State of Georgia

Department of Community Health

# SFY 2014 External Quality Review Annual Report

Including

CY 2012 Performance Measures

SFY 2013 Reported Performance Improvement Projects

SFY 2014 Compliance Reviews

*for*

# Georgia Families Care Management Organizations

December 2013

HSAG Health Services Advisory Group

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HSAG HEALTH SERVICES ADVISORY GROUP

# CONTENTS

# 1. Executive Summary

## Purpose of Report

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. The State refers to its Medicaid managed care program as Georgia Families (GF) and to its CHIP program as PeachCare for Kids®. For the purposes of this report, "Georgia Families" refers to all Medicaid and CHIP members enrolled in managed care, approximately 1.1 million beneficiaries.[1-1]

The Code of Federal Regulations (CFR) at 42 CFR §438.358[1-2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the quality, timeliness of, and access to the health care services that managed care organizations provide.

The technical report must describe how the EQRO drew conclusions as to the quality, timeliness of, and access to care furnished by a state's managed care organizations. The report of results must also contain an assessment of the strengths and weaknesses of the managed care organizations regarding health care quality, timeliness, and access and must make recommendations for improvement. Finally, the report must assess the degree to which the managed care organizations addressed recommendations made within the previous external quality review (EQR).

To comply with these requirements, DCH contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to aggregate and analyze the GF CMOs' data and prepare an annual technical report. HSAG used the Centers for Medicare & Medicaid Services' (CMS') November 9, 2012, update of its External Quality Review Toolkit for States when preparing this report.[1-3]

This report provides:

- An overview of the GF program.
- A description of the scope of EQR activities included in this report.
- An aggregate assessment of health care timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures (PMs), and performance improvement projects (PIPs).

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 12/2/2013."

[1-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

[1-3] The Centers for Medicare & Medicaid Services. External Quality Review Toolkit, November 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Downloads/EQR-Toolkit.pdf. Accessed on September 24, 2013.

- CMO-specific findings and an assessment of the CMOs' strengths and weaknesses.
- Recommendations to DCH to improve the CMOs' compliance with State and federal requirements that will subsequently lead to improvements in the quality, timeliness, and access to services provided to GF members.
- Recommendations for the CMOs to improve member access to care, quality of care, and timeliness of care.

## Overview of the External Quality Review

To produce this report, HSAG analyzed and aggregated data submitted and/or gathered by the CMOs. The data addressed the following three federally mandated EQR activities:

- *Review of compliance with federal and State-specified operational standards*. HSAG evaluated the CMOs' compliance with State and federal requirements for organizational and structural performance. The DCH contracts with the EQRO to conduct a review of one-third of the full set of standards each year in order to complete the cycle within a three-year period of time. HSAG conducted on-site compliance reviews in July and August 2013. The CMOs submitted documentation that covered the state fiscal year (SFY) 2013 review period of July 1, 2012, through June 30, 2013. HSAG provided detailed, final audit reports to the CMOs and DCH in December 2013.
- *Validation of PMs*. HSAG validated the PM rates required by DCH to evaluate the accuracy of the PM results reported by the CMOs. The validation also determined the extent to which the DCH-specific PM rates calculated by the CMOs followed specifications established by DCH. HSAG assessed the PM results and their impact on improving the health outcomes of members. HSAG began validation of the CMOs' PM rates in March 2013 and completed the validation activities in June 2013. The CMOs submitted PM data that generally reflected the period of January 1, 2012, through December 31, 2012. HSAG provided final PM validation reports to the CMOs and DCH in September 2013. In addition to validation of the CMOs' data, DCH used HSAG to conduct validation of the PM rates calculated by its Medicaid Management Information System (MMIS) vendor, Hewlett Packard (HP). HSAG also determined HP's compliance with generating rates for the GF program, the Fee-for-Service (FFS) Program, all members enrolled in the Medicaid and CHIP programs (ALL), the Medicaid Adult Only population (MAO), and the Community Care Services Program (CCSP). HSAG provided final PM validation reports to HP and DCH in November 2013.
- *Validation of PIPs*. HSAG reviewed PIPs for each CMO to ensure the CMOs designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocols for validating PIPs. HSAG assessed the PIPs for real improvements in care and services to give confidence to the reported improvements. In addition, HSAG assessed the CMOs' PIP outcomes and impacts on improving care and services provided to members. HSAG validated PIPs between July 1, 2013, and August 8, 2013. The CMOs submitted PIP data that reflected varying time periods, depending on the PIP topic. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in November 2013.

In addition to the federally mandated activities, DCH conducted the Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-4] surveys for its Medicaid adult, Medicaid and PeachCare for Kids® child, and PeachCare for Kids® only populations during the review period to learn more about member experiences with their care. HSAG included the results from the CAHPS surveys for all three populations.

## Overall Findings, Conclusions, and Recommendations

CMS chose the domains of quality, access, and timeliness as keys to evaluating the performance of Medicaid managed care plans. In this report, HSAG provides overall findings, conclusions, and recommendations regarding the CMOs' aggregate performance during the review period for each domain of care.

### *Quality*

The quality domain of care relates to the CMOs' structural and operational characteristics and their ability to increase desired health outcomes for GF members (through the provision of health care services).

PM and PIP results are used to assess the care each of the CMOs delivers (through its provider network) to members in areas such as preventive screenings and well-care visits, chronic disease management, and appropriate treatment for acute conditions. Interventions associated with increasing performance in these areas are likely to improve health outcomes. In addition, DCH monitors aspects of each CMO's operational structure that supports the delivery of quality care, including the adoption of practice guidelines by each CMO's contracted providers, the effectiveness of each CMO's quality assessment and performance improvement program, and the assessment of each CMO's health information system used to support the delivery of care and services.

HSAG used the CMOs' PM rates (which reflect CY 2012 measurement data), PIP validation results and outcomes, CAHPS survey results, and scores from the review of compliance with standards related to measurement and improvement to assess the quality domain of care.

The DCH required the CMOs to report rates in SFY 2013 for 44 of 47 measure categories from the original required list, reflecting the measurement period of January 1, 2012, through December 31, 2012. The measure list consisted of clinical quality, access, and utilization measures, as well as health plan descriptive information. Many of the 44 measure categories included multiple components or age stratifications, resulting in a higher number of total measure rates reported by each CMO. The DCH deferred CMO reporting on one measure, *Developmental Screening in the First Three Years of Life,* until 2014, and two dental services-related measures required for federal reporting were being calculated by CMS on behalf of DCH using parallel reporting information obtained through the CMS-416 form.

Similar to findings from last year, the CMOs demonstrated the greatest opportunity for improvement in the quality domain of care. HSAG found that each CMO had appropriate structures

[1-4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

in place to support the overall delivery of care but struggled to demonstrate improved health outcomes. For example, the CMOs did well ensuring that clinical practice guidelines were adopted and disseminated on clinical conditions relevant to the Medicaid and PeachCare for Kids® populations. However, the CMOs had challenges with their providers adhering to the guidelines for some conditions and lacked effective processes to ensure that noncompliant providers were monitored until acceptable performance was reached.

The targeted file review of emergency room and inpatient hospital visits showed mixed results; however, all CMOs have an opportunity to improve transitions of care for their members. Improved transitions of care should lead to fewer emergency room visits, lower readmission rates, improved health outcomes, and overall improved quality of care.

Overall, when compared to the DCH-established performance targets, the CMOs did not meet the targets for most measures. Opportunities continue to exist in the areas of causal/barrier analysis and intervention development to address areas in need of improvement. The PIP analysis showed that the CMOs were not always aligning interventions to barriers and/or the barriers were not well-substantiated. HSAG's review again found implemented interventions that would not have an impact on the PIP indicators. The CMOs must continue to improve quality and performance improvement initiatives to meet the State-established targets for all measures.

### Access

The access domain of care relates to the CMOs' standards, established by the State, to ensure the availability of and access to all covered services for GF members.

The DCH contracts require the CMOs to ensure access to and the availability of services to members. In addition to its own internal monitoring activities, DCH uses HSAG to conduct monitoring processes, including audits, to assess CMO compliance with access standards.

The CMOs demonstrated some improvement in the measure rates within the Access area, including statistically significant improvement for the *Annual Dental Visit* rates for several age groups, and for the *Children's Access to Preventive Health Services* measure. All three CMOs achieved sustained improvement for the Annual Dental Visits PIP for both targeted age groups.

The CMOs showed some effort to engage members in providing input to the quality program and participating in focus groups. This is a good strategy for identifying barriers and discussing potential improvement interventions.

### Timeliness

The timeliness domain of care relates to the CMOs' ability to make timely utilization decisions based on the clinical urgency of the situation, minimize any disruptions to care, and provide a health care service quickly after a need is identified.

The DCH's CMO contracts require that CMOs ensure timeliness of care. HSAG conducts review activities to assess the CMOs' compliance with these standards in areas such as enrollee rights and

protections, the grievance system, continuity and coordination of care, and utilization management. PMs related to childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to the provision of a health care service within a recommended period after a need is identified. Members' satisfaction with receiving timely care also falls under the timeliness domain of care.

The emergency room visits and transitions of care file reviews showed opportunities to improve care coordination in an effort to reduce emergency room visits and inpatient hospitalizations. The reviews found that members rarely contacted the CMO or their providers prior to visiting an emergency room with routine complaints. It appears that many of their concerns and complaints could have been addressed at a lower level of care if the member had first contacted the CMO or a provider for direction.

The CAHPS surveys revealed the *Rating of the Health Plan* global rating results were below the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] 2013 Medicaid national 25th percentile for adult members and below the HEDIS 2013 Medicaid national 50th percentile for the Medicaid and PeachCare for Kids® child populations. Medicaid adults also rated the *Getting Care Quickly* and *How Well Doctors Communicate* composite ratings below HEDIS 2013 Medicaid national 50th percentiles. These represent areas for improvement.

In general, the PeachCare for Kids® population had results above the HEDIS 2013 Medicaid national 90th percentiles for two of the global ratings and all four of the composite measures for which comparisons could be made.

## Conclusions and Recommendations

As noted in the prior year's technical report, the CMOs scored high in the areas of compliance for policies and procedures, design for PIPs, and reporting valid PM rates; however, they were less likely to manage health care outcomes effectively. The CMOs have opportunities to align programs, processes, and efforts to achieve goals more effectively. For example, there were missed opportunities with the CMOs' efforts to monitor adherence to clinical practice guidelines through medical record reviews. It would have been beneficial for the CMOs to include PM indicators such as monitoring diabetic testing control values, in addition to the assessment of tests performed, to determine adherence to the guidelines. In addition, providers who were noncompliant with clinical practice guidelines were not consistently monitored and reevaluated to bring up their level of performance. HSAG encouraged the CMOs to better align their disease and case management programs' goals with PM and PIP targets. Also, the CMOs must focus on improving health outcomes, including care coordination and transitions of care. One effective effort would be for the CMOs to obtain discharge instructions for their hospitalized members and work with them to ensure discharge needs are met. Such efforts would likely reduce the number of hospital readmissions.

HSAG encouraged the CMOs to build a rapport with their members, particularly those receiving case management services. Members will be more likely to contact the CMO or their provider prior to visiting an emergency room if they have a trusting relationship with a case manager at the CMO.

[1-5] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

The members can then be directed to the most appropriate setting, i.e., emergency room, urgent care clinic, or provider's office, to meet their needs.

In general, HSAG recommended that the CMOs implement rapid-cycles of improvement that include small tests of change as a mechanism to measure success, and spread effective interventions or make mid-course corrections. Too often the results of the CMOs' performance improvement efforts are not realized until after a year or more, making the timeline for achieving performance goals undesirable. Ongoing technical assistance in the areas of quality improvement along with tools and techniques for internal performance evaluation are recommended for all CMOs.

Despite many areas that still show opportunities for improvement, the review did note many CMO strengths, including compliance with standards and several actions taken by the CMOs based on prior-year recommendations. HSAG did note substantial efforts on the part of the CMOs to better incorporate member feedback and input into the quality improvement program. This was noted as a strength among all three CMOs. Appendix E includes a detailed summary of the prior-year recommendations and the actions taken.

Based on the review of the CMO's performance on the PM results, PIP outcomes, and compliance with State and federal standards, HSAG provides specific recommendations based on each activity's review findings at the end of each section.

HSAG will evaluate DCH's and the CMO's progress in the next annual report.

## Georgia's Medicaid and PeachCare for Kids® Programs

The DCH was created in 1999 to serve as the lead agency for health care planning and purchasing issues in Georgia. Its mission is to provide affordable quality health care to Georgians through effective planning, purchasing, and oversight. The DCH is dedicated to a healthy Georgia.

As the largest DCH Division, the Division of Medical Assistance Plans administers the Medicaid and CHIP programs. Georgia's standalone CHIP program is known locally as PeachCare for Kids®. The Medicaid program provides health care for low-income families; refugees; pregnant women; children; and those who are aging, blind, and disabled. The DCH is designated as the single State agency for Medicaid.

The DCH has administered the FFS model since the inception of Medicaid. The FFS model delivers services to Medicaid and some PeachCare for Kids® members through a statewide provider network. In addition to the FFS model, the State of Georgia introduced the GF managed care program in 2006 and currently partners with three private CMOs to deliver services to these members.

The GF program includes more than half of the State's Medicaid population and the PeachCare for Kids® population. Enrollment is mandatory for PeachCare for Kids® members; however, in some cases they can receive an exemption from enrollment. For Georgia Medicaid, enrollment in GF is mandatory for the following Medicaid eligibility categories:

- 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
- Women with breast and cervical cancer
- Women participating in the Planning for Healthy Babies® (P4HB®) program

## GF Care Management Organizations

The DCH held contracts with three CMOs during the review period of July 1, 2012, through June 30, 2013. All three CMOs provide services to the State's GF members. In addition to providing medical and mental health Medicaid and CHIP-covered services to members, the CMOs also provide a range of enhanced services, including dental and vision services, disease management and education, and wellness/prevention programs.

### *AMERIGROUP Community Care (AMERIGROUP)*

AMERIGROUP Community Care (AMERIGROUP) is a wholly-owned subsidiary of WellPoint, Inc.

### *Peach State Health Plan (Peach State)*

Peach State Health Plan (Peach State) is part of the multistate national parent company, Centene Corp.

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

WellCare of Georgia, Inc. (WellCare) is part of the national corporation, WellCare Health Plans, Inc., a multistate provider of only government-sponsored health products.

## GF Quality Strategy

Federal regulations require that state Medicaid agencies 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 the state and its contracted plans must meet. The state must conduct periodic reviews to examine the scope and content of its quality strategy, evaluate its effectiveness, and update it as needed.

To comply with federal regulations, DCH submitted to CMS its initial GF Quality Strategic Plan in June 2007 for ensuring that the Department provided timely, accessible, and quality services to GF members. The plan was approved by CMS in 2008, and quality strategic plan updates were completed in January 2010 and again in November 2011.[2-1] The DCH is presently preparing another update to the quality strategic plan. The DCH publishes the updated plans on its Web site (http://dch.georgia.gov/medicaid-quality-reporting).

[2-1] Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: http://dch.georgia.gov/medicaid-quality-reporting. Accessed on: December 4, 2013.

Since November 2011, DCH:

- Received recognition in Secretary Sebelius' *2012 Annual Report on the Quality of Care for Children in Medicaid and CHIP* for reporting 19 of the 24 CHIPRA Initial Core Set measures for both Medicaid and CHIP in federal fiscal year 2011—more than any other state.
- Participated, along with the Georgia Department of Behavioral Health and Developmental Disabilities, in a tri-state grant with Maryland and Wyoming aimed at improving clinical, functional, and social outcomes for children with serious behavioral health needs through a Care Management Entity (CME) provider model, which incorporates wrap-around services, peer supports, and intensive care coordination.
- Continued, since FY 2012, the Medicaid and Children's Health Insurance Program (CHIP) Redesign Initiative. The redesign identified and evaluated various strategic options to improve members' health outcomes as the division worked to achieve long-term program savings and financial sustainability. The Strategy Report was published in mid-FY 2012 and included wide-scale stakeholder input.
- Decided not to undertake a wholesale restructuring of the Georgia Medicaid program as described in the Strategy Report. However, the department began planning for the transition of the FFS population to a care coordination service delivery model.
- Began its commitment, as a component of the redesign effort, to transition approximately 27,000 foster care, adoption assistance, and juvenile justice children in residential placement from FFS Medicaid to a single CMO for their health care coverage. Moving these populations to a designated CMO should result in improved care coordination, continuity of care, and better health outcomes for the enrollees. The DCH selected AMERIGROUP as the designated CMO, and the transition is slated for March 2014.
- Was awarded a CHIPRA Cycle II grant to combine technology solutions to simplify, streamline, and better coordinate enrollment and renewal for Medicaid and PeachCare for Kids® members.
- Received notice of a grant award in FY 2012 for the Balancing Incentives Payment (BIP) program providing financial incentives to the state for the investment and strengthening of access to non-institutionally based long-term services and supports. The Georgia award was estimated at $64.3 million.
- Joined the CMS Quality Improvement Workshop Series, QI 201, and selected postpartum care rates as its project focus. The DCH and its CMOs are now collaborating with the National Initiative for Children's Healthcare Quality (NICHQ) to increase the CMOs' postpartum care rates, incorporate the reproductive life plan discussion into the postpartum care visit, and encourage reproductive life plan and long-acting reversible contraceptive discussions in the antepartum visits as well. The DCH and the CMOs are collaborating with the Georgia OB/Gyn Society in this effort.
- Applied for but was not awarded a CMS Strong Start grant. However, DCH continued its partnership with the March of Dimes and the United Way of Greater Atlanta (both agencies are supporting the Strong Start grant awardee in Georgia) to support the Centering Pregnancy Program, a prenatal care delivery model which would have been DCH's focus had it received a Strong Start grant.
- Modified the CMOs' study indicator for their Dental PIP to specifically focus their improvement efforts on achieving the CMS Oral Health Initiative's performance targets for Georgia by the end of the federal fiscal year (FFY) 2015.

- Collaborated with the CMOs to consolidate several PIPs into one common "Bright Futures" PIP to drive improvements in all of the activities slated to be performed during each preventive health visit as described in the Bright Futures Periodicity Schedule. Held a "Bright Futures" PIP conference for CMO and DCH staff members in October 2013. A participant from the Georgia Chapter of the AAP also attended. This new PIP begins in January 2014.
- Engaged its EQRO, HSAG, to provide tutorials to the CMOs on conducting PIPs
- Moved toward mandated compliance with the International Classification of Diseases, 10th Edition (ICD-10) code sets within the Medical Assistance Plans Division. ICD-10 will replace ICD-9 code sets used to report medical diagnoses and inpatient procedures.
- Disbursed, from September 2011 through June 2012 (partial year FY 2012), more than $66 million in Health Information Technology (Health IT) funds into the Georgia economy through federally funded incentive payments to more than 693 eligible Medicaid professionals and 89 eligible hospitals for incorporating a certified electronic health record system into their practice or hospital.
- Continued coordination, during FY 2012, of statewide Non-Emergency Transportation (NET) services for both GF and FFS members on a capitated basis. The number of NET vendors was reduced from three to two.

## GF Quality Initiatives Driving Improvement

HSAG noted several DCH initiatives during the review period of July 1, 2012, through June 30, 2013, that supported the improvement of quality of care and services for GF members, as well as activities that supported the CMOs' improvement efforts.

### *Auto-Assignment Program*

In 2010, DCH developed a program that awards the CMOs with auto-assignment of enrollees based on a calculation of the CMOs' costs for providing services and the quality of the services provided. Being awarded auto-assignment for low-cost, high-quality services encourages the CMOs to achieve better quality outcomes for their members.

The DCH selected the eight clinical PMs listed below to serve as the basis for determining the quality scores, using CY 2011 data to inform the CY 2013 auto-assignment.

- *Adolescent Well-Care Visits*
- *Chlamydia Screening in Women*
- *Childhood Immunization Status—Combination 3*
- *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0 Percent)*
- *Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)*
- *Frequency of Ongoing Prenatal Care (81+ Percent)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*

In spring 2013, DCH expanded the number of PMs included in the auto-assignment algorithm for CY 2014 auto-assignment to 19 PMs per each six-month cycle.

### Quality Improvement Conference

The DCH worked with HSAG to conduct a quality improvement conference, *Moving the Needle—Shifting from Documentation Compliance to Improved Health Outcomes*, on January 11, 2013. Two primary conference topics were targeted. First, each CMO presented its Rapid Cycle Improvement Project's findings related to the *Follow-Up Care for Children Prescribed Attention Deficit Hyperactivity Disorder (ADHD) Medication* PM. Presentations included information on data analysis and test-site selection, test-site barrier analysis, and test-site intervention and evaluation. Second, an HSAG staff member presented on emerging themes related to case and disease management programs as a result of the compliance reviews that HSAG conducted in August and September 2012. In addition, each CMO presented an overview of its case and disease management programs, including successes and lessons learned. The primary audience for the 2013 conference included CMO staff members as well as key stakeholders interested in the GF quality improvement activities. A secondary audience included the GF DCH staff members who support and monitor the CMOs in the areas of contract compliance, performance measurement, and quality improvement.

### Planning for Healthy Babies® (P4HB®) Program

P4HB is Georgia's 1115 Demonstration created by DCH and approved by CMS in October 2010. The program aims to reduce the number of low birth weight (LBW) and very low birth weight (VLBW) births in Georgia. It was implemented in January 2011.

LBW is defined as babies born weighing less than 2,500 grams (5 pounds, 8 ounces), and VLBW is the category of babies born weighing less than 1,500 grams (3 pounds, 5 ounces). The P4HB program offers family planning services for women who do not qualify for other Medicaid benefits or who have lost Medicaid or PeachCare for Kids® coverage. The program also offers interpregnancy care (IPC) services to women who meet the program's eligibility requirements and deliver very low birth weight infants on or after January 1, 2011. In addition to services related to family planning, women participating in the IPC component of P4HB are able to receive primary care visits; management and treatment of chronic diseases; substance use disorder treatment (detoxification and intensive outpatient rehabilitation); case management; Resource Mother Outreach (support services such as supportive counseling, non-emergency transportation, and linkage to community resources); limited dental services; and prescription drugs (non-family planning).

The P4HB program also offers nurse case management and Resource Mother outreach for Medicaid-eligible women who deliver a very low birth weight infant on or after January 1, 2011.

### Adult Medicaid Quality Grant

The DCH was the recipient of a grant awarded by CMS in December 2012. The grant allows DCH the opportunity to collect and validate PM data on the Medicaid adult population consistent with the

Adult Core Set of Medicaid measures released by CMS in February 2013. These data will be used to compare Georgia's performance against other states.

As part of the grant, DCH is working with the Division of Aging in the Department of Human Services and the 12 Area Agencies on Aging (AAAs) serving the CCSP population to measure and improve the care management of members with depression.

Many of the 26 measures selected to be part of the Medicaid Adult Core Set are touched upon throughout this report. A complete list of these measures, as well as rates where available, can be found in Section 6, Adult Quality Measures.

### *Reducing Avoidable Emergency Room Visits*

The DCH, in partnership with its CMOs, embarked on a collaborative performance improvement project to explore interventions aimed at reducing members seeking care in the emergency room (ER) for conditions that could have been more appropriately managed in another setting. Avoidable ER visits are costly and may point to access issues or suboptimal care for Medicaid and PeachCare for Kids® members.

### *Collaborative Improvement and Innovation Network to Reduce Infant Mortality*

Georgia is one of 13 states participating in the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality. The project aims to reduce infant mortality by targeting the following areas:

1. Eliminating early elective deliveries
2. Promoting safe sleep practices for infants
3. Encouraging smoking cessation in parents
4. Helping hospitals adhere to standards of perinatal practice
5. Improving access to care for mothers before and between pregnancies

Subsequent to Georgia's participation in the CoIIN and in response to a legislative directive, DCH implemented an early elective deliveries policy in October 2013. The policy clearly articulates that Georgia's Medicaid program will not pay for non-medically necessary elective inductions or deliveries prior to 39 weeks gestation. The DCH P4HB Program's IPC component has also been identified as a program that targets improvements in access to care for mothers between pregnancies. Lastly, DCH is working with its CMOs, as described above, to improve postpartum care rates and increase timely reproductive life plan discussions for all pregnant and non-pregnant women.

## Review of Compliance With Standards

The DCH contracted with HSAG to perform a review of the CMOs' compliance with standards, one of the three federally mandated activities. The requirements described at 42 CFR §438.358 specify that a review must be conducted within a three-year period to assess the CMOs' compliance with State and federal requirements related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. HSAG reviews one-third of this full set of standards each year so that over a three-year cycle, all requirements will be reviewed. HSAG conducted on-site compliance reviews in July and August 2013. The CMOs submitted documentation that covered the review period of July 1, 2012, through June 30, 2013. HSAG provided detailed, final audit reports to the CMOs and DCH in December 2013. During this cycle, HSAG reviewed the CMOs' performance in the following areas related to access to services:

- Practice Guidelines
- Quality Assessment and Performance Improvement (QAPI)
- Health Information Systems
- Re-review of all *Partially Met* and *Not Met* elements from the prior year's review

In addition to the above-mentioned review areas, HSAG performed case-specific file reviews which focused on case management enrollees with emergency room visits and hospital admissions during a six-month period. HSAG reviewed eight cases per CMO. where a member enrolled in case management visited the emergency room between October 1, 2012, and March 31, 2013. The reviews focused on the directions the members received, if any, to present to the emergency room and if the members' needs could have been met in another setting without risk to the members' health. HSAG also reviewed eight cases, per CMO, of members enrolled in case management who had two or more acute inpatient hospitalizations between October 1, 2012, and March 31, 2013. The reviews looked for gaps in the transitions of care and discharge planning to determine if any of the hospitalizations could have been avoided.

Appendix A contains a detailed description of HSAG's methodology for conducting the reviews.

## SFY 2014 Findings

HSAG organized, aggregated, and analyzed results from the compliance reviews to draw conclusions about the CMOs' performance in providing quality, accessible, and timely health care services to GF members.

Table 3-1 displays the standards and compliance scores.

**Table 3-1—Standards and Compliance Score**

| Standard # | Standard Name | # of Elements* | # of Applicable Elements** | # *Met**** | # *Partially Met* | # *Not Met* | # *Not Applicable* | Total Compliance Score |
|---|---|---|---|---|---|---|---|---|
| I | Practice Guidelines | 10 | 10 | A: 9<br>P: 8<br>W: 9 | A: 1<br>P: 2<br>W: 1 | A: 0<br>P: 0<br>W: 0 | A: 0<br>P: 0<br>W: 0 | A: 95.0%<br>P: 90.0%<br>W: 95.0% |
| II | Quality Assessment and Performance Improvement | 30 | 30 | A: 28<br>P: 28<br>W: 28 | A: 2<br>P: 2<br>W: 2 | A: 0<br>P: 0<br>W: 0 | A: 0<br>P: 0<br>W: 0 | A: 96.7%<br>P: 96.7%<br>W: 96.7% |
| III | Health Information Systems | 8 | 8 | A: 8<br>P: 8<br>W: 8 | A: 0<br>P: 0<br>W: 0 | A: 0<br>P: 0<br>W: 0 | A: 0<br>P: 0<br>W: 0 | A: 100%<br>P: 100%<br>W: 100% |
| Varied | Follow-up From the SFY 2013 Review | A: 5<br>P: 6<br>W: 3 | A: 5<br>P: 6<br>W: 3 | A: 3<br>P: 6<br>W: 0 | A: 2<br>P: 0<br>W: 3 | A: 0<br>P: 0<br>W: 0 | A: 0<br>P: 0<br>W: 0 | A: 80.0%<br>P: 100%<br>W: 50.0% |
| | ****Total Compliance Score | A: 53<br>P: 54<br>W: 51 | A: 53<br>P: 54<br>W: 51 | A: 48<br>P: 50<br>W: 45 | A: 5<br>P: 4<br>W: 6 | A: 0<br>P: 0<br>W: 0 | A: 0<br>P: 0<br>W: 0 | A: 95.3%<br>P: 96.3%<br>W: 94.1% |

*** 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.*

******* AMERIGROUP (A); Peach State (P); WellCare (W)

**** **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.

For standards assessed during the review period, HSAG found that performance for all three CMOs on the applicable documentation requirements across the three standards and the follow-up reviews was sufficient to result in an overall *Met* score.

The CMOs had ample documentation describing their processes, practices, action plans, and performance results/outcomes related to each review requirement. During the on-site interviews, the responses of the CMOs' staff members to HSAG's questions, including their descriptions and examples of their processes and practices for ensuring compliance with the requirements, were consistent with the documentation.

The statewide percentage-of-compliance score for Peach State was 97.2 percent, while AMERIGROUP received a score of 95.3 percent and WellCare received a score of 94.1 percent.

Following its review, HSAG prepared an initial draft report of its findings and forwarded the draft to DCH and the CMOs for their review prior to issuing this final report.

## Findings

HSAG noted overall strengths across the three CMOs for each of the standards. The strengths were generally noted in the areas of documentation compliance for required policies and procedures as well as operational and structural supports such as staffing resources, committee structure, and information systems necessary to support the quality program.

The areas of weakness were generally related to efforts necessary for understanding the reasons for suboptimal performance and the actions needed for improving performance. The greatest opportunity is for each CMO to reexamine the aims of required activities and take advantage of the efforts to drive improvement. One general impression from HSAG's review is that the quality improvement activities were implemented to meet federal and State requirements rather than to improve the delivery of care and overall health outcomes. For example, all CMOs monitored their providers against clinical practice guidelines, but efforts to raise the competency of providers were either absent or not robust enough to have an overall impact on provider practice.

The outcome of quality improvement monitoring activities must be viewed as the goal rather than perfunctory activities that must be conducted to meet requirements. Overall compliance scores remained high for the CMOs because the federal protocols evaluate the structure and operations needed to support the overall quality improvement program versus evaluation of content and effectiveness. For example, one federal standard simply assesses whether a quality improvement evaluation was generated by the CMO rather than focusing on evaluation of the content.

HSAG provides aggregated observations across the CMOs for each of the standards reviewed followed by individual CMO key findings.

### Standard I: Clinical Practice Guidelines

- Overall, the CMOs demonstrated that their clinical practice guidelines (CPGs) were based on the health care needs of their population and consistent with reliable clinical evidence. The CMOs included network providers in the review of the CPGs, which were developed with the consensus of health care professionals.
- All the CMOs were using the DCH-approved methodology for evaluating CPG compliance; however, none of the CMOs achieved the 90 percent compliance standard. Additionally, one CMO did not follow the DCH-approved methodology for reviewing the appropriate number of charts during the CPG compliance review process and was required to resubmit the information.
- The CMOs provided multiple written documents including member newsletters, provider newsletters, policies, procedures, compliance analyses, and committee meeting minutes as evidence of CPG activities.
- Despite all CMOs complying with CPG monitoring, overall, the process for using the results to target suboptimal performance was lacking in part or in whole.

## Standard II: Quality Assessment and Performance Improvement (QAPI)

- Overall, the CMOs have an adequate structure in place for their quality assessment and performance improvement programs. The CMOs' committee structure included a broad representation of providers as well as enhanced efforts to obtain member input into the quality program. While the CMOs met the structural requirements of the QAPI program, in general, their annual program evaluations were not robust in providing an assessment of why goals or metrics were not met. The DCH's review of the QAPI programs showed discrepancies with data reported by the CMOs in many instances.
- In addition, the annual QAPI evaluations did not effectively analyze overall metrics to determine patterns or areas of concern in need of improvement. For example, the CMOs did not link results from provider adequacy with PM rates and results of members' experience to understand if and how the information was related.

## Standard III: Health Information Systems

- HSAG did not identify any findings for the Health Information Systems standard.

## Follow-Up Review

The CMOs corrected many of the previously identified areas of deficiency. One CMO was able to effectively resolve all six of the areas identified as deficiencies from the previous year's review.

## Hospital Admissions and Emergency Room File Review

Overall, HSAG found opportunities at each CMO to reduce the number of emergency room visits. Members did not appear to contact their CMO prior to visiting an emergency room. HSAG found that many of the complaints and concerns bringing the members to an emergency room could have been treated at a lower level of care (i.e., provider's office or urgent care clinic). Documentation did not show that members generally contacted their providers or health plans prior to an emergency room visit. One CMO implemented an Emergency Room Case Management program whereby participating hospitals notified the CMO within a designated time frame when a member visited the emergency room. However, in the cases reviewed, the members generally did not visit an emergency room of a participating hospital.

The CMOs' processes for discharge planning and transitions of care varied. HSAG found ineffective processes for transitions of care at two of the CMOs. The third CMO had more effective processes though it still had opportunities for improvement. Often the CMOs' process for discharge planning relied on members obtaining their own discharge plans. HSAG found that, overall, communication between the case manager and the member post-discharge was lacking. Additionally, the medication reconciliation process must be strengthened and implemented consistently by the CMOs.

All CMOs appeared to face challenges in successfully contacting the members. Overcoming this challenge would facilitate the CMOs in reducing the number of inappropriate emergency room visits and improve transitions of care, thereby reducing the number of hospital readmissions.

## *CMO Comparison—Key Findings*

HSAG highlighted the following compliance review findings and recommendations for each of the CMOs.

### AMERIGROUP

#### Compliance Review Findings

AMERIGROUP demonstrated the following strengths and opportunities for improvement:

- Had an adequate structure in place for its quality assessment and performance improvement program. This was demonstrated through a description of the Medicaid quality management program that outlined the goals, scope, objectives, structure and accountability, and resources.
- Included members and a broad representation of providers on committees to ensure they had input into the quality program. The CMO enhanced its process for recruiting and engaging members to participate on the Health Education Advisory Committee. The CMO held these meetings in provider offices in order to increase member participation. These committee members contributed by reviewing medical forms, pamphlets, and surveys the CMO intended to use and made adjustments to the materials based on member and provider feedback. In addition, the CMO has used this committee to serve as a focus group to gather input on a wide range of quality improvement initiatives.
- Maintained a robust health information system that collected, integrated, tracked, analyzed, and reported its health care data. The collected data included utilization, grievance, appeals, enrollment, provider, and member characteristics. Reporting capabilities were sufficient to provide standard and ad-hoc reports to various committees.
- Had processes in place to validate accuracy of data and enhanced its health information systems with custom interfaces to ensure systems integration.
- Did not have 90 percent of its providers achieve compliance with the CPGs during the review period. Only 52 percent of providers were compliant with the Diabetes CPG, 75 percent were compliant with the Asthma CPG, and 77 percent of providers were compliant with the ADHD CPG.
- Lacked a process to effectively reevaluate all noncompliant providers to ensure compliance with the CPGs.
- Did not meet the DCH-established performance targets for all measures.
- Lacked robust analysis of metrics within the annual evaluation report and integration of metrics to inform improvement efforts.
- Lacked a process to ensure review of utilization data for members in care management.
- Lacked consistency with obtaining discharge plans for members in an inpatient facility.

#### Recommendations

Based on the compliance review results, HSAG recommends that AMERIGROUP:

- Continually reevaluate noncompliant providers for CPG compliance until the provider complies with the CPG process.

- Improve performance to meet the State-established targets for all measures.
- Include all quality elements and provide an integrated assessment of the overall performance in the QAPI report.
- Formalize the case managers' review process to include periodic review of patient utilization data. This review and documented findings should occur at least quarterly for members enrolled in case management.
- Implement a discharge process that includes the case manager obtaining discharge instructions from the hospital, then discussing those instructions with the member, and reconciling the medications with the member in a timely manner to assure optimal care.
- Improve patient engagement, particularly with the complex population. The CMO must consider more face-to-face visits and involve the member's family and caregivers, when possible.
- More closely examine members' barriers to improved health and access to care, and use available resources, including community resources, to assist members in overcoming identified barriers.

## Peach State

### Compliance Review Findings

Peach State demonstrated the following strengths and opportunities for improvement:

- Provided clinical practice guidelines for the Diagnosis and Management of Asthma, General Diabetes Care, and the Diagnosis and Evaluation of the Child with Attention-Deficit/ Hyperactivity/Disorder. Each CPG was reviewed and updated appropriately to the standard requirements. The CMO monitored CPG compliance annually; and when providers were not in compliance, the CMO issued a corrective action plan. When the evaluation of compliance was conducted the following year, the CMO pulled its normal sample to conduct the compliance evaluation and ensured that those providers not receiving a compliant score the previous year would also be re-reviewed. The process ensured that noncompliant providers were reviewed at least annually until they were compliant.
- The Quality Committee had oversight of the program. Participating providers were included on various committees, and the CMO ensured that a diverse group of providers were participating on the committee to ensure a cross-section of specialties, races, and genders was represented.
- Had a robust health information system that tracked, trended, collected, analyzed, and reported all types of health care data. The CMO used a performance dashboard to view performance rates as soon as the data were available. Peach State provided many utilization, grievance, and provider reports to monitor performance and track utilization trends. CMO staff indicated that when data anomalies were identified, staff members investigated to find the opportunities for improvement.
- Formalized its discharge planning program and demonstrated consistent application of its process, including efforts to obtain the discharge plan for members.
- Identified members for case management activities using data. The CMO conducted a health risk assessment; and if any condition was identified, the member was forwarded for case management.

- Did not achieve 90 percent compliance for providers practicing consistently with CPGs. In addition, Peach State did not review the appropriate number of charts during the CPG compliance review process and the CMO had to revise its report after this issue was identified.
- Did not meet all DCH-established targets for all PMs.
- Lacked robust analysis within the annual quality program evaluation. In many cases, the CMO failed to achieve its targets, yet the barriers and analyses were lacking and the recommendations often cited continuation of efforts that had not proven to be successful.
- Lacked a process to routinely review claims information for members enrolled in case management as a mechanism to address avoidable emergency room use.

### Recommendations

Based on the compliance review results, HSAG recommends that Peach State:

- Ensure at least 90 percent of its providers are compliant with the CPGs.
- Improve performance to meet the State-established targets for all measures.
- Include all quality elements and provide an integrated assessment of overall performance within the QAPI evaluation report. The CMO must provide more robust analyses for areas that did not meet the desired performance to provide better direction and focus for future efforts.
- Implement a protocol for case managers to regularly review the claims information. This information should be used to then reach out to members who recently visited an emergency room or experienced a hospital admission.
- Improve patient engagement, particularly with the complex population. The CMOs must consider more face-to-face visits and involve the member's family and caregivers, when possible.
- More closely examine members' barriers to improved health and access to care, and use available resources, including community resources, to assist members in overcoming identified barriers.

## WellCare

### Compliance Review Findings

WellCare demonstrated the following strengths and opportunities for improvement:

- Had CPGs that were based on the health care needs of its population and consistent with reliable clinical evidence. It included network providers in the review of the CPGs, which were developed with the consensus of health care professionals.
- Included members and providers on committees to ensure they have input on health care materials the CMO distributes. The Member Advisory Committee included CMO members, and they provided input on marketing materials, initiatives, and preferred methods to contact members.
- Maintained a robust health information system that collected, integrated, tracked, analyzed, and reported its health care data. The collected data included utilization, grievance, appeals, enrollment, provider, and member characteristics. Reporting capabilities were sufficient to provide standard and ad-hoc reports to various committees.

- Had processes in place to validate accuracy of data and enhanced its commercial health information systems with custom interfaces to ensure systems integration.
- Addressed some aspects of the prior year's deficiencies, including demonstration that it had implemented a member incentive program which included a plan for evaluation of the strategy. WellCare also demonstrated better alignment within its documentation across case management, disease management, transitions of care, and discharge planning processes.
- Did not meet CPG compliance standards of 90 percent. Eighty-one percent of providers were compliant with the Diabetes CPG, 86 percent were compliant with the Asthma CPG, while 96 percent of providers were compliant with the ADHD CPG.
- Lacked a process to reevaluate providers who were noncompliant with CPGs.
- Did not meet DCH-established performance targets.
- Lacked robust analyses within the QAPI evaluation.
- Did not fully resolve all three areas identified as deficiencies from the prior year's review. All of these deficiencies were related to implementing CMO policies and procedures in the area of coordination and continuity of care. Specifically, the case management review showed infrequent contact and inadequate follow-through by the case manager for many cases. In addition, discharge plans were not routinely obtained and discharge needs were not incorporated into members' care plans.
- Lacked strategies to improve member engagement within the case management process.

## Recommendations

Based on the compliance review results, HSAG recommends WellCare do the following:

- Reevaluate providers for CPG compliance until the provider complies with the CPG process.
- Improve performance to meet the State-established targets for all measures. Include all quality elements and provide an integrated assessment of the overall performance within the QAPI evaluation report.
- Demonstrate an adequate process in place to coordinate care consistent with the information outlined in its policies and procedures.
- Ensure that processes to identify members for case management efficiently capture high emergency room utilizers.
- Improve patient engagement, particularly with the complex population. The CMOs must consider more face-to-face visits and involve the member's family and caregivers, when possible.
- Examine members' barriers to improved health and access to care, and use available resources, including community resources, to assist members in overcoming identified barriers.
- Encourage members to contact the case manager, other CMO representatives (e.g., a nurse line or NurseWise), or the provider to determine the most appropriate level of care prior to presenting to an emergency room.
- Implement a process to obtain discharge plans from the hospital after each discharge. The case managers must review the instructions, reconcile the medications, and refer the member to community resources, as needed.

# 4. Performance Measures

The DCH annually selects PMs to evaluate the quality of care delivered to GF members by the CMOs. The selected PMs reflect the State's priorities and areas of concern for all Medicaid and PeachCare for Kids® members and include PMs from HEDIS, the Agency for Healthcare Research and Quality (AHRQ), the Children's Health Insurance Program Reauthorization Act (CHIPRA) core set, and CMS' adult core set. The CMOs calculate and report data consistent with the most current reporting-year specifications.

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 PMs 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 EQRO to conduct the PM validation.

The purpose of PM validation is to ensure that managed care plans calculate PM 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 SFY 2013, DCH required its CMOs to report PM rates in June 2013 using CY 2012 as the measurement period. To facilitate rate comparisons, monitor waiver population performance, and to prepare for reporting of data to CMS for the CHIPRA and adult core set measures, DCH contracted with HP, its MMIS vendor, to calculate PM rates for the Medicaid and PeachCare for Kids® programs for the following populations:

- **Georgia Families Managed Care**—the GF population consisted of Medicaid and PeachCare for Kids® members enrolled in the three contracted CMOs:[4-1] AMERIGROUP, Peach State, and WellCare. To be included in the GF rates, a member had to be continuously enrolled in any one CMO or could have switched CMOs during the measurement period with no more than a 30-day break in enrollment. The GF rates excluded dual eligible members.

- **Fee-for-Service (FFS)**—the FFS population included Medicaid and PeachCare for Kids® members not enrolled in the GF managed care program. To be included in the FFS rates, a member had to be continuously enrolled in the FFS population for the entire measurement period with no more than a 30-day break in enrollment. The FFS rates excluded dual eligible members.

- **Total Population (ALL)**—the ALL population consisted of all members covered under the Georgia Medicaid and PeachCare for Kids® programs during the measurement period, including the members in the FFS and GF populations, as well as members who may have switched between managed care and FFS during the measurement period with no more than a 30-day break in enrollment. The ALL population rates excluded dual eligible members.

[4-1] The DCH required its CMOs to contract with an NCQA-licensed audit organization and undergo an NCQA HEDIS Compliance Audit™. To validate the rates calculated for the non-HEDIS measures, DCH contracted HSAG to perform an independent performance measure validation for each CMO. Results for these validations are presented in each CMO-specific Performance Measures Validation report.

- **Medicaid Adult Only (MAO)**—the MAO population was composed of the members included in the ALL population during the measurement period, excluding the PeachCare for Kids® population. The MAO rates excluded dual eligible members.

- **Community Care Services Program (CCSP)**—the CCSP is a Medicaid waiver program that provides community-based social, health, and support services to eligible members as an alternative to institutional placement in a nursing facility. The DCH's Division of Medical Assistance Plans partners with the Division of Aging Services (DAS) within the Department of Human Services (DHS) for the operational management of the program. Approximately 70 percent of the CCSP population was composed of dual eligible members (i.e., members eligible for Medicare and Medicaid), and the measure rates were calculated for all members covered under the CCSP waiver program, including the dual eligible members.

All GF CMOs underwent an independent National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ [4-2] by a licensed organization to ensure that the CMOs followed specifications to produce valid and reliable HEDIS measure results. HSAG received the final, audited CMO rates and ensured that the HEDIS compliance protocol met CMS' requirements for validating PMs. Additionally, HSAG validated PMs that were not covered under the scope of the HEDIS Compliance Audit, which consisted of measures developed by AHRQ or as part of the CHIPRA or adult core set measures. Finally, HSAG used the CMOs' audited hybrid rates to calculate a GF weighted average for the hybrid measures. Appendix B contains a more detailed description of the method used to conduct the PM validation activities.

## Performance Measure Requirements and Targets

The DCH requires that CMOs collect and report PM rates, allowing for a standardized method to objectively evaluate the CMOs' delivery of services. The DCH's requirement for the CMOs to report PM data annually supports the overall GF strategic plan objective: improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance.

Beginning in 2009, DCH adopted standardized and nationally accepted PMs and required its GF CMOs to use these standardized measures in their reporting of data to allow for comparability among the CMOs as well as against other state and national benchmarks.

The DCH required the CMOs to report rates in SFY 2013 for 44 measure categories from the original required list of 47 measure categories, generally reflecting the measurement period of January 1, 2012, through December 31, 2012. These rates were reported in June 2013. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information. Many of the 44 measure categories included multiple components or age stratifications. The DCH deferred CMO reporting on one measure, *Developmental Screening in the First Three Years of Life,* until 2014; and two measures related to dental services required for federal reporting were being calculated by CMS on behalf of the Georgia Medicaid Program using parallel reporting information obtained through the CMS-416 report.

[4-2] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance.

For the CY 2012 data, DCH established performance targets for many of the required measure categories and their associated components. Forty targets were established. These performance targets for CY 2012 data were based on NCQA national Medicaid percentiles and the Nationwide Inpatient Sample (NIS) for the AHRQ measures. The DCH reevaluates performance targets each year to continue to drive increased performance. The DCH has the ability to impose financial penalties for the CMOs that fail to achieve the established performance targets.

# Findings

## *Performance Measure Validation Key Findings*

All three DCH-contracted CMOs underwent PM validation for rates calculated using CY 2012 measurement period data. For HEDIS measures, the CMOs underwent an NCQA HEDIS Compliance Audit performed by a certified HEDIS compliance auditor. For non-HEDIS measures, HSAG conducted the audit following the CMS protocols for PM validation activities. HSAG conducted the audit of HP, which calculated rates for the GF, FFS, ALL, MAO, and CCSP populations.

## *CMOs*

### Strengths

- All three CMOs were able to report rates for all required measures.
- The CMOs have demonstrated greater proficiency calculating core set and non-HEDIS measures.

### Challenges

- While the CMOs were able to report rates for all measures, after the close of the audit period HSAG identified that Peach State and WellCare did not provide updated rates for their COPD admission rate measure using the revised technical specifications released in May 2013. HSAG received the corrected rates after releasing and finalizing the CMO-specific PM validation reports; however, HSAG displays the corrected rates in this report.
- In the HP review, HSAG reviewed encounter data rejection reports. These reports showed two of the CMOs, AMERIGROUP and Peach State, had approximately 2.5 percent of the encounter data rejected by HP, while the third CMO, WellCare, had a 9.6 percent error rejection rate. Overall, the error rejection rate was approximately 6 percent. The DCH required CMOs to meet a 99 percent pass rate, so currently this standard has not been met. The high error rejection rate for WellCare must be explored to determine the reasons for data rejection, and it must be corrected by the CMO. Incomplete encounter data can negatively impact the rates for the GF and the ALL populations.

### *HP*

## Strengths

- HP appropriately included members within the GF, FFS, ALL, MAO, and CCSP populations according to DCH specifications. HP also properly captured data as provided, and ICD-9 specificity appeared to be enforced for submission of claims.
- HSAG noted substantial improvement by HP in capturing 4th- and 5th-digit coding specificity between last year's and this year's audits. 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 PM rate reporting. This specificity issue was not completely eliminated, but HSAG determined the final rates were not biased for reporting measures impacted by the specificity.

## Challenges

HSAG identified the following changes related to PM validation:

- The State contracted with a pharmacy vendor, Catamaran, to administer pharmacy benefits to its FFS population. HP was able to demonstrate adequate reconciliation between pharmacy data and financial payments. However, pharmacy reversals were included in the extracted files sent to ViPS, the NCQA-Certified software vendor, for rate calculation. Reversed pharmacy claims usually occur when a member presents a prescription to a pharmacy but then fails to return to pick up the prescription. After seven days, the pharmacy must return the prescription to stock and submit a reversed claim to HP. Including these reversed pharmacy claims, therefore, may inflate rates, since members who did not pick up the prescription will appear to have received the medication. For this year, NCQA allowed this process; therefore, the auditors did not assess bias to any rates. HSAG recommends that HP explore options to reconcile pharmacy reversals to ensure the pharmacy data are not overstated, and that rates are reportable.
- As identified last year, DCH did not require the capture of a rendering provider type on all claims. This impacts measures that require a specific provider type to perform the service, such as the well-child visit measures and mental health follow-up measures. For hybrid measures, this typically results in increased medical record review, but the rate should not be biased. However, for administrative-only measures, the missing rendering provider information may cause a significantly biased, under-reported rate. This issue is especially important for group providers such as federally qualified health centers (FQHCs). The FQHCs often submit the facility identification as the rendering provider. HP confirmed that the issue with obtaining the rendering provider's identification from the FQHCs had not changed. HSAG recommends that DCH and HP continue to work toward requiring that the appropriate rendering provider's identification be completed for all claims. HSAG recognizes the challenge for DCH, given that states are not currently required to have FQHCs submit a rendering provider on claims since the FQHC receives prospective payments.
- The dual-eligible population was excluded from the PM rate calculations this year for all populations with the exception of CCSP, for which HP appropriately included dual-eligible members based on direction from DCH. However, during the rate review validation process, it appeared that the eligible populations contained more members than expected, since dual-

eligible members were excluded. HSAG recommends that HP research this issue further for future reporting years.

- While HP calculated the *Childhood Immunization Status* measures appropriately, the audit team did query Hepatitis B (Hep B) shots to determine why this rate appeared low, especially with the additional use of the GRITS immunization registry. It appeared the birthing hospitals, which provide the first Hep B immunization, were not billing for the Hep B immunization on the baby's or the mother's claim; therefore, this information was not included in the administrative data, nor was it submitted to GRITS. HSAG recommended that the State examine numerator-compliant Hep B shots from the CMOs and compare those to Hep B negative cases within the MMIS to determine how the CMOs were receiving these data. This information will help to drive appropriate interventions for DCH.
- HP does not use a DRG grouper for CMO-submitted encounter data, which may result in under-reporting of inpatient utilization data for the GF and ALL population rates.
- For the *Care Transition—Transition Record Transmitted to Health Care Professional* measure, HP only calculated the denominator since the measure set specifications for the numerator did not provide CPT or ICD-9 codes for calculation. Therefore, these rates were not reportable for any populations with the exception of CCSP, since HP used the hybrid methodology to collect data.

During the medical record review process, HSAG identified several issues that could be attributed to the Georgia Medical Care Foundation's (GMCF's) procurement and abstraction practices. GMCF is a subcontractor to HP and abstracts the medical records for the HEDIS hybrid measures. The issues were:

- Incomplete Roadmap Submission: HP and GMCF did not adequately identify changes from the prior year to their medical record review process in their HEDIS Roadmap submission to HSAG. GMCF notified HSAG of the addition of 11 new reviewers at the conclusion of the medical record review process. Had this factor been known to HSAG at the onset of the medical record reviews, a convenience sample would have been requested across all reported hybrid measures, not just the new hybrid measures.
- Potential Medical Record Procurement Process Concerns: GMCF procured medical record data from CY 2010 through CY 2012 regardless of the measure review period. This resulted in a large volume of unusable data that the GMCF reviewers were required to review. This fact could potentially have resulted in a higher number of abstraction errors.
- Abstraction Practices Not in Alignment with the NCQA Technical Specifications for the Measures: HSAG identified trends related to the errors found for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* and *Adolescent Well-Care Visits (AWC)* measures, which were not in alignment with the NCQA Technical Specifications. This may have been attributed to the volume of new staff members hired by GMCF for the HEDIS 2013 season.
- Insufficient Oversight of Medical Record Review Staff: The GMCF Quality Assurance/Inter-rater Reliability (IRR) Policy contained the requirement that GMCF conduct IRR review of 5 percent of the total review volume of sample cases per abstractor. IRR reports submitted to HSAG demonstrated that GMCF did not consistently adhere to the requirement. GMCF cited issues with the automated IRR calculation in the vendor database. In addition, a 5 percent oversight may not have been sufficient for the volume of new reviewers.

HSAG recommends that prior to future hybrid reporting, GMCF and HP provide complete responses in the Roadmap that accurately reflect the medical record review process (i.e., addition of new review staffing). To identify abstraction errors early in the medical record review process, IRR must begin immediately and continue throughout the project at a minimum of 5 percent. IRR should be conducted at a higher percentage for all new review staff members. Regarding vendor oversight, HP should enhance its vendor oversight above the weekly review of GMCF IRR reports. As in prior years, HSAG recommends that GMCF request additional training by ViPS to better understand the software as it pertains to the tracking, storing, and consolidation of records.

## *Performance Measure Results*

Using the validated PM rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about the CMOs' performance in providing accessible, timely, and quality care and services to GF, FFS, ALL, MAO, and CCSP members.

Table 4-1, Table 4-3, Table 4-5, Table 4-7, Table 4-9, and Table 4-11 present the GF, FFS, ALL, MAO, and CCSP weighted averages for both administrative and hybrid measures. Table 4-2, Table 4-4, Table 4-6, Table 4-8, Table 4-10, and Table 4-12 display the individual CMO-specific performance measure rates.

Similar to groupings used in the GF Quality Strategy, HSAG grouped clinical PMs into the areas of access to care, children's health, women's health, chronic conditions, behavioral health, medication management, and utilization to assess the overall care provided by the CMOs. HSAG compared the CY 2012 GF weighted average rates with the prior year's rates. Additionally, for CY 2012, the GF weighted average rates were compared to the FFS rates, ALL, MAO, and the CCSP population rates, and the CMOs' performance targets.

The DCH required HP to use the hybrid methodology, when specified by the measure, to calculate rates for the FFS, MAO, CCSP, and ALL populations for CY 2012 data, which allowed the State greater opportunity to compare rates across the CMOs and to compare rates between the managed care and the FFS populations. While hybrid methodology was used across all populations, the CMOs' rates may reflect higher performance for some measures as the CMOs had the opportunity to incorporate supplemental data sources, such as lab value data to augment administrative and medical record data. Appendix D contains the utilization measure results along with measures related to health plan membership.

Following each set of results presented for the GF, FFS, ALL, MAO, and CCSP populations, HSAG displays CMO-specific rates for all CY 2012 required PMs in the areas of access, children's health, women's health, chronic conditions, behavioral health, and medication management.

### Access to Care

Table 4-1 and Table 4-2 display results for access measures. Access to care measures focus on access to primary care providers for children and adolescents, access to preventive/ambulatory health services for adults, and annual dental visits for people aged 2–21 years.

| Table 4-1—2012 Performance Measure Results—Access | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| **Children's and Adolescents' Access to Primary Care Providers** | | | | | | |
| Ages 12–24 Months | 94.17%↑ | 92.38% | 94.34%↑ | | | |
| Ages 25 Months–6 Years | 86.27% | 84.60% | 85.29%↓ | | | |
| Ages 7–11 Years | 88.52%↑ | 84.51% | 87.51% | | | |
| Ages 12–19 Years | 85.42%↑ | 77.31% | 83.71%↑ | | | |
| Total | 87.20%↑ | 81.32% | 86.10% | | | |
| **Adults' Access to Preventive/Ambulatory Health Services** | | | | | | |
| Ages 20–44 Years | 84.75% | 74.69%↓ | 80.57% | 80.56% | 92.89% | 88.5% |
| Ages 45–64 Years | 90.27% | 87.82%↑ | 88.07%↑ | 88.07% | 91.95% | |
| Ages 65 Years and Above | 66.67% | 86.23%↑ | 86.23%↑ | 86.23% | 85.69% | |
| Total | 85.50% | 83.62%↑ | 84.34%↑ | 84.34% | 87.63% | |
| **Oral Health (Annual Dental Visit Rate)** | | | | | | |
| Ages 2–3 Years | 48.03%↑ | 41.47% | 46.69%↑ | 46.34% | NA | |
| Ages 4–6 Years | 77.08%↑ | 64.69% | 74.53%↑ | 73.50% | NA | |
| Ages 7–10 Years | 79.49%↑ | 65.49% | 76.78% | 74.36% | NA | |
| Ages 11–14 Years | 71.95%↑ | 59.43% | 69.33%↑ | 66.02% | NA | |
| Ages 15–18 Years | 61.11%↑ | 50.34% | 58.57%↑ | 54.32% | 45.16% | |
| Ages 19–21 Years | 38.92% | 30.04% | 33.33% | 32.04% | NA | |
| All Members (Ages 2–21 Years) | 69.77%↑ | 54.52%↑ | 66.64%↑ | 64.09% | 42.50% | 64.1% |
| **Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment** | | | | | | |
| Initiation | 38.48%↓ | 43.36%↓ | 41.49%↓ | 41.58% | 42.58% | |
| Engagement | 7.31%↓ | 6.27% | 6.49%↓ | 6.47% | 0.65% | |
| **Annual HIV/AIDS Medical Visit** | | | | | | |
| 90 Days Apart | 43.79% | 56.29% | 54.01% | 54.04% | 59.46% | |
| 180 Days Apart | 25.18% | 43.05% | 40.79% | 40.81% | 51.35% | |
| **Care Transition—Transition Record Transmitted to Health Care Professional** | | | | | | |
| Care Transition—Transition Record Transmitted to Health Care Professional | NR | NR | NR | NR | 0.00% | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.

[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.

[3] CY 2012 ALL population rates reflect data for members in the GF population, FFS population, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.

[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.

[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and they also include dual eligible members. The measurement year was from January 1, 2012, through December 31, 2012.

[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.

Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.

NR indicates rate was Not Reportable due to material bias.

| Table 4-1—2012 Performance Measure Results—Access | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |

NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.
↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.

### *Access Measure Results*

Within the *Children's and Adolescents' Access to Primary Care Providers* measure, the GF population outperformed the FFS population, and the GF rates demonstrated a statistically significant improvement over last year's rate for most age stratifications.

Similarly, within the *Adults' Access to Preventive/Ambulatory Health Services* measure, the GF population outperformed the FFS populations for most age bands with the exception of the *Ages 65 Years and Above* age group where the FFS, ALL, MAO, and CCSP rates were nearly 20 percentage points higher than the GF rate. Additionally, the CCSP rate for the *Ages 20–44 Years* rate (92.89 percent) was more than 4 percentage points higher than the DCH-established performance target of 88.5 percent.

For the *Oral Health* measures, the GF rates were higher than the FFS rates in all age stratifications. In each age group with the exception of *Ages 19–21 Years*, the CY 2012 GF rates demonstrated statistically significant improvement over CY 2011 rates. The DCH established a performance target of 64.1 percent for the *Annual Dental Visit* measure and the GF, ALL, and MAO rates exceeded the performance target.

Within the *Alcohol and Other Drug Dependence Treatment* measure, FFS outperformed the managed care population by nearly 5 percent. For the GF, FFS, and ALL populations, the rates were statistically significantly below their rates from last year. For the *Engagement* measure rates, GF outperformed FFS, 7.31 percent and 6.27 percent, respectively. Both the CY 2012 GF and the ALL rates were significantly lower than the rates in CY 2011 for the measures.

| Table 4-2—Access Measures, CMO Comparison | | | | CY 2012 Performance Target[2] |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| **Children's and Adolescents' Access to Primary Care Providers** | | | | |
| Ages 12–24 Months | 97.55% | 96.98%↑ | 97.56%↑ | |
| Ages 25 Months–6 Years | 91.44% | 90.43% | 91.63%↑ | |
| Ages 7–11 Years | 92.26% | 90.81%↑ | 91.80%↑ | |
| Ages 12–19 Years | 90.08% | 87.97%↑ | 89.57%↑ | 91.8% |
| **Adults' Access to Preventive/Ambulatory Health Services** | | | | |
| Ages 20–44 Years | 83.84% | 84.94% | 85.81% | 88.5% |

| Table 4-2—Access Measures, CMO Comparison | | | | CY 2012 Performance Target[2] |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| Ages 45–64 Years | 90.25% | 89.36% | 91.21% | |
| Total | 84.97% | 85.23% | 86.51% | |
| **Oral Health (Annual Dental Visit)** | | | | |
| Ages 2–3 Years | 48.50% | 43.96% | 52.22%↑ | |
| Ages 4–6 Years | 77.44% | 76.01% | 77.61% | |
| Ages 7–10 Years | 79.64% | 78.32% | 80.37% | |
| Ages 11–14 Years | 72.39% | 70.02% | 73.72%↑ | |
| Ages 15–18 Years | 61.55% | 59.42% | 63.06%↑ | |
| Ages 19–21 Years | 35.70% | 38.85% | 41.88% | |
| Total | 69.92% | 67.92%↑ | 71.48%↑ | 64.1% |

[1] CY 2012 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2012, through December 31, 2012.
[2] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established.

### *CMOs' Access Measure Results*

For the Access measures, DCH selected three performance targets for CY 2012. All CMOs exceeded the performance target for the *Oral Health (Annual Dental Visit Rate—Total)* measure, while none of the CMOs met the performance targets for the other two measures.

For the *Children's and Adolescents' Access to Primary Care Providers* measure, WellCare and AMERIGROUP outperformed Peach State for the *Ages 12–24 Months* measure. There was virtually no difference between WellCare's and AMERIGROUP's performance for this measure. WellCare outperformed the other two CMOs for the *Ages 25 Months–6 Years* measure. AMERIGROUP outperformed the other two CMOs for the *Ages 7–11 Years* and *Ages 12–19 Years* measures. Peach State ranked last among all four measures.

For the *Adults' Access to Preventive/Ambulatory Health Services* measures, WellCare outperformed the other CMOs for both the *Ages 20–44 Years* and the *Ages 45–64 Years* measures.

All three CMOs exceeded the CY 2012 performance target of 64.1 percent for the *Oral Health (Annual Dental Visit Rate—Total)* measure. AMERIGROUP's total rate was 69.92 percent, 5.82 percentage points greater than the target. Peach State's total rate was 67.92 percent, 3.82 percentage points greater than the target; and WellCare's total rate was 71.48 percent, 7.38 percentage points greater than the target rate. Additionally, WellCare outperformed the other CMOs in all six of the age-specific oral health measures.

Findings suggest that opportunities exist for the development of effective strategies to increase performance for the *Children's and Adolescents' Access to Primary Care Providers—Ages 12–19*

*Years* and the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* measures since none of the CMOs met the CY 2012 performance targets for these measures.

## Children's Health

Table 4-3 and Table 4-4 display results for the children's health measures. The children's health measures focus on well-child/well-care visits, immunization and screening, weight assessment and counseling for nutrition and physical activity for children/adolescents, appropriate treatment for children with upper respiratory infection, and annual hemoglobin (HbA1c) testing.

**Table 4-3—2012 Performance Measure Results—Children's Health**

| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
|---|---|---|---|---|---|---|
| **Well-Child/Well-Care Visits** | | | | | | |
| First 15 Months of Life: Six or More Visits | 62.66%↑ | 24.33% | 56.93%↑ | | | |
| Third, Fourth, Fifth, and Sixth Years of Life | 68.17% | 57.80%↑ | 57.32%↓ | | | |
| Adolescent Well-Care Visits | 49.97% | 30.66% | 39.90%↑ | | | |
| **Immunization and Screening** | | | | | | |
| Childhood Immunization Status—Combination 3 | 79.19% | 52.80%↑ | 58.39%↑ | | | |
| Childhood Immunization Status—Combination 6 | 5.13% | 30.41% | 30.66% | | | |
| Childhood Immunization Status—Combination 10 | 34.00%↑ | 17.52%↑ | 22.87%↑ | | | |
| Lead Screening in Children | 74.72% | 65.45%↑ | 72.02%↑ | | | |
| Appropriate Testing for Children with Pharyngitis | 77.47%↑ | 71.24%↑ | 74.91%↑ | | | |
| Immunizations for Adolescents—Combination 1 Total | 71.17%↑ | 66.18%↑ | 69.23%↑ | | | |
| Developmental Screening in the First Three Years of Life | 22.40% | 20.58% | 21.58% | | | |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents** | | | | | | |
| Body Mass Index (BMI) Percentile | 41.47%↓ | 27.25%↑ | 28.22%↑ | | | |
| Counseling for Nutrition | 54.90%↑ | 37.47%↓ | 43.07%↓ | | | |
| Counseling for Physical Activity | 43.02%↑ | 27.74%↓ | 31.14%↓ | | | |
| **Upper Respiratory Infection** | | | | | | |
| Appropriate Treatment for Children With Upper Respiratory Infection | 82.79%↓ | 79.26%↓ | 80.73%↓ | | | |
| **Annual Pediatric Hemoglobin** | | | | | | |
| Annual Pediatric Hemoglobin† | 74.14% | 75.52% | 77.49% | | | |

| Table 4-3—2012 Performance Measure Results—Children's Health | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.
[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.
[3] CY 2012 ALL population rates reflect data for members in the GF population, FFS population, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.
[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.
[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and they also include dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.
[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.
NR indicates rate was Not Reportable due to material bias.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
↑ Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.
↓ Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.
† Due to changes in data collection methodologies between years, HSAG did not conduct statistical significance testing.

### *Children's Health Measures Results*

For the *Well-Child/Well-Care Visits* set of measures, the GF rate of 62.66 percent was dramatically better than the FFS rate of 24.33 percent. Although the GF, FFS, and ALL rates were significantly increased from the prior year's rate for *Adolescent Well Care Visits*, the GF rate of 49.97 percent was 19.31 percentage points above the FFS rate of 30.66 percent.

Many of the rates included in the *Immunization and Screening* categories exhibited statistically significant improvement over the CY 2011 rate. Notably, the GF rates for *Childhood Immunization Status—Combination 10, Appropriate Testing for Children with Pharyngitis*, and *Immunizations for Adolescents—Combination 1* were all significantly improved over the CY 2011 rates. The FFS and ALL rates for *Childhood Immunization Status—Combination 3, Childhood Immunization Status—Combination 10, Lead Screening, Appropriate Testing for Children with Pharyngitis,* and *Immunizations for Adolescents—Combination 1* were significantly higher than the CY 2011 rates.

The GF rates for *Body Mass Index (BMI) Percentile*, *Counseling for Nutrition*, and *Counseling for Physical Activity* were all well above the rates for the FFS or ALL populations and demonstrated statistically significant improvement over the CY 2011 rates for *Counseling for Nutrition and Counseling for Physical Activity*.

For the *Appropriate Treatment of Children With Upper Respiratory Infection* measure, the rates for the GF, FFS, and ALL populations were significantly lower than the rates from CY 2011; however, of the populations, the GF rate was the highest at 82.79 percent.

| Table 4-4—Children's Health Measures, CMO Comparison | | | | 2012 Performance Target[2] |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| **Well-Child/Well-Care Visits** | | | | |
| First 15 Months of Life: Six or More Visits | 63.03% | 55.32%↑ | 66.58%↑ | 69.7% |
| Third, Fourth, Fifth, and Sixth Years of Life | 68.21%↓ | 67.59% | 68.46%↑ | 71.8% |
| Adolescent Well-Care Visits | 46.58%↑ | 43.98% | 51.58%↑ | 46.8% |
| **Immunization and Screening** | | | | |
| Childhood Immunization Status—Combination 3 | 82.64%↑ | 76.74% | 78.83%↓ | 82.0% |
| Childhood Immunization Status—Combination 10 | 31.94%↑ | 27.91%↑ | 38.44%↑ | |
| Lead Screening in Children | 74.06%↓ | 74.19%↑ | 75.34%↓ | 81.0% |
| Appropriate Testing for Children with Pharyngitis | 77.44% | 73.80%↑ | 75.70%↑ | 73.5% |
| Immunizations for Adolescents—Combination 1 Total | 71.43%↑ | 71.30% | 70.98% | 65.9% |
| **Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents** | | | | |
| BMI Percentile (Total) | 40.74%↑ | 47.69%↑ | 38.69%↓ | 45.2% |
| Counseling for Nutrition (Total) | 52.31%↓ | 56.02%↑ | 55.47%↑ | 57.7% |
| Counseling for Physical Activity (Total) | 39.81%↓ | 47.69%↑ | 42.09%↑ | 45.5% |
| **Upper Respiratory Infection (URI)** | | | | |
| Appropriate Treatment for Children With URI | 82.66%↓ | 80.47% | 79.95% | |
| **Annual Pediatric Hemoglobin** | | | | |
| Annual Pediatric Hemoglobin | 84.02% | 83.38% | 82.97% | 81.1% |

[1] CY 2012 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2012, through December 31, 2012.
[2] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established.

### *CMOs' Children's Health Measures Results*

For the children's health measures, DCH again selected 11 performance targets for CY 2012.

For the *Well-Child/Well-Care Visits* measures, WellCare exceeded the performance target for the *Adolescent Well-Care Visits* measure while AMERIGROUP's performance rate fell short of the target by only 0.22 percentage points. All three CMOs have an opportunity to improve their performance for the *Well-Child Visits in the First 15 Months of Life: Six or More Visits* and *Third, Fourth, Fifth, and Sixth Years of Life* measures.

For the *Immunization and Screening* measures, AMERIGROUP slightly surpassed the performance target for *Childhood Immunization Status—Combination 3.* All three CMOs exceeded the performance target for *Immunizations for Adolescents—Combination 1 Total* again this year*;* all three CMOs also exceeded the performance target for the *Appropriate Testing for Children with Pharyngitis* measure. None of the CMOs achieved the performance target for *Lead Screening in Children.* While a performance target was not set for *Childhood Immunization Status—Combination 10,* the performance rates for the three CMOs were low; the highest rate achieved was 38.44 percent. These results suggest that the CMOs must continue to reinforce to parents the need to obtain both Combination 3 and Combination 10 series immunizations as well as lead screening for their children.

For the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* measure, Peach State exceeded the performance targets for the *BMI Percentile (Total)* and the *Counseling for Physical Activity (Total)* measures. For the *Counseling for Nutrition (Total)* measure, AMERIGROUP's rate decreased by 6 percent this year; the CMO did not meet the performance target for this measure as it did last year. Peach State increased its performance rate for this measure by an impressive 15.32 percent, and WellCare increased its performance rate for this measure by 5.07 percent; however, neither CMO was able to meet the performance target.

Regarding the *Appropriate Treatment for Children With URI* measure, while a performance target had not been established for this measure for CY 2012, AMERIGROUP outperformed the other two CMOs.

All three CMOs exceeded the performance target for the *Annual Pediatric Hemoglobin (HbA1c)* measure. AMERIGROUP outperformed the other two CMOs for this measure.

Children's health measure findings demonstrate the need for the CMOs to continue their efforts to ensure children obtain these necessary services. While the number of rates reaching their respective performance targets has increased, opportunities for improvement remain. HSAG encouraged the CMOs to continue to increase the educational opportunities that focus on children obtaining these necessary services, continue to improve partnerships with their providers, promote use of the available clinical guidelines and information regarding the PM requirements, and ensure their providers are notified in a timely manner of members who have not received the necessary services.

## Women's Health

Table 4-5 and Table 4-6 display results for the women's health measures. Women's health measures focus on prevention and screening, prenatal care and birth outcomes, and frequency of ongoing prenatal care.

**Table 4-5—2012 Performance Measure Results—Women's Health**

| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
|---|---|---|---|---|---|---|
| **Prevention and Screening** | | | | | | |
| Cervical Cancer Screening | 72.70%↑ | 40.39%↑ | 50.85% | 50.61% | 17.27% | 78.9% |
| Breast Cancer Screening | 56.49% | 31.98%↓ | 34.53%↓ | 34.53% | 18.64% | 59.6% |
| Chlamydia Screening—Ages 16–20 Years | 46.98%↑ | 42.27% | 46.20%↑ | 47.96% | NA | |

| Table 4-5—2012 Performance Measure Results—Women's Health | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| Chlamydia Screening—Ages 21–24 Years | 66.17%↑ | 39.96% | 60.26%↑ | 60.26% | NA | |
| Chlamydia Screening—Total | 51.56%↑ | 41.34% | 50.59%↑ | 52.50% | NA | 55.7% |
| Human Papillomavirus Vaccine for Female Adolescents | 16.08% | 11.68% | 16.30% | | | |
| **Prenatal Care and Birth Outcomes** | | | | | | |
| Timeliness of Prenatal Care | 85.00%↑ | 64.72% | 68.61%↑ | 72.02% | | |
| Postpartum Care | 64.31%↑ | 48.18% | 56.45%↑ | 64.96% | | |
| Cesarean Rate for Nulliparous Singleton Vertex | 19.07% | 12.72% | 16.68% | 16.68% | | |
| Elective Delivery | 34.29% | 28.47% | 33.79% | 33.81% | | |
| Antenatal Steroids | 4.70% | 4.11% | 4.00% | 4.02% | | |
| Cesarean Delivery Rates (AHRQ measure)* | 31.25%↓ | 27.48%↓ | 29.58% | 29.59% | | |
| Rate of Infants With Low Birth Weight (AHRQ measure)* | 8.59% | 8.52% | 8.44% | 8.45% | | |
| **Weeks of Pregnancy at Time of Enrollment** | | | | | | |
| < 0 Weeks | 9.71% | 7.80% | 10.57% | 17.57% | | |
| 1–12 Weeks | 9.46% | 0.82% | 17.92% | 42.61% | | |
| 13–27 Weeks | 57.19% | 2.60% | 36.59% | 14.10% | | |
| 28+ Weeks | 15.49% | 80.50% | 26.71% | 18.25% | | |
| Unknown Weeks | 8.14% | 8.28% | 8.22% | 7.48% | | |
| **Frequency of Ongoing Prenatal Care** | | | | | | |
| < 21 Percent | 11.21%↓ | 36.50%↑ | 35.77%↑ | 36.25% | | |
| 21–40 Percent | 4.71%↑ | 5.84%↓ | 2.68%↓ | 2.43% | | |
| 41–60 Percent | 6.45% | 10.22%↓ | 5.60%↓ | 4.38% | | |
| 61–80 Percent | 13.53%↑ | 9.25%↓ | 12.90%↑ | 9.49% | | |
| 81+ Percent | 64.11%↑ | 38.20%↑ | 43.07%↓ | 47.45% | | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.

[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.

[3] CY 2012 ALL population rates reflect data for members in the GF population, FFS population, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.

[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.

[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and they also include dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.

[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.

Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.

NR indicates rate was Not Reportable due to material bias.

| Table 4-5—2012 Performance Measure Results—Women's Health | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |

NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.
↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.
* A lower rate indicates better performance.

### *Women's Health Measures Results*

The majority of the measures under the *Women's Health* category showed the GF population outperforming the FFS population. The GF population had several women's health measures' rates with statistically significant improvement between CY 2012 and CY 2011. The majority of the *Prevention* and *Screening* measures that were reported both this year and last showed the gap between managed care and FFS increasing. All of the PM rates for the women's health measures with a DCH-established performance target (*Cervical Cancer Screening, Breast Cancer Screening* and *Chlamydia Testing—Total*) fell short of those targets. Two of the three did show statistically significant improvement for the GF population. *Breast Cancer Screening* did not show any statistically significant improvement for GF, and for the FFS population there was a decrease of statistical significance. GF showed statistically significant improvement in several measures while three measures showed a statistically significant decrease in performance. FFS only had three measures with statistically significant improvement and five with a relative decrease. The performance highlight of the *Women's Health* measures is the *GF* population's performance within the *Prevention and Screening* set of measures, with four of the six showing statistically significant improvement. The most concerning item is that both cesarean rates showed a statistically significant increase in the rates, demonstrating a decline in performance.

| Table 4-6—Women's Health Measures, CMO Comparison | | | | |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | 2012 Performance Target[2] |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| **Prevention and Screening** | | | | |
| Cervical Cancer Screening | 72.09%↓ | 73.54%↑ | 72.51%↑ | 78.9% |
| Breast Cancer Screening | 59.22% | 56.46% | 55.78% | 59.6% |
| Chlamydia Screening—Ages 16–20 Years | 53.93%↑ | 54.68% | 44.26% | |
| Chlamydia Screening—Ages 21–24 Years | 68.86%↑ | 72.93% | 62.42% | |
| Chlamydia Screening—Total | 56.98%↑ | 59.60% | 48.66% | 55.7% |
| **Prenatal Care and Birth Outcomes** | | | | |
| Timeliness of Prenatal Care | 84.72%↓ | 86.71%↑ | 84.18%↑ | 90.0% |
| Postpartum Care | 59.49%↓ | 71.56%↑ | 62.53% | 70.3% |

| Table 4-6—Women's Health Measures, CMO Comparison | | | | |
|---|---|---|---|---|
| Measure | AMERIGROUP CY 2012 Rate[1] | Peach State CY 2012 Rate[1] | WellCare CY 2012 Rate[1] | 2012 Performance Target[2] |
| Cesarean Rate for Nulliparous Singleton Vertex | 18.14% | 19.63% | 16.86% | |
| Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance* | 29.76%↓ | 30.01%↓ | 29.10%↓ | 31.0% |
| Rate of Infants With Low Birth Weight (Rate per 100) *A lower rate indicates better performance* | 8.45%↑ | 8.53%↑ | 8.02% | 8.15% |
| **Frequency of Ongoing Prenatal Care** | | | | |
| < 21 Percent | 10.65%↑ | 8.62%↑ | 12.90%↓ | |
| 21–40 Percent | 4.17%↑ | 4.43%↑ | 5.11% | |
| 41–60 Percent | 7.64%↑ | 6.99%↑ | 5.60%↓ | |
| 61–80 Percent | 11.11% | 14.92%↑ | 13.87%↑ | |
| 81+ Percent | 66.44%↓ | 65.03%↓ | 62.53%↑ | 73.7% |

[1] CY 2012 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2012, through December 31, 2012.
[2] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established.

### *CMOs' Women's Health Measures Results*

For the women's health measures, DCH selected eight PM targets for CY 2012. Seven targets were achieved in CY 2012, a decrease from the eight targets that were achieved in CY 2011. Of the 15 rates reported, AMERIGROUP performed best on three of the rates, Peach State performed best on eight rates, and WellCare performed best on four rates.

For the *Prevention and Screening* measures, again this year, none of the CMOs were able to reach the performance targets for the *Cervical Cancer Screening* and *Breast Cancer Screening* measures. AMERIGROUP and Peach State exceeded the performance target for the *Chlamydia Screening—Total* measure. HSAG encouraged the CMOs to ensure that the clinical guidelines and measure requirements are shared with the providers.

Additionally, the CMOs should supply providers with lists of members who are not receiving the necessary screenings.

For the *Prenatal Care and Birth Outcomes* measures, none of the CMOs met the performance target for the *Timeliness of Prenatal Care* measure. However, all three CMOs decreased their rates for the *Cesarean Delivery Rate (Rate per 100)* measure and exceeded the performance target for CY 2012. (A lower rate indicates better performance for this measure.) This was an improvement over last year when none of the CMOs met the target performance for this measure. For the *Postpartum Care*

measure, Peach State was the only CMO to meet/exceed the performance target, while WellCare was the only CMO to meet/exceed the performance target for the *Rate of Infants With Low Birth Weight (Rate per 100)* measure. To facilitate timely postpartum visits, the CMOs must have a process in place to ensure that they are receiving timely notifications of births.

The *Frequency of Ongoing Prenatal Care* category includes five measures, one of which has a performance target. The measure *81+ Percent,* which indicates the percent of deliveries with mothers who received at least 81 percent of the recommended prenatal visits, had a performance target rate of 73.7 percent. None of the CMOs achieved this performance target; AMERIGROUP and Peach State demonstrated rate decreases for this measure. All three CMOs must increase their prenatal visit rates to achieve PM targets.

## Chronic Conditions

Table 4-7 and Table 4-8 display results for the chronic conditions measures.

**Table 4-7—2012 Performance Measure Results—Chronic Conditions**

| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
|---|---|---|---|---|---|---|
| **Diabetes** | | | | | | |
| **Comprehensive Diabetes Care** | | | | | | |
| Hemoglobin A1c (HbA1c) Testing | 79.03% | 60.22%↓ | 64.78%↑ | 64.42% | 55.84% | 86.4% |
| HbA1c Poor Control (>9.0) *A lower rate indicates better performance* | 54.30% | 67.88%↓ | 70.80%↓ | 68.61% | 64.78% | 43.2% |
| HbA1c Control (<8.0) | 39.05% | 27.55%↓ | 24.64%↓ | 28.47% | 29.93% | 46.6% |
| HbA1c Control (<7.0) | 30.70% | 23.98%↑ | 20.17%↑ | 20.73% | 31.88% | 35.5% |
| Eye Exam (Retinal) Performed | 46.67% | 42.70% | 40.69%↓ | 39.05% | 41.61% | 54.0% |
| LDL-C Screening | 70.00% | 57.66%↓ | 53.28% | 57.85% | 46.35% | 75.4% |
| LDL-C Control (<100 mg/dL) | 25.87% | 21.17%↓ | 16.24%↓ | 20.62% | 25.18% | 33.6% |
| Medical Attention for Nephropathy | 73.32% | 69.53% | 67.88%↑ | 70.26% | 72.26% | 77.7% |
| Blood Pressure Control (<140/80 mm/Hg) | 29.10%↓ | 26.46%↓ | 23.18%↑ | 29.20% | 33.03% | 36.7% |
| Blood Pressure Control (<140/90 mm/Hg) | 52.97% | 39.96%↓ | 34.49%↑ | 39.60% | 41.24% | 61.6% |
| **Diabetes, Short-Term Complications Admission Rate** | | | | | | |
| Diabetes Short-Term Complications Admission Rate (per 100,000)† | 95.24 | 344.13 | 309.12 | 316.98 | 264.17 | |
| **Respiratory Conditions** | | | | | | |
| **Use of Appropriate Medications for People With Asthma** | | | | | | |
| Ages 5–11 Years | 89.54%↓ | 90.51%↓ | 89.69%↓ | 88.74% | NA | |
| Ages 12–18 Years | 87.36%↓ | 85.41%↓ | 86.76%↓ | 85.40% | NA | |

| Table 4-7—2012 Performance Measure Results—Chronic Conditions | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| Ages 19–50 Years | 70.71% | 68.50%↓ | 69.28%↓ | 69.17% | NA | |
| Ages 51–64 Years | 68.42% | 64.90% | 65.36% | 65.36% | NA | |
| Total | 88.11%↓ | 79.68%↓ | 85.89%↓ | 84.29% | NA | |
| **Medication Management for People With Asthma** | | | | | | |
| 50 Percent Compliance (Total) | 48.97% | 68.47% | 54.68% | 54.61% | 80.00% | |
| 75 Percent Compliance (Total) | 27.18% | 49.21% | 33.27% | 33.58% | 40.00% | |
| **Adult Asthma Admission Rate** | | | | | | |
| Per 100,000 Members (18–64 Years) | 59.17 | 387.37 | 311.30 | 322.57 | 344.53 | |
| Per 100,000 Members (65+ Years) | 0.00 | 1,244.28 | 1,245.25 | 1,244.15 | 895.41 | |
| Asthma Admission Rate (per 100,000) | 59.16 | 545.98 | 441.15 | 454.74 | 726.46 | |
| **Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits** | | | | | | |
| Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit* | 13.51%↓ | 17.01%↓ | 12.81%↓ | | | |
| **Pharmacotherapy Management of COPD Exacerbation** | | | | | | |
| Systemic Corticosteroid | 70.78% | 36.24%↑ | 37.37%↑ | 37.37% | 7.55% | |
| Bronchodilator | 83.12% | 49.85% | 51.00% | 51.01% | 16.98% | |
| **Chronic Obstructive Pulmonary Disease (COPD) Admission Rate** | | | | | | |
| Per 100,000 Members (18–64 Years) | 75.54 | 1,480.15 | 1,099.84 | 1,139.94 | 2,024.12 | |
| Per 100,000 Members (65+ Years) | 0.00 | 19,871.07 | 19,886.58 | 19,892.07 | 6,896.55 | |
| Per 100,000 Members (Total) | 75.52 | 4,884.12 | 3,711.77 | 3,829.24 | 5,402.19 | |
| **Cardiovascular Conditions** | | | | | | |
| **Controlling High Blood Pressure** | | | | | | |
| Controlling High Blood Pressure | 47.19% | 38.93% | 35.04% | 32.36% | 44.04% | |
| **Persistence of Beta-Blocker Treatment After a Heart Attack** | | | | | | |
| Persistence of Beta-Blocker Treatment After a Heart Attack | 80.77% | 58.68% | 59.86% | 59.86% | 28.57% | |
| **Congestive Heart Failure Rate** | | | | | | |
| Admission Rate—Per 100,000 Members (18–64 Years) | 26.44 | 991.51 | 721.45 | 748.19 | 2,196.38 | |
| Admission Rate—Per 100,000 Members (65+ Years) | 0.00 | 24,096.99 | 24,115.80 | 24,114.70 | 4,400.84 | |

| Table 4-7—2012 Performance Measure Results—Chronic Conditions | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| Admission Rate—Per 100,000 Members (Total) | 26.43 | 5,268.09 | 3,973.98 | 4,099.24 | 3,724.74 | |
| **Prevention and Screening** | | | | | | |
| Adult BMI Assessment | | 7.64% | 38.20% | 39.66% | 46.72% | 47.6% |
| Colorectal Cancer Screening | | 31.63% | 32.12% | 32.12% | 33.82% | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.
[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.
[3] CY 2012 ALL population rates reflect data for members in the GF population, FFS population, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.
[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.
[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and it also includes dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.
[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.
NR indicates rate was Not Reportable due to material bias.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
↑ Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.
↓ Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.
* A lower rate indicates better performance.
† Due to changes in data collection methodologies between years, HSAG did not conduct statistical significance testing.

## *Chronic Conditions Health Measure Result Findings*

The *Chronic Conditions* measures include PMs related to diabetes, respiratory conditions (asthma and chronic obstructive pulmonary disease), cardiovascular conditions (hypertension, beta-blocker treatments after a heart attack, and congestive heart failure), and prevention and screening. CY 2012 performance targets were defined only for the *Comprehensive Diabetes Care* measures within the Diabetes category and the *Adult BMI Assessment* measure within the Prevention and Screening category. None of the populations achieved rates that achieved the *Comprehensive Diabetes Care* PM targets. The FFS and ALL populations did not achieve the CY 2012 PM target for the *Adult BMI Assessment* measure, while the CMOs were not required to report a rate for this measure.

Within the *Comprehensive Diabetes Care* measures, GF outperformed FFS in all measures. Nonetheless, GF showed a decrease in performance while the FFS and ALL populations both showed a statistically significant decline in performance for the *HbA1c Poor Control* measure rate. The FFS and ALL populations also showed a statistically significant decline in performance for the *HbA1c Control (<8.0)* and *HbA1c Control (<7.0)* measure rates. Neither GF nor the FFS population achieved any statistically significant improvements in this category. The ALL population achieved statistically significant increases in the following PM rates within this category:

- *Hemoglobin A1c (HbA1c) Testing*
- *HbA1c Control (<7.0)*
- *Medical Attention for Nephropathy*
- *Blood Pressure Control (<140/80 mm/Hg)*
- *Blood Pressure Control (<140/90 mm/Hg)*

Within the *Respiratory Conditions* measures pertaining to asthma, the GF, FFS, and ALL populations showed a decrease from last year's performance for the *Ages 5–11 Years* and *Ages 12–18 Years* PMs. With the exception of the *Ages 5–11 Years* measure, GF outperformed the FFS population within the remaining age groups and total measure rate. The FFS population outperformed the GF population in all of the *Medication Management for People With Asthma* measures. The GF population showed remarkably lower rates for the *Adult Asthma Admission Rate.* All populations showed statistically significant increases in their *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visits* PM rate.

None of the populations showed a significant difference over the CY 2011 PM rates in the *Pharmacotherapy Management of COPD Exacerbation* category. The GF population outperformed the FFS population in all measures within the *Chronic Obstructive Pulmonary Disease (COPD) Admission Rate* category.

PM rates were not reported for the FFS or ALL populations last year within the *Cardiovascular Conditions* category. This year, the GF population outperformed the FFS and ALL populations in all measures within this category.

The GF and the FFS populations reported PM rates for 40 measures. The GF population outperformed the FFS population in 31 measures. The FFS population outperformed the GF population in nine asthma-related measures in the Respiratory Conditions category. Statistically significant declines in the PM rates were shown in seven measures within the area of *Comprehensive Diabetes Care*. Both the GF and the FFS populations need to improve their performance in all measures within this area to achieve the performance targets. Improved performance in the areas pertaining to control should lead to fewer emergency room visits related to chronic conditions, and fewer hospital readmissions.

| Table 4-8—Physical Health Conditions: Chronic Conditions Measures, CMO Comparison | | | | CY 2012 Performance Target[2] |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| **Diabetes** | | | | |
| **Comprehensive Diabetes Care** | | | | |
| Hemoglobin A1c (HbA1c) Testing | 79.37% | 79.83% | 78.47% | 86.4% |
| HbA1c Poor Control (>9.0) *A lower rate indicates better performance* | 53.58% | 55.48% | 54.01% | 43.2% |
| HbA1c Control (<8.0) | 38.94% | 39.13% | 39.05%↓ | 46.6% |

| Table 4-8—Physical Health Conditions: Chronic Conditions Measures, CMO Comparison | | | | CY 2012 Performance Target[2] |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| HbA1c Control (<7.0) | 30.56% | 27.61% | 32.36% | 35.5% |
| Eye Exam (Retinal) Performed | 48.25%↑ | 57.22% | 40.51%↓ | 54.0% |
| LDL-C Screening | 73.21% | 67.83% | 69.71% | 75.4% |
| LDL-C Control (<100 mg/dL) | 27.29% | 20.35%↓ | 28.10%↑ | 33.6% |
| Medical Attention for Nephropathy | 74.38% | 73.39% | 72.81% | 77.7% |
| Blood Pressure Control (<140/80 mm/Hg) | 32.61% | 27.30%↓ | 28.47% | 36.7% |
| Blood Pressure Control (<140/90 mm/Hg) | 55.07% | 53.74%↓ | 51.64% | 61.6% |
| **Respiratory Conditions** | | | | |
| **Use of Appropriate Medications for People With Asthma** | | | | |
| 5–11 Years | 90.32%↓ | 90.58% | 90.56%↓ | |
| 12–18 Years | 88.69% | 88.40% | 88.16% | |
| 19–50 Years | 69.17% | 72.39% | 75.65% | |
| 51–64 Years | NA | NA | NA | |
| Total | 89.03%↓ | 89.22% | 89.12%↓ | 92.8% |
| **Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit** | | | | |
| Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit *A lower rate indicates better performance* | 12.88%↑ | 12.64%↑ | 12.23%↑ | |
| **Pharmacotherapy Management of COPD Exacerbation** | | | | |
| Systemic Corticosteroid | 63.27% | 63.64% | 73.28% | |
| Bronchodilator | 83.67% | 78.18% | 84.73% | |
| **Chronic Obstructive Pulmonary Disease (COPD) Admission Rate** | | | | |
| Per 100,000 Members (Total) | 76.56 | 71.03* | 91.05* | |
| **Cardiovascular Conditions** | | | | |
| **Congestive Heart Failure Rate** | | | | |
| Admission Rate—Per 100,000 Members (Total) | 29.64 | 25.53 | 41.04 | |
| **Controlling High Blood Pressure** | | | | |
| Controlling High Blood Pressure | 38.72%↓ | 49.78% | 49.64%↑ | |

| Table 4-8—Physical Health Conditions: Chronic Conditions Measures, CMO Comparison | | | | CY 2012 Performance Target[2] |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011.
Shaded boxes are displayed when no DCH CY 2011 performance target was established.
NA—The CMO was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30).
NR—Not Reportable
* These rates were revised and calculated to reflect the revised specifications for this measure released by CMS in May 2013.

### *CMOs' Chronic Conditions Health Measure Result Findings*

For the chronic conditions measures, which were related to diabetes, respiratory conditions, and cardiovascular conditions, DCH selected 11 performance targets for CY 2012. One of the reported rates exceeded the performance target, which is an improvement from CY 2011 when no targets were met for these measures. Specifically, Peach State exceeded the performance target for the *Comprehensive Diabetes Care—Eye Exam* measure.

Opportunities for improvement remain for all three CMOs regarding chronic conditions measures. The CMOs' case management and disease management programs must be positioned to improve care for members with chronic conditions and improve performance rates. Both programs must include care plans with measureable goals and interventions aimed at improving health outcomes. Significant improvement to these programs could translate to improvement across the chronic conditions PMs.

For the *Comprehensive Diabetes Care* measure, AMERIGROUP outperformed the other two CMOs in five PMs; Peach State outperformed the other two CMOs in three PMs; and WellCare outperformed the other two CMOs in two PMs. One CMO, Peach State, met the performance target for one measure, *Eye Exam*. All CMOs demonstrated a need to improve both screening and control measures for diabetes care. The CMOs and their network providers must focus on improving actual health outcomes through active case and disease management.

For the *Respiratory Conditions* measures, only the *Use of Appropriate Medications for People With Asthma—Total* measure had a performance target set by DCH. Again this year, all the CMOs performed similarly for this measure, with total rates within 0.19 percentage points of each other; however, none reached the performance target rate. All CMOs demonstrated a slight decrease in performance for the *5–11 Years* and *12–18 Years* measures from last year. AMERIGROUP demonstrated a slight improvement in performance for the *19–50 Years* measure, while Peach State and WellCare both demonstrated a slight decrease in performance for this measure from last year.

All CMOs demonstrated a slight rate increase for the *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit* measure from last year. A rate increase for this measure demonstrates a decline in performance as it indicates that asthma-related emergency room visits for members diagnosed with asthma actually increased. All three CMOs must work

toward improving their performance with this measure. For both of the *Pharmacotherapy Management of COPD Exacerbation* measures, *Systemic Corticosteroid* and *Bronchodilator*, WellCare outperformed the other two CMOs.

For the *Controlling High Blood Pressure* measure, Peach State earned the highest rate of 49.78 percent, followed closely by WellCare at 49.64 percent, then AMERIGROUP at 38.72 percent. Again this year, the rates for this measure indicated that more than 50 percent of the members with diagnosed hypertension had uncontrolled high blood pressure, putting them at greater risk for heart attacks and strokes. The CMOs have an opportunity to align intervention strategies with national initiatives to increase blood pressure control rates. One national initiative, sponsored by the U.S. Department of Health and Human Services, is the Million Hearts initiative, which seeks to prevent one million heart attacks and strokes by 2017.[4-3]

## Behavioral Health

Table 4-9 and Table 4-10 display results for the behavioral health measures.

**Table 4-9—2012 Performance Measure Results—Behavioral Health**

| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
|---|---|---|---|---|---|---|
| **Screening for Clinical Depression and Follow-Up Plan** | | | | | | |
| Screening for Clinical Depression and Follow-Up Plan (hybrid for CCSP population only) | 0.00% | 0.01% | 0.01% | 0.01% | 0.00% | |
| **Adherence to Antipsychotics for Individuals with Schizophrenia (CMS)** | | | | | | |
| Adherence to Antipsychotics for Individuals with Schizophrenia (CMS) | 43.88% | 65.36% | 64.45% | 64.44% | NA | |
| **Follow-Up After Hospitalization for Mental Illness** | | | | | | |
| Follow-Up Within 7 Days | 47.04% | 40.17%↑ | 42.81%↑ | 41.93% | 35.90% | |
| Follow-Up Within 30 Days | 65.11%↓ | 61.26%↑ | 63.00% | 62.05% | 53.85% | |
| **Follow-Up Care for Children Prescribed ADHD Medication** | | | | | | |
| Initiation Phase | 35.73% | 31.68% | 34.60%↓ | | | |
| Continuation and Maintenance Phase | 48.32% | 42.30% | 45.64% | | | |
| **Antidepressant Medication Management** | | | | | | |
| Effective Acute Phase Treatment | 53.36%↑ | 60.26%↑ | 59.19%↑ | 59.26% | 60.00% | |
| Effective Continuation Phase Treatment | 35.73%↑ | 47.19%↑ | 43.43%↑ | 43.50% | 30.00% | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.
[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.

[4-3] Million Hearts: The Initiative. Overview. Available at: http://millionhearts.hhs.gov/index.html. Accessed on October 22, 2013.

| Table 4-9—2012 Performance Measure Results—Behavioral Health | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |

[3] CY 2012 ALL population rates reflect data for members in the GF and FFS populations, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.
[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.
[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and they also include dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.
[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.
NR indicates rate was Not Reportable due to material bias.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.
↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.

### *Behavioral Health Measure Results*

The performance of both the GF and the FFS populations in the *Behavioral Health* measures was mixed. Each population outperformed the other in four of the eight measures. FFS had a statistically significant increase in half of the measures and did not have any with a statistically significant decline. Both of the *Antidepressant Medication Management* measures for the GF population showed a statistically significant increase. However, the GF population had a statistically significant decrease in the *Follow-Up After Hospitalization for Mental Illness Within 30 Days* measure. The clear high point of the *Behavioral Health* measures shown here was the across-the-board improvement seen in both *Antidepressant Medication Management* measures for all populations where comparison was possible.

| Table 4-10—Behavioral Health Measures, CMO Comparison | | | | |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | CY 2012 Performance Target[2] |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| **Follow-Up Care for Children Prescribed ADHD Medication** | | | | |
| Initiation Phase | 42.32% | 43.73% | 39.39% | 48.1% |
| Continuation and Maintenance Phase | 58.15% | 58.60% | 53.10% | 57.6% |
| **Follow-Up After Hospitalization for Mental Illness** | | | | |
| Follow-Up Within 7 Days | 45.80% | 52.52% | 60.37%↑ | 64.3% |
| Follow-Up Within 30 Days | 67.29%↓ | 70.79% | 77.16% | 83.6% |
| **Antidepressant Medication Management** | | | | |
| Effective Acute Phase Treatment | 54.16%↑ | 43.92% | 50.00% | |
| Effective Continuation Phase Treatment | 36.81% | 28.13% | 32.74% | |

| Table 4-10—Behavioral Health Measures, CMO Comparison | | | | |
|---|---|---|---|---|
| Measure | AMERIGROUP CY 2012 Rate[1] | Peach State CY 2012 Rate[1] | WellCare CY 2012 Rate[1] | CY 2012 Performance Target[2] |
| **Initiation and Engagement of AOD Dependence Treatment** | | | | |
| Initiation | 41.87% | 39.74%↑ | 48.28%↑ | |
| Engagement | 10.01% | 8.27% | 12.27%↑ | |

[1] CY 2012 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2012, through December 31, 2012.
[2] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established.

### *CMOs' Behavioral Health Measure Results*

For the *Behavioral Health* measures, DCH set four performance targets. Both Peach State and AMERIGROUP exceeded the performance target rate for the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* measures. No other performance targets were met by any of the CMOs for these measures.

Eight measures were reported for behavioral health. WellCare outperformed AMERIGROUP and Peach State, demonstrating four of the highest performance rates. Again this year, WellCare outperformed the other two CMOs for both of the *Follow-Up After Hospitalization for Mental Illness* measures—*Follow-Up Within 7 Days* and *Follow-Up Within 30 Days*. WellCare also outperformed AMERIGROUP and Peach State for both components (Initiation and Engagement) of the *Initiation and Engagement of AOD Dependence Treatment* measure. AMERIGROUP demonstrated the highest rates for both *Antidepressant Medication Management* measures—*Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment.* Peach State demonstrated the highest rates for both *Follow-Up Care for Children Prescribed ADHD Medication* measures—*Initiation Phase* and *Continuation and Maintenance Phase.*

With only one performance target met in CY 2012, all three CMOs have an opportunity for improvement in the *Behavioral Health* measures category.

## Medication Management

Table 4-11 and Table 4-12 display results for the medication management measures.

| Table 4-11—2012 Performance Measure Results—Medication Management | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| **Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions** | | | | | | |
| Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions | 40.93% | 43.55% | 42.31% | 41.69% | 49.56% | |

| Table 4-11—2012 Performance Measure Results—Medication Management | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| **Annual Monitoring of Patients on Persistent Medications** | | | | | | |
| Annual Monitoring of Patients on Persistent Medications | 87.52%↑ | 85.25%↑ | 85.48%↑ | 85.50% | 75.00% | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.
[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.
[3] CY 2012 ALL population rates reflect data for members in the GF population, FFS population, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.
[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.
[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and it also includes dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.
[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.
NR indicates rate was Not Reportable due to material bias.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.
↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.

### *Medication Management Measure Result Findings*

For the *Antibiotic Utilization–Percent of Antibiotics of Concern of All Antibiotic Prescriptions* measure, the FFS, ALL, MAO, and CCSP rates were higher than the GF rate. The CCSP rate was highest at 49.56 percent.

The GF rate for the *Annual Monitoring of Patients on Persistent Medications* measure was higher than all other populations at 87.52 percent. The GF, FFS, and ALL rates were significantly higher than the CY 2011 rates for this measure.

| Table 4-12—Medication Management Measure, CMO Comparison | | | | |
|---|---|---|---|---|
| | AMERIGROUP | Peach State | WellCare | CY 2012 Performance Target[2] |
| Measure | CY 2012 Rate[1] | CY 2012 Rate[1] | CY 2012 Rate[1] | |
| **Annual Monitoring for Patients on Persistent Medication** | | | | |
| Total | 89.32% | 86.87%↑ | 87.06% | |

[1] CY 2012 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2012, through December 31, 2012.
[2] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.
Shaded boxes are displayed when no DCH CY 2012 performance target was established.

### *CMOs' Medication Management Measure Result Findings*

For the *Medication Management* measures, AMERIGROUP again outperformed the other CMOs on the *Annual Monitoring for Patients on Persistent Medication—Total* measure. A performance target was not set for this measure; all CMOs demonstrated a slight increase in their PM rates over last year.

The CMOs are encouraged to continue their efforts to improve the *Medication Management* measure results.

## FFS, ALL, MAO, and CCSP Population Comparisons

In addition to comparing GF performance to national benchmarks and targets, HSAG compared GF performance to the Medicaid FFS and ALL populations. Comparisons among the GF, FFS, and ALL populations should be made with caution. The GF reported data may reflect a more accurate assessment of care provided, since the CMOs had the ability to incorporate supplemental data sources such as lab value data to increase data capture for some measures. While all three populations use medical record review, using supplemental data could have an increased advantage for identifying results not located in the medical record.

PM results showed that the GF population had better performance than the FFS and ALL populations on nearly all measures. This is similar to the findings of previous years.

## Utilization Measures

In addition to clinical PMs, DCH requires the CMOs to report utilization rates for *Mental Health, Ambulatory Care, Plan All-Cause Readmissions,* and *Inpatient Utilization.* This information can be helpful to the CMOs in reviewing patterns of suspected under- and over-utilization of services. High or low rates of utilization do not necessarily indicate better or worse performance. Appendix D contains the tables of the utilization measure rates by population. Comparisons can be made to further analyze utilization patterns for potential issues related to provider practice patterns and geographical accessibility, among others. These rates do not necessarily imply a need to evaluate performance but may provide DCH with information to allow comparison to national rates as well as across populations.

## Health Plan Demographics

Demographic information for race/ethnicity of membership was reported by population. Appendix D contains these rates. There is not much variation across the populations per race, with the exception of the CCSP population, which has a White population of 57.12 percent while the White populations of the other groups range from 36.25 percent to 39.66 percent.

Health plan demographic information can be useful when considering targeted interventions to ensure that the strategies are appropriate and culturally appropriate services are available to all members.

## Conclusions

Overall, HSAG found that all three of the CMOs and HP were compliant with the required information system standards to report valid PM rates. The CMOs had the ability to process, receive, and enter medical and service data efficiently, accurately, timely, and completely. Overall, of the 40 CY 2012 performance targets, GF performed best in the areas of *Oral Health (Annual Dental Visit Rate)—Ages 2–21 years.*

When comparing measures with both CY 2011 and CY 2012 rates, the GF rates showed statistically significant improvement in the following areas:

- Children's and Adolescents' Access to Primary Care
  - Ages 12–24 Months
  - Ages 7–11 Years
  - Ages 12–19 Years
  - Total
- Oral Health (Annual Dental Visit Rate)
  - Ages 2–3 Years
  - Ages 4–6 Years
  - Ages 7–10 Years
  - Ages 11–14 Years
  - Ages 15–18 Years
  - All Members (Ages 2–21 years)
- Well-Child/Well-Care Visits
  - First 15 Months of Life: 6 or More Visits
  - Adolescent Well-Care
- Immunizations and Screenings
  - Childhood Immunizations Status—Combination 10
  - Immunizations for Adolescents—Combination 1 Total
- Appropriate Testing for Children with Pharyngitis
- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents
  - Counseling for Nutrition
  - Counseling for Physical Activity
- Prevention and Screening
  - Cervical Cancer Screening
  - Chlamydia Screening—Ages 16–20 Years
  - Chlamydia Screening—Ages 21–24 Years
  - Chlamydia Screening—Total
- Prenatal Care and Birth Outcomes
  - Timeliness of Prenatal Care
  - Postpartum Care

- Frequency of Ongoing Prenatal Care
  - 21–40 Percent
  - 61–80 Percent
  - 81+ Percent

Several opportunities for improvement exist for the CMOs collectively. The measures that have the greatest opportunity for improvement include the following: *Adults' Access to Preventive/ Ambulatory Health Service—Ages 20–44*, *Cervical Cancer Screening*, *Breast Cancer Screening*, *Chlamydia Screening—Total*, and all of the *Comprehensive Diabetes Care* measures. All of these measures did not reach the CY 2012 performance targets. The *Blood Pressure Control (<140/80 mm/Hg)* measure experienced a statistically significant decline in CY 2012.

Based on CY 2012 CMO performance, Peach State was the highest overall performing CMO. Table 4-13 shows the number of performance targets each CMO met for each set of measures.

**Table 4-13—Number of Performance Targets Met by CMO**

| Measure Set | AMERIGROUP | Peach State | WellCare |
|---|---|---|---|
| Access to Care | 1 | 1 | 1 |
| Children's Health | 4 | 5 | 4 |
| Women's Health | 2 | 3 | 2 |
| Chronic Conditions | 0 | 1 | 0 |
| Behavioral Health | 1 | 1 | 0 |
| Total | 8 | 11 | 7 |

Peach State met 11 of the CY 2012 targets while AMERIGROUP met eight and WellCare met seven performance targets. All of the CMOs performed best within the Children's Health measures.

All CMOs have the opportunity to make improvements related to meeting performance targets.

## Recommendations

Based on the CY 2012 PM rates and the validation of those rates, HSAG provides the following recommendations for improving the quality, timeliness of, and access to care and services for members. HSAG encourages DCH to:

- More closely monitor the error rejection rates of the CMOs' encounter claims submitted to HP and focus efforts on WellCare since it had the highest rejection rate.
- Provide continued oversight of its vendor, HP, and its medical record review vendor to improve medical record abstraction efficiency.

HSAG encourages the CMOs to:

- Focus additional attention on the Chronic Conditions measures for further improvement efforts. As an example, within the Chronic Conditions measures, of the 30 opportunities to meet *Comprehensive Diabetes Care* performance targets, just one performance target was met.

- Focus on their disease and case management efforts based on the poor performance areas identified.
- Focus quality improvement efforts as follows: AMERIGROUP needs to focus quality improvement efforts on Children's Health measures as well as the Prenatal Care measures; Peach State and WellCare should focus on *Comprehensive Diabetes Care* measures.

# 5. Performance Improvement Projects

The purpose of a PIP is to achieve, through ongoing measurements and interventions, statistically significant improvement that is sustained over time in both clinical and nonclinical areas.

HSAG reviewed each PIP using CMS' validation protocol to ensure that the CMOs designed, conducted, and reported the PIPs in a methodologically sound manner and met all State and federal requirements. The validation was to ensure that DCH and interested parties could have confidence in the reported improvements that resulted from the PIPs.

The CMOs each had nine DCH-selected PIP topic areas in progress during the review period. The PIP topics included:

- Adolescent Well-Care Visits
- Annual Dental Visits
- Appropriate Use of ADHD Medications
- Avoidable Emergency Room Visits (Collaborative)
- Childhood Immunizations—Combination 10
- Childhood Obesity
- Comprehensive Diabetes Care
- Member Satisfaction
- Provider Satisfaction

Validating PIPs is one of three federally mandated external quality review activities. The requirement allows states, agents that are not a managed care organization, or an EQRO to conduct the PIP validations. The DCH contracted with HSAG to conduct the functions associated with validation of PIPs. The details on CMO-specific PIP reports can be seen in table format in Appendix C, Performance Improvement Project Progress.

## Validation of Performance Improvement Projects

As noted in its Quality Strategic Plan Update (November 2011), DCH identified the improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance as one of its four performance-driven goals. The goals are designed to demonstrate success or identify challenges in achieving intended outcomes related to providing quality, accessible, and timely services. The June 30, 2013, through August 1, 2013, PIP submission included seven clinical PIPs (*Adolescent Well-Care Visits*, *Annual Dental Visits*, *Appropriate Use of ADHD Medications*, *Avoidable Emergency Room Visits (Collaborative)*, *Childhood Immunizations—Combination 10*, *Childhood Obesity*, and *Comprehensive Diabetes Care)* as well as two nonclinical PIPs (*Member Satisfaction* and *Provider Satisfaction)*.

HSAG organized, aggregated, and analyzed the three CMOs' PIP data to draw conclusions about the CMOs' quality improvement efforts in the areas of quality, access, and timeliness. The PIP validation process evaluated both the technical methods of each PIP (i.e., the study design) and the

PM outcomes associated with the implementation of interventions. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving improved study indicator outcomes. Appendix C provides additional detail on the methodology HSAG used for validating the PIPs.

Table 5-1 displays aggregate CMO validation results for all PIPs evaluated between June 2013 and August 2013. The CMOs submitted PIP data that reflected varying time periods, depending on the PIP topic. HSAG provided final, CMO-specific PIP validation reports to the CMOs and DCH in November 2013. This table illustrates the CMOs' overall understanding of the PIP process for the studies' Design, Implementation, and Outcomes stages. Each activity is composed of individual evaluation elements scored as ***Met, Partially Met,*** or ***Not Met***. Elements receiving a ***Met*** score have satisfied the necessary technical requirements for a specific element. The percentage of applicable evaluation elements that received ***Met*** scores is included in the table. Appendix C, Tables C–2, C–5, and C–8, provide the CMO-specific validation scores.

**Table 5-1—SFY 2013 Performance Improvement Projects' Validation Results for Georgia Families (N=27 PIPs)**

| Study Stage | Activity | Percentage of Applicable Elements Scored *Met* |
|---|---|---|
| **Design** | I. Appropriate Study Topic(s) | 96%<br>147/153 |
| | II. Clearly Defined, Answerable Study Question(s) | 100%<br>54/54 |
| | III. Clearly Defined Study Indicator(s) | 96%<br>159/165 |
| | IV. Correctly Identified Study Population | 92%<br>70/76 |
| | V. Valid Sampling Techniques (if sampling was used) | 99%<br>101/102 |
| | VI. Accurate/Complete Data Collection | 85%<br>194/227 |
| **Design Total** | | 93%<br>725/777 |
| **Implementation** | VII. Sufficient Data Analysis and Interpretation | 85%<br>177/209 |
| | VIII. Appropriate Improvement Strategies | 68%<br>49/72 |
| **Implementation Total** | | 80%<br>226/281 |
| **Outcomes** | IX. Real Improvement Achieved | 58%<br>49/84 |
| | X. Sustained Improvement Achieved | 75%<br>3/4 |
| **Outcomes Total** | | 59%<br>52/88 |
| **Overall Percentage of Applicable Evaluation Elements Scored *Met*** | | 88%<br>1,003/1,146 |

# Findings

## *Performance Improvement Project Validation Key Findings*

The overall aggregated validation results for the Design Total during the review period demonstrated the CMOs' understanding and application of the Design stage. The sufficient design of the PIPs created a foundation for the CMOs to progress to subsequent PIP stages—i.e., implementing improvement strategies and accurately assessing and achieving study outcomes.

The CMOs met 77 to 85 percent of the requirements in the two activities that make up the Implementation stage. A common challenge was that the CMOs did not report accurate data components in some of their PIPs. Additionally, the area of causal/barrier analysis was an area of concern. Documentation, analysis, and utilization of the causal/barrier process showed room for improvement. Such discrepancies can lead to a lack of relative and/or effective interventions being identified.

In the Outcomes stage, HSAG assessed for statistically significant and sustained improvement over baseline across all study indicators. The low overall percentage score for the Outcomes stage can be attributed to all three CMOs not achieving statistically significant improvement and not sustaining this improvement across all study indicators.

## *CMO Comparison Key Findings*

Table 5-2 displays the CMOs' validation results by study stage for all nine PIPs conducted by each of the three CMOs and evaluated during the review period.

**Table 5-2—Performance Improvement Project Validation Results Comparison by CMO (N=27 PIPs)**

| Study Stage | Activities | Percentage of Applicable Elements Scored *Met* | | |
|---|---|---|---|---|
| | | AMERIGROUP | Peach State | WellCare |
| Design | Activities I–VI | 93%<br>243/262 | 96%<br>241/252 | 92%<br>241/263 |
| Implementation | Activities VII–VIII | 77%<br>72/93 | 79%<br>73/93 | 85%<br>81/95 |
| Outcomes | Activities IX–X | 53%<br>16/30 | 66%<br>19/29 | 59%<br>17/29 |
| **Overall Percentage of Applicable Evaluation Elements Scored *Met*** | | **86%<br>331/385** | **89%<br>333/374** | **88%<br>339/387** |

All three CMOs met 92 to 96 percent of the requirements across all nine PIPs for all activities within the Design stage. Overall, the CMOs designed scientifically sound studies that were supported by the use of key research principles. The collaborative PIP, *Avoidable Emergency Room Visits*, negatively affected the Design stage score. Challenges in the design of this study included structural flaws. Of the six study indicators, two showed identical numerators and denominators, necessitating a correction. Five of the six study indicators did not align with the study question.

With the exception of the *Avoidable Emergency Room Visits* PIP, the technical design of the PIPs was sufficient.

The CMOs met 77 to 85 percent of the requirements in the Implementation stage. A common opportunity exists for all three CMOs to improve in the area of selecting relevant, effective interventions. Improved initial and follow-up causal/barrier analysis being performed and the successful implementation of corresponding improvement strategies should lead to achieving and sustaining improved outcomes across all study indicators.

All three CMOs scored lower in the Outcomes stage since very few of the study indicators showed statistically significant improvement. The CMOs ranged from 53 to 66 percent of the requirements in this stage being met. The culmination of the above-mentioned challenges attributes to a lack of real and sustained improvement.

## Overall Intervention and Outcome Results

### Adolescent Well-Child Visits

AMERIGROUP's interventions included:

- Conducting member outreach calls.
- Expanding its Provider Quality Incentive Program (PQIP), which educated providers on conducting well-care assessments during other visits, or educating providers on billing after-hour codes for completing services after normal business hours.
- Piloting the My Health Direct program, which allowed internal associates to schedule adolescent well-care visits while they were engaged with members on the telephone and allowed providers to block a portion of their day for AMERIGROUP members' appointments.
- Conducting CMO-specific interventions focused on member and provider education delivered primarily through member and provider newsletters.

This non-targeted education did not lend itself to evaluation and was not associated with any improvement in performance. Although AMERIGROUP identified barriers, how the barriers were prioritized was unclear. Documentation of methods involved in creating/designing interventions and evaluating them was lacking.

AMERIGROUP did not achieve statistically significant improvement from baseline to Remeasurement 1 in the *Adolescent Well-Care Visits* PIP. The study indicator's rate increased by 2.7 percentage points, but the change was not statistically significant. The Remeasurement 1 rate remained below the DCH target rate of 46.8 percent.

Peach State's interventions included the following: implementing a provider bonus program; creating a "tip-sheet" to educate providers about completing well-child assessments during sick visits/sports physicals; implementing CareGaps, an internal system alert to let internal employees and members know who is due for preventive services; addressing member barriers (e.g., calling members, supplying transportation, scheduling appointments); and using its medical record review

vendor to provide education to providers. Implementation of this many strategies emphasizes the need to have an evaluation plan in place to identify which interventions directly impact improvement results.

In the first remeasurement period of the *Adolescent Well-Care Visits* PIP, Peach State achieved statistically significant improvement in the rate of members 12–21 years of age who had at least one well-care visit during the measurement year. The Remeasurement 1 rate of 39.1 percent was still below the CY 2012 DCH target of 46.8 percent and below the 25th percentile (39.6 percent) of national Medicaid HEDIS 2011 rates.

Some of WellCare's interventions included conducting member educational outreach calls; implementing the Community Outreach and Field Short Term Case Management Program, reinforcing the need for members to make well-care appointments; targeting Health Check schedule reminder letters at 120 days of CMO enrollment and during each member's birthday month; creating monthly provider membership lists that specify children eligible for the health check visit who have not had an encounter within 120 days of joining the CMO; and offering a Provider Pay for Performance Incentive. The CMO should have a process in place to know which interventions directly impact improvements and which ones need to be revised or eliminated.

WellCare achieved statistically significant improvement at Remeasurement 1 in the *Adolescent Well-Care Visits* PIP, with an increase of 10.2 percentage points over the baseline rate. The CMO's CY 2012 rate of eligible adolescent members who had at least one well-care visit during the measurement year exceeded the DCH target rate of 46.8 percent and was between the 50th and 75th percentiles of the national Medicaid HEDIS 2011 rates.

### *Annual Dental Visits*

The interventions AMERIGROUP put into place for this PIP included health fairs, health promotion events, additional dental coverage benefits, missed opportunity reports through the provider portal, dental rate report cards, and quarterly report reviews assessing for noncompliant populations. Although this PIP has been successful, the CMO must ensure that each intervention is evaluated for effectiveness. Without this evaluation, the CMO cannot be sure which interventions should be continued, modified, or discontinued.

For the *Annual Dental Visits* PIP, AMERIGROUP sustained statistically significant improvement over baseline rates for both indicators at Remeasurement 3. The rate for members 2–21 years of age (Study Indicator 1) exceeded the CY 2012 DCH target rate of 64.1 percent. Additionally, the Remeasurement 3 rates for both study indicators exceeded the national HEDIS 2011 Medicaid 90th percentiles of 64.5 percent (2–21 years of age) and 46.9 percent (2–3 years of age), respectively.

Peach State implemented some new interventions such as the Preventistry Provider Sealant Program, a provider-based intervention. The CMO also revised the "Mobile Van" program by adding the "Safety Net" program. This program includes sending a mobile van to area schools so that dental exams can be performed, scheduling appointments for dentals exams, educating members on the importance of recommended dental visits, and assisting with transportation, if needed. Rational behind the addition, continuation, or discontinuation of certain interventions was

not supported by any analysis. This kind of research could lead to a more efficient effort toward significant improvement.

Peach State sustained statistically significant improvement at Remeasurement 3 in the *Annual Dental Visits* PIP. The CY2012 rates for both study indicators continued to demonstrate significant and real improvement over baseline rates. Furthermore, the rate for Study Indicator 2 (members 2–21 years of age) exceeded the CY 2012 DCH target rate of 64.1 percent and the Medicaid national HEDIS 2011 90th percentile of 64.5 percent.

WellCare's efforts in part included the following interventions: DentaQuest conducted a targeted provider mailing regarding a sealant program and member listing; targeted 120-Day Provider Reminder letters with a list of noncompliant members; targeted dental missed appointment letters were sent to members who had not had a dental service in the prior six months; targeted 120-Day Member Reminder letters; targeted Periodicity letters sent to members annually; and the Inbound Care Gap Program where customer service representatives identified any gap in dental or other HEDIS requirements and assisted members with scheduling appointments. It is unclear which of these strategies directly impacted improvement. A plan to evaluate the effectiveness of the interventions must be in place.

At Remeasurement 3 for the *Annual Dental Visits* PIP, WellCare sustained significant improvement over baseline for both study indicators. Both indicators also increased significantly over the previous year's rates. The CMO's CY 2012 rates for members 2–3 years of age and 2–21 years of age who had at least one dental visit during the measurement year exceeded the national HEDIS 2011 Medicaid 90th percentiles of 46.9 percent and 64.5 percent, respectively. The rate for members 2–21 years of age also surpassed the DCH CY 2012 target of 64.1 percent by 7.4 percentage points.

### *Appropriate Use of ADHD Medications*

AMERIGROUP's interventions included conducting reminder calls to members, distributing ADHD CPGs to providers, distributing HEDIS report cards to providers that showed providers' performance on ADHD follow-up, educating providers on how to retrieve missed opportunity reports via the provider portal, and hand-delivering and faxing "First Fill" letters to providers who prescribed ADHD medications. These efforts were not tracked and monitored. Evaluating intervention outcomes would have indicated a lack of improvement and alerted the CMO to adjust strategies.

Neither study indicator in the *Appropriate Use of ADHD Medications* PIP achieved statistically significant improvement at Remeasurement 1 for AMERIGROUP. Conversely, the rates of follow-up care visits for children newly prescribed ADHD medication declined for both the initiation phase (Study Indicator 1) and for the continuation and maintenance phase (Study Indicator 2), though neither decline was statistically significant. The rate for Study Indicator 1 (Initiation) remained below the DCH target rate of 48.1 percent and fell just below the national Medicaid HEDIS 2011 75th percentile of 43.6 percent. The rate for Study Indicator 2 (continuation) exceeded the DCH target rate of 57.6 percent and fell between the 75th (52.6 percent) and 90th (62.5 percent) percentiles of the national Medicaid HEDIS 2011 rates.

Some of the interventions implemented by Peach State included: a CPG compliance program; Quality Improvement and Public Relations collaboration to educate behavioral health providers on HEDIS measures and the ADHD CPGs; Peach State Days targeting noncompliant members with appointment scheduling, transportation assistance, and nominal incentives; and Pharmacy Liaison education visits to non-psychiatric practitioners with high-volume ADHD prescriptions. More in-depth causal/barrier analysis as well as a prioritization of the barriers would improve the process of selecting interventions. Another area for improvement would be the addition of a plan to evaluate the effectiveness of each intervention's impact on the study indicator rates.

Neither of Peach State's study indicators in the *Appropriate Use of ADHD Medications* PIP achieved statistically significant improvement from baseline to Remeasurement 1. Though the rate of follow-up care visits for children newly prescribed ADHD medication did not decline for either study indicator, the rate of follow-up visits during the initiation phase (Study Indicator 1) remained constant at 43.7 percent, and there was only a non-significant increase of 1.2 percentage points in the rate of follow-up visits during the continuation and maintenance phase (Study Indicator 2). The Remeasurement 1 rates for both indicators fell below the CY 2012 DCH targets of 48.1 percent (initiation) and 57.6 percent (continuation), respectively. In comparison with the Medicaid national HEDIS 2011 rates, Peach State's CY 2012 rates were better than the corresponding 75th percentile rates of 43.6 percent (initiation phase) and 52.6 percent (continuation phase).

WellCare's interventions included the following:

- Distribution of a "Best Practice" flyer to PCPs and psychiatrists identifying the need to educate members on the importance of continuation of medication and stressing the importance of the follow-up visit and education of the practitioners on the HEDIS measures.
- A provider newsletter stressing the importance of the follow-up visit.
- Targeted blast fax communications to providers to ensure members with newly prescribed medication were scheduled for a visit.
- Targeted member mailing reminding members to schedule a follow-up visit, then reminding members of the newly scheduled follow-up visit.
- WellCare hired a licensed master social worker to focus on behavioral health initiatives with an emphasis on ADHD.

Not all of these interventions addressed the barriers identified by the CMO or linked to the study indicators. WellCare must have more detailed documentation on how the interventions were selected and how they link to the barriers identified. The CMO would benefit from evaluating current interventions for successful outcomes as well as researching any decline in performance, using findings to develop new improvement strategies.

At Remeasurement 1 in the *Appropriate Use of ADHD Medications* PIP, WellCare did not achieve statistically significant improvement over baseline. The CY 2012 rates of ADHD follow-up visits for the initiation phase (Study Indicator 1) and the continuation phases (Study Indicator 2) were lower than the respective baseline rates, though neither declined significantly. The CMO's CY 2012 follow-up visit rates did not meet the corresponding DCH target rates of 48.1 percent (initiation) and 57.6 percent (continuation and maintenance). Compared to the Medicaid HEDIS 2011 national

rates, the rate for the initiation phase was slightly above the 50th percentile of 38.3 percent, and the rate for the continuation phase was slightly better than the 75th percentile of 52.6 percent.

### *Avoidable Emergency Room Visits*

All three CMOs are participating in this collaborative with DCH to address avoidable emergency room visits. The provider and member interventions included:

- Shared data regarding ER rates with practices to identify members using the ER during regular office hours.
- Notified providers regarding additional reimbursement for care provided after-hours.
- Increased percentage of practices using electronic health records through referral to the Georgia Health Information Technology Regional Extension Center (GA-HITREC).
- Continued ER case management programs for live outreach to members who frequent the ER.
- Educational mailings to members regarding patient-centered medical homes (PCMHs) and nurse advice hotlines.
- Provided materials to members regarding transportation vendors and assistance to members to arrange transportation, when needed.

The documentation did not reflect processes in place to evaluate the effectiveness of these interventions. The lack of improvement should be met with a collaborative effort to investigate the decrease in performance and adjust according to the findings.

Study Indicators 1 through 5 assessed the 10 metro-Atlanta provider practices associated with the highest number of avoidable emergency room visits, and Study Indicator 6 assessed visits to the emergency departments of three Children's Healthcare of Atlanta facilities. Study Indicators 1 through 5 were incorporated at the direction of the State to serve as lead measures. Lead indicators can be helpful in predicting changes that the CMO may use to make mid-course corrections to allow for timely, rapid cycles of improvement rather than waiting for the lag or outcome measure of the PIP, which relies on annual measurement. The initial data for these lead measures were collected by the CMOs during the course of the PIP, and the results showed that these measures did not allow an opportunity for improvement in Study Indicators 1 (percentage of providers who provide same-day appointments) and 3 (percentage of practices that have the ability to document after-hours clinical advice) because the baseline rate for each indicator was 100 percent. The study indicators were created before some of the baseline data were obtained from the participating practices and as such, the CMOs were unaware these baseline rates would be 100 percent. The rates of Study Indicators 2, 4, and 5 had non-statistically significant improvement from baseline to Remeasurement 1. The rate of Study Indicator 5 (percentage of practices that receive ER visit information from study hospitals) reached 100 percent at Remeasurement 1; therefore, this indicator has no room for improvement in future measurement periods for the metro-Atlanta pilot practices. Study Indicator 6, the percentage of emergency room visits for the specified subset of avoidable diagnoses, is the only indicator that did not improve, as there was a significant increase of 1.14 percentage points in the rate of avoidable emergency room visits from baseline to Remeasurement 1. HSAG recommends the CMOs modify their reporting of this PIP for the next remeasurement period and include the lead measures in Activity VIII on the PIP report template.

**Table 5-3—Performance Improvement Project Outcomes for *Avoidable Emergency Room Visits***

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| 1. The percentage of practices that provide the same day appointments for routine and urgent care. | 100% | 100% | NA |
| 2. The percentage of practices that provide routine and urgent care appointments after hours. | 50% | 70% | NA |
| 3. The percentage of practices that provide appointments for routine and urgent care after hours and have the ability to document after hours clinical advice in the patient's record. | 100% | 100% | NA |
| 4. The percentage of practices that have access to and utilize electronic health records. | 70% | 90% | NA |
| 5. The percentage of practices that receive information regarding ER visits from the study hospitals. | 80% | 100% | NA |
| 6. The percentage of ER visits for 'avoidable' diagnoses (dx382–Acute Suppurative otitis:382.9–Unspecified otitis:462–Acute pharyngitis:465.9–Acute upper respiratory infection:466 –Acute bronchitis:786.2–Cough) among members under 21 years of age who had a visit to the ED in three selected Children's Hospital of Atlanta facilities in the Atlanta region. | 19.38% | 20.52%↓* | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

### *Childhood Immunizations—Combination 10*

AMERIGROUP's interventions included expanding its PQIP to incorporate 13 additional high-volume providers, prepaying for PeachCare for Kids® members' vaccines, aligning claims codes with HEDIS specifications to ensure providers were paid accordingly, and sending letters and conducting face-to-face discussions regarding unavailable vaccines and plans to ensure all patients received all immunizations as they became available. As with other PIPS, the CMO must develop a process to evaluate the effectiveness of each intervention to determine which interventions could be relevant in continuing improvement.

AMERIGROUP achieved statistically significant improvement over the baseline rate in the first Remeasurement period for the *Childhood Immunizations—Combination 10* PIP, with an increase of 21.5 percentage points. The Remeasurement 1 rate also exceeded the national HEDIS 2011 Medicaid 90th percentile of 23.6 percent.

Peach State's interventions included: placing outreach calls to members in need of immunizations; implementing CareGaps, an internal system alert to let Peach State employees and members know

which members are due or past due for preventive services; scheduling appointments; facilitating non-emergency transportation to appointments; sending lists of noncompliant members to providers; implementing a members incentive program; participating in the "Centene Childhood Immunization Mailing" pilot program, and distributing a quarterly reminder mailing to members. Data and efforts to ensure intervention effectiveness were lacking.

For the *Childhood Immunizations—Combination 10* PIP, Peach State achieved statistically significant improvement over baseline at Remeasurement 1, with an increase of 10.3 percentage points in the rate of eligible child members who had received all necessary immunizations by their second birthday. The Remeasurement 1 rate also surpassed the Medicaid HEDIS 2011 90th percentile of 23.6 percent.

WellCare's interventions included incentivizing the customer service team with $5 for each appointment made; conducting outbound member reminder calls; establishing a centralized telephonic outreach program; targeted 120-Day Member Reminder letters; targeted Periodicity letters sent to members annually; monthly member noncompliant list sent to providers; targeted 120-Day Provider Reminder letters with a list of noncompliant members; and HEDIS tool kits distributed during Pay-for-Performance visits. As with other PIPs, WellCare's interventions did not address all of the identified barriers. A plan to evaluate effectiveness is also needed for this PIP.

WellCare demonstrated significant improvement in the *Childhood Immunizations—Combination 10* PIP, with an increase of 18.2 percentage points from baseline to Remeasurement 1 in the rate of eligible child members who received the recommended vaccinations by their second birthday. The CMO's rate also exceeded the HEDIS 2011 90th percentile of 23.6 percent.

### *Childhood Obesity*

Some of the Interventions used by AMERIGROUP for this PIP included implementing interactive case management, distributing nearly 7,000 fliers on childhood obesity, text messaging 5,400 households, and hosting obesity events. These interventions go beyond the documentation scope of this PIP. Interventions geared toward providers would better serve this HEDIS measure-related PIP.

AMERIGROUP's *Childhood Obesity* PIP sustained statistically significant improvement over the baseline rate at Remeasurement 3 for Study Indicators 1 (BMI percentile documentation) and 2 (evidence of nutrition counseling). The rate for Study Indicator 3 (evidence of physical activity counseling) declined at Remeasurement 3 and was no longer significantly higher than the baseline rate. All three of the study indicators fell below their respective DCH CY 2012 goals of 45.2 percent (BMI percentile documentation), 57.7 percent (evidence of nutrition counseling), and 45.5 percent (evidence of physical activity counseling). The CMO's rates for Study Indicators 1 and 2 were slightly above the 50th percentile of the Medicaid HEDIS 2011 rates of 37.5 percent and 51.1 percent, respectively. The rate for Study Indicator 3 fell below the HEDIS 2011 50th percentile of 40.6 percent.

Peach State's interventions included quarterly meetings with the medical record review vendor to reinforce content and materials for practitioner training, one-on-one provider education on the importance of obtaining and documenting BMI percentiles, and a "Start Strong" education and goal-setting pilot program targeting overweight members 4–17 years of age. The Start Strong

intervention is an example of not effectively linking an intervention to study indicators. No plan is currently in place to measure the effectiveness of interventions.

Peach State's outcomes for the *Childhood Obesity* PIP at Remeasurement 3 were significantly better than the previous year for all three study indicators. Additionally, the CY 2012 rates of BMI percentile documentation (Study Indicator 1) and physical activity counseling (Study Indicator 3) achieved statistically significant improvement over baseline for the first time. The PIP will be evaluated for sustained improvement at Remeasurement 4, when all three study indicators will have at least one subsequent measurement after achieving significant improvement. The CMO's rates of BMI documentation and physical activity counseling also surpassed the respective CY 2012 DCH target rates of 45.2 percent and 45.5 percent, while the rate of nutrition counseling (Study Indicator 2) fell short of the DCH target rate of 57.7 percent. When compared to the Medicaid HEDIS 2011 national rates, the Remeasurement 3 rates of all three study indicators fell between the 50th and 75th percentiles.

Some of the interventions implemented by WellCare included partnering with the Boys & Girls Club to establish memberships for youth across the State in an effort to engage them in healthy activities, and paying for 604 Boys & Girls Club memberships in 2012; publishing an article in the provider newsletter stating the ages for which BMI percentile is required; conducting 250 WellCare Days at the Women, Infants, and Children (WIC) offices, provider offices, health departments and Division of Family and Children Services (DFCS) offices, reaching over 2,367 members; launching a Weight Watchers program for youth to teach them how to eat healthy balanced meals; distributing HEDIS tool kits by mail and hand delivering them to targeted providers; sending postcards to targeted pediatricians outlining the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measure; handing out postcards at a conference to providers outlining the WCC measure; providing a DCH-approved BMI percentile documentation form for providers via the provider Web site; and e-mailing independent practice associations (IPAs) BMI percentile forms and WCC postcards. Despite HSAG's feedback included in last year's validation, the CMO continued to address many barriers and implement interventions that had no effect on the study indicator outcomes. All three study indicators are looking for documentation by providers; member interventions are of little or no value for this PIP. WellCare must focus on strategies that will have an impact on the rate. Follow-up to identify each intervention's success is an important step that must be implemented. For example, for the providers who received a HEDIS tool kit or postcard, did their compliance improve?

One of WellCare's three study indicators for the *Childhood Obesity* PIP, evidence of counseling for nutrition, has continued its year-over-year improvement at Remeasurement 3 and maintained a significant increase from the baseline rate. The Remeasurement 3 rates for the remaining study indicators, BMI percentile documentation and evidence of counseling for physical activity, are not significantly better than their respective baseline rates, with the rate of BMI documentation 18.2 percentage points lower than the previous year, a significant decline. The CMO's rates fell below the respective CY 2012 DCH targets of 45.2 percent for BMI percentile documentation, 57.7 percent for evidence of counseling for nutrition, and 45.5 percent for evidence of counseling for physical activity. In comparison with the national Medicaid 2011 HEDIS rates, WellCare's CY 2012 rates are slightly better than the 50th percentile for BMI percentile documentation (37.5 percent) and evidence of counseling for physical activity (40.6 percent) and between the 50th (51.1 percent) and 75th percentile (61.6 percent) for evidence of counseling for nutrition.

### *Diabetes Care*

Some of the interventions implemented by AMERIGROUP included placing robotic reminder calls to members, launching a new member incentive program which allowed for a $25 reward to members who had all three screenings, piloting a project that supplied 15 diabetic members with an appointment book and expanding the pilot to 100 more members, distributing HEDIS report cards showing providers their performance on HbA1c testing, sending letters to providers that listed noncompliant diabetic members needing services, and sending letters to noncompliant members notifying them of diabetic services needed. All of the study indicators in this PIP concentrate on controlling HbA1c, blood pressure, and LDL-C levels. Strategies engaging providers to increase control for members with diabetes would better serve this focus.

For AMERIGROUP, none of the study indicators for the *Comprehensive Diabetes Care* PIP achieved statistically significant improvement over baseline rates at Remeasurement 1. While there was no statistically significant change in any of the indicators, the rates of Study Indicators 1 (HbA1c Control < 7.0%) and 3 (Blood Pressure [BP] Control < 140/90 mmHg) decreased, and the rate of Study Indicator 2 (LDL-C Control < 100 mg/ml) increased non-significantly. The Remeasurement 1 rates for all three study indicators fell below the CY 2012 DCH targets of 35.5 percent (HbA1c control < 7.0%), 33.6 percent (LDL-C control < 100 mg/ml), and 61.6 percent (BP Control < 140/90 mmHg), and all were below the corresponding Medicaid HEDIS 2011 50th percentile rates of 35.2 percent (HbA1c Control < 7.0% and LDL-C Control < 100 mg/ml) and 61.2 percent (BP Control < 140/90 mmHg).

Peach State's interventions for the *Comprehensive Diabetes Care* PIP were unlikely to impact the study outcomes. The study focused on controlling levels while the interventions were geared toward improving screening rates. Examples of these interventions included provider outreach to obtain screening results identified as missing in the HEDIS reporting system; "Push" initiative to outreach to schedule appointments, assist with transportation, and offer an incentive for obtaining preventive services; and CareGaps, an internal system alert to let employees, providers, and members know about due or past due preventive services. Stronger causal/barrier analysis may have led to more relevant interventions, while evaluating effectiveness of interventions would have shown the need for adjustment to and/or creation of new interventions to positively impact the outcomes.

None of the study indicators in the *Comprehensive Diabetes Care* PIP achieved statistically significant improvement over baseline at Remeasurement 1 for Peach State. All three study indicators declined during the remeasurement period with the decline in Study Indicator 2 (LDL-C Control < 100 mg/ml) being statistically significant. The CY 2012 rates for all three indicators fell below the DCH target rates of 35.5 percent (HbA1c Control < 7.0%), 33.6 percent (LDL-C Control < 100 mg/ml), and 61.6 percent (BP Control < 140/90 mmHg), respectively. The Remeasurement 1 rates for all three study indicators also fell below the 25th percentile of the respective Medicaid HEDIS 2011 national rates.

WellCare's member and provider interventions included periodicity letters to members within 45 days of joining the CMO and during the birth month of current members to remind them of screenings and immunizations; community education events to which the Member Outreach Team

invited diabetic members; and a Diabetes Education Program which was also run by Member Outreach Team staff to identify diabetic members who needed to be educated about their chronic disease and how to manage it to avoid complications; and a HEDIS education screening program that reached out to targeted members with a gap in care.

There was essentially no change from baseline to Remeasurement 1 in the study indicator rates for the *Comprehensive Diabetes Care* PIP. The rates of Study Indicator 1 (HbA1c Control < 7.0%) and Study Indicator 3 (BP Control < 140/90 mmHg) remained constant, and the rate of Study Indicator 2 increased non-significantly by 2.9 percentage points. The CMO's rates fell below the CY 2012 DCH goals of 35.5 percent (HbA1c Control < 7.0%), 33.6 percent (LDL-C Control < 100 mg/ml), and 61.6 percent (BP Control < 140/90 mmHg), respectively. The rates for Study Indicators 1 and 2 were between the 25th and 50th percentiles of the Medicaid HEDIS 2011 national rates, and the rate for Study Indicator 3 fell below the 25th percentile.

### *Member Satisfaction*

All three of the CMOs initiated a new *Member Satisfaction* PIP in 2012–2013 to fulfill their contractual requirements to DCH. AMERIGROUP's study indicator, based on Question 36 of AMERIGROUP's 2012 CAHPS Child Medicaid Survey, assessed the overall rating parents/guardians selected for the CMO as their child's health plan, with "0" being the lowest rating and "10" being the highest possible rating. The baseline rate of respondents giving AMERIGROUP a rating of "8" or higher was 85.8 percent, slightly lower than the CMO's baseline goal of 86.6 percent, the 2012 Child Medicaid Quality Compass 75th percentile.

Peach State's study indicator, based on Question 36 of Peach State's 2013 CAHPS Child Medicaid Survey, assessed the overall rating parents/guardians selected for the CMO as their child's health plan, with "0" being the lowest possible rating and "10" being the highest possible rating. The baseline rate of respondents giving Peach State a score of "8" or higher was 87.0 percent, slightly lower than the CMO's baseline goal (The Myers Group 90th percentile) of 88.7 percent.

WellCare's study indicator, based on Question 36 of WellCare's 2013 CAHPS Child Medicaid Survey, assessed the overall rating parents/guardians selected for the CMO as their child's health plan, with "0" being the lowest possible score and "10" being the highest possible score. The baseline rate of respondents giving WellCare a score of "8" or higher was 88.3 percent. It should be noted that the baseline rate for this PIP was already above the CMO's baseline goal of 85.0 percent.

### *Provider Satisfaction*

AMERIGROUP collected baseline data for a new *Provider Satisfaction* PIP in CY 2012. The study indicator from the CMO's 2012 provider satisfaction survey assessed providers' overall satisfaction. The baseline rate of providers who reported being "Somewhat satisfied" or "Very satisfied" with AMERIGROUP was 79.6 percent. The CMO stated in the SFY 2014 PIP Summary Form that its goal was to increase the baseline rate by 5 percent; therefore, the goal was for 83.6 percent of providers to report being "Somewhat satisfied" or "Very satisfied" with AMERIGROUP at Remeasurement 1.

Peach State also collected baseline data for a new *Provider Satisfaction* PIP in 2012–2013. The study indicator from the CMO's 2012 provider satisfaction survey assessed providers' overall satisfaction. The baseline rate of providers who reported being "Somewhat satisfied" or "Very satisfied" with Peach State was 76.3 percent. The CMO stated in the SFY 2014 PIP Summary Form that its goal was to increase the baseline rate by 2 percentage points; therefore, the goal was for 78.3 percent of providers to report being "Somewhat satisfied" or "Very satisfied" with Peach State at Remeasurement 1.

WellCare's new Provider Satisfaction PIP in 2012 used the study indicator from the CMO's 2012 provider satisfaction survey assessed providers' overall satisfaction. The baseline rate of providers who reported being "Somewhat satisfied" or "Very satisfied" with WellCare was 81.0 percent, surpassing the CMO's baseline goal of 74.7 percent. The CMO stated in the SFY 2014 PIP Summary Form that its goal was to increase the rate of overall provider satisfaction by 5 percentage points annually; therefore, the CY 2013 survey goal was for 86.0 percent of providers to report being "Somewhat satisfied" or "Very satisfied" with WellCare at Remeasurement 1.

**Table 5-4—Performance Improvement Project Outcomes (validated during SFY 2013) Comparison by CMO**

| PIP Topic | AMERIGROUP | | Peach State | | WellCare | |
|---|---|---|---|---|---|---|
| | Remeasurement 3 Period 1/1/12–12/31/12 | Sustained Improvement | Remeasurement 3 Period 1/1/12–12/31/12 | Sustained Improvement | Remeasurement 3 Period 1/1/12–12/31/12 | Sustained Improvement^ |
| *Annual Dental Visit—2–3 Years of Age* | 48.5% | Yes | 44.0% | Yes | 52.2%↑* | Yes |
| *Annual Dental Visit—2–21 Years of Age* | 69.9% | Yes | 67.9%↑* | Yes | 71.5%↑* | Yes |
| *Childhood Obesity—BMI Documentation* | 40.7%↑* | Yes | 47.7%↑* | NA | 38.7%↓* | NA |
| *Childhood Obesity—Counseling for Nutrition* | 52.3% | Yes | 56.0%↑* | NA | 55.5% | NA |
| *Childhood Obesity—Counseling for Physical Activity* | 39.8% | No | 47.7%↑* | NA | 42.1% | NA |

| Table 5-4—Performance Improvement Project Outcomes (validated during SFY 2013) Comparison by CMO | | | | | | |
|---|---|---|---|---|---|---|
| PIP Topic | AMERIGROUP | | Peach State | | WellCare | |
| | Remeasurement 1 Period 1/1/12–12/31/12 | Sustained Improvement | Remeasurement 1 Period 1/1/12–12/31/12 | Sustained Improvement | Remeasurement 1 Period 1/1/12–12/31/12 | Sustained Improvement^ |
| *Adolescent Well-Care Visits* | 46.6% | NA | 39.1%↑* | NA | 51.6%↑* | NA |
| *Appropriate use of ADHD Medications—Initiation Phase* | 42.3% | NA | 43.7% | NA | 39.4% | NA |
| *Appropriate use of ADHD Medications—Continuation Phase* | 58.2% | NA | 58.6% | NA | 53.1% | NA |
| *Childhood Immunizations—Combination 10* | 31.9%↑* | NA | 27.9%↑* | NA | 38.4%↑* | NA |
| *Comprehensive Diabetes Care—HbA1c control < 7.0* | 30.6% | NA | 27.6% | NA | 32.4% | NA |
| *Comprehensive Diabetes Care—LDL-C control < 100mg/ml* | 27.3% | NA | 20.4%↓* | NA | 28.1% | NA |
| *Comprehensive Diabetes Care—BP control < 140/90 mmHg* | 55.1% | NA | 53.7% | NA | 51.6% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

Six PIPs were HEDIS-based PIPs. Only one, *Annual Dental Visits*, demonstrated statistically significant improvement across all CMOs. AMERIGROUP demonstrated statistically significant improvement for 4 of the 12 HEDIS-based study indicators. Peach State and WellCare each only demonstrated such improvement for 2 of the 12 study indicators.

The PIPs based on provider and member satisfaction were redesigned this year to better align the CMOs' efforts and results. The baseline data collected for member satisfaction were slightly below

goal except in WellCare's case where baseline data were above the baseline goal. Provider satisfaction results were all slightly below the goals that were set by the CMOs.

The collaborative PIP, *Avoidable Emergency Room Visits*, had six study indicators. Only one of the six indicators aligned with the study question. Study Indicator 6, the percentage of emergency room visits for the specified subset of avoidable diagnoses, is the only indicator that did not improve. Instead, there was a significant increase of 1.14 percentage points in the rate of avoidable emergency room visits from baseline to Remeasurement 1.

**Table 5-5—Performance Improvement Project Outcomes for Member Satisfaction Comparison by CMO**

| PIP Topic | AMERIGROUP | | Peach State | | WellCare | |
|---|---|---|---|---|---|---|
| | Baseline Period 2/22/12–5/9/13 | Sustained Improvement | Baseline Period 3/13/12–5/22/13 | Sustained Improvement | Baseline Period 1/1/13–5/31/13 | Sustained Improvement^ |
| The percentage of respondents who rate the health plan an 8, 9, or 10 in response to Q36—"Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?" | 85.8% | NA | 87.0% | NA | 88.3% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

| Table 5-6—Performance Improvement Project Outcomes for Provider Satisfaction Comparison by CMO | | | | | | |
|---|---|---|---|---|---|---|
| PIP Topic | AMERIGROUP | | Peach State | | WellCare | |
| | Baseline Period 8/1/12–11/30/12 | Sustained Improvement | Baseline Period 11/14/12–1/16/13 | Sustained Improvement | Baseline Period 8/1/12–10/31/12 | Sustained Improvement^ |
| The percentage of providers who respond, "Very satisfied" or, "Somewhat satisfied" to the question—"Please rate your overall satisfaction with X health plan." | 79.6% | NA | 76.3%% | NA | 81.0% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

| Table 5-7—Performance Improvement Project Outcomes for Avoidable Emergency Room Visits (Collaborative) Comparison by CMO | | | |
|---|---|---|---|
| **PIP Topic** | **Baseline Period 1/1/11–12/31/11** | **Remeasurement 1 1/1/12–12/31/12** | **Sustained Improvement^** |
| 1. The percentage of practices that provide the same day appointments for routine and urgent care. | 100% | 100% | NA |
| 2. The percentage of practices that provide routine and urgent care appointments after hours. | 50% | 70% | NA |
| 3. The percentage of practices that provide appointments for routine and urgent care after hours and have the ability to document after hours clinical advice in the patient's record. | 100% | 100% | NA |
| 4. The percentage of practices that have access to and utilize electronic health records. | 70% | 90% | NA |
| 5. The percentage of practices that receive information regarding ER visits from the study hospitals. | 80% | 100% | NA |
| 6. The percentage of ER visits for 'avoidable' diagnoses (dx382–Acute Suppurative otitis:382.9–Unspecified otitis:462–Acute pharyngitis:465.9–Acute upper respiratory infection:466 –Acute bronchitis:786.2–Cough) among members under 21 years of age who had a visit to the ED in three selected Children's Hospital of Atlanta facilities in the Atlanta region. | 19.38% | 20.52%↓* | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

↓* Designates statistically significant decline in performance over the prior measurement period ($p$ value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

## *Conclusions*

The PIP study indicators demonstrated some success, with a few indicators showing statistically significant improvement and sustaining the improvement. The majority of the indicators did not show this level of improvement and sometimes showed a significant decline in performance. A critical analysis of the PIP process of all three CMOs showed some consistent trends. For the most part, the CMOs had sound study design methods which build a good foundation to progress to the implementation and outcomes stages.

The critical analysis highlighted a few areas for improvement in the Implementation stage. Logically linking interventions back to the study indicators is important to accomplishing the

outcomes desired. Sufficiently interpreting the collected and available data should lead to appropriate interventions. In some cases, the documentation was lacking; in other instances, understanding the documentation was the barrier. In addition, all three CMOs need to identify and implement a process to evaluate the effectiveness of the interventions. Tracking the success being demonstrated by an intervention improves efficiency and success rates. Continuing an ineffective intervention is as unlikely to improve outcomes as one that is unrelated to the study indicators.

HSAG's critical analysis indicated areas for improvement for each CMO. While there were some successes, the majority of the outcomes did not demonstrate the improvement expected (statistically significant improvement, State goals not met, and performance at NCQA's 25th percentile). In addition, because the CMOs did not evaluate the effectiveness of their interventions, HSAG had difficulty attributing success to the PIP efforts. Concentrated efforts geared toward intervention relevance as well as continued evaluation of interventions could greatly improve PIP success rates along with better linking of improvements to the associated PIP interventions.

### *Recommendations for the CMOs*

- Ensure that all data components reported in each PIP are accurate and consistently documented throughout the PIP, and align with the data that have been reported in the CMO's final audit reports.
- Ensure that all statistical testing is done correctly and that documentation of statistical testing outcomes is accurate and consistent throughout the PIP.
- Conduct an annual causal/barrier analysis including drill-down analysis as well as additional quarterly analyses of its outcome data. The CMOs must accurately document the analyses, providing the results, identified barriers, and rationale for how barriers are prioritized.
- Ensure that the interventions implemented to address a specific barrier are directly linked to that barrier and will directly impact study outcomes.
- Have a process in place, for any intervention implemented, to evaluate the efficacy of the intervention to determine if it is having the desired effect. The results of each intervention's evaluation for each remeasurement period should be included in the PIP. If the interventions are not having the desired effect, the CMO should discuss how it will address these deficiencies and what changes will be made to its improvement strategies.

### *Technical Assistance*

In September 2013, HSAG conducted technical assistance sessions with each of the CMOs. The session began with an overview of the Plan-Do-Study-Act process, then focused on individualized technical assistance with specific PIPs. Prior to the on-site sessions, HSAG requested each CMO complete a survey about their current quality improvement processes. HSAG requested that staff involved with quality improvement complete the anonymous survey. The survey results allowed HSAG to tailor each session to the CMO's particular needs and requests. Additionally, once HSAG determined the PIPS to be discussed at each session, HSAG then asked the CMO to submit data around those PIPs. HSAG incorporated the data into the discussions, demonstrating how the CMOs might use the data to assess barriers and determine interventions.

The technical assistance sessions were well received by all CMOs. Each session was very interactive, with the CMOs analyzing their current interventions, then performing a barrier analysis and determining possible interventions for those PIPs under discussion.

# 6. Adult Quality Measures

## Overview of the Medicaid Adult Quality Measures Grant

The DCH was the recipient of a grant awarded by CMS in December 2012 that allowed DCH the opportunity to collect and validate PM data on the Medicaid adult population consistent with the Adult Core Set of Medicaid measures released by CMS in February 2013. Several of the PMs for the MAO population are also HEDIS measures; however, some of these measures, while consistent with most aspects of the specifications, require rates for specific age bands. The DCH used its vendor, HP, to calculate the MAO measures and its EQRO to validate the measure rates.

## Performance Measures

Table 6-1 summarizes the rates reported for the MAO population. Comparisons, where appropriate to other populations, are included in Section 4 of this report.

**Table 6-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population**

| Measure | Rate |
|---|---|
| Cervical Cancer Screening | 50.61% |
| Breast Cancer Screening | |
| Ages 42–64 Years | 36.74% |
| Ages 65–69 Years | 21.53% |
| Prenatal and Postpartum Care | |
| Postpartum Care | 64.96% |
| Chlamydia Screening in Women | |
| Ages 21–24 Years | 60.26% |
| Comprehensive Diabetes Care | |
| LDL-C Screening | |
| Ages 18–64 Years | 55.33% |
| Ages 65–75 Years | 28.43% |
| Total | 57.85% |
| HbA1c Testing | |
| Ages 18–64 Years | 62.70% |
| Ages 65–75 Years | 37.30% |
| Total | 64.42% |
| Follow-Up After Hospitalization for Mental Illness | |
| 7-Day Follow-Up | |
| Ages 21–64 Years | 38.61% |
| Ages 65+ Years | 18.67% |
| 30-Day Follow-Up | |
| Ages 21–64 Years | 59.36% |
| Ages 65+ Years | 36.44% |

| Table 6-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population | |
|---|---|
| **Measure** | **Rate** |
| Antidepressant Medication Management | |
| Effective Acute Phase Treatment | |
| Ages 18–64 Years | 60.00% |
| Ages 65 and older | 37.50% |
| Effective Continuation Phase Treatment | |
| Ages 18–64 Years | 44.43% |
| Ages 65 and older | 18.48% |
| Diabetes, Short-term Complications Admission Rate | |
| Ages 18–64 Years | 305.83/100,000 members |
| Ages 65+ Years | 383.58/100,000 members |
| Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (Per 100,000) | |
| Ages 18–64 Years | 1,139.94/100,000 members |
| Ages 65+ Years | 19,892.07/100,000 members |
| Congestive Heart Failure Admission Rate (Per 100,000) | |
| Ages 18–64 Years | 748.19/100,000 members |
| Ages 65+ Years | 24,114.70/100,000 members |
| Adult Asthma Admission Rate (Per 100,000) | |
| Ages 18–64 Years | 322.57/100,000 members |
| Ages 65+ Years | 1,244.15/100,000 members |
| Controlling High Blood Pressure | |
| Ages 18–64 Years | NR |
| Ages 65–85 Years | NR |
| Total | 32.36% |
| Annual Monitoring for Patients on Persistent Medications | |
| ACE/ARB | |
| Ages 18–64 Years | 89.78% |
| Ages 65+ Years | 78.57% |
| Anticonvulsants | |
| Ages 18–64 Years | 65.74% |
| Ages 65+ Years | 60.85% |
| Digoxin | |
| Ages 18–64 Years | 90.38% |
| Ages 65+ Years | 84.34% |
| Diuretics | |
| Ages 18–64 Years | 89.76% |
| Ages 65+ Years | 76.34% |
| Total | |
| Ages 18–64 Years | 86.19% |
| Ages 65+ Years | 76.36% |
| Annual HIV/AIDS Medical Visit 180 Days Apart | |
| Ages 18–64 Years | 40.65% |

| Table 6-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population | |
|---|---|
| **Measure** | **Rate** |
| Ages 65+ Years | 44.52% |
| Annual HIV/AIDS Medical Visit 90 Days Apart<br>Ages 18–64 Years<br>Ages 65+ Years | <br>53.91%<br>57.14% |
| Adult BMI Assessment<br>Ages 18–64 Years<br>Ages 65+ Years | <br>7.61%<br>7.09% |
| Elective Delivery | 33.81% |
| Antenatal Steroids | 4.02% |
| Adherence to Antipsychotic Medications for Individuals with Schizophrenia | 64.44% |
| Flu Shots for Adults Ages 50–64 | NR |
| Medical Assistance With Smoking and Tobacco Use Cessation | NR |
| Screening for Clinical Depression and Follow-Up Plan—Total | 0.01% |
| Plan All-Cause Readmission Rate<br>Ages 18–44 Years<br>Ages 45–54 Years<br>Ages 55–64 Years<br>Ages 65+ Years<br>Total | <br>12.78%<br>12.28%<br>11.25%<br>2.49%<br>9.42% |
| Care Transition—Transition Record Transmitted to Health Care Professional | NR |
| Initiation and Engagement of Alcohol and Other Drug Dependence Treatment<br>Initiation of Treatment Total<br>Ages 18–64 Years<br>Ages 65+ Years<br>Engagement of Treatment Total<br>Ages 18–64 Years<br>Ages 65+ Years | <br><br>40.77%<br>56.37%<br><br>6.11%<br>6.64% |

## Quality Improvement Projects

The DCH is working with the Division of Aging in the Department of Human Services and the 12 Area Agencies on Aging serving the Community Care Services Program population to measure and improve the care management of members with depression.

# 7. Consumer Assessment of Healthcare Providers and Systems (CAHPS)

## Consumer Assessment of Healthcare Providers and Systems Overview

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. The DCH periodically assesses the perceptions and experiences of GF members as part of its process for evaluating the quality of health care services provided by plans to their members.

The administration of the CAHPS Surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their health care services. The DCH requires that CAHPS Surveys are administered to both adult members and parents or caretakers of child members at the county level unless otherwise specified. In 2013, DATASTAT, Inc., administered standardized survey instruments, CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys, to the PeachCare for Kids®, Medicaid and PeachCare for Kids® children, and Medicaid adult members.

## Findings

HSAG used the CAHPS data that were organized, aggregated, and analyzed by DATASTAT, Inc. These data can be used to evaluate performance in providing quality, accessible, and timely care and service to members. The results can also be used to drive quality initiatives. The evaluation focus is on four global rating measures and five composite measures as follows:

CAHPS Global Rating Measures:

- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

CAHPS Composite Measures:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making

## National Comparisons

To assess the overall performance of the Georgia Medicaid and PeachCare for Kids® programs, HSAG compared the aggregated results to the National Committee for Quality Assurance's

(NCQA's) HEDIS benchmarks and thresholds or NCQA's national Medicaid data, where applicable. Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating (i.e., *Poor*) and five is the highest possible rating (i.e., *Excellent*).

Star ratings were determined for each CAHPS measure using the following percentile distributions in Table 7-1.

**Table 7-1—Star Ratings Crosswalk**

| Stars | Adult and Child Percentiles |
|---|---|
| ★★★★★ Excellent | At or above the 90th percentile |
| ★★★★ Very Good | At or above the 75th and below the 90th percentiles |
| ★★★ Good | At or above the 50th and below the 75th percentiles |
| ★★ Fair | At or above the 25th and below the 50th percentiles |
| ★ Poor | Below the 25th percentile |

Table 7-2 displays the ratings for each global rating and composite measure.

**Table 7-2—CAHPS® Results**

| | Adult Medicaid | | Child Medicaid | | PeachCare for Kids® | |
|---|---|---|---|---|---|---|
| Measure | Rate | Comparison to Benchmark | Rate | Comparison to Benchmark | Rate | Comparison to Benchmark |
| **Global Ratings** | | | | | | |
| Rating of Personal Doctor | 62.79% | ★★★ | 76.88% | ★★★★★ | 72.54% | ★★★ |
| Rating of Specialist Seen Most Often | NA | NA | NA | NA | 72.73% | ★★★★ |
| Rating of All Health Care | 52.63% | ★★★ | 67.83% | ★★★★ | 69.82% | ★★★★★ |
| Rating of Health Plan | 49.29% | ★ | 68.65% | ★★★ | 65.43% | ★★ |
| **Composite Measures** | | | | | | |
| Getting Needed Care | 78.09% | ★★★ | 86.47% | ★★★★ | 87.42% | ★★★★★ |
| Getting Care Quickly | 81.13% | ★★ | 88.60% | ★★★ | 92.36% | ★★★★★ |
| How Well Doctors Communicate | 85.97% | ★★ | 92.47% | ★★★ | 95.70% | ★★★★★ |
| Customer Service | NA | NA | 88.32% | ★★★★ | 91.59% | ★★★★★ |

| Table 7-2—CAHPS® Results | | | | | | |
|---|---|---|---|---|---|---|
| | Adult Medicaid | | Child Medicaid | | PeachCare for Kids® | |
| Measure | Rate | Comparison to Benchmark | Rate | Comparison to Benchmark | Rate | Comparison to Benchmark |
| Shared Decision Making | NA | NA | 54.73% | No comparison available | 48.22% | No comparison available |

The majority of findings were "Good," "Very Good," and "Excellent" when compared to national Medicaid data. There were a few instances of "Fair" and "Poor" findings in the global ratings of Rating of Health Plan and in the composite measure areas of Getting Care Quickly and How Well Doctors Communicate.

## Performance Highlights

The PeachCare for Kids® composite measures were all at or above the 90th Percentile where comparisons were available.

## Conclusions and Recommendations

The DCH demonstrates a commitment to monitor and improve members' satisfaction through administration of the CAHPS Survey. The CAHPS Survey plays an important role as a quality improvement tool. The standardized data and results can be used to identify relative strengths and weaknesses in performance, identify areas for improvement, and trend progress over time.

Based on the 2012 CAHPS performance, there are opportunities to improve members' satisfaction with care and services. The Adult Medicaid results show the most need for improvement efforts with three of the measures showing poor or fair performance.

The Rating of Health Plan, Getting Care Quickly, and How Well Doctors Communicate measures offer the greatest opportunities for plan improvement. Low performance in these areas may point to issues with access to and timeliness of care.

HSAG provides the following global recommendations for improvement:

- The Georgia Medicaid program needs to conduct a barrier analysis or focus groups to identify factors contributing to areas of low performance and consider implementing interventions.
- The Georgia Medicaid program should consider selecting member satisfaction measure(s) as a formal quality improvement project and strategy for improving results.

# Appendix A. **Methodology for Reviewing Compliance With Standards**

## Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the GF 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.

## Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs. HSAG assembled a team to:

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

To accomplish its objective, and based on the results of 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 contractual requirements. The review tool included requirements that addressed the following performance areas:

- Standard I—Practice Guidelines
- Standard II—Quality Assessment and Performance Improvement
- Standard III—Health Information Systems
- Focused Reviews—Emergency Room (ER) Visits and Hospital Admissions
- Follow-up on areas of partial compliance or noncompliance from the prior year's review

The 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.

The SFY 2014 review was the third year of the current three-year cycle of CMO compliance reviews.

## HSAG's Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal 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 CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[A-1] for the following activities:

**Pre-on-site review activities** included:

- Developing the compliance review tools.
- Preparing and forwarding to the 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 agenda for 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 the documents. 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.
- Generating a list of eight sample cases plus an oversample of three cases for ER visits and eight sample cases plus an oversample of three cases for hospital readmissions for the on-site CMOs' audits from the list of such members submitted to HSAG from the CMOs.

**On-site review activities:** HSAG's reviewers conducted an on-site review for each CMO, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2013.

- A review of the documents HSAG requested that the CMO have available on-site.
- A review of the member cases HSAG requested from the CMO.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG's reviewers summarized their preliminary findings.

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

## Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written 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-1 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-1—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 | July 1, 2012–June 30, 2013 |
| Information obtained through interviews | July 1, 2012—the last day of each CMO's on-site review |
| Information obtained from a review of a sample of the CMOs' records for file reviews | July 1, 2012–June 30, 2013 |

## Data Aggregation and Analysis

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, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. The protocol describes the scoring as follows:

1. ***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.

2. ***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.

3. ***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 not 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 seven standards and an overall percentage-of-compliance score across the seven 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 areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to care and services the 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 seven standards.
- The overall percentage-of-compliance score calculated across the seven 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*.

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

# Appendix B. Methodology for Conducting Validation of Performance Measures

The following is a description of how HSAG conducted the validation of PM activity for DCH GF CMOs. It includes:

- The objectives for conducting the activity.
- The technical methods used to collect and analyze the data.
- A description of the data obtained.

## Objectives

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

- Evaluate the accuracy of the PM data collected by the CMOs and DCH.
- Determine the extent to which the specific PMs calculated by the CMOs or the State (or on behalf of the CMOs or the State) followed the specifications established for each PM.

HSAG began PM validation in February 2013 for the CMOs and completed validation in June 2013. The CMOs submitted PM data that reflected the period of January 1, 2012, through December 31, 2012. HSAG provided final PM validation reports to the CMOs and DCH in September 2013. HSAG began PM validation of HP in March 2013 and completed validation in October 2013. HSAG provided the final PM validation report to DCH in November 2013.

## Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Pre-on-site activities and document review were conducted, followed by an on-site visit to each CMO and HP that included interviews with key staff and system demonstrations. Finally, post-review follow-up was conducted with each CMO and HP on any issues identified during the site visit. Information and documentation from these processes were used to assess the validity of the PMs.

The CMS PM 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 these data:

**NCQA's HEDIS 2013 Roadmap**: The CMOs and HP/DCH completed and submitted the required and relevant portions of their Roadmaps for review by the validation team. The validation team used responses from the Roadmaps to complete the pre-on-site assessment of the information systems.

**Source code (programming language) for PMs:** The CMOs contracted with Inovalon, an NCQA-Certified software vendor, to calculate rates for both HEDIS and non-HEDIS measures. The source

code review was conducted via a Web-assisted session where Inovalon explained the process and source code to HSAG's source code review team.

- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

### *On-Site Activities*

HSAG conducted an on-site visit with each CMO and HP. 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 staff members involved in the PM activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.

- **Evaluation of system compliance:** The evaluation included a review of the information systems, focusing on the processing of claims and encounter data, provider data, patient data, and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the PM rates, 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:** The review included processes used for collecting, storing, validating, and reporting PM rates. This session was designed to be interactive with key staff members so that the validation team could obtain a complete picture of all the steps taken to generate the PM rates. The goal of the session was to obtain a confidence level as to the degree of compliance with written documentation compared to the actual process. HSAG conducted interviews 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.

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

# Appendix C. Methodology for Conducting Validation of Performance Improvement Projects

The following is a description of how HSAG conducted the validation of PIPs for the GF CMOs. It includes:

- Objective for conducting the activity.
- Technical methods used to collect and analyze the data.
- Description of data obtained.

HSAG followed standardized processes in conducting the validation of each CMO's PIPs.

## Objective

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 improvements in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

## Technical Methods of Data Collection and Analysis

In this sixth year of validating CMO PIPs, HSAG conducted PIP validation on nine DCH-selected PIPs for each CMO. The topics were:

- Adolescent Well-Care Visits
- Annual Dental Visits
- Appropriate Use of ADHD Medications
- Avoidable Emergency Room Visits (Collaborative)
- Childhood Immunizations—Combination 10
- Childhood Obesity
- Comprehensive Diabetes Care
- Member Satisfaction
- Provider Satisfaction

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, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory*

*Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[C-1] 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.

Using the CMS PIP validation protocol as its guide, HSAG developed a PIP Validation Tool, which was approved by DCH. This tool ensured the uniform assessment of PIPs across all CMOs and contained the following validation activities:

- Activity I. Appropriate Study Topic(s)
- Activity II. Clearly Defined, Answerable Study Question(s)
- Activity III. Correctly Identified Study Population
- Activity IV. Clearly Defined Study Indicator(s)
- Activity V. Valid Sampling Techniques (if sampling was used)
- Activity VI. Accurate/Complete Data Collection
- Activity VII. Sufficient Data Analysis and Interpretation
- Activity VIII. Appropriate Improvement Strategies
- Activity IX. Real Improvement Achieved
- Activity X. Sustained Improvement Achieved

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP Review Team scored evaluation elements within each activity 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 included 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:

[C-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

- *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.

## Description of Data Obtained

To validate the PIPs, HSAG obtained and reviewed information from each CMO's PIP Summary Form. The CMOs were required to submit a PIP Summary Form for each DCH-selected topic for validation. The PIP Summary Forms contained detailed information about each PIP and the activities completed for the validation cycle. HSAG began PIP validation in July 2013 and completed validation in August 2013. The CMOs submitted PIP data that reflected varying time periods, depending on the PIP topic. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in October 2013.

The following table displays the data source used in the validation of each performance improvement project and the time period to which the data applied.

**Table C–1—Description of Data Sources**

| CMO | Data Obtained | Time Period to Which the Data Applied |
|---|---|---|
| AMERIGROUP Peach State WellCare | *Adolescent Well-Care Visits* PIP | January 1, 2012–December 31, 2012 |
| | *Annual Dentist Visits* PIP | |
| | *Appropriate Use of ADHD Medications* PIP | |
| | *Avoidable ER Visits* Collaborative PIP | |
| | *Childhood Immunization Combination 10* PIP | |
| | *Childhood Obesity* PIP | |
| | *Comprehensive Diabetes Care* PIP | |
| AMERIGROUP | *Member Satisfaction* PIP | February 22, 2013–May 19, 2013 |
| | *Provider Satisfaction* PIP | August 1, 2012–November 30, 2012 |
| Peach State | *Member Satisfaction* PIP | March 13, 2013–May 22, 2013 |
| | *Provider Satisfaction* PIP | November 14, 2012–January 16, 2013 |
| WellCare | *Member Satisfaction* PIP | January 1, 2013–May 31, 2013 |
| | *Provider Satisfaction* PIP | August 1, 2012–October 31, 2012 |

HSAG provided CMO-specific PIP validation reports to DCH and the CMOs that detailed information about the process and the PIPs' validation findings. The following tables provide the CMO-specific results.

## AMERIGROUP

**Table C-2—SFY 2013 Performance Improvement Project Validation Results for Georgia Families Care Management Organizations (N=9 PIPs)**

| Study Stage | Activity | Percentage of Applicable Elements | | |
|---|---|---|---|---|
| | | *Met* | *Partially Met* | *Not Met* |
| Design | Appropriate Study Topic | 96% (49/51) | 0% (0/51) | 4% (2/51) |
| | Clearly Defined, Answerable Study Question(s) | 100% (18/18) | 0% (0/18) | 0% (0/18) |
| | Clearly Defined Study Indicator(s) | 96% (53/55) | 4% (2/55) | 0% (0/55) |
| | Correctly Identified Study Population | 92% (23/25) | 8% (2/25) | 0% (0/25) |
| | Valid Sampling Techniques (if sampling was used) | 100% (36/36) | 0% (0/36) | 0% (0/36) |
| | Accurate/Complete Data Collection | 83% (64/77) | 4% (3/77) | 13% (10/77) |
| **Design Total*** | | **93% (243/262)** | **3% (7/262)** | **5% (12/262)** |
| Implementation | Sufficient Data Analysis and Interpretation of Results | 77% (54/70) | 20% (14/70) | 3% (2/70) |
| | Appropriate Improvement Strategies | 78% (18/23) | 22% (5/23) | 0% (0/23) |
| **Implementation Total*** | | **77% (72/93)** | **20% (19/93)** | **2% (2/93)** |
| Outcomes | Real Improvement Achieved | 54% (15/28) | 14% (4/28) | 32% (9/28) |
| | Sustained Improvement Achieved | 50% (1/2) | 50% (1/2) | 0% (0/2) |
| **Outcomes Total** | | **53% (16/30)** | **17% (5/30)** | **30% (9/30)** |
| **Percentage of Applicable Evaluation Elements Scored *Met*** | | **86% (331/385)** | | |

* Percentages do not total 100 percent due to rounding.

**Table C-3—HEDIS-Based Performance Improvement Project Outcomes for AMERIGROUP Community Care**

| PIP Study Indicator | Baseline Period (1/1/09-12/31/09) | Remeasurement 1 (1/1/10-12/31/10) | Remeasurement 2 (1/1/11-12/31/11) | Remeasurement 3 (1/1/12-12/31/12) | Sustained Improvement^ |
|---|---|---|---|---|---|
| ***Annual Dental Visits*** | | | | | |
| Percentage of members 2–3 years of age who had at least one dental visit. | 42.7% | 47.3%↑* | 47.7% | 48.5% | Yes |
| Percentage of members 2–21 years of age who had at least one dental visit. | 66.7% | 69.1%↑* | 69.7%↑* | 69.9% | Yes |
| ***Childhood Obesity*** | | | | | |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation. | 13.7% | 28.5%↑* | 33.3% | 40.7%↑* | Yes |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition. | 40.7% | 48.8%↑* | 58.3%↑* | 52.3% | Yes |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity. | 35.6% | 30.9% | 44.9%↑* | 39.8% | No |

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | |
| The percentage of members 12–21 years of age who had at least one comprehensive well-care visit with ta PCP or an OB/GYN practitioner during the measurement year. | 43.9% | 46.6% | NA |
| ***Appropriate Use of ADHD Medication*** | | | |
| The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. | 44.3% | 42.3% | NA |
| The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner from 31–300 days following the IPSD. One of the two visits (during days 31–300) may be a telephone visit with a practitioner. | 61.2% | 58.2% | NA |
| ***Childhood Immunizations—Combination 10*** | | | |
| The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. | 10.4% | 31.9%↑* | NA |
| ***Comprehensive Diabetes Care*** | | | |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c control < 7.0%. | 32.1% | 30.6% | NA |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a LDL-C control < 100mg/ml. | 26.4% | 27.3% | NA |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a BP control < 140/90 mmHg. | 58.2% | 55.1% | NA |
| ***Avoidable Emergency Room Visits*** | | | |
| The percentage of practices that provide the same day appointments for routine and urgent care. | 100% | 100% | NA |
| The percentage of practices that provide routine and urgent care appointments after hours. | 50% | 70% | NA |
| The percentage of practices that provide appointments for routine and urgent care after hours and have the ability to document after hours clinical advice in the patient's record. | 100% | 100% | NA |
| The percentage of practices that have access to and utilize electronic health records. | 70% | 90% | NA |

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| The percentage of practices that receive information regarding ER visits from the study hospitals. | 80% | 100% | NA |
| The percentage of ER visits for "avoidable" diagnoses (dx382–Acute Suppurative otitis:382.9–Unspecified otitis:462–Acute pharyngitis:465.9–Acute upper respiratory infection:466 –Acute bronchitis:786.2–Cough) among members under 21 years of age who had a visit to the ED in three selected Children's Hospital of Atlanta facilities in the Atlanta region. | 19.38% | 20.52%↓* | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

¥ Caution should be used when comparing rates due to a methodology change.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

**Table C-4—Satisfaction-Based Performance Improvement Project Outcomes for AMERIGROUP Community Care**

| PIP Study Indicator | Baseline Period | Sustained Improvement^ |
|---|---|---|
| ***Member Satisfaction*** | | |
| The percentage of respondents who rate the health plan an 8, 9, or 10 in response to Q36 – "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?" | 85.8% | NA |
| ***Provider Satisfaction*** | | |
| The percentage of providers who respond, "Very satisfied" or, "Somewhat satisfied" to Q48 – "Please rate your overall satisfaction with AMERIGROUP." | 79.6% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

## Peach State

**Table C-5—Performance Improvement Project Validation Results for Georgia Families Care Management Organizations (N=9 PIPs)**

| Study Stage | Activity | Percentage of Applicable Elements | | |
|---|---|---|---|---|
| | | *Met* | *Partially Met* | *Not Met* |
| Design | Appropriate Study Topic | 100% (51/51) | 0% (0/51) | 0% (0/51) |
| | Clearly Defined, Answerable Study Question(s) | 100% (18/18) | 0% (0/18) | 0% (0/18) |
| | Clearly Defined Study Indicator(s) | 96% (53/55) | 4% (2/55) | 0% (0/55) |
| | Correctly Identified Study Population | 92% (23/25 | 8% (2/25) | 0% (0/25) |
| | Valid Sampling Techniques (if sampling was used) | 100% (30/30) | 0% (0/30) | 0% (0/30) |
| | Accurate/Complete Data Collection | 90% (66/73) | 3% (2/73) | 7% (5/73) |
| **Design Total*** | | **96% (241/252)** | **2% (6/252)** | **2% (5/252)** |
| Implementation | Sufficient Data Analysis and Interpretation of Results | 88% (61/69) | 12% (8/69) | 0% (0/69) |
| | Appropriate Improvement Strategies | 50% (12/24) | 50% (12/24) | 0% (0/24) |
| **Implementation Total*** | | **79 (73/93)** | **22 (20/93)** | **0% (0/93)** |
| Outcomes | Real Improvement Achieved | 64% (18/28) | 11% (3/28) | 25% (7/28) |
| | Sustained Improvement Achieved | 100% (1/1) | 0% (0/1) | 0% (0/1) |
| **Outcomes Total** | | **66% (19/29)** | **10% (3/29)** | **24% (7/29)** |
| **Percentage of Applicable Evaluation Elements Scored *Met*** | | **89% (333/374)** | | |

* Percentages do not total 100 percent due to rounding.

**Table C-6—HEDIS-Based Performance Improvement Project Outcomes for Peach State Health Plan**

| PIP Study Indicator | Baseline Period (1/1/09-12/31/09) | Remeasurement 1 (1/1/10-12/31/10) | Remeasurement 2 (1/1/11-12/31/11) | Remeasurement 3 (1/1/12-12/31/12) | Sustained Improvement^ |
|---|---|---|---|---|---|
| ***Annual Dental Visits*** | | | | | |
| Percentage of members 2–3 years of age who had at least one dental visit. | 33.8% | 38.8%↑* | 43.9%↑* | 44.0% | Yes |
| Percentage of members 2–21 years of age who had at least one dental visit. | 60.2% | 63.6%↑* | 67.5%↑* | 67.9%↑* | Yes |
| ***Childhood Obesity*** | | | | | |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation. | 32.1% | 29.0% | 22.7%↓* | 47.7%↑* | NA |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition. | 36.7% | 45.5%↑* | 40.7% | 56.0%↑* | NA |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity. | 28.2% | 32.0% | 29.4% | 47.7%↑* | NA |

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | |
| The percentage of members 12–21 years of age who had at least one comprehensive well-care visit with ta PCP or an OB/GYN practitioner during the measurement year. | 38.5% | 39.1%↑* | NA |
| ***Appropriate Use of ADHD Medication*** | | | |
| The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. | 43.7% | 43.7% | NA |
| The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner from 31–300 days following the IPSD. One of the two visits (during days 31–300) may be a telephone visit with a practitioner. | 57.4% | 58.6% | NA |
| ***Childhood Immunizations – Combination 10*** | | | |
| The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. | 17.6% | 27.9%↑* | NA |
| ***Avoidable Emergency Room Visits*** | | | |
| The percentage of practices that provide the same day appointments for routine and urgent care. | 100% | 100% | NA |
| The percentage of practices that provide routine and urgent care appointments after hours. | 50% | 70% | NA |
| The percentage of practices that provide appointments for routine and urgent care after hours and have the ability to document after hours clinical advice in the patient's record. | 100% | 100% | NA |
| The percentage of practices that have access to and utilize electronic health records. | 70% | 90% | NA |
| The percentage of practices that receive information regarding ER visits from the study hospitals. | 80% | 100% | NA |
| The percentage of ER visits for "avoidable" diagnoses (dx382–Acute Suppurative otitis:382.9–Unspecified otitis:462–Acute pharyngitis:465.9–Acute upper respiratory infection:466 –Acute bronchitis:786.2–Cough) among members under 21 years of age who had a visit to the ED in three selected Children's Hospital of Atlanta facilities in the Atlanta region. | 19.38% | 20.52%↓* | NA |

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| ***Comprehensive Diabetes Care*** | | | |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c control < 7.0%. | 28.8% | 27.6% | NA |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a LDL-C control < 100mg/ml. | 27.5% | 20.4%↓* | NA |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a BP control < 140/90 mmHg. | 58.0% | 53.7% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

¥ Caution should be used when comparing rates due to a methodology change.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

**Table C-7—Satisfaction-Based Performance Improvement Project Outcomes for Peach State Health Plan**

| PIP Study Indicator | Baseline Period | Sustained Improvement^ |
|---|---|---|
| ***Member Satisfaction*** | | |
| The percentage of respondents who rate the health plan an 8, 9, or 10 in response to Q36 – "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?" | 87.0% | NA |
| ***Provider Satisfaction*** | | |
| The percentage of providers who respond, "Very satisfied" or, "Somewhat satisfied" to Q48 – "Please rate your overall satisfaction with Peach State." | 76.3% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

## WellCare

**Table C-8—Performance Improvement Project Validation Results For WellCare of Georgia, Inc. (N=9 PIPs)**

| Study Stage | Activity | Percentage of Applicable Elements | | |
|---|---|---|---|---|
| | | *Met* | *Partially Met* | *Not Met* |
| Design | Appropriate Study Topic | 92% (47/51) | 0% (0/51) | 8% (4/51) |
| | Clearly Defined, Answerable Study Question(s) | 100% (18/18) | 0% (0/18) | 0% (0/18) |
| | Clearly Defined Study Indicator(s) | 96% 53/55 | 4% 2/55 | 0% 0/55 |
| | Correctly Identified Study Population | 92% 24/26 | 8% 2/26 | 0% 0/26 |
| | Valid Sampling Techniques (if sampling was used) | 97% 35/36 | 0% 0/36 | 3% 1/36 |
| | Accurate/Complete Data Collection | 83% 64/77 | 8% 6/77 | 9% 7/77 |
| **Design Total*** | | **92% 241/263** | **4% 10/263** | **5% 12/263** |
| Implementation | Sufficient Data Analysis and Interpretation of Results | 89% 62/70 | 11% 8/70 | 0% 0/70 |
| | Appropriate Improvement Strategies | 76% 19/25 | 20% 5/25 | 4% 1/25 |
| **Implementation Total*** | | **85% 81/95** | **14% 13/95** | **1% 1/95** |
| Outcomes | Real Improvement Achieved | 57% 16/28 | 18% 5/28 | 25% 7/28 |
| | Sustained Improvement Achieved | 100% 1/1 | 0% 0/1 | 0% 0/1 |
| **Outcomes Total** | | **59% 17/29** | **17% 5/29** | **24% 7/29** |
| **Percentage of Applicable Evaluation Elements Scored *Met*** | | **88% (339/387)** | | |

* Percentages do not total 100 percent due to rounding.

**Table C-9—HEDIS-Based Performance Improvement Project Outcomes for WellCare**

| PIP Study Indicator | Baseline Period (1/1/09-12/31/09) | Remeasurement 1 (1/1/10-12/31/10) | Remeasurement 2 (1/1/11-12/31/11) | Remeasurement 3 (1/1/12-12/31/12) | Sustained Improvement^ |
|---|---|---|---|---|---|
| ***Annual Dental Visits*** | | | | | |
| Percentage of members 2–3 years of age who had at least one dental visit. | 40.4% | 45.5%↑* | 50.0%↑* | 52.2%↑* | Yes |
| Percentage of members 2–21 years of age who had at least one dental visit. | 65.2% | 67.5%↑* | 70.5%↑* | 71.5%↑* | Yes |
| ***Childhood Obesity*** | | | | | |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation. | 36.5% | 30.4% | 56.9%↑* | 38.7%↓* | NA |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition. | 42.3% | 48.9% | 50.4%↑* | 55.5% | NA |
| The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity. | 38.7% | 30.9%↓* | 37.0% | 42.1% | NA |

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| ***Adolescent Well-Care Visits*** | | | |
| The percentage of members 12–21 years of age who had at least one comprehensive well-care visit with ta PCP or an OB/GYN practitioner during the measurement year. | 41.4% | 51.6%↑* | NA |
| ***Appropriate Use of ADHD Medications*** | | | |
| The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day Initiation Phase. | 40.0% | 39.4% | NA |
| The percentage of members 6–12 years of age as of the Index Prescription Start Date (IPSD) with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner from 31–300 days following the IPSD. One of the two visits (during days 31–300) may be a telephone visit with a practitioner. | 54.6% | 53.1% | NA |
| ***Childhood Immunizations—Combination 10*** | | | |
| The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps, rubella (MMR); three H influenza type B (HiB); three hepatitis B (HepB); one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. | 20.2% | 38.4%↑* | NA |
| ***Avoidable Emergency Room Visits*** | | | |
| The percentage of practices that provide the same day appointments for routine and urgent care. | 100% | 100% | NA |
| The percentage of practices that provide routine and urgent care appointments after hours. | 50% | 70% | NA |
| The percentage of practices that provide appointments for routine and urgent care after hours and have the ability to document after hours clinical advice in the patient's record. | 100% | 100% | NA |
| The percentage of practices that have access to and utilize electronic health records. | 70% | 90% | NA |
| The percentage of practices that receive information regarding ER visits from the study hospitals. | 80% | 100% | NA |
| The percentage of ER visits for "avoidable" diagnoses (dx382–Acute Suppurative otitis:382.9–Unspecified otitis:462–Acute pharyngitis:465.9–Acute upper respiratory infection:466 –Acute bronchitis:786.2–Cough) among members under 21 years of age who had a visit to the ED in three selected Children's Hospital of Atlanta facilities in the Atlanta region. | 19.38% | 20.52%↓* | NA |

| PIP Study Indicator | Baseline Period (1/1/11–12/31/11) | Remeasurement 1 (1/1/12–12/31/12) | Sustained Improvement^ |
|---|---|---|---|
| ***Comprehensive Diabetes Care*** | | | |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had an HbA1c control < 7.0%. | 32.4% | 32.4% | NA |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a LDL-C control < 100mg/ml. | 25.2% | 28.1% | NA |
| The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had a BP control < 140/90 mmHg. | 51.6% | 51.6% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

¥ Caution should be used when comparing rates due to a methodology change.

↑* Designates statistically significant improvement over the prior measurement period (*p* value < 0.05).

↓* Designates statistically significant decline in performance over the prior measurement period (*p* value < 0.05).

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

**Table C-10—Satisfaction-Based Performance Improvement Project Outcomes for WellCare of Georgia, Inc.**

| PIP Study Indicator | Baseline Period | Sustained Improvement^ |
|---|---|---|
| ***Member Satisfaction*** | | |
| The percentage of respondents who rate the health plan an 8, 9, or 10 in response to Q36 – "Using any number from 0 to 10, where 0 is the worst health plan possible and 10 is the best health plan possible, what number would you use to rate your child's health plan?" | 88.3% | NA |
| ***Provider Satisfaction*** | | |
| The percentage of providers who respond, "Very satisfied" or, "Somewhat satisfied" to Q48 – "Please rate your overall satisfaction with WellCare." | 81.0% | NA |

NA Statistically significant improvement over baseline and a subsequent measurement must occur for all study indicators before sustained improvement can be assessed.

^ Sustained improvement is defined as statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators.

| Table C-11—Adolescent Well-Care Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| AMERIGROUP did not achieve statistically significant improvement from baseline to Remeasurement 1 in the *Adolescent Well-Care Visits* PIP. The study indicator's rate increased by 2.7 percentage points, but the change was not statistically significant. The Remeasurement 1 rate remained below the DCH target rate of 46.8 percent and was below the Medicaid national HEDIS 2011 90th percentile of 64.1 percent. | ◆ Conducted member outreach calls.<br>◆ Expanded the PQIP, educating providers on conducting well-care assessments during a sick visit, or educating providers on billing after-hour codes for completing services after normal business hours.<br>◆ Piloted its new My Health Direct program with three providers. This program allowed internal associates to schedule adolescent well-visit appointments while they were engaged with members on the telephone and allowed providers to block a portion of their day for AMERIGROUP members' appointments.<br>◆ CMO-specific interventions focused on member and provider education delivered primarily through member and provider newsletters. This non-targeted education did not | Not Met | ◆ Specific results were not documented. The CMO did not provide the rationale for how it prioritized barriers. The CMO did not provide the rationale for continuing interventions that were not associated with outcome improvement.<br>◆ The CMO did not have an evaluation plan for any of the interventions.<br>◆ The CMO tracked the adolescent well-care visit claims and reported that 81 percent were linked to the member outreach calls; however, no method was documented that would support this conclusion.<br>◆ The CMO did not track or monitor its other intervention efforts which included expanding the PQIP, educating providers on conducting well-care assessments during a sick visit, or educating providers on billing after-hour codes for completing services after normal business hours. |

| Table C-11—Adolescent Well-Care Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | lend itself to evaluation and was not associated with any improvement in performance. | | ◆ The CMO did not document how the providers were selected for its My Health Direct program or evaluate the visit rates for these specific providers after the intervention was initiated<br>◆ CMO-specific interventions, focused on member and provider education, were delivered primarily through member and provider newsletters. This non-targeted education did not lend itself to evaluation and was not associated with any improvement in performance.<br>◆ Interventions that are data-driven and targeted may be an overall more effective strategy, especially with a growing GF population and finite resources. |
| **Peach State** | | | |
| In the first remeasurement period of the *Adolescent Well-Care Visits* PIP, Peach State achieved statistically significant improvement in the rate of members 12–21 years of age who had at least one well- | ◆ Implemented a provider bonus program based on the provider successfully contacting noncompliant members and providing them with well-child visits.<br>◆ Partnered with its medical | Partially Met | ◆ Peach State documented that the implemented interventions have caused the statistically significant improvement reported. However, the CMO did not provide any data to support this documentation. |

| Table C-11—Adolescent Well-Care Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| care visit during the measurement year. The Remeasurement 1 rate of 39.1 percent is still, however, below the CY 2012 DCH target of 46.8 percent and below the 25th percentile (39.6 percent) of national Medicaid HEDIS 2011 rates. | record review vendor to extend provider education through "tip sheets" and face-to-face meetings, communicating that preventive care could be performed during a sick visit or sports physical.<br>◆ Implemented CareGaps, an internal system alert to let Peach State employees and members (secure portal) know about members who are due or past due for preventive services.<br>◆ Called members, scheduled appointments, placed reminder calls, and facilitated non-emergency transportation to appointments. | | HSAG anticipated that the CMO would have documented a data-driven process that monitored the interventions and then measured the study outcomes for the targeted population. Peach State should have processes in place to evaluate the effectiveness for each of its interventions.<br>◆ With the implementation of any intervention (and especially for multiple interventions), the CMO must ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of each intervention, the CMO cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance. |
| **WellCare** | | | |
| WellCare achieved statistically significant improvement at Remeasurement 1 in the | ◆ Member telephone outreach to educate members on the importance of adolescent | Met | Although the study indicator achieved statistically significant improvement and the CMO |

| Table C-11—Adolescent Well-Care Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| *Adolescent Well-Care Visits* PIP, with an increase of 10.2 percentage points over the baseline rate. The CMO's CY 2012 rate of eligible adolescent members who had at least one well-care visit during the measurement year exceeded the DCH target rate of 46.8 percent and was between the 50th and 75th percentiles of the national Medicaid HEDIS 2011 rates. | well-care visits and schedule appointments.<br>◆ Community Outreach and Field Short Term Case Management Program—Outreach to educate members and identify any needs members had regarding their health. This outreach reinforced the need for members to make well-care appointments that addressed early and periodic screening, diagnostic, and treatment (EPSDT services).<br>◆ Targeted Health Check schedule reminder letters sent at 120 days of plan enrollment and during the member's birthday month.<br>◆ Monthly provider membership lists that specified children eligible for the health check who had not had an encounter within 120 days of joining the health plan or were not in compliance with the Health Check Program. | | monitors its data continuously, WellCare did not have processes in place to evaluate the effectiveness of each implemented intervention. For example, the CMO did not track those members who received outreach calls or education, or were in the short term case management program to see if they had an encounter for an adolescent well-care visit as a result of the intervention. As a consequence of not evaluating the interventions, the CMO did not have information to determine which of the interventions implemented were successful, making it difficult to eliminate any ineffective interventions. Continuing to implement ineffective interventions prevents the CMO from redirecting efforts and resources that could be used for other areas in need of improvement or expanding and sustaining effective interventions. |

| Table C-11—Adolescent Well-Care Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | ◆ Provider Pay for Performance Incentive. | | |

| Table C-12—Annual Dental Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| AMERIGROUP sustained statistically significant improvement over baseline rates for both indicators at Remeasurement 3. The rate for members 2–21 years of age (Study Indicator 1) exceeded the CY 2012 DCH target rate of 64.1 percent. Additionally, the Remeasurement 3 rates for both study indicators exceeded the national HEDIS 2011 Medicaid 90th percentiles of 64.5 percent (2–21 years of age) and 46.9 percent (2–3 years of age). | ◆ Due to the PIP's success, the CMO continued its previous year's interventions and implemented monthly meetings with SCION, its dental vendor, to discuss GeoAccess, appointment availability call center statistics, survey results, and performance tracking.<br>◆ The CMO's interventions for this PIP included reminder calls, health fairs, health promotion events, additional dental coverage benefits, missed opportunity reports through the provider portal for primary care practices, and annual dental rate report cards. | Partially Met | Although the CMO improved and sustained its outcomes, it must ensure that each intervention includes an evaluation plan. Without a method to evaluate the effectiveness of the intervention, the plan cannot determine which intervention to modify or discontinue, or when to implement new interventions, thereby reducing the likelihood of achieving project objectives and improving performance. |
| **Peach State** | | | |
| Peach State sustained statistically significant improvement at Remeasurement 3 in the Annual Dental Visits PIP. The | ◆ Peach State implemented a provider-based intervention, "Preventistry Provider Sealant Program," to help prevent damage to | Partially Met | Peach State documented that it believed the above interventions had caused the reported improvement in the study indicator rates. However, the CMO did not |

| Table C-12—Annual Dental Visits | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| CY 2012 rates for both study indicators continued to demonstrate significant and real improvement over baseline rates. Furthermore, the rate for Study Indicator 2 (members 2–21 years of age) exceeded the CY 2012 DCH target rate of 64.1 percent and the Medicaid national HEDIS 2011 90th percentile of 64.5 percent. | tooth enamel.<br>◆ Peach State implemented a revised "Mobile Van" program by adding the "Safety Net" program. The program included sending a mobile van to area schools so that dental exams can be performed, scheduling appointments for dental exams, educating members on the importance of recommended dental visits, and assisting with transportation, if needed. | | provide any data to support this assertion. HSAG anticipated that the CMO would have documented a data-driven process that linked the interventions to the study indicator outcomes. For example, Peach State could have indicated the number of members who received a dental exam as a result of its Mobile Van program. HSAG encourages Peach State to have processes in place that evaluate the effectiveness of all of its implemented interventions. |
| **WellCare** | | | |
| At Remeasurement 3 for *Annual Dental Visits*, WellCare sustained significant improvement over baseline for both study indicators. Both indicators also increased significantly over the previous year's rates. The CMO's CY 2012 rates for members 2–3 years of age and 2–21 years of age who had at least one dental visit during the measurement year were better than the national HEDIS 2011 Medicaid | ◆ In January 2012, DentaQuest conducted a targeted provider mailing which included the GA WellCare Preventistry Sealant Program Letter and member listing.<br>◆ Targeted 120-Day Provider Reminder letters with a list of noncompliant members.<br>◆ Targeted dental missed appointment letters were sent to members who had not had a dental service in | Met | Although both study indicators have achieved statistically significant and sustained improvement, it was unclear to HSAG how the Preventistry Sealant Program and mailed letters for this program would increase the percentage of members receiving an annual dental exam. WellCare must implement processes to evaluate the effectiveness of each implemented intervention. For example, for the targeted missed dental appointment letters, how |

| Table C-12—Annual Dental Visits | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| 90th percentiles of 46.9 percent and 64.5 percent, respectively. The rate for members 2–21 years of age also surpassed the DCH CY 2012 target of 64.1 percent by 7.4 percentage points. | the prior six months.<br>◆ Targeted 120-Day Member Reminder letters.<br>◆ Targeted Periodicity letters sent to members annually.<br>◆ Inbound Care Gap Program: At the time the member called in, the customer service representative identified whether the member had a dental or other HEDIS measure service needed. If so, the representative advised the member of the needed service(s) and assisted them with scheduling the appointments. | | many of those members who were mailed a letter, had an encounter for a dental visit following the mailing of the letter? Without an evaluation process in place, the CMO cannot determine if an intervention was successful. |

| Table C-13—Appropriate Use of ADHD Medications | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| Neither study indicator in the *Appropriate Use of ADHD Medications* PIP achieved statistically significant improvement at Remeasurement 1. Conversely, the rates of follow-up care visits for children newly prescribed ADHD medication declined for both the initiation phase (Study Indicator 1) and for the continuation and maintenance phases (Study Indicator 2), though neither decline was statistically significant. The rate for Study Indicator 1 (Initiation) remained below the DCH target rate of 48.1 percent and fell just below the national Medicaid HEDIS 2011 75th percentile of 43.6 percent. The rate for Study Indicator 2 (continuation) exceeded the DCH target rate of 57.6 percent and fell between the 75th (52.6 percent) and 90th (62.5 percent) percentiles of the national Medicaid HEDIS 2011 rates. | ◆ Distributing ADHD CPGs to providers.<br>◆ Distributing HEDIS report cards to providers that showed the providers' performance on ADHD follow-up.<br>◆ Educating providers on how to retrieve missed opportunity reports via the provider portal so providers could take action to ensure compliance.<br>◆ Hand-delivered and faxed "First Fill" letters to providers who prescribed ADHD medications. The "First Fill" letters reminded providers to ensure there was a scheduled follow-up with their patients. | Not Met | AMERIGROUP must implement a process to evaluate each PIP intervention. Specifically for this PIP, the CMO must evaluate whether or not expanding the PQIP to include the ADHD measure would be an effective approach. Based on the decline in performance for both study indicators, which should have been detected during the quarterly reviews of data, HSAG anticipated that the CMOs would have evaluated the effectiveness of each intervention, performed additional data mining to determine the cause of the decline in performance, and implemented targeted improvement strategies. |

| Table C-13—Appropriate Use of ADHD Medications | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **Peach State** | | | |
| Neither study indicator in the *Appropriate Use of ADHD Medications* PIP achieved statistically significant improvement from baseline to Remeasurement 1. Though the rate of follow-up care visits for children newly prescribed ADHD medication did not decline for either study indicator, the rate of follow-up visits during the initiation phase (Study Indicator 1) remained constant at 43.7 percent, and there was only a non-significant increase of 1.2 percentage points in the rate of follow-up visits during the continuation and maintenance phase (Study Indicator 2). The Remeasurement 1 rates for both indicators fell below the CY 2012 DCH targets of 48.1 percent (initiation) and 57.6 percent (continuation), respectively. In comparison with the Medicaid national HEDIS 2011 rates, Peach State's CY 2012 rates were | ◆ Implementation of a CPG compliance program.<br>◆ Initiation of a Quality Improvement and Public Relations collaboration to educate behavioral health providers on HEDIS measures and the ADHD CPG.<br>◆ Peach State Days—targeting noncompliant members with appointment scheduling, transportation assistance, and nominal incentives.<br>◆ Pharmacy Liaison education visits to non-psychiatric practitioners with high-volume ADHD prescriptions. | Not Met | ◆ Despite a lack of significant improvement in the study indicators, Peach State's HEDIS Steering Committee identified the CPG compliance program and the Quality Improvement—Public Relations collaboration as the most effective interventions. It was unclear, however, what data or process was used to identify these as effective interventions. The committee also recommended additional member outreach interventions to further improve the rate of appropriate ADHD medication follow-up visits in future measurement periods. Again, it was not clear what data supported the recommendation to prioritize additional member outreach interventions for implementation.<br>◆ The CMO reported that it would be pursuing a more in-depth causal/barrier analysis in CY 2013 to identify increasingly effective |

| Table C-13—Appropriate Use of ADHD Medications | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| better than the corresponding 75th percentile rates of 43.6 percent (initiation phase) and 52.6 percent (continuation phase). | | | interventions. The causal/ barrier analysis process should include clear documentation of the data-driven tools and processes used to identify and link barriers and interventions. Additionally, a process must be implemented to evaluate the effectiveness of each intervention's impact on the study indicator rates. |
| **WellCare** | | | |
| At Remeasurement 1 in the *Appropriate Use of ADHD Medications* PIP, WellCare did not achieve statistically significant improvement over baseline. The CY 2012 rates of ADHD follow-up visits for the initiation phase (Study Indicator 1) and the continuation phase (Study Indicator 2) were lower than the respective baseline rates, though neither declined significantly. The CMO's CY 2012 rates of follow-up visits did not meet the corresponding DCH target rates of 48.1 percent (initiation) and 57.6 | ◆ Distribution of a "Best Practice" flyer to PCPs and psychiatrists identifying the need to educate members on the importance of continuation of medication and stressing the importance of the follow-up visit and education of practitioners on the HEDIS measures.<br>◆ Provider visits from pharmacy, public relations, and quality department staff to provide education on HEDIS measures and the importance of the visit.<br>◆ Provider newsletter stressing the importance of | Not Met | Not all listed interventions addressed the barriers documented by the CMO. It was unclear from the CMO's documentation which intervention(s) addressed the barrier of member lack of education over giving medications on holidays/weekends or providers writing prescriptions without seeing the member at a follow-up visit. The CMO also documented that it would be continuing all interventions. WellCare must provide a more detailed description of how the barriers listed in the PIP and in the attachment were identified, the process of how the CMO prioritizes its barriers, and |

| Table C-13—Appropriate Use of ADHD Medications | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| percent (continuation and maintenance). Compared to the Medicaid HEDIS 2011 national rates, the rate for the initiation phase was slightly above the 50th percentile of 38.3 percent, and the rate for the continuation phase was slightly better than the 75th percentile of 52.6 percent. | the visit.<br>◆ Targeted provider faxing to ensure members with newly prescribed medication were scheduled for a visit.<br>◆ Targeted member mailing reminding members to schedule a follow-up visit.<br>◆ WellCare hired a Licensed Master Social Worker to focus on behavioral health initiatives with an emphasis on ADHD.<br>◆ Targeted member mailings reminding members of follow-up appointments. | | how the barriers were linked to the interventions. WellCare must ensure that the interventions implemented logically link to the barrier and can directly impact the study indicator outcomes. WellCare must have processes in place to evaluate the effectiveness of each implemented intervention. Furthermore, the CMO must investigate the reasons for the decline in performance and based on the findings, develop new improvement strategies |

| Table C-14—Childhood Immunizations—Combination 10 | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| AMERIGROUP achieved statistically significant improvement over the baseline rate in the first remeasurement period for the *Childhood Immunizations—Combination 10* PIP, with an increase of 21.5 percentage points. The Remeasurement 1 rate also exceeded the national HEDIS 2011 Medicaid 90th percentile of 23.6 percent. | ◆ Expansion of its PQIP to incorporate 13 additional high-volume providers. To be eligible to participate, providers must have demonstrated high-quality scores. Reimbursement was dependent on eligible providers' medical loss ratio.<br>◆ Prepayment for PeachCare for Kids® members' vaccines prior to them being given by the provider. The CMO implemented this initiative because immunizations for PeachCare for Kids® members are not available under the Vaccines for Children (VFC) Program and must be provided by the CMO for this population<br>◆ The CMO reviewed HEDIS specifications and aligned claims codes with these specifications to ensure providers were being paid accordingly.<br>◆ CMO sent letters to providers and conducted face-to-face | Met | Although the study indicator achieved statistically significant improvement, the CMO must develop processes to evaluate the effectiveness of each intervention. This will assist the CMO in determining what worked and which interventions could be instrumental in sustaining the statistically significant improvement achieved. |

| Table C-14—Childhood Immunizations—Combination 10 | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | discussions regarding unavailable vaccines. AMERIGROUP asked its providers to work around the availability of these vaccines to ensure all vaccines were eventually administered. | | |
| **Peach State** | | | |
| For the *Childhood Immunizations—Combination10* PIP, Peach State achieved statistically significant improvement over baseline at Remeasurement 1, with an increase of 10.3 percentage points in the rate of eligible child members who had received all necessary immunizations by their second birthday. The Remeasurement 1 rate also surpassed the Medicaid HEDIS 2011 90th percentile of 23.6 percent. | ◆ Placed outreach calls to noncompliant members in need of immunizations.<br>◆ Implemented CareGaps, an internal system alert to let Peach State employees and members (secure portal) know about members who are due or past due for preventive services.<br>◆ To address member barriers, called members, scheduled appointments, performed reminder calls, and facilitated non-emergency transportation to appointments.<br>◆ Sent providers a list of noncompliant members to enable provider outreach to members.<br>◆ Implemented a member | Partially Met | Peach State documented that it believes the interventions implemented have caused the statistically significant improvement reported. However, the CMO did not provide any data to support this claim. HSAG anticipated that the CMO would have documented a data-driven evaluation of the intervention's effectiveness. Peach State must have processes in place to evaluate the effectiveness for all of its interventions, tracking the members who receive the interventions back to the study indicator outcome. |

| Table C-14—Childhood Immunizations—Combination 10 | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | incentive program targeting noncompliant members to receive immunizations by 2 years of age.<br>◆ Participated in the "Centene Childhood Immunization Mailing" pilot program. Quarterly, members were mailed postcards encouraging them to contact their PCP to find out which immunizations had not been administered to date. The PCP's name and address were included in the postcard. | | |
| **WellCare** | | | |
| WellCare demonstrated significant improvement in the *Childhood Immunizations—Combination 10* PIP, with an increase of 18.2 percentage points from baseline to Remeasurement 1 in the rate of eligible child members who received the recommended vaccinations by their second birthday. The CMO's rate also exceeded the Medicaid HEDIS 2011 90th percentile of 23.6 | ◆ Customer Service team incentivized $5 per appointment process.<br>◆ Outbound member reminder calls.<br>◆ Centralized telephonic outreach program.<br>◆ Targeted 120-Day Member Reminder letters.<br>◆ Targeted Periodicity letters sent to members annually.<br>◆ Monthly member noncompliant list to | Partially Met | Although the study indicator achieved statistically significant improvement, HSAG identified that not all listed interventions addressed the barriers documented by the CMO. It was unclear from the CMO's documentation which intervention(s) addressed the barrier of members refusing assistance with appointments. The CMO did not link all of its interventions to identified barriers. As stated previously, WellCare did not have |

| Table C-14—Childhood Immunizations—Combination 10 | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| percent. | providers.<br>◆ Targeted 120-Day Provider Reminder letters with a list of noncompliant members.<br>◆ HEDIS Toolkits distributed during Pay-for-Performance visits. | | processes in place to evaluate the effectiveness of each intervention. The CMO should be tracking the members who were mailed the Targeted 120-Day Member Reminder letter to see if any of these members had an encounter for the necessary services after receiving the letter. |

| Table C-15—Childhood Obesity | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| AMERIGROUP sustained statistically significant improvement over the baseline rate at Remeasurement 3 for Study Indicators 1 (BMI percentile documentation) and 2 (evidence of nutrition counseling). The rate for Study Indicator 3 (evidence of physical activity counseling) declined at Remeasurement 3 and was no longer significantly higher than the baseline rate. All three of the study indicators fell below their respective DCH CY 2012 goals of 45.2 percent (BMI percentile documentation), 57.7 percent (evidence of nutrition counseling), and 45.5 percent (evidence of physical activity counseling). The CMO's rates for Study Indicators 1 (BMI percentile documentation) and 2 (evidence of nutrition counseling) were slightly above the 50th percentile of the Medicaid HEDIS 2011 rates of 37.5 percent and 51.1 percent, | ◆ Addressed obesity concerns with members through interactive case management.<br>◆ Distributed nearly 7,000 fliers on childhood obesity.<br>◆ Sent text messages to 5,400 households via a free cellular telephone provided by Safelink.<br>◆ Hosted three obesity events where 180 members attended. | Partially Met | AMERIGROUP needs to implement provider-focused interventions and address why providers had decreased documentation of counseling for nutrition and counseling for physical activity for Study Indicator 3 from Remeasurement 2 to Remeasurement 3.<br><br>AMERIGROUP appears to have aims that extend beyond the HEDIS-based study indicators in this PIP to address broader issues, such as educating members on obesity. If the CMO wants to include these initiatives as part of its PIP, it should restructure the PIP to include study indicators that measure the intended outcome. In addition, HSAG recommends that the CMO have processes in place to evaluate the success of each intervention. |

| Table C-15—Childhood Obesity | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| respectively. The rate for Study Indicator 3 (evidence of physical activity counseling) fell below the HEDIS 2011 50th percentile of 40.6 percent. | | | |
| **Peach State** | | | |
| The outcomes for the *Childhood Obesity* PIP at Remeasurement 3 were significantly better than the previous year for all three study indicators. Additionally, the CY 2012 rates of BMI percentile documentation (Study Indicator 1) and Physical Activity Counseling (Study Indicator 3) achieved statistically significant improvement over baseline for the first time. The PIP will be evaluated for sustained improvement at Remeasurement 4, when all three study indicators will have at least one subsequent measurement after achieving significant improvement. The CMO's rates of BMI Documentation and Physical Activity Counseling also | ◆ Quarterly meetings with the medical record review vendor to reinforce content and materials for practitioner training on BMI percentile documentation, counseling for nutrition, and counseling for physical activity.<br>◆ One-on-one provider education on the importance of obtaining and documenting BMI percentile, counseling for nutrition, and counseling for physical activity.<br>◆ A "Start Strong" education and goal-setting pilot program targeting overweight members 4–17 years of age. | Partially Met | ◆ Despite HSAG's feedback last year, Peach State continued to implement interventions that cannot be clearly linked to the *Childhood Obesity* PIP study indicators. For example, the CMO documented that the member education intervention, "Start Strong," targeting overweight members 4–17 years of age, had the primary goals of reducing BMI percentile and attaining lifestyle goals of participants. Improvement in the outcomes for these study indicators are dependent on providers performing and documenting the necessary services during an office visit, not on member education per se.<br>◆ While Peach State acknowledged the importance of evaluating the effectiveness |

| Table C-15—Childhood Obesity | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| surpassed the respective CY 2012 DCH target rates of 45.2 percent and 45.5 percent, while the rate of Nutrition Counseling (Study Indicator 2) fell short of the DCH target rate of 57.7 percent. When compared to the Medicaid HEDIS 2011 national rates, the Remeasurement 3 rates of all three study indicators fell between the 50th and 75th percentiles. | | | of interventions, the CMO did not have an evaluation plan in place for any of the interventions. |
| **WellCare** | | | |
| One of the three study indicators for the *Childhood Obesity* PIP, evidence of counseling for nutrition, has continued its year-over-year improvement at Remeasurement 3 and maintained a significant increase from the baseline rate. The Remeasurement 3 rates for the remaining study indicators, BMI percentile documentation and evidence of counseling for physical activity, are not significantly better than their respective baseline rates, with | ◆ Partnered with the Boys & Girls Club to establish memberships for youth across the State in an effort to engage them in healthy lifestyle activities. WellCare paid for 604 memberships in 2012.<br>◆ Published an article in the provider newsletter stating the ages for which BMI percentile is required.<br>◆ Held 250 WellCare days at the WIC offices, provider offices, health departments, and DFCS offices across | Partially Met | Despite HSAG's feedback in last year's validation, the CMO continues to address many barriers and implement interventions that will have no effect on the study indicator outcomes. WellCare documented that "they will work closely with Provider Relations in an effort to drill down the issue with BMI percentile documentation. WellCare will work on targeted interventions with providers in order to improve rates for all measures. Interventions such as Weight Watchers Program and provider |

| Table C-15—Childhood Obesity | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| the rate of BMI documentation 18.2 percentage points lower than the previous year, a significant decline. The CMO's rates fell below the respective CY 2012 DCH targets of 45.2 percent for BMI percentile documentation, 57.7 percent for evidence of counseling for nutrition, and 45.5 percent for evidence of counseling for physical activity. In comparison with the national Medicaid 2011 HEDIS benchmarks, WellCare's CY 2012 rates were slightly better than the 50th percentile for BMI percentile documentation (37.5 percent) and evidence of counseling for physical activity (40.6 percent) and between the 50th (51.1 percent) and 75th percentile (61.6 percent) for evidence of counseling for nutrition. | the state. Over 2,367 members were reached during this outreach.<br>◆ Launched a Weight Watchers program for youth to teach them how to eat healthy balanced meals. One hundred twenty-six youth between the ages of 13–17 were enrolled in the program in 2012.<br>◆ Distributed HEDIS tool kits by mail and hand delivered others to targeted providers.<br>◆ Targeted pediatricians received postcard outlining the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)* measure.<br>◆ Postcards outlining the WCC measure were handed out to providers at a pediatric conference.<br>◆ Provided a DCH-approved BMI percentile documentation form for providers via their provider Web site. | | education are likely to induce permanent change and hopefully increase compliance." The three study indicators for this PIP are all process measures that only evaluate the presence of documentation of BMI, counseling for nutrition, and counseling for physical activity. Given the measures, all member-based interventions will not impact the rates for any of the study indicators. Only a few of the interventions implemented have the potential to affect the indicator rates. WellCare must focus its efforts and resources on improvement strategies that will directly impact the rate, and pay special attention as to why there was such a decline in performance for Study Indicator 1, documentation of BMI percentile.<br>◆ For the providers that received a HEDIS tool kit or postcard outlining the WCC measure, the CMO should assess to see if these providers demonstrated better compliance with the WCC documentation |

| Table C-15—Childhood Obesity | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | ◆ E-mailed independent practice associations (IPAs) and included BMI percentile forms and WCC postcards. | | requirements. This is an example of the type of intervention tracking WellCare must be doing to determine if interventions are successful. |

| Table C-16—Comprehensive Diabetes Care | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| None of the study indicators for the *Comprehensive Diabetes Care* PIP achieved statistically significant improvement over baseline rates at Remeasurement 1. While there was no statistically significant change in any of the indicators, the rates of Study Indicators 1 (HbA1c Control < 7.0%) and 3 (Blood Pressure (BP) control < 140/90 mmHg) decreased, and the rate of Study Indicator 2 (LDL-C < 100 mg/ml) increased non-significantly. The Remeasurement 1 rates for all three study indicators fell below the CY 2012 DCH targets of 35.5 percent (HbA1c control < 7.0%), 33.6 percent (LDL-C control < 100 mg/ml), and 61.6 percent (BP Control < 40/90 mmHg), and all were below the corresponding Medicaid HEDIS 2011 50th percentile rates of 35.2 percent (HbA1c Control < 7.0% and LDL-C control < 100 mg/ml) | ◆ Placed robotic calls to diabetic members to remind them of diabetic screenings.<br>◆ Implemented a new member incentive program that allowed for the distribution of $25 for every member who received an HbA1c, LDL-C, and BP screening.<br>◆ Piloted a project that distributed an appointment book to 15 adult members with diabetes to see if this improved compliance with attending office visits would promote positive health outcomes, and improve performance of the study indicators. Based on the result of the pilot, the intervention was expanded to provide 100 calendars that were distributed by case managers to members with diabetes who had a history of missed appointments. | Not Met | Due to the lack of statistically significant improvement across all study indicators, HSAG encourages AMERIGROUP to revisit its causal/barrier analysis to determine the reason for the lack of improvement and revise current interventions and/or implement new strategies to address members' successfully controlling their HbA1c, LDL-C, and BP levels. The CMO may need to shift focus to engaging providers for strategies to increase control for members with diabetes since members with poor control are at an increased risk for eye disease, kidney disease, heart disease, nerve damage, stroke, and lower extremity amputation, among other health problems. |

| Table C-16—Comprehensive Diabetes Care | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| and 61.2 percent (BP Control < 140/90 mmHg). | ◆ Distributed HEDIS report cards showing providers their performance on HbA1c testing.<br>◆ Mailed letters to providers that listed noncompliant diabetic members needing services.<br>◆ Mailed letters to noncompliant members notifying them of the diabetic services needed. | | |
| **Peach State** | | | |
| None of the study indicators in the *Comprehensive Diabetes Care* PIP achieved statistically significant improvement over baseline at Remeasurement 1. All three study indicators declined during the remeasurement period with the decline in Study Indicator 2 (LDL-C control < 100 mg/ml) being statistically significant. The CY 2012 rates for all three indicators fell below the DCH target rates of 35.5 percent (HbA1c control < 7.0%), 33.6 percent (LDL-C control < 100 mg/ml), and 61.6 percent (BP | ◆ Provider outreach to obtain screening results identified as missing in the HEDIS reporting system.<br>◆ "Push" Initiative—live member outreach to schedule appointments, assist with transportation, and offer an incentive for obtaining due and past due preventive services.<br>◆ CareGaps, an internal system alert to let Peach State employees, providers, and members (secure portal) know about due or past due preventive services. | Not Met | Peach State reported that the HEDIS Steering Committee identified the Diabetes Management Program and the CareGaps system as the most effective interventions; however, the CMO did not explain how the committee arrived as this conclusion. While Peach State stated that it monitors monthly administrative rates, it did not describe a process by which individual interventions were evaluated for effectiveness. For example, the CMO did not track the members who were reached through the Diabetes Disease |

| Table C-16—Comprehensive Diabetes Care | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| control < 140/90 mmHg), respectively. The Remeasurement 1 rates for all three study indicators also fell below the 25th percentile of the respective Medicaid HEDIS 2011 national rates. | | | Management program to determine their performance on the study indicators. Evaluating the effectiveness of each intervention is an integral step in achieving significant improvement in the study indicators. |
| **WellCare** | | | |
| There was essentially no change from baseline to Remeasurement 1 in the study indicator rates for the *Comprehensive Diabetes Care* PIP. The rates of Study Indicator 1 (HbA1c control < 7.0%) and Study Indicator 3 (BP control < 140/90 mmHg) remained constant, and the rate of Study Indicator 2 increased non-significantly by 2.9 percentage points. The CMO's rates fell below the CY 2012 DCH goals of 35.5 percent (HbA1c control < 7.0%), 33.6 percent (LDL-C control < 100 mg/ml), and 61.6 percent (BP control < 140/90 mmHG), respectively. The rates for Study Indicators 1 and 2 were | ◆ Periodicity Letters—Letters are mailed to new members within 45 days of joining the CMO and during the birth month of current members to remind them of upcoming health screenings and immunizations.<br>◆ Community Education Events—the Member Outreach team invited diabetic members to attend community education events. Ten-to-fifteen members meet with a member of the Member Outreach team and were educated on diabetes.<br>◆ Diabetes Education Program—Member Outreach staff identified | Not Met | WellCare needs to provide a more detailed description of how the barriers listed were identified, prioritized, and linked to the interventions. The PIP documentation must include a description of the CMO's process for revising its interventions. Based on the lack of statistically significant improvement achieved and stagnant rates for Study Indicators 1 and 2, WellCare must revisit its causal/barrier analysis process and drill down to determine the cause for the lack of improvement. Additionally, some of the interventions were focused on member screening when the focus of the study indicators was on good control of the HbA1c, LDL, and blood pressure. While |

| Table C-16—Comprehensive Diabetes Care | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| between the 25th and 50th percentiles of the Medicaid HEDIS 2011 national rates, and the rate for Study Indicator 3 fell below the 25th percentile. | diabetic members who need to be educated on their chronic condition disease and the management of it to avoid complications. Members received one-on-one education in their homes, provider offices, or telephonically, depending on their preference. The diabetes presentation included information on the background of diabetes, complications, care (HbA1c, blood pressure, cholesterol, diet and dental, exercise and eye exam, foot care, and glucose monitoring), and a diabetes care schedule.<br>◆ HEDIS Education Screening Program—WellCare identified members with a care gap during the calendar year based on claims data. RNs across the company contacted those diabetic members with care gaps. During the call, the nurse | | increasing the number of screened members could improve the study indicator rates if those additional screened members had HbA1c and LDL levels controlled, current efforts do not appear to be targeting the increase in the percentage of members whose diabetes is controlled and to move them into control. WellCare's indicator rate for screening rates for HbA1c was 78.41 percent, and for LDL-C screening, the rate was 69.71 percent; therefore, focusing solely on increased screening only has the potential to improve rates by approximately 22–31 percent. Efforts aimed at both increased screening and control may yield a greater increase and more rapid rate of improvement. |

| Table C-16—Comprehensive Diabetes Care | | | |
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| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | provided education and assisted with making an appointment to visit the provider's office. | | |

| Table C-17—Avoidable Emergency Room Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP, Peach State, and WellCare Collaborative** | | | |
| This collaborative PIP had six study indicators and was piloted in the metro-Atlanta region of the State. Three of the six study indicators demonstrated non-statistically significant improvement from baseline to the first remeasurement. One indicator, Study Indicator 5, was 100 percent at baseline and Remeasurement 1; therefore, there was no room for improvement. The one study indicator measuring avoidable emergency room visits, Study Indicator 6, was the only indicator that did not improve, demonstrating a statistically significant decline in performance. | ◆ Increased percentage of practices using electronic health records through referral to GA-HITREC.<br>◆ Shared data regarding ER rates with practices to identify members using the ER during regular office hours.<br>◆ Notified providers regarding additional reimbursement of care provided after-hours<br>◆ Continued ER case management programs for live outreach to members who frequent the ER.<br>◆ Educational mailings to members regarding PCMHs and nurse advice hotlines.<br>◆ Provided materials to members regarding transportation vendors and assistance to members to arrange transportation, when needed. | Not Met | ◆ HSAG noted structural flaws in the documentation of the study design. The numerator and denominator descriptions for Study Indicators 2 and 3 that were documented by the CMOs were identical. The CMOs will need to correct this prior to the next annual submission.<br>◆ The CMOs did not completely define the study population.<br>◆ For the data collection methodology, the CMOs did not include the codes used to identify emergency room visits (denominator for Study Indicator 6). Additionally, it was unclear how the survey used by the CMOs captured data for Study Indicators 2 and 3.<br>◆ Although there are advantages to having lead measures, since many of the lead measures cannot achieve statistically significant improvement, HSAG is recommending that the CMOs move them to Activity VIII of the PIP and remove them as formal lag outcomes and study |

| Table C-17—Avoidable Emergency Room Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | | | indicators of the PIP.<br>◆ In Activity VIII, Implement Intervention and Improvement Strategies, the CMOs documented that a multidisciplinary team of participants from the three CMOs, representatives from DCH, and several study participants reviewed the baseline results of the provider survey, as well as the member focus study, to determine barriers and opportunities for improvement. Interventions were developed to address member, provider, and resource barriers.<br>◆ Prior to the three CMOs coming together, AMERIGROUP documented that it implemented interventions at the plan level to decrease avoidable emergency room visits. One of these interventions was the emergency room case management program for members with high emergency room utilization. Outbound calls were made to these members to discuss the reasons for their visits to the ER. |

| Table C-17—Avoidable Emergency Room Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | | | AMERIGROUP also provided weekly ER utilization reports to targeted groups via the provider portal.<br>◆ Peach State implemented an ER case management program where high-volume hospitals notified the CMO of members who were considered "frequent flyers." These members received a mailing and telephone call to discuss the appropriate use of an ER and their medical home.<br>◆ Prior to the three CMOs coming together, WellCare implemented the ER Outreach initiative. The CMO provided education to specific members to change behavior on the utilization of the emergency room via the telephone and mailed education. WellCare evaluated ER reports to identify members with frequent ER visits, three or more narcotics, three or more physicians, and three or more utilization of pharmacies. These members were contacted within 24–48 hours of the visit.<br>◆ The PIP documentation did not |

| Table C-17—Avoidable Emergency Room Visits | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| | | | reflect any processes that were in place to evaluate the effectiveness of any interventions. Although the CMOs discussed follow-up activities planned, due to the decline in performance for the avoidable ER visit rate indicator (Study Indicator 6), HSAG recommends the CMOs, collaboratively, investigate the reasons for the decrease in performance and based on the findings, implement strategies to improve performance. |

| Table C-18—Member Satisfaction | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| The baseline rate of respondents giving AMERIGROUP a rating of "8" or higher was 85.8 percent, slightly lower than the CMO's baseline goal of 86.6 percent, which was derived from the national 2012 Child Medicaid Quality Compass 75th percentile benchmark. | No intervention planned while collecting baseline data | Met | Although the CMO implemented interventions for both its *Member* and *Provider Satisfaction* PIPs, the PIPs were validated through Activity VII because only baseline data were reported. As these PIPs progress to reporting Remeasurement 1 data, HSAG will evaluate the CMO's causal/barrier analysis process and interventions. |
| **Peach State** | | | |
| The baseline rate of respondents giving Peach State a score of "8" or higher was 87.0 percent, slightly lower than the CMO's baseline goal (The Myers Group 90th percentile) of 88.7 percent. | | Met | The *Member* and *Provider Satisfaction* PIPs were validated through Activity VII because the CMO reported only baseline data and did not report interventions. As these PIPs progress to reporting Remeasurement 1 data, HSAG will evaluate the CMO's causal/barrier analysis process and interventions. HSAG recommends that Peach State incorporate the feedback provided for its other PIPs as it pertains to having targeted and relevant interventions that will directly impact study indicator outcomes and implement processes to evaluate the effectiveness of each intervention. |

| Table C-18—Member Satisfaction | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **WellCare** | | | |
| The baseline rate of respondents giving WellCare a score of "8" or higher was 88.3 percent. It should be noted that the baseline rate for this PIP was already above the CMO's baseline goal of 85.0 percent. | | Met | WellCare had not progressed to reporting its causal/barrier analysis processes or interventions for both satisfaction PIPs. |

| Table C-19—Provider Satisfaction | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **AMERIGROUP** | | | |
| The baseline rate of providers who reported being "Somewhat satisfied" or "Very satisfied" with AMERIGROUP was 79.6 percent. | | Met | Although the CMO implemented interventions for both its *Member* and *Provider Satisfaction* PIPs, the PIPs were validated through Activity VII because only baseline data were reported. As these PIPs progress to reporting Remeasurement 1 data, HSAG will evaluate the CMO's causal/barrier analysis process and interventions. |
| **Peach State** | | | |
| The baseline rate of providers who reported being "Somewhat satisfied" or "Very satisfied" with Peach State was 76.3 percent. | | Met | The *Member* and *Provider Satisfaction* PIPs were validated through Activity VII because the CMO reported only baseline data and did not report interventions. As these PIPs progress to reporting Remeasurement 1 data, HSAG will evaluate the CMO's causal/barrier analysis process and interventions. HSAG recommends that Peach State incorporate the feedback provided for its other PIPs as it pertains to having targeted and relevant interventions that will directly impact study indicator outcomes and implement processes to evaluate the effectiveness of each intervention. |

| Table C-19—Provider Satisfaction | | | |
|---|---|---|---|
| **Summary of Performance** | **PIP Intervention and Activities** | **EQR Validation Rating** | **EQR Discussion and Recommendation** |
| **WellCare** | | | |
| The baseline rate of providers who reported being "Somewhat satisfied" or "Very satisfied" with WellCare was 81.0 percent, surpassing the CMO's baseline goal of 74.7 percent. | | Met | WellCare had not progressed to reporting its causal/barrier analysis processes or interventions for both satisfaction PIPs. |

# Appendix D. Utilization Measure Rates and Demographic Information

| Table D-1—2012 Performance Measure Results—Mental Health Utilization | | | | | | |
|---|---|---|---|---|---|---|
| | 0–12 Years | 13–17 Years | 18–64 Years | 65+ Years | Unknown | Total |
| **Georgia Families** | | | | | | |
| Any Services: Total | 6.39% | 11.89% | 9.77% | 10.04% | 0.00% | 7.89% |
| Inpatient: Total | 0.12% | 1.06% | 0.97% | 0.00% | 0.00% | 0.41% |
| Intensive Outpatient/ Partial: Total | 0.06% | 0.36% | 0.19% | 0.00% | 0.00% | 0.14% |
| Outpatient/ED: Total | 6.36% | 11.64% | 9.36% | 10.04% | 0.00% | 7.76% |
| **Fee-For-Service** | | | | | | |
| Any Services: Total | 14.38% | 28.56% | 19.78% | 9.77% | 0.00% | 13.38% |
| Inpatient: Total | 0.26% | 1.73% | 2.73% | 6.39% | 0.00% | 2.56% |
| Intensive Outpatient/ Partial: Total | 0.08% | 0.22% | 0.07% | 0.00% | 0.00% | 0.07% |
| Outpatient/ED: Total | 14.33% | 28.30% | 19.04% | 4.00% | 0.00% | 16.02% |
| **ALL** | | | | | | |
| Any Services: Total | 7.78% | 14.70% | 15.32% | 9.77% | 0.00% | 10.77% |
| Inpatient: Total | 0.14% | 1.19% | 1.96% | 6.39% | 0.00% | 1.06% |
| Intensive Outpatient/ Partial: Total | 0.05% | 0.27% | 0.11% | 0.00% | 0.00% | 0.10% |
| Outpatient/ED: Total | 7.76% | 14.52% | 14.77% | 4.00% | 0.00% | 10.31% |
| **Medicaid Adult Only** | | | | | | |
| Any Services: Total | 7.98% | 16.49% | 15.59% | 9.77% | 0.00% | 11.27% |
| Inpatient: Total | 0.15% | 1.31% | 1.99% | 6.39% | 0.00% | 1.17% |
| Intensive Outpatient/ Partial: Total | 0.06% | 0.28% | 0.11% | 0.00% | 0.00% | 0.10% |
| Outpatient/ED: Total | 7.96% | 16.28% | 15.03% | 4.00% | 0.00% | 10.75% |
| **CCSP** | | | | | | |
| Any Services: Total | 8.67% | 11.05% | 14.35% | 6.91% | 0.00% | 9.22% |
| Inpatient: Total | 0.00% | 0.00% | 1.76% | 1.78% | 0.00% | 1.75% |
| Intensive Outpatient/ Partial: Total | 0.00% | 0.00% | 0.05% | 0.00% | 0.00% | 0.02% |
| Outpatient/ED: Total | 8.67% | 11.05% | 13.32% | 5.48% | 0.00% | 7.90% |

| Table D-2—2012 Performance Measure Results—Utilization | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| **Ambulatory Care (Per 1,000 Members)** | | | | | | |
| ED Visits | 58.12% | 92.95%↑ | 70.20%↑ | 76.19% | 99.30% | |
| OP Visits | 343.01% | 462.91% | 382.10% | 394.30% | 659.49% | |
| **Plan All-Cause Readmissions** | | | | | | |
| Plan All-Cause Readmissions | 9.90% | 9.28% | 9.42% | 9.42% | 1.57% | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.

[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.

[3] CY 2012 ALL population rates reflect data for members in the GF populations, FFS populations, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.

[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.

[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and it also includes dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.

[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.

Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.

NR indicates rate was Not Reportable due to material bias.

NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.

↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.

| Table D-3—2012 Performance Measure Results—Inpatient Utilization—General Hospital/Acute Care | | | | | | |
|---|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] | CY 2012 Performance Target[6] |
| **Days/1,000 Member Months** | | | | | | |
| Inpatient Total | 19.40 | 107.34 | 45.65 | 52.36 | 189.57 | |
| Medicine Total | 3.80 | 51.29 | 18.09 | 20.67 | 117.60 | |
| Surgery Total | 3.52 | 48.45 | 16.87 | 19.32 | 71.93 | |
| Maternity Total | 26.04 | 12.44 | 21.08 | 24.74 | 0.13 | |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.

[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.

[3] CY 2012 ALL population rates reflect data for members in the GF populations, FFS populations, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.

[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.

[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and it also includes dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.

[6] CY 2012 performance targets reflect the DCH-established CMO performance targets for 2012.

Shaded boxes are displayed when no DCH CY 2012 performance target was established or when a rate was not calculated for a specific population.

NR indicates rate was Not Reportable due to material bias.

NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.

↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.

| Table D-4—2012 Performance Measure Results—Diversity of Membership | | | | | |
|---|---|---|---|---|---|
| | CY 2012 GF Rate[1] | CY 2012 FFS Rate[2] | CY 2012 ALL Rate[3] | CY 2012 Adult Only Rate[4] | CY 2012 CCSP Rate[5] |
| **Race/Ethnicity Diversity of Membership** | | | | | |
| White | 39.66% | 36.25% | 39.08% | 39.55% | 57.12% |
| Black or African-American | 48.24% | 43.95% | 44.81% | 46.75% | 41.04% |
| American-Indian and Alaska Native | 0.10% | 0.11% | 0.10% | 0.11% | 0.08% |
| Asian | 2.61% | 2.06% | 2.11% | 1.84% | 0.57% |
| Native Hawaiian and Other Pacific Islanders | 0.09% | 0.07% | 0.07% | 0.08% | 0.04% |
| Some Other Race | 4.01% | 2.39% | 3.15% | 1.78% | 0.15% |
| Two or More Races | 0.00% | 0.00% | 0.00% | 0.00% | 0.00% |
| Unknown | 0.28% | 9.31% | 5.28% | 5.98% | 0.70% |
| Declined | 5.03% | 5.87% | 5.41% | 3.92% | 0.30% |

[1] CY 2012 GF rates reflect the weighted averages from the three CMOs' reported and audited data for the hybrid measures during the measurement year, which is January 1, 2012, through December 31, 2012, and 2012 rates are displayed where applicable. CY 2012 GF administrative measure rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These administrative rates included members who transitioned between CMOs during the measurement year.

[2] CY 2012 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2012, through December 31, 2012.

[3] CY 2012 ALL population rates reflect data for members in the GF populations, FFS populations, and members who transferred between GF and FFS during the measurement year, which is January 1, 2012, through December 31, 2012.

[4] CY 2012 MAO population rates reflect data for adult members in the ALL population, excluding the PeachCare for Kids® population and dual-eligible members during the measurement year, which is January 1, 2012, through December 31, 2012.

[5] CY 2012 CCSP population rates reflect data for this Medicaid waiver program and they also include dual-eligible members. The measurement year was from January 1, 2012, through December 31, 2012.

NR indicates rate was Not Reportable due to material bias.

NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

↑Indicates a statistically significant increase between the 2011 and 2012 weighted average rates.

↓Indicates a statistically significant decrease between the 2011 and 2012 weighted average rates.

# Appendix E. 2012–2013 EQR Recommendations and Follow-Up

The table below provides the 2012–2013 EQR recommendations and the CMOs' and/or DCH's actions taken through June 30, 2013, that address the recommendations.

| Table E-1—Recommendations and Follow-Up Activities | |
|---|---|
| **2012–2013 EQR Recommendation** | **Actions through June 30, 2013, that Address the Recommendation** |
| **Review of Compliance with Standards** | |
| The CMOs should develop more individualized, specific goals for members. Goals should be measurable, attainable, timely, and realistic, and should reflect the information obtained during the assessment process. | The EQR file review of emergency room and hospital admissions showed mixed results among the CMOs. The CMOs still have an opportunity to continue to individualize member care plans. |
| The CMOs should increase accountability for member care plans by implementing outcome measures through the quantifying and assigning of values to care plan goals and interventions, and requiring reporting on the percentage of care plan goals met, not met, partially met, etc. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should implement mechanisms to demonstrate improved member health outcomes related to the specific case management and disease management problems, interventions, and goals set for the member within the care plan. The care plan goals set for a member, such as a reduction in the HbA1c level for a diabetic member, should be the criteria against which results can later be measured to determine specific outcomes. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should increase efforts to engage providers in care plan development and monitoring activities to ensure all needed treatments and services are being provided to the member and treatment goals are coordinated between the providers and case manager. Additionally, members' support systems should be engaged in the case management process. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should improve care coordination and work flow activities to ensure that case managers are notified when their members are admitted to an inpatient facility and are included in the discharge planning process, and that they obtain the discharge plans to allow the hospital's instructions to be incorporated into the care plan and monitoring activities. | The CMOs still have opportunities to comply with this recommendation. |

| Table E-1—Recommendations and Follow-Up Activities | |
|---|---|
| **2012–2013 EQR Recommendation** | **Actions through June 30, 2013, that Address the Recommendation** |
| The CMOs should reevaluate the frequency of member contact; allow the needs of the member to drive the monitoring activities, and develop ways to increase member engagement and strengthen member/case manager relationships to increase member retention. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should improve and streamline the delivery of disease management program services by implementing a single stratification disease management program focusing on active disease management interventions only and incorporating those activities into the case management program as Level 1 case management. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should improve care plan and clinical guideline processes by ensuring that clinical guidelines are reflected in care plan goals and care plan goals are linked with outcome measures to monitor member improvements. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should explore and expand the variety of educational materials in disease management available to members in order to include interactive, dynamic educational tools that engage members. | The CMOs have demonstrated implementation of new strategies to educate members. |
| The CMOs should explore using online, mobile apps and other interactive tools for members to log lab value results. Consider sending testing reminders to members, providing online chats with a disease manager, or implementing member Health Report Cards so members can track lab value results and gauge their progress over time. Additionally, the Health Report Cards can be used to track and report on specific outcome measures. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should increase efforts to engage providers in the disease management process by performing outreach to providers and improving collaboration to obtain clinical information. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should increase efforts to engage members and ensure that disease management monitoring and follow-up activities are tied to care plan goals and disease-specific clinical guidelines. | The CMOs still have opportunities to comply with this recommendation. |
| While member coverage includes a transportation benefit, DCH should consider reducing barriers to this benefit by reducing restrictions on the distance members can be transported, the call-ahead reservation time required, and the number of co-riders that are permitted to accompany members. | The transportation benefit remains static; however, some efforts to discuss these concerns have been conducted. |

| Table E-1—Recommendations and Follow-Up Activities | |
|---|---|
| **2012–2013 EQR Recommendation** | **Actions through June 30, 2013, that Address the Recommendation** |
| Currently, DCH provides a broad outline of case management and disease management program requirements in the contract between DCH and the CMOs. However, DCH may consider revising the program requirements to include more specific and prescriptive requirements (e.g., process standards to require assessments, care plans, and initiation of services to be completed within a set time frame; and CMOs to offer a common menu of service items to standardize processes across the state). | The DCH is revising the CM and DM reporting requirements. |
| The DCH may consider allowing member eligibility for longer periods instead of every six months to help ensure consistency and quality delivery of case management and disease management services and prevent members from experiencing frequent disruptions in services due to eligibility issues. | This recommendation has not been implemented; however, the State is making progress on policy changes to address this issue, which will be effective January 1, 2014. |
| The DCH should consider standardizing case manager caseload size. HSAG observed variation in caseload size across CMOs ranging from 100 to 300 members. High caseloads prevent case managers from devoting time to individual members and require them to spend their time with crisis case management instead. Because there is no single accepted industry standard for caseload size, DCH may consider convening a work group to explore the results of several published white papers and solicit input from its CMOs and case management organizations before establishing a threshold. | The DCH did demonstrate efforts to explore caseload size and requested assistance from the EQRO. HSAG researched caseload thresholds and found that there is still variance within the industry and no expected thresholds have been established. |
| The DCH should consider implementing incentives and disincentives for case management and disease management for CMO outcome measures. | This recommendation has not been selected by DCH for action. |
| The DCH should implement case reviews and require reporting of all members who expire while enrolled in a case management or disease management program. Additionally, explore implementation of an incident reporting process and ensure quality assurance using required CAPs. | This recommendation has not been selected by DCH for action as DCH has limited resources to implement this recommendation. |
| **Performance Measures** | |
| The DCH should continue to use medical record review methodology to capture FFS and ALL population rates for hybrid measures. This activity would allow for comparisons across the three populations as well as comparison of year-over-year performance. | The DCH has implemented this recommendation and has the ability to compare across the populations. |
| The DCH may want to consider measures with low | The DCH selected eight clinical PMs as the basis to |

| Table E-1—Recommendations and Follow-Up Activities | |
|---|---|
| **2012–2013 EQR Recommendation** | **Actions through June 30, 2013, that Address the Recommendation** |
| performance for the auto-assignment program as a mechanism to drive improvement. | determine the quality scores using CY 2011 data to inform the CY 2013 auto-assignment. The DCH has made further revisions to include a more comprehensive set of measures for the auto-assignment calculation in future years. |
| The DCH may consider retiring PMs with improved CMO performance to allow the CMOs to focus on areas of low performance. | The DCH annually assesses the required PM set. Due to increased accountability, including the reporting of measures for federal reporting, this recommendation will not be implemented. |
| The CMOs should evaluate their case management and disease management programs to assess these programs' effectiveness in improving care and make modifications to increase their impact on PM rates. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should ensure that clinical guidelines and performance measurement requirements are shared with providers. | The CMOs demonstrated adequate processes for disseminating clinical guidelines and PM requirements to their providers. |
| The CMOs should supply providers with lists of members who have not received the required services. | The CMOs have implemented processes to give their providers performance feedback across many PMs. This includes identifying members who have not received recommended services. |
| AMERIGROUP needs to focus quality improvement efforts in the areas of diabetes care and prenatal and postpartum care. Peach State and WellCare need to focus quality improvement efforts in the areas of diabetes care and well-care visits. These efforts should include conducting a causal/barrier analysis; evaluating existing interventions; and developing new, targeted strategies that directly address the identified barriers. | All CMOs have PIPs in these recommended areas of focus. Further efforts in quality improvement practice are needed to have an impact on the rates. |
| **Performance Improvement Projects** | |
| The CMOs should ensure that all numerators, denominators, rates, and statistical testing findings are reported accurately in the PIP documentation. This includes reporting data that correspond to the PM rates submitted to NCQA. | The CMOs continue to have opportunities for improvement with accurate documentation of data components, indicator rates, and statistical testing findings. |
| The CMOs should select interventions for system changes that increase the likelihood of achieving and sustaining improvement instead of one-time interventions. | The CMOs still have opportunities to develop interventions that promote system changes and increase the likelihood of success. |
| For any intervention implemented, the CMOs should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. This evaluation process should be detailed in the PIP documentation. If the interventions are not having | The CMOs still have opportunities to comply with this recommendation. |

| Table E-1—Recommendations and Follow-Up Activities | |
|---|---|
| **2012–2013 EQR Recommendation** | **Actions through June 30, 2013, that Address the Recommendation** |
| the desired effect, the CMOs should discuss how they will be addressing these deficiencies and what changes will be made to their improvement strategies. | |
| The CMOs should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier. | The CMOs still have opportunities to comply with this recommendation. |
| For study indicators that have not achieved statistically significant improvement or have been assessed for sustained improvement, the CMOs should build upon strengths and lessons learned from the PIPs that have been successful. | The CMOs still have opportunities to comply with this recommendation. |
| The CMOs should be cognizant of the timing of interventions. Interventions implemented late in the year will not have been in place long enough to impact the rates. | The CMOs still have opportunities to comply with this recommendation. |
| For member and provider satisfaction study indicators that have not been assessed for statistically significant or sustained improvement, the CMOs should consider hosting focus group discussions (i.e., one focused on member satisfaction and one focused on provider satisfaction). These focus groups would enable the CMOs to interact with potential satisfaction survey participants and gain valuable input on the specific areas that cause dissatisfaction with services provided. Once areas of dissatisfaction are identified, the CMOs and respective providers should implement system changes to combat the areas of dissatisfaction that were identified. | The CMOs demonstrated efforts to incorporate member feedback and input into the quality improvement process. The CMOs recruited members to participate on advisory committees, which at times have served as focus groups. This has helped the CMOs better understand barriers from the member's perspective. However, the CMOs now have an opportunity to use this information to target interventions to address concerns identified by members. |