

State of Georgia



Department of Community Health (DCH)

**2009–2010**  
**EXTERNAL QUALITY REVIEW ANNUAL REPORT**  
*for*  
**Georgia Families**  
**Care Management Organizations (CMOs)**

July 2010



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This is the second year for which the Georgia Department of Community Health (DCH) contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO), to conduct a quality review of three mandatory Medicaid activities and to prepare an annual report of results, as federally required. The three activities included a review and evaluation of compliance with federal Medicaid managed care regulations and the associated State contract requirements; validation of performance improvement projects (PIPs); and validation of performance measures.

As part of the review, HSAG identified strengths and weaknesses of the Georgia Families care management organizations (CMOs) and offered recommendations for improvement. Because the Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, access, and timeliness as keys to evaluating performance, HSAG also evaluated and drew conclusions about the performance of the CMOs in each of these domains.

### Overview of the 2009–2010 External Quality Review Activities

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, states that each contract with a Medicaid managed care organization must provide for an annual external quality review (EQR), conducted by a qualified independent entity, of the quality outcomes and timeliness of, and access to, the care and services for which the organization is responsible.<sup>1-1</sup>

The Code of Federal Regulations (CFR) also describes EQR activities that must occur regarding state Medicaid managed care programs. These are described specifically at 42 CFR 438.358(b). As noted above, they require a review and evaluation of compliance with federal Medicaid managed care regulations and the associated State contract requirements, and the validation of PIPs and performance measures.

DCH is responsible for the administration and oversight of the Medicaid managed care program in the State of Georgia. DCH contracts with three privately owned managed care organizations to deliver services to its members who are enrolled in its Medicaid managed care program and its Children's Health Insurance Program (CHIP). The State refers to its Medicaid managed care program as Georgia Families and to its CHIP program as PeachCare for Kids™. DCH refers to its three Medicaid managed care contractors as care management organizations (CMOs). The three CMOs under contract with DCH during 2009–2010 were AMERIGROUP Community Care (AMERIGROUP), Peach State Health Plan (Peach State), and WellCare of Georgia, Inc. (WellCare).

Following is a brief description of the scope of work for each EQR activity:

- ◆ *Review of compliance with State-specified operational standards.* HSAG's review determined the CMOs' compliance with requirements for six DCH-selected performance categories, or

<sup>1-1</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. *Legislative Summary: Balanced Budget Act of 1997 Medicare and Medicaid Provisions.*

standards, which are sets of related requirements. The six included requirements associated with federal Medicaid managed care structure and operations standards found at 42 CFR 438.214–230, as well as the additional requirements cross-referenced within them.

- ◆ *Validation of performance measures.* HSAG validated the DCH-selected set of six performance measures 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 six DCH-selected PIPs per CMO 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 creating confidence in the reported improvements.

## Conclusions

For each of the EQR activities, HSAG conducted a thorough review and analysis of the data. Because the activities varied in types of data, the methodology for identifying strengths and weaknesses was designed to accommodate the data available for each activity.

### **Compliance With State-Specified Operational Standards**

HSAG's compliance audit for the DCH-contracted CMOs consisted of a desk review of each CMO's documents and an on-site review of additional documents, as well as 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, or standards:

- I. Selecting, credentialing, and recredentialing providers.
- II. Subcontractual relationships and delegation of CMO administrative responsibilities.
- III. Ensuring member rights and protections.
- IV. Information provided to members.
- V. Member grievances, appeals, and access to State administrative law hearings.
- VI. Disenrollment requirements and limitations.

HSAG assigned a score of *Met* (value of 1 point), *Partially Met* (value of .5 points), or *Not Met* (value of 0 points) to reflect a CMO's performance in complying with each of the requirements. If a requirement was not applicable to a CMO for the period covered by the review, HSAG used a *Not Applicable (NA)* designation. Individual CMO scores were then calculated for each standard and across all standards (total points divided by the number of applicable standards). Table 1-1 presents the statewide and CMO-specific performance for all six standards. The statewide overall compliance score was 91 percent. No CMO had a percentage-of-compliance score of less than 90 percent. While none of the CMOs had areas of weakness as defined by scores at or below 60 percent, opportunities for improvement were identified for one or more of the CMOs for all standards except Standard III.

Table 1-1—Individual CMO and Statewide Compliance Scores					
Standard #	Standard Name	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
I	Provider Selection, Credentialing and Recredentialing	90%	100%	100%	97%
II	Subcontractual Relationships and Delegation	92%	83%	100%	92%
III	Member Rights and Protections	100%	100%	100%	100%
IV	Member Information	90%	93%	85%	89%
V	Grievance System	90%	89%	84%	88%
VI	Disenrollment Requirements and Limitations	100%	81%	100%	94%
<b>Overall Percentage-of-Compliance Scores</b>		<b>92%</b>	<b>91%</b>	<b>90%</b>	<b>91%</b>

AMERIGROUP received the highest overall percentage-of-compliance score (92 percent), followed by Peach State (91 percent), and WellCare (90 percent). These findings suggest that all three CMOs demonstrated fairly strong performance across the six standards, most notably for Standard III, for which all CMOs received fully compliant scores.

HSAG provided specific recommendations to each CMO for any scores that were less than *Met*. The CMOs were required to develop corrective action plans (CAPs) and implement interventions to address the deficiencies and bring the areas into full compliance.

**Performance Improvement Projects (PIPs)**

PIPs are designed to assess health care processes, implement process improvements, and improve outcomes of care. In 2009–2010, DCH selected and HSAG validated six PIPs for each of the three CMOs, for a total of 18 PIPs. The six PIP topics were:

- ◆ *Access/Service Capacity*
- ◆ *Childhood Immunization*
- ◆ *Improving Childhood Lead Screening Rates*
- ◆ *Member Satisfaction*
- ◆ *Provider Satisfaction*
- ◆ *Well-Child Visits During the First 15 Months of Life With Six or More Visits*

This was a second-year validation. Once the PIPs have progressed to the point that remeasurement data become available for comparison to baseline results, HSAG will also evaluate the PIP results for statistically significant improvement.

Table 1-2 shows that the total percentage of all evaluation elements receiving a score of *Met* was 99 percent, demonstrating a high level of success for the CMOs’ efforts on their second-year submissions. All 18 PIPs received a *Met* validation status, which was a major improvement from the

previous year, when three of the nine PIPs evaluated received a *Met* validation status and the remaining six received a validation status of either *Partially Met* or *Not Met*.

**Table 1-2—PIP Validation Status by CMO and Statewide**

	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
<b>Overall CMO Performance</b>				
<b>Total Percentage Score for Evaluation Elements <i>Met</i></b>	<b>98%</b>	<b>99%</b>	<b>98%</b>	<b>99%</b>
<b>Number of PIPs by Validation Status</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>18</b>
<i>Not Met</i>	0	0	0	0
<i>Partially Met</i>	0	0	0	0
<i>Met</i>	6	6	6	18

During 2009–2010, the Georgia Families CMOs not only exhibited improvements in conducting and documenting PIPs from their first-year submission, but also applied lessons learned from existing PIPs to the new PIPs.

While the CMOs demonstrated numerous strengths, HSAG also identified areas for improvement. It is HSAG’s recommendation that the CMOs review HSAG’s comments and recommendations in the PIP reports and make the suggested changes for the next submission for all applicable evaluation elements not achieving a *Met* score or receiving a *Point of Clarification*. It is also HSAG’s recommendation that DCH hold the CMOs accountable for making these changes to enhance PIP performance.

**Performance Measures**

HSAG designed the validation of performance measures activity to ensure the accuracy of the performance indicator results the CMOs reported to DCH. To determine that the results were valid and accurate, HSAG evaluated the CMOs’ data collection and calculation processes. HSAG validated six performance measures for each CMO to assess its compliance with performance measure technical requirements, specifications, and construction. The six were:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- ◆ *Childhood Immunization Status—Combination 2*
- ◆ *Lead Screening in Children*
- ◆ *Adults’ Access to Preventive/Ambulatory Health Services*

The performance indicators were reported and validated for CMO data from calendar year 2008 (January 1, 2008, through December 31, 2008). HSAG scored all the measures *Fully Compliant* for each CMO. Additionally, the CMOs achieved acceptable performance on data integration, data control, and performance indicator documentation, and their medical record abstraction processes were a strength. The CMOs used adequate processes for claims, enrollment, and provider data

processing, and all CMOs used a software vendor certified by the National Committee for Quality Assurance (NCQA) to generate the Healthcare Effectiveness Data and Information Set (HEDIS<sup>®</sup>) rates.

With respect to performance levels, HSAG analyzed the performance measure data by comparing each CMO’s reported rate for each performance measure to the national HEDIS 2008 Medicaid percentiles. Table 1-3 presents the performance measure rates for the Georgia Families CMOs. Any CMO rate that exceeded the high performance level (HPL) on a given measure<sup>1-2</sup> was considered an area of strength for the CMO, and any CMO rate that was below the low performance level (LPL) was considered an area of weakness. CMO rates that fell between the HPL and the LPL presented opportunities for improvement.

**Table 1-3—Performance Measure Results, Statewide and by CMO**

Indicator	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
1. Comprehensive Diabetes Care—HbA1c Testing	74.50%	64.23% <sup>a</sup>	72.26%	70.46% <sup>b</sup>
2. Use of Appropriate Medications for People With Asthma	91.84%	91.12% <sup>a</sup>	90.58%	91.09%
3. Well-Child Visits in the First 15 Months of Life—Six or More Visits	62.25%	51.58% <sup>a</sup>	57.42% <sup>c</sup>	Not Calculated <sup>c</sup>
4. Childhood Immunization Status—Combination 2	29.84% <sup>d</sup>	62.77% <sup>a</sup>	75.91%	Not Calculated <sup>e</sup>
5. Lead Screening in Children	68.21%	57.18% <sup>a</sup>	65.94%	Not Calculated <sup>f</sup>
6. Adults’ Access to Preventive/Ambulatory Health Services				
20 to 44 Years of Age	81.20%	78.88%	78.64%	79.19%
45 to 64 Years of Age	86.29%	80.98%	84.58%	83.91%

<sup>a</sup> This rate represents only the Georgia Medicaid population; the PeachCare for Kids population was not included.

<sup>b</sup> Because the number of PeachCare for Kids members who qualified for the age requirement of this measure (i.e., 18 years of age or older) would be small, Peach State’s exclusion of this population from this measure should not substantially affect the statewide rate.

<sup>c</sup> The statewide rate was not calculated because WellCare calculated the measure based on a different time frame for medical record procurement. The CMO did not start to collect medical records for the measure until summer 2009. Peach State did not include PeachCare for Kids in its calculation of the measure.

<sup>d</sup> AMERIGROUP reported the measure using the administrative method (e.g., no medical record review was conducted).

<sup>e</sup> The statewide rate was not calculated because AMERIGROUP reported the administrative-only rate while WellCare reported the hybrid rate. Peach State did not include PeachCare for Kids in its calculation of this measure.

<sup>f</sup> The statewide rate was not calculated because Peach State did not include PeachCare for Kids in its calculation of this measure.

HSAG observed strong performance across all CMOs for the *Use of Appropriate Medications for People With Asthma* measure, with the statewide rate just below the national 2008 HEDIS 90th

<sup>1-2</sup> The national Medicaid HEDIS percentiles were published by NCQA. The high performance level was identified as meeting or exceeding the most recent national Medicaid HEDIS 90th percentile for most measures. The low performance level was identified as the most recent national Medicaid 25th HEDIS percentile.



percentile (the HPL). Pharmacological management of asthmatics appears to be a strength for the Georgia Families program.

HSAG also noted some opportunities for improvement. The statewide rate for *Comprehensive Diabetes Care—HbA1c Testing* ranked between the national HEDIS 2008 Medicaid 10th and 25th percentiles. For this measure, all CMOs were below the national HEDIS 2008 Medicaid 50th percentile (79.6 percent), with two CMOs performing below the 25th percentile (74.2 percent). The CMOs should focus efforts on ensuring that all diabetics receive the HbA1c test. Additionally, rates for both age group categories for the *Adults' Access to Preventive/Ambulatory Health Services* ranked between the 25th and 50th percentiles and represented areas in which the CMOs should focus improvement efforts. Exploring barriers to accessing care, including assessing network adequacy, appointment wait times, transportation and other member-related issues should be considered. Finally, one CMO experienced challenges with reporting the measures on the required populations, which impacted the ability to evaluate statewide performance across all measures. For future performance measure reporting, DCH has clarified with the CMOs that all measures must include the appropriate populations. While opportunities exist to improve performance on several key performance measures, focused, targeted improvement efforts coupled with sound causal-barrier analysis by the CMOs should result in improved performance in subsequent years.

### **Quality, Timeliness, and Access to Care**

For each of the three mandatory activities, HSAG prepared and submitted individual, CMO-specific reports of HSAG results to DCH and the CMOs. HSAG's findings, conclusions, and recommendations to improve the CMOs' performance on quality, timeliness, and access to care and services are described in greater detail in Section 6 of this report.

This section of the report includes a brief history of the DCH Georgia Families Medicaid managed care program and a description of DCH's quality assessment and performance improvement (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 CMO performance on DCH-selected measures and to evaluate the validity of and improvements achieved through the CMOs' DCH-specified performance improvement projects.

### 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 in a competitive bid process, DCH provides services to individuals enrolled in the State's managed care Medicaid and PeachCare for Kids™ programs. According to DCH, 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 is 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.

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 a majority of the State's PeachCare for Kids™ population. Enrollment is mandatory for the following Medicaid eligibility categories: the Low Income Medicaid (LIM) program, transitional Medicaid, pregnant women and children in the Right from the Start Medicaid (RSM) program, newborns of Medicaid-covered women, refugees, and women with breast and cervical cancer. The majority of Georgia Families members are children. Members have the right to choose from the CMOs providing services within their respective geographic regions. For members not making a choice, DCH uses several 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 dental and vision services, enhanced 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 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 managed care organizations (MCOs), prepaid inpatient health plans (PIHPs), and prepaid ambulatory health plans (PAHPs) must meet. A 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 at least as stringent as the 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 by 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 a state's quality strategy.
- ◆ Standards at least as stringent as those described in 42 CFR 438.206–242.

DCH 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 mechanisms 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 and March 2009, DCH submitted to CMS its Quality Strategic Plan Update progress reports.

### **Quality Strategy Objectives**

DCH's March 2009 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 dates and whether the State was on schedule, at risk of being behind schedule, or critically delayed. DCH also included a narrative description of the status of each of its strategic actions.

The four DCH goals described in both its initial strategy and its March 2009 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 2009 progress report update 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 2009 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 the 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. The series is composed of the following vaccinations—four diphtheria, tetanus, and pertussis (DTaP); three polio; one measles, mumps, and rubella (MMR); three Haemophilus influenzae type b (Hib); three hepatitis B (Hep B); and one varicella zoster virus (chicken pox, or VZV).
  - 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 to 44 years of age in Medicaid managed care plans.

- Twenty percentage points for members eligible for managed care who are 18 to 75 years of age with diabetes and have had at 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 2009 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—DCH described objectives in its 2009 progress report that were consistent with the six “aims for improvement” described in the Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. These six “aims for improvement” were: safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity. DCH's objective was to promote acceptable standards of health care within managed care programs by monitoring internal and external processes for improvement opportunities. DCH sought 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 March 2009 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.

After assessing the progress achieved under its original Georgia Families Quality Strategic Plan and the March 2009 update, DCH identified its accomplishments and opportunities for improvement. DCH also reevaluated its initiatives and established goals identified in the plan update submitted to CMS in February 2010.

## ***Operational Standards Requirements***

Through its contract with the three CMOs, DCH requires compliance with contractual standards that are 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. These requirements, and the standards cross-referenced within them, address performance related to access, structure and operations, and measurement and improvement standards. DCH continually evaluates the sufficiency of its contract terms and conditions in both incorporating all applicable CMS Medicaid managed care regulations and in continually driving improvement in CMO performance across a broad range of quality, access, and timeliness-of-care indicators, as well as administrative efficiencies. Based on these assessments, DCH has, with CMS approval, updated its CMO contract several times and is revising it further.

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. For the second year of the contract, and as described in detail in this report, DCH asked HSAG to conduct the review of the CMOs' compliance with the CMS structure and operations standards described at 42 CFR 438.214–230 and the associated DCH contract requirements. For the third year of the contract, the EQRO will evaluate the CMOs' performance for the remaining set of federal Medicaid managed care standards (i.e., the measurement and improvement standards described at 42 CFR 438.236–242) and the associated DCH contract requirements.

## ***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 lead 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

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

- ◆ 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 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 the following three PIPs for each CMO:

- ◆ Lead screens
- ◆ EPSDT well-child visits
- ◆ Provider satisfaction

As described in detail in this report, for the second contract year, DCH selected the following six PIPs for HSAG to validate for each of the CMOs:

- ◆ Access/service capacity
- ◆ Childhood immunizations
- ◆ Improving childhood lead screening rates
- ◆ Provider satisfaction
- ◆ Well-child visits during the first 15 months of life, with six or more visits
- ◆ Member satisfaction

DCH also contracted with HSAG to facilitate and participate with DCH and the CMOs in meeting collaboratively to identify barriers and improvement strategies for increasing performance across the CMOs for the well-child visit PIP.

### **Performance Measure Requirements**

During the period covered by this report, DCH:

- ◆ Increased the overall number of CMO performance metrics that it monitors to a total of 32 to provide a better perspective of the health of Georgia's Medicaid managed care population and incorporated the new metrics into the CMO contract amendment.



- ◆ Moved from HEDIS-like to HEDIS performance measures and Agency for Healthcare Research and Quality (AHRQ) prevention metrics. Results will be reported and analyzed in the 2010–2011 EQR Annual Report.
- ◆ Established performance metric targets that align with HEDIS and AHRQ percentiles and benchmarks, allowing Georgia’s Medicaid managed care performance to be compared with that of other states.
- ◆ Continually reviewed and updated its metrics of performance reports the CMOs are required to submit to DCH.

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

- ◆ Validate the same three performance measures for each CMO.
- ◆ Report its findings for two of the measures (i.e., diabetes—the percentage of members with diabetes who had 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.

For the second year of the contract, and as described in detail in this report, DCH contracted with HSAG to validate and report its findings for the following six measures for each of the CMOs:

- ◆ Comprehensive Diabetes Care—HbA1c Testing (Hybrid—i.e., a method that uses both administrative data and medical record data/documentation when calculating the rates)
- ◆ Use of Appropriate Medications for People With Asthma
- ◆ Well-Child Visits in the First 15 Months of Life—Six of More Visits (Hybrid)
- ◆ Childhood Immunization Status—Combination 2 (Hybrid)
- ◆ Lead Screening in Children (Hybrid)
- ◆ Adults’ Access to Preventive/Ambulatory Health Services

### Mandatory Activities

The CFR describes the mandatory activities at 42 CFR, Part 438, Managed Care, Subpart E, External Quality Review, 438.358(b). The three mandatory activities are: (1) validating 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.”

In the second year of its EQRO contract with HSAG (i.e., contract year 2009–2010) 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 that make up the Georgia Families 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 structure and operations standards (as described at 42 CFR 438.214–230) and the associated DCH contract requirements for the second year of a three-year cycle of compliance reviews.
- ◆ Validated six performance measures for each of the three CMOs.
- ◆ Validated six 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.

HSAG planned for and conducted the three mandatory activities in a manner consistent with the guidelines set forth by CMS in the following protocols for conducting Medicaid external quality review (EQR) activities:

- ◆ *Conducting Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality 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.
- ◆ *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., February 11, 2003.

## Optional Activities

For the second year of its EQRO contract, DCH requested that HSAG conduct one CMS-specified optional activity—encounter data validation (EDV)—for each of its three CMOs. One component of the study included evaluating EPSDT components in the medical record, as well as the evaluation of encounter data compared to medical record documentation. This study component addressed the following questions:

1. To what extent are services omitted from administrative and medical record sources?
2. To what extent are administrative encounters for services coded accurately?
3. To what extent are required components of an EPSDT visit documented in the medical record?

The EDV study included the abstraction of medical records by HSAG's trained record reviewers. HSAG used a customized medical record data collection tool approved by DCH to validate encounter data. HSAG has implemented policies and procedures, operational practices, and internal auditing systems to maintain a work place compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) for all EQRO activities.

HSAG planned for and conducted the EDV activities in a manner consistent with the guidelines set forth by CMS in its protocol, *Validating Encounter Data: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, Department of Health and Human Services, Centers for Medicare & Medicaid Services: Final Protocol, Version 1.0, May 1, 2002.

Due to the timelines negotiated by DCH and HSAG for conducting the EDV activities, HSAG's findings, conclusions, and recommendations from conducting the activities were not available to include in this report.

## Technical Reporting to Assess Progress in Meeting Quality Goals and Objectives

DCH also contracted with HSAG to aggregate and analyze the data it obtained from conducting the activities and to prepare this CMS-required 2009–2010 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 members.

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: compliance with standards, calculating and reporting performance measures, and conducting 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 of its contracts with the CMOs to strengthen and add 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 DCH 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.

### **Categorizing EQR Activity Results**

The Centers for Medicare & Medicaid Services (CMS) has chosen the domains of quality, access, and timeliness as keys to evaluating the performance of MCOs and PIHPs. HSAG used the following methodology to evaluate and draw conclusions about the performance of the CMOs in each of these domains.

To draw conclusions and make recommendations about the quality and timeliness of, and access to, care provided by the CMOs, HSAG assigned the components reviewed for each EQR activity (compliance reviews, validation of PIPs, and validation of performance measures) to one or more of the three domains: quality, timeliness, and access. Of note is that for validation of PIPs and validation of performance measures, the EQR activities were primarily evaluating the quality/validity of the PIP process and the validity of the performance measure calculation and reporting processes rather than the actual performance results for the select performance measures or PIP study indicators. Nonetheless, performance outcomes for these two activities still reflected the CMOs' efforts and commitment to improve performance in the quality, timeliness, and access domains.

HSAG used the following definitions for the purpose of categorizing the EQR activity results:

#### **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."<sup>3-1</sup>

#### **Timeliness**

The National Committee for Quality Assurance (NCQA) defined timeliness relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."<sup>3-2</sup> NCQA further discussed the intent of this

<sup>3-1</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register. Code of Federal Regulations*. Title 42, Vol 3, October 1, 2005.

<sup>3-2</sup> National Committee for Quality Assurance. 2006 Standards and Guidelines for MCOs and MBHOs.

standard to minimize any disruption in the provision of health care. HSAG extends this definition of timeliness to include other managed care provisions that impact services to enrollees and that require a timely response by the MCO or PIHP—e.g., processing expedited appeals and providing timely follow-up care.

**Access**

In the preamble to the BBA Rules and Regulations<sup>3-3</sup> CMS discusses access to and the availability of services to Medicaid enrollees as the degree to which MCOs and 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 reflects the needs and characteristics of the enrollees served by the MCO or PIHP.

Table 3-1 below displays the assignment of the EQR activity components reviewed to the categories of quality, access, and timeliness.

Table 3-1—Categorizing Related to Quality, Access, and Timeliness				
Review of Compliance With Standards				
Standard		Quality	Access	Timeliness
I.	Provider Selection, Credentialing, and Recredentialing	√		
II.	Subcontractual Relationships and Delegation	√		
III.	Member Rights and Protections	√		
IV.	Member Information		√	
V.	Grievance System	√		√
VI.	Disenrollment Requirements and Limitations		√	
PIPs				
PIP		Quality	Access	Timeliness
I.	Access/Service Capacity	√	√	
II.	Improving Childhood Lead Screening Rates	√		
III.	Childhood Immunization	√		
IV.	Well-Child Visits During the First 15 Months of Life With Six or More Visits	√		
V.	Provider Satisfaction	√	√	
VI.	Member Satisfaction	√	√	√
Performance Measures				
Performance Measure		Quality	Access	Timeliness
I.	Comprehensive Diabetic Care—HbA1c (Hybrid)	√		
II.	Use of Appropriate Medications for People With Asthma	√		
III.	Well-Child Visits in the First 15 Months of Life—Six or More Visits (Hybrid)	√		
IV.	Childhood Immunization Status—Combination 2 (Hybrid)	√		
V.	Lead Screening in Children (Hybrid)	√		
VI.	Adults’ Access to Preventive/Ambulatory Health Services	√	√	

<sup>3-3</sup> Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.

## Georgia Department of Community Health Quality Initiatives

In its commitment to continually improve access to, and the quality and timelines of, the care and services provided to members through its three Medicaid CMOs, DCH implemented and/or actively participated with other stakeholders in numerous improvement initiatives. From July 2008 through September 2009, these initiatives included the following:

- ◆ Sponsored a Dental Colloquium in spring 2009.
- ◆ Actively participated in the Obesity Action Network to decrease childhood obesity in Georgia.
- ◆ Assumed an active role in working on the new Medicaid Management Information System (MMIS) in the areas of EPSDT, periodicity schedules, and performance measures.
- ◆ Moved from HEDIS-like to HEDIS performance measures and AHRQ prevention metrics in spring 2009.
- ◆ Increased the overall number of metrics monitored to 32 to provide a better perspective of the health of Georgia's Medicaid managed care population. Incorporated the new metrics into the CMO contract amendment.
- ◆ Established performance metric targets that align with HEDIS and AHRQ percentiles and benchmarks, allowing a comparison of Georgia's Medicaid managed care performance to that of other states.
- ◆ Added language to the CMOs' contract relative to their failure to achieve the quality performance metric targets to encourage achievement of those targets. Updated the Quality Strategic Plan to reflect the above changes in the performance metrics.
- ◆ After discussions with CMS, discussed the mandatory components of EPSDT visits with the CMO quality and medical directors, who were to ensure their network providers were compliant in performing all required EPSDT visit components during each periodic visit. Added clarifying language in the EPSDT section of the CMO contract amendment.
- ◆ Established and participated with the CMOs and HSAG on a well-child visit collaborative PIP to improve members' access to and utilization of primary care providers (PCPs).
- ◆ Supported the establishment of common study questions for each PIP conducted by the CMOs.
- ◆ Included member data for PeachCare for Kids in the CMOs' results for PIPs and performance measures.
- ◆ Modified the CMO contract amendment to allow nominal-value incentives for providers and members to encourage compliance with EPSDT requirements.
- ◆ Gained clarity regarding the vaccine source for members of PeachCare for Kids enrolled in the CMOs and communicated this to the CMOs through the contract amendment.
- ◆ Allowed the CMOs to include Georgia's immunization registry information/data in their future performance data to obtain a more complete picture of the immunization status of Georgia Medicaid members.

- ◆ Stressed to the CMOs the importance of proper screening and documentation for lead exposure and required the reporting of all lead screening results to the Georgia Division of Public Health.
- ◆ Streamlined and revised the required quality reports to allow the CMOs to focus their attention on initiatives that would result in improved health outcomes.
- ◆ Enhanced monitoring of the CMOs' case and disease management programs and activities by adding CMO quarterly reporting requirements to the contracts.
- ◆ Initiated a project to reduce low birth weight (LBW) rates to address Georgia's high LBW rate.
- ◆ Formed a Strategic Quality Council, which is focusing on preventing and decreasing cardiovascular deaths.
- ◆ Contracted and worked collaboratively with HSAG in developing an enhanced member auto-assignment algorithm to include CMO performance on select quality performance indicators.
- ◆ Contracted and worked collaboratively with HSAG to design and conduct encounter data validation with a special focus on providers performing, documenting, and submitting encounters for DCH-required EPSDT well-child visits.

## 5. 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 noteworthy CMO practices.

DCH's June 2007 Quality Strategic Plan and its March 2009 plan update described the strategic actions DCH had initiated or planned to implement. These actions were designed 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. In its contracts with the CMOs, DCH incorporated standards at least as stringent as—and frequently more stringent than—federal regulations. 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 noteworthy 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 measures, and validating CMO PIPs).

The noteworthy practices included the following:

- ◆ The CMOs had Web sites that would convert the site, including all associated documents, from English into Spanish (the only non-English prevalent language spoken by members) by clicking the “en español” button.
- ◆ Two of the CMOs (AMERIGROUP and Peach State) had member handbooks that had both the English and Spanish versions in the same booklet (front half/back half).

For AMERIGROUP:

- ◆ AMERIGROUP's provider directory for members contained all the required elements and had an additional feature that was considered a best practice. The directory contained a section that alphabetically listed languages (e.g., Spanish, French, Russian) and identified the PCPs who spoke that language.
- ◆ AMERIGROUP had step-by-step grievance system procedures that went hand in hand with its written policies related to member grievances, appeals, and requests for State administrative law hearings and trained staff members on each step.
- ◆ AMERIGROUP had a high percentage of claims received electronically (approximately 90 percent), and a high percentage of these (approximately 82 percent) were automatically adjudicated. This high level of electronically received and auto-adjudicated claims enables a high degree of efficiency related to the timeliness of claims processing, as well as a high degree of reliability based on the accuracy of claims.
- ◆ AMERIGROUP used certified software to produce the hybrid performance measure samples and to calculate the HEDIS measures. In addition, the CMO used a medical record abstraction vendor



to collect the medical record information and had well-documented, excellent processes in place to perform oversight of the medical record and data vendors.

- ◆ AMERIGROUP had good processes in place to ensure complete pharmacy data, meeting weekly with the pharmacy to address utilization/edits and issues with claims that were incorrectly paid or denied. This practice may have contributed to the high ranking of the asthma measure (at the 90th percentile).
- ◆ The CMO reported that it had also reduced the preauthorization requirement list and provided extensive member educational outreach efforts through its case management, disease management, and quality management/health promotion using both telephone contacts and mailings to members/families.

For Peach State:

- ◆ Peach State processed the majority of claims using optical character recognition (OCR) technology, and the claims were automatically loaded into the transaction system (Amysis). The CMO tightly controlled paper claims as they were received in the mailroom and during processing. The structure of the mailroom and claims-processing department procedures were best practices for Peach State. The processes in place in the mailroom were impressive.
- ◆ Peach State used certified software to generate the hybrid samples and calculate the HEDIS measures. The CMO also used a medical record abstraction vendor. Peach State staff had exceptional processes in place to conduct oversight of the medical record review vendor. These processes included performing ongoing reliability testing, reviewing all exclusions and replacement selections, and monitoring the timeliness of important milestones. Peach State also tightly controlled data exchange between the CMO, the NCQA-certified software vendor, and the medical record abstraction vendor.
- ◆ Peach State reported that it had also:
  - Received the Silver Honors 2009 URAC Best Practices Award in Health Care Consumer Empowerment and Protection for its Connections Plus Program for providing free, pre-programmed cell phones to high-risk members who do not have steady access to a telephone.
  - Implemented the Physician Summit Award program, which honors primary care physicians who demonstrate exemplary performance on HEDIS scores.
  - Implemented a new provider pay-for-performance program for HEDIS and other quality initiatives.
  - Conducted quarterly medical management meetings with key providers to discuss quality/cost profiles and recommendations for improving health care outcomes.

For WellCare:

- ◆ In addition to its other outreach and provider education efforts, WellCare provided step-by-step instructional materials to providers on how they should resubmit encounter data if files are rejected, especially when they have to work with a clearinghouse to achieve resubmission. This demonstrated the CMO's commitment to complete encounter data reporting.
- ◆ For the credentialing process, WellCare used a tracking form for entering and editing information into its electronic systems. This demonstrated the CMO's efforts to ensure that provider data are entered completely and accurately throughout the provider data load process.

- ◆ WellCare conducted an independent over-read of records abstracted by its vendor. The CMO took the extra step of monitoring its vendor by conducting a separate assessment of vendor abstraction accuracy, even though the vendor conducted its own internal, independent over-read activities. This additional step exemplified the CMO's thorough oversight of its medical record review vendor.
- ◆ To improve performance on childhood immunizations, lead screenings, and well-child visits during the first 15 months of life, the CMO reported that it implemented telephonic outreach protocols to educate and assist noncompliant members who had not received preventive services. The outreach included proactive appointment scheduling and transportation referrals. The CMO also conducted member reminder calls to reinforce the need to keep scheduled appointments.
- ◆ To improve performance on the asthma measure, WellCare reported that it performed targeted in-home assessments on identified members with asthma who were not compliant with recommended pharmaceutical treatment. WellCare provided to the members/families, as appropriate, peak flow meters, nebulizers, pest control agents, and sheet casings. The goal was to improve members' living conditions, provide education, and increase member knowledge of asthma and environmental factors that affect the condition.
- ◆ To improve member satisfaction survey results, WellCare strengthened its Cultural Competency Program by adding customized questions to the 2009 Medicaid Child Consumer Assessment of Healthcare Providers and Systems (CAHPS<sup>®</sup>) survey that focused on the use of interpretation services for members in their communications with health care providers.
- ◆ The CMO developed a HEDIS provider tool kit used by provider relations representatives to assist physicians in their outreach to noncompliant members.

## 6. External Quality Review Activities: Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access

### Introduction

This section of the report provides a summary of HSAG's findings and its conclusions about each CMO's performance in providing quality, timely, and accessible services to Georgia Families members. Section 8 of this report, Plan Comparison, provides data comparing CMO performance for each of the three activities.

### Review of Compliance With Operational Standards

For the compliance review, the second year of a three-year cycle of HSAG external quality reviews for the DCH-contracted CMOs, 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 structure and operations standards found at 42 CFR 438.214–438.230. The standards HSAG evaluated included requirements for:

- ◆ Selecting, credentialing, and recredentialing providers.
- ◆ Subcontractual relationships and delegation of CMO administrative responsibilities.
- ◆ Member rights and protections.
- ◆ Member information.
- ◆ Member grievances, appeals, and access to State administrative law hearings.
- ◆ Disenrollment requirements and limitations.

Based on its findings for each CMO, HSAG assigned a score of *Met*, *Partially Met*, or *Not Met* to the CMO's performance in complying with each of the requirements. HSAG also calculated a percentage-of-compliance score for each standard and an overall percentage-of-compliance score across the six standards. If a requirement was not applicable to a CMO for the period covered by the review, HSAG used an *NA* designation.

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.*

Appendix A, Reviewing Compliance With Operational Standards, contains a complete description of HSAG’s methodology.

## AMERIGROUP Community Care

### Findings

Table 6-1 presents a summary of the results from HSAG’s review, reporting 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 the 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	Provider Selection, Credentialing, and Recredentialing	10	10	8	2	0	0	90%
II	Subcontractual Relationships and Delegation	6	6	5	1	0	0	92%
III	Member Rights and Protections	6	6	6	0	0	0	100%
IV	Member Information	20	20	16	4	0	0	90%
V	Grievance System	35	35	28	7	0	0	90%
VI	Disenrollment Requirements and Limitations	8	8	8	0	0	0	100%
<b>Totals</b>		<b>85</b>	<b>85</b>	<b>71</b>	<b>14</b>	<b>0</b>	<b>0</b>	<b>92%</b>
<b>Total # of Elements:</b> The total number of elements in each standard.								
<b>Total # of Applicable Elements:</b> The total number of elements within each standard minus any elements that received a designation of <i>NA</i> .								
<b>Total Compliance Score:</b> The overall percentages were calculated by adding the number of elements that received a score of <i>Met</i> to the weighted (multiplied by 0.50) number that received a score of <i>Partially Met</i> , 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 and 71 out of 85 requirements receiving a score of *Met*. Performance for two standards (Standard III—Member Rights and Protections, and Standard VI—Disenrollment Requirements and Limitations) received a score of 100 percent. Performance for the other four standards received scores of 90 percent or more.

AMERIGROUP’s performance strengths for each standard are summarized below.

### **Standard I—Provider Selection, Credentialing, and Recredentialing**

In addition to providing clearly written documents to its providers, delegates, and staff that contained accurate information related to the CMO's requirements and expectations for selecting, credentialing, and recredentialing its providers. AMERIGROUP's approach to ensuring strong performance for this standard included regular performance monitoring, timely and automated comparisons of all contracted providers against the Office of Inspector General (OIG) database to ensure that the CMO did not contract with providers on the federal list of excluded individuals and entities, and the incorporation of NCQA guidelines into its grids/checklists to facilitate and ensure its compliance with the requirements for this standard.

### **Standard II—Subcontractual Relationships and Delegation**

The CMO had policies, processes, and practices in place to ensure that all contracted entities complied with applicable federal and State regulations and requirements related to delegated functions. The CMO conducted predelegation audits to ensure that a prospective subcontractor had the ability to perform the delegated activities. Its oversight process, which included the activities of multiple committees, and its ongoing monitoring of reports also enabled the CMO to work diligently and collaboratively with its providers and delegates to identify and address any deficiencies the CMO identified in their performance.

### **Standard III—Member Rights and Protections**

AMERIGROUP used the activities of multiple departments (i.e., the Associate Services Department, Communications Department, Provider Services—Corporate Department, and National Contact Center) to ensure that members, providers, and staff were informed about member rights and the staff's and providers' responsibilities related to them. The CMO included the list of member rights and the providers' responsibilities in the provider manual, newsletters, and contracts and conducted monitoring activities to ensure the CMO's compliance with the requirements for this standard.

### **Standard IV—Member Information**

AMERIGROUP's efforts to ensure that members could understand the plan benefits and requirements included: (1) providing, or having available, the member handbook in Spanish and English, in large print, in an audio version, and in Braille; (2) maintaining a CMO Web site where the information could be easily converted to Spanish; and (3) providing highly trained member services staff to assist members with questions. In its provider directory available to members, the CMO's addition of a section that alphabetically listed different languages spoken by primary care providers was considered a best practice.

### **Standard V—Grievance System**

The CMO had a sophisticated system for processing, documenting, and tracking grievances and administrative reviews and developed step-by-step instructions to ensure its staff members had a clear understanding of the two processes. The CMO sent the required written notices of proposed action within the required time frames, and the notices contained the required information. In

addition, the member handbook contained easy-to-understand information for members about their right to file grievances and appeals and the processes for filing them. Other strengths included AMERIGROUP's timely performance in sending out acknowledgment letters following receipt of member grievances, resolving grievances, and having staff with appropriate levels of expertise for resolving the grievances.

### **Standard VI—Disenrollment Requirements and Limitations**

AMERIGROUP included the disenrollment requirements in the member handbook. An additional strength was the CMO's provision of additional assistance to members wishing to disenroll after CMO efforts to resolve issues and to retain the member (e.g., providing the disenrollment form to members and referring them to DCH to conduct the disenrollment determinations).

### **Opportunities for Improvement and Recommendations**

Based on HSAG's review of AMERIGROUP's performance, the CMO was required to complete a corrective action plan and implement corrective actions for four standards: Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; Standard IV—Member Information; and Standard V—Grievance System.

#### **Standard I—Provider Selection, Credentialing, and Recredentialing**

While HSAG scored 8 of the 10 applicable elements for this standard as *Met*, two elements received a *Partially Met* score, resulting in a total percentage-of-compliance score of 90 percent. To improve its compliance, AMERIGROUP was required to ensure that all providers' credentialing records included documentation of OIG verification and documentation of primary source verification.

#### **Standard II—Subcontractual Relationships and Delegation**

For this standard, five of the six applicable requirements received a *Met* score and one received a *Partially Met* score, resulting in a total compliance score of 92 percent. To improve compliance with this standard, AMERIGROUP was required to define in each of its written delegation agreements the specific functions, activities, and reporting responsibilities for each delegated activity and to revise its delegation agreement with National Imaging Associates to reflect the actual (current) activities the CMO delegated to the contractor.

#### **Standard IV—Member Information**

Of the 20 applicable requirements, HSAG scored 16 as *Met* and 4 as *Partially Met*, resulting in a total compliance score of 90 percent. Although AMERIGROUP was revising the member handbook at the time of the review, the version available to members at the time of HSAG's review was evaluated for this audit. Based on the results, AMERIGROUP was required to submit to DCH and implement DCH-approved corrective actions for the four requirements HSAG scored as *Partially Met*. To improve compliance, the CMO was required to provide additional information to members about their rights related to: (1) not being liable for the CMO's debts or payment for covered services, (2) the name of the appropriate State agency for filing complaints concerning provider

noncompliance with advance directive requirements, (3) obtaining assistance when filing an appeal, and (4) the rules that govern representation at an administrative law hearing.

### **Standard V—Grievance System**

Of the 35 applicable requirements, AMERIGROUP received a *Met* score for 28 requirements and a *Partially Met* score for 7 requirements, resulting in a compliance score of 90 percent for the standard. To improve compliance, the CMO was required to: (1) update all applicable documents to include complete definitions of an “action” and the accurate associated timelines and (2) develop a process for ensuring that a notice of action is sent to the member when failing to meet grievance and appeal/administrative review timelines. In addition, AMERIGROUP was required to ensure that the revised member handbook includes accurate information about filing grievances and the CMO’s review process, including the definition of an action, the phone number for the teletype/telecommunications device for the deaf (TTY/TDD), the right to present evidence and review files during an administrative law hearing, and the time frames for requesting continuation of benefits and how to begin the process. The CMO was also required to update its provider manual to include information about each element in the member grievance system. To be consistent with the grievance filing process, AMERIGROUP was required to revise its template documents so that members who filed an oral grievance were not required to follow up with a written grievance submission. Lastly, the CMO was required to go beyond mailing an “unable to contact” letter to members after multiple attempts to follow up on the initial grievance. The CMO was required to investigate all matters to the extent possible and send a resolution letter that included any information the CMO was able to obtain and the resolution.

### **Summary**

AMERIGROUP demonstrated strong performance in all three domains (i.e., providing quality, accessible, and timely care and services to its members). All four standards related to the quality domain received a compliance score of at least 90 percent, and one achieved full compliance (Standard III—Member Rights and Protections). At the requirement level, 47 of 57 requirements in the standards related to quality received a score of *Met*. Similarly, both of the standards (Standard IV—Member Information and Standard VI—Disenrollment Requirements and Limitations) related to the access domain received a compliance score of at least 90 percent, with 24 of the 28 applicable requirements receiving a score of *Met*. In addition, performance for Standard VI—Disenrollment Requirements and Limitations, was scored as fully compliant. Lastly, the CMO’s performance for the only standard related to the timeliness domain (Standard V—Grievance System) was scored as 90 percent compliant.

## **Peach State Health Plan**

### **Findings**

Table 6-2 presents a summary of the results from HSAG’s review, reporting 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	Provider Selection, Credentialing, and Recredentialing	10	10	10	0	0	0	100%
II	Subcontractual Relationships and Delegation	6	6	4	2	0	0	83%
III	Member Rights and Protections	6	6	6	0	0	0	100%
IV	Member Information	20	20	17	3	0	0	93%
V	Grievance System	35	35	27	8	0	0	89%
VI	Disenrollment Requirements and Limitations	8	8	5	3	0	0	81%
<b>Totals</b>		<b>85</b>	<b>85</b>	<b>69</b>	<b>16</b>	<b>0</b>	<b>0</b>	<b>91%</b>

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

**Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *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 good, with a total percentage-of-compliance score of 91 percent across all standards. Two standards (Standard I—Provider Selection, Credentialing, and Recredentialing, and Standard III—Member Rights and Protections) received overall percentage-of-compliance scores of 100 percent. Performance for Standard IV (Member Information) received an overall compliance score of 93 percent.

Peach State’s strengths for each standard are summarized below.

### Standard I—Provider Selection, Credentialing, and Recredentialing

Peach State’s comprehensive policies and procedures were not only consistent with the standards established by NCQA, but they also incorporated standards from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the Utilization Review Accreditation Commission (URAC). The CMO’s policies and procedures supported a nondiscriminatory approach to provider selection and adequately addressed all applicable federal Medicaid managed care and DCH requirements. Peach State’s staff was knowledgeable of the credentialing and recredentialing policies and demonstrated strong understanding of the related procedures. In addition, results from



the on-site credentialing and recredentialing file reviews showed that all files HSAG reviewed contained the required documents and were processed within the required time frame.

### **Standard II—Subcontractual Relationships and Delegation**

Peach State had policies related to delegation and followed a documented process to evaluate prospective subcontractors' ability to perform the proposed delegated administrative functions. In addition, the CMO provided adequate documentation of each delegation contract, and each contract contained the required revocation clause. Peach State also conducted ongoing monitoring and formal reviews of each delegate related to the delegated functions. Its policies required the delegate to submit to the CMO and to implement corrective actions for any deficiencies/areas for improvement the CMO identified as part of its monitoring processes. Documentation HSAG reviewed demonstrated the CMO's strong monitoring and oversight processes related to its delegates. The documentation included examples of the CMO's monitoring activities, notices it issued to delegates of required corrective actions, and follow-up reviews to determine whether the plans had been implemented and effective in correcting the deficiencies. Peach State staff was knowledgeable about the CMO's written policies and procedures related to the requirements and processes associated with this standard.

### **Standard III—Member Rights and Protections**

Peach State's comprehensive staff training and member and provider materials ensured that its staff and providers were informed about and protected member rights. New hire orientation included training on member rights. Staff was also required to complete annual compliance and ethics training and was subject to routine HIPAA desk audits related to protected health information. For providers, the CMO included a list of member rights in the provider manual, newsletters, and on the Web site and specific requirements in the provider contracts/agreements. Providers were also required to offer interpreter services to members free of charge.

### **Standard IV—Member Information**

Peach State ensured that members were informed of their rights, covered services and benefits, and other information through multiple avenues, including: (1) initial mailings of the member handbook, provider directory, and welcome letter, all written at a fifth-grade reading level and available in various formats such as compact disc, Braille and large print; (2) a welcome call; (3) a Web site that easily converted from English to a Spanish version; and (4) comprehensively trained member services representatives. The member handbook included information on all available Georgia Families benefits and services, with information related to limitations, copays, and noncovered services. The CMO's Member Connections<sup>TM</sup> representatives offered assistance not only in obtaining health plan services but also in accessing social services.

### **Standard V—Grievance System**

The CMO had an organized system for processing, documenting, and tracking grievances and administrative reviews, with detailed processes for its operations. Staff members had a clear understanding of the processes as well as the differences between grievances and administrative

reviews. Notices of proposed action contained required information and were issued within the required time frames. Administrative review decisions were made by physicians not previously involved with the case. In addition, Peach State informed members in the member handbook of their rights related to, and the processes for filing, grievances and appeals. Documentation HSAG reviewed related to specific grievances from members appeared sufficient, and each case was handled within the required time frame by individuals with the appropriate expertise.

### **Standard VI—Disenrollment Requirements and Limitations**

Peach State’s disenrollment requirements were congruent with the DCH contract requirements and were included in the member handbook. The CMO also offered assistance to members wishing to disenroll—including working with members in an effort to resolve any problems and to retain the member, providing disenrollment forms to members wishing to disenroll, and referring them to DCH for disenrollment determinations.

## **Opportunities for Improvement and Recommendations**

Based on HSAG’s review of Peach State’s performance, CMO corrective action was required for four standards: Standard II—Subcontractual Relationships and Delegation; Standard IV—Member Information; Standard V—Grievance System; and Standard VI—Disenrollment Requirements and Limitations. For three of the standards (Standards II, V, and VI) scores fell below 90 percent, suggesting considerable opportunities for improvement.

### **Standard II—Subcontractual Relationships and Delegation**

For this standard, two of the six applicable requirements received a *Partially Met* score, resulting in a total compliance score of 83 percent. To improve its compliance, Peach State was required to: (1) review each delegation agreement and ensure that the functions/activities listed as delegated reflected those actually and currently performed by the delegate and (2) revise each agreement as needed.

### **Standard IV—Member Information**

For this standard, 3 of the 20 applicable requirements received a *Partially Met* score, resulting in a total compliance score of 93 percent. To improve compliance with the requirements, Peach State was required to use easy-to-understand terms and language when informing members about their right “to get services in agreement with QAPI Access Standards” and to define terms such as “administrative law hearing” and “administrative review.” The CMO was also required to clarify its written information about providers’ appeal rights.

### **Standard V—Grievance System**

Of the 35 applicable requirements in the Grievance System standard, the CMO’s performance received a *Partially Met* score for 8 requirements, resulting in a total compliance score of 89 percent. To improve compliance with this standard, the CMO was required to revise the member handbook to include the time frame for filing requests for administrative reviews, requirements related to continuation of benefits, a clear definition of appeals and administrative reviews,

procedures for obtaining assistance for requesting administrative law hearings, and the fact that the time frame for authorization decisions may be extended. In addition, Peach State needed to review and revise all applicable documents and other materials related to multiple aspects of the administrative review processes and its notices of action and resolution letters. The CMO was required to train its staff on the changes to processes, notices, and resolution letters. Lastly, Peach State was required to include all required information about the member grievance system in all appropriate provider materials.

### **Standard VI—Disenrollment Requirements and Limitations**

Three of the eight applicable requirements received a *Partially Met* score for this standard, resulting in an overall compliance score of 81 percent. To improve compliance with requirements for this standard, the CMO was required to revise the member handbook to include all the allowable reasons to request disenrollment. Additionally, the CMO was required to include in its disenrollment policy the fact that one of the plan's reasons for requesting member disenrollment was the member's noncompliance with the treating physician's plan of care.

### **Summary**

Peach State demonstrated mixed performance related to the domain of providing care and services to improve the likelihood of quality outcomes, with two standards (Standard I—Provider Selection, Credentialing, and Recredentialing, and Standard III—Member Rights and Protections) receiving a score of 100 percent and the scores for the other two falling below 90 percent (Standard II—Subcontractual Relationships and Delegation, and Standard V—Grievance System). Of the 57 requirements in the standards related to quality, 10 received a score of *Partially Met*, indicating opportunities for improvement, especially for requirements in Standard V. With only one of the two access-related standards (Standard IV—Member Information) achieving a compliance score of at least 90 percent, Peach State's performance related to providing accessible care and services suggested room for improvement. More specifically, of the 28 applicable requirements, 6 received a *Partially Met* score, requiring the CMO to implement corrective actions. Last, with 8 of the 35 applicable requirements for the Grievance System standard receiving a score of *Partially Met*, Peach State's compliance performance for the Grievance System requirements, some of which related to the timeliness domain, also suggested considerable room for improvement.

**WellCare of Georgia, Inc.**

**Findings**

Table 6-3 presents a summary of the results from HSAG’s review, reporting 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, Inc.**

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# Met	# Partially Met	# Not Met	# Not Applicable	Total Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	10	10	10	0	0	0	100%
II	Subcontractual Relationships and Delegation	6	6	6	0	0	0	100%
III	Member Rights and Protections	6	6	6	0	0	0	100%
IV	Member Information	20	20	14	6	0	0	85%
V	Grievance System	35	35	24	11	0	0	84%
VI	Disenrollment Requirements and Limitations	8	8	8	0	0	0	100%
<b>Totals</b>		<b>85</b>	<b>85</b>	<b>68</b>	<b>17</b>	<b>0</b>	<b>0</b>	<b>90%</b>
<b>Total # of Elements:</b> The total number of elements in each standard.								
<b>Total # of Applicable Elements:</b> The total number of elements within each standard minus any elements that received a designation of <i>NA</i> .								
<b>Total Compliance Score:</b> The overall percentages were calculated by adding the number of elements that received a score of <i>Met</i> to the weighted (multiplied by 0.50) number that received a score of <i>Partially Met</i> , then dividing this total by the total number of applicable elements.								

**Strengths**

Overall, WellCare’s performance was good, with a total percentage-of-compliance score of 90 percent across all standards. Four standards (Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; Standard III—Member Rights and Protections; and Standard VI—Disenrollment Requirements and Limitations) received a compliance score of 100 percent.

WellCare’s strengths related to each standard are summarized below:

### **Standard I—Provider Selection, Credentialing, and Recredentialing**

WellCare’s comprehensive policies and procedures demonstrated consistency with the standards established by NCQA, JCAHO, and URAC and adequately addressed all applicable federal Medicaid managed care and DCH contract requirements. Staff was well trained and educated in the credentialing and recredentialing policies and demonstrated a strong understanding of the related procedures. In addition, all credentialing and recredentialing files HSAG reviewed on-site contained the required documents and were processed within the required time frames.

### **Standard II—Subcontractual Relationships and Delegation**

The CMO had policies that defined the delegation activities and WellCare’s procedures for addressing each of the applicable requirements, including conducting predelegation assessments of the prospective subcontractor’s ability to perform the delegated functions. Written delegation agreements with each contractor contained all applicable provisions, including a revocation clause. WellCare conducted ongoing monitoring and formal reviews for all delegated functions and, as applicable, required delegates to submit and implement corrective actions for deficiencies WellCare had identified during its monitoring/review processes. Documentation available for HSAG’s review demonstrated that WellCare ensured that the delegates satisfactorily completed the required corrective actions.

### **Standard III—Member Rights and Protections**

WellCare ensured that members were informed of their rights by including and describing member rights and protections in the member handbook. The provider manual informed providers about these member rights/protections and their obligations related to them. The CMO also incorporated the rights and provider obligations into the provider written agreements and monitored for evidence of compliance through medical record reviews and provider site inspections. Providers were also required to post member rights in offices/facilities. WellCare provided comprehensive training related to member rights to its customer service representatives, which included staff obligations related to member rights.

### **Standard IV—Member Information**

WellCare ensured that members had easy and appropriate access to member information through multiple avenues, including: (1) initial mailings of the member handbook, provider directory, and welcome letter, all written at a fifth-grade reading level and available in Spanish, as well as in various alternative formats such as compact disc, Braille and large print; (2) a welcome call; (3) a Web site that was easily converted to a Spanish version; and (4) comprehensively trained member services representatives available to assist members with needed information. Multiple documents HSAG reviewed also demonstrated that the CMO provided oral interpretation services to members free of charge.

### **Standard V—Grievance System**

WellCare had a sophisticated system for processing, documenting, and tracking grievances and administrative reviews and processes for accepting both oral and written member requests. Notices

of proposed action contained the required information and were sent within the required time frames. Administrative reviews conducted by independent physicians were processed and resolved in a timely manner. Documentation of grievances and administrative reviews included all required information. The CMO also had a system for sending resolution letters in the member's primary language. In addition, WellCare informed the members in the member handbook, written in easy-to-understand language, of their rights and processes related to filing grievances and appeals. The CMO informed providers about the member grievance system in the provider manual. HSAG's review of a sample of WellCare's member grievance records confirmed that all grievances were resolved within the required time frames and decisions were made by individuals with an appropriate level of expertise.

### **Standard VI—Disenrollment Requirements and Limitations**

All WellCare enrollment and disenrollment policies were aligned and consistent with the applicable DCH contract requirements. In addition, the CMO provided its associates with training materials that described how they were to handle processes for member voluntary and involuntary disenrollment. WellCare had a policy related to disenrollment and trained its staff on disenrollment procedures. Using its standardized template, the CMO mailed letters to members who requested voluntary disenrollment within 24 hours of receiving the request. Members were instructed to call Georgia Families' toll-free number to disenroll. Member data in the eligibility maintenance system were updated based on the disenrollment request. The CMO submitted monthly disenrollment reports to DCH.

### **Opportunities for Improvement and Recommendations**

HSAG's review of WellCare's performance identified room for improvement and required corrective actions for two standards: Standard IV—Member Information and Standard V—Grievance System. Scores for these standards were below 90 percent, indicating considerable opportunities for improvement.

#### **Standard IV—Member Information**

For this standard, of the 20 applicable requirements, 6 received a score of *Partially Met*, resulting in a total compliance score of 85 percent. To improve compliance with requirements for this standard, WellCare was required to include in the list of member rights it communicated to members and providers, the right to be furnished services in accordance with federal requirements and the right to be responsible for cost-sharing only as specified in the DCH contract. The CMO was also required to clarify the member's right regarding requesting, receiving, or amending his or her medical records and the right not to be held liable for the CMO's debts. WellCare was also required to provide information to members about: (1) the State agency to which they should direct complaints concerning provider noncompliance with advance directive requirements and (2) rules governing representation at an administrative law hearing. Lastly, the CMO was required to remove a statement in the member handbook that required members to tell the plan before seeking emergent/urgent care and poststabilization services.

## Standard V—Grievance System

Of the 35 applicable requirements for this standard, WellCare received a score of *Partially Met* for 11 requirements, resulting in an overall compliance score of 84 percent. To improve compliance with the requirements, the CMO was required to clarify in its policies and procedures the definition of a proposed action and the time frames associated with all grievance-related processes. WellCare was also required to revise its policies and corresponding training documents to ensure that they addressed and were consistent with all applicable requirements. In addition, the CMO was required to develop a method to ensure that it used easy-to-understand language in the customized sections of the notices of proposed action letters. Finally, WellCare was required to revise its member handbook and applicable provider materials to include all required information about the requirements and procedures related to the member grievance system.

### Summary

WellCare demonstrated mixed performance related to the standards that addressed providing care and services in ways that increase the likelihood of quality outcomes, with compliance scores of 100 percent for three standards (Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; and Standard III—Member Rights and Protections) and a compliance score of 84 percent for the remaining standard (Standard V—Grievance System). Of the 57 requirements related to the quality domain, 11 requirements, all within Standard V, received a score of *Partially Met*, indicating opportunities for improving performance related to these requirements. Performance for one of the two standards that related to providing access to care and services (Standard VI—Disenrollment Requirements and Limitations) achieved a compliance score of 100 percent. The second standard (Standard IV—Member Information) received a score of 85 percent, suggesting mixed performance related to the access domain. More specifically, of the 28 applicable requirements, 6 received a score of *Partially Met*, requiring the CMO to implement corrective action to improve its performance. Lastly, a number of the elements of the Grievance System standard related to the timeliness domain. WellCare's scores of *Partially Met* for 11 of the 35 requirements in this standard reinforced the need for corrective actions in this area.

## Validation of Performance Improvement Projects

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. During this second contract year, DCH selected the following six PIPs for HSAG to validate for each CMO:

- ◆ *Access/Service Capacity*
- ◆ *Childhood Immunization*
- ◆ *Improving Childhood Lead Screening Rates*
- ◆ *Member Satisfaction*
- ◆ *Provider Satisfaction*
- ◆ *Well-Child Visits During the First 15 Months of Life With Six or More Visits*

Appendix B—Validating Performance Improvement Projects (PIPs) contains a complete description of HSAG's methodology for this activity.

The following findings sections provide PIP results in tables that present each CMO's performance for each PIP and an overall performance score across the six PIPs. In addition to detailed performance results by activity, the tables also report 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. The findings sections also include narrative discussions of each CMO's strengths and opportunities for improvement.

### **AMERIGROUP Community Care**

#### **Findings**

Five of AMERIGROUP's submitted PIPs were validated through Activity VI, while the remaining PIP was validated through Activity IX. Table 6-4 displays AMERIGROUP's performance for each PIP and an overall performance score across the six PIPs.



Table 6-4—AMERIGROUP Community Care’s 2009–2010 PIP Performance

Activities	Access/ Service Capacity	Childhood Immunization	Lead Screening Rates	Member Satisfaction	Provider Satisfaction	Well-Child Visits	Overall Performance Across 6 PIPs
<b>Study Design</b>	<b>16/16 (100%)</b>	<b>17/17 (100%)</b>	<b>17/17 (100%)</b>	<b>17/17 (100%)</b>	<b>15/15 (100%)</b>	<b>17/17 (100%)</b>	<b>99/99 (100%)</b>
I. Choose the Study Topic	5/5 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	4/4 (100%)	6/6 (100%)	32/32 (100%)
II. Define the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	12/12 (100%)
III. Select the Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	7/7 (100%)	6/6 (100%)	6/6 (100%)	37/37 (100%)
IV. Use a Representative and Generalizable Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	18/18 (100%)
<b>Study Implementation</b>	<b>5/5 (100%)</b>	<b>5/5 (100%)</b>	<b>5/5 (100%)</b>	<b>15/15 (100%)</b>	<b>18/18 (100%)</b>	<b>5/5 (100%)</b>	<b>53/53 (100%)</b>
V. Use Sound Sampling Techniques	0/0	0/0	0/0	6/6 (100%)	6/6 (100%)	0/0	12/12 (100%)
VI. Use Valid and Reliable Data Collection Procedures	5/5 (100%)	5/5 (100%)	5/5 (100%)	9/9 (100%)	9/9 (100%)	5/5 (100%)	38/38 (100%)
VII. Include Improvement Strategies	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	3/3 (100%)	<i>Not Assessed</i>	3/3 (100%)
<b>Quality Outcomes Achieved</b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b>10/13 (77%)</b>	<b><i>Not Assessed</i></b>	<b>10/13 (77%)</b>
VIII. Data Analysis and Interpretation of Study Results	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	7/9 (78%)	<i>Not Assessed</i>	7/9 (78%)
IX. Assess for Real Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	3/4 (75%)	<i>Not Assessed</i>	3/4 (75%)
X. Assess for Sustained Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>
<b>Overall PIP Performance</b>							
Percentage Score of Evaluation Elements <i>Met</i>	100%	100%	100%	100%	93%	100%	98%
Percentage Score of Critical Elements <i>Met</i>	100%	100%	100%	100%	100%	100%	100%
Validation Status	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>

## Strengths

Overall, AMERIGROUP staff demonstrated a strong understanding of the requirements, especially related to the study design and implementation of a PIP. Ninety-eight percent of all evaluation elements across the six PIPs had a *Met* score, and 100 percent of all critical evaluation elements had a *Met* score. All of the applicable evaluation elements in these categories scored a *Met*, with individual overall PIP scores ranging from 93 to 100 percent. Five of AMERIGROUP's six submitted PIPs scored 100 percent.

At the activity level, all six PIPs had 100 percent of the evaluation elements scoring a *Met* for Activities I through VI. The only PIP that was validated past Activity VI received *Met* scores for all of the evaluation elements in Activity VII. All of the critical elements were scored a *Met*.

AMERIGROUP's strengths were very consistent across all six PIPs, which included thorough background documentation for the selection of the study topic, development of the study question and respective study indicators, identifying the study population, explaining the sampling methodology, defining the data collection procedures, developing the improvement strategies based on causes/barriers identified through data analysis and quality improvement processes, and the CMO's ability to design and implement interventions that lead to system-level changes.

## Opportunities for Improvement and Recommendations

Any evaluation elements that did not receive a *Met* status constituted an opportunity for improvement. Although all of the PIPs received an overall *Met* status, the one PIP that went through Activity IX did not receive *Met* scores for all evaluation elements within Activities VIII and IX. The *Provider Satisfaction* PIP scored a *Met* for only 78 percent of the elements in Activity VIII and 75 percent of the elements in Activity IX, representing opportunities for improvement.

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

- ◆ AMERIGROUP focus on the elements that received either a *Point of Clarification* or a score of *Partially Met* or *Not Met*, including those in Activities VIII and IX, and make appropriate changes associated with those evaluation elements. More specifically, HSAG recommended that AMERIGROUP ensure that the study results are presented in a way that provides accurate, clear, and easily understood information. The CMO should also be sure to provide accurate statistical testing results.
- ◆ AMERIGROUP carefully review each PIP across all activities before submission to ensure consistency throughout the PIP, and to ensure that results and processes are included correctly in the PIP Summary Form when working with vendors.

## Summary

Overall, AMERIGROUP demonstrated a strong understanding of the PIP requirements, especially those related to the study design and implementation of a PIP. Individual overall PIP scores ranged

from 93 to 100 percent, with five of the six submitted PIPs scoring 100 percent. AMERIGROUP's strengths in conducting Activities I through VI were extremely consistent across all six PIPs. AMERIGROUP also had some opportunities for improvement, including those related to the evaluation elements within Activities VIII and IX that did not receive *Met* scores and HSAG's *Points of Clarification* documented within the submitted PIPs.

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting PIPs, HSAG also identified that AMERIGROUP's submitted PIPs contained study indicators related to the quality, access, and timeliness domains. More specifically, all six PIPs provided an opportunity for AMERIGROUP to improve the quality of care for its members. The *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care.

## ***Peach State Health Plan***

### **Findings**

Five of Peach State's submitted PIPs were validated through Activity VI, while the remaining PIP was validated through Activity IX. Table 6-5 displays Peach State's performance across the six submitted PIPs and reports the overall PIP performance for this year's submission.

Table 6-5—Peach State Health Plan’s 2009–2010 PIP Performance

Activities	Access/ Service Capacity	Childhood Immunization	Lead Screening Rates	Member Satisfaction	Provider Satisfaction	Well-Child Visits	Overall Performance Across 6 PIPs
<b>Study Design</b>	<b>16/16 (100%)</b>	<b>17/17 (100%)</b>	<b>17/17 (100%)</b>	<b>17/17 (100%)</b>	<b>15/15 (100%)</b>	<b>17/17 (100%)</b>	<b>99/99 (100%)</b>
I. Choose the Study Topic(s)	5/5 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	4/4 (100%)	6/6 (100%)	32/32 (100%)
II. Define the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	12/12 (100%)
III. Select the Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	7/7 (100%)	6/6 (100%)	6/6 (100%)	37/37 (100%)
IV. Use a Representative and Generalizable Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	18/18 (100%)
<b>Study Implementation</b>	<b>5/5 (100%)</b>	<b>5/5 (100%)</b>	<b>5/5 (100%)</b>	<b>15/15 (100%)</b>	<b>12/12 (100%)</b>	<b>5/5 (100%)</b>	<b>47/47 (100%)</b>
V. Use Sound Sampling Techniques	0/0	0/0	0/0	6/6 (100%)	0/0	0/0	6/6 (100%)
VI. Use Valid and Reliable Data Collection Procedures	5/5 (100%)	5/5 (100%)	5/5 (100%)	9/9 (100%)	9/9 (100%)	5/5 (100%)	38/38 (100%)
VII. Include Improvement Strategies	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	3/3 (100%)	<i>Not Assessed</i>	3/3 (100%)
<b>Quality Outcomes Achieved</b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b>12/13 (92%)</b>	<b><i>Not Assessed</i></b>	<b>12/13 (92%)</b>
VIII. Data Analysis and Interpretation of Study Results	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	9/9 (100%)	<i>Not Assessed</i>	9/9 (100%)
IX. Assess for Real Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	3/4 (75%)	<i>Not Assessed</i>	3/4 (75%)
X. Assess for Sustained Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>
<b>Overall PIP Performance</b>							
Percentage Score of Evaluation Elements <i>Met</i>	100%	100%	100%	100%	98%	100%	99%
Percentage Score of Critical Elements <i>Met</i>	100%	100%	100%	100%	100%	100%	100%
Validation Status	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>

## Strengths

Peach State staff had a solid understanding of the activities and the documentation requirements needed for the study design and implementation of a PIP, as all six PIPs scored 100 percent of the evaluation elements *Met* for Activities I through VI. For overall PIP performance, one PIP scored 98 percent while the remaining five PIPs scored 100 percent.

At the activity level and for each of the six PIPs, all evaluation elements achieved a *Met* score for Activities I through VI. The one PIP that progressed to Activity IX also scored 100 percent for all applicable evaluation elements in Activities VII and VIII. All critical elements in each of the six PIPs were scored a *Met*.

Peach State's strengths were consistent across all six PIPs, including having adequate documentation of how the study topic was selected; appropriate and well-defined study questions and indicators; a sufficiently identified study population; an explanation of the sampling methodology; defined data collection procedures; and barrier-driven, system-level improvement strategies through data analysis and quality improvement processes.

## Opportunities for Improvement and Recommendations

HSAG identified opportunities for improvement for the one Peach State PIP that was validated through Activity IX, as one evaluation element did not receive a *Met* score in that activity. The element indicated the CMO's lack of statistical evidence to demonstrate real improvement in all the study indicators. In addition, HSAG documented five unique *Points of Clarification* for Peach State's PIPs. Based on these PIP validation results, HSAG recommended that:

- ◆ Peach State focus on and make appropriate changes to the evaluation elements that received either a *Point of Clarification* or a score of *Partially Met*, including those in Activity IX.
- ◆ Peach State carefully review each PIP across all activities before submission to ensure the consistency of statements made in more than one activity of the PIP and to ensure that results and processes are included correctly in the PIP Summary Form when working with vendors.

## Summary

Overall, Peach State had a solid understanding of the PIP requirements, especially those related to the study design and implementation of a PIP. Individual overall PIP scores ranged from 98 to 100 percent, with five of the six submitted PIPs scoring 100 percent. Peach State's strengths in conducting Activities I through VI were extremely consistent across all six PIPs. HSAG also identified opportunities for Peach State to further improve its performance. HSAG recommended that Peach State target its improvement efforts on those evaluation elements within Activity IX that did not receive *Met* scores and the *Points of Clarification* HSAG described for the PIPs Peach State submitted.

While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of Peach State's processes for conducting PIPs, HSAG also recognized that the PIPs Peach State submitted contained study indicators related to the quality and timeliness of, and access to,

care and services provided to members. More specifically, all six PIPs provided an opportunity for Peach State to improve the quality of outcomes for its members. The *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care. Finally, some study indicators for the *Member Satisfaction* PIP were identified as ones that addressed timeliness of care.

### **WellCare of Georgia, Inc.**

#### **Findings**

Five of WellCare's six submitted PIPs were validated through Activity VI, while the remaining PIP was validated through Activity IX. Table 6-6 displays WellCare's individual PIP and overall performance results across all activities.

Table 6-6—WellCare of Georgia, Inc.'s 2009–2010 PIP Performance

Activities	Access/ Service Capacity	Childhood Immunization	Lead Screening Rates	Member Satisfaction	Provider Satisfaction	Well-Child Visits	Overall Performance Across 6 PIPs
<b>Study Design</b>	<b>16/16 (100%)</b>	<b>17/17 (100%)</b>	<b>17/17 (100%)</b>	<b>17/17 (100%)</b>	<b>15/15 (100%)</b>	<b>17/17 (100%)</b>	<b>99/99 (100%)</b>
I. Choose the Study Topic(s)	5/5 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	4/4 (100%)	6/6 (100%)	32/32 (100%)
II. Define the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	12/12 (100%)
III. Select the Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	7/7 (100%)	6/6 (100%)	6/6 (100%)	37/37 (100%)
IV. Use a Representative and Generalizable Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	18/18 (100%)
<b>Study Implementation</b>	<b>5/5 (100%)</b>	<b>5/5 (100%)</b>	<b>5/5 (100%)</b>	<b>15/15 (100%)</b>	<b>18/18 (100%)</b>	<b>5/5 (100%)</b>	<b>53/53 (100%)</b>
V. Use Sound Sampling Techniques	0/0	0/0	0/0	6/6 (100%)	6/6 (100%)	0/0	12/12 (100%)
VI. Use Valid and Reliable Data Collection Procedures	5/5 (100%)	5/5 (100%)	5/5 (100%)	9/9 (100%)	9/9 (100%)	5/5 (100%)	38/38 (100%)
VII. Include Improvement Strategies	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	3/3 (100%)	<i>Not Assessed</i>	3/3 (100%)
<b>Quality Outcomes Achieved</b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b><i>Not Assessed</i></b>	<b>10/13 (77%)</b>	<b><i>Not Assessed</i></b>	<b>10/13 (77%)</b>
VIII. Data Analysis and Interpretation of Study Results	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	9/9 (100%)	<i>Not Assessed</i>	9/9 (100%)
IX. Assess for Real Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	1/4 (25%)	<i>Not Assessed</i>	1/4 (25%)
X. Assess for Sustained Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>
<b>Overall PIP Performance</b>							
Percentage Score of Evaluation Elements <i>Met</i>	100%	100%	100%	100%	93%	100%	98%
Percentage Score of Critical Elements <i>Met</i>	100%	100%	100%	100%	100%	100%	100%
Validation Status	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>

## Strengths

Based on this year's PIP performance, WellCare's staff demonstrated a strong understanding of all the review activities, as 98 percent of all the evaluation elements received a score of *Met* and 100 percent of all the critical elements were scored as *Met* across all six PIPs. The CMO had an excellent command of the requirements related to the study design of a PIP, with 100 percent of the applicable evaluation elements in this category scored as *Met* for all six PIPs. Performance for all six PIPs was also excellent related to the Study Implementation category, with 100 percent of the applicable elements scored as *Met*. Among the individual overall PIP scores, one PIP scored 93 percent while the five remaining PIPs scored 100 percent.

At the activity level and for each of the six PIPs, all evaluation elements achieved a *Met* score for Activities I through VI. The only PIP that progressed to Activity IX received *Met* scores for 100 percent of its applicable evaluation elements in Activities VII and VIII. All critical elements in each of the six PIPs were scored as *Met*.

WellCare's strength was consistent and impressive across all six PIPs. These strengths included having 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 three evaluation elements that did not receive a *Met* score, and HSAG documented only three unique *Points of Clarification* for each PIP. Based on the validation results for these PIPs, HSAG recommended that:

- ◆ WellCare focus on and make appropriate changes to the evaluation elements that received a *Point of Clarification* or a score of *Partially Met*, including those in Activity IX.
- ◆ WellCare carefully review each PIP across all activities before submission to ensure the consistency of statements made in more than one activity of the PIP and to ensure that results and processes are included correctly in the PIP Summary Form when working with vendors.

## Summary

Overall, WellCare staff had a solid understanding of the requirements for conducting PIPs, especially related to the study design and implementation of a PIP. Individual overall PIP scores ranged from 93 to 100 percent, with five of the six submitted PIPs scoring 100 percent. WellCare's strengths in conducting Activities I through VI were very consistent across all six PIPs.

HSAG also identified some opportunities for WellCare to improve its performance, including those related to evaluation elements in Activity IX that did not receive *Met* scores and those related to HSAG's documentation of *Points of Clarification* within the PIPs WellCare submitted.



While the primary purpose of HSAG's PIP validation methodology was to assess the validity and quality of processes for conducting valid PIPs, HSAG also identified that WellCare's submitted PIPs contained study indicators related to the quality and access domains. More specifically, all six PIPs provided an opportunity for WellCare to improve the quality of outcomes for its members. The *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care.

## Validation of Performance Measures

For the validation of performance measures, DCH required that the measures be calculated using NCQA's HEDIS<sup>®</sup> 2009 specifications. During the second contract year, HSAG validated the following set of six performance indicators selected by DCH:

- ◆ *Comprehensive Diabetes Care—HbA1c Testing (Hybrid)*
- ◆ *Use of Appropriate Medications for People With Asthma*
- ◆ *Well-Child Visits in the First 15 Months of Life—Six or More Visits (Hybrid)*
- ◆ *Childhood Immunization Status—Combination 2 (Hybrid)*
- ◆ *Lead Screening in Children (Hybrid)*
- ◆ *Adults' Access to Preventive/Ambulatory Health Services*

While the CMOs followed HEDIS specifications in reporting their performance measures, the validation of performance measures audit time frame was considered “HEDIS-like” as it was outside the standard HEDIS time frame. The audit was outside the scope of the standard HEDIS time frame because it was conducted retrospectively (after rates were submitted). Although the audit was considered “HEDIS-like,” it met the requirements and was conducted consistent with the CMS validation of performance measures protocol. Appendix C—Validating Performance Measures (PMs), contains a complete description of HSAG's methodology for this activity.

## AMERIGROUP Community Care

### Findings

Table 6-7 presents the results of HSAG's validation of AMERIGROUP's performance measures and the CMO's reported rates. The November 2009 Validation of Performance Measures Report for AMERIGROUP Community Care included additional details of the validation results. The *Childhood Immunization Status—Combination 2* rate was substantially lower than the national 2008 HEDIS Medicaid 10th percentile. It is important to note, however, that the rate for this measure was obtained using administrative data only, while national benchmarks include mostly hybrid results.

Table 6-7—Performance Measure Results for AMERIGROUP Community Care			
	Indicator	Reported Rate	Audit Designation
1.	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	74.50%	<i>Fully Compliant</i>
2.	<i>Use of Appropriate Medications for People With Asthma</i>	91.84%	<i>Fully Compliant</i>
3.	<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	62.25%	<i>Fully Compliant</i>
4.	<i>Childhood Immunization Status—Combination 2</i>	29.84%	<i>Fully Compliant</i>
5.	<i>Lead Screening in Children</i>	68.21%	<i>Fully Compliant</i>
6.	<i>Adults’ Access to Preventive/Ambulatory Health Services</i>		
	20 to 44 Years of Age	81.20%	<i>Fully Compliant</i>
	45 to 64 Years of Age	86.29%	

### Strengths

HSAG determined that AMERIGROUP’s processes related to data integration, data control, and performance indicator documentation were all acceptable. For medical record procurement and abstraction services, AMERIGROUP contracted with Outcomes, Inc., which demonstrated excellent processes for medical record abstraction. In addition, AMERIGROUP had sufficient processes in place for processing claims, enrollment, and provider data. Another noteworthy strength was AMERIGROUP’s use of an NCQA-certified software vendor to generate the HEDIS rates, newly implemented for this year’s calculation of HEDIS rates. An additional strength was the CMO’s rate for the *Use of Appropriate Medications for People With Asthma* measure, which almost reached the national 2008 HEDIS Medicaid 90th percentile of 91.9 percent. Finally, AMERIGROUP improved performance on its *HbA1c Testing* rate by using supplemental lab data obtained directly from its lab vendor. The use of these data was approved by the audit team to be compliant with NCQA requirements. Although the performance measure results from the prior year are not directly comparable due to different measurement periods (FY 2007 versus CY 2008), the *HbA1c Testing* rate increased by 15 percentage points to 74.50 percent, demonstrating a strength for AMERIGROUP.

### Opportunities for Improvement and Recommendations

Although AMERIGROUP did not have any data collection and reporting issues related to the measures, the CMO’s performance on these measures suggested opportunities for improvement. Only one measure, *Use of Appropriate Medications for People With Asthma*, was close to the national 2008 HEDIS Medicaid 90th percentile, and four of the seven measures ranked between the national Medicaid 50th and 75th percentiles. AMERIGROUP should evaluate which measures require targeted interventions to meet DCH’s performance targets.

### Summary

In general, AMERIGROUP demonstrated valid, sound processes for the calculation of performance measure rates, as indicated by its procedures for data integration and data control and its documentation of the performance indicators. HSAG’s only recommendation was to align the supplemental data sources with NCQA requirements.

HSAG also reviewed AMERIGROUP’s actual performance results for the indicators related to quality outcomes and the accessibility and timeliness of services provided to members. All of the performance measures were related to the quality domain. The *Adults’ Access to Preventive/Ambulatory Health Services* measure was also related to access. None of the measures was related to the timeliness domain. AMERIGROUP’s performance on measures designed to increase quality outcomes for members varied, with results for four of the seven measures ranking between the national 2008 HEDIS Medicaid 50th and 75th percentiles, and another measure nearly reaching the national 2008 HEDIS Medicaid 90th percentile. For the *Use of Appropriate Medications for People With Asthma* measure, AMERIGROUP’s performance was very close to the national 2008 HEDIS Medicaid 90th percentile (91.9 percent), suggesting strong CMO commitment to providing high-quality asthma care to its members. HSAG recommended that AMERIGROUP consider using the hybrid method for the *Childhood Immunization Status—Combination 2* measure to produce a rate comparable to the national HEDIS Medicaid percentiles. AMERIGROUP’s performance related to the access domain was reflected in the measure *Adults’ Access to Preventive/Ambulatory Health Services*. With rates between the national 2008 HEDIS Medicaid 50th and 75th percentiles, the CMO’s results were slightly above the national average for both the 20-to-44-year-old and 45-to-64-year-old age groups.

## Peach State Health Plan

### Findings

Table 6-8 presents the results of HSAG’s validation of Peach State’s performance measures and the reported rates. The November 2009 Validation of Performance Measures Report for Peach State Health Plan includes additional details of the validation results. Of note is that the PeachCare for Kids population was not included for all performance measures.

	<b>Indicator</b>	<b>Reported Rate</b>	<b>Audit Designation</b>
1.	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	64.23%	<i>Fully Compliant</i>
2.	<i>Use of Appropriate Medications for People With Asthma</i>	91.12%	<i>Fully Compliant</i>
3.	<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	51.58%	<i>Fully Compliant</i>
4.	<i>Childhood Immunization Status—Combination 2</i>	62.77%	<i>Fully Compliant</i>
5.	<i>Lead Screening in Children</i>	57.18%	<i>Fully Compliant</i>
6.	<i>Adults’ Access to Preventive/Ambulatory Health Services</i>		<i>Fully Compliant</i>
	20 to 44 Years of Age	78.88%	
	45 to 64 Years of Age	80.98%	

Note: Peach State reported all measures only for the Georgia Medicaid population; the PeachCare for Kids population was not included.

## Strengths

HSAG determined that Peach State's processes related to data integration, data control, and performance indicator documentation were all acceptable. For medical record procurement and abstraction services, Peach State contracted with Outcomes, Inc., which demonstrated excellent processes for medical record abstraction. In addition, Peach State had sufficient processes in place for processing claims, enrollment, and provider data. Another noteworthy strength was Peach State's use of an NCQA-certified software vendor to generate the HEDIS rates, newly implemented for this year's calculation of HEDIS rates.

## Opportunities for Improvement and Recommendations

Although Peach State did not have any data collection and reporting issues related to the measures, the CMO's performance on these measures suggested opportunities for improvement. For *Childhood Immunization Status—Combination 2*, Peach State performed between the national 2008 HEDIS Medicaid 10th and 25th percentiles. For *Comprehensive Diabetes Care—HbA1c Testing*, Peach State performed below the national 2008 HEDIS Medicaid 10th percentile. HSAG recommended that Peach State include all appropriate populations in the calculations of the performance measures. The CMO should also evaluate which measures require targeted interventions to meet DCH's performance targets.

## Summary

In general, Peach State demonstrated valid, reliable processes for the calculation of performance measures, as indicated by its procedures for data integration and data control and its documentation of performance indicators. HSAG's only recommendation was to align the supplemental data sources with NCQA requirements.

HSAG also assessed Peach State's actual performance results for the indicators related to quality outcomes and access to and timeliness of care and services provided to members. With only one exception, all of the performance measures were related only to the domain of quality. The *Adults' Access to Preventive/Ambulatory Health Services* measure was also related to access. No measures were related to the timeliness domain. Peach State's performances on the measures addressing quality outcomes varied, with four of the seven measures ranking between the national 2008 HEDIS Medicaid 25th and 50th percentiles and only one measure performing between the national 2008 HEDIS Medicaid 75th and 90th percentiles. The two remaining measures performed below the national 2008 HEDIS Medicaid 25th percentile. For the *Use of Appropriate Medications for People With Asthma* measure, Peach State's performance was very close to the national 2008 HEDIS Medicaid 90th percentile (91.9 percent), suggesting strong CMO commitment to providing high-quality asthma care to its members. Peach State's performance related to access to care and services was reflected in the *Adults' Access to Preventive/Ambulatory Health Services* measure. With rates between the national 2008 HEDIS Medicaid 25th and 50th percentiles, the CMO was performing below the national average for both the 20-to-44-year-old and 45-to-64-year-old age groups. This finding suggests opportunities for improvement in members accessing this service.

## WellCare of Georgia, Inc.

### Findings

Table 6-9 presents the results of the validation of performance measures and the reported rates. The November 2009 Validation of Performance Measures Report for WellCare of Georgia, Inc., includes additional details of the validation results. Through the validation process, HSAG noted that WellCare of Georgia, Inc., did not follow the HEDIS time frame for medical record review for all hybrid measures.

	<b>Indicator</b>	<b>Reported Rate</b>	<b>Audit Designation</b>
1.	<i>Comprehensive Diabetes Care—HbA1c Testing</i>	72.26%	<i>Fully Compliant</i>
2.	<i>Use of Appropriate Medications for People With Asthma</i>	90.58%	<i>Fully Compliant</i>
3.	<i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	57.42%	<i>Fully Compliant</i>
4.	<i>Childhood Immunization Status—Combination 2</i>	75.91%	<i>Fully Compliant</i>
5.	<i>Lead Screening in Children</i>	65.94%	<i>Fully Compliant</i>
6.	<i>Adults’ Access to Preventive/Ambulatory Health Services</i>		<i>Fully Compliant</i>
	20 to 44 Years of Age	78.64%	
	45 to 64 Years of Age	84.58%	

### Strengths

HSAG determined that WellCare’s processes related to data integration, data control, and performance indicator documentation were all acceptable. For medical record procurement and abstraction services, WellCare contracted with Outcomes, Inc., which demonstrated excellent processes for medical record abstraction. In addition, WellCare had sufficient processes in place for processing claims, enrollment, and provider data. For its supplemental data, WellCare confirmed that all data sources undergo the same staging process for de-duplication and other checks. Another noteworthy strength was that WellCare reported all but one measure (i.e., *Well-Child Visits in the First 15 Months of Life*) out of CRMS, an NCQA-certified software product. Source code for this one measure, although developed outside of the software certification, was approved on-site by HSAG.

### Opportunities for Improvement and Recommendations

HSAG recommended that WellCare continue enhancing its mechanism for tracking and monitoring rejected claims/encounters from the data clearinghouses. HSAG also suggested that WellCare implement a formal reconciliation process for its provider data between CACTUS, the initial database into which data is entered, and Paradigm, the database where data is eventually loaded.

## Summary

In general, WellCare employed acceptable processes for the calculation of performance measures, as indicated by its procedures for data integration and data control and its documentation of performance indicators. However, HSAG provided several recommendations, including those for improving its data clearinghouse mechanisms for tracking and monitoring, employing a formal reconciliation process for provider data, and aligning supplemental data with NCQA requirements.

HSAG also reviewed WellCare's performance on the indicators related to quality member outcomes and providing accessible and timely services to members. All but one of the performance measures were related only to the quality domain. The *Adults' Access to Preventive/Ambulatory Health Services* measure also related to the access domain. No measures were related to the timeliness domain. WellCare's performance varied across the quality measures, with three of the seven quality-related measures ranking between the national HEDIS 2008 Medicaid 50th and 75th percentiles, three ranking between the national HEDIS 2008 Medicaid 25th and 50th percentiles, and one measure ranking between the 10th and 25th percentiles. For three of the measures—*Use of Appropriate Medications for People With Asthma*, *Childhood Immunizations—Combination 2*, and *Lead Screening for Children*—WellCare performed between the national HEDIS 2008 Medicaid 50th and 75th percentiles. However, WellCare did not perform as well for the remaining measures, as three of them—i.e., *Well-Child Visits in the First 15 Months of Life—Six or More Visits* and the two *Adults' Access to Preventive/Ambulatory Health Services* measures—were between the national HEDIS 2008 Medicaid 25th and 50th percentiles. The *Comprehensive Diabetes Care—HbA1c Testing* measure was between the national HEDIS 2008 Medicaid 10th and 25th percentiles. Considerable opportunities exist for improving the rates for these four measures. WellCare's performance in the access domain was reflected in the measure, *Adults' Access to Preventive/Ambulatory Health Services*. With its rates between the national 2008 HEDIS Medicaid 25th and 50th percentiles, the plan was performing below the national average for the 20-to-44-year-old and 45-to-64-year-old age groups. This finding also suggests opportunities for improving performance for this measure of access to care and services.

## Suggestions and Other Considerations

While HSAG's primary role during these EQR activities was to evaluate and report on the validity of the CMOs' PIP and performance measure processes and data, HSAG also recognizes the importance of the CMOs demonstrating continuous improvement in the results of the PIPs and the rates achieved for the performance measures. For performance measures and PIPs that address HEDIS measures, HSAG, through its experience in working with numerous states, has identified various best practices related to improving HEDIS rates. To this end, the following initiatives and interventions have been found to be successful for other health plans in other states and are included as a resource for the CMOs when addressing similar barriers and desired outcomes identified within their own populations and the DCH Medicaid managed care environment. Supplemented by current literature, the following information serves only to augment DCH's and the CMOs' efforts in these areas. Whenever available and appropriate, evidence-based interventions are described that target specific areas and/or HEDIS rates, which HSAG identified as opportunities for CMO performance improvement.

Many of the same interventions implemented to improve well visits and access to care for other age groups are used to improve the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS measure results. One potential strategy includes a patient-centered care model to improve a patient's health outcomes and satisfaction. The Economic and Social Research Institute Report outlines barriers and lessons learned in implementing this approach.<sup>6-1</sup> While the Medicaid population is insured, navigating through the health care system can be challenging for members.

Components related to access include:

- ◆ Providing a "medical home."
- ◆ Keeping waiting times to a minimum.
- ◆ Providing convenient service hours.
- ◆ Promoting access and patient flow.
- ◆ Educating patients on how to access and navigate the health care system.

One method to operationalize this model includes developing a collaborative project such as a statewide PIP. HSAG has documented successful interventions for increasing member satisfaction with provider interactions and also for improving customer service and communication in the adult member population.

Interventions include:

- ◆ Keeping medical records for all family members in one folder.
- ◆ Providing Web-based clinical guidelines.
- ◆ Supplying refrigerator magnets with plan contact information to members.
- ◆ Encouraging patient-provider joint decision making through a "Patient Action Plan."

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<sup>6-1</sup> Silow-Carroll S, Alteras T, Stepnick L. Patient-Centered Care for the Underserved Populations: Definition and Best Practices. Economic and Social Research Institute. 2006.



- ◆ Providing a postvisit summary to members that includes the following: provider seen, location seen, diagnosis, medications being taken and/or prescribed, and referrals made.

The patient-centered care model and any related interventions can also apply to other HEDIS screening-related measures and chronic disease management.

The CMOs were required to report measure results using HEDIS specifications. However, based on this year's performance validation audit, the CMOs used different populations and data collection methodologies for generating their HEDIS measures. As such, the reported rates for four of the six measures were not comparable across CMOs, and statewide performance could not be summarized. DCH has clarified the reporting requirements and appropriate populations for future performance measure reporting. In addition, individual CMO performances on the *Comprehensive Diabetes Care—HbA1c Testing* measure showed that the rates for all three CMOs were below the national HEDIS 2008 50th percentile (79.6 percent), with two CMOs' rates falling below the 25th percentile (74.2 percent).

HSAG has documented several successful interventions that have been implemented to improve *Comprehensive Diabetes Care* HEDIS rates. Successful in this context is defined as achieving sustained improvement over several years. PIPs focusing on diabetes care have been effective in improving HEDIS rates corresponding to the *Comprehensive Diabetes Care* measures of *Eye Exam*, *HbA1c Testing* and *LDL-C Screening*. HSAG has compiled information from PIPs demonstrating sustained improvement for these HEDIS rates.<sup>6-2</sup> After identifying specific barriers from causal/barrier analyses, health plans have implemented one or more of the following interventions:

For both members and providers:

- ◆ Instituted a Diabetic Health Management Program
- ◆ Changed the benefit to eliminate referral requirements for diabetic members' annual eye exams
- ◆ Created a dedicated diabetes health management committee to develop and implement interventions and program improvements, and to review guidelines

For members:

- ◆ Identified diabetic members in a new member welcome call assessment
- ◆ Distributed health report cards to members with their testing and result history
- ◆ Provided incentives to members compliant with all screening requirements
- ◆ Distributed quarterly newsletters with diabetes articles and updates
- ◆ Contacted noncompliant members using reminder letters/calls

For providers:

- ◆ Informed providers of member incentives

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<sup>6-2</sup> Health Services Advisory Group. Validation of Performance and Quality Improvement Projects. Studies validated between 2004 and 2009.

- ◆ Sent report cards to providers documenting their care of diabetic members and included the identification of diabetic members, a summary of all diabetes services received, and a chart tool
- ◆ Recognized top-performing practitioners in diabetes care
- ◆ Mailed diabetes clinical care guidelines to practitioners, including an assessment tool
- ◆ Posted diabetes clinical care guidelines for practitioners on the Web site
- ◆ Distributed monthly newsletters to practitioners with articles related to diabetic guidelines and care

Interventions related to education, either for the member or practitioner, were more successful if they were repeated numerous times and the educational materials were distributed using varied modalities.

### **Complete Data**

Improving data completeness is a common goal among states. Three targeted components are: claims and encounter data, supplemental data sources, and vendor data from sources such as labs, radiology facilities, and pharmacies. Efforts to improve the submission of encounter data have the potential to improve all HEDIS rates as well as reduce the burden of medical record review. Regardless of the plan type, plans that establish a method to collect individual dates of service, either through global billing documentation requirements or the use of monitoring programs, have successfully decreased their reliance on medical record review and improved performance results. In addition, performing a data refresh of the encounter/claims data prior to the final reporting of HEDIS rates is valuable in producing more accurate and complete results and accounting for any lags in reporting.

Identifying supplemental data sources also appears to be successful in increasing data completeness. The use of state registries and even internal registries is valuable in identifying data that could be missing from administrative data. Other internal databases created from the collection of supplemental member data derived from standardized forms or electronic tools are additional methods to enhance data completeness. Another important source of supplemental data is noncontract entities that may be providing services. Plans could negotiate arrangements with these entities to obtain the data.

Plans that work closely with vendors such as labs, radiology facilities, and pharmacies seem to be able to enhance the completeness of their data. Once a secure contract is in place, oversight and ongoing monitoring are necessary. Reconciling vendor claims with test results often leads to improved rates. Many plans have found that creating a case management registry allows for the tracking of current lab results and prescriptions.

### **Identify Barriers**

In approaching barrier analysis, plans should identify and evaluate barriers to improvement in terms of the greatest impact. A comprehensive barrier analysis can assist in targeting interventions that would bring about the most effective results. Several Web sites provide reliable information on effective interventions. The AHRQ Health Care Innovations Exchange Web site documents

successful interventions addressing a wide range of barriers.<sup>6-3</sup> More importantly, it also provides examples of interventions that were not successful. A review of preventive service interventions with corresponding task force ratings can also be found on the Community Guide Web site.<sup>6-4</sup>

Interventions focused on providers can educate, inform, and/or reward providers. Data mining can highlight areas for improvement such as identifying missed opportunities, patterns of inadequate data submissions, and the omission of data sharing with registries. Supplying providers with feedback on their data serves to both educate and inform. In addition, implementing tracking tools and standardized forms has led to improved rates across numerous HEDIS measures. In conjunction with financial incentives based on achieving specific goals or benchmarks, pay for performance can also be used to promote quality improvement by awarding bonuses for significant improvement of HEDIS rates.<sup>6-5</sup>

Ideally, member interventions should specifically target identified barriers. Effective communication is necessary to address any cultural barriers and to educate and inform plan members of any required services. While several interventions are often implemented simultaneously, stepped interventions have been shown to be effective in improving rates for preventive services. Members are initially notified by mail of a required service. Those members who have not responded to the mailing are then called. Members who still have not responded to the two previous interventions are then provided case management and receive a home visit.<sup>6-6</sup>

### Share Best Practices

Ideally, health plans should be afforded the opportunity and routinely encouraged to share successes. Clearly documenting the details of an intervention and the results facilitate the transition from study to practice. Even if a plan does not plan to publish its study, adapting aspects of the Standards for Quality Improvement Reporting Excellence, or SQUIRE, permits a plan to share its successes in such a way that the results can be replicated by other plans.<sup>6-7</sup> The Center for Health Transformation has provided a location for each state to report its best practices for the Medicaid program. While outcomes are not provided, many states have included detailed descriptions of their successful initiatives/reforms.<sup>6-8</sup>

PIPs, most notably those conducted statewide, have the potential to improve statewide HEDIS rates. Through a statewide collaborative project, managed care organizations go through a formalized process for evaluating interventions, and through collective wisdom, are more likely to identify and develop evidence-based practices.

<sup>6-3</sup> AHRQ Innovations Exchange. Innovation and Tools to Improve Quality and Reduce Disparities. Available at <http://www.innovations.ahrq.gov/index.aspx>.

<sup>6-4</sup> The Community Guide. What works to promote health. Available at: <http://www.thecommunityguide.org>. Accessed August 7, 2009.

<sup>6-5</sup> Rosenthal MB, Fernandopulle R, et al. Paying For Quality: Providers' Incentives For Quality Improvement. *Health Affairs*. 2004. 23(2):127-141.

<sup>6-6</sup> Hambridge SJ, Phibbs SL, et al. A Stepped Intervention Increases Well-Child Care and Immunization Rates in a Disadvantaged Population. *Pediatrics*. 2009, 124(2):455.

<sup>6-7</sup> Davidoff F, Batalden P, et al. Publication Guidelines for Improvement Studies in Health Care: Evolution of the SQUIRE Project. *Ann Intern Med*. 2008, 149:670-676.

<sup>6-8</sup> Center for Health Transformation. Better Health, Lower Cost. Available at: <http://www.healthtransformation.net>. Accessed August 7, 2009.

## 7. Assessment of CMO Follow-up on Prior Recommendations

This section presents the improvement actions the CMOs took in response to recommendations HSAG made the prior year (2008–2009) as a result of its EQRO activities (i.e., review of compliance with federal Medicaid managed care regulations and the associated State standards, validation of PIPs, and validation of performance measures). The information provided as “follow-up” in this section was reported in documentation the CMOs submitted to HSAG.

### AMERIGROUP Community Care

#### *Compliance With Standards*

AMERIGROUP’s performance in complying with the federal Medicaid managed care regulations and the associated DCH contract requirements that HSAG reviewed for the first year of a three-year cycle of compliance reviews resulted in several recommendations to improve the CMO’s performance. For the requirements for which HSAG found AMERIGROUP’s performance as not fully compliant, AMERIGROUP was required to prepare and submit to DCH corrective action plans (CAPs) addressing each HSAG recommendation. Once the CAPs were approved, AMERIGROUP reported that it implemented the following performance improvement activities in response to each recommendation. The recommendations and the information AMERIGROUP submitted describing its follow-up actions are listed below. HSAG recommended that AMERIGROUP:

- ◆ Continue recruitment efforts to achieve a utilization management (UM) committee (or other committee that performs UM tasks) composed of network providers from each service area. Follow-up: AMERIGROUP successfully recruited an additional provider from each of the two areas that had not been represented on the CMO’s UM committee at the time of HSAG’s review.
- ◆ Revise its applicable policies/procedures, program descriptions, and other documents to: (1) clarify the decision and notification time frames for standard authorization decisions and extensions and for expedited authorizations and extensions and (2) ensure that the information in the documents is consistent across all applicable policies/procedures and other relevant documents. Follow-up: AMERIGROUP stated it had reviewed and, as needed, revised all relevant policies and procedures, program descriptions, and the member and provider manuals to ensure that they were consistent and accurate in addressing the time frames.
- ◆ Revise its policies/procedures and program descriptions to ensure that they accurately describe the requirements related to notices of action for decisions to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested. Information across all applicable documents must be consistent and compliant with Medicaid managed care regulations and the associated DCH contract requirements. Follow-up: AMERIGROUP revised its policies/procedures and program descriptions to ensure that they accurately and consistently described the requirements related to notices of action for decisions to deny a service

authorization request or to authorize a service in an amount, duration, or scope that is less than requested.

- ◆ Revise its applicable policies/procedures to ensure that they address the readability, language, and format of notices of action. Follow-up: AMERIGROUP reviewed and revised the applicable policies/procedures to address the readability, language, and format of notices of action.
- ◆ Revise its policies/procedures to ensure that they accurately describe the requirements related to the content of notices of action. All applicable documents must be consistent in content related to the requirement and comply with Medicaid managed care regulations and associated DCH contract requirements. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies and procedures and other documents to ensure that they accurately and consistently described the requirements related to the content of notices of actions.
- ◆ Revise its policies/procedures to accurately describe the requirements related to notices of action for denials of requests for services; authorizations in an amount, duration, or scope that is less than requested; and decisions that suspend, reduce, or terminate services that have been previously authorized. Information in all these documents must be consistent and comply with the applicable Medicaid managed care regulations and associated DCH contract requirements. Most importantly, the information must reflect AMERIGROUP's actual processes and practices. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies/procedures and other documents to ensure that they accurately and consistently described the requirements related to the content of notices of actions.
- ◆ While the payment dispute process is crucial to health plans and resolves the majority of payment denial challenges, once the final decision is made that a payment is denied with no further resolution possible, AMERIGROUP should consider this an action as defined in the Medicaid managed care regulations (see 42 CFR 438.400[b][3]). Therefore, AMERIGROUP should provide notice of action at the time it makes a final decision to deny payment of a provider claim. Follow-up: AMERIGROUP, with DCH's and HSAG's consultation and review, revised the notice—i.e., the Explanation of Benefits (EOB)—it provides to members when it denies payment to a provider for services provided to a member. The CMO prepared the revised notice in both English and Spanish following DCH's approval of the revision, and implementation was scheduled approximately 90 days following the approval.
- ◆ Revise policies/procedures or program descriptions to ensure that they address notification of members and providers of the authorization decision time frame (and resulting notice of action). All documents must comply with the applicable Medicaid managed care regulations and associated DCH contract requirements and must reflect AMERIGROUP's operations. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies, procedures, and other relevant documents to ensure that they accurately and consistently described the requirements related to notifying members and providers of authorization decision time frames (and resulting notices of action). AMERIGROUP also addressed the requirement to carry out decisions as expeditiously as a member's health condition requires and not later than the date the extension expires.
- ◆ Ensure that it has policies/procedures that address the requirement for providing notice of action if AMERIGROUP does not reach a decision for a standard and/or expedited authorization within the required time frame. All applicable policies/procedures and other written documents, and the CMOs' practices, must comply with the applicable Medicaid managed care regulations and associated DCH contract requirements and must reflect AMERIGROUP's operations and

practices. Follow-up: AMERIGROUP reviewed and, as applicable, revised its policies/procedures and other relevant documents to ensure that they accurately and consistently addressed the requirement for providing notice of action if AMERIGROUP does not reach a decision for a standard and/or expedited authorization within the required time frame.

- ◆ Use the prudent layperson standard to determine if visits to the emergency room were actual emergencies. AMERIGROUP must also inform members that the prudent layperson standard is used to determine if the member might be charged a copay for emergency services. Follow-up: AMERIGROUP made the decision to remove the copay from all emergency visits and revised all applicable documents accordingly, including the provider and member manuals and the Emergency Care—GA policy and procedure.
- ◆ Revise provider and member materials and applicable policies and procedures to specifically address the fact that AMERIGROUP will not charge members any more for out-of-network poststabilization services than it would charge had the services been obtained through an in-network provider. Follow-up: AMERIGROUP revised its provider and member manuals and applicable policies/procedures to address the CMO’s policy and practice of not charging members any more for out-of-network poststabilization services than it would have charged for services obtained through an in-network provider. AMERIGROUP submitted the revised member and provider manuals to DCH for review and approval.

### **Performance Improvement Projects**

As a result of its findings from validating AMERIGROUP’s PIPs, HSAG made the following recommendations:

- ◆ For the *Well-Child Visits During the First 15 Months of Life With Six or More Visits* PIP, HSAG recommended the following:
  - The documentation in Activity I should include a discussion regarding the eligible study population and the inclusion or exclusion criteria for members with special health care needs.
  - The study question should set the framework for the study. The study question should also reflect the focus of the study, which was to improve rates for six or more well-child visits in the first 15 months of life.
  - The study indicator should be completely defined, objective, and measurable. The PIP documentation should accurately reflect DCH specifications pertaining to the study indicator.
  - The guidelines used for the study indicator should be documented in the “description/rationale” of the study indicator.
  - The study indicator and the study question should align, allowing for the study indicator to answer the study question and be structured to measure changes in member health and functional status.
  - The study population definition should capture all members to whom the study question applies.
  - The documentation in Activity V should clearly specify that sampling techniques were not used and that the entire eligible population was used for the study.

- A defined and systematic process for the collection of baseline and remeasurement data should be outlined in the PIP documentation and include complete date ranges for each measurement period.
- The PIP should discuss the administrative data process that shows all activities involved in the production of the study indicator, and it should include the estimated degree of administrative completeness with the process of how the plan calculated the reported percentage.

Follow-up: AMERIGROUP reported that it took the following actions in response to HSAG's recommendations for this PIP:

- AMERIGROUP replaced the PIP HSAG reviewed with the collaborative PIP involving DCH, HSAG, and the three CMOs. Activity I of the new baseline PIP included a discussion of the eligible study population and included criteria for members with special health care needs.
  - The study question for the collaborative PIP was agreed to and approved by DCH, HSAG, and the three CMOs and reflected the focus of the study.
  - The study indicator was completely defined, with the numerator and denominator following HEDIS specifications. The study indicator and study question were aligned to allow the indicator to answer the study question. The study indicator was structured to measure changes in member health and functional status.
  - The study population definition captured all members to whom the question applied. The study question for the collaborative PIP was restated to maintain the focus of the study.
  - Documentation was added stating that sampling was not used and that the entire eligible population was used for this study.
  - The resubmitted PIP documented a defined and systemic process for collecting baseline and remeasurement data with date ranges.
  - The resubmitted PIP described an administrative process that shows the activities involved in the production of the study indicator.
  - The resubmitted PIP provided documentation of the estimated degree of administrative data completeness and the process used to calculate the percentage of completeness.
- ◆ For the *Improving Childhood Lead Rates* PIP, HSAG recommended the following:
- The documentation in Activity I should include a discussion regarding the eligible study population.
  - Activity I should include the inclusion or exclusion criteria for members with special health care needs.
  - The study question should set the framework for the study. The study question should be restated to reflect the focus of the study, which was to increase the percentage of members who received at least one blood lead screening on or before 25 months of age.

- The study indicator should be completely defined, objective, and measurable. The PIP documentation should accurately reflect the DCH specifications pertaining to the study indicator.
- The guidelines used for the study indicator should be documented in the “description/rationale” of the study indicator.
- The study indicator and study question should align, allowing for the study indicator to answer the study question and be structured to measure changes in member health and functional status.
- The study population definition should capture all members to whom the study question applies.
- The documentation in Activity V should clearly specify that sampling techniques were not used and that the study used the entire eligible population.
- The PIP documentation should outline a defined and systematic process for the collection of baseline and remeasurement data and include complete date ranges for each measurement period.
- The PIP should discuss the administrative data process that shows all activities involved in the production of the study indicator, and it should include the estimated degree of administrative completeness with the process of how the plan calculated the reported percentage.

Follow-up: In response to HSAG’s recommendations for this PIP, AMERIGROUP reported the following information and actions:

- The PIP HSAG reviewed was replaced with a new baseline PIP using administrative HEDIS specifications. Activity I of the new baseline PIP included a discussion of the eligible study population and the inclusion criteria for members with special health care needs.
- The study question for the new baseline PIP was restated and reflects the focus of the study.
- The study indicator was completely defined, with the numerator and denominator following HEDIS specifications. The study indicator and study question were aligned to allow the indicator to answer the study question. The study indicator was structured to measure changes in member health and functional status.
- The study population definition captured all members to whom the study question applied. The study question for the new baseline PIP was restated to maintain the focus of the study.
- Documentation was added stating that sampling was not used and that the entire eligible population was used for this study.
- The PIP documented a defined and systemic process for collecting baseline and remeasurement data with date ranges.
- The PIP described an administrative process that shows the activities involved in the production of the study indicator.
- The PIP documented an estimated degree of administrative data completeness and the process used to calculate the percentage of completeness.



- ◆ For AMERIGROUP's *Provider Satisfaction* PIP, HSAG recommended the following:
  - The PIP should include the data in Activity I as background information as to why the CMO wanted to focus on Questions 7, 8, 9, and 17.
  - Activity I should include a discussion of the eligible study population and how the providers were broken out for the study.
  - The PIP should document complete date ranges for the measurement period dates.
  - In addition to providing information regarding the basis for each study indicator in Activity VIII, the PIP should also document the information in Activity III. Information regarding the "key driver analysis" by the vendor should also be included in the rationale for each study indicator.
  - The PIP should include a complete definition of the study population that includes an anchor date for when the provider list is pulled.
  - If a particular study indicator requires that a provider be contracted with the CMO for a length of time, then the required contract time should be documented in the study population.
  - The PIP documentation should include the provider population size. The sampling techniques should ensure a representative sample of the eligible population and be in accordance with generally accepted principles of research design and statistical analysis.
  - The PIP documentation should outline a defined and systematic process for the collection of baseline and remeasurement data and include complete date ranges for each measurement period.
  - The PIP should include the qualifications, experience, and training of the data collection staff (phone survey).
  - An overview of the purpose of the study should be included on the provider survey. If a cover letter was provided to the providers, this should be included with the PIP submission.
  - The PIP should include a complete description of the data collection process. The PIP should provide a flow chart or algorithm that shows the production of the study indicators.

In response to HSAG's recommendations, AMERIGROUP reported that it took the following corrective actions:

- AMERIGROUP added plan-specific data to Activity I as background information as to why the CMO focused on Questions 7, 8, 9, and 17. Discussion of the eligible study population and the inclusion criteria for members with special health care needs were added to Activity I.
- AMERIGROUP added complete date ranges for the measurement periods. Documentation of information regarding the basis for each study activity was added to the PIP. The key driver analysis was also added.
- The resubmitted PIP documented the complete definition of the study population, including the anchor date for when the provider list was pulled. There was no requirement for length of service as an in-network provider to be part of the survey sample, and this was documented in the PIP.

- The resubmitted PIP included the provider population size and sampling techniques and added the number of PCPs and specialty care providers (SCPs) selected from each of the segments that make up the providers selected as part of the sample frame. A vendor conducted sampling techniques using acceptable principles of research and statistical design.

## Performance Measures

As a result of its findings from validating AMERIGROUP's performance measures, HSAG made just two recommendations:

- ◆ AMERIGROUP should create a data freeze for the data used to generate the measures to ensure that the same original data can be used if the queries need to be run again. Follow-up: As the methodology and specific performance measures were changed for the second year of the contract, AMERIGROUP began using HEDIS specifications.
- ◆ AMERIGROUP should continue to ensure that all data are being received from capitated providers. Follow-up: AMERIGROUP reported that this was an ongoing challenge when using medical record chart review to identify potential issues related to claims submission for services rendered. The CMO enhanced its provider education to address this issue through contact with provider relations staff members and other communication mechanisms.

While not related to the validity of its performance measure calculation and reporting processes, the actual rate of 59.3 percent attained for the HbA1c measure represented an additional opportunity for improvement. Follow-up: AMERIGROUP reported that its initiatives to improve the rates included enhancing member outreach by the CMO's vision vendor and enhancing AMERIGROUP's vision benefit to include members older than 21 years of age.

## Peach State Health Plan

### Compliance With Standards

HSAG's findings from its review of Peach State's performance in complying with federal Medicaid managed care regulations and the associated DCH contract requirements that HSAG reviewed for the first year of a three-year cycle resulted in several recommendations to improve the CMO's performance. For the requirements for which HSAG found Peach State's performance as not fully compliant, the CMO was required to prepare and submit to DCH corrective action plans addressing each HSAG recommendation. Once the CAPs were approved, Peach State submitted documentation demonstrating that the CMO implemented the performance improvement activities described below in response to each recommendation. HSAG recommended the following:

- ◆ The CMO must ensure that it provides sufficient detail in its cultural competency plan (e.g., specific actions/activities planned, goals/objectives for each, evaluation methodologies, timelines for milestones and completing the activities, and individuals/organizational units accountable for each) that describes specific, planned actions/activities and provides the basis upon which the CMO can evaluate its performance in meeting the goals and objectives. Follow-

up: Peach State reported that during the year, it implemented numerous activities to ensure that it had a comprehensive cultural competency program. These activities included the following:

- The CMO continued to increase its presence in the community through participation in collaborative meetings and health fairs with faith- and community-based organizations. Peach State described numerous, specific examples of these activities.
  - Peach State recognized various cultures by participating in heritage appreciation month, including articles in its employee newsletter, and participating in community events. Peach State provided specific examples.
  - In 2009 Peach State launched the following internship and emerging talents programs (e.g., the General Internship Program), which included three general interns with various educational backgrounds who participated in an 8–10 week internship; the Professional Internship Program, which included three fourth-year pharmacy students who participated in a five-week internship; and Emerging Talent—The 2009 Inaugural Class, which included six inductees from different internal departments. The program included a diverse group of emerging top performers, providing opportunities to further develop their talent and leadership skills related to cultural competency.
  - Peach State’s Human Resources Department began participating in the Consortium for Graduate Study in Management. The consortium is the country’s preeminent organization for promoting diversity and inclusion in American business. Peach State employees are receiving ongoing cultural competency and diversity training.
  - Peach State employees completed the annual diversity training offered through Centene University: Centene 101 Diversity and Anti Harassment Course 46. Peach State described several additional training programs the CMO provides.
  - Peach State employees received annual compliance and ethics training, which included informing them about the importance of being compliant with the cultural competency strategic plan.
- ◆ Peach State must revise applicable documents related to standard authorization decision time frames and extensions to reflect actual Peach State practice, provide contracted providers with accurate information, and reflect consistency across documents. HSAG strongly encourages Peach State to consider using extension time or, at a minimum, more of the CMS-allotted 14 calendar days for decisions and notifications when additional information is required. Follow-up: Peach State reported that in addition to updating its policies and procedures and related documents that address timeliness of UM decisions and notifications, the CMO initiated several additional actions to address HSAG’s recommendations. These actions included: (1) staff retraining—effective January 2009, the UM staff is retrained each quarter on UM policies and procedures, including clinical guidelines and decision time frames; and (2) weekly file audits—effective October 2008, all managers review and audit random files for each staff member and provide weekly feedback to the staff on areas of excellence and areas needing improvement.
  - ◆ Peach State must ensure that its delegate complies with CMS’ and DCH’s required time frames for authorization of services. Follow-up: Peach State reported that in May 2009, the CMO advised each vendor that the applicable policies and procedures and practices had to be updated to align with the time frames required by CMS and the DCH contract; vendors were required to provide copies of their newly updated policies and procedures to Peach State as part of their delegated oversight activities; and the CMO’s UM audit tool was updated to reflect these time frames to ensure that the correct standards are applied during reviews of delegated functions.

- ◆ Peach State must revise applicable documents related to expedited authorization decision time frames and extensions to reflect Peach State's practice, provide contracted providers with accurate information, and reflect consistency across documents. Follow-up: Peach State updated applicable policies and procedures, the relevant section in the provider manual, and the UM and call center staff training material to include references to these time frames.
- ◆ Peach State must revise its Adverse Determinations (Denial) Notices policy to address notices of action sent to members and providers for any decision to authorize a service in an amount, duration, or scope that is less than requested. Follow-up: Peach State: (1) added to the applicable policy to show that all adverse determination notifications for services that are authorized in an amount, duration, or scope that is less than requested are sent to both the member and provider and (2) added the requirement to the denial and appeal coordinators' training and conducted ongoing oversight of the process.
- ◆ Peach State must revise the applicable policy to address the format of notice of proposed adverse action letters. Follow-up: Peach State updated its applicable policy to note that the Spanish version of the adverse determination letter is available to members and to provide direction for hearing and visually impaired members for accessing assistance. The information the CMO provided stated that the changes were made to the notice of proposed action letter template, which directs members who have trouble understanding the letter to the member services call center for assistance. The letter template was reviewed and approved by DCH and judged to be at a fifth-grade reading level.
- ◆ Peach State must revise its policies and processes to be consistent with each other 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. Follow-up: Peach State: (1) revised the applicable policies to add language addressing proposed actions to terminate, suspend, or reduce previously authorized, covered services; and (2) trained denial and appeal coordinators on the process.
- ◆ Since the DCH contract requires that CMOs have written policies and procedures that address each requirement in the UM section of the contract, once Peach State determines how it will handle (or if it will allow) time frame extensions, it must develop or revise applicable policies and other documents to reflect Peach State's practice and inform providers and/or members of the process. Follow-up: Peach State reported that it revised the applicable policies and letter templates or, in some instances, developed new ones to address extensions of time frames. The CMO trained UM staff and call center representatives on extensions of time frame requirements, including the process for requesting an extension, appropriate extensions, and the process for approving a request for an extension. Peach State developed a letter template in early 2009 to direct the process for possible requests for an extended time frame.
- ◆ Since the DCH contract requires that CMOs have written policies and procedures that address each requirement in the UM section of the DCH contract, Peach State must develop policies that address standard and expedited authorization decisions not reached within the required time frames and the process for sending the resulting notice of action. Follow-up: Peach State updated the applicable policy to address authorization decisions not reached within the required time frame. The CMO also developed a letter template for this purpose and trained UM staff and call center representatives on handling such events.

## Performance Improvement Projects

Based on its prior-year EQR findings from validating three Peach State Health Plan (PSHP) PIPs, HSAG recommended that the CMO implement a number of enhancements to improve the future validity of its PIPs.

- ◆ For the *Improving Blood Lead Screening Rates in PSHP Children Age 24 Months* PIP, HSAG’s recommendations were that:
  - The study question should set the framework for the study and be answerable through the study indicator. Follow-up: The CMO revised the question to read: “Do standard blood lead testing promotional activities by Peach State Health Plan targeted to parents and providers increase the number of blood tests performed on Peach State’s members age 24 months during the measurement period?”
  - The study indicator should align with the study question. Follow-up: Peach State revised the study indicator to read: “The percent of members, age 2 in the reporting period, who received a blood test screening and who were continuously enrolled 12 months during the measurement period.”
  - The study population should be completely and accurately defined and should capture all eligible members to whom the study question applies. Follow-up: The CMO further defined the study population to include the data type, eligibility, time frame, source code, and procedure code as provided by Thompson-Reuters on October 22, 2008.
  - Future submissions of the PIP should include the date range for data collection for Remeasurement 2. Follow-up: Peach State included the timeline for collecting baseline and remeasurement data.
- ◆ For the *Well-Child Visits During Their First 15 Months of Life With Six or More Visits* PIP, HSAG recommended the following:
  - Activity I should include a discussion of the eligible population. Follow-up: Peach State enhanced the discussion of the eligible population to include the following: (1) children, age 0 to 2 years of age, represent 16 percent of PSHP’s population as of December 31, 2008; (2) the eligible population includes all children who turned 15 months of age in 2008, were continuously enrolled from 31 days after birth to 15 months of age, and had no more than a one-month gap in coverage, as enrollment is verified monthly for Medicaid beneficiaries; (3) children represent a high-volume, high-risk group of PSHP members; (4) no special needs children were excluded; and (5) the study was selected as the Georgia CMO collaborative PIP project.
  - The study question should set the framework for the study and be answerable through the study indicator. Follow-up: The CMO rewrote the study question to state: “Does directing targeted interventions to providers and parents of children aged 15 months and under, increase the rate/percentage of PSHP children who have the recommended six plus well child visits before their 15 month birthday?”
  - The study indicator should align with the study question. Follow-up: Peach State rewrote the selected study indicator to read: “The percent of members who turned 15 months in the reporting period and who received the recommended six or more well-child visits with a PCP during their first 15 months of life.”

- The study population should capture all eligible members to whom the study question applied. Follow-up: The CMO defined the study population as follows: “The eligible population is identified based on the following criteria: all Medicaid and PeachCare for Kids children who turn 15 months of age during 2008; the anchor date applied towards this measure was the day the child turns 15 months old; continuous enrollment from 31 days after birth to 15 months of age; had no more than a one-month gap in coverage, as enrollment is verified monthly for Medicaid beneficiaries; and no special needs children were excluded.”
- Activity VI should include complete timelines for both the baseline and remeasurement periods. Follow-up: On resubmission of the PIP, Peach State included the timeline for collecting baseline and remeasurement data.
- Future submissions of the PIP should specify the process the CMO used to identify barriers (e.g., brainstorming, fishbone diagramming, etc.). Follow-up: Peach State stated in the documentation submitted to HSAG that in the 2009–2010 submission, the PIP activity was again one of collecting baseline measurement data due to the PIP becoming a collaborative PIP for all of the CMOs. Therefore, identifying causes/barriers through data analysis and quality improvement processes was not applicable as the study had not progressed to the point of developing and implementing improvement strategies.

For Peach State’s *Provider Satisfaction* PIP, HSAG recommended that:

- The survey results that determined the key drivers for the study indicators should be included in Activity I; Activity I should include a discussion of how the study topic, provider satisfaction, addresses a broad spectrum of care and services; and future submissions of the PIP should include a discussion in Activity I of the eligible study population and how the providers were broken out in the study. Follow-up: Peach State revised the study topic to include information about the survey respondents for 2007 and 2008, such as the specialty, number of doctors in practice, years in practice, and managed care volume of practice. In addition, Peach State reported that the key drivers of satisfaction for both 2007 and 2008 and the correlation coefficients were included in the PIP resubmission.
- Future submissions of the PIP should restate the study questions as discussed in detail in the PIP Validation Tool, the PIP should include complete date ranges when referencing measurement periods and data collection timelines, and the PIP should include a more descriptive basis for the study indicators as discussed in detail in the PIP Validation Tool. Follow-up: The CMO rewrote the study question as follows: “Will health plan actions (interventions) designed to increase PCP provider satisfaction improve scores of targeted questions on the provider satisfaction survey?” Peach State also rewrote the study indicators and added complete date ranges when resubmitting the PIP.
- The PIP should include a complete definition for the study population that includes an anchor date for when the provider list is pulled. The PIP should also explain that if a study indicator requires that a provider be contracted with the CMO for a certain length of time, the required time should be documented in the study population. Follow-up: In describing its follow-up actions, Peach State stated that the dates indicating when the provider lists were pulled were added to the resubmissions. The resubmissions also stated that there was no requirement for length of time providers were contracted with the CMO.

- The PIP should include a complete description of the data collection process and a flow chart or algorithm that shows the production of the study indicators. The PIP documentation should provide information on the training provided to staff responsible for conducting the phone surveys, as well as the qualifications and experience of this staff. Activity VI should include complete date ranges for all remeasurement data collection timelines. Instructions for conducting the phone survey should be provided if they are different than the instructions on the mailed survey. The PIP should provide a detailed explanation of how the responses from the Internet and phone surveys will be combined with the mail option. An overview or purpose of the study should be included in the written instructions for the survey. (A cover letter that accompanies the provider survey would also be acceptable.) Follow-up: The CMO stated that all the information listed above was obtained and added as attachments or embedded in the PIP resubmission.
- Activity VII should provide an explanation of the two tables provided. Follow-up: After further review, Peach State determined that the second table was redundant and removed it for the resubmission of the PIP.

### **Performance Measures**

Based on its prior-year EQR findings from validating Peach State's performance measures, HSAG recommended the following:

- ◆ Peach State should save final numerator and denominator files used to calculate reported rates and put in place 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). Follow-up: Peach State's documentation describing its follow-up stated the CMO now: (1) saves numerator and denominator information within the CRMS HEDIS warehouse, where the calculation is performed and member-level information is stored; (2) reviews numerators and denominators at the time of initial warehouse availability and prior to reporting to confirm appropriate selection for the measure as well as to check for compliance/noncompliance with the specifications, (3) selects 10 to 15 members from the populations, and (4) reviews the claims history in Amisys to confirm compliance or noncompliance.
- ◆ HSAG recommends that Peach State save the final numerator and denominator files used to calculate reported rates and archive quarterly files that are run for performance measure reporting for future reference and validation activities. Follow-up: In documenting its follow-up actions, Peach State stated that: (1) the CMO had contracted with McKesson for the HEDIS CRMS software package, (2) HEDIS warehouses are built and maintained in this platform annually for HEDIS as well as quarterly for project management purposes, (3) quarterly warehouses are available for 9 to 12 months, and (4) reportable annual HEDIS rates are maintained for 3 to 4 years.

In addition, the actual rates attained for both measures (i.e., 73 percent for HbA1c testing, which was below the national HEDIS Medicaid 10th percentile, and 80.11 percent for appropriate medications for asthma) represented opportunities for improvement. Follow-up: In documenting its follow-up actions, Peach State stated that the rates resulted from following the HEDIS-like specifications the State used for the time frame of October 1, 2006, through September 30, 2007. Subsequent to this, Peach State transitioned to the HEDIS specifications as directed by DCH, and

the 2009 HEDIS year was a baseline against the formal HEDIS specifications. In 2009, following the results of its second HEDIS season, Peach State established a data team to review and improve data capture and completeness. The data team investigated its data extract and loading processes to ensure data completeness and to identify any potential areas for improvement, and conducted an intensive mapping session held in September 2009 that revealed several actionable items. Peach State reported that the results of this team's investigation should be reflected in the HEDIS 2010 reported rates.

## WellCare of Georgia, Inc.

### Compliance With Standards

HSAG had only two recommendations for WellCare related to its performance for the first year of HSAG's external quality review of the CMO's performance in complying with the standards HSAG reviewed. Both recommendations addressed the written information the CMO communicated to members and providers related to emergency services. WellCare was required to revise the information to clearly communicate that authorization was not required for emergency services and to avoid language in communicating with members that could potentially discourage them from seeking needed emergency services. Follow-up: WellCare submitted a CAP to DCH addressing each recommendation/required action. Following approval of the CAP, the CMO stated in documentation submitted to HSAG that WellCare: (1) revised its member and provider written information to ensure it clearly communicated that authorization was not required for emergency services and (2) revised its member informational materials to ensure they did not unintentionally discourage members from seeking emergency care, including affirmatively stating that there was no copay for emergency services.

### Performance Improvement Projects

As a result of its validation of WellCare's PIPs, HSAG had a limited number of recommendations associated with the CMOs' performance for each of the three PIPs HSAG validated.

- ◆ For the *Improving Lead Screening Rates for Members Birth to 24 Months of Age* PIP, HSAG recommended the following: (1) future submissions of the PIP should provide complete date ranges for data collection timelines, (2) documentation for Activity VI should discuss the process used to calculate the estimate of 100 percent administrative data completeness, and (3) the PIP should include the type of process used to identify the barriers (e.g., brainstorming or fishbone diagramming). Follow-up: In response to the recommendations, WellCare's HEDIS 2008–2009 improving lead screening PIP included the data collection timelines in Activity VIb and a completeness statement that outlined how the estimated degree of automated data completeness was determined. WellCare also reported that because the methodology changed from HEDIS-like to HEDIS, the 2008–2009 CMO submission required documentation only through Activity VI. Therefore, documentation of the methods for identifying barriers was not applicable for the 2008–2009 submission.



- ◆ For the *Well-Child Visits During the First 15 Months of Life With Six or More Visits* PIP, HSAG recommended the following: (1) future submissions of the PIP should provide complete date ranges for data collection timelines, (2) Activity VI should discuss the process used to calculate the estimate of 100 percent administrative data completeness, and (3) the PIP should include the type of process used to identify barriers (e.g., brainstorming or fishbone diagramming). Follow-up: In response to the recommendations, WellCare stated that its HEDIS 2008–2009 well-child visits in the first 15 months of life PIP included the data collection timelines in Activity VIb. The CMO will continue to include this information in future PIP submissions. Activity VI included a completeness statement that outlined how the estimated degree of administrative data completeness was determined. The CMO was required to submit only Activities I–VI for the 2008–2009 submission. Documentation of the methods for identifying barriers was not applicable for the 2008–2009 submission.
- ◆ For the *Provider Satisfaction* PIP, HSAG recommended the following: (1) the PIP should include a complete definition for the study population that includes an anchor date for when the provider list is pulled; (2) if a study indicator requires that a provider be contracted with the CMO for a certain length of time, the required time should be documented in the study population; (3) the PIP documentation should discuss the training and experience of the Meyers Group staff conducting the phone surveys; (4) when a phone survey is used for nonresponders, future submissions of the PIP should provide the instructions given to staff if they were different than the instructions included on the mailed survey; and (5) an overview or purpose of the PIP should be included on the survey instructions, or a cover letter to providers explaining the purpose of the survey should be included as part of the PIP. Follow-up: In response to the recommendations, WellCare stated in the documentation describing its follow-up actions that the CMO:
  - Added the following to the revised version of the PIP submitted to HSAG September 4, 2009, in the first paragraph of Section D, Activity IV: “The provider population data was pulled in February 2009 and included the entire physician practitioner network who were contracted with the CMO for all 12 months of the measurement year with an anchor date of December 31, 2008.”
  - Added text to Section F, Activity VIa, stating, “The Research Analyst involved with this PIP has 4 years of SPSS programming experience analyzing health care data. For the CATI (i.e., Computer Assisted Telephone Interviewing) staff, TMG (i.e., The Myers Group) performs regular, simultaneous visual and audio, unobtrusive electronic monitoring of interviewers and maintains a ratio of monitors to interviewers of at least 1:9.”
  - Added Attachment I, “Interviewer Training May 2008 TMG.doc” and Attachment H, “CATI Training Methods and Quality Assurance.doc.”
  - Added Attachment E, “WCGA Provider Sat CATI Script.pdf.”

## Performance Measures

As with the compliance review, HSAG had only two recommendations for WellCare to further strengthen its performance related to the validity of its data reported for the DCH-required measures.

HSAG encouraged WellCare to consider implementing encounter data-to-medical record audits to ensure that data obtained by high-volume providers are complete and accurate. In addition, HSAG recommended that WellCare continue its close monitoring of its subcapitated providers to ensure that the data are complete. Follow-up: WellCare reported that it initiated an encounter data-to-medical records audit process that included using an Excel tool to randomly determine the specific member records for review. WellCare used a medical record vendor to review the records at the applicable provider office and to complete a specialized claims validation survey tool. In response to HSAG's second recommendation, WellCare stated in documentation related to its follow-up that the CMO's processes include monthly evaluations of the data submitted by capitated providers, including trending month-over-month and year-over-year changes to identify any potential data issues.

While not related to the validity of the data, HSAG also noted that the actual rates obtained for both the measures HSAG validated (appropriate asthma medications and HbA1c testing) represented further opportunities for improvement. Follow-up: For the asthma measure, WellCare's follow-up documentation stated that the CMO took the following actions designed to improve the CMO's performance results:

- ◆ Contracted with a community agency specifically focused on the disease state to provide in-home asthma assessments and conduct education on the asthmatic condition to members in the Atlanta region. Staff from the agency also trained WellCare outreach workers so the service could be provided in all regions statewide.
- ◆ Secured peak flow meters, nebulizers, pest control agents, and sheet casings to distribute during the in-home visits.
- ◆ Conducted in-home visits with members who needed improved medication management and performed both an environmental and educational assessment, reinforced the PCP's asthma treatment plan, conveyed the importance of taking/using medications appropriately, provided education on the proper use of peak flow meters and nebulizers, assisted with PCP appointments, and facilitated community agency referrals as needed.
- ◆ Arranged for information from home visit assessments to be uploaded to the WellCare disease management system, enabling reinforcement of the educational message upon repeat contact with the member.
- ◆ Informed involved PCPs:
  - By letter, of those members on their panel who would receive a communication regarding the availability of this outreach initiative.
  - Through in-office consultation of members in need of improved medication management and assisted the provider practice with member appointment scheduling as needed.

To address the rate of HbA1c testing, WellCare stated that the CMO:

- ◆ Developed a community educational offering on diabetes, which consisted of educational material promoted by the ADA. Appropriate testing, including the importance of HbA1c testing at regular intervals, was emphasized. The offering included providing a glucometer and pharmaceutical consultation regarding medication use.

- ◆ Invited members to the community educational offering who, based on the lack of HbA1c testing, were in need of focused education on diabetes. For members presenting with the comorbidity of high blood pressure, communication also referenced instruction on securing and using a blood pressure cuff.
- ◆ Conducted sessions with members in need of diabetic education, who could be reached.
- ◆ Educated the members on the self-management aspects of diabetes, such as the importance of diet, regular monitoring of blood sugar, and taking medication consistently (as appropriate).
- ◆ Instructed members on appropriate equipment use (glucometer and blood pressure cuff), reviewed current medications, scheduled PCP appointments, and facilitated community agency referrals as needed.
- ◆ Arranged for information provided during educational sessions to be uploaded into the WellCare disease management system, enabling reinforcement of the educational message upon repeat contact with the member.

### Introduction

This section provides a high-level overview of the statewide CMO performance and a comparison of the CMOs' individual performance for each of the three mandatory EQR activities HSAG conducted.

### Plan Comparisons

#### *Review of Compliance With Operational Standards*

#### Findings

Figure 8-1 compares the percentages of applicable requirements scored as *Met*, *Partially Met*, and *Not Met* across the three CMOs for all six standards HSAG reviewed. These percentages were derived by strictly dividing the total number of *Met* and *Partially Met* elements by the total number of applicable elements. Figure 8-1 shows that the Georgia Families CMOs demonstrated excellent performance for Standard III—Member Rights and Protections, with performance for all of the applicable requirements receiving a score of *Met*. None of the CMOs received a score of *Not Met* for all the requirements within a standard. Nonetheless, CMO performance varied widely for Standard I—Provider Selection, Credentialing, and Recredentialing; Standard II—Subcontractual Relationships and Delegation; and Standard VI—Disenrollment Requirements and Limitations, with at least one CMO having all requirements scored as *Met* and one CMO with at least 20 percent of the requirements scored as *Partially Met*. Across all the CMOs, at least 15 percent of the applicable requirements were scored as *Partially Met* for Standards IV and V.

Figure 8-1—CMO Compliance with Requirements by Standard

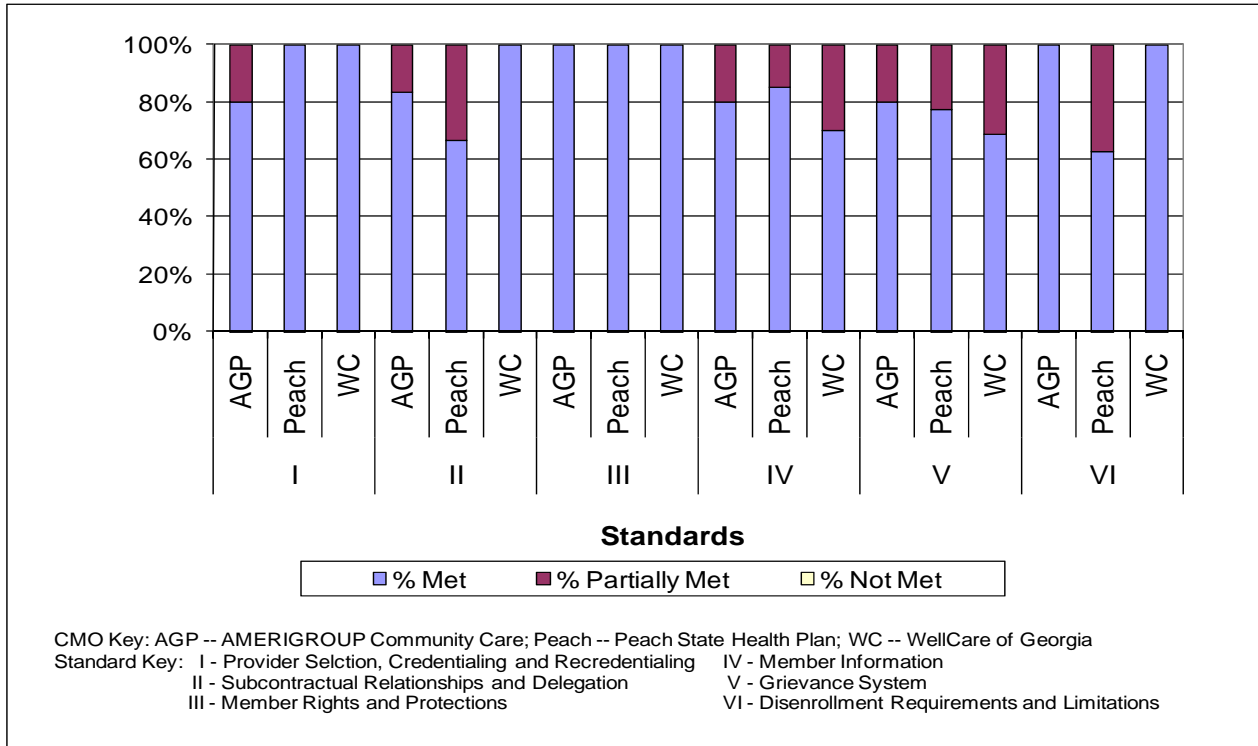


Table 8-1 presents the statewide and CMO-specific performance for all six standards. For this table, the overall compliance percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.5) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

Standard #	Standard Name	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
I	<i>Provider Selection, Credentialing, and Recredentialing</i>	90%	100%	100%	97%
II	<i>Subcontractual Relationships and Delegation</i>	92%	83%	100%	92%
III	<i>Member Rights and Protections</i>	100%	100%	100%	100%
IV	<i>Member Information</i>	90%	93%	85%	89%
V	<i>Grievance System</i>	90%	89%	84%	88%
VI	<i>Disenrollment Requirements and Limitations</i>	100%	81%	100%	94%
<b>Overall Percentage-of-Compliance Scores</b>		<b>92%</b>	<b>91%</b>	<b>90%</b>	<b>91%</b>

## Strengths

Overall statewide performance in complying with the requirements across the standards was good, with performance for 208 of the 255 total applicable requirements receiving a *Met* score and a statewide overall percentage-of-compliance score of 91 percent. All three CMOs received a score of 100 percent compliance for Standard III—Member Rights and Protections). Two CMOs received full compliance scores for Standard I—Provider Selection, Credentialing, and Recredentialing, and Standard VI—Disenrollment Requirements and Limitations. Strengths HSAG identified for each CMO are described in Section 6, External Quality Review Activities: Findings, Strengths, and Recommendations With Conclusions Related to Health Care Quality, Timeliness, and Access (the Findings Section). Strengths HSAG identified for more than one CMO for each standard are summarized below.

Statewide performance for Standard I—Provider Selection, Credentialing, and Recredentialing, was strong, with a statewide compliance score of 97 percent. Two CMOs demonstrated excellent performance by achieving a score of 100 percent, and one CMO exhibited good performance with a score of 90 percent. In general, the CMOs maintained and followed clear and accurate policies and procedures that were consistent with the standards established by NCQA and addressed all applicable federal Medicaid managed care regulations and DCH contract requirements. HSAG’s review of provider credentialing and recredentialing files demonstrated that they contained almost all of the required documents and were processed within the required time frames.

For Standard II—Subcontractual Relationships and Delegation, all the CMOs had policies and procedures in place prior to subcontracting to ensure that all potential delegates had the ability to perform the delegated functions. Most delegation contracts contained adequate documentation. The CMOs also conducted ongoing monitoring of the delegates’ performance related to the delegated functions and, as needed, required the delegates to submit to the CMO a corrective action plan for any identified deficiencies. The CMOs worked diligently with the delegated entities to ensure that the corrective actions were implemented and the deficiencies resolved.

For Standard III—Member Rights and Protection, all CMOs achieved full compliance and demonstrated excellent performance related to ensuring that members, providers, and staff were informed about member rights. CMO actions included listing member rights in the member handbooks and on the CMOs’ Web sites, which addressed both members’ rights and the providers’ responsibilities related to them. The CMOs also used multiple informational and media resources to provide the information to providers (e.g., contracts/agreements, provider manuals, and provider newsletters). The CMOs conducted comprehensive staff training during new hire orientation, conducted staff annual training, required providers to post member rights in their offices/facilities, and conducted provider medical record reviews and office/site inspections.

While the statewide compliance score for Standard IV—Member Information, was only 89 percent, several CMO strengths related to this standard should be noted. All CMOs provided the member handbook in multiple versions, including English and Spanish, and had the ability to make them available if needed in large print, on audio tape, in Braille, and/or on compact disc. Member handbooks were written at a fifth-grade reading level. In addition, CMOs maintained a Web site with a convenient feature for clicking on a link to move between English and Spanish versions. Other CMO strengths included listing all available Georgia Families benefits and covered services

in the member handbook and making assistance in obtaining covered services and accessing other social services available to members.

The statewide performance for Standard V—Grievance System, was the lowest of the six standards. However, the CMOs in general did maintain an organized system for processing, documenting, and tracking grievances and administrative reviews. For all the CMOs, notices of proposed action contained all required information and were sent within the required time frames. The member handbook descriptions of member rights related to, and processes for, filing grievances and appeals were written in easy-to-understand language. For two of the CMOs, documentation and information staff members provided during the interviews demonstrated that administrative reviews were conducted by physicians who had not been involved with the case, and grievances were handled within the required time frame by staff with the appropriate level of expertise.

For Standard VI—Disenrollment Requirements and Limitations, statewide performance was good, with a compliance score of 94 percent. All the CMOs included the disenrollment requirements in the member handbook and offered assistance to members wishing to disenroll, including helping them when they were considering disenrollment, giving them the disenrollment forms, and referring them to DCH for disenrollment determinations.

### **Opportunities for Improvement and Recommendations**

Statewide compliance scores for all but one of the six standards (Standard III—Member Rights and Protections) presented opportunities for improvement for the CMOs. All CMOs were required to implement corrective actions related to their performance for Standard IV—Member Information, and Standard V—Grievance System. Statewide compliance scores were below 90 percent (89 percent and 88 percent, respectively). Highlighted below is a summary of the opportunities for improvement and required corrective actions related to performance for requirements in Standards II, IV, and V that HSAG identified for more than one CMO.

Two CMOs received a compliance score of less than 95 percent for Standard II—Subcontractual Relationships and Delegation. The CMOs were required to ensure that each written delegation agreement described all of the administrative functions the CMO delegated and the delegate performed on behalf of the CMO.

All CMOs received a compliance score of 93 percent or less for Standard IV—Member Information, and a score of 90 percent or less for Standard V—Grievance System. For Standard IV, the CMOs were required to include or clarify in the member handbook a number of member rights related to the member not being held liable for a CMO's debts or for payment for covered services, the process for filing complaints with the applicable State agency when a provider did not comply with advance directive requirements, requirements for filing an appeal, and rules that govern representation at an administrative law hearing. For Standard V, all CMOs were required to update all applicable documents, including the member handbook and policies/procedures, to include complete and consistent definitions of terms and a description of the processes and timelines related to grievances and administrative reviews. Additionally, all CMOs were required to include information about the member grievance system in all appropriate provider materials.

## Summary

Overall, the CMOs' performance related to the quality domain was mixed, with all CMOs demonstrating fairly consistent and strong performance on two of the four standards but diverse and moderate performance on the other two standards. All CMOs demonstrated excellent performance for Standard III—Member Rights and Protection (100 percent). Strong statewide performance of 97 percent for Standard I—Provider Selection, Credentialing, and Recredentialing, was also noted, with two CMOs achieving full compliance scores and one achieving 90 percent. However, statewide performance on the other two standards addressing the quality domain (i.e., Standard II—Subcontractual Relationships and Delegation, and Standard V—Grievance System, reflected considerable variation in CMO compliance scores, with scores for two CMOs falling below 93 percent for Standard II and scores for all three CMOs falling below 91 percent for Standard V. Statewide performance on standards related to the access domain (Standards IV and VI) was moderately good, with overall compliance scores of 89 percent and 94 percent, respectively. For Standard IV—Member Information, none of the CMOs achieved a compliance score of greater than 93 percent. CMO variation in compliance scores was the greatest for Standard VI—Disenrollment Requirements and Limitations, which had a difference in compliance scores of 19 percentage points (i.e., from 81 percent for one CMO to 100 percent for the other two CMOs). These results demonstrate inconsistent CMO performance and suggest the need for CMO-specific and targeted improvement actions for these standards. Lastly, only one standard (Standard V—Grievance System) was related to the timeliness domain. With all three CMOs scoring no greater than 90 percent, statewide performance highlights the need for DCH and the CMOs to collaborate in:

- ◆ Exploring root causes to identify the CMOs' barriers to performing at a higher level.
- ◆ Ensuring that the DCH contract with the CMOs clearly and consistently reflects the terminology and requirements of the applicable CMS federal Medicaid managed care regulations related to member grievances, appeals, and requests for State administrative law hearings.
- ◆ Ensuring that the CMOs design and implement rapid-cycle performance improvement initiatives to ensure that their documentation and actions are consistent and compliant with the DCH and CMS requirements.

## Validation of Performance Improvement Projects

Table 8-2 presents the overall CMO performance results for each of the six PIPs HSAG validated for each CMO and the overall PIP results at the statewide level. With an overall score of 99 percent for the 18 PIPs, the Georgia Families CMOs demonstrated a high level of success on their second-year submissions. All CMOs received a *Met* status for all of their PIPs, with very little variation among the CMOs in the percentage scores for evaluation elements receiving a score of *Met* (i.e., scores ranged from 98 percent to 99 percent). This finding demonstrated strong performance across all CMOs for all 18 PIPs. The *Well-Child Visits* and *Improving Lead Screening Rates* PIPs—for which the methodology changed from the first- to the second-year submissions—were again designated as first-year PIPs. These two PIPs and the other new first-year PIPs were evaluated through Activity VI per DCH instructions. Only the *Provider Satisfaction* PIPs had progressed through Activity IX.



Table 8-2—Comparison of PIP Validation Status by CMO and Statewide				
	AMERIGROUP	Peach State	WellCare	Statewide
<b>Overall CMO Performance</b>				
<b>Total Percentage Score for Evaluation Elements Met</b>	<b>98%</b>	<b>99%</b>	<b>98%</b>	<b>99%</b>
<b>Number of PIPs by Validation Status</b>	<b>6</b>	<b>6</b>	<b>6</b>	<b>18</b>
<i>Not Met</i>	0	0	0	0
<i>Partially Met</i>	0	0	0	0
<i>Met</i>	6	6	6	18

Table 8-3 compares the overall CMO performance on PIPs submitted previously with the second-year submission for those same PIPs. The table shows that for the three PIPs submitted for the first time during the 2008–2009 submission there was wide variation in CMO performance, ranging from 62 percent to 94 percent. During the current submission year, the quality of these PIPs improved and the variation among the CMOs decreased. The CMOs’ overall performance on these PIPs ranged from 98 percent to 99 percent. Although the methodology for the *Improving Lead Screening Rates* and *Well-Child Visits* PIPs changed from HEDIS-like to HEDIS, the comparison of the PIP process between submission years for these PIPs was still valid.

Table 8-3—Comparison of CMO Performance on Select PIPs, by Submission Year <sup>1</sup>						
Submission Year	AMERIGROUP		Peach State		WellCare	
	2008-2009	2009-2010	2008-2009	2009-2010	2008-2009	2009-2010
<b>Overall Performance Score</b>	<b>62%</b>	<b>97%</b>	<b>77%</b>	<b>99%</b>	<b>94%</b>	<b>97%</b>
<i>Provider Satisfaction</i>	79%	93%	73%	98%	91%	93%
<i>Well-Child Visits</i>	50%	100%	79%	100%	96%	100%
<i>Improving Lead Screening Rates</i>	50%	100%	79%	100%	96%	100%

<sup>1</sup> Comparison is limited to PIPs submitted in the first contract year (2008–2009).

Table 8-4 presents the overall statewide and CMO-specific percentages of applicable evaluation elements achieving a *Met* score for all the PIPs, broken down by activity and the three overarching categories (i.e., Study Design, Study Implementation, and Quality Outcomes Achieved).

Table 8-4—Comparison of Performance on PIP Activities I–X (N=18 PIPs)* by CMO and Statewide				
Activities	AMERIGROUP	Peach State	WellCare	Statewide
<b>Study Design</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
I. Choose the Study Topic(s)	100%	100%	100%	100%
II. Define the Study Question(s)	100%	100%	100%	100%
III. Select the Study Indicator(s)	100%	100%	100%	100%
IV. Use a Representative and Generalizable Study Population	100%	100%	100%	100%
<b>Study Implementation</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>	<b>100%</b>
V. Use Sound Sampling Techniques (N=5)	100%	100%	100%	100%
VI. Use Valid and Reliable Data Collection Procedures	100%	100%	100%	100%
VII. Include Improvement Strategies (N=3)	100%	100%	100%	100%
<b>Quality Outcomes Achieved (N=3)</b>	<b>77%</b>	<b>92%</b>	<b>77%</b>	<b>82%</b>
VIII. Data Analysis and Interpretation of Study Results	78%	100%	100%	93%
IX. Assess for Real Improvement	75%	75%	25%	58%
X. Assess for Sustained Improvement **	--	--	--	--
* All 18 PIPs were assessed for each activity unless otherwise noted.				
** No PIPs were assessed for this activity.				

### Strengths

Based on the CMOs’ performance in conducting these PIPs, HSAG was confident that the reported results were valid. All 18 PIPs submitted this year achieved a *Met* validation status, indicating that they were likely to improve the health and functional status of members, member satisfaction, and provider satisfaction. Results from Table 8-2 and Table 8-3 show that the Georgia Families CMOs not only exhibited improvements in conducting and documenting PIPs since their first-year submissions, but also applied lessons learned from existing PIPs to new PIPs submitted in the second year. This is particularly evident since all the CMOs’ PIPs received a *Met* score across all applicable evaluation elements for Activity I through Activity VI.

### Opportunities for Improvement and Recommendations

Despite the strengths identified and most notable in the study design and study implementation activities, HSAG did note some opportunities for improvement. For all the applicable evaluation elements not achieving a *Met* score or receiving a *Point of Clarification*, HSAG recommends that the CMOs review the specific comments and recommendations HSAG described in its individual CMO PIP reports and make the suggested changes prior to the next submission. HSAG also recommends that DCH hold the CMOs accountable for making these changes to improve their PIP performance.

Not all the PIPs progressed to the stage at which baseline and remeasurement results could be compared and evaluated. Of those that progressed to the activities related to quality outcomes achieved (i.e., Activities VIII–X), there was some variation in CMO performance. The CMOs should focus on improving their documentation of PIPs, especially for Activity IX—Assess for Real Improvement, as the overall scores for this activity ranged from 25 percent to 75 percent. The

CMOs should carefully review each PIP across all activities before submission to ensure the consistency of statements throughout the PIP and that results and processes are included correctly in the PIP Summary Form when working with vendors.

## Summary

This year's CMO PIP performance demonstrated strengths, with impressive improvement from the prior year's submission. Overall performance for PIPs submitted the first year improved substantively for the current submission. New PIPs submitted this year also received satisfactory validation results.

Nonetheless, the CMOs' processes for conducting and documenting valid PIPs have room for improvement, especially as more PIPs will progress to the results comparison stage. For each PIP validated, HSAG identified and documented in its reports the areas in which the CMOs could improve their PIP processes and recommended ways to strengthen the current PIP structure and achieve improvement across all study indicators. HSAG also recommended that DCH continue to hold the CMOs accountable for making these changes to improve their PIP performance.

While the primary purpose of HSAG's PIP validation methodology was to evaluate the validity and quality of processes for conducting PIPs, HSAG recognizes that the CMOs' PIPs contained study indicators related to access to, and the quality and timeliness of, member care and services. More specifically, all 18 PIPs provided an opportunity for the CMOs to improve the quality of care and outcomes for their members. In addition to improving quality of care, the *Access/Service Capacity*, *Provider Satisfaction*, and *Member Satisfaction* PIP study indicators were also designed to improve members' access to care. The *Member Satisfaction* PIP was the only one to contain study indicators intended to address timeliness of care.

## Validation of Performance Measures

Table 8-5 presents the rates for the four hybrid and two administrative-only performance measures for the Georgia Families CMOs. Four of the six performance measures reported for the first time in the current measurement year were: *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Childhood Immunization Status—Combination 2*, *Lead Screening in Children*, and *Adults' Access to Preventive/Ambulatory Health Services*.

For five of the measures (i.e., *Comprehensive Diabetes Care—HbA1c Testing*, *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Childhood Immunization Status—Combination 2*, *Use of Appropriate Medications for People with Asthma*, and *Lead Screening in Children*), the CMOs reported that they had calculated the rates using different populations, as described in the footnotes to Table 8-5 below. For most measures, the reported rates for these measures were not comparable across CMOs, and statewide rates were not calculated.

Statewide rates were calculated for the two administrative-only measures and the *Comprehensive Diabetes Care—HbA1c Testing* hybrid measure. For the *Comprehensive Diabetes Care—HbA1c Testing* measure, because the number of PeachCare for Kids members who qualified for the age requirement for this measure (i.e., 18 years of age or older) would be small, Peach State's exclusion of this population from the measure should not substantially affect the statewide rate. Statewide

rates were not calculated, however, for the other three hybrid measures since the CMOs used different populations.

**Table 8-5—Performance Measure Results Statewide and by CMO**

Indicator	AMERIGROUP Community Care	Peach State Health Plan	WellCare of Georgia, Inc.	Statewide
1. <i>Comprehensive Diabetes Care—HbA1c Testing</i>	74.50%	64.23% <sup>a</sup>	72.26%	70.46% <sup>b</sup>
2. <i>Use of Appropriate Medications for People With Asthma</i>	91.84%	91.12% <sup>a</sup>	90.58%	91.09%
3. <i>Well-Child Visits in the First 15 Months of Life—Six or More Visits</i>	62.25%	51.58% <sup>a</sup>	57.42% <sup>c</sup>	<i>Not Calculated</i> <sup>c</sup>
4. <i>Childhood Immunization Status—Combination 2</i>	29.84% <sup>d</sup>	62.77% <sup>a</sup>	75.91%	<i>Not Calculated</i> <sup>e</sup>
5. <i>Lead Screening in Children</i>	68.21%	57.18% <sup>a</sup>	65.94%	<i>Not Calculated</i> <sup>f</sup>
6. <i>Adults’ Access to Preventive/Ambulatory Health Services</i>				
20 to 44 Years of Age	81.20%	78.88%	78.64%	79.19%
45 to 64 Years of Age	86.29%	80.98%	84.58%	83.91%

<sup>a</sup> The rate represents only the Georgia Medicaid population; the PeachCare for Kids population was not included.

<sup>b</sup> Because the number of PeachCare for Kids members who qualified for the age requirement of this measure (i.e., 18 years of age or older) would be small, Peach State’s exclusion of this population from this measure should not substantially affect the statewide rate.

<sup>c</sup> The statewide rate was not calculated because WellCare calculated the measure based on a different time frame for medical record procurement. The CMO did not start to collect medical records for the measure until summer 2009. Peach State did not include PeachCare for Kids data in its calculation of this measure.

<sup>d</sup> AMERIGROUP reported the measure using the administrative method (i.e., no medical record review was conducted).

<sup>e</sup> The statewide rate was not calculated because AMERIGROUP reported the administrative-only rate while WellCare reported the hybrid rate. Peach State did not include PeachCare for Kids in its calculation of this measure.

<sup>f</sup> The statewide rate was not calculated because Peach State did not include PeachCare for Kids in its calculation of this measure.

### Strengths

Overall, all CMOs achieved acceptable performance for data integration and data control, and the CMOs’ performance indicator documentation was also acceptable. This year’s performance measure validation process and results suggested that by contracting with the same medical record procurement organization, all three CMOs demonstrated excellent processes for medical record abstraction. In addition, all three CMOs had sufficient processes in place for processing claims, enrollment, and provider data and started using NCQA-certified software vendors to generate the HEDIS rates.

With the rates for all three CMOs above 90 percent, statewide performance on the *Use of Appropriate Medications for People With Asthma* measure was strong. The statewide rate (91.1 percent) almost reached the national HEDIS 2008 Medicaid 90th percentile (91.9 percent).

## Opportunities for Improvement and Recommendations

While all of the CMOs demonstrated valid and appropriate processes related to performance measures, HSAG identified opportunities for improvement in lower-performing measures. Recommendations specific to each CMO are presented in Section 6 of this report (i.e., the Findings section).

The statewide rate for *Comprehensive Diabetes Care—HbA1c Testing* presented an opportunity for improvement, with a rate ranking between the national HEDIS 2008 Medicaid 10th and 25th percentiles. Because the number of PeachCare for Kids members who qualified for the age requirement of this measure (i.e., 18 years of age or older) would be small, Peach State's exclusion of this population from the measure should not substantially affect the statewide rate. With its ranking between the national HEDIS 2008 Medicaid 25th and 50th percentiles, statewide performance on the *Adult's Access to Preventive/Ambulatory Health Services* measure (79.19 percent for the 20-to-44-year-old age group and 83.91 percent for the 45-to-64-year-old age group) presented opportunities for improvement. Two of the CMOs consistently reported lower rates on the two *Adults' Access* measures. For the 45-to-64-year-old age group, the difference between the low-performing CMO (80.98 percent) and high-performing CMO (86.29 percent) was 5.31 percentage points. The CMOs should initiate aggressive performance improvement efforts related to these measures to ensure that in future submissions, their rates meet the applicable DCH performance targets.

## Summary

All of the CMOs generally demonstrated strong processes, including data control and integration and performance indicator documentation, related to performance measures. For one CMO, HSAG identified a few recommendations for improving its performance measure processes.

HSAG also reviewed the CMOs' performance on the indicators related to quality, access, and timeliness. All of the performance measures were related only to quality, except for the *Adults' Access to Preventive/Ambulatory Health Services* measure, which was also related to access. No measures were related to the timeliness domain. Since the CMOs used different data collection methodologies (i.e., administrative vs. hybrid) to generate their measures, statewide performance could only be summarized and discussed for the *Comprehensive Diabetes Care—HbA1c Testing*, the *Use of Appropriate Medications for People With Asthma*, and the *Adults' Access to Preventive/Ambulatory Health Services* measures. Statewide performance varied for these three quality measures. The results for the *Comprehensive Diabetes Care—HbA1c Testing* measure ranked between the 10th and 25th national HEDIS 2008 percentiles. The results for the *Use of Appropriate Medications for People With Asthma* measure almost reached the national 2008 HEDIS 90th percentile (91.9 percent), and results for the *Adults' Access* measure fell below the 50th percentile for both age groups. In addition to the *Comprehensive Diabetes Care—HbA1c Testing* measure, since the *Adults' Access* measure also represented statewide performance related to access to care and services, the Georgia Families CMOs should focus on improving their rates for both of these measures. For future performance measure reporting, DCH has clarified the populations to be included, which will allow for comparison across the CMOs.

## *Appendix A.* **Reviewing Compliance With Operational Standards**

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the DCH Georgia Families CMOs addresses HSAG’s:

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

HSAG followed standardized processes in conducting the review of each CMO’s performance.

### **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 certain federal Medicaid managed care regulations, State rules, and the associated DCH contractual requirements. The review tool included requirements that addressed the following six performance areas:

- ◆ Standard I—Provider Selection, Credentialing, and Recredentialing
- ◆ Standard II—Subcontractual Relationships and Delegation
- ◆ Standard III—Member Rights and Protections
- ◆ Standard IV—Member Information
- ◆ Standard V—Grievance System
- ◆ Standard VI—Disenrollment Requirements and Limitations

HSAG also evaluated how the CMOs implemented a number of the requirements by using work sheets to review the CMOs’ records/files associated with the requirements. HSAG used the work sheets to review a sample of the CMOs’ provider credentialing and recredentialing files and a sample of member grievances, including associated documentation of the CMOs’ decisions/actions and correspondence. HSAG reviewers also reviewed a sample of each CMO’s fully executed contracts/agreements for delegation of its administrative functions.

The 2009–2010 review was the second year of a three-year cycle of compliance reviews that the EQRO will conduct for the CMOs under its contract with DCH.

## HSAG's Objective for Conducting the Review

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs. DCH and the CMOs will use the information and findings that resulted from HSAG's review to:

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

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 report of its findings.

## HSAG's Methodology for Conducting the Review

Before beginning the compliance review, HSAG developed a data collection tool to guide and document the review. The requirements in the tool were selected based on applicable federal and State regulations and laws, and on the requirements set forth in the contract between DCH and the CMOs as they related to the scope of the review.

HSAG also followed 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 associated reviewer work sheets.
- ◆ Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- ◆ Scheduling the on-site reviews.
- ◆ Developing the on-site review agendas for each day of the two-day on-site review.
- ◆ Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to 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. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification, and begin compiling information before the on-site review.

**On-site review activities:** HSAG reviewers conducted 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.
- ◆ A closing conference during which HSAG reviewers summarized their preliminary findings.

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

Table A-1 presents a more detailed, chronological description of the above activities that HSAG performed throughout its review.

Table A-1—Compliance Review Activities HSAG Performed	
For this step,	HSAG...
<b>Step 1:</b>	<b>Established the review schedule.</b>
	Before the review, HSAG coordinated with DCH and the CMOs to set the schedule and assigned HSAG reviewers to the review team.
<b>Step 2:</b>	<b>Prepared the data collection tool for reviewing the six standards and submitted it to DCH for review and comment.</b>
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the contract between DCH and the CMOs to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used the federal Medicaid managed care regulations described at 42 CFR 438, with revisions issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tool included applicable State and federal requirements. Prior to finalizing the tool, HSAG submitted the draft to DCH for its review and comments.
<b>Step 3:</b>	<b>Prepared and submitted the Desk Review Form to the CMOs.</b>
	HSAG prepared and forwarded a Desk Review Form to the CMOs and requested that they submit specific information and documents to HSAG within a specified number of days of the request. The Desk Review Form included instructions for organizing and preparing the documents related to the review of the six standards, submitting documentation for HSAG’s desk review, and having additional documents available for HSAG’s on-site review.
<b>Step 4:</b>	<b>Forwarded a Documentation Request and Evaluation Form to the CMOs.</b>
	HSAG forwarded to the CMOs, as an attachment to the Desk Review Form, a Documentation Request and Evaluation Form containing the same standards and DCH contractual requirements as the tool HSAG used to assess the CMOs’ compliance with each of the requirements within the standards. The Desk Review Form included instructions for completing the “Evidence/Documentation as



<b>Table A-1—Compliance Review Activities HSAG Performed</b>	
<b>For this step,</b>	<b>HSAG...</b>
	Submitted by the CMO” portion of this form. This step: (1) provided the opportunity for the CMOs to identify for each requirement the specific documents or other information that provided evidence of their compliance with the requirement and (2) streamlined the ability of HSAG’s reviewers to identify all applicable documentation for their review.
<b>Step 5:</b>	<b>Developed a compliance monitoring on-site review agenda and submitted it to the CMOs.</b>
	HSAG developed an agenda to assist the CMOs’ staff members in planning for their participation in HSAG’s on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to an organization’s day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames.
<b>Step 6:</b>	<b>Provided orientation for the CMOs</b>
	If requested by a CMO, HSAG staff members conducted an orientation for the CMO to preview HSAG’s 2009–2010 desk and on-site review processes and to respond to any questions from the CMO staff members.
<b>Step 7:</b>	<b>Responded to the CMOs’ questions related to the review and provided any other needed information before the on-site reviews.</b>
	Prior to conducting the on-site reviews, HSAG maintained contact with the CMOs as needed to answer questions and provide information to key management staff members. This telephone and/or e-mail contact gave the CMOs’ representatives the opportunity to request clarification about the request for documentation for HSAG’s desk review and the on-site review processes. HSAG communicated regularly with DCH about its discussions with the CMOs and its responses to the CMOs’ questions.
<b>Step 8:</b>	<b>Received the CMOs’ documents for HSAG’s desk review and evaluated the information before conducting the on-site reviews.</b>
	<p>HSAG reviewers used the documentation received from the CMOs to gain insight into the organizations’ structure, provider network, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and preliminary findings before the on-site portion of the review.</p> <p>During the desk review process, reviewers:</p> <ul style="list-style-type: none"> <li>◆ Documented findings from the review of the materials submitted by the CMOs as evidence of their compliance with the requirements.</li> <li>◆ Identified areas and issues requiring further clarification or follow-up during the on-site interviews.</li> <li>◆ Identified information not found in the desk review documentation to be requested during the on-site reviews.</li> </ul>
<b>Step 9:</b>	<b>Received from the CMOs lists of providers credentialed and recredentialed and a list of member grievances.</b>
	The Desk Review Form provided the CMOs with the purpose, timelines, and

<b>Table A-1—Compliance Review Activities HSAG Performed</b>	
<b>For this step,</b>	<b>HSAG...</b>
	instructions for submitting lists of providers credentialed and recredentialed during the time period specified and a list of member grievances received during the time period specified. From the lists, HSAG selected a sample of 10 and an oversample of 5 unduplicated records. Fourteen days prior to each CMO’s on-site review, HSAG posted the applicable list of records that the CMO was to have available for HSAG’s review when on-site. HSAG also reviewed a sample of the CMOs’ fully executed written delegation agreements selected from lists the CMOs submitted.
<b>Step 10:</b>	<b>Conducted the on-site portion of the review.</b>
	<p>During the on-site review, staff members from the CMOs were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG’s activities completed during the on-site review included the following:</p> <ul style="list-style-type: none"> <li>◆ Conducted an opening conference that included introductions, HSAG’s overview of the on-site review process and schedule, the CMOs’ overview of their structure and processes, and a discussion about any changes needed to the two-day agenda and general logistical issues.</li> <li>◆ Conducted interviews with the CMOs’ staff. HSAG used the interviews to obtain a complete picture of the CMOs’ compliance with federal Medicaid managed care standards and associated DCH contract requirements, explore any issues not fully addressed in the documents that HSAG had reviewed, and increase HSAG reviewers’ overall understanding of the CMOs’ performance.</li> <li>◆ Reviewed additional documentation while on-site and used the review tool to identify relevant information sources and to document its review findings. Documents reviewed on-site included written policies and procedures, minutes of key committee or other group meetings, data and reports across a broad range of areas, provider credentialing and recredentialing files, member grievances, and delegation agreements. Reviewers used standardized work sheets to document their findings regarding requirements for the CMOs’ processes, actions, and correspondence associated with provider credentialing and recredentialing and with processing and responding to member grievances. Reviewers used the completed work sheets as a source of information to arrive at their findings and to assign scores for the associated requirements in the compliance review tool.</li> <li>◆ Summarized findings at the completion of the on-site portion of the review. As a final step, HSAG conducted a closing conference the last day of the on-site reviews to provide the CMOs’ staff members with a high-level summary of HSAG’s preliminary findings. For each of the six standards, the findings included HSAG’s assessment of an organization’s strengths and, when applicable, the areas requiring corrective action.</li> </ul>
<b>Step 11:</b>	<b>Calculated the individual scores and determined the overall compliance score for the CMOs’ performance.</b>
	HSAG evaluated the CMOs’ performance in complying with the requirements in each of the six standards contained in the review tool. HSAG analyzed the information to determine the CMOs’ performance for each of the requirements in the six standards. HSAG used <i>Met</i> , <i>Partially Met</i> , and <i>Not Met</i> scores to

Table A-1—Compliance Review Activities HSAG Performed	
For this step,	HSAG...
	document the degree to which the organizations complied with each of the requirements. A designation of <i>NA (Not Applicable)</i> was used if an individual requirement did not apply to the CMOs during the period covered by the review.
<b>Step 12:</b>	<b>Prepared a report of findings and required corrective actions.</b>
	After completing the documentation of findings and scoring for each of the six standards, HSAG prepared a draft report for each of the CMOs that described HSAG’s compliance review findings, the scores it assigned for each requirement within the six standards, and HSAG’s assessment of the CMO’s strengths and any areas requiring corrective action. HSAG forwarded the reports to DCH and the CMOs for their review and comment. Following DCH’s approval of the draft report, HSAG issued the final reports to DCH and the CMOs.

**Technical Methods of Collecting the Data, Including a Description of the Data Obtained**

To assess the CMOs’ compliance with federal regulations, State rules, and DCH contract requirements, 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 informational materials
- ◆ Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMOs’ key staff members.

Table A-2 lists the major data sources HSAG used in determining the CMOs’ performance in complying with requirements and the time period to which the data applied.

Table A-2—Description of the CMOs’ Data Sources	
Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during the on-site review	October 31, 2008, through the last day of the on-site review
Information obtained through interviews	October 31, 2008, through the last day of the on-site review
List of providers credentialed and recredentialed	March 1, 2009–August 31, 2009
List of member grievances	January 1, 2009–June 30, 2009

## Aggregating and Analyzing the Data and Information Collected

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *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, dated February 11, 2003. 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.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the six standards and an overall percentage-of-compliance score across the six standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

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

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

- ◆ Documented findings describing the CMOs' performance in complying with each of the requirements.
- ◆ Scores assigned to the CMOs' performance for each requirement.
- ◆ The total percentage-of-compliance score calculated for each of the six standards.

- ◆ The overall percentage-of-compliance score calculated across the six standards.
- ◆ Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

### ***Processes for Preparing the Draft and Final Reports of Findings***

Based on the results of the data aggregation and analysis, HSAG prepared a draft report of its external quality review of compliance findings for each of the CMOs. The reports described the CMOs' strengths and, when applicable, actions required to bring their performance into compliance with the requirements. Each report also included as an attachment the compliance review tool HSAG used to evaluate the CMO's performance and to document its findings and the performance scores it assigned for each requirement. HSAG forwarded the draft reports to DCH and to the CMOs for their review and comment prior to preparing and issuing the final reports.

## Appendix B. Validating Performance Improvement Projects (PIPs)

### 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 services provided to the CMOs' Medicaid and PeachCare for Kids™ (CHIP) members DCH selected the six performance improvement projects HSAG validated for each CMO. Each CMO submitted the following PIPs:

- ◆ *Access/Service Capacity*
- ◆ *Childhood Immunization*
- ◆ *Improving Childhood Lead Screening Rates*
- ◆ *Member Satisfaction*
- ◆ *Provider Satisfaction*
- ◆ *Well-Child Visits during the First 15 Months of Life With Six or More Visits*

This was the second year the CMOs submitted PIPs to DCH and to HSAG for validation. Due to the DCH-directed realignment of measurement parameters from HEDIS-like criteria to the *HEDIS 2009 Technical Specifications*, a new baseline was established for each PIP (except for the *Provider Satisfaction* PIP). With this change, HSAG validated Activities I through VI for the second contract year of the PIP validation cycle for the PIPs that changed to HEDIS measures. For the *Provider Satisfaction* PIP, HSAG validated Activities I–IX.

### HSAG's Objective for Validating the PIPs

The primary objective of PIP validation was 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.

### HSAG's Methodology for Validating the PIPs

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician 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. 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 ensured 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 PIP to the appropriate point of progression following the CMS PIP validation protocol steps:

- ◆ Step I. Review the Selected Study Topic(s)
- ◆ Step II. Review the Study Question(s)
- ◆ Step III. Review the Selected Study Indicator(s)
- ◆ Step IV. Review the Identified Study Population
- ◆ Step V. Review Sampling Methods
- ◆ Step VI. Review the MCO's/PIHP's Data Collection Procedures
- ◆ Step VII. Assess the MCO's/PIHP's Improvement Strategies
- ◆ Step VIII. Review Data Analysis and the Interpretation of Study Results
- ◆ Step IX. Assess for Real Improvement
- ◆ Step X. Assess for Sustained Improvement

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 activities completed and evaluated for the 2009–2010 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* score resulted in an overall validation rating for the PIP of *Not Met*. A CMO would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*.

HSAG documented a *Point of Clarification* in its reports 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). HSAG calculated the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculated a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *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 following three determinations of validation status:

- ◆ *Met*: High confidence/confidence in the reported PIP results.
- ◆ *Partially Met*: Low confidence in the reported PIP results.
- ◆ *Not Met*: Reported PIP results that were not credible.

After completing the validation review, HSAG prepared a 2009–2010 PIP validation report of its 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 2009–2010 PIP validation reports were then sent to the applicable CMOs. In addition, HSAG prepared and submitted to DCH an annual summary PIP report with aggregate statewide results and recommendations.

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*.



### Conducting the Activity

As set forth at 42 CFR 438.358, 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 the current review period, DCH contracted with three CMOs to provide all services to the Medicaid managed care-eligible population. 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).

### HSAG's Objectives for Validating the Performance Measures

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 calendar year (CY) 2008 (January 1, 2008, through December 31, 2008) CMO data.

### HSAG's Methodology for Validating the Performance Measures

#### *Pre-Audit Strategy*

HSAG conducted the validation activities as outlined in the CMS Performance Measure Validation Protocol as well as in the NCQA *HEDIS Compliance Audit™: Standards, Policies, and Procedures*, Volume 5. HSAG obtained a list of the indicators that DCH selected for validation. DCH also provided the indicator reporting templates for review by the HSAG validation team.

HSAG prepared a document request letter that was submitted to each CMO outlining the steps in the performance measure validation process. The document request letter included a request for each CMO's HEDIS Roadmap, source code for each performance measure, the final audit reports from previous HEDIS audits, and any additional supporting documentation necessary to complete the audit. HSAG sent an additional letter to the CMOs describing the medical record over-read process for the hybrid measures. This letter requested that each CMO submit numerator-positive

case listings for the two selected over-read measures. HSAG responded to the CMO's Roadmap and medical record-related questions during the pre-on-site phase.

HSAG prepared an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG forwarded the agendas to the respective CMOs approximately three weeks prior to the on-site visit. When requested, HSAG conducted pre-on-site conference calls with the CMOs to discuss any outstanding Roadmap questions and on-site visit activities.

### **Technical Methods of Data Collection and Analysis**

The CMS Performance Measure Validation Protocol identified key types of data that should be reviewed as part of the validation process. The list below indicates the type of data collected and how HSAG conducted an analysis of this data:

- ◆ *A HEDIS Record of Administration, Data Management, and Processes (Roadmap)* was requested and received from each CMO. Upon receipt, HSAG conducted a high-level review of the Roadmaps to ensure that all sections were completed and all attachments were present. The Roadmaps were then forwarded to the validation team for review. The validation team reviewed all Roadmap documents, noting issues or items that needed further follow-up. The review team used information included in the Roadmap to begin completing the review tools, as applicable.
- ◆ *Source code (programming language) for performance indicators* was requested. CMOs that calculated the indicators using automated computer code submitted the requested information. During the site visit, the review team completed line-by-line code review and observation of program logic flow to ensure compliance with State indicator definitions. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the indicator and assess the degree of bias (if any). If a CMO contracted with an NCQA-certified software vendor to calculate its performance indicators, submitting source code was not necessary.
- ◆ *NCQA HEDIS 2009 Final Audit Reports* were reviewed by the validation team.
- ◆ *Supporting documentation* included any documentation that provided reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, with issues or clarifications flagged for further follow-up.

### **Description of Data Obtained**

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

- ◆ **HEDIS Record of Administration, Data Management, and Processes (Roadmap)**—HSAG received this tool from each CMO. The completed Roadmap 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 (if applicable). HSAG used the code to determine compliance with the performance measure definitions.
- ◆ **Previous performance measure reports**—HSAG obtained these reports from each CMO and reviewed the reports 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 DCH and each of the CMOs.
- ◆ **On-site interviews and demonstrations**—HSAG also obtained information through interaction, discussion, and formal interviews with key CMO staff members, as well as through system demonstrations.

Table C-1 displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table C-1—Description of Data Sources	
Data Obtained	Time Period to Which the Data Applied
Roadmap (From CMOs)	CY 2008
Source Code (Programming Language) for Performance Measures (From CMOs)	CY 2008
Previous Performance Measure Reports (From CMOs)	CY 2008
Supporting Documentation (From CMOs)	CY 2008
Current Performance Measure Results (From CMOs and DCH)	CY 2008
On-site Interviews and Demonstrations (From CMOs)	CY 2008

### On-Site Activities

HSAG conducted on-site visits to each CMO. Information was collected using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- ◆ **Opening meetings**—introductions of HSAG’s validation team members and key CMO staff involved in the performance indicator activities. The discussions addressed the purpose of the review, the required documentation, basic meeting logistics, and queries to be performed.
- ◆ **Evaluation of system compliance**—included an information systems assessment focusing on the processing of claims and encounter data, member/patient data, and provider data. Additionally, the review evaluated the processes used to collect and calculate the performance indicators, including accurate numerator and denominator identification and algorithmic

compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

- ◆ **Review of Roadmap and supporting documentation**—included a review of the processes used for collecting, storing, validating, and reporting performance indicator data. This session was designed to be interactive with key CMO staff members so the review team could obtain a complete picture of all the steps taken to generate the performance indicators. The goal of the session was to obtain a complete picture of the degree of compliance with written documentation. Interviews were used to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- ◆ **Medical record review**—included a review of the CMOs' medical record processes. This included a review of the methods for medical record procurement, development and training on medical record abstraction tools, data entry and validation, and oversight of the medical record process.
- ◆ **Overview of data integration and control procedures**—included discussion and observation of source code logic and a review of how all data sources were combined and how the analytic file was produced for the reporting of selected performance indicators. Primary source verification was performed to further validate the output files. Backup documentation on data integration was reviewed. Data control and security procedures were also addressed during this session.
- ◆ **Closing conference**—summarized preliminary findings based on the review of the Roadmap and the on-site visit, and revisited the documentation requirements for any postvisit activities.