child Visits*			
All evaluation elements *Met*	75%	50%	96%
Critical elements *Met*	67%	44%	100%

Overall, CMO performance for the compliance standards addressing aspects of the quality of care and services provided to members was excellent and indicated a statewide strength. All CMOs achieved full compliance for all requirements for the Availability of Services and Coordination and Continuity of Care standards, and an overall percentage-of-compliance score of 98 percent for the Cultural Competence standard.

While results can be a function of both actual performance and the completeness and accuracy of the data collected, the CMOs' results for performance measures related to quality of care and services presented considerable opportunities for improvement. For the *Members with Asthma Receiving Appropriate Medications* measure, although the statewide rate was above the national 2007 HEDIS Medicaid 10th percentile (81.5 percent), two of the three CMOs performed below the 10th percentile. Performance for this measure was somewhat stronger than for the second measure—*Members with Diabetes that had at Least One HbA1c Test*. Potential strategies to improve actual performance could focus on provider-level interventions such as distributing to physicians and clinical staff updated clinical practice guidelines or developing an asthma disease registry for asthma patient alerts.

Because the rate for the *Members with Diabetes that had at Least One HbA1c Test* measure was reported using administrative data only, comparison with the national 2007 HEDIS Medicaid benchmarks would not be meaningful. Nonetheless, performance by all CMOs in the current year

suggested considerable room for improvement. Strategies focusing on distributing practice guidelines, HEDIS results, and lists of noncompliant patients to physicians managing diabetes patients would be a good place to start. In addition, providing or enhancing education of members regarding HbA1c testing should also be considered.

Based on the results of this year's performance measure validation findings, HSAG recommends that DCH consider adopting HEDIS measures as the required performance measures for the CMOs to report. This would alleviate any issues with developing additional specifications and allow the CMOs to use their certified software vendors, if they are using one of these venders, to calculate the Medicaid rates. In addition, DCH should develop a codebook that outlines the most current measure specifications and protocols for calculating the measures and distribute it to the CMOs. The codebook should include any instructions regarding whether CMOs can use additional/supplemental data sources and, if applicable, how to use them.

The Georgia Families CMOs' overall PIP performance was generally consistent with the performance of other organizations in their first submission for external validation. Commendable is the fact that the CMOs' PIPs reflected more strengths than opportunities for improvements. Three of the nine PIPs had more than 90 percent of the elements receiving a *Met* score and subsequently received a *Met* validation status. Four PIPs had all critical elements scored as *Met*.

Based on the PIP validation findings, HSAG identified opportunities for continued improvement in the CMOs' PIP activities. In Section 8—Validating Performance Improvement Projects, HSAG has described the specific performance improvement opportunities for each of the CMOs as it moves forward with its PIP activities. HSAG has also recommended ways to strengthen the current PIP structure and achieve improvement across all study indicators.

Timeliness

Table 1-7 displays the statewide scores and the lowest and highest scores among the CMOs for measures assessing **timeliness** of care and services.

Table 1-7—Measures Assessing Timeliness

Measure	Statewide Score	CMO Low Score	CMO High Score
Compliance Standards			
Standard II. Furnishing of Services	100%	100%	100%
Standard V. Coverage and Authorization of Services	71%	68%	100%
Standard VI. Emergency and Poststabilization Services	93%	95%	100%

Overall, the CMOs' performance for the standards that measured aspects of timeliness of care and services and/or CMO actions/decisions was somewhat mixed. All of the CMOs performed well for the Furnishing of Services standard (100 percent) and the Emergency and Poststabilization Services standard (93 percent), but performance was either average or relatively poor for two of the three CMOs for the Coverage and Authorization of Services standard, which heavily weighted the 71 percent statewide percentage-of-compliance score for this standard. CMO strengths included:

- Meeting DCH's minimum benchmark of 80 percent compliance for timely appointment standards, a benchmark that DCH indicated it plans to progressively increase in the future.
- Conducting aggressive and creative provider recruitment activities to continually improve geographic access to members across provider types in both rural and urban areas.
- Providing for ease of/direct member access to in-network providers, including PCPs, most specialty provider types, OB/GYNs for females, and second opinions.
- Making and communicating decisions regarding requests for services within the required timelines.

HSAG recommended that:

- The applicable CMOs have complete, accurate, and consistent written policies and procedures that address all Medicaid managed care and the associated DCH contract requirements related to the coverage and authorization/denial of services.
- The CMOs' performance and actions/decisions comply with the written policies and procedures.

Access

Table 1-8 displays the statewide scores and the lowest and highest scores among the CMOs for measures assessing aspects of performance related to **access** to care and services.

Table 1-8—Measures Assessing Access

Measure	Statewide Score	CMO Low Score	CMO High Score
Compliance Monitoring Standards			
Standard I. Availability of Services	100%	100%	100%
Standard II. Furnishing of Services	100%	100%	100%
Standard III. Cultural Competence	98%	96%	100%
Standard IV. Coordination and Continuity of Care	100%	100%	100%
Standard V. Coverage and Authorization of Services	71%	68%	100%
Standard VI. Emergency and Poststabilization Services	93%	95%	100%

The CMOs' performance was strong, with one exception, for those standards that addressed requirements related to access to care and services. For four of the standards (Availability of Services, Furnishing of Services, Cultural Competence, and Coordination and Continuity of Care) performance was excellent and commendable. The Coverage and Authorization of Services standard included requirements that addressed both timeliness and access dimensions of providing care and services. It was the only standard that addressed dimensions of providing accessible services where there was substantive room for improvement for two of the CMOs related primarily to their policies and procedures as described above for the dimension of timeliness.

Overall, the CMOs' performance was strong in providing accessible, coordinated, and culturally competent care and services for their Georgia Families members.

2. Background

This section of the report includes a brief history of the DCH Georgia Families Medicaid managed care program and a description of DCH's QAPI strategy. The description of the QAPI strategy summarizes DCH's:

- Quality strategy goals and objectives.
- Operational performance standards used to evaluate CMO performance in complying with BBA regulations and State contract requirements.
- Requirements and targets used to evaluate contractor performance on DCH-selected measures and to evaluate the validity of and improvements achieved through the CMOs' DCH-specified PIPs.

History of the Georgia Medicaid Managed Care Program

The State of Georgia implemented its Georgia Families Medicaid managed care program in 2006. Through its three private CMO contractors that DCH selected through a competitive bid process, DCH provides services to individuals enrolled in the State's Medicaid and PeachCare for Kids™ (i.e., State Children's Health Insurance program [SCHIP]) managed care programs. DCH stated that it implemented the Georgia Families program to:

- Offer care coordination to members.
- Enhance access to health care services.
- Achieve budget predictability as well as cost containment.
- Create systemwide performance improvements.
- Continuously and incrementally improve the quality of health care and services provided to members.
- Improve efficiency at all levels.

Based on these drivers, DCH established the following program goals:

- Improve the health care status of the member population
- Establish contractual accountability for access to, and the quality of, health care
- Lower costs through more effective utilization management
- Establish budget predictability and administrative simplicity

DCH's three-part mission was to ensure:

- Access to affordable, quality health care in the community.
- Responsible health planning and use of health care resources.
- Healthy behaviors and improved health outcomes.

Based on the results of its competitive bid process, DCH awarded contracts to the current three CMOs. Each CMO was contracted to deliver services within three or more of the six designated geographic regions. To ensure a smooth and successful transition from fee for service to the Georgia Families managed care program, DCH implemented the program in two phases, beginning with two of the six regions (Atlanta and Central) on June 1, 2006, followed by the remaining four regions (North, East, Southeast, and Southwest) on September 1, 2006. DCH awarded contracts to at least two CMOs within each of the six geographic regions.

The Georgia Families program includes more than half of the State's Medicaid population and the majority of the State's PeachCare for Kids™ population. Enrollment is mandatory for the following eligibility groups: low-income families, transitional Medicaid, pregnant women, children, newborn children, women eligible due to breast or cervical cancer, and refugees. The majority of members within the Georgia Families program are children. Members have the right to choose among the CMOs providing services within their respective geographic regions. For members not making a choice, DCH uses a number of criteria to assign them to a health plan, such as maintaining family continuity by enrolling all family members in the same CMO and maintaining member-to-provider relationships. In addition to providing all medically necessary Medicaid-covered services to members, the CMOs also provide a range of enhanced services to members, including such things as dental and vision services, enhanced ease of access to specialty services, and disease management and education/wellness/preventive services and programs.

Georgia Department of Community Health Quality Strategy

Section 1932(c)(1) of the Social Security Act (the Act) sets forth specifications for the quality assessment and performance improvement strategies that states must implement to ensure the delivery of quality health care by all managed care organizations. The CMS Medicaid managed care regulations at 42 CFR §438.200 and §438.202 implemented Section 1932(c)(1) of the Act, defining certain Medicaid state agency responsibilities. The regulations require Medicaid state agencies operating Medicaid managed care programs to develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards that the state and its contracted MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) must meet. The Medicaid state agency must:

- Conduct periodic reviews to examine the scope and content of its quality strategy and evaluate its effectiveness.
- Ensure compliance with standards established by the state that are consistent with federal Medicaid managed care regulations.
- Update the strategy periodically as needed.
- Submit to CMS a copy of the state's initial strategy, a copy of its revised strategy whenever significant changes have occurred in the program, and regular reports describing the implementation and effectiveness of the strategy.

Federal Medicaid managed care regulations specify at 42 CFR §438.204 the elements that, at a minimum, the state Medicaid agencies must address in their quality strategies. The elements include:

- MCO or PIHP contract provisions that incorporate the standards specified in 42 CFR 438 related to access, structure and operations, and measurement and improvement.
- Procedures that:
  - Assess the quality and appropriateness of care and services furnished to all Medicaid enrollees under the MCO or PIHP contracts, and to individuals with special health care needs.
  - Identify the race, ethnicity, and primary language spoken of each Medicaid enrollee and provide this information to the MCOs and PIHPs for each Medicaid enrollee at the time of enrollment.
  - Regularly monitor and evaluate MCO and PIHP compliance with the standards.
  - Arrange for external, independent reviews each year of quality outcomes and the timeliness of, and access to, services covered under each MCO and PIHP contract.
  - For MCOs, appropriately use intermediate sanctions that, at a minimum, meet the applicable requirements.
- Any national performance measures and levels that may be identified and developed by CMS in consultation with states and other relevant stakeholders.
- An information system that supports initial and ongoing operation and review of the state's quality strategy.
- Standards at least as stringent as those described in 42 CFR §438.206–242.

DCH drafted and obtained public input on its initial June 2007 Quality Strategic Plan for ensuring that it provided timely, accessible, and quality services to members of Georgia Families. The initial strategy described the strategies DCH would use to continually assess the quality of care delivered through the CMOs and how, based on its assessment, DCH would improve the quality of care the CMOs provided to members. In July 2008, DCH submitted to CMS a Quality Strategy Plan Update progress report and DCH's proposed revisions to the CMO contract.

Quality Strategy Objectives

DCH's July 2008 Quality Strategic Plan Update progress report was well organized, detailed, and specific in describing the mechanisms DCH planned to continue or initiate to ensure that Georgia Families members received accessible, timely, and quality care/services. The progress report also included mechanisms to ensure that the CMOs complied with federal Medicaid managed care regulations and the associated DCH contract requirements. The progress report described the State's four primary goals and the associated process and/or outcome objectives. For each objective, the progress report described DCH's specific strategic actions, and for each of these actions, the initial or revised target completion data and whether the State was on schedule, at risk of being behind schedule, or critically delayed. For each strategic action, the information also included DCH's narrative description of the status of its actions.

The four DCH goals described in both its initial strategy and its July 2008 Quality Strategic Plan Update progress report were to:

1. Promote commitment across the organization to quality of care and services.

2. Improve and enhance the quality of patient care through ongoing, objective, and systematic measurement, analysis, and improvement of performance.
3. Promote a system of health delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction.
4. Promote acceptable standards of health care within managed care programs by monitoring internal and external processes for improvement opportunities.

As noted previously, for each of the four goals described in the plan and progress report, DCH also described its process and/or outcome objectives.

Goal 1—The 2008 progress report stated that DCH's objectives in promoting commitment across the organization to quality of care and services were to:

- Establish an EQRO to provide an independent evaluation of the Georgia Families program.
- Ensure CMO compliance with adoption and dissemination of three clinical practice guidelines.

Goal 2—The 2008 progress report described DCH's objectives for improving and enhancing the quality of patient care through ongoing, objective, and systematic performance measurement, analysis, and improvement. The objectives were to:

- Ensure the provision of quality care and ongoing improvement in health baseline and health outcomes through performance-based measurement and performance-driven objectives.
- For children's preventive health:
  - Over the next five years, meet or exceed the Healthcare Effectiveness Data and Information Set (HEDIS) 2006 90th percentile for managed care-eligible children with well-child visits during their first 15 months of life.
  - Over the next five years, in collaboration with Georgia's immunization program, demonstrate an improvement of 5 percentage points in the number of managed care-eligible children younger than 36 months of age who are compliant with the 4:3:1:3:3:1 immunization series—4 DTaP (Diphtheria, Tetanus, and Pertussis); 3 Polio; 1 MMR (Measles, Mumps, and Rubella); 3 Hib (Haemophilus Influenza Type B); 3 Hep B (Hepatitis B); and 1 Varicella.
  - Over the next five years, in collaboration with Georgia's Childhood Lead Poisoning Prevention Program (GCLPP), demonstrate an improvement of 10 percentage points in the number of children eligible for managed care who are 1 and 2 years of age and receive a blood screening for lead.
- Within the next five years demonstrate an improvement of:
  - Ten percentage points in ambulatory or preventive care visits, bringing Georgia to the HEDIS 2006 90th percentile level for adults 21–44 years of age in Medicaid managed care plans.
  - Twenty percentage points for members eligible for managed care who are 18–75 years of age with diabetes and have had a least one HbA1c test, bringing Georgia to the HEDIS 2006 75th percentile level for Medicaid managed care plans.

  - Five percentage points for members eligible for managed care who have asthma and received appropriate medications, bringing Georgia to the HEDIS 2006 90th percentile level for Medicaid managed care plans.
- Within the next five years, demonstrate a 10-percent decrease in the rate of low-birth-weight babies in managed care, improving Georgia's infant mortality rates.
- Coordinate with Georgia's transparency Web site to facilitate increased and informed decision-making, leading to improved health choices.

Goal 3—The objectives DCH described in its 2008 progress report for promoting a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction were to:

- Ensure an ongoing CMO quality management program.
- Develop a plan for preferential auto-assignment of new members to CMOs that demonstrate improved quality of care.
- Ensure CMO compliance with contractual standards related to:
  - Access to care.
  - Coordination of care.
  - Covered services.

Goal 4—As described in its 2008 progress report—and consistent with the Institute of Medicine (IOM) Aim(s) for Improvement: Patient Centered, Safe, and Efficient recommendations—DCH's objectives for promoting acceptable standards of health care within managed care programs by monitoring internal and external processes for improvement opportunities were to ensure CMO compliance with contractual standards in the following areas:

- Grievance system (i.e., member appeals and member grievances)
- Subcontractor relations
- Structure and operations
- Utilization management

DCH also documented in its July 2008 Quality Strategic Plan Update progress report that DCH was on schedule for implementing almost all of the strategic actions described for meeting each objective. The plan update described a very small number of strategic actions at risk of being behind schedule. None of the actions was identified as critically delayed.

Operational Standards Requirements

Through its contracts, DCH required the CMOs to comply with DCH standards that were as stringent, and in many instances, more stringent and detailed, than the CMS requirements for Medicaid managed care plans described in 42 CFR §§438.206–242—and the standards cross-referenced within them—for performance related to access, structure and operation, and measurement and improvement standards. In its review of DCH's initial contract with the CMOs when preparing to conduct its review of the CMOs' compliance with select standards as described

elsewhere in this report, HSAG was very impressed with DCH's detailed knowledge of, and diligence in including, all CMS-required performance standards in its CMO contracts. In addition, DCH prepared an impressive and detailed "Quality Street" roadmap document for internal quality control purposes and for HSAG to use in preparing its review of CMO compliance. The document provided a crosswalk for each applicable CFR citation that included the type of information HSAG would need to obtain from the State (e.g., the prevalent languages spoken by Medicaid-enrolled members), the specific information or the citation in the document that included it (e.g., the CMO contract), the DCH business owner (e.g., Member Services, Provider Services), and, as applicable, additional notes. The crosswalk ensured both DCH and HSAG that the CMO contract included, at a minimum, standards at least as stringent as Medicaid managed care regulations.

While HSAG reviewed the CMOs' performance under the initial DCH contract, HSAG also reviewed DCH's draft revised contract submitted to, and later approved by, CMS. HSAG was impressed with the detail with which DCH specified additional requirements, demonstrating its strong command of CMS Medicaid managed care standards and commitment to ensuring continuously improved CMO compliance with performance standards for providing quality, accessible, and timely care and services to members that, ideally, result in improved member health status and outcomes.

For the first year of its EQRO contract, DCH requested that HSAG conduct a review of the CMOs' performance in complying with one of the three sets of federal Medicaid managed care standards (i.e., the access standards described at 42 CFR 438.206–210) and the associated DCH contract requirements. In each of the second and third contract years the EQRO will evaluate the CMOs' performance for one of the two remaining sets of federal Medicaid managed care standards (i.e., structure and operations standards and measurement and improvement standards) and the associated DCH contract requirements.

Performance Measure Requirements

DCH required the CMOs to collect and report data for the following measures of CMO performance:

- Percentage of members with diabetes with at least one HbA1c test
- Percentage of members with asthma receiving appropriate medications
- Percentage of children with well-child visits in the first 15 months of life
- Percentage of children younger than 35 months of age who are fully immunized (defined as the 4:3:1:3:3:1 series)
- Percentage of 1- and 2-year-olds with a blood lead level screening at (a) 9–15 months of age and (b) 21–27 months of age
- Percentage of adults 21 years of age and older with at least one preventative health visit in the year

DCH reported to HSAG that the CMOs submitted performance data to DCH for all the measures. DCH provided the data reports to HSAG.

For the first year of its EQRO contract, DCH requested that HSAG:

- Validate the same three measures for each CMO.
- Report its findings for two of the measures (i.e., diabetes—the percentage of members with diabetes with at least one HbA1c test, and asthma—the percentage of members with asthma receiving appropriate medications).
- Provide information to DCH about the readiness of the CMOs to report complete and accurate data for a third measure, childhood immunizations.

Section 1—Executive Summary provides a summary of HSAG's findings and recommendations for the two measures it validated and reported to DCH and the CMOs in individual CMO reports. Section 7—Validating Performance Measures provides a detailed description of these findings and recommendations.

Performance Improvement Project Requirements

DCH required the CMOs to conduct PIPs that crossed both clinical and nonclinical areas. The CMOs had to conduct PIPs that addressed the following clinical areas:

- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screens
- Childhood immunizations
- Blood level screens
- Detection of chronic kidney disease
- Emergency room treatment

DCH required the CMOs to perform one additional clinical PIP chosen from the following areas:

- Coordination/continuity-of-care management
- High-volume or high-risk conditions

In nonclinical areas, DCH required the CMOs to conduct PIPs that addressed:

- Member satisfaction.
- Provider satisfaction.

DCH required one additional nonclinical PIP that the CMOs could select from any of the following areas:

- Cultural competence
- Appeals/grievances/provider complaints
- Access/service capacity
- Appointment availability

The CMOs were required to submit to DCH any and all data necessary to enable the State to measure and evaluate the CMOs' performance in conducting their PIPs, including the CMOs'

mechanisms and interventions for tracking and improving performance over time, the effectiveness of the interventions, and CMO activities for increasing and sustaining improvement. In addition, the CMOs had to document for DCH's review their data collection methodologies, including the steps they took to ensure that their data were valid and reliable. DCH reported to HSAG that the CMOs complied with the requirements to report to DCH the status and results of their PIPs and provided examples of the reports to HSAG.

For the first year of its EQRO contract with HSAG, DCH requested that HSAG validate and report its findings for three of the PIPs for each CMO (i.e., lead screens, EPSDT well-child visits, and provider satisfaction). Section 1—Executive Summary presents a summary of HSAG's findings and recommendations, and Section 8—Validating Performance Improvement Projects presents a detailed description of these findings and recommendations.

Mandatory Activities

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, §438.358(b) and (c). The three mandatory activities are: (1) validating performance improvement projects (PIPs), (2) validating performance measures, and (3) conducting reviews to determine compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g). According to 42 CFR 438.358(a), "The State, its agent that is not an MCO or PIHP, or an EQRO may perform the mandatory and optional EQR-related activities."

Under its first EQRO contract with HSAG (i.e., contract year 2008–2009) and as described in Section 1—Executive Summary, DCH contracted with HSAG to perform the functions associated with the three CMS mandatory activities. These activities were performed for the State's three CMOs contracted with the Georgia Families Medicaid program. The CMOs are managed care organizations as defined by CMS.

In accordance with its contract with DCH, HSAG:

- Conducted a review of the CMOs' performance in complying with federal Medicaid managed care regulations related to access and availability of care and services (as described at 42 CFR §438.206–210) and the associated DCH contract requirements for the first year of a three-year cycle of compliance reviews.
- Validated three performance measures for each of the three CMOs. For two of the measures HSAG reported the results summarized in Section 1—Executive Summary of this report and described in detail in Section 7—Validating Performance Measures. HSAG validated a third measure as a readiness review to provide feedback to DCH and the CMOs about the data the CMOs used to calculate performance rates for the measure.
- Validated three PIPs for each of the CMOs.

For each of the three mandatory activities it conducted, HSAG prepared individual CMO reports of its findings and recommendations and submitted the reports to DCH and the appropriate CMOs.

DCH also contracted with HSAG to aggregate and analyze the data it obtained from conducting the activities and to prepare this CMS-required 2008–2009 EQR annual report of findings and recommendations related to the quality and timeliness of, and access to, care and services the three CMOs provided to their Georgia Families Medicaid members.

Optional Activities

DCH's 2008–2009 contract with HSAG did not require HSAG to conduct or analyze and report results of, or provide conclusions for, any CMS-defined optional activities conducted by DCH (e.g.,

validating encounter data, conducting focused studies of health care quality, and assessing information systems capabilities). However, HSAG did work with and provide information to DCH regarding additional activities that DCH anticipates including in future years of its contracts with an EQRO, such as validation of encounter data

Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

DCH plans to use the information HSAG obtained from conducting each of the three mandatory activities and documented in this EQR annual report to, in part:

- Strengthen its processes for further educating and working with the CMOs to both understand and fully comply with the Medicaid managed care regulations and the associated DCH contract requirements.
- Identify needs and opportunities for CMO-wide collaborative performance improvement initiatives across the three activities of compliance with standards, calculate and report performance measures, and conduct valid and reliable PIPs that result in sustained improvement.
- Identify areas for strengthening DCH monitoring and oversight of the CMOs' performance.
- Identify areas for systematically increasing the benchmarks for CMO performance (e.g., compliance with appointment timeliness standards and geographic access standards).
- Guide future revisions to its contracts with the CMOs to strengthen and add additional detail to select requirements and performance areas.
- Inform DCH about current CMO performance and select minimum performance standards, benchmarks, and goals regarding quality measures as it moves forward with plans to implement a system to add quality-based auto-assignment of members to its current algorithms.
- Guide specifications for future requests for proposals (RFPs) for CMOs.

Georgia Department of Community Health Quality Initiatives

In Section 2 of this report (Background), HSAG described DCH's commitment to continuous quality improvement as documented in its June 2007 Georgia Families Quality Strategic Plan and its July 2008 update progress report. Section 2 summarized DCH's quality improvement goals and objectives described and discussed in detail in its strategic plan update progress report. For each objective, DCH described its strategic actions in progress or coming up, as well as the associated timelines.

There are numerous examples of DCH's commitment to driving continuous quality improvement. During the period when HSAG prepared for and conducted the three mandatory activities for DCH's contracted Georgia Families CMOs as described in this report, DCH:

- Required the CMOs to measure and report on an extensive set of quality performance indicators, only two of which it selected for HSAG's external validation and reporting of findings for each CMO.
- Required the CMOs to conduct a wide range of PIPs that addressed both clinical and nonclinical areas, only three of which it selected for HSAG's external validation and reporting of findings for each CMO.
- Was actively involved with its vendor in directing the design, specifications, and capabilities of a new management information system that will provide enhanced reporting and data analysis capabilities across multiple indicators of CMO performance.
- Initiated a planning process to develop and incorporate CMO quality performance measure results into its current algorithms for auto assignment of members to the CMOs.
- Conducted an assessment of the volume, reasonability, and validity of the encounter data used to calculate and report CMO performance on multiple quality measures.
- Initiated discussions with HSAG with regard to adding optional activities (e.g., validating CMO encounter data) to the mandatory activities it contracts with an EQRO to conduct in future years of its EQRO contract.
- Was actively revising its clinical practice guidelines to more clearly define its expectations for the CMOs with regard to ensuring that:
  - Guidelines are based on valid and reliable clinical evidence and adopted in consultation with participating providers, and that the guidelines are disseminated to CMO providers.
  - The CMOs monitor and trend results from measuring provider performance in adhering to the guidelines in their clinical practices.
- Continued its collaboration with the DCH Health Information and Transparency Technology (HITT) team and the CMOs to design a Web site for communicating health care information to providers, consumers/members, and other constituents.
- Worked with and supported the CMOs in their efforts to gain NCQA accreditation.

Georgia Department of Community Health CMO Best and Emerging Practices

Through its work under the EQRO contract with DCH and in conducting the three mandatory activities for each of the DCH-contracted Georgia Families CMOs, HSAG identified several best and emerging practices by DCH and the CMOs.

DCH's July 2008 Quality Strategic Plan detailed the strategic actions DCH had initiated or planned to implement to ensure a system of continuous improvements throughout the Georgia Families program in providing timely, accessible, and quality services that result in improved member health outcomes. DCH staff members demonstrated a comprehensive understanding of the federal Medicaid managed care regulations applicable to DCH's contracted CMOs and incorporated standards at least as stringent as—and frequently more stringent than—the federal regulations in its contracts with the CMOs. As a result, the CMOs had clear and detailed information about DCH's expectations for their performance under the contract.

HSAG had an opportunity—through its on-site observations, reviews of multiple documents, and information CMO staff members provided during formal on-site interviews or other discussions—to identify several best or emerging practices used by one or more of the CMOs. HSAG identified these practices through its work with the CMOs when conducting the three mandatory activities (reviewing CMO compliance with federal Medicaid managed care regulations and State contract requirements, validating select CMO performance measure reporting, and validating CMO PIPs). The best or emerging practices included the following:

- Although there was variation among the CMOs, each used multiple sources of data to evaluate the sufficiency of its provider network and conducted aggressive and creative outreach and recruitment activities to continuously improve performance with regard to providing geographic access to all provider types for members in both urban and rural areas.
- Each of the CMOs had developed and implemented its own customized and sophisticated electronic systems for managing the important data/information related to requests for services. The systems also managed the CMO's service authorization processes related to paperwork and ensuring that the CMO complied with all applicable CMS Medicaid managed care regulations and the associated, often more stringent, DCH contract requirements.
- All of the CMOs used multiple sources of data to identify members needing enhanced care coordination/case management beyond that provided by the PCPs. HSAG considered this as not only a best management practice, but also a best clinical practice for ensuring that members who needed increasing levels of case management were identified through data about the care and services they were receiving. This data source was in addition to requests for case management services from members or providers.
- Two of the CMOs had sophisticated electronic systems for managing case management tasks and due dates for case management activities that were models of best practices. One of the two

systems was linked with the CMO's authorization system to support cross-department communication and sharing of information.

- One of the CMOs had a best practice model for accepting, tracking, and processing claims. In addition, the CMO displayed graphs and charts documenting claims processing staff performance.

Conducting the Activity

According to 42 CFR 438.358, which describes activities related to required external quality reviews, a state Medicaid agency, its agent that is not a Medicaid MCO or PIHP, or an EQRO must conduct a review within each three-year period to determine the state's contracted MCOs' and PIHPs' compliance with state standards. In accordance with 42 CFR 438.204(g), the state standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438—Managed Care, which address requirements related to access, structure and operations, and measurement and improvement. DCH contracted with HSAG as its EQRO to:

- Conduct compliance reviews for its Georgia Families MCOs, which are CMOs in the State of Georgia.
- Prepare a report of findings with respect to each CMO's performance strengths and areas requiring corrective action to improve performance related to the quality and timeliness of, and access to, the care and services it provided.

HSAG is an EQRO that meets the competency and independence requirements of 42 CFR §438.352(b) and (c). HSAG has extensive experience and expertise in conducting reviews to evaluate MCO and PIHP compliance with Medicaid managed care regulations and associated state contract requirements. It uses the information and data it derives from the reviews to reach conclusions and make recommendations about the quality and timeliness of, and access to, care and services a state's MCOs and PIHPs provide.

Objectives for Conducting the Activity

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs regarding the CMOs' performance in complying with federal Medicaid managed care regulations and associated DCH contract 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, schedules for the desk review and on-site review activities, and agenda for the on-site review.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the individual CMO reports of HSAG's findings.

For the review, the first year of a three-year cycle of external quality reviews, HSAG performed a desk review of each CMO's documents and an on-site review that included reviewing additional documents and conducting interviews with key CMO staff members. HSAG evaluated the degree to which each CMO complied with federal Medicaid managed care regulations and the associated DCH contract requirements in six performance categories (i.e., standards). The six standards

included requirements associated with federal Medicaid managed care access standards found at 42 CFR §438.206–§438.210. The standards HSAG evaluated included requirements for:

- Ensuring the availability of all contractually-required covered services and the adequacy of the provider network.
- Furnishing services to members in accordance with all contractually-required standards for timeliness and geographic access.
- Providing culturally competent services to members.
- Ensuring coordination and continuity of member care across services and providers.
- Receiving and responding to member/provider requests for service authorizations according to all contractual requirements, including those related to timeliness of decision making and the timeliness and content of communications to members/providers about CMO decisions.
- Providing and covering payment for emergency and poststabilization services in accordance with all applicable federal and State regulations/requirements and DCH contract requirements.

Methodology for Conducting the Activity

To accomplish its objective, and based on the results of its collaborative planning with DCH, HSAG developed and used a data collection tool to assess and document the CMOs' compliance with the federal Medicaid managed care access regulations, State rules, and the associated DCH contractual requirements. The review tool included requirements grouped within each of the following six performance areas:

- Standard I—Availability of Services
- Standard II—Furnishing of Services
- Standard III—Cultural Competence
- Standard IV—Coordination and Continuity of Care
- Standard V—Coverage and Authorization of Services
- Standard VI—Emergency and Poststabilization Services

HSAG also evaluated how the CMOs implemented a number of the requirements by using a reviewer worksheet to evaluate the CMOs' records/files associated with the requirements. HSAG used the worksheet to review a sample of provider requests for service authorizations and the associated documentation of the CMOs' decisions/actions and correspondence to providers and members about the CMOs' decisions.

HSAG planned for and conducted the compliance review process and activities in a manner that was consistent with the guidelines set forth in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the following activities.

Pre-on-site review activities included:

- Developing the compliance review tool and an associated reviewer worksheet.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing the form and for submitting requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing and forwarding to the CMOs the on-site review agendas for each day of the two-day on-site reviews.
- Conducting an orientation for the CMOs. The orientation included previewing HSAG's desk review and on-site review processes and answering any questions the CMOs had about the activities.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to help facilitate their preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMOs submitted to HSAG. HSAG obtained information from a wide range of written documents produced by the CMOs, including 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
  - Cultural competency plans
  - Narrative and/or data reports across a broad range of performance areas

The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification during the on-site interviews, and begin compiling information before the on-site review.

On-site review activities: Two HSAG reviewers conducted the on-site reviews, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents HSAG requested that the CMOs have available on-site.
- Interviews conducted with the CMOs' key administrative and program staff members for each of the six standards and associated requirements that HSAG reviewed.
- A closing conference during which HSAG summarized its preliminary findings regarding the CMOs' performance strengths and any areas requiring corrective action for each of the six standards.

Reviewers documented their findings in the data collection (compliance review) tool, which served as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the CMOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. HSAG used a designation of *NA* when a requirement

was not applicable to a CMO during the period covered by HSAG's review. To calculate the compliance score, the total number of applicable elements that scored *Partially Met* was multiplied by 0.5 before adding it to the total number of applicable elements that scored *Met*. This number was then divided by the summed totals of applicable elements for a particular standard. This scoring methodology is consistent with CMS' protocol. 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.

Partially Met indicates partial compliance defined as either 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.

Not Met indicates noncompliance defined as either of the following:

- No documentation is present and 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* or *Partially Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

CMO-Specific Results

The following information describes for each of the three CMOs HSAG's findings, the scores it assigned to the CMO's performance for each of the six standards, the CMO's strengths, and—as applicable—areas requiring corrective action to bring performance into full compliance with the requirements.

AMERIGROUP Community Care

Findings

Table 6-1 presents a summary of the results from HSAG's review, showing the number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or *NA*. HSAG's External Quality Review of Compliance With Standards for AMERIGROUP Community Care report contained complete details of HSAG's review findings.

Table 6-1––Standards and Compliance Scores for *AMERIGROUP Community Care*

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	0	100%
II	Furnishing of Services	21	20	20	0	0	1	100%
III	Cultural Competence	14	13	13	0	0	1	100%
IV	Coordination and Continuity of Care	11	11	11	0	0	0	100%
V	Coverage and Authorization of Services	25	25	12	10	3	0	68%
VI	Emergency and Poststabilization Services	20	20	18	2	0	0	95%
	Totals	108	106	91	12	3	2	92%

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 score of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Overall, AMERIGROUP's performance was good with a total percentage-of-compliance score of 92 percent across all standards. For four of the six standards (i.e., Availability of Services, Furnishing of Services, Cultural Competence, and Coordination and Continuity of Care) AMERIGROUP demonstrated performance that was 100 percent compliant with all associated requirements.

Standard I—Availability of Services

AMERIGROUP's documentation and information staff members provided during the interviews demonstrated that the CMO had a strong commitment to ensuring that it collected and analyzed multiple sources of data. This commitment was evident in its efforts to develop and continually evaluate the sufficiency of its network of providers in providing access to all services covered under its DCH contract. The sources of data the CMO used included its current Georgia Families enrollment and any anticipated changes to it; expected utilization of services, taking into consideration the characteristics and health care needs of Medicaid members; the number and types of providers needed; the number of providers with closed panels; and the geographic location and accessibility of providers in relationship to member location.

AMERIGROUP members had direct access to in-network specialists without an authorization from the CMO, and females had similar unrestricted, direct access to OB/GYNs. PCPs were responsible for coordinating member care among all involved providers. The CMO provided specialized care/case management services based on a comprehensive member assessment and treatment/care plan, as well as the intensity, acuity, complexity, or chronicity of a member's medical and/or behavioral health conditions.

When requested by a member, the member's representative, or a provider, AMERIGROUP provided direct access for members to a second opinion by an appropriate in-network provider. If an appropriate in-network provider was not available, the CMO authorized the second opinion from an out-of-network provider. If members needed medically necessary services and an appropriate network provider was not available, the CMO identified, arranged for, and authorized the services from an out-of-network provider. Providers, whether in or out of the network, were prohibited from balance-billing members for CMO-covered and authorized services, and were required to accept the CMO's payment as payment in full. AMERIGROUP did not charge members for second opinions or require members to pay more for CMO-authorized out-of-network services than they would for in-network provider services.

Standard II—Furnishing of Services

AMERIGROUP's written contracts with its network providers required them to meet the CMO's/DCH's standards for providing timely access to member appointments. The CMO conducted, and required its delegate for the dental network to conduct, quarterly telephone surveys of appointment availability for a statistically valid sample of providers. When a provider's performance fell below the standard, AMERIGROUP required the provider to submit a corrective action plan (CAP) within 30 days of receiving the notice letter from AMERIGROUP. The CMO then added the provider to the list of those that would be surveyed the following quarter to determine if performance had improved and met the standard. The CMO also required PCPs to have an AMERIGROUP-approved mechanism in place for after-hours coverage for members, and conducted after-hours phone surveys to evaluate providers' compliance with the requirement.

In the second quarter of 2008, the most recent quarter that data were available for HSAG's review, AMERIGROUP's performance in meeting timely appointment standards was above the DCH benchmark of 80 percent for each provider type for which it was required to report performance to DCH. (HSAG reviewed data concerning PCP adult and child well and sick visits, pregnant women

seeing OB/GYNs, mental health services, and urgent care services.) Performance ranged from 100 percent for OB/GYN appointments for pregnant women and 97 percent for mental health provider appointments to 83 and 84 percent for adult sick and routine visits, respectively. Performance by AMERIGROUP's delegate for the dental network demonstrated that for 100 percent of requests for a dental visit, appointments were available within the required timelines. During the interview, the CMO staff members described their work with providers not meeting the standards to identify root causes of performance that was less than acceptable, required provider CAPs, and resurveyed the providers to assess whether performance had improved. Staff members stated that in some instances, a low penetration rate of the applicable providers in some of the rural areas and multiple failed attempts to identify and/or recruit providers contributed to somewhat longer wait times for appointments with providers located in those areas.

Based on its data, AMERIGROUP's performance was also strong in meeting the DCH contract standards for providing geographic access to services for its members. The standards specified the maximum acceptable miles and length of drive time for members to access providers for rural and urban areas. With limited exceptions for a few specialty provider types in certain geographic subareas, 80 percent or more of members had access within the specified standards for PCPs, approximately 40 different specialty provider types, hospitals, pharmacies open 24 hours a day/seven days a week, and mental health providers. For hospitals and dental providers, 100 percent of members had access within the required standards. For mental health, 100 percent of members had access to providers within the standards for three of the four service areas and 97 percent for the fourth area.

Multiple examples of AMERIGROUP's corrective action data reports documented the specific causes for performance falling below the GeoAccess standards, the impact on member access, and the actions the CMO had taken and/or planned to take in an effort to improve performance.

Both its documentation and information staff members provided during the interview demonstrated AMERIGROUP's strong commitment and aggressive, persistent, and creative efforts to identify and recruit additional providers in areas where the CMO did not meet the standard for one or more provider types. If additional providers were either not located in the geographic area or refused three or more attempts to contract with the CMO, staff arranged for members to be seen by providers in a bordering service area or out-of-network providers, and ensured that transportation was available for the appointments.

AMERIGROUP provided multiple documents for HSAG's desk and on-site reviews, in addition to the information staff members described during the interviews, demonstrating that AMERIGROUP had robust processes for monitoring and evaluating the performance of its providers and delegates in complying with contract terms and requirements. This performance included, as applicable, provider/delegate performance related to network adequacy, credentialing and recredentialing providers, and performance in meeting quality, access, and timeliness standards. AMERIGROUP required providers/delegates to submit and implement CAPs following CMO findings of less-than-satisfactory performance and conducted follow-up to ensure that providers/delegates implemented improvement actions and performance complied with the applicable standard/requirement.

Documentation and information staff provided during the interview also demonstrated that AMERIGROUP submitted all required access and availability reports to DCH in a timely manner

and in a format specified by or acceptable to DCH. AMERIGROUP notified DCH, applicable providers, and members of any significant changes to the provider network.

Standard III—Cultural Competence

AMERIGROUP had multiple documents that demonstrated the CMO's commitment to assessing members' demographic profiles and providing culturally sensitive, appropriate, and responsive care and services. Both the initial 2005 DCH-approved cultural competency plan and the updated/proposed 2008 Cultural Competency Strategic Plan AMERIGROUP submitted to DCH for review and approval included AMERIGROUP's philosophy and principles underlying its commitment to providing culturally competent care and services, its strategic objectives, and for each objective, the general strategies/methods for obtaining the objective. The proposed 2008 plan submitted to DCH for its review and approval was considerably enhanced from the 2005 plan in the detail it provided about AMERIGROUP's strategies in meeting each of the objectives. The objectives included the following:

- Maintain current knowledge of the cultural diversity of AMERIGROUP's service area
- Provide high-performance organizational awareness, values, cultural sensitivity, and customer service that support, attract, and retain diverse staff
- Develop comprehensive training curriculum for cultural competency
- Have clinical assessments and plans of care that reflect relevant cultural issues
- Provide language assistance services, at no cost, to members with limited English proficiency or impaired hearing at all points of contact
- Have easy-to-understand member materials available
- Develop collaborative relationships with communities
- Ensure that culturally competent care is delivered to all members

During the interview, staff members described in detail the CMO's specific processes and activities associated with each of the objectives.

Documentation and information AMERIGROUP staff members provided during the interview also demonstrated that the CMO had implemented processes for:

- Educating/training staff and providers about the cultural needs of its members and providing culturally competent and sensitive services to them. The CMO informed providers through the provider manual and the new provider orientation, and informed staff members during new employee orientation. The CMO also required staff to complete, with a passing test score, the online cultural competency training within 90 days of hire.
- Informing members about the availability of interpreter services and written materials in alternative formats or any non-English language. All member informational, educational, and marketing materials, including the member handbook, were printed in both English and in Spanish—the only non-English language meeting the threshold to be considered a "prevalent" non-English language spoken by members in AMERIGROUP's service areas.

AMERIGROUP collected and analyzed demographic data about its members and used the information to proportionately recruit staff and providers who shared similar ethnic backgrounds and were fluent in the predominant non-English language spoken by members in their homes.

The CMO also conducted rigorous review and approval processes involving multiple components of the organization to ensure that all member informational, educational, marketing, and other pertinent written materials met the highest standards for professionalism and appropriate and accurate content. The review also ensured that materials met DCH and reviewer standards for readability and understandability.

AMERIGROUP informed providers that they were prohibited from segregating Medicaid members or treating them differently than their other patients or discriminating against them based on their age, color, creed, national origin, health status, income status, or physical or mental health disability. Staff followed up on any member complaints that providers had treated them differently than other patients and reported that there had been no member complaints alleging that providers discriminated against them based on any of these member characteristics/conditions. Staff members conducted new provider on-site office visits to ensure that provider offices were accessible to members with physical disabilities.

Standard IV—Coordination and Continuity of Care

AMERIGROUP had a system for using data to identify members in the greatest need for care coordination. Its process included using a stratification method to determine members' risk level to design the care plan for the needs of each member. The CMO used its provider manual as a tool for communicating expectations regarding the PCP's role in coordinating care. Medical record reviews, conducted quarterly by AMERIGROUP to ensure PCPs' compliance with requirements for coordinating and documenting care, were comprehensive. The CMO also used aggregate data on performance audits for multiple quality measures to evaluate the outcomes of care provided by its contracted providers. These audits included elements that evaluated care coordination and referral to specialty providers and other services such as dental and vision. HSAG also found evidence that corrective actions were required when physicians did not meet the requirements for documentation of services and care coordination activities. AMERIGROUP used its member handbook to describe for its members the role of the PCP and encouraged members to choose and visit their PCP.

Standard V—Coverage and Authorization of Services

AMERIGROUP's definition of medical necessity was consistent with DCH's definition. Its Utilization Management (UM) Program included systems and processes to ensure that members received services in the amount, duration, and scope needed. HSAG's on-site review of the CMO's records documenting its processes in reaching and communicating decisions related to provider requests for prior authorization of services demonstrated that UM determinations were based on medical necessity and the use of nationally recognized criteria (InterQual, Miliman, ASAM). UM committee meeting minutes indicated that the committee met regularly and reviewed reports and data as required.

AMERIGROUP had systems for ensuring consistent application of review criteria, including providing extensive training and conducting IRR testing.

HSAG reviewed 10 files associated with provider requests for prior authorization of services for the accuracy and completeness of documentation and for the timeliness of the authorization decision and notification of that decision. Of the 10 records reviewed, 8 were requests for standard authorizations and 2 were requests for expedited reviews/decisions. Six requests were approved as requested, one request received a limited authorization, and three requests were denied. AMERIGROUP notified the provider and member, as appropriate, within the required time frame. Each denial decision was made by a medical director or physician designee. All written notices of action HSAG reviewed included all requirements. Although the notice of action template language was easy to understand, the language used in the "Reason for the Decision" section of the notices was somewhat less understandable. It was evident to HSAG reviewers that AMERIGROUP had attempted to simplify this language in the "Reason for the Decision" section. HSAG encouraged the CMO to consider continuing its efforts to make the language in the notice of action letters even more consumer/member-friendly.

Standard VI—Emergency and Poststabilization Services

AMERIGROUP's policies, provider manual, and member handbook included DCH-compliant definitions of an emergency medical condition, urgent care, and poststabilization services. The majority of the applicable requirements were included in AMERIGROUP's policies and procedures.

Opportunities for Improvement and Recommendations

HSAG's review of AMERIGROUP's performance resulted in findings of room for improvement and required corrective actions for two standards. While HSAG scored 12 of the 25 applicable requirements for Standard V (Coverage and Authorization of Services) as *Met*, it scored the CMO's performance for 10 requirements as only *Partially Met* and 3 as *Not Met*, resulting in a total compliance score of only 68 percent for this standard and 13 required corrective actions. Performance for this standard was relatively poor. Many of the required improvement actions related to ensuring that AMERIGROUP's policies, procedures, and practices include and are consistent in describing requirements and processes that comply with the applicable federal Medicaid managed care regulations and the associated DCH contract requirements for the CMO's Georgia Families Medicaid members.

AMERIGROUP's performance for Standard VI (Emergency and Poststabilization Services) was also somewhat mixed. HSAG scored the CMO's performance for 18 of the 20 total applicable requirements as *Met*, and 2 as *Partially Met*, requiring corrective actions and yielding a compliance score of 95 percent for the standard.

Standard V—Coverage and Authorization of Services

HSAG's review of AMERIGROUP's policies revealed inconsistencies and inaccuracies related to extending time frames for authorization decisions. Policies contained conflicting information either within the same policy or with other policies. Also, the policies did not accurately reflect AMERIGROUP's practice or were not in compliance with federal Medicaid managed care regulations and the associated DCH contract requirements. AMERIGROUP was required to change

its policies and procedures to comply with federal Medicaid managed care regulations and associated DCH contract requirements and describe/reflect AMERIGROUP's actual practices.

AMERIGROUP was not sending notices of action following a denial of payment. Because CMS includes denial of payment as one of the MCO or PIHP "actions" that requires sending a notice of action as described in the federal Medicaid managed care regulations, AMERIGROUP was required to develop policies and processes to ensure that it sends notices of action when making a final decision to deny, in whole or in part, payment for services provided.

While AMERIGROUP reported that the composition of the Medical Advisory Committee (functioning as the UM committee) included providers from each of its four service areas, HSAG's review of committee minutes and the committee roster indicated that 10 of 11 members of the committee were from the Atlanta region and 1 member was from the East region. AMERIGROUP was required to continue its efforts to recruit committee members from the remaining regions.

Standard VI—Emergency and Poststabilization Services

AMERIGROUP was using a list of diagnoses to determine if the member co-pay for emergency services applied (co-pays were required if the service was determined to be a nonemergency). AMERIGROUP was required to revise its processes and information in the member handbook to clarify that the prudent layperson standard is used to define an emergency and to determine if a member co-pay can be applied.

Additional HSAG Recommendations

While HSAG's findings did not result in requiring AMERIGROUP to take corrective action to comply with select additional requirements, HSAG did encourage the CMO to consider three additional recommendations.

- Although no corrective actions were required for the Cultural Competence standard, HSAG encouraged AMERIGROUP to consider adding to either its cultural competency plan or a separate work plan additional information such as specific planned actions/tasks/activities, the position(s) and/or organizational units/committees/departments accountable for ensuring implementation and reporting on progress/completion, timelines for milestones and completing the action/task/activity, method(s) the CMO planned to use to evaluate the effectiveness of the action/task/activity in meeting the associated objective(s), evaluation results, and, when applicable, next steps and/or reevaluation methods and timelines.
- While HSAG scored AMERIGROUP's performance as 100 percent compliant for the Coordination and Continuity of Care standard and determined that the CMO's policies and procedures were compliant with the BBA and DCH contract requirements, some policies and procedures were very general and did not reflect the CMO's practices. HSAG encouraged AMERIGROUP to review and revise its policies to reflect the CMO's practice.
- Although AMERIGROUP's documents addressed emergency, urgent, and poststabilization care, both its provider manual and member handbook had sections with incomplete information. Taken together, the information presented in the member handbook and the provider manual included enough information to meet the requirements; however, if all the information is not present in each section where the topic is addressed, members or providers, as applicable, may

be confused. HSAG encouraged AMERIGROUP to consider revising its documents to ensure consistency and completeness of information about emergency, urgent, and poststabilization services presented in each section of the provider manual and the member handbook where a particular topic is presented.

Summary

AMERIGROUP demonstrated strong performance in providing quality care to members. Performance was somewhat mixed across the domains of timeliness and access.

The CMO achieved full (100 percent) compliance with scores of *Met* for all 41 applicable requirements across the three standards that addressed aspects of quality (Availability of Services, Cultural Competence, and Coordination and Continuity of Care).

AMERIGROUP's performance for one of the three standards that addressed aspects of timeliness of care (Furnishing of Services) was also strong, with the CMO receiving a score of *Met* for all 20 applicable requirements. However, performance for the other two standards (Coverage and Authorization of Services and Emergency and Poststabilization Services) was not in full compliance and, as a result, only 50 of the 65 total applicable requirements (i.e., 77 percent) across the three standards evaluating aspects of timelines received a score of *Met*. The findings indicated opportunities for improvement in performance, particularly for the requirements related to the Coverage and Authorization of services standard. In addition, the CMO's performance for these two standards (that also addressed aspects of performance related to access to care) resulted in performance that was less than fully compliant across all six standards that included requirements related to access to care. Across the six standards that addressed aspects of access to care and services AMERIGROUP received a score of *Met* for only 91 of the 106 total applicable requirements (i.e., 86 percent).

Peach State Health Plan

Findings

Table 6-2 presents the results from HSAG's review, showing the number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or *NA*. HSAG's External Quality Review of Compliance With Standards for Peach State Health Plan report contained complete details of HSAG's review findings.

Table 6-2––Standards and Compliance Scores for *Peach State Health Plan*

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	0	100%
II	Furnishing of Services	21	20	20	0	0	1	100%
III	Cultural Competence	14	13	12	1	0	1	96%
IV	Coordination and Continuity of Care	11	11	11	0	0	0	100%
V	Coverage and Authorization of Services	25	25	16	6	3	0	76%
VI	Emergency and Poststabilization Services	20	20	20	0	0	0	100%
	Totals	108	106	96	7	3	2	94%

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 score of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Overall, Peach State's performance was very good, with a total compliance score of 94 percent across all six standards. HSAG found that the CMO's performance for four of the standards (i.e., Availability of Services, Furnishing of Services, Coordination and Continuity of Care, and Emergency and Post Stabilization Services) reviewed was 100 percent compliant with all associated requirements.

Standard I—Availability of Services

Peach State had policies and procedures that described its processes for collecting and analyzing data from multiple sources of information when evaluating the sufficiency of, and the need to make adjustments to, the composition of its provider network. The data sources included current and anticipated changes to the Medicaid Georgia Families enrollment; trends and expected utilization of services based on member characteristics and health care needs; the number, types, and specialty

providers needed; the geographic locations of, and languages spoken by, members compared to provider locations and those speaking a second language; and the number of open and closed provider panels in each of the geographic areas.

Peach State's member handbook, provider manual, written policies and procedures, and information provided by staff members during the interviews demonstrated that Peach State members had direct access to in-network second opinions and to those specialists not on the Peach State list of specialists requiring prior authorization. Female members had similar unrestricted, direct access to OB/GYNs.

When an appropriate in-network provider was not available, Peach State authorized medically necessary services, including second opinions, through single-case agreements with out-of-network providers. The CMO informed out-of-network providers that if they provided Peach State-authorized services to members, they could not balance-bill members and must accept the Peach State-negotiated rate with the provider as payment in full. Peach State also had processes in place, and reviewed data from member grievances and appeals, to ensure that members were not charged more than they would have been if the services had been provided within the network. If, in violation of the single-case agreement and letter of authorization terms and conditions, a provider balance-billed the member and—through member complaints or other information, Peach State became aware of the incident—Peach State notified the provider of the violation and ensured the member that he or she did not need to pay the provider bill. If the member informed Peach State that he or she had already paid the bill, the CMO reimbursed the member for the inappropriate billing when provided with acceptable documentation that the member paid the bill.

The provider manual, member handbook, provider contracts, Peach State's written policies and procedures, and information staff members described during the interview demonstrated that PCPs were responsible for assessing member needs, developing a treatment/service plan for each member, and coordinating care among all service providers for the members on their panels. If needed, based on such factors as the complexity, acuity, and chronicity of a member's clinical picture, or utilization patterns, the CMO authorized and provided more intensive case/care management and care coordination services. Peach State's medical directors were actively involved in case reviews, medical rounds, peer-to-peer consultations and reviews, and clinical case conferences with case managers and care coordinators for members receiving those services. The medical directors were also regularly involved with case reviews and approving services for members requiring increasingly intensive levels of care. The medical directors were the only individuals who could make final decisions to deny requested services. They also worked collaboratively with emergency room and inpatient providers with respect to both clinical case reviews/staffings and developing approaches for more effectively managing inappropriate utilization of services.

Peach State's documentation and information staff members provided during the interviews demonstrated that the CMO had policies, procedures, and processes for ensuring that its independent practitioners and its organizational providers were appropriately and timely credentialed/recredentialed, and that staff members conducted oversight reviews of its delegates' performance. As applicable, Peach State required delegates to complete CAPs to improve performance for any deficiencies Peach State identified.

Standard II—Furnishing of Services

Peach State required its providers to offer office hours to Medicaid members that were comparable to those of other patients and to ensure that patients did not wait an unreasonable amount of time in the waiting room after appointment check-in before being seen. The CMO analyzed member data from grievances and responses to member surveys to assess the degree to which providers complied with the requirements.

Peach State informed providers through their contracts and provider manual, and members through the member handbook, about the CMO's standards for providing timely access to appointments and required providers to ensure 24-hour coverage through after-hours mechanisms for members to receive needed care. The CMO used telephone surveys to provider offices/facilities to evaluate compliance with the appointment timelines and after-hours coverage requirements. In addition, the CMO analyzed member grievances and responses to satisfaction surveys as additional data about provider performance. When providers or delegates did not comply with the applicable appointment timeliness standards, the CMO worked with the providers to identify root causes and any CMO barriers that Peach State could resolve, and required providers to submit to Peach State and implement CAPs.

Performance data indicated that, while Peach State's performance was mixed for specialists by type of specialist by subareas, performance was consistently strong across most geographic areas for PCP and multiple specialty provider types, including neurologists, nephrologists, general surgeons, allergists, audiologists, home health providers, orthopedists, ophthalmologists, gastroenterologists, and ear, nose, and throat (ENT) specialists. Performance was excellent for providing required geographic access to dental services, hospitals, and individual behavioral health practitioners.

Minutes of the Clinical Quality/Utilization Management (UM) Committee documented that staff members provided regular updates to the committee on the CMO's performance in meeting timely appointment and geographic access standards. Peach State's documentation demonstrated that it submitted in a timely manner all required reports to DCH related to its performance in providing timely and accessible care to its members.

Standard III—Cultural Competence

Peach State's initial comprehensive and detailed written Cultural Competency Strategic Plan provided an overview of Peach State's commitment to, and philosophy about, the importance of cultural competency; an overview of Georgia demographics; Peach State's six priority areas; a framework for its goals and objectives; and for each of the six goals, associated objectives and references.

The six priority areas addressed Peach State's commitment to:

- A continuously evolving plan and program for cultural competency evaluated by Peach State.
- Maintaining diverse representation throughout all levels of the company.
- Establishing and maintaining current demographic, cultural, and epidemiological profiles of its communities and conducting needs assessments.
- Maintaining, offering, and providing language assistance services.

- Providing culturally appropriate and competent care and services to members that are understandable and respectful.
- Ensuring that accurate data are collected about individual members that identify their race, ethnicity, and language.

The plan included demographic information about State of Georgia residents and Peach State members. For each of the six priority areas, the plan identified goals. For each goal, the plan identified associated objectives that described the methods the CMO would employ to ensure that it met the goals. For each of the objectives, the plan described the performance indicators and the targeted/desired outcomes. The performance indicators were very specific, measureable, and, as applicable, included timelines. In addition, for each objective, the plan described the methods the CMO would use to evaluate the outcomes and the functional organizational areas responsible for accomplishing the objective. HSAG considered the initial 2005 plan a best practice model for a comprehensive cultural competency plan.

Peach State's Health Plan Provider Manual included a Cultural Competency section that provided an overview of Peach State's cultural competency philosophy and plan. The section, Understanding the Need for Culturally Competent Services, and the section, Preparing Cultural Competency Development, provided information about the importance of providers' self-awareness and knowing about their patients' culture and language. The section also provided facts about health disparities and the Web site link for providers to access the manual, A Physician's Practical Guide to Culturally Competent Care, for additional information on developing and meeting cultural competency standards within the provider's practice. The information also included the toll-free number for Peach State Provider Relations. The section, Other PCP Responsibilities to Members, informed providers that one of their responsibilities was to provide culturally competent care to members. Cenpatico Behavioral Health (the CMO's delegate for providing behavioral health services to members and managing the behavioral health provider network) also included a cultural competency section in its provider manual.

Peach State kept providers focused on the importance of providing culturally competent services to members by periodically including articles about cultural competency in provider newsletters, some of which were full-page articles.

Information in the CMO's written policies and procedures, member handbook, provider manual and newsletters, and cultural competency plan informed members and providers that oral interpreter services were available to members. The information included how to access/request the services both during and after normal business hours and in an emergency. The CMO had written policies and procedures for ensuring that written member materials were available in both English and Spanish and in alternative formats such as large-font print, Braille, and audio. Peach State also had written policies and procedures for ensuring that the written information it provided to members was understandable and written at or below the fifth-grade reading level.

The provider manual informed providers that they could not segregate Medicaid members from their other patients, treat them differently than other patients, or discriminate against them based on member characteristics such as age, income, sexual preference, religion, disability, race, etc. During the interview, the CMO staff members described the methods/sources of data the CMO used to

monitor provider performance to ensure that they did not segregate or discriminate against Georgia Families Medicaid members.

During the interview, staff members described several examples of the CMO's activities in fostering culturally competent care and services and in partnering with other organizations and community resources to provide culturally appropriate preventive and treatment services to members. Minutes of the April 22, 2008, Clinical Quality/UM Committee meeting documented the committee's discussion of information/data from the Language Line reports and the committee's discussions of additional opportunities to improve the accessibility of providers speaking non-English languages.

Standard IV—Coordination and Continuity of Care

Peach State had policies and procedures that described the CMO's processes and systems for using data and referrals to identify members who have the greatest need for care coordination. Its processes included a stratification method to determine members' risk level to design the care plan for the needs of each member. Peach State's processes also included assessment of individuals with special health care needs and the development of member-specific care plans, which included referral to and coordination with other health care entities and community organizations. Peach State provided documentation that demonstrated its monitoring of case management staff and its delegate in completing their respective case management activities.

Peach State used its provider manual as a tool for communicating expectations regarding the PCPs' role in coordinating care. Likewise, Peach State used its member handbook to describe the role of a PCP to its members. Peach State's medical record audits included elements that evaluated coordination and referral to specialty providers and to community services. HSAG found evidence that the CMO required corrective action when physicians did not meet the requirements for documenting services and care coordination activities.

Standard V—Coverage and Authorization of Services

Peach State's written definition of medical necessity was consistent with the DCH definition. The CMO's UM Program included systems and processes to ensure that members receive services in an amount, duration, and scope needed. Systems Peach State used for ensuring consistent application of criteria included extensive training and IRR testing. There was evidence that Peach State used corrective action, retraining, and retesting if initial IRR scores were not passing scores. HSAG's review of medical record documentation related to the CMO's decisions about provider requests for authorization of services indicated that UM determinations were based on medical necessity and using nationally recognized criteria (InterQual). Turnaround time reports, including both physical health and behavioral health data, demonstrated that authorization decisions were made within the required time frames. Delegation audit reports demonstrated that Peach State monitored its delegate (Cenpatico) for the timeliness and accuracy of its behavioral health utilization determinations and for the quality and appropriateness of services provided to members.

HSAG reviewed records associated with 10 provider requests for authorization of services for the accuracy and completeness of documentation and for the timeliness of the authorization decisions and notification of those decision. Of the 10 records reviewed, 9 were for standard requests and 1 was for an expedited request. Five requests were approved and five requests were denied. Peach

State notified the provider and member, as appropriate, within the required time frame. Each denial decision was made by a medical director or physician designee. All notices of action HSAG reviewed included all required information. The template sections for notice of action letters were written in language that was easily understood. It was also clear that Peach State had put considerable effort into making the language used in the "Reason for the Decision" section of the notices as understandable as possible.

Standard VI—Emergency and Poststabilization Services

Peach State's definition of an emergency medical condition was consistent with the DCH definition, and its emergency and poststabilization services policies and procedures included all the requirements. The CMO's provider manual and member handbook defined an emergency medical condition, urgent care, and poststabilization services. The member handbook informed members that prior authorization was not required for any of these services (emergency, urgent care, and poststabilization).

Opportunities for Improvement and Recommendations

HSAG's evaluation of Peach State's performance resulted in required corrective actions to improve the CMO's performance associated with two of the standards. HSAG scored 12 of the 13 applicable requirements for Standard III (Cultural Competence) as *Met* with performance for the 1 remaining requirement scored as *Partially Met* and requiring corrective action. The CMO's overall performance for the Cultural Competence standard was still excellent with 96 percent compliant.

While mixed, Peach State's performance for Standard V—Coverage and Authorization of Services, was just average overall with only 16 of the 25 total applicable requirements receiving a score of *Met*. HSAG scored performance for six requirements as *Partially Met*, and the remaining three requirements as *Not Met*. Nine corrective actions were required for this standard, resulting in a compliance score of 76 percent.

The areas of Peach State's noncompliance and requiring corrective actions for Standard III—Cultural Competency and for Standard V—Coverage and Authorization of Services are separately described in detail below.

Standard III—Cultural Competence

While HSAG reviewers considered Peach State's initial 2005 cultural competency plan as a best practice and strength, its revised 2008 plan was written at a very high level in describing the CMO's general philosophy about and commitment/approach to providing culturally competent services to members. It did not describe specific information about the CMO's planned activities, specific goals and objectives, timelines, methods for evaluating the success of the activities in accomplishing the goals/objectives, or the individual(s)/organizational unit responsible. Based on the revised plan, it would be difficult to demonstrate, upon evaluation of performance, if the plan had been successful.

For Peach State to be compliant with the requirement, the CMO was required to implement corrective actions to ensure that its current and ongoing cultural competency plans include sufficient details (i.e., the actions/activities planned, goals/objectives for each action/activity, timelines, evaluation methodologies, and the individuals/organizational unit responsible for implementing

each activity) to function as a true roadmap and to provide the basis for evaluating the CMO's performance in accomplishing the goals and meeting the objectives.

Standard V—Coverage and Authorization of Services

Peach State's Delegation Audit Report for Cenpatico indicated that the timelines the CMO used to review compliance for expedited authorization decisions was within the NCQA 72-hour time frame. While Peach State staff members reported that the time frame used in the delegation audit of timeliness for authorization decisions was the 24-hour time frame required by the BBA, there was no substantiating documentation available for HSAG's review. Peach State was required to implement corrective actions to ensure that its delegate complies with the BBA-required time frames for authorization of services.

Peach State's policies and procedures did not address notices of action for limited authorization or authorization of services in an amount, duration, or scope that is less than requested. In addition, Peach State did not notify members of a denial, reduction, or termination of a previously authorized service if the CMO deemed that the member was not financially responsible. Peach State was required to implement corrective action by revising its policies and processes to be consistent with each other and in compliance with the federal Medicaid managed care regulations and associated DCH contract requirements. The revised policies were to include procedures to ensure that—for all proposed actions to terminate, suspend, or reduce previously authorized covered services—Peach State mails the notice of proposed action 10 calendar days before the date of the proposed action or no later than the date of the proposed action in the event of one of the permitted exceptions.

While neither the BBA nor the DCH contract requires that CMOs use the 14-calendar-day extension allowed for making decisions about requests for service authorization, the DCH contract requires the CMOs to have written policies and procedures that address each of the requirements in the utilization management section of the contract. Peach State was required to revise applicable documents related to standard authorization decision time frames and extensions to reflect actual Peach State practice, address each DCH contract requirement, provide contracted providers with accurate information, and reflect consistency across documents.

While Peach State's policies and procedures addressed the format of member materials, notice of action letters were not defined specifically as a member material, and the utilization management policies did not address the format of notice of action letters. Peach State was required to revise its applicable policy or policies to address the requirements for the format of member materials to include notices of proposed adverse action letters.

Additional HSAG Recommendations

- While no corrective actions were required for Standard II (Furnishing of Services), HSAG encouraged Peach State to consider evaluating and revising the ways in which it reports its performance data for provider appointment availability and for geographic access to providers. These changes would ensure that those reviewing the data within the company and, when applicable, outside the company could easily—and with confidence—reach conclusions about the CMO's performance. The documents Peach State provided for HSAG's review related to performance in these areas varied considerably in what data were reported and for which

provider types. As a result, HSAG reviewers found it challenging to track and compare performance for each of the required performance indicators related to appointment availability and geographic access sequentially across reporting quarters. HSAG would have had greater confidence in its conclusions that, at the time of the review, Peach State's performance met all the requirements for timely appointments and geographic access by provider type if data had been complete and consistent across reports and reporting periods and if reports covered the same sequential reporting periods (e.g., quarterly) for both sets of indicators.

- Although Peach State's policies associated with requirements for coverage and authorization of services included the majority of the requirements, there were several inconsistencies and inaccuracies between some of the policies and inconsistency between the policies and other documents, such as the provider manual. In addition, HSAG noted that a few of Peach State's policies provided incomplete information, but when several policies were considered in combination, Peach State met all of the requirements. HSAG encouraged Peach State to consider revising or combining policies to ensure consistency and to decrease confusion for staff members who use these policies, HSAG also strongly encouraged Peach State to consider using extensions or, at a minimum, to use the allowed 14-calendar-day time frame more often for making decisions and providing notification when additional information is required from members or providers. This would ensure that members and providers have a reasonable amount of time to provide the additional information to Peach State.
- While Peach State's provider manual defined poststabilization services, it did not provide any information as to whether poststabilization services required prior authorization. HSAG encouraged Peach State to consider revising its provider manual to clarify that prior authorization is not needed for poststabilization services.

Summary

Peach State demonstrated strong performance in the domain of quality. The CMO achieved full compliance with all requirements for two of the three standards that addressed aspects of quality (Availability of Services and Coordination and Continuity of Care). Performance for the third standard (Cultural Competence) was 96 percent compliant with scores of *Met* for 12 of the 13 total applicable requirements. Overall across the three standards, 98 percent of the total applicable requirements received a score of *Met*.

Although Peach State's performance for two of the three standards that addressed aspects of timeliness (Furnishing of Services and Emergency and Poststabilization Services) was in full compliance, its performance for the third standard (Coverage and Authorization of Services) received a score of 76 percent, representing average performance for this standard. Across the three standards, Peach State received a score of *Met* for only 56 of the 65 of the total applicable requirements (i.e., 86 percent).

Finally, the CMO's performance across the six standards that each addressed aspects of access to care was good, with 91 percent of all applicable requirements across the six standards receiving a score of *Met*.

WellCare of Georgia

Findings

Table 6-3 presents the results from HSAG's review, showing the number of elements for each of the standards that received a score of *Met*, *Partially Met*, *Not Met*, or *NA*. HSAG's External Quality Review of Compliance With Standards for WellCare of Georgia, Inc. report contained complete details of HSAG's review findings.

Table 6-3––Standards and Compliance Scores for *WellCare of Georgia*

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	0	100%
II	Furnishing of Services	21	20	20	0	0	1	100%
III	Cultural Competence	14	14	14	0	0	0	100%
IV	Coordination and Continuity of Care	11	11	11	0	0	0	100%
V	Coverage and Authorization of Services	25	25	25	0	0	0	100%
VI	Emergency and Poststabilization Services	20	20	18	2	0	0	95%
	Totals	**108**	**107**	**105**	**2**	**0**	**1**	**99%**

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 score of *NA*.

Total Compliance Score: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Strengths

Overall, WellCare's performance was excellent and commendable, with a total compliance score of 99 percent across all six standards. HSAG scored WellCare's performance for five of the six standards reviewed as 100 percent compliant with all associated requirements.

Standard I—Availability of Services

WellCare had multiple written documents that clearly and accurately communicated to members, providers, delegates, and staff the CMO's expectations and standards for performance related to ensuring that all covered services were available and provided to members according to their needs and in compliance with applicable federal Medicaid managed care and State contract requirements. These documents included written policies and procedures, provider contracts and manuals, WellCare's handbooks and newsletters for members and providers, and minutes of committee meetings.

In developing and maintaining the network, WellCare collected and analyzed data from multiple sources to inform staff about the composition and location of providers needed to ensure timely and geographic access and culturally responsive services for its members. The data included demographic information describing the profiles and characteristics of the CMO membership; current and anticipated changes in enrollment; the numbers and types (i.e., training, experience, specialization) of providers required to deliver the Medicaid-covered services; provider-to-member ratios; the number of open/closed provider panels; the geographic location of members and providers; and member complaints/grievances and responses to satisfaction surveys.

The CMO regularly monitored its providers' and delegates' performance in meeting contractual requirements. When necessary, WellCare required, and worked collaboratively with, providers/delegates to develop and implement CAPs and improvement strategies.

WellCare was aggressive in its efforts to ensure the adequacy and sufficiency of its network in meeting both the health care and the culturally responsive service delivery needs of its members. Staff members collected and analyzed data from multiple sources to compare member needs and the service delivery network and performance in providing both timely and geographic access to services. WellCare's performance was consistently strong in meeting and frequently exceeding goals and standards for timely appointments and geographic access (as measured by the time and distance members had to travel to receive services) in both urban and in the more challenging rural areas.

WellCare's documentation and information staff members provided during interviews was consistent in demonstrating that the CMO provided:

- Direct access for females to OB/GYNs.
- Direct access to specialists for members needing a course of treatment and ongoing monitoring.
- Medically necessary services out of network when an appropriate in-network provider was not available, and at a cost to the member that was no greater than it would have been if the services had been provided within the network.
- Second opinions when requested by a physician, member, or a member's representative, and at no cost to the member.

In limited instances when performance appeared to be declining or was not continuing to improve, detailed documentation in minutes of the Quality Improvement Committee meetings, work plans, CAPs, and information staff members provided during the interviews demonstrated that WellCare took aggressive action. The CMO identified and analyzed barriers/root causes contributing to less-than-ideal performance results and identified and implemented improvement activities selected based on the critical factors identified as the most significant barriers/root causes.

Standard II—Furnishing of Services

WellCare's documentation and information staff members provided during the interviews consistently demonstrated that the CMO had policies, processes, and practices ensuring that WellCare and its providers and delegates performed in compliance with federal Medicaid managed care regulations and the associated State requirements related to providing timely appointments when requested by members and geographic accessibility to services.

WellCare clearly and frequently communicated to its providers and delegates the standards for providing timely appointments and regularly, systematically monitored performance against the standards. The CMO was diligent and collaborative in working with providers and delegates as needed to identify any deficiencies and to develop and implement performance improvement strategies. If deficiencies were noted for a provider or across the same provider type, or across providers within a specific geographic service area, WellCare's quality and provider relations teams collaborated in conducting a root-cause analysis. This analysis was to determine if the deficiencies could be attributed to provider failure to perform or to broader, systemic issues such as not having a sufficient number and mix of providers. Once the variable(s) was identified, WellCare initiated steps to address the root cause, including, when applicable, conducting aggressive and creative identification of potential providers and repeated attempts to recruit them as network providers. These processes, discussions, and planned/implemented activities were documented in detail in the CMO's records, minutes of meetings, reports, correspondence, and databases.

WellCare's and, as applicable, its delegate's performance was consistently and commendably strong with performance results at or typically above both DCH's and WellCare's more stringent goals/benchmarks for providing timely appointments for:

- Primary care provider (PCP) well and sick visits for both adults and children.
- Visits with a specialist.
- Postenrollment visits for pregnant women and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) checks for children.
- Urgent care services.
- Mental health services.
- Dental services.

WellCare required its providers to have a CMO-approved mechanism to provide after-hours coverage and had emergency services available 24 hours a day, seven days a week.

WellCare's performance was equally strong in providing geographically accessible services to members within the required standards for distance/drive time in both rural and urban areas for PCPs, specialists, hospitals, pharmacies open 24 hours a day/seven days a week, dental services, and mental health services.

WellCare informed providers that they were prohibited from discriminating against members based on characteristics such as race, religion, age, or disability or knowingly treating Medicaid patients differently with respect to things like appointment scheduling. Providers could not make patients wait in the waiting room for an unreasonable time and ideally, patients should wait less than an hour. The CMO reviewed and analyzed multiple sources of data to ensure that providers complied with the requirements, including member grievances (complaints) and responses to member satisfaction surveys.

Policies and procedures and documentation/deliverable tracking logs demonstrated that WellCare submitted to DCH timely reports related to its network adequacy/sufficiency for both regular and special reports (i.e., notices of changes to the network).

Standard III—Cultural Competence

WellCare had a written cultural competency policy and plan that described the organization's commitment to providing culturally competent care and services to its members. The areas addressed in the plan included WellCare's approach to needs assessment, organizational readiness, program development/deployment, and performance improvement.

The CMO had clearly defined processes and accountabilities to ensure that members had easy and appropriate access to information about their health care services, benefits, and other pertinent information by making the materials available, as needed, in alternative formats or translating the materials into other languages. WellCare's members were also informed about and had access to translation services through the language line, teletype (TTY), and in-person interpreters free of charge to members needing those services. WellCare prepared and presented written information in member-friendly and respectful language that an individual reading at a fifth-grade level could easily understand.

The CMO educated its staff and providers about WellCare's cultural competency plan and expectations for providing culturally sensitive and appropriate services to members. For newly paneled/credentialed providers, staff conducted an on-site office visit to ensure that the facility and office were accessible to the disabled. While on-site, staff conducted a cultural competency health care provider office self-assessment with the provider using the tool that was included with each provider contract.

WellCare conducted demographic assessments of its membership. Using the results from the data analysis, the CMO engaged in targeted outreach and recruitment efforts to ensure that the composition of the provider network offered members access to providers with similar ethnic backgrounds and providers able to communicate with them in their preferred languages.

Staff members described numerous WellCare initiatives designed to increase the culturally relevant resources available to both its staff/providers and members. WellCare engaged in research, clinical reviews, and studies of cultural myths and barriers to members receiving culturally appropriate and quality care to guide the CMO in effectively promoting and providing high-quality care to members.

Standard IV—Coordination and Continuity of Care

WellCare had a variety of methods for identifying members with special health care needs and/or members who could benefit from being included in one of the case management (CM) or disease management (DM) programs. Methods included mining data, using a trigger list of diagnoses, training utilization management (UM) staff to recognize diagnoses or frequent utilization of certain services, and accepting referrals from PCPs, specialty providers, and family members.

WellCare's coordination-of-care policies addressed all the applicable Medicaid managed care requirements. HSAG found detailed and well-organized evidence that WellCare monitored its delegates for the content of the delegates' policies and administrative documents, as well as for the content of medical records indicating the quality of care provided to members. WellCare used its provider handbook as a tool for communicating expectations regarding the PCP's role in

coordinating care. WellCare's medical record reviews were comprehensive and conducted quarterly to ensure PCPs' compliance with requirements for coordinating and documenting care.

Case examples HSAG reviewed on-site demonstrated that WellCare's case managers coordinated members' care with community agencies and other provider types (durable medical equipment [DME] companies, home health agencies, inpatient facilities, etc.). WellCare provided evidence that it required corrective action when PCPs fell below the standards for care coordination or documentation of services provided.

The member handbook explained the importance and role of the PCP and was written in member-friendly language that was easy to understand.

HSAG considered WellCare's electronic system for documenting administrative data as a best practice. Although WellCare was in the final stages of implementing the new system, the advantages of the system were already evident. The system allowed both the case management staff and the UM staff to see real-time data about a member's treatment, services requested, services provided, and authorization history.

Standard V—Coverage and Authorization of Services

WellCare's UM policies and procedures included all of the required elements, and its definition of medical necessity was consistent with the DCH definition. The CMO's UM Program included systems and processes to ensure that members receive services in the amount, duration, and scope needed. The review of authorization/denial records indicated that WellCare made UM determinations based on medical necessity, nationally recognized criteria (InterQual), and member-specific factors such as comorbidities and a member's medical history. Systems for ensuring consistent application of criteria included UM staff training and IRR testing (using the McKesson/InterQual index). Although the McKesson/InterQual IRR testing methodology was new to WellCare, the first set of results indicated that the WellCare staff's average score was 90 percent—well above McKesson's benchmark of 80 percent for a passing score.

WellCare's oversight of delegates included reviewing policies for required content and monitoring performance for the delegated functions. UM committee meeting minutes indicated that the committee met regularly and reviewed reports and data as required.

HSAG reviewed 10 records associated with provider requests for services for the accuracy and completeness of documentation and for the timeliness of the CMO's decision and notification of that decision. All 10 records reviewed were for requests for standard authorizations. Nine requests were faxed and one was received via a telephone call. Seven requests were for a diagnostic procedure—three of these requests were approved and four were denied for lack of medical necessity. One request was for outpatient therapy (approved), one request was for DME (approved), and the final request was for inpatient rehabilitation (INR), which was denied with the medical director recommending subacute rehabilitation (a scope of service that was less than requested).

The five decisions to deny the requests (including the request that was approved for a lesser scope than was requested) were made by a physician. All decisions were made, and notices of action sent to members, within the 14-calendar day time frame and included all of the required information.

Standard VI—Emergency and Poststabilization Services

WellCare's definition of an emergency medical condition was consistent with the DCH definition. Emergency and poststabilization services policies/procedures addressed all the requirements. Case examples HSAG reviewed demonstrated WellCare's payment of out-of-network emergency services.

Opportunities for Improvement and Recommendations

WellCare was required to submit CAPs to improve its performance to comply with only two of the 107 total applicable requirements HSAG evaluated across the six standards. Both of the requirements were associated with Standard VI—Emergency and Poststabilization Services. HSAG scored 2 of the 20 total applicable requirements for Standard VI as *Partially Met*.

Standard VI—Emergency and Poststabilization Services

The CMO's hospital services handbook stated that unplanned, urgent admissions required notification rather than prior authorization; however, in the UM Quick Reference Guide found in provider handbooks, the sections listing services not requiring prior authorization did not include poststabilization services. While the member handbook directed members to go immediately to the nearest emergency room and clearly stated that prior authorization was not needed for urgent care, the list of services available without authorization did not include emergency care, urgent care, or poststabilization services. The behavioral health section of the member handbook did not address emergency, urgent, or poststabilization services regarding authorization requirements. WellCare was required to review provider and member materials and revise the materials as needed to remedy the inconsistencies and omissions regarding the requirement that authorization is not needed for emergency, urgent, or poststabilization care.

While both provider handbooks and the Emergency Services policy clearly stated that coverage of emergency services was based on the prudent layperson standard, two statements in the member handbook could discourage members from seeking emergency services:

- The "What To Do In An Emergency" section stated that the doctor will decide if it was an emergency and cautioned the members that if it was not an emergency, they may have to pay. Holding the standard for emergency service coverage at the physician level is inconsistent with the prudent layperson standard. In addition, not clarifying in this section that the co-pay for emergency care provided for nonemergencies is only $6 may cause members to refrain from seeking care when there is an emergency.
- The behavioral health section of the member handbook cautioned the member to make sure that it is a mental health emergency before going to the emergency room, but did not indicate that an emergency was determined based on the prudent layperson standard.

WellCare was required to review and revise member materials so as not to include language that could discourage members from seeking emergency care. While HSAG reviewers recognized the need to discourage emergency room overuse and abuse, the statements in the handbook were inconsistent with Medicaid managed care regulations and DCH contract requirements when defining an emergency. HSAG encouraged WellCare to add language that approximates the prudent

layperson standard, written in language that is easy to understand, as one way to balance the language that would discourage emergency room overuse or abuse.

Additional HSAG Recommendations

While HSAG did not identify any required corrective actions for Standard III (Cultural Competence), reviewers did encourage WellCare to include in future cultural competency plans greater detail about the CMO's ongoing and planned activities. HSAG further encouraged the CMO to identify in its written plan the specific activities planned, and for each activity, the associated goals, methods, timelines, accountabilities, and evaluation methodologies.

The template part of WellCare's notice of action letter was very easy to understand; however, the section of the letters that described the reason for the CMO's decision used very technical language and included a significant amount of medical terminology. While WellCare's notice of CMO action letters were fully compliant with all the requirements, HSAG encouraged the CMO to make the information about and reason for denying requested services easier for members to understand.

Summary

WellCare demonstrated excellent performance for the standards that addressed aspects of the three domains of quality, timeliness, and access.

The CMO achieved full (100 percent) compliance with all requirements for the three standards that addressed aspects of quality of care (Availability of Services, Cultural Competence, and Coordination and Continuity of Care).

For the three standards that addressed aspects of timeliness, HSAG scored WellCare's performance as fully compliant with all requirements for Standard II (Furnishing of Services) and Standard V (Coverage and Authorization of Services.). For the third standard (Standard VI—Emergency and Poststabilization Services), HSAG scored WellCare's performance for 18 of the 20 requirements as *Met* and as *Partially Met* for two requirements. As a result, across the three standards that measured aspects of timeliness, WellCare's performance was fully compliant (i.e., received a score of *Met)* for 97 percent of the applicable requirements.

All six of the standards included requirements that addressed aspects of access to care. HSAG assessed WellCare's performance as fully complying with all requirements for five of the six standards. As noted above, for the remaining standard (Standard XI—Emergency and Poststabilization Services), HSAG scored WellCare's performance for 18 of the 20 requirements as *Met* and as *Partially Met* for the other two requirements. As a result, WellCare's performance across all six of the standards that addressed aspects of access to care was fully compliant with 98 percent of the total applicable requirements.

Comparative Results Across the CMOs

Findings

Figure 6-1 compares the percentage of applicable elements scored as *Met*, *Partially Met*, and *Not Met* across the three CMOs for all six standards. As shown in the figure, all CMOs demonstrated consistent and excellent performance for Standards I, II, and IV with no variation in scores observed among them. CMO performance varied widely for Standard V and corrective actions were required for two of the CMOs. Corrective actions were also required for one CMO for Standard III, and for two of the CMOs for Standard VI.

Figure 6-1—Percentage of Applicable Requirements by Standard

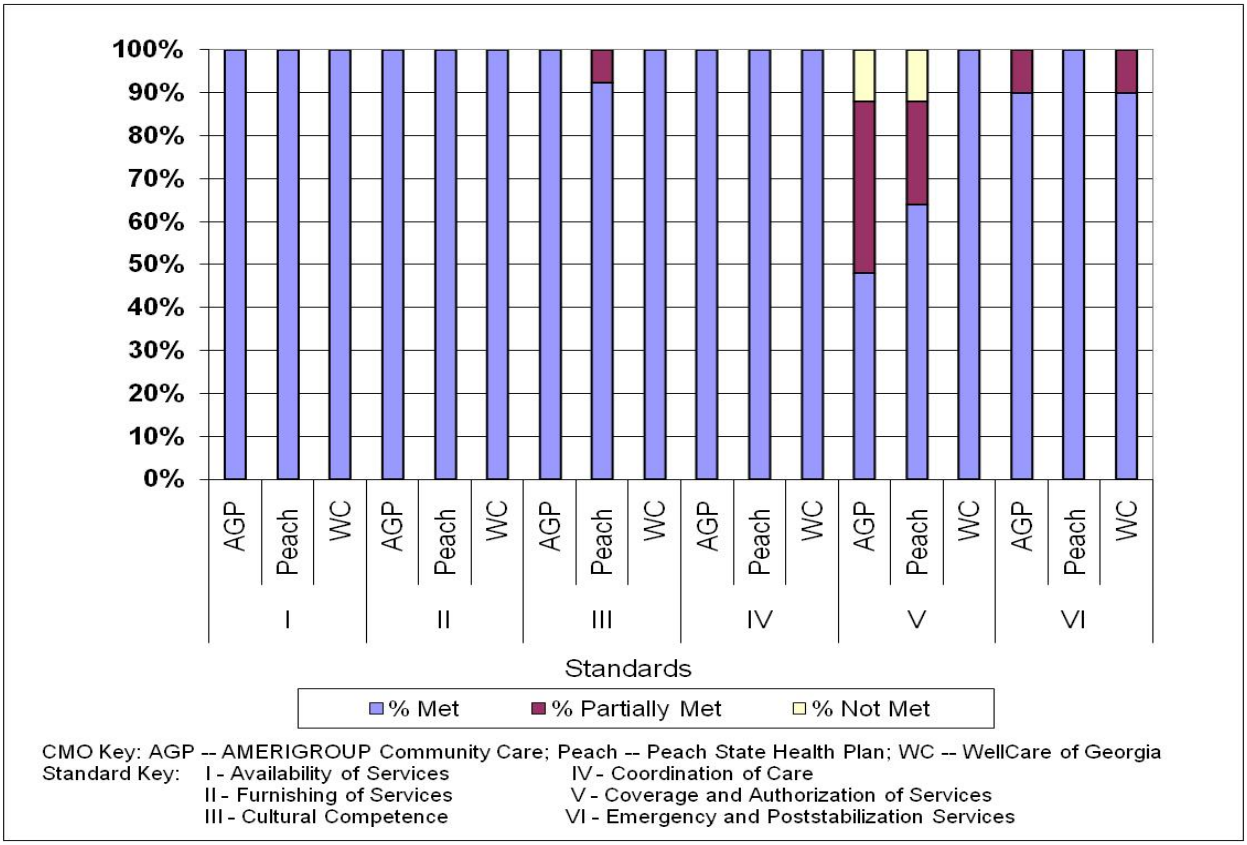

Table 6-4 presents the Statewide and CMO-specific results from the 2008–2009 compliance review, showing the compliance scores for each of the standards and the overall scores.

Table 6-4—Individual CMO and Statewide Compliance Scores					
Standard #	**Standard Name**	**AMERIGROUP Community Care**	**Peach State Health Plan**	**WellCare of Georgia**	**Statewide Scores**
I	Availability of Services	**100%**	**100%**	**100%**	**100%**
II	Furnishing of Services	**100%**	**100%**	**100%**	**100%**
III	Cultural Competence	**100%**	**96%**	**100%**	**99%**
IV	Coordination and Continuity of Care	**100%**	**100%**	**100%**	**100%**
V	Coverage and Authorization of Services	**68%**	**76%**	**100%**	**81%**
VI	Emergency and Poststabilization Services	**95%**	**100%**	**95%**	**97%**
	Overall Compliance Rating	**92%**	**94%**	**99%**	**95%**

Strengths

Overall, statewide performance in complying with the requirements across the standards was excellent, with 292 of the 319 total applicable requirements receiving a *Met* score and an overall compliance score of 95 percent. Most notably, for three of the standards (i.e., Availability of Services, Furnishing of Services, and Coordination and Continuity of Care) all three CMOs received scores of *Met* for all the applicable requirements HSAG evaluated. In addition, two CMOs were determined as 100 percent compliant with requirements for the Cultural Competence standard, and the third as 99 percent compliant.

For the Availability of Services standard, all CMOs had policies and procedures to ensure the use of multiple data sources to develop and continually evaluate the adequacy of the provider network. Members had direct access to PCP services and to services from most specialists. Female members had unrestricted, direct access to an OB/GYN in addition to their PCP. Members also had direct access to a second opinion by in-network providers, and if needed, the CMOs authorized services by out-of-network providers. When an appropriately qualified in-network provider was not available, the CMOs authorized medically necessary services from out-of-network providers. Providers were not allowed to balance-bill members and were required to accept the CMOs' negotiated rate as payment in full.

For the Furnishing of Services standard, all CMOs had communicated in written documents (e.g., the provider manual and provider contracts) with network providers and delegates the standards for providing timely access to appointments. The CMOs also had robust processes for monitoring and evaluating provider performance in meeting the standards and required providers to implement corrective action when performance was not satisfactory. In general, all CMOs demonstrated strong performance in meeting standards for ensuring geographic access to services as measured in drive

time or miles. While performance varied somewhat among the CMOs, each CMO implemented aggressive and creative approaches for recruiting additional in-network providers and/or engaging providers willing to provide out-of-network services to its members by entering into single-case agreements with the CMO for specific members.

To meet the Cultural Competence requirements, all CMOs had written cultural competency strategic plans that provided an overview of their commitment to, and philosophy about, the importance of cultural competency and their goals and values related to providing culturally competent and responsive services to members. All CMOs provided education/training to staff and providers regarding the cultural needs of their members and informed and educated them about the importance of providing culturally competent services to members. Member informational materials, including member handbooks, were written in both English and Spanish, and in language that was easy to understand. The CMOs provided free access to members for interpreter and TTY services and, when requested, written information in alternative formats (large print, audio, Braille, etc.) The CMOs regularly reviewed member grievances and responses to satisfaction surveys to identify any deficiencies related to providing culturally competent and responsive services and to ensure that providers did not discriminate against members based on the federally prohibited member characteristics (e.g., race, color, disability, or religion) or treat Georgia Families Medicaid members differently than other patients regarding things like office or appointment wait times.

For the Coordination and Continuity of Care standard, all CMOs exhibited similar approaches. Provider manuals were used as a communication tool for emphasizing the PCP's role in coordinating care, and member handbooks included information regarding the role and importance of PCPs. In addition, all CMOs used medical record audits to monitor provider compliance with documentation and coordination-of-care requirements and required CAPs from those not meeting them. While there was variation among the CMOs, each had robust processes for coordinating and case managing the care of members needing more intensive care coordination/case management services—e.g., using stratification methods to identify members with the greatest need for care coordination, data mining to identify members with complex conditions or long-term care needs, a trigger list of diagnoses, referrals from PCPs, and training staff to identify the members. For these members, the CMOs conducted comprehensive assessments and developed care plans. HSAG considered WellCare's electronic system for documenting administrative data as a best practice because the system provided real-time data for staff to use about a member's treatment, services requested, services provided, and authorization history to facilitate care coordination.

For the Coverage and Authorization standard, all CMOs had written definitions of medical necessity consistent with the DCH definition. Each CMO also had a UM system in place to ensure members received medically necessary services in the amount, duration, and scope needed. Utilization determinations were based on medical necessity and nationally accepted criteria such as McKesson/InterQual index. The CMOs also used extensive training and IRR testing to ensure that reviewers were consistent in applying the criteria.

For the Emergency and Poststabilization Services standard, all CMOs had a definition of an emergency medical condition consistent with the DCH definition and for the most part communicated complete and accurate information to providers and members about emergency, urgent care, and poststabilization services. Documentation in policies/procedures and claims

submitted and paid demonstrated that the CMOs were compliant with the regulations prohibiting them from requiring prior authorization for these services and paid provider claims as required.

Opportunities for Improvement and Recommendations

Statewide compliance scores for the Cultural Competence (99 percent), Coverage and Authorization of Services (81 percent), and Emergency of Poststabilization Services (97 percent) presented opportunities for improvement for select CMOs. While varying among the CMOs (as previously described in the CMO-specific descriptions of HSAG's findings and CMO's strengths, and opportunities for improvement), corrective actions were required to ensure that the applicable CMOs:

- Have sufficient detail in their cultural competency written plans to provide a detailed road map for providing culturally competent services to members and to facilitate evaluation of the CMOs' performance in meeting their goals and objectives.
- Have complete, accurate, and consistent written policies and procedures that address all Medicaid managed care and the associated DCH contract requirements associated with the coverage and authorization/denial of services, as well as performance and actions/decisions that comply with the written policies and procedures.
- Provide complete, accurate, and consistent information to providers and members about the definitions of emergency, urgent care, and poststabilization services (including the fact that emergency services are defined based on the prudent layperson criteria), how to access the services, and the fact that prior authorization is not required prior to receiving the services.

Summary

Overall, the Georgia Families CMOs demonstrated strong performance for the three standards that addressed aspects of performance in providing quality care and services to members (i.e., Standard 1—Availability of Services, Standard III—Cultural Competence, and Standard IV—Coordination and Continuity of Care). All three CMOs achieved full compliance for Standards I and IV. For Standard III, two of the CMOs were in compliance with 100 percent of the requirements and the third CMO was in full compliance with all but one of the requirements, resulting in an overall performance score of 96 percent for the standard. The overall Statewide performance score was 99 percent

Performance related to the timeliness domain was good, with all CMOs demonstrating excellent performance for the Furnishing of Services standard (100 percent) and strong performance for the Emergency and Poststabilization Services standard (97 percent). Performance was mixed among the CMOs for the Coverage and Authorization of Services standard with excellent performance for one CMO, average performance for the second, and relatively poor performance for the third, which resulted in a Statewide score of 81 percent across the three CMOs.

For the access domain, the CMOs' performance across all six standards, each addressing aspects of access to care, was somewhat mixed, with standard-specific statewide compliance scores ranging from 81 percent (Coverage and Authorization of Services) to 100 percent (Availability of Services,

Furnishing of Services, and Coordination and Continuity of Care). The widest variation in individual CMO performance was also observed for the Coverage and Authorization of Services standard. Performance was considerably stronger and more consistent among the CMOs for the Cultural Competence and the Emergency and Poststabilization Services standards, where the statewide performance results were 99 percent and 97, respectively.

In conclusion, for the first year in which the CMOs' performance was evaluated by an EQRO, with limited exceptions as described in this section, the CMOs performed extremely well on the requirements associated with Medicaid managed care access to care standards described at 42 CFR §438.206-210 and the associated DCH contract requirements.

Conducting the Activity

As set forth at 42 CFR 438.358, validation of performance measures is one of the mandatory EQR activities. Validation of performance measures is one of three mandatory EQR activities that the BBA requires state Medicaid agencies to perform. HSAG, the EQRO for DCH, conducted the validation activities. For FY 2007, DCH contracted with three CMOs to provide all services to Medicaid-eligible recipients. DCH identified a set of performance measures (indicators) that the CMOs calculated and reported for validation. HSAG conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS Performance Measure Validation Protocol).

Objectives for Conducting the Activity

The primary objectives of HSAG's performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the CMOs.
- Determine the extent to which the specific performance measures calculated by the CMOs (or on behalf of the CMOs) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

HSAG validated a set of performance indicators that DCH developed and selected for HSAG's validation. DCH also specified the reporting cycle and review period for each indicator. The performance indicators were reported and validated for FY 2007 (October 1, 2006, through September 30, 2007).

Methodology for Conducting the Activity

HSAG followed the same process when validating each performance measure for each CMO, which included the following steps:

- **Pre-review Activities**: Based on the measure definitions and reporting guidelines, HSAG reviewed:
  - Measure-specific worksheets developed by HSAG based on the CMS protocol and used to improve the efficiency of validation work performed on-site.
  - An Information Systems Capabilities Assessment Tool (ISCAT) customized to Goergia's service delivery system and used to collect the necessary background information on the CMOs' policies, processes, and data needed for the on-site performance validation activities.
  - Other requested documents. Prior to the on-site reviews, HSAG asked each CMO to complete the ISCAT. In addition to the ISCAT, other requested documents included source

code for performance measure calculation, prior performance measure reports, and supporting documentation that provided reviewers with additional information to complete the validation process. Other pre-review activities included scheduling the on-site reviews and preparing the agendas for the on-site visits. When requested, HSAG conducted pre-on-site conference calls with the CMOs to discuss any outstanding ISCAT questions and the on-site visit activities.

- **On-site Review**: HSAG conducted site visits to each CMO to validate the processes used to collect performance data and report the performance indicators.

  The on-site reviews, which lasted one day, included:

  - An opening meeting to review the purpose, required documentation, basic meeting logistics, and queries to be performed.
  - Assessment of information systems compliance, focusing on the processing of claims and encounters, recipient Medicaid eligibility data, and provider data. Additionally, the review evaluated the processes used by the CMOs to collect and calculate the performance measures, including accurate numerator and denominator identifications and algorithmic compliance to determine if rate calculations were correct.
  - Review of the ISCAT and supporting documentation, including a review of processes used for collecting, storing, validating, and reporting the performance measure data. This interactive session with key CMO staff members allowed HSAG to obtain a complete picture of the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that the CMOs used and followed written policies and procedures in daily practice.
  - An overview of data integration and control procedures, including discussion and observation of source code logic and a review of how all data sources were combined. The data file was produced for the reporting of the selected performance measures. Primary source verification further validated the output files. HSAG reviewed backup documentation on data integration and addressed data control and security procedures during this session.
  - A closing conference to summarize preliminary findings based on the review of the ISCAT and the on-site review, and to revisit the documentation requirements for any post-review activities.

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data as part of the validation of performance measures:

- **Information Systems Capabilities Assessment Tool (ISCAT).** HSAG received this tool from each CMO. The completed ISCATs provided HSAG with background information on the CMOs' policies, processes, and data in preparation for the on-site validation activities.
- **Source Code (Programming Language) for Performance Measures.** HSAG obtained this source code from each CMO. HSAG used the code to determine compliance with the performance measure definitions.
- **Previous Performance Measure Reports.** HSAG obtained and reviewed these reports from each CMO to assess trending patterns and rate reasonability.
- **Supporting Documentation.** This documentation provided additional information needed by HSAG reviewers to complete the validation process, including performance measure

definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.

- **Current Performance Measure Results.** HSAG obtained the calculated results from each of the CMOs.
- **On-site Interviews and Demonstrations.** HSAG obtained information through interaction, discussion, and formal interviews with key CMO staff members, as well as through system demonstrations.

Based on all validation activities, HSAG gave a validation finding of *Fully Compliant*, *Substantially Compliant*, *Not Valid*, or *Not Applicable* for each performance measure. Each validation finding was based on the magnitude of errors detected for the measure's evaluation elements and not the number of elements determined to be *Not Met*.

After completing the validation process, HSAG prepared a report of its performance measure review findings and recommendations for each CMO. HSAG forwarded these reports, which complied with 42 CFR 438.364, to DCH and the appropriate CMOs.

CMO-Specific Results

AMERIGROUP Community Care

Findings

Table 7-1 presents the results of the validation of performance measures and the reported rates. The FY 2007 Validation of Performance Measures Report for AMERIGROUP Community Care includes additional details of the validation results.

Table 7-1—FY 2007 Performance Measure Results *for* AMERIGROUP Community Care

Indicator		Reported Rate	Audit Designation
1.	Percent of members with diabetes who had at least one HbA1c test	59.3%	*Fully Compliant*
2.	Percent of members with asthma receiving appropriate medications	95.7%	*Fully Compliant*

Strengths

HSAG determined that AMERIGROUP's processes related to data integration, data control, and performance indicator documentation were all acceptable. In addition, despite the fact that the CMO had multiple office locations in Virginia Beach and Georgia, the workflow and logistics between staff members were seamless. Staff members were very knowledgeable about the processes related to capturing and reporting DCH performance measures. AMERIGROUP's strong commitment to data quality and completeness was evident in its auditing procedures for claims/encounter data processing, efficient reconciliation of Medicaid eligibility files and FACETS data, and the timely reconciliation and correction of errors in edit reports.

Opportunities for Improvement and Recommendations

HSAG recommended that AMERIGROUP create a data freeze of data used to report the performance measures so that measures can be re-run against the original data set, if necessary. In addition, AMERIGROUP should continue to ensure that it receives all data from capitated providers.

As specified by DCH, AMERIGROUP reported the *Members with Diabetes that had at Least One HbA1c Test* measure with administrative data only. With fewer than 6 out of 10 diabetic members (59.3 percent) having their HbA1c tested, AMERIGROUP should distribute practice guidelines, HEDIS results, and lists of noncompliant patients to physicians managing patients with diabetes. Educational materials should also be sent to members with diabetes as a reminder for HbA1c testing.

Summary

All of the performance measures reported for this year were related to quality. No measures were related to the access and timeliness domains. For the *Members with Asthma Receiving Appropriate Medications* measure, AMERIGROUP's performance was above the national 2007 HEDIS Medicaid 90th percentile (92.0 percent), suggesting a strong commitment to provide high-quality asthma care to its members. Because the rate for the *Members with Diabetes that had at Least One HbA1c Test* measure was reported using administrative data only, comparison with the national 2007 HEDIS Medicaid benchmarks would not be meaningful since this is a hybrid measure.

Peach State Health Plan

Findings

Table 7-2 presents the results of the validation of performance measures and the reported rates. The FY 2007 Validation of Performance Measures Report for Peach State Health Plan includes additional details of the validation results.

Table 7-2—FY 2007 Performance Measure Results *for* Peach State Health Plan

	Indicator	Reported Rate	Audit Designation
1.	Percent of members with diabetes who had at least one HbA1c test	73.00%	*Fully Compliant*
2.	Percent of members with asthma receiving appropriate medications	80.11%	*Fully Compliant*

Strengths

HSAG determined that Peach State's processes related to data integration, data control, and performance indicator documentation were all acceptable. In addition, Peach State demonstrated a strong commitment to improving performance measure rates through extensive quality initiatives targeted at members with diabetes and asthma, and at families and children. The processes that the claims shop had in place for visually tracking claims processing activities were identified as best practices. Peach State also displayed the daily goals and monitoring results of performance for claims processing staff members, from mail receipt to the processing of claims. This proactive and innovative approach appeared to ensure high quality and efficiencies.

Opportunities for Improvement and Recommendations

HSAG recommended that Peach State establish a formal validation process to verify that final output files are in compliance with specifications (i.e., a spot check of members in the numerator and denominator). For validation purposes, Peach State should also save the final numerator and denominator files used to calculate reported rates. In addition, because of the data issue identified via source code review, HSAG recommended that Peach State archive quarterly files run for performance measure reporting for future reference and validation activities.

As specified by DCH, Peach State reported the *Members with Diabetes that had at Least One HbA1c Test* measure with administrative data only. With less than three quarters of diabetic members (73 percent) having their HbA1c tested, Peach State should distribute practice guidelines, HEDIS results, and lists of noncompliant patients to physicians managing diabetes patients. Educational materials should also be sent to members with diabetes as a reminder for HbA1c testing.

Summary

All of the performance measures reported for this year were related to quality. No measures were related to the access and timeliness domains. For the *Members with Asthma Receiving Appropriate Medications* measure, Peach State's performance was below the national 2007 HEDIS Medicaid 10th percentile (81.5 percent), suggesting room for improvement. Because the rate for the *Members with Diabetes that had at Least One HbA1c Test* measure was reported using administrative data only, comparison with the national 2007 HEDIS Medicaid benchmarks would not be meaningful since this is a hybrid measure.

WellCare of Georgia

Findings

Table 7-3 presents the results of the validation of performance measures and the reported rates. The FY 2007 Validation of Performance Measures Report for WellCare of Georgia includes additional details of the validation results.

Table 7-3—FY 2007 Performance Measure Results *for* WellCare of Georgia

	Indicator	Reported Rate	Audit Designation
1.	Percent of members with diabetes who had at least one HbA1c test	65.66%	*Fully Compliant*
2.	Percent of members with asthma receiving appropriate medications	73.72%	*Fully Compliant*

Strengths

HSAG determined that WellCare's processes related to data integration, data control, and performance indicator documentation were all acceptable. In addition, WellCare adopted a highly collaborative approach to the performance measure calculation and reporting process, with sufficient oversight of these activities at multiple levels of the organization. The CMO's data accuracy was enhanced through a high percentage of automated functions for claims/encounter processing, along with minimal manual data entry. Also, WellCare had abundant checks and balances in place for claims scanning and reconciliation, from the point of claims scanning to receipt by its vendor Affiliated Computer Services (ACS).

Opportunities for Improvement and Recommendations

HSAG recommended that WellCare continue its close monitoring of subcapitated providers to ensure data completeness. In addition, the CMO may want to consider developing a formal process for auditing encounter data to medical records. Having a process like this that targets high-volume providers may reveal unbundling, overcoding/undercoding patterns, which would ultimately improve data completeness and accuracy.

As specified by DCH, WellCare reported the *Members with Diabetes that had at Least One HbA1c Test* measure with administrative data only. With less than three quarters of diabetic members (65.66 percent) having their HbA1c tested, WellCare should distribute practice guidelines, HEDIS results, and lists of noncompliant patients to physicians managing diabetes patients. Educational materials should also be sent to members with diabetes as a reminder for HbA1c testing.

In addition, the reported rate for the *Members with Asthma Receiving Appropriate Medications* measure (73.72 percent) was below the national 2007 HEDIS Medicaid 10th percentile of 81.5 percent. This measure presents room for improvement for WellCare. HSAG recommended that WellCare update physicians and clinical staff members with clinical practice guidelines and/or build an asthma disease registry for physician alerts when patients are seen in the emergency room for acute care due to asthma exacerbations. These efforts would provide an opportunity to target patients at risk for inappropriate medications.

Summary

All of the performance measures reported for this year were related to quality. No measures were related to the access and timeliness domains. For the *Members with Asthma Receiving Appropriate Medications* measure, WellCare's performance was below the national 2007 HEDIS Medicaid 10th percentile (81.5 percent), suggesting room for improvement. Because the rate for the *Members with Diabetes that had at Least One HbA1c Test* measure was reported using administrative data only, comparison with the national 2007 HEDIS Medicaid benchmarks would not be meaningful since this is a hybrid measure.

Comparative Results Across the CMOs

Findings

Table 7-4 presents a statewide summary of the rates for the performance measures for FY 2007 and a comparison of rates across the three CMOs. All the performance measures were reported for the first time in the current measurement year.

Table 7-4—FY 2007 Performance Measure Results, Statewide and by CMO

Indicator		AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia	Statewide Results
1.	Percent of members with diabetes who had at least one HbA1c test	59.30%	73.00%	65.66%	64.63%
2.	Percent of members with asthma receiving appropriate medications	95.70%	80.11%	73.72%	85.82%

Strengths

Overall, all CMOs attained acceptable performance on data integration and data control, and the CMOs' performance indicator documentation was acceptable. The Georgia Families CMOs presented a diversity of strengths in their reporting of performance measures. For example, AMERIGROUP's strengths were primarily in ensuring seamless workflow and logistics among staff, excellent auditing procedures, and an efficient reconciliation process. WellCare's strengths were in its highly automated claims/encounter processing functions and multiple-level oversights for calculating and reporting. For Peach State, HSAG identified its claims processing as a best practice. Another strength for Peach State was its extensive quality initiatives targeting members.

Opportunities for Improvement and Recommendations

Although the statewide ranking for the *Members with Asthma Receiving Appropriate Medications* measure was above the national HEDIS 2007 Medicaid 10th percentile (81.5 percent), Georgia's CMOs still have considerable room for improvement on this measure. Improvement strategies could focus on provider-level interventions such as distributing updated clinical practice guidelines to physicians and clinical staff or developing an asthma disease registry for asthma patient alerts.

Georgia's performance on the *Members with Diabetes that had at Least One HbA1c Test* measure was not comparable with the national benchmark because only the administrative method was used for generating the rate. Nonetheless, performance for all three CMOs in the current year suggested considerable room for improvement. Strategies focusing on distributing practice guidelines, HEDIS results, and lists of noncompliant patients to physicians managing diabetes patients would be good

places to start. In addition, the CMOs should consider implementing or strengthening member-level education regarding HbA1c testing.

Based on the results of this year's performance measure validation findings, HSAG recommends that DCH consider adopting HEDIS measures as the required performance measures for the CMOs to report. This would alleviate any issues with developing additional specifications and allow the CMOs to use a certified software vendor, if they already use one, to calculate the Medicaid rates. This would also allow the CMOs to use medical record data to enhance the administrative rates, possibly providing a better indication of the true care provided to members. HSAG also recommends that DCH consider following HEDIS methodology in future years as it pertains to timelines, audits, and data submission. In addition, DCH should develop a codebook that outlines the most current measure specifications and protocols for calculating the measures and distribute it to the CMOs. The codebook should also include any instructions, if applicable, regarding how the CMOs should use any additional/supplemental data sources.

Summary

All of the performance measures reported for this year were related to quality. No measures were related to the access and timeliness domains. For the *Members with Asthma Receiving Appropriate Medications* measure, the Georgia Families CMOs' overall performance was above the national 2007 HEDIS Medicaid 10th percentile (81.5 percent). Two of the three CMOs performed below the 10th percentile, suggesting room for improvement. Because the rate for the *Members with Diabetes that had at Least One HbA1c Test* measure was reported using administrative data only, comparison with the national 2007 HEDIS Medicaid benchmarks would not be meaningful.

Conducting the Activity

DCH required each CMO to conduct PIPs in accordance with 42 CFR 438.240. The purpose of PIPs is to achieve—through ongoing assessments, measurements, and interventions—improvement sustained over time in clinical and nonclinical areas. As one of three mandatory EQR activities under the BBA, Public Law 105-33, the State is required to annually validate the PIPs conducted by its contracted Medicaid managed care organizations. To meet this requirement for the CMOs, DCH contracted with HSAG to validate the CMOs' PIPs. The PIP validation focused on Medicaid services only and did not include data for services provided to members enrolled in the PeachCare for Kids™ (SCHIP) program.

DCH determined the three quality improvement projects validated by HSAG. Each CMO submitted the following PIPs:

- *Improving Childhood Lead Rates (Medicaid)*
- *Provider Satisfaction*
- *Well-Child Visits during the First 15 Months of Life with Six or More Visits*

This was the first year the CMOs submitted these PIPs to DCH and to HSAG for validation. DCH directed HSAG to validate only Steps I through VII.

Objectives for Conducting the Activity

The primary objectives of PIP validation were to determine each CMO's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Methodology for Conducting the Activity

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a reviewer with expertise in performance improvement processes. The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS Protocol). Using this protocol, HSAG, in collaboration with DCH, developed a PIP Summary Form to ensure uniform validation of PIPs. The PIP Summary Form standardized the process for

submitting information regarding the PIPs and assured that all CMS PIP Protocol requirements were addressed.

With DCH input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. Using this tool, HSAG reviewed each of the following seven CMS PIP Protocol steps:

- Step 1. Review the Selected Study Topic(s)
- Step 2. Review the Study Questions(s)
- Step 3. Review the Selected Study Indicator(s)
- Step 4. Review the Identified Study Population
- Step 5. Review Sampling Methods
- Step 6. Review the MCO's/PIHP's Data Collection Procedures
- Step 7. Assess the MCO's/PIHP's Improvement Strategies

HSAG obtained the data needed to conduct the PIP validation from the CMO's PIP Summary Form. This form provided detailed information about each CMO's PIPs related to the seven steps reviewed and evaluated for the 2008–2009 validation cycle.

Each required protocol step consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP Review Team scored evaluation elements within each step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results. Given the importance of critical elements to this scoring methodology, any critical element that received a *Not Met* status resulted in an overall validation rating for the PIP of *Not Met*. A CMO would be given a *Partially Met* score if 60–79 percent of all evaluation elements were *Met* across all activities or one or more critical elements were *Partially Met*.

HSAG used a *Point of Clarification* when documentation for an evaluation element included the basic components to meet requirements for the evaluation element, but enhanced documentation would demonstrate a stronger understanding of the CMS Protocol.

In addition to the validation status (e.g., *Met*) each PIP was given an overall percentage score for all evaluation elements (including critical elements), which HSAG calculated by dividing the total *Met* by the sum of the total *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the study's findings on the validity and reliability of the results with one of the three following determinations of validation status:

- *Met*: Confidence/high confidence in reported PIP results.
- *Partially Met*: Low confidence in reported PIP results.
- *Not Met*: Reported PIP results not credible.

After completing the validation review, HSAG prepared a 2008–2009 PIP validation report of the findings and recommendations for each CMO's PIPs. These reports, which complied with 42 CFR 438.364, were forwarded to DCH for comment and approval. The final 2008–2009 PIP validation reports were sent to the specific CMOs. In addition, HSAG prepared a PIP annual summary report with aggregate results.

HSAG anticipates that as the PIPs progress, the CMOs will submit a revised PIP Summary Form that includes additional information to address any *Points of Clarification* and any critical and noncritical areas scored as *Partially Met* or *Not Met*.

CMO-Specific Results

In this report, HSAG refers to "steps" when discussing the PIP validation process and CMS protocols for validating PIPs. HSAG refers to "activities" when discussing conducting a PIP and CMS protocols for conducting PIPs based on the CMS publication, *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002.

AMERIGROUP Community Care

Findings

Table 8-1 displays AMERIGROUP's performance for each PIP and an overall performance score across the three PIPs. In addition to detailed performance by step, the table also reports PIP performance based on three overarching categories (i.e., Study Design, Study Implementation, and Quality Outcomes Achieved). These categories, in general, follow the PIP design, implementation, and evaluation of quality improvement processes. The values within the parentheses show the percentage of applicable evaluation elements with a *Met* score. For example, four out of six applicable evaluation elements in Step I, Review the Selected Study Topic(s), from the *Improving Childhood Lead Rates (Medicaid)* PIP were scored *Met*, yielding a rate of 67 percent. The last column presents the overall performance across the three PIPs.

Table 8-1—AMERIGROUP Community Care's 2008–2009 PIP Performance

Review Step	*Improving Childhood Lead Rates (Medicaid)*	*Provider Satisfaction*	*Well-Child Visits during the First 15 Months of Life with Six or More Visits*	Overall Performance Across 3 PIPs
Study Design	**8/16 (50%)**	**14/15 (93%)**	**8/16 (50%)**	**30/47 (64%)**
I. Review the Selected Study Topic(s)	4/6 (67%)	4/4 (100%)	4/6 (67%)	12/16 (75%)
II. Review the Study Question(s)	0/2 (0%)	2/2 (100%)	0/2 (0%)	2/6 (33%)
III. Review the Selected Study Indicator(s)	2/5 (40%)	6/6 (100%)	2/5 (40%)	10/16 (63%)
IV. Review the Identified Study Population	2/3 (67%)	2/3 (67%)	2/3 (67%)	6/9 (67%)
Study Implementation	**4/8 (50%)**	**12/18 (67%)**	**4/8 (50%)**	**20/34 (59%)**
V. Review Sampling Methods	--	4/6 (67%)	--	4/6 (67%)
VI. Review Data Collection Procedures	2/6 (33%)	5/9 (56%)	2/6 (33%)	9/21 (43%)
VII. Assess Improvement Strategies	2/2 (100%)	3/3 (100%)	2/2 (100%)	7/7 (100%)
Quality Outcomes Achieved	Not Assessed			--
VIII. Review Data Analysis and Study Results	*Not Assessed*			--
IX. Assess for Real Improvement	*Not Assessed*			--
X. Assess for Sustained Improvement	*Not Assessed*			--
Overall PIP Performance				
Percentage Score of Evaluation Elements *Met*	50%	79%	50%	62%
Percentage Score of Critical Elements *Met*	44%	91%	44%	62%
Validation Status	*Not Met*	*Partially Met*	*Not Met*	--

Strengths

Overall, AMERIGROUP had an adequate understanding of the requirements related to the study design of a PIP. Sixty-four percent of applicable evaluation elements in this category scored a *Met*, with individual PIP scores ranging from 50 to 93 percent. Of note was AMERIGROUP's strong understanding related to designing the *Provider Satisfaction* PIP (93 percent).

At the activity level, AMERIGROUP had a strong understanding of the activities involved and documentation requirements needed for developing improvement strategies. All three PIPs had 100 percent of the evaluation elements scoring a *Met* for Step VII, Assess Improvement Strategies. In addition, three quarters (75 percent) of the evaluation elements in Step I across all three PIPs achieved a *Met* score, indicating that the CMO had an adequate understanding of the documentation requirements for selecting a study topic. Further, each PIP AMERIGROUP conducted had at least one step with all the evaluation elements achieving a *Met* score. One PIP (*Provider Satisfaction*) had 100 percent of the evaluation elements achieving a *Met* score for more than one step (Steps I, II, III, and VII), suggesting that the PIP is likely to yield valid and reliable results.

AMERIGROUP's strengths were fairly consistent across all three PIPs, which included thorough background documentation in selecting the study topic, development of improvement strategies based on causes/barriers identified through data analysis and quality improvement processes, and its ability to design and implement interventions that induce system-level changes.

Opportunities for Improvement and Recommendations

Any evaluation elements not receiving a *Met* status constituted an opportunity for improvement. AMERIGROUP's performance on these PIPs resembled the performance of health plans that have just started their PIP process. None of the PIPs received a *Met* validation status; two PIPs received a status of *Not Met* and one PIP a *Partially Met* status. For the two PIPs with a *Not Met* validation status (i.e., *Improving Childhood Lead Rates [Medicaid]* and *Well-Child Visits*), AMERIGROUP had opportunities for improvement from Activity I through VI, with a special focus on developing appropriate study questions (Activity II). The CMO should also focus on elements in Activity VI (Accurate/Complete Data Collection) and in Activity III (Clearly Defined Study Indicators), which did not receive a *Met* score.

Based on the validation results of these PIPs, AMERIGROUP had 31 evaluation elements that did not receive a *Met* score and a total of 11 unique *Points of Clarification* from these PIPs. HSAG recommended that:

- AMERIGROUP focus on the critical elements that did not receive a *Met* score, including those in Activity II, III, and IV. More specifically, AMERIGROUP should ensure that the study questions align closely with the PIP study topics. As indicated in Table 8-1, none of the elements in Step II received a *Met* score for two of the PIPs, suggesting the CMO's challenges in developing study questions for these two PIPs. Improvement made in the evaluation elements under Step II would help set the framework for the study.
- AMERIGROUP review HSAG's comments and recommendations in its PIP reports and make appropriate changes associated with evaluation elements that received either a *Point of Clarification* or a score of *Partially Met* or *Not Met*. These comments and recommendations

provide valuable directions to the CMO for documenting its PIPs at the level required within the CMS protocols.

- AMERIGROUP review all the documentation requirements for the subsequent activities (i.e., VIII, IX, and X) for the next submission to improve future PIP validation scores.

Summary

All three PIPs provided an opportunity for AMERIGROUP to improve the quality of care it provides. In addition, the focus of two PIPs, *Improving Childhood Lead Rates* (*Medicaid*) and *Well-Child Visits during the First 15 Months of Life with Six or More Visits*, was to improve member access to care. However, the EQR activities themselves related to these PIPs were designed to evaluate the validity and quality of AMERIGROUP's processes for conducting valid PIPs. Therefore, the summary assessment of AMERIGROUP's PIP validation results related to the domain of quality.

AMERIGROUP demonstrated adequate performance related to the quality of its PIPs and a basic understanding of the requirements of the CMS protocol for conducting PIPs. AMERIGROUP performed similarly in the *Improving Childhood Lead Rates* (*Medicaid*) and *Well-Child Visits during the First 15 Months of Life with Six or More Visits* PIPs. Nonetheless, HSAG identified opportunities for improvement for all three PIPs and provided recommendations in the CMO-specific reports to AMERIGROUP on ways to strengthen the current PIP structure and achieve improvement across all study indicators.

For the 2008–2009 validation cycle, AMERIGROUP reported baseline data for the *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits* PIPs. These PIPs had not progressed far enough in the study to begin assessing the impact of the improvement strategies on quality and access to care. Although AMERIGROUP provided baseline and Remeasurement 1 data for the *Provider Satisfaction* PIP, HSAG only validated through Step VII as this was a first-year submission. Nonetheless, because none of the PIPs received a validation status of *Met* and two PIPs received a validation status of *Not Met*, HSAG had low confidence in the reported results.

Peach State Health Plan

Findings

Table 8-2 compares Peach State's performance across the three submitted PIPs and reports the overall PIP performance for this year's submission. The 10 validation steps are grouped into three overarching categories (Study Design, Study Implementation, and Quality Outcomes Achieved). The values within the parentheses show the percentage of applicable evaluation elements scored as *Met* within each review step. For example, for the *Improving Childhood Lead Rates (Medicaid)* PIP, all six applicable evaluation elements in Step I, Review the Selected Study Topic(s), were scored *Met*, yielding a 100 percent rate.

Table 8-2—Peach State Health Plan's 2008–2009 PIP Performance

Review Step	*Improving Childhood Lead Rates (Medicaid)*	*Provider Satisfaction*	*Well-Child Visits during the First 15 Months of Life with Six or More Visits*	Overall Performance Across 3 PIPs
Study Design	**11/16 (69%)**	**13/15 (87%)**	**11/16 (69%)**	**35/47 (74%)**
I. Review the Selected Study Topic(s)	6/6 (100%)	3/4 (75%)	5/6 (83%)	14/16 (88%)
II. Review the Study Question(s)	0/2 (0%)	2/2 (100%)	0/2 (0%)	2/6 (33%)
III. Review the Selected Study Indicator(s)	4/5 (80%)	6/6 (100%)	4/5 (40%)	14/16 (88%)
IV. Review the Identified Study Population	1/3 (33%)	2/3 (67%)	2/3 (67%)	5/9 (56%)
Study Implementation	**8/8 (100%)**	**6/11 (55%)**	**8/8 (100%)**	**22/27 (81%)**
V. Review Sampling Methods	--	--	--	--
VI. Review Data Collection Procedures	6/6 (100%)	4/9 (44%)	6/6 (100%)	16/21 (76%)
VII. Assess Improvement Strategies	2/2 (100%)	2/2 (100%)	2/2 (100%)	6/6 (100%)
Quality Outcomes Achieved	Not Assessed			
VIII. Review Data Analysis and Study Results	*Not Assessed*			--
IX. Assess for Real Improvement	*Not Assessed*			--
X. Assess for Sustained Improvement	*Not Assessed*			--
Overall PIP Performance				
Percentage Score of Evaluation Elements *Met*	79%	73%	79%	77%
Percentage Score of Critical Elements *Met*	44%	100%	56%	68%
Validation Status	*Partially Met*	*Partially Met*	*Partially Met*	--

Strengths

Peach State had strong understanding of the activities and the documentation requirements needed for developing improvement strategies. The CMO had an adequate understanding of the requirements related to the study design of a PIP, with 74 percent of applicable evaluation elements in this category scored as *Met*. Individual PIP scores for this category ranged from 69 to 87 percent. Peach State had a strong understanding with regard to defining the study question and study indicators for the *Provider Satisfaction* PIP, which scored 87 percent overall for this category. Although the CMO had 81 percent of the applicable elements scoring a *Met* in the Study

Implementation category, its strength was its thorough documentation of appropriate improvement strategies (Activity VII). All PIPs attained a *Met* for all the applicable evaluation elements in this activity.

At the activity level and for each of the three PIPs, all evaluation elements achieved a *Met* score for Step VII (Assess Improvement Strategies). In addition, 88 percent of the evaluation elements in Step I across all three PIPs achieved a *Met* score, indicating that the CMO had a good understanding of the documentation requirements for selecting a study topic. Further, each PIP Peach State conducted had at least two steps with all the evaluation elements achieving a *Met* score. Two PIPs (*Improving Childhood Lead Rates [Medicaid]* and *Provider Satisfaction*) had all evaluation elements receiving a *Met* score for more than two steps. For the *Improving Childhood Lead Rates (Medicaid)* PIP, these were Steps I, VI, and VII. For the *Provider Satisfaction* PIP, these were Steps II, III, and VII. The findings suggest that these PIPs are likely to yield valid and reliable results.

Peach State's strength was consistent across all three PIPs, including adequate documentation of how the study topic was selected, and development of barrier-driven, system-level improvement strategies through data analysis and quality improvement processes. Other strengths less prevalent throughout all the PIPs included defined and systematic data collection methodologies.

Opportunities for Improvement and Recommendations

HSAG identified opportunities for improvement for all three of Peach State's PIPs in Steps IV and VI. While all critical elements received a *Met* score for the Provider Satisfaction PIP, the overall performance was lower than for the other two PIPs. As a whole, Peach State had 17 evaluation elements that did not receive a *Met* score and a total of 11 unique *Points of Clarification* for these PIPs. Based on the validation results of the PIPs, HSAG recommended that:

- Peach State focus on the critical elements that did not receive a *Met* score, including those in Steps II, III, and IV. Peach State should concentrate on developing appropriate study questions. As indicated in Table 8-2, none of the elements in Step II for the *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits* PIPs received a *Met* score. This suggested that the CMO had challenges in developing study questions for these two PIPs and in setting the framework for the study. Peach State should ensure that the study questions align closely with the PIP study topics.
- Peach State review HSAG's comments and recommendations contained in HSAG's individual Peach State PIP reports and make appropriate changes for evaluation elements that received either a *Point of Clarification* or a score of *Partially Met* or *Not Met*. These comments and recommendations provide valuable directions to the CMO for documenting its PIPs at the level required within the CMS protocols.
- Peach State review all the documentation requirements for subsequent activities (i.e., VIII, IX, and X) for the next submission to improve future PIP validation scores.

Summary

All three PIPs provided an opportunity to improve the quality of care Peach State provides to its members. In addition, the focus of two PIPs, *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits*, was to improve access

to care. However, the EQR activities themselves related to these PIPs were designed to evaluate the validity and quality of Peach State Health Plan's processes for conducting valid PIPs. Therefore, the summary assessment of Peach State's PIP validation results related to the domain of quality.

Peach State demonstrated adequate performance related to the quality of its PIPs and a basic understanding of the requirements of the CMS protocol for conducting PIPs. Nonetheless, with all three PIPs receiving a validation status of *Partially Met,* the CMO had opportunities for improvement in conducting these PIPs. More specifically, HSAG identified a significant need for improvement for two PIPs based on HEDIS methodology. Peach State's performance for these two PIPs was similar. Based on the validation of these PIPs, HSAG had low confidence in the report results. In the individual PIP reports, HSAG identified the specific opportunities for improvement for all three PIPs and provided recommendations to Peach State on how to strengthen the current PIP structure and achieve improvement across all study indicators.

For the 2008–2009 validation cycle, Peach State reported baseline data for the *Improving Childhood Lead Rates (Medicaid), Well-Child Visits during the First 15 Months of Life with Six or More Visits,* and *Provider Satisfaction* PIPs. HSAG did not validate the baseline results because the PIPs were only validated through Step VII of the CMS Protocols. In addition, these PIPs had not progressed far enough in the study to begin assessing the impact of the improvement strategies on quality and access to care.

WellCare of Georgia

Findings

Table 8-3 displays WellCare's specific PIP and overall performance results across all review steps. The 10 validation steps are grouped into three overarching categories (Study Design, Study Implementation, and Quality Outcomes Achieved), with WellCare's performance in these categories. The values within the parentheses show the percentage of applicable evaluation elements scored as *Met* within each review step. As an example, for the *Improving Childhood Lead Rates (Medicaid)* PIP, all six applicable evaluation elements in Step I, Review the Selected Study Topic(s), were scored *Met*, yielding a 100 percent rate.

Table 8-3—WellCare's 2008–2009 PIP Performance

Review Step	*Improving Childhood Lead Rates (Medicaid)*	*Provider Satisfaction*	*Well-Child Visits during the First 15 Months of Life with Six or More Visits*	Overall Performance Across 3 PIPs
Study Design	**16/16 (100%)**	**14/15 (93%)**	**16/16 (100%)**	**46/47 (98%)**
I. Review the Selected Study Topic(s)	6/6 (100%)	4/4 (100%)	6/6 (100%)	16/16 (100%)
II. Review the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	6/6 (100%)
III. Review the Selected Study Indicator(s)	5/5 (100%)	6/6 (100%)	5/5 (100%)	16/16 (100%)
IV. Review the Identified Study Population	3/3 (100%)	2/3 (67%)	3/3 (100%)	8/9 (89%)
Study Implementation	**7/8 (88%)**	**15/17 (88%)**	**7/8 (88%)**	**29/33 (88%)**
V. Review Sampling Methods	--	6/6 (100%)	--	6/6 (100%)
VI. Review Data Collection Procedures	5/6 (83%)	7/9 (78%)	5/6 (83%)	17/21 (81%)
VII. Assess Improvement Strategies	2/2 (100%)	2/2 (100%)	2/2 (100%)	6/6 (100%)
Quality Outcomes Achieved	Not Assessed			
VIII. Review Data Analysis and Study Results	*Not Assessed*			--
IX. Assess for Real Improvement	*Not Assessed*			--
X. Assess for Sustained Improvement	*Not Assessed*			--
Overall PIP Performance				
Percentage Score of Evaluation Elements *Met*	96%	91%	96%	94%
Percentage Score of Critical Elements *Met*	100%	100%	100%	100%
Validation Status	*Met*	*Met*	*Met*	--

Strengths

Based on this year's PIP performance, WellCare demonstrated a strong understanding of all the review activities. The CMO had an excellent understanding of the requirements related to the study design of a PIP, with 98 percent of applicable evaluation elements in this category scored as *Met*. Individual PIP scores ranged from 93 to 100 percent. Two PIPs (*Improving Childhood Lead Rates [Medicaid]* and *Well-Child Visits*) had excellent documentation of all elements required in the Study Design category. WellCare exhibited good performance in the Study Implementation category, with 88 percent of applicable elements scored as *Met*. WellCare's strength in this category

was its thorough documentation of appropriate improvement strategies (Activity VII), with all PIPs attaining a *Met* for all the applicable evaluation elements.

All three of WellCare's PIPs received a *Met* validation status, indicating high confidence in the likelihood of each PIP generating valid and reliable results. In particular, all three PIPs had 100 percent of the evaluation elements achieving a *Met* score in at least five of the seven steps. For both the *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits* PIPs, WellCare achieved a *Met* score for 100 percent of the evaluation elements in Steps I through IV and VII. For the *Provider Satisfaction* PIP, WellCare achieved a *Met* score for 100 percent of the evaluation elements in Steps I, II, III, V, and VII. Nearly 90 percent of the evaluation elements in Step IV, Review the Identified Study Population, across all three PIPs achieved a *Met* score.

WellCare's strength was consistent and extensive across all three PIPs. These strengths included solid documentation of all required evaluation elements at the study design stage (i.e., selecting an appropriate study topic, designing a focused study question, and defining an appropriate study indicator and study population); systematic and well-documented data collection processes; and appropriate improvement strategies identified through well-documented quality improvement processes.

Opportunities for Improvement and Recommendations

Any elements not receiving a *Met* status constituted an opportunity for improvement. WellCare had only a few evaluation elements not receiving a *Met* score and only two unique *Points of Clarification* for each PIP. Based on the validation results for these PIPs, HSAG recommends that:

- WellCare review HSAG's comments and recommendations contained in its individual PIP reports and make appropriate changes related to the few evaluation elements receiving either a *Point of Clarification* or a score of *Partially Met* or *Not Met*. These comments and recommendations provide valuable directions to the CMO for documenting its PIPs at the level required within the CMS protocols. More specifically, WellCare should focus on documenting the process for calculating its administrative data completeness in the data collection processes (Step VI) for its *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits* PIPs.
- The CMO focus on clearly explaining the enrollment requirement for providers included in the *Provider Satisfaction* PIP (Activity IV: Use a Representative and Generalizable Study Population), providing clear documentation for staff administering the survey processes and including a copy of the cover letter for the survey (Activity VI: Accurate/Complete Data Collection).
- WellCare review all the documentation requirements for subsequent activities (i.e., VIII, IX, and X) for the next submission to improve future PIP validation scores.

Summary

All three PIPs provided an opportunity to improve the quality of care WellCare provides to its members. In addition, the focus of two PIPs, *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits*, was to improve access to care. However, the EQR activities themselves related to these PIPs were designed to evaluate the

validity and quality of WellCare's processes for conducting valid PIPs. Therefore, the summary assessment of WellCare's PIP validation results related to the domain of quality.

WellCare demonstrated strong performance related to the quality of its PIPs and a thorough understanding of the CMS protocol requirements for conducting PIPs. WellCare's performance was strongest for the two PIPs that were based on HEDIS methodology. Based on its validation of WellCare's three PIPs, HSAG had high confidence in the reported results. Even with all three PIPs receiving a validation status of *Met*, WellCare's processes for conducting valid PIPs still had opportunities for improvement. In the individual WellCare PIP reports HSAG detailed opportunities for improvement and recommendations for further strengthening WellCare's current PIP structure to achieve improvement across all study indicators.

For the 2008–2009 validation cycle, WellCare reported baseline data for the *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits* PIPs. These PIPs had not progressed far enough in the study to begin assessing the impact of the improvement strategies on quality and access to care. Although WellCare provided baseline and Remeasurement 1 data for the *Provider Satisfaction* PIP, DCH directed HSAG to validate only Steps I through VII as this was the first year for these PIP submissions.

Comparative Results Across the CMOs

HSAG conducted a review of three PIPs for each of the three Georgia Families CMOs. All PIPs were at their first-year submission.

Findings

Table 8-4 presents an overview of the number of PIPs conducted by each CMO that attained a *Not Met*, *Partially Met*, or *Met* validation status. It also reports PIP results at the statewide level. Of the nine PIPs submitted for this year's validation, two received a *Not Met* status, four a *Partially Met* status, and three a *Met* status. Seventy-eight percent of all evaluation elements from all nine PIPs submitted received a *Met* score, with individual CMO-specific scores varying from 62 to 94 percent.

Table 8-4—Comparison of PIP Validation Status, by CMO and Statewide

Review Activity	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia	Statewide
Overall CMO Performance				
Total Percentage Score for Evaluation Elements *Met*	**62%**	**77%**	**94%**	**77%**
Number of PIPs by Validation Status	**3**	**3**	**3**	**9**
Not Met	2	0	0	2
Partially Met	1	3	0	4
Met	0	0	3	3

Figure 8-1 compares the percentage of evaluation elements scored *Met* and the percentage of critical elements scored *Met* among the three CMOs. In general, CMO performance on the *Improving Childhood Lead Rates (Medicaid)* PIPs was similar to performance on the *Well-Child Visits* PIPs, both of which exhibited wider variations among CMO performance than the *Provider Satisfaction* PIPs. On the other hand, AMERIGROUP and Peach State performed similarly in that their *Provider Satisfaction* PIP performance was stronger than it was for the two PIPs that used HEDIS methodology (i.e., *Improving Childhood Lead Rates [Medicaid]* and *Well-Child Visits*). WellCare's PIP performance pattern was the reverse of results for AMERIGROUP and Peach State in that its performance for the *Provider Satisfaction* PIP was not as strong as the two HEDIS-based PIPs. Yet, overall, WellCare received the highest validation scores for all three PIPs and demonstrated the strongest performance across all CMOs.

Figure 8-1—Comparison of CMO Performance

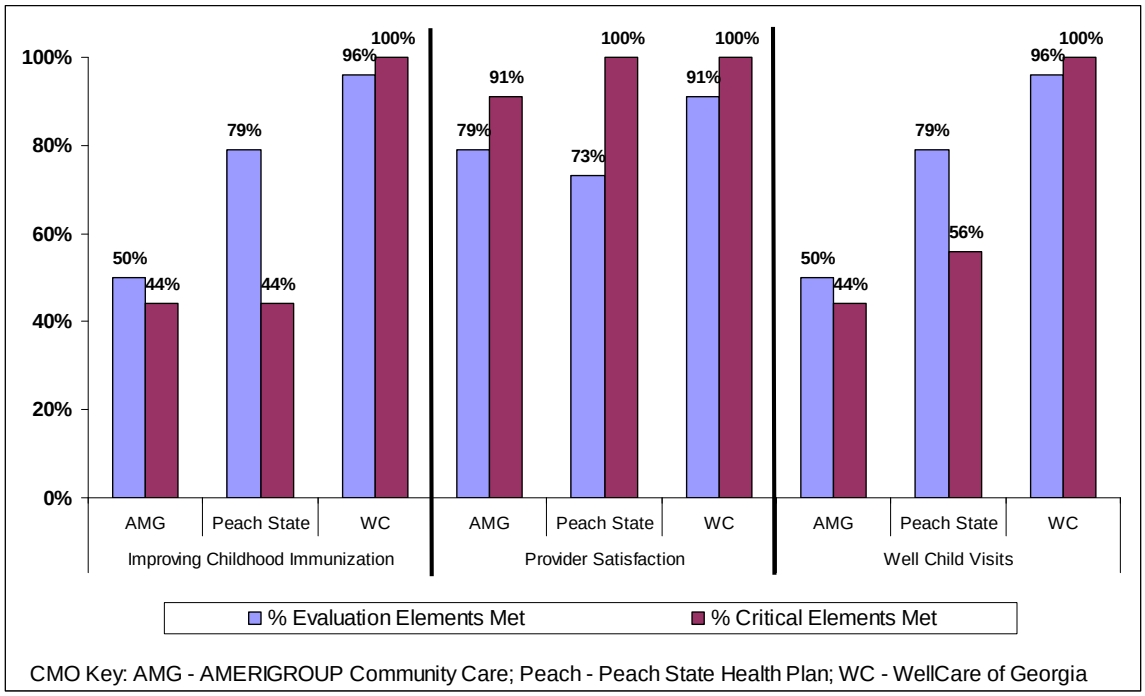

Table 8-5 presents the overall statewide and CMO-specific percentages of evaluation elements achieving a *Met* score for all the PIPs. The table also presents performance results based on the three overarching categories (i.e., Study Design, Study Implementation, and Quality Outcomes Achieved). The CMOs' documentation of PIP processes varied at the category and activity levels.

Table 8-5—Comparison of Overall PIP Performance by CMO and Statewide				
Review Step	**AMERIGROUP Community Care**	**Peach State Health Plan**	**WellCare of Georgia**	**Statewide**
Study Design	**64%**	**74%**	**98%**	**79%**
I. Review the Selected Study Topic(s)	75%	88%	100%	88%
II. Review the Study Question(s)	33%	33%	100%	56%
III. Review the Selected Study Indicator(s)	63%	88%	100%	83%
IV. Review the Identified Study Population	67%	56%	89%	70%
Study Implementation	**59%**	**81%**	**88%**	**76%**
V. Review Sampling Methods	67%*	--	100%*	83%**
VI. Review Data Collection Procedures	43%	76%	81%	67%
VII. Assess Improvement Strategies	100%	100%	100%	100%
Quality Outcomes Achieved				
VIII. Review Data Analysis and Study Results	--	--	--	--
IX. Assess for Real Improvement	--	--	--	--
X. Assess for Sustained Improvement	--	--	--	--
* Only one PIP used sampling methodology. ** A total of two PIPs used sampling methodology.				

Strengths

With the overall score for the nine PIPs as 77 percent, the Georgia CMOs demonstrated a high level of success on their first-year submissions. Three of the nine submitted PIPs achieved a *Met* validation status, indicating that they were likely to produce appropriately valid and generalizable results for improving the health and functional status of members, and provider satisfaction. Step VII was a particular strength for the CMOs, all of which demonstrated strength in designing appropriate improvement strategies for each of the PIPs.

Statewide performance in conducting PIPs in the Study Design category demonstrated fair understanding of the requirements for selecting a study topic, developing study questions and indicators, and designing appropriate methodologies for the overall PIP study. Although 79 percent of all applicable elements had a *Met* status, performance across the CMOs varied widely, from 64 to 98 percent. CMOs, in general, had fair performance in implementing the PIPs, with 76 percent of all applicable elements included in the Study Implementation category receiving a *Met* status. Two CMOs (i.e., Peach State and WellCare) performed well for their three PIPs, with at least 80 percent of the applicable elements in this category attaining a *Met* status.

At the activity level, statewide performance indicated the best scores were achieved for Activities I and VII. Eighty-eight percent of evaluation elements from all PIPs received a *Met* score for selecting an appropriate study topic (Activity I). In addition, all PIPs received a *Met* score for all the evaluation elements in Activity VII, Assess Improvement Strategies. This suggests that in general,

Georgia's CMOs had an excellent understanding of and maintained sufficient documentation of the elements involved in designing improvement strategies for the selected study topics.

The CMOs varied widely in how well they conducted and documented their PIPs. WellCare's strong performance in conducting and documenting its PIPs resulted in a *Met* validation status for all three of its PIPs, while Peach State achieved a *Partially Met* status for its three PIPs and AMERIGROUP had one *Partially Met* and two *Not Met* PIPs.

Opportunities for Improvement and Recommendations

HSAG identified opportunities for improvement whenever a step did not have *Met* scores for all of the applicable evaluations elements. Therefore, the Georgia Families CMOs should focus on improving their documentation of PIPs in all activities except Step VII, Assess Improvement Strategies. Steps II and VI were scored the lowest of the seven that were validated. For Step II, slightly more than half (56 percent) of the evaluation elements in the nine PIPs received a *Met* score. This finding for Step II, Review the Study Question(s), indicated challenges in meeting the requirements for a clearly defined and answerable study question. In addition, with only 67 percent of the evaluation elements scored as *Met* across nine PIPs, Step VI, Review Data Collection Procedures, also presented an opportunity for improvement.

Knowledge and experiences in conducting and documenting PIPs varied among CMOs. In this first-year submission, both AMERIGROUP and Peach State did not have any of their PIPs receiving a *Met* validation status, suggesting a considerable opportunity for improvement for both CMOs. Both CMOs appeared to have difficulty developing study questions for their PIPs. Comparing the three CMOs, AMERIGROUP's PIP performance ranked the lowest, making the CMO's need for systematic improvement efforts the most critical of the three CMOs. For all the evaluation elements not achieving a *Met* score or receiving a *Point of Clarification*, HSAG recommends that the CMOs review specific comments and recommendations reported in the PIP reports and make suggested changes for the next submission. HSAG also recommends that DCH hold the CMOs accountable for making these changes to improve their PIP performance.

Summary

All the PIP topics submitted for this year's validation provided an opportunity to improve the quality of care. In addition, the focus of two PIP topics, *Improving Childhood Lead Rates (Medicaid)* and *Well-Child Visits during the First 15 Months of Life with Six or More Visits*, was to improve access to care. However, the EQR activities themselves related to these PIPs were designed to evaluate the validity and quality of each CMO's processes for conducting valid PIPs. Therefore, the summary assessment of the CMOs' PIP validation results related to the domain of quality.

The CMOs' PIP performance this year was typical of health plans starting the PIP process. The CMOs demonstrated more strengths than opportunities for improvement. Of the nine PIPs, three PIPs (i.e., one-third) had more than 90 percent of their evaluation elements receiving a *Met* score and, subsequently, a *Met* validation status. In addition, four PIPs had all their critical elements scored as *Met*.

The CMOs' processes for conducting and documenting valid PIPs had room for improvement, with only three out of nine PIPs receiving a validation status of *Met*. For each PIP validated, HSAG identified areas the CMOs could improve to move forward with their PIP process and recommended ways to strengthen the current PIP structure and achieve improvement across all study indicators. Since understanding critical elements is the foundation of a reliable and valid PIP, documentation requirements for these elements should be a primary focus for the CMOs. With only one CMO achieving a *Met* validation status on its PIPs, the CMOs have had different experiences and levels of understanding regarding how to achieve compliance in conducting PIPs and meeting the CMS requirements. Based on this finding, HSAG recommends that DCH consider requiring the CMOs to conduct a collaborative PIP that would facilitate the sharing of knowledge among the CMOs.