Georgia Department of Community Health

Validation of the Performance Measures Reporting Period – CY 2010

for

Georgia Department of Community Health

March 2012

HSAG HEALTH SERVICES ADVISORY GROUP

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Validation of Performance Measures

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Validation Overview

The Centers for Medicare & Medicaid Services (CMS) requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of these performance measures is one of the three mandatory external quality review activities described at 42 CFR 438.358(b)(2). The requirement allows states, agents that are not a managed care organization, or an external quality review organization (EQRO) to conduct the performance measure validation.

The purpose of performance measure validation is to ensure that managed care plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the managed care plans' information systems provide accurate and complete information.

During state fiscal year (SFY) 2011, the Georgia Department of Community Health (DCH) required its care management organizations (CMOs) to report performance measure data using calendar year 2010 (CY10) as the reporting period. Additionally, the DCH contracted with Hewlett-Packard Enterprise Services (HP), its medical management information systems (MMIS) vendor, to calculate performance measures for the Medicaid and PeachCare for Kids® Fee-for-Service (FFS) populations, Georgia Families Medicaid and PeachCare for Kids® managed care populations (Georgia Families), and the total of all Medicaid and PeachCare for Kids® (ALL) populations for the purposes of rate comparison, and for voluntary reporting of data to CMS for the Children's Health Insurance Program Reauthorization Act (CHIPRA) for core set measures. PeachCare for Kids® is the name of Georgia's stand alone Children's Health Insurance Program (CHIP).

DCH contracted with Health Services Advisory Group, Inc. (HSAG), to conduct performance measure validation (PMV) activities on the performance measure results generated for each of these three (3) populations and this report addresses the validation of the state's FFS, Georgia Families, and ALL populations' performance measure results. DCH identified a set of performance measures calculated and reported by HP for validation. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (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).

Georgia Department of Community Health Information

HSAG validated performance measures calculated and reported by HP on behalf of the DCH. Information about DCH appears in Table 1.

Table 1—Georgia Department of Community Health	
DCH Location:	2 Peachtree Street, NW Atlanta, GA 30303
DCH Contact:	Janice M. Carson, MD, MSA Deputy Director, Performance, Quality and Outcomes (404) 463-2832 jcarson@dch.ga.gov
Site Visit Location:	Hewlett-Packard Enterprise Services 100 Crescent Centre, Ste. 1100 Tucker, GA 30084
HP Contact:	Michelle Hunter, Services Information Developer III (972) 605-8853 michele.hunter@hp.com
Site Visit Date:	December 1–2, 2011

Audited Populations

Fee-for-Service (FFS)—the FFS population included Medicaid and PeachCare for Kids® members not enrolled in the Georgia Families managed care program. In order to be included in the FFS rates, a member had to be continuously enrolled in the FFS population for the entire measurement period.

Georgia Families Managed Care (Georgia Families)—the Georgia Families population consists of Medicaid and PeachCare for Kids® members enrolled in the three contracted care management organizations (CMOs): Peach State Health Plan, WellCare of Georgia, and AMERIGROUP Community Care. Georgia Families rates are calculated by HP using encounter data submitted by the CMOs on a monthly basis. HSAG is contracted to perform performance measure validation audits for each CMO and review their processes and procedures for calculating CMO-specific performance measures for non-HEDIS® measures. The DCH also requires its CMOs to undergo an NCQA HEDIS Compliance Audit™. Where applicable, the individual CMO rates were used to test for reasonability of the calculated Georgia Families rates. In order to be included in the Georgia Families rate, a member had to be continuously enrolled in any CMO or could have switched CMOs during the measurement period.

Total Population (ALL)—the ALL population consists of all members covered under the Georgia Medicaid and PeachCare for Kids® programs during the measurement period. The ALL population includes the members included in the FFS and Georgia Families populations, as well as members that may have switched between managed care and FFS during the measurement period.

Performance Measures Validated

DCH identified a set of performance measures for the FFS, Georgia Families, and ALL populations for validation. The measure set included National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures and Agency for Healthcare Research and Quality (AHRQ) measures. The measurement period was calendar year (CY) 2010. Table 2 lists the performance measures validated for these populations.

Table 2—List of Performance Measures for CY 2010

	Measure	Measure Set
1.	Well-Child Visits in the First 15 Months of Life	HEDIS
2.	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	HEDIS
3.	Adolescent Well-Care Visits	HEDIS
4.	Children's and Adolescents' Access to Primary Care Practitioners	HEDIS
5.	Adults' Access to Preventive/Ambulatory Health Services	HEDIS
6.	Childhood Immunization Status (Combo 10)	HEDIS
7.	Childhood Immunization Status (Combo 3)	HEDIS
8.	Lead Screening in Children	HEDIS
9.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	HEDIS
10.	Annual Dental Visit	HEDIS
11.	Cervical Cancer Screening	HEDIS
12.	Breast Cancer Screening	HEDIS
13.	Prenatal and Postpartum Care	HEDIS
14.	Frequency of Ongoing Prenatal Care	HEDIS
15.	Chlamydia Screening for Women	HEDIS
16.	Immunizations for Adolescents	HEDIS
17.	Appropriate Testing for Children With Pharyngitis	HEDIS
18.	Use of Appropriate Medications for People With Asthma	HEDIS
19.	Comprehensive Diabetes Care	HEDIS
20.	Follow-Up Care for Children Prescribed ADHD Medication	HEDIS
21.	Follow-Up After Hospitalization for Mental Illness	HEDIS
22.	Ambulatory Care	HEDIS
23.	Inpatient Utilization—General Hospital/Acute Care	HEDIS
24.	Appropriate Treatment for Children With Upper Respiratory Infection	HEDIS
25.	Weeks of Pregnancy at Time of Enrollment	HEDIS

Table 2—List of Performance Measures for CY 2010		
	Measure	Measure Set
26.	Race/Ethnicity Diversity of Membership	HEDIS
27.	Language Diversity of Membership	HEDIS
28.	Cesarean Delivery Rate: Number of Provider-Level Cesarean Deliveries per 100 Deliveries	AHRQ
29.	Rate of Infants With Low Birth Weight: Rate of Low-Weight Infants per 100 Births	AHRQ
30.	Diabetes Short-term Complications Admission Rate: Rate per 100,000 Population	AHRQ
31.	Asthma Admission Rate: Rate per 100,000 Population	AHRQ
32.	Asthma ER: Percent of Members Who Have Had a Visit to an Emergency Department/Urgent Care Office for Asthma in the Past Six Months.	AHRQ

Description of Validation Activities

Pre-audit Strategy

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

HSAG then prepared a document request letter that was submitted to DCH outlining the steps in the performance measure validation process. The document request letter included a request for a completed Information Systems Capabilities Assessment Tool (ISCAT), or Appendix Z of the CMS protocol; source code for each performance measure (unless the source code was produced by NCQA-certified software); and any additional supporting documentation necessary to complete the audit. HSAG responded to ISCAT-related questions directly during the pre-on-site phase.

HSAG conducted a pre-on-site conference call with HP, DCH's performance measure calculation vendor, and the Georgia Medical Care Foundation (GMCF), the medical record review vendor, to discuss the medical record review procurement and abstraction process. HSAG designed an ISCAT supplement pertaining to medical record review. GMCF and HP submitted the ISCAT and supporting documentation to HSAG.

For the on-site visit, HSAG prepared an agenda describing all visit activities and indicating the type of staff needed for each session. HSAG provided the agenda to DCH approximately one week prior to the on-site visit. HSAG also frequently communicated with DCH to discuss on-site visit expectations.

Validation Team

The HSAG performance measure validation team was composed of a lead auditor and validation team members. HSAG assembled the team based on the skills required for the validation and the requirements of DCH. Some team members, including the lead auditor, participated in the on-site

meetings at DCH; others conducted their work at HSAG's offices. Table 3 lists the validation team members, their positions, and their skills and expertise.

Table 3—Validation Team

Name / Role	Skills and Expertise
Wendy Talbot, MPH, CHCA *Associate Director, Audits*	Certified HEDIS compliance auditor with extensive experience in leading HEDIS audits and PMV activities in multiple states. Additional experience in epidemiology, data analysis and management, state Medicaid programs and health care/disease program management.
David Mabb, MS, CHCA *Lead Auditor; Associate Director, Audits; Source Code Review Manager*	Certified HEDIS compliance auditor, HEDIS knowledge, source code review management, statistics, analysis and source code programming knowledge
Jennifer Lenz, MPH, CHCA *Secondary Auditor; Executive Director, State and Corporate Services*	Certified HEDIS compliance auditor, HEDIS knowledge, statistics and analysis
Marilea Rose, RN, BA *Associate Director, State and Corporate Services; Medical Record Review, Over-read Process Supervisor*	Medical record review, clinical consulting and expertise, abstraction, tool development, HEDIS knowledge and supervision of nurse reviewers
Ron Holcomb, AS *Source Code Reviewer*	Statistics, analysis and source code programming knowledge
Tammy GianFrancisco *Project Leader, Audits*	Health plan and physician organization communications, project coordination, HEDIS and P4P knowledge, scheduling, organization, tracking and administrative support

Technical Methods of Data Collection and Analysis

The CMS performance measure validation protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of this data:

- **Information Systems Capabilities Assessment Tool (ISCAT):** DCH and HP were responsible for completing and submitting the ISCAT document to HSAG. Upon receipt, HSAG conducted a cursory review of the ISCAT to ensure that DCH and HP completed all sections and included all attachments. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used the information in the ISCAT to complete the review tools, as applicable.
- **Medical record documentation:** HP and its contracted medical record review vendor, GMCF, were responsible for completing the medical record review supplement to the ISCAT. In addition, the following attachments were requested and reviewed by HSAG: medical record hybrid tools and instructions, training materials for medical record review staff, and policies and procedures outlining the processes for monitoring the accuracy of the review staff.

- **Source code (programming language) for performance measures:** HSAG requested source code (computer programming language) from HP for all performance measures except the HEDIS performance measures generated using NCQA-certified software. HSAG source code reviewers completed a line-by-line code review and evaluation of program logic flow to ensure compliance with State measure definitions. The source code reviewers identified areas of deviation and shared them with HP for adjustment. The source code reviewers also informed the audit team of any deviations from the measure specifications so the team could evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- **Supporting documentation**: HSAG requested any documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for follow-up.

On-site Activities

HSAG conducted an on-site visit with DCH on December 1–2, 2011. HSAG collected information 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 Meeting**: The opening meeting included an introduction of the validation team and key DCH and HP staff involved in the performance measure activities. The review purpose, the required documentation, basic meeting logistics and session topics were discussed.
- **Evaluation of System Compliance**: The evaluation included a review of the information systems assessment, focusing on the processing of claims and encounter data, pharmacy data, and enrollment/eligibility information.

  Additionally, the review evaluated the processes used to collect and calculate the performance measures, 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 ISCAT and Supporting Documentation**: The review included the processes used for collecting, storing, validating and reporting performance measure data. The goal was to obtain a confidence level as to the degree of compliance with written documentation compared to actual processes. HSAG conducted interviews to confirm findings from the documentation review, clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- **Overview of Data Integration and Control Procedures**: The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measures. HSAG performed primary source verification to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures.

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

HSAG conducted several interviews with key individuals who were involved in performance measure reporting. Table 4 lists key interviewees:

Table 4—List of Interviewees

Name	Title
Dr. Janice Carson	Deputy Director, Performance, Quality and Outcomes (DCH)
Melinda Ford-Williams	Compliance Auditor (DCH)
Michele Hunter	Services Information Developer III (HP)
Theresa Harris	Information Analyst-Developer (HP)
Yolanda Calhoun	Systems Analyst Supervisor (DCH)
David Burnett	Solution Architect (HP)
Betsy Elrod	Project Manager for Managed Care, TPL, Performance Reporting (HP)
Franklin Martin	Project Manager (HP)
Ashley Summers Hannoush	Pharmacy Intern (DCH)
Yvonne Greene	Eligibility Program Director, Medicaid (DCH)
Turkesia Robertson-Jones	Pharmacy Operations Manager (DCH)
Linda Wiant	Director of Pharmacy (DCH)
Terry Greene	Managed Care Quality Director (DCH)
Tina Hawkins	System Analyst (DCH)
Charles Ball	Tech Lead, Managed Care (HP)
Cheryl Collier	Account Executive (HP)
Ivan Fleet	MMIS Director (DCH)
Ramona Clark	Program Director II, Office of Inspector General (DCH)
Keyonia Belcher (HP)	Claims Manager (HP)
Anita Maddox	Data Capture Supervisor (HP)
Juanita Hines	Director (DCH)

Data Integration, Data Control, and Performance Measure Documentation

There are several aspects crucial to the calculation of performance measures. These include data integration, data control, and documentation of performance measure calculations. Each of the following sections describes the validation processes used and the validation findings. For more detailed information, see Appendix A of this report.

Data Integration

Accurate data integration is essential to calculating valid performance measures. The steps used to combine various data sources, including claims/encounter data, eligibility data, and other administrative data, must be carefully controlled and validated. HSAG validated the data integration process used by DCH and its vendor, HP, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Overall, the validation team determined that the data integration processes at DCH were:

☒ Acceptable

☐ Not acceptable

Data Control

The organizational infrastructure must support all necessary information systems. The quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. HSAG validated the data control processes used by DCH and its vendors, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the validation team determined that the data control processes at DCH were:

☒ Acceptable

☐ Not acceptable

Performance Measure Documentation

Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by DCH and HP. HSAG reviewed all related documentation, which included the completed ISCAT, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. Overall, the validation team determined that the documentation of performance measure calculations was:

☒ Acceptable

☐ Not acceptable

Validation Results

Through the validation process the audit team evaluated HP's data systems for processing of each type of data used for reporting the DCH-required performance measures. General findings are described below.

Enrollment Data

DCH described its process for providing HP three eligibility data file feeds on a daily basis, which included a file from the Division of Family and Children Services within the Department of Human Services, data from the PeachCare for Kids® program, and a data interface from the Social Security Administration. The auditors did not identify any issues related to the processing of enrollment files for the use in performance measure reporting.

DCH allows its providers to enter newborn data into the system, assigning them a unique member ID at birth, but links the newborn's ID to the mother's Medicaid ID. Once the baby is assigned its own Medicaid ID a reconciliation process is conducted to identify potential duplicates when merging enrollment data for reporting. The audit team determined that the current process for assigning an ID at birth was advantageous for the purposes of ensuring complete data for the newborn; however, the audit team indicated the potential for duplicate payment. This is possible when a provider bills for a newborn "baby boy" and then resubmits a duplicate claim with the child's actual name if the link has not been performed at the time of payment. DCH may consider conducting a reconciliation of all births on a periodic basis.

The audit revealed approximately 29 percent of the FFS population as dual-eligibles for Medicare and Medicaid. Because Medicare is the primary payer for these members and there is a potential for missing data, the audit team determined that FFS rates could be impacted, resulting in lower rates since Medicare is not required to share data. Consistent with NCQA technical specifications for HEDIS reporting, the audit team recommended that DCH consider excluding the dual-eligible population for performance measure validation reporting in subsequent years.

Medical Service Data (Encounters)

HP began serving as DCH's fiscal agent as of November 1, 2010. Encounter data were submitted to HP by the three contracted CMOs on a monthly basis. CMOs can submit encounter data as frequently as they'd like but per their contract, at a minimum, they are required to submit encounter data monthly. All CMO encounter data were transmitted to HP using an 837 file through secure data transfer. There were no issues identified with the encounter data submitted by the CMOs. These encounter data were used in the calculation of the Georgia Families rates.

Medical Service Data (Claims)

Claims data were submitted to HP by all FFS contracted providers and facilities. Paper claims were received at the HP facility. The audit team performed a physical inspection of the mail room and

observed actual claims processing. HP demonstrated adequate control procedures for paper claims processing. Additionally, HP has quality checks in place for oversight of the scanning of claims, and the data entry and the processing of claims. HP confirmed that it does not use/accept non-standard codes.

During the claims processing review, the auditors confirmed the appropriate use of standard code sets and HP indicated that it had claim edits in place to accurately capture 4th and 5th digit specificity for ICD-9 codes. However, the audit team requested a query and determined that a significant number of paid claims had invalid ICD-9 codes (i.e., missing 4th and 5th digit specificity when required). It is unclear if these paid claims were part of the previous fiscal agent's data, which was outside of HP's control. The audit team will continue to monitor this area in subsequent audits. Accepting ICD-9 codes without a required 4th or 5th digit specificity has the ability to impact the following HEDIS measures: *Comprehensive Diabetes Care, Follow-up After Hospitalization for Mental Illness, Prenatal and Postpartum Care, Frequency of Ongoing Prenatal Care, Ambulatory Care, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Chlamydia Screening for Women, Appropriate Treatment for Children with Upper Respiratory Infection, Use of Appropriate Medications for People with Asthma, and Follow-up Care for Children Prescribed ADHD Medication*. HSAG acknowledged that DCH's policy does not require 4th or 5th digit specificity for payment of claims but HSAG's findings are specific to those measures where a 4th or 5th digit is required for accurate reporting. Despite the potential impact on these measures, the audit team did not find a significant bias of the 2010 calendar year rates.

Upon further review of coding, the auditors evaluated the use of DRG and MS-DRG codes by the hospitals in Georgia since the AHRQ specifications use both types of codes in many of their measure specifications. It was determined that the Georgia hospitals have not switched to using the MS-DRGs at this time. In addition, it was determined during the performance measure validation audits at the three CMOs that they receive the ICD-9 and CPT codes from the hospitals, but may not receive the DRGs. Therefore, the CMOs and HP were required to use a DRG grouper on inpatient claims in order to run many of the AHRQ measures. The audit found that HP used a DRG grouper for its FFS claims data; however, HP did not apply the DRG grouper to the encounter data submitted by the three CMOs. Not using the DRG grouper on the CMO encounter data could result in missing or underreported data when calculating the Georgia Families rates for AHRQ measures that require DRGs. The Georgia Families rates were calculated using the submitted encounter data from the CMOs.

The State contracts with a pharmacy vendor to administer pharmacy benefits to its FFS population. HP was able to demonstrate adequate reconciliation between pharmacy data and financial payment; however, it does not monitor monthly data volume. The audit team recommends that HP monitor vendor data volume on a monthly basis to ensure data are being submitted on an ongoing basis instead of solely relying on financial reconciliation. Doing this monitoring throughout the year allows data losses to be detected and resolved in a timely manner.

The audit revealed that a significant portion of claims for deliveries were paid through global billing. Global billing is submission of a single claim for a fixed-fee that covers all care related to a particular procedure, over a particular period of time, such as prenatal and post-partum care visits claimed at the time of delivery. HSAG conducted primary source verification on measures impacted

by global billing and identified that the global bill represents the date of delivery, which is important for the calculation of the *Prenatal and Postpartum Care* and *Frequency of Ongoing Prenatal Care* measures. While outside the scope of the performance measure audit, the site visit revealed that global billing could result in overpayment of postpartum care visits. DCH may consider analyzing paid postpartum care visit claims in conjunction with global bills for maternity service since the postpartum care visit should be included in the global bill rate and not billed separately. Additionally, DCH should consider setting a minimum number of visits before a provider is eligible to submit a global bill. The existing policy allows for a global bill even if that member was never seen prenatally, which results in overpayment of a global delivery rate versus a delivery claim. HP should ensure that its claims edits do not pay for a postpartum care claim if a global bill has been submitted. DCH and HP indicated that there were claims edits in place to prevent this practice; however, HSAG recommends periodic monitoring/auditing to ensure the claims edits are working appropriately. While there were significant financial implications, these issues did not have an impact on the calculation of the prenatal and postpartum care measures.

Provider Data

State contracted providers were enrolled via a paper-based or web-based application submission. Each provider was assigned a provider type and/or specialty based on the provider license. The audit team reviewed the provider mapping crosswalk used by ViPS, HP's vendor, to produce performance measure results and found the mapping to be appropriate for the measures being audited.

During primary source verification of the *Follow-Up After Hospitalization for Mental Illness* measure, the audit team found that claims could be submitted by Federally Qualified Health Centers (FQHCs) without a specific rendering provider identified and that certain FQHCs were designated as mental health providers. The specifications for this measure clearly define the qualifying providers to meet the measure criteria; therefore, there is the potential that some visits submitted by these agencies may not have met the measure requirements for appropriate rendering provider and should not have counted towards numerator compliance. The audit team reviewed claims counts of FQHCs and performed a reasonability check against the CMO reported rates that were submitted to HSAG as part of each CMO's Performance Measure Validation audit conducted in the spring of 2011. The audit team determined that there was not a significant bias in the reported rate for this measure; however, HP should work towards requiring that the rendering provider data field be completed for all claims.

Data Integration

On a weekly basis, HP pulled data into the data warehouse (ad-hoc system). HP used data stored within the ad-hoc system to provide the data extract to ViPS. HP worked with ViPS on data issues identified throughout the data import process until all issues were resolved. HP used test files to ensure mapping back to the ad-hoc system prior to the submission. HP retained its change order and technical/testing documents. Data were reconciled between HP and ViPS data to ensure no data were lost during transfer procedures. The audit team did not identify any areas of concern within the data integration process.

Medical Record Data

Several of the required measures were reported using the hybrid method—a combination of administrative claims, encounter data and medical record abstracted data. HP contracted with GMCF to perform the medical record abstraction. GMCF used a vendor's (ViPS/MedCapture) hybrid reporting tools to collect the hybrid data. The MedCapture hybrid tool screen prints and corresponding instructions were reviewed by HSAG. The hybrid tools contained all of the required measure specific data elements and appropriate edits. GMCF reviewer qualifications and the processes in place for training, procurement and data entry were sufficient to ensure reliability of the data collected.

DCH's intent was for HSAG to validate the Georgia Families and FFS hybrid rates and if valid, combine these rates using appropriate methodology to produce the ALL population rates for the purposes of CHIPRA reporting. During the review process, HSAG determined that there was not a valid methodology to combine these hybrid rates for the ALL population given that there was a substantial group of members in the ALL population that had not met the continuous enrollment criteria to be included in the Georgia Families or FFS populations. HSAG recommended that in subsequent years that DCH consider using HSAG to combine CMO reported and audited rates to derive rates for the Georgia Families population and conduct a hybrid review of the FFS and ALL populations. HSAG was not able to validate any hybrid rates for the ALL population for calendar year 2010 data.

HSAG had concerns with GMCF's inter-rater reliability (IRR) and oversight processes of the reviewers and abstractors. Initially GMCF was only reviewing one percent (1%) of the abstracted medical record data, which is not sufficient per industry standards. It was recommended that GMCF increase its oversight to a more reliable level of five percent (5%). GMCF complied with the recommendation and increased its oversight to five percent (5%) of all abstracted records. A convenience sample was required and identified some significant abstraction issues early in the abstraction process. Based on the convenience sample results, education and retraining were provided to the GMCF abstraction staff. An expanded convenience sample review was conducted along with additional feedback and retraining. At the end of this process, GMCF subsequently passed the convenience sample process.

Towards the end of the medical record abstraction process, HSAG selected measures for medical record validation overread. This process included the selection of two to three measures and reabstraction by the audit team of thirty (30) cases for each measure to ensure the accuracy of the abstraction process. The overread process included a review of three measures. The results of the medical record validation overread are displayed in Table 5.

Table 5—Selected Measures for Medical Record Validation			
Measure	**Number of Records Overread**	**T-test Results**	**Pass/Fail**
Comprehensive Diabetes Care – HbA1c Testing	30	N/A	Pass
Postpartum Care	30	-6.658	Pass
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI across both age bands	30	N/A	Pass

While GMCF passed its medical record validation overread, HSAG identified several issues that impacted HP's ability to report some of the hybrid measure rates. These issues are detailed as follows:

- **Potential for Missing Chart Data** - GMCF utilized the chart review prioritization tool in MedMeasures for targeting and prioritizing providers for chart review. The tool allowed GMCF to specify a maximum number of chart reviews for each measure by measure and population. For the Georgia Families population, the system lists the "Plan Name" in the place of the enrollment PCP data field; therefore, the identification of the PCP was not a viable option to utilize as part of the chase logic.
- **Potential Record Tracking Issues -** GMCF sent record requests to providers for administrative (admin) positive members. As a result, the procurement reports had to be manipulated in order to provide HSAG with ongoing procurement rates for hybrid members only. The audit team had difficulty matching the ViPS generated results reports and the HP procurement report.
- **Potential Incomplete Records -** All records were received via fax/mail directly from the provider offices; therefore, the actual reviewer may not have had the advantage of the entire chart for the specific review period. This created a potential for missing data such as labs and growth charts.
- **Potential Problems with Record Storage -** For measures with sub-indicators (e.g., CDC), GMCF filed portions of the record for the same measures into various folders. For example, if one provider record contained an eye exam, the portion of the record that contained the eye exam documentation was placed in one folder and a provider record that contained a LDL-C was placed in another folder. At over-read time, GMCF had difficulty locating the various pieces of documentation. For example, GMCF submitted eye exam documentation instead of the requested HbA1c documentation and advised HSAG that they could not locate the record. Upon further investigation, all records were located but it took several days. HSAG is not confident that all data was thoroughly reviewed for each CDC sub-indicator.
- **Potential Data Integration Issue** - During the convenience sample review, it was noted that the MedCapture abstraction screens contained multiple entries for a single date of service, from admin and hybrid sources, and with multiple providers and/or the same provider. Per GMCF, ViPS provides admin data and entries for all provider chases for each member, which is an acceptable practice. However, GMCF did not demonstrate understanding of the screen print displays and was advised by HSAG to request further training by ViPS. Upon the additional

training, GMCF learned that the GMCF manager was required to de-select entries that were not compliant. HSAG is not confident whether an entry that would have made the member compliant could have been inadvertently de-selected by this manual method.

- **Potential Underreporting of Rates –** In addition to several of the potential issues mentioned above, GMCF had very low procurement rates for obtaining medical record information. Due to the inability to gather all of the records during the medical record review process, there was potential that many positive hits were not received and abstracted, which would have increased the reported hybrid rates. This conclusion was reached based on comparison of the individual CMO reported rates for the hybrid measures and the calculated Georgia Families rates. The rates were not comparable and therefore it was determined that many of the hybrid measures could not be reported and only the administrative rates were valid. Additionally, the audit team evaluated the percent of numerator compliant hits for the medical records received, the rate of records not obtained, and determined whether the rate was biased due to underreporting.

While the abstraction procedures in place at GMCF were approved and the measures passed overread, it was determined that the procurement rates were too low to truly report validate hybrid rates for these populations. For future years DCH, HP, and GMCF should begin the medical record review process earlier and also develop a chase and procurement logic to efficiently gather the most charts possible.

Performance Measure Specific Findings

Based on all validation activities, the HSAG validation team determined validation results for each performance measure. Table 6 displays the key review results. The ALL population did not have valid hybrid rates; therefore, the key findings noted do not reference the ALL population for hybrid measures. For more detailed information, see Appendix B.

Table 6—Key Review Results for DCH Performance Measures for Georgia Families (GF), FFS, and ALL Populations

	Measure	Key Review Results
1.	Well-Child Visits in the First 15 Months of Life	No concerns were identified for the GF hybrid rate. The FFS hybrid rate did not have complete data due to the low procurement rate.
2.	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	No concerns were identified for the GF hybrid rate. The FFS hybrid rate did not have complete data due to the low procurement rate.
3.	Adolescent Well-Care Visits	No concerns were identified for the GF hybrid rate. The FFS hybrid rate did not have complete data due to the low procurement rate.
4.	Children's and Adolescents' Access to Primary Care Practitioners	No concerns were identified.
5.	Adults' Access to Preventive/Ambulatory Health Services	No concerns were identified.
6.	Childhood Immunization Status (Combo 10)	No concerns were identified.
7.	Childhood Immunization Status (Combo 3)	Both GF and FFS hybrid rates were underreported due to low procurement rates.
8.	Lead Screening in Children	No concerns were identified for the GF hybrid rate. The FFS hybrid rate did not have complete data due to the low procurement rate.
9.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Both GF and FFS hybrid rates were underreported due to low procurement rates.
10.	Annual Dental Visit	No concerns were identified.
11.	Cervical Cancer Screening	The GF and FFS hybrid rates were underreported due to low procurement rates.
12.	Breast Cancer Screening	No concerns were identified.
13.	Prenatal and Postpartum Care	The GF and FFS, hybrid rates were underreported due to low procurement rates.
14.	Frequency of Ongoing Prenatal Care	The GF and FFS hybrid rates were underreported due to low procurement rates.
15.	Chlamydia Screening for Women	No concerns were identified.
16.	Immunizations for Adolescents	Both GF and FFS hybrid rates were underreported due to low procurement rates.
17.	Appropriate Testing for Children With Pharyngitis	No concerns were identified.

Table 6—Key Review Results for DCH Performance Measures for Georgia Families (GF), FFS, and ALL Populations		
Measure		**Key Review Results**
18.	Use of Appropriate Medications for People With Asthma	No concerns were identified.
19.	Comprehensive Diabetes Care	Medical record abstraction excluded members from the sample inappropriately for both GF and FFS.
20.	Follow-Up Care for Children Prescribed ADHD Medication	No concerns were identified.
21.	Follow-Up After Hospitalization for Mental Illness	HP is not capturing the rendering provider for FQHCs when calculating GF, FFS, and ALL populations; however, the audit team determined there was not a significant bias.
22.	Ambulatory Care	No concerns were identified.
23.	Inpatient Utilization—General Hospital/Acute Care	The average length of stay of 438.36 days for the inpatient maternity measure for the fee-for-service population was outside of reasonable benchmarks.
24.	Appropriate Treatment For Children With Upper Respiratory Infection	No concerns were identified.
25.	Weeks of Pregnancy at Time of Enrollment	No concerns were identified.
26.	Race/Ethnicity Diversity of Membership	No concerns were identified.
27.	Language Diversity of Membership	No concerns were identified.
28.	Cesarean Delivery Rate: Number of Provider-Level Cesarean Deliveries per 100 Deliveries	The eligible population identified for the denominator was significantly lower than a reasonability check of the individual CMO's reported denominators for the *Prenatal and Postpartum Care* and low birth weight denominators.
29.	Rate of Infants With Low Birth Weight: Rate of Low-Weight Infants per 100 Births	No concerns were identified.
30.	Diabetes Short-term Complications Admission Rate: Rate per 100,000 Population	No concerns were identified.
31.	Asthma Admission Rate: Rate per 100,000 Population	No concerns were identified.
32.	Asthma ER: Percent of Members Who Have Had a Visit to an Emergency Department/Urgent Care Office for Asthma in the Past Six Months.	No concerns were identified.

Validation Findings

HSAG provided an audit designation for each performance measure as defined in Table 7:

Table 7—Validation Findings Definitions	
Report (R)	The organization followed the specifications and produced a reportable rate or result for the measure.
Not Report (NR)	The calculated rate was materially biased, or the organization chose not to report the measure, or the organization was not required to report the measure.

According to the CMS protocol, the validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be "Not Reportable." Consequently, it is possible that an error for a single audit element may result in a designation of "NR" because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, resulting in a measure designation of "R."

Table 8 displays the final validation findings for each DCH performance measure. All administrative rates—rates generated using only claims data—were reportable across all three populations with the exception of the *Cesarean Delivery Rate* measure and the FFS *Inpatient Utilization—General Hospital/Acute Care's Maternity—Average Length of Stay* measure. Performance on hybrid reporting varied across measures and populations. The hybrid rates required medical record data in addition to claims data.

Table 8—Validation Findings for DCH Performance Measures

	Measure	Georgia Families	FFS	ALL
1.	Well-Child Visits in the First 15 Months of Life	Admin - R Hybrid - R	Admin - R Hybrid - NR	Admin - R Hybrid - NR
2.	Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Admin - R Hybrid - R	Admin - R Hybrid - NR	Admin - R Hybrid - NR
3.	Adolescent Well-Care Visits	Admin - R Hybrid - R	Admin - R Hybrid - NR	Admin - R Hybrid - NR
4.	Children's and Adolescents' Access to Primary Care Practitioners	R	R	R
5.	Adults' Access to Preventive/Ambulatory Health Services	R	R	R
6.	Childhood Immunization Status (Combo 10)	R	R	R
7.	Childhood Immunization Status (Combo 3)	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
8.	Lead Screening in Children	Admin - R Hybrid - R	Admin - R Hybrid - NR	Admin - R Hybrid - NR
9.	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
10.	Annual Dental Visit	R	R	R
11.	Cervical Cancer Screening	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
12.	Breast Cancer Screening	R	R	R
13.	Prenatal and Postpartum Care	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
14.	Frequency of Ongoing Prenatal Care	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
15.	Chlamydia Screening for Women	R	R	R
16.	Immunizations for Adolescents	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
17.	Appropriate Testing for Children With Pharyngitis	R	R	R

Table 8—Validation Findings for DCH Performance Measures				
Measure		Georgia Families	FFS	ALL
18.	Use of Appropriate Medications for People With Asthma	R	R	R
19.	Comprehensive Diabetes Care	Admin - R Hybrid - NR	Admin - R Hybrid - NR	Admin - R Hybrid - NR
20.	Follow-Up Care for Children Prescribed ADHD Medication	R	R	R
21.	Follow-Up After Hospitalization for Mental Illness	R	R	R
22.	Ambulatory Care	R	R	R
23.	Inpatient Utilization—General Hospital/Acute Care	R	R (NR for the Maternity—Average Length of Stay measure)	R
24.	Appropriate Treatment For Children With Upper Respiratory Infection	R	R	R
25.	Weeks of Pregnancy at Time of Enrollment	R	R	R
26.	Race/Ethnicity Diversity of Membership	R	R	R
27.	Language Diversity of Membership	R	R	R
28.	Cesarean Delivery Rate: Number of Provider-Level Cesarean Deliveries per 100 Deliveries	NR	NR	NR
29.	Rate of Infants With Low Birth Weight: Rate of Low-Weight Infants per 100 Births	R	R	R
30.	Diabetes Short-term Complications Admission Rate: Rate per 100,000 Population	R	R	R
31.	Asthma Admission Rate: Rate per 100,000 Population	R	R	R
32.	Asthma ER: Percent of Members Who Have Had a Visit to an Emergency Department/Urgent Care Office for Asthma in the Past Six Months	R	R	R
R (Report) = The organization followed the specifications and produced a reportable rate or result for the measure. NR (Not Report) = The calculated rate was materially biased, or the organization chose not to report the measure, or the organization was not required to report the measure.				

Appendix A. Data Integration and Control Findings

for **Georgia Department of Community Health**

Documentation Worksheet

Name:	Georgia Department of Community Health and Hewlett-Packard Enterprise Services
On-Site Visit Date:	December 1–2, 2011
Reviewers:	David Mabb, MS, CHCA; Jennifer Lenz, MPH, CHCA

Data Integration and Control Element	Met	Not Met	N/A	Comments
Accuracy of data transfers to assigned performance measure data repository				
The State accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the calculations of the performance measures have been completed and validated.	☒	☐	☐	
Samples of data from the performance measure data repository are complete and accurate.	☒	☐	☐	
Accuracy of file consolidations, extracts, and derivations				
The State's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	☒	☐	☐	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	☒	☐	☐	
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	☒	☐	☐	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	☒	☐	☐	
If the State uses a performance measure data repository, its structure and format facilitates any required programming necessary to calculate and report required performance measures.				
The performance measure data repository's design, program flow charts, and source codes enable analyses and reports.	☒	☐	☐	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	☒	☐	☐	

Data Integration and Control Element	Met	Not Met	N/A	Comments
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including State production activity logs and the State staff review of report runs, is adequate.	☒	☐	☐	
Prescribed data cutoff dates are followed.	☒	☐	☐	
The State retains copies of files or databases used for performance measure reporting in case results need to be reproduced.	☒	☐	☐	
The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	☒	☐	☐	
The State's processes and documentation comply with the State standards associated with reporting program specifications, code review, and testing.	☒	☐	☐	

HSAG HEALTH SERVICES ADVISORY GROUP

Appendix B. Denominator and Numerator Validation Findings

for **Georgia Department of Community Health**

Reviewer Worksheets

Name:	Georgia Department of Community Health and Hewlett-Packard Enterprise Services
On-Site Visit Date:	December 1–2, 2011
Reviewers:	David Mabb, MS, CHCA; Jennifer Lenz, MPH, CHCA

Table B-1—Denominator Validation Findings for Georgia Department of Community Health

Audit Element	Met	Not Met	N/A	Comments
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	☒	☐	☐	HSAG confirmed that HP appropriately included members within the GF, FFS, and ALL populations correctly according to DCH's specifications.
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	☐	☒	☐	The eligible population for the AHRQ Cesarean delivery rate measure did not appear to be calculated correctly. Significant differences exist between the denominators for the LBW and PPC measures compared to the Cesarean Section measure.
The State correctly calculates member months and member years if applicable to the performance measure.	☒	☐	☐	
The State properly evaluates the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes are appropriately identified and applied as specified in each performance measure.	☒	☐	☐	HP needs to ensure that it applies claims edits that require 5th digit specificity in subsequent audits. Although this did not impact the measures being reported for this year, it could impact measures in subsequent years.
If any time parameters are required by the specifications of the performance measure, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	☒	☐	☐	
Exclusion criteria included in the performance measure specifications are followed.	☐	☒	☐	Medical record review abstraction inappropriately excluded members in the CDC measure.
Systems or methods used by the State to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	☐	☐	☒	

Table B-2—Numerator Validation Findings for Georgia Department of Community Health				
Audit Element	**Met**	**Not Met**	**N/A**	**Comments**
The State uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	☒	☐	☐	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	☒	☐	☐	
The State avoids or eliminates all double-counted members or numerator events.	☒	☐	☐	
Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	☐	☐	☒	DCH and HP do not accept or use any non-standard codes.
If any time parameters are required by the specifications of the performance measure, they are followed (i.e., the measured event occurred during the time period specified or defined in the performance measure).	☒	☐	☐	

DCH Audited Calendar Year 2010 HEDIS®/AHRQ Performance Measurement Report

Measure	Georgia Families		FFS		All	
	Admin Rate	Hybrid Rate	Admin Rate	Hybrid Rate	Admin Rate	Hybrid Rate
Well-Child Visits in the First 15 Months of Life - Zero Visits **Note: Lower rate is better**	7.20	6.57	22.63	NR	7.57	NR
Well-Child Visits in the First 15 Months of Life - One Visit	4.16	4.87	7.14	NR	4.35	NR
Well-Child Visits in the First 15 Months of Life - Two Visits	4.57	3.65	7.34	NR	4.93	NR
Well-Child Visits in the First 15 Months of Life - Three Visits	6.40	6.81	9.68	NR	7.13	NR
Well-Child Visits in the First 15 Months of Life - Four Visits	10.28	10.95	16.82	NR	11.81	NR
Well-Child Visits in the First 15 Months of Life - Five Visits	17.98	12.90	15.49	NR	19.13	NR
Well-Child Visits in the First 15 Months of Life - Six or More Visits	49.40	54.26	20.90	NR	45.07	NR
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	59.03	59.60	51.11	NR	57.69	NR
Adolescent Well-Care Visits	34.25	36.50	24.67	NR	32.05	NR
Childrens and Adolescents Access to Primary Care Providers - Ages 12-24 Months	93.76		88.58		93.60	
Childrens and Adolescents Access to Primary Care Providers - Ages 25 Months - 6 Years	87.13		83.07		86.44	
Childrens and Adolescents Access to Primary Care Providers - Ages 7-11 Years	88.96		84.50		88.11	

Childrens and Adolescents Access to Primary Care Providers - Ages 12-19 Years	85.07		77.34		83.65	
Childrens and Adolescents Access to Primary Care Providers - Total (12 Months - 19 Years)	87.62		80.85		86.71	
Adults Access to Preventive/Ambulatory Health Services - Ages 20-44 Years	85.49		73.46		79.86	
Childhood Immunization Status - Combo 10	4.62		2.49		4.05	
Childhood Immunization Status - Combo 3	24.83	NR	16.06	NR	22.96	NR
Lead Screening in Children	51.61	54.01	43.45	NR	49.53	NR
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	1.01	NR	0.96	NR	0.99	NR
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	0.50	NR	1.44	NR	0.69	NR
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	0.14	NR	0.06	NR	0.13	NR
Annual Dental Visit - Ages 2-3 Years	44.65		38.24		42.49	

Annual Dental Visit - Ages 4-6 Years	74.94		62.94		72.67	
Annual Dental Visit - Ages 7-10 Years	77.74		65.23		75.48	
Annual Dental Visit - Ages 11-14 Years	70.06		58.84		67.81	
Annual Dental Visit - Ages 15-18 Years	58.97		51.18		56.75	
Annual Dental Visit - Ages 19-21 Years	39.93		33.07		35.09	
Annual Dental Visit - Total	67.16		54.01		64.23	
Cervical Cancer Screening	69.10	NR	31.09	NR	45.30	NR
Breast Cancer Screening	52.95		41.59		42.46	
Comprehensive Diabetes Care - HbA1c Testing	74.37	NR	45.86	NR	48.17	NR
Comprehensive Diabetes Care - HbA1c Poor Control **Note: Lower rate is better**	99.91	NR	99.03	NR	99.11	NR
Comprehensive Diabetes Care - HbA1c Good Control <8.0	0.07	NR	0.67	NR	0.62	NR

Comprehensive Diabetes Care - HbA1c Good Control <7.0	0.08	NR	0.53	NR	0.44	NR
Comprehensive Diabetes Care - Eye Exam	40.49	NR	33.55	NR	34.03	NR
Comprehensive Diabetes Care - LDL-C Screening	64.90	NR	38.93	NR	40.97	NR
Comprehensive Diabetes Care - LDL-C Level	0.16	NR	0.89	NR	0.83	NR
Comprehensive Diabetes Care - Medical Attention to Nephropathy	66.25	NR	54.36	NR	55.36	NR
Comprehensive Diabetes Care - Blood Pressure Control <140/80	0.16	NR	0.72	NR	0.67	NR
Comprehensive Diabetes Care - Blood Pressure Control <140/90	0.25	NR	1.00	NR	0.93	NR
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	36.94		34.64		36.38	
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	48.53		43.92		47.19	
Follow-Up After Hospitalization for Mental Illness - 30-Day Follow-Up	65.84		57.57		60.51	
Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	44.30		35.06		38.30	

Inpatient Utilization—General Hospital/Acute Care	Rates reported in separate table		Rates reported in separate table		Rates reported in separate table	
Prenatal and Postpartum Care - Timeliness of Prenatal Care	36.02	NR	49.01	NR	56.00	NR
Prenatal and Postpartum Care - Postpartum Care	40.28	NR	27.51	NR	38.89	NR
Frequency of Ongoing Prenatal Care - <21 Percent	56.17	NR	45.36	NR	40.85	NR
Frequency of Ongoing Prenatal Care - 21-40 Percent	24.18	NR	33.35	NR	36.71	NR
Frequency of Ongoing Prenatal Care - 41-60 Percent	9.17	NR	11.53	NR	11.67	NR
Frequency of Ongoing Prenatal Care - 61-80 Percent	4.44	NR	4.88	NR	5.54	NR
Frequency of Ongoing Prenatal Care - 81+ Percent	6.04	NR	4.88	NR	5.23	NR
Weeks of Pregnancy at Time of Enrollment - <0 Weeks	10.17		7.17		17.46	
Weeks of Pregnancy at Time of Enrollment - <1-12 Weeks	8.28		0.82		40.76	
Weeks of Pregnancy at Time of Enrollment - <13-27 Weeks	58.43		2.49		13.52	

Weeks of Pregnancy at Time of Enrollment - <28 or More Weeks	14.69		81.05		20.68	
Weeks of Pregnancy at Time of Enrollment - Unknown	8.43		8.46		7.58	
Chlamydia Screening - Ages 16-20 Years	42.08		40.52		44.64	
Chlamydia Screening - Ages 21-24 Years	59.22		38.70		57.77	
Chlamydia Screening - Total	46.33		39.84		48.71	
Immunizations for Adolescents - Combination #1 Total	55.80	NR	45.33	NR	52.93	NR
Immunizations for Adolescents - Meningococcal Total	60.58	NR	49.22	NR	57.71	NR
Immunizations for Adolescents - Tdap/Td Total	68.62	NR	57.37	NR	65.39	NR
Appropriate Testing for Children With Pharyngitis	67.49		64.65		67.12	
Use of Appropriate Medications for People with Asthma - Ages 5-11 Years	91.83		94.57		91.79	
Use of Appropriate Medications for People with Asthma - Ages 12-50 Years	88.31		88.40		88.13	

Use of Appropriate Medications for People with Asthma - Total	90.52		90.36		90.14	
Appropriate Treatment For Children With Upper Respiratory Infection **Note: Inverted Rate**	78.62		77.19		78.62	
Race/Ethnicity Diversity of Membership	Rates reported in separate table		Rates reported in separate table		Rates reported in separate table	
Language Diversity of Membership	Rates reported in separate table		Rates reported in separate table		Rates reported in separate table	
Ambulatory Care-Outpatient	358.90 per 1000 MM		398.22 per 1000 MM		372.44 per 1000 MM	
Ambulatory Care-ED Visits	58.71 per 1000 MM		78.60 per 1000 MM		65.56 per 1000 MM	
Cesarean Delivery Rate	NR - rate was biased		NR - rate was biased		NR - rate was biased	
Rate of Infants with Low Birth Weight	8.08 per 100 births		7.67 per 100 births		7.97 per 100 births	
Asthma Admission Rate/100,000	50.67 per 100,000 members		415.24 per 100,000 members		350.16 per 100,000 members	
Diabetes Short-term Complications Admission Rate /100,000	25.57 per 100,000 members		43.13 per 100,000 members		30.31 per 100,000 members	
Asthma ER Rate	1.40		1.10		1.30	

Source: HEDIS 2011 Final Audited IDSS, AHRQ self-reported rates (validated by HSAG)

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)

Georgia Families

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	6287		33094	31.71	5.26
1-9	7112		22254	3.54	3.13
10-19	15437		45637	10.59	2.96
20-44	58078		162971	112.41	2.81
45-64	2015		9312	68.43	4.62
65-74	4		15	31.71	3.75
75-84	0		0	0.00	0.00
85+	0		0	0.00	0.00
Unknown	0		0	0.00	0.00
Total	88933		273283	20.67	3.07

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	5012		18811	18.02	3.75
1-9	5428		14280	2.27	2.63
10-19	2377		7292	1.69	3.07
20-44	3199		11005	7.59	3.44
45-64	1071		4107	30.18	3.83
65-74	3		12	25.37	4.00
75-84	0		0	0.00	0.00
85+	0		0	0.00	0.00
Unknown	0		0	0.00	0.00
Total	17090		55507	4.2	3.25

Surgery					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
<1	1275		14283	13.68	11.20
1-9	1684		7974	1.27	4.74
10-19	1575		7874	1.83	5.00
20-44	2873		13558	9.35	4.72
45-64	895		5062	37.20	5.66
65-74	1		3	6.34	3.00
75-84	0		0	0.00	0.00
85+	0		0	0.00	0.00
Unknown	0		0	0.00	0.00
Total	8303		48754	3.69	5.87
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	11485		30471	7.07	2.65
20-44	52006		138408	95.47	2.66
45-64	49		143	1.05	2.92
Unknown	0		0		0
Total	63540		169022	28.67	2.66

***For discharges, only discharges per 1000 member years were reported, not discharges per 1000 member months.**

****The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)

Fee for Service

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months*	Days	Days / 1,000 Members Months	Average Length of Stay
<1	1936		17891	152.64	9.24
1-9	5066		26168	24.48	5.17
10-19	6848		33508	33.56	4.89
20-44	38544		539816	416.48	14.01
45-64	47388		649162	394.03	13.70
65-74	16828		413673	461.91	24.58
75-84	12557		273503	449.08	21.78
85+	7599		121463	389.63	15.98
Unknown	0		0	0.00	0.00
Total	136766		2075184	298.83	15.17

Medicine

Age	Discharges	Discharges / 1,000 Member Months*	Days	Days / 1,000 Members Months	Average Length of Stay
<1	1440		6994	59.67	4.86
1-9	3656		13715	12.83	3.75
10-19	2771		12070	12.09	4.36
20-44	12500		108762	83.91	8.70
45-64	31019		304127	184.60	9.80
65-74	11247		90761	101.34	8.07
75-84	8973		161791	265.65	18.03
85+	6078		27525	88.30	4.53
Unknown	0		0	0.00	0.00
Total	77684		725745	104.51	9.34

Surgery

Age	Discharges	Discharges / 1,000 Member Months*	Days	Days / 1,000 Members Months	Average Length of Stay
<1	496		10897	92.97	21.97
1-9	1410		12453	11.65	8.83
10-19	1252		10342	10.36	8.26
20-44	6816		191296	147.59	28.07
45-64	16288		310338	188.37	19.05
65-74	5581		322912	360.57	57.86
75-84	3584		111712	183.43	31.17
85+	1521		93938	301.34	61.76
Unknown	0		0	0.00	0.00

Total	36948		1063888	153.20	28.79
Maternity**					
Age	**Discharges**	**Discharges / 1,000 Member Months***	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	2825		11096	11.11	3.93
20-44	19228		239758	184.98	12.47
45-64	81		34697	21.06	NR - rate was biased
Unknown	0		0	0.00	0.00
Total	22134		285551	72.44	12.90

***For discharges, only discharges per1000 member years were reported, not discharges per 1000 member months.**

****The maternity category is calculated using member months for members 10-64 years.**

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)

All

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	8223		50985	43.91	6.20
1-9	12178		48422	6.59	3.98
10-19	22285		79145	14.91	3.55
20-44	96622		702787	255.94	7.27
45-64	49403		658474	369.19	13.33
65-74	16832		413688	461.68	24.58
75-84	12557		273503	449.05	21.78
85+	7599		121463	389.62	15.98
Unknown	0		0	0.00	0.00
Total	225699		2348467	116.46	10.41

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	6452		25805	22.23	4.00
1-9	9084		27995	3.81	3.08
10-19	5148		19362	3.65	3.76
20-44	15699		119767	43.62	7.63
45-64	32090		308234	172.82	9.61
65-74	11250		90773	101.30	8.07
75-84	8973		161791	265.64	18.03
85+	6078		27525	88.29	4.53
Unknown	0		0	0.00	0.00
Total	94774		781252	38.74	8.24

Surgery

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	1771		25180	21.69	14.22
1-9	3094		20427	2.78	6.60
10-19	2827		18216	3.43	6.44
20-44	9689		204854	74.60	21.14
45-64	17183		315400	176.84	18.36
65-74	5582		322915	360.38	57.85
75-84	3584		111712	183.41	31.17
85+	1521		93938	301.33	61.76
Unknown	0		0	0.00	0.00

Total	45251		1112642	55.17	24.59
Maternity*					
Age	**Discharges**	**Discharges / 1,000 Member Months**	**Days**	**Days / 1,000 Members Months**	**Average Length of Stay**
10-19	14310		41567	7.93	2.90
20-44	71234		378166	137.72	5.31
45-64	130		34840	19.53	2.68
Unknown	0		0	0.00	0.00
Total	85674		454573	46.21	5.31

***For discharges, only discharges per1000 member years were reported, not discharges per 1000 member months.**
****The maternity category is calculated using member months for members 10-64 years.**

Race/Ethnicity Diversity of Membership (RDM)

Georgia Families

Race	Hispanic or Latino		Not Hispanic or Latino		Unknown Ethnicity		Declined Ethnicity		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White	144967	9.51%	137826	9.04%	385316	25.27%	0	0.00%	668109	43.82%
Black or African American	2896	0.19%	227467	14.99%	487020	31.94%	0	0.00%	718383	47.12%
American-Indian and Alaska Native	270	0.02%	462	0.03%	320	0.02%	0	0.00%	1052	0.07%
Asian	548	0.04%	5581	0.37%	23310	1.53%	0	0.00%	29439	1.93%
Native Hawaiian and Other Pacific Islanders	598	0.04%	183	0.01%	388	0.03%	0	0.00%	1169	0.08%
Some Other Race	46480	3.05%	3460	0.23%	5443	0.36%	0	0.00%	55383	3.63%
Two or More Races	0	0.00%	6	0.00%	3	0.00%	0	0.00%	9	0.00%
Unknown	68	0.00%	64	0.00%	1002	0.07%	0	0.00%	1134	0.07%
Declined	342	0.02%	14194	0.93%	35365	2.32%	0	0.00%	49901	3.27%
Total									1524579	100.00%

Race/Ethnicity Diversity of Membership (RDM)

Fee for Service

Race	Hispanic or Latino		Not Hispanic or Latino		Unknown Ethnicity		Declined Ethnicity		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White	88020	7.24%	202389	16.64%	231665	19.05%	0	0.00%	522074	42.93%
Black or African American	1861	0.15%	274252	22.55%	272655	22.42%	0	0.00%	548768	45.13%
American-Indian and Alaska Native	163	0.01%	517	0.04%	224	0.02%	0	0.00%	904	0.07%
Asian	480	0.04%	10750	0.88%	11863	0.98%	0	0.00%	23093	1.90%
Native Hawaiian and Other Pacific Islanders	333	0.03%	166	0.01%	277	0.02%	0	0.00%	776	0.06%
Some Other Race	16712	1.37%	6138	0.50%	3240	0.27%	0	0.00%	26090	2.15%
Two or More Races	0	0.00%	2	0.00%	1	0.00%	0	0.00%	3	0.00%
Unknown	348	0.03%	15170	1.25%	7711	0.63%	0	0.00%	23229	1.91%
Declined	1168	0.10%	36257	2.98%	33687	2.77%	0	0.00%	71112	5.85%
Total									1216049	100.00%

Race/Ethnicity Diversity of Membership (RDM)

All

Race	Hispanic or Latino		Not Hispanic or Latino		Unknown Ethnicity		Declined Ethnicity		Total	
	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White	169138	8.00%	271010	12.82%	471610	22.31%	0	0.00%	911758	43.13%
Black or African American	3357	0.16%	392072	18.54%	571593	27.04%	0	0.00%	967022	45.74%
American-Indian and Alaska Native	316	0.01%	762	0.04%	392	0.02%	0	0.00%	1470	0.07%
Asian	731	0.03%	13099	0.62%	26883	1.27%	0	0.00%	40713	1.93%
Native Hawaiian and Other Pacific Islanders	672	0.03%	261	0.01%	488	0.02%	0	0.00%	1421	0.07%
Some Other Race	49448	2.34%	7969	0.38%	6410	0.30%	0	0.00%	63827	3.02%
Two or More Races	0	0.00%	8	0.00%	4	0.00%	0	0.00%	12	0.00%
Unknown	359	0.02%	15184	0.72%	7883	0.37%	0	0.00%	23426	1.11%
Declined	1270	0.06%	48630	2.30%	54629	2.58%	0	0.00%	104529	4.94%
Total									2114178	100.00%

Language Diversity of Membership (LDM)

	Georgia Families		FFS		All	
Spoken Language Preferred for Health Care						
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
English	1399469	91.79%	1056922	86.91%	1876093	88.74%
Non-English	111616	7.32%	67710	5.57%	135275	6.40%
Unknown	13494	0.89%	91417	7.52%	102810	4.86%
Declined	0	0.00%	0	0.00%	0	0.00%
Total: this should sum to 100%	1524579	100.00%	1216049	100.00%	2114178	100.00%
Language Preferred for Written Materials						
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
English	1399469	91.79%	1056922	86.91%	1876093	88.74%
Non-English	111616	7.32%	67710	5.57%	135275	6.40%
Unknown	13494	0.89%	91417	7.52%	102810	4.86%
Declined	0	0.00%	0	0.00%	0	0.00%
Total: this should sum to 100%	1524579	100.00%	1216049	100.00%	2114178	100.00%
Other Languages Needs						
	Number	**Percentage**	**Number**	**Percentage**	**Number**	**Percentage**
English	0	0.00%	0	0.00%	0	0.00%
Non-English	0	0.00%	0	0.00%	0	0.00%
Unknown	1524579	100.00%	1216049	100.00%	2114178	100.00%
Declined	0	0.00%	0	0.00%	0	0.00%
Total: this should sum to 100%	1524579	100.00%	1216049	100.00%	2114178	100.00%