State of Georgia

Department of Community Health

2015 External Quality Review Annual Report

Including

Compliance Review Results

(Review Period: July 1, 2013–June 30, 2014)

CY 2013 Performance Measure Rates

CY 2013 Performance Improvement Project Results

For the

Georgia Families Care Management Organizations

HSAG Health Services Advisory Group

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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 1.3 million beneficiaries.[1-1] In March 2014, DCH transitioned children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system into the Georgia Families (GF) 360° managed care program.

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 CMOs' performance data across mandatory and optional activities 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 and GF 360° programs.
- A description of the scope of EQR activities included in this report.

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 9/2/2014."

[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.

- An assessment of each CMO's strengths and weaknesses for providing health care timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures, and performance improvement projects (PIPs).
- Recommendations for the CMOs to improve member access to care, quality of care, and timeliness of care.
- An aggregate assessment of the GF program for providing health care timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures, and PIPs, as well as the member satisfaction survey (Consumer Assessment of Healthcare Providers and Systems [CAHPS®][1-4]) activity results.
- 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.

Overview of the External Quality Review

To produce this report, HSAG analyzed CMO-specific data 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 2014. The CMOs submitted documentation that covered the state fiscal year (SFY) 2014 review period of July 1, 2013, through June 30, 2014. HSAG provided detailed, final audit reports to the CMOs and DCH in December 2014.
- *Validation of Performance Measures*. HSAG validated the performance measure rates required by DCH to evaluate the accuracy of the performance measure results reported by the CMOs. The validation also determined the extent to which the DCH-specific performance measure rates calculated by the CMOs followed specifications established by DCH. HSAG assessed the performance measure results and their impact on improving the health outcomes of members. HSAG began validation of the CMOs' performance measure rates in March 2014 and completed the validation activities in June 2014. The CMOs submitted performance measure data that generally reflected the period of January 1, 2013, through December 31, 2013. HSAG provided final performance measure validation reports to the CMOs and DCH in November 2014. In addition to validation of the CMOs' data, DCH used HSAG to conduct validation of the performance measure 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); the Community Care Services Program (CCSP); and the GF 360° Program. HSAG provided final performance measure validation reports to HP and DCH in January 2015.
- *Validation of PIPs*. HSAG validated PIPs for each CMO to ensure the CMOs designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS

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

protocols for validating PIPs. HSAG assessed the PIPs for real improvements in care and services to validate 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, 2014, and August 15, 2014. 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 2014.

- *CAHPS surveys*. The DCH conducted the CAHPS survey for its PeachCare for Kids® only population to learn more about member experiences with their care and meet CMS requirements for its CHIP population. In addition to the mandatory reporting for CHIP, DCH conducted the CAHPS surveys for its Medicaid adult population, as well as its Medicaid and PeachCare for Kids® child populations during the review period. HSAG included the results from the CAHPS surveys for all three populations.

Because the GF 360° program was implemented in March 2014, performance measures and PIPs for this managed care population were not conducted during this evaluation period. HSAG conducted a review of the GF 360° program's compliance with federal and State standards and included the results of that review in this report.

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), including coordination and continuity of care.

Performance measure and PIP results are used to assess the care delivered by each CMO (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 improving performance in these areas are likely to improve health outcomes. In addition, DCH monitors aspects of each CMO's operational structure that support 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' performance measure rates (which reflect CY 2013 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.

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 in place to support the overall delivery of care but struggled with their strategic planning approach for quality improvement initiatives that would demonstrate improved health outcomes.

The case management and disease management file review that HSAG conducted as part of the comprehensive review in July 2014 showed some opportunities for all of the CMOs to improve in the area of continuity and coordination of care. For members in case or disease management programs, the care plans were not always individualized to the member, and the member or caregiver was not always involved in the care plan creation process. The CMOs did not consistently use a multidisciplinary team approach when monitoring those members in case management. Additionally, discharge planning documentation was limited to information provided by the member or guardian after discharge rather than obtained through a proactive approach that included the CMO arranging and coordinating the member's discharge with the facility's staff. Improved transitions of care should lead to fewer emergency room visits, lower readmission rates, improved health outcomes, and overall improved quality of care.

The DCH required the CMOs to report rates in SFY 2014 for 52 of 54 measure categories from the original required list, reflecting the measurement period of January 1, 2013, through December 31, 2013. The measure list consisted of clinical quality, access, and utilization measures, as well as health plan descriptive information. Many of the 52 measure categories included multiple components or age stratifications, resulting in a higher number of total measure rates reported by each CMO. Overall, when compared to the DCH-established performance targets, the CMOs' rates did not meet the targets for most measures. However, the statewide weighted average performance measure rates for child health measures showed statistically significant improvement for several measures demonstrating progress in the right direction. Conversely, the CMOs performed poorly on women's health measures and chronic disease management measures, with many having statistically significant declines.

Opportunities continued to exist in the area of PIPs, specifically the CMOs' quality improvement strategies. The CMOs were not consistently conducting appropriate causal/barrier analysis, evaluating the effectiveness of each implemented intervention, or providing quantitative results to substantiate the continuation of interventions. HSAG's critical analysis showed that the CMOs implemented interventions that (1) were not always logically linked to identified barriers, and (2) could not directly impact study indicator outcomes. The CMOs must continue to improve quality and performance improvement initiatives and activities to meet the State-established targets for all measures.

Members' satisfaction with care measured through the CAHPS surveys revealed that global rating results for Rating of Personal Doctor, Rating of Specialist Seen Most Often, Rating of All Health Care, and Rating of Health Plan were all above the Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] 2013 Medicaid national 90th percentiles for the adult, child, and PeachCare for Kids® populations. Rates for the Child Medicaid population for How Well Doctors Communicate, and Customer Service were below HEDIS 2013 Medicaid national 50th percentiles. These scores indicate that child members and/or their parents were mostly satisfied with their providers;

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

however, they were less satisfied with delivered care. While no national comparisons were available for the Shared Decision Making composite, the scores across all three populations reveal an opportunity to improve communication as roughly half of respondents did not indicate being included in care and treatment decisions. Improving member involvement in health care decisions may be an opportunity to improve the quality of care by engaging and activating patients in their own health care.

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.

In conducting compliance reviews, HSAG found that none of the CMOs met all geographic access requirements. Also, none of the CMOs met all of the timely access requirements. The CAHPS surveys revealed mixed results. The rates for the Child Medicaid population composite measures of Getting Needed Care and Getting Care Quickly were below the National Committee for Quality Assurance (NCQA) Medicaid national 50th percentiles. However, results for the Adult Medicaid population were above the 50th percentiles, and the PeachCare for Kids® population was at or above the 90th percentiles for these same measures.

The CMOs demonstrated some improvement in the access-related performance measure rates, including statistically significant improvement for the *Children's and Adolescents' Access to Primary Care Providers* rates for several age groups. Two of the three CMOs achieved sustained improvement for the *Childhood Obesity* PIP.

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 contracts with the CMOs require them to ensure timeliness of care. HSAG conducts review activities to assess the CMOs' compliance with these standards in areas such as member rights and protections, the grievance system, and utilization management.

Performance measures 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.

All three CMOs achieved sustained improvement for the *Childhood Immunizations—Combo 10* PIP. Each CMO approached improvement efforts differently and increased performance between

18.7 to 27.3 percentage points from baseline to Remeasurement 2 in the rate of eligible child members who had received all necessary immunizations by their second birthday. The Remeasurement 2 rate for all three CMOs surpassed the 90th percentile of the national Medicaid HEDIS 2012 rates.

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, and PIP design; however, they were less likely to have a strategic approach for planning quality improvement efforts and managing health care outcomes effectively. The CMOs have opportunities to align programs, processes, and efforts to achieve goals more effectively. For example, case manager care plan monitoring was not consistent with continuity of care procedures, and care plans were not consistently member-centered and measurable. It was also noted that the member or caregiver was not always included in the creation of the care plan, which was further supported by members' poor rating of Shared Decision Making. By obtaining discharge instructions for hospitalized members and working with these members to ensure discharge needs are met, the CMOs would likely reduce the number of hospital readmissions.

HSAG recommended the CMOs reassess their strategic plans and ensure they align with initiatives specific to the Georgia market. Training on the principles of strategic planning and differentiation of goals, objectives, and strategies, as well as aligning the quality assessment performance improvement programs across the quality program description, work plan, and evaluation would also be beneficial to the CMOs. All three CMOs were encouraged to better align the goals of their disease and case management programs with performance measure and PIP targets. The CMOs must focus on improving health outcomes, care coordination, and transitions of care. HSAG encouraged the CMOs to build a rapport with their members, particularly those receiving case management services. Members may 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. 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.

The Child Medicaid CAHPS scores indicated that members were satisfied with providers, but were less satisfied when polled about the care that is received. Child members and/or parents rated the measures Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service as either "Fair" or "Poor." HSAG encouraged the CMOs to review access to care policies and procedures to ensure CMO practices were not impeding members from obtaining needed services.

Based on the review of the CMOs' performance on the performance measure results, PIP outcomes, compliance with State and federal standards, and CAHPS results, HSAG provides specific

recommendations based on each activity's review findings at the end of each section. HSAG provides specific recommendations to DCH based on the CMOs' overall performance and for the program as a whole in the Program-Level Results section of this report.

GF 360° Conclusions and Recommendations

HSAG's early review of AMERIGROUP's GF 360° population showed a tremendous effort on the CMO's part to carefully plan the transition of members moving from FFS to managed care. The CMO established partnerships with multiple state agencies to help streamline the continuity and coordination of care for members and to ensure that access to care was not disrupted. HSAG noted similar opportunities for improvement related to care planning for the GF 360° population as it did for the GF population.

AMERIGROUP had some challenges in completing timely assessments for the GF 360° population during the early months of the transition process. In addition, some contract requirements were outside of the CMO's control as they relied on services being provided by other agencies. The CMO and DCH should revisit these contract requirements.

Georgia Medicaid Managed Care Service Delivery System Overview

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 Medical Assistance Plans Division 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 and the PeachCare for Kids® populations. Enrollment is mandatory for certain Medicaid and PeachCare for Kids® members. In some cases, PeachCare for Kids® members can receive an exemption from enrollment into the GF program. For Georgia Medicaid, enrollment in the GF program 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

In addition to the GF population, which includes both Medicaid and CHIP populations, DCH implemented GF 360° managed care coverage in March 2014 for the following populations.

1. Children in state custody
2. Children receiving adoption assistance
3. Certain youth in the custody of the Department of Juvenile Justice (DJJ)

Georgia Families (GF) Care Management Organizations

The DCH held contracts with three CMOs (AMERIGROUP, Peach State, and WellCare) during the review period for this annual report. 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.

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 the strategy's 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 preparing a new quality strategic plan to coincide with the reprocurement of the GF and GF 360° managed care contractors. The new Quality Strategic Plan will follow the CMS 2012 Quality Strategic Plan template. Quality Strategic Plan activities occurring since November 2011 include:

- Transitioned approximately 27,000 foster care, adoption assistance, and juvenile justice children in residential placement from FFS Medicaid to AMERIGROUP, the DCH-selected vendor for the GF 360° program, on March 3, 2014. The goals of this program are to improve care coordination, continuity of care, and health outcomes for members.
- Awarded an Adult Quality Measures grant that allowed for the generation of the CMS Adult Core Set of measures for the Medicaid Adult Only population. The grant also required and funded two PIPs that were conducted by the Georgia Department of Human Services Division of Aging Services. The projects focused on screening for clinical depression and follow-up care, and antidepressant medication management in the Community Care Services Program (CCSP) waiver population.
- Collaborated with CMS and HSAG to develop a rapid-cycle process improvement validation process for the CMOs' rapid-cycle PIPs.
- Implemented a policy to deny payment for non-medically necessary labor inductions and Cesarean sections for women less than 39 weeks gestation.
- Participation in the CMS QI 101 and 201 projects with a State focus on the postpartum visit and reproductive life plan discussions.

[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.

- Submission of a State plan amendment that granted approval for the collaboration between the DCH and the Georgia Department of Public Health (DPH) for initial perinatal case management assessments including reproductive life plan discussions and development of care plans for pregnant women conducted by the local public health agencies across the State and shared with the women's CMOs and/or obstetrics providers.
- Submission of a transition plan for the 1115 Demonstration, Planning for Healthy Babies® (P4HB®), and subsequent preparation for the submission of an extension request for P4HB®.
- Submitted a request to the Designated Standards Maintenance Organization (DSMO) to allow the CMS 1500 form to be modified to capture the estimated delivery date (EDD) on the claims. This information will allow the calculation of gestational age from claims data and remove the need for vital statistics data to compute gestational age.
- Participation in the CMS Quality Technical Advisory Group.
- Revised the auto-assignment algorithm to include up to 19 performance measures and CAHPS survey response scores for each of the two auto-assignment cycles for the CMOs.
- Began the process to reprocure the GF and GF 360° managed care contractors.
- Continued policy and MMIS activities to ensure mandated compliance with the International Classification of Diseases, 10th Edition (ICD-10) code sets within the Medical Assistance Plans Division.

GF Quality Initiatives Driving Improvement

HSAG noted several DCH initiatives during the review period 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

DCH awards the CMOs with auto-assignment of members 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 revised the auto-assignment algorithm with the new algorithm becoming effective for CY 2014 auto-assignments. The DCH established two auto-assignment periods: January through June and July through December. For the first scoring period, DCH selected the 17 clinical performance measures listed below to serve as the basis for determining the quality scores, using CY 2012 data to inform the CY 2014 auto-assignment.

- *Adolescent Well-Care Visits*
- *Annual Dental Visits (2–3 years)*
- *Appropriate Testing for Children with Pharyngitis*
- *Appropriate Testing for Children with Upper Respiratory Infection*
- *Cesarean Delivery Rate*

- *Childhood Immunization Status—Combination 6*
- *Children's and Adolescents' Access to Primary Care Providers (12–19 years)*
- *Follow-Up Care for Children Prescribed ADHD Medication (Initiation Phase)*
- *Frequency of Ongoing Prenatal Care (81+ Percent)*
- *Immunizations for Adolescents (Combo 1)*
- *Lead Screening in Children*
- *Percentage of Eligibles that Received Preventive Dental Services*
- *Percentage of Live Births Weighing Less than 2,500 Grams*
- *Prenatal and Postpartum Care (Postpartum Care)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents: BMI Total*
- *Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*
- *Well-Child Visits in the First 15 Months of Life (6 or more Visits)*

For the second scoring period, DCH selected the 19 performance measures listed below to serve as the basis for determining the quality scores, using CY 2012 data to inform the CY 2014 auto-assignment.

- *Adult BMI Assessment*
- *Adults' Access to Preventive/Ambulatory Health Services (Age 20–44 years)*
- *Ambulatory Care: ED Visits Total (Visits/1,000 MM)*
- *Annual Monitoring of Patients on Persistent Medications (Anticonvulsants)*
- *Antibiotic Utilization: Percentage of Antibiotics of Concern for All Antibiotic Prescriptions (Total)*
- *Antidepressant Medication Management (Effective Acute Phase Treatment)*
- *Asthma in Older Adults Admission Rate (Per 100,000)*
- *Asthma in Younger Adults Admission Rate (Per 100,000)*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women (Total)*
- *Comprehensive Diabetes Care: HbA1c Poor Control (> 9.0 Percent)*
- *Congestive Heart Failure (CHF) Admission Rate (Per 100,000)*
- *Controlling High Blood Pressure*
- *Diabetes, Short-Term Complications Admission Rate (Per 100,000)*
- *Follow-up After Hospitalization for Mental Illness (7-Day Follow-Up)*
- *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment (Initiation—Total)*
- *Medical Assistance with Smoking and Tobacco Use Cessation (Cessation Strategies)*
- *Provider Satisfaction Survey (Overall Satisfaction)*

Quality Improvement Conference

The DCH worked with HSAG to conduct a quality improvement conference, *Georgia, Under Control—Managing Chronic Conditions,* on January 10, 2014. The conference focused on two primary topics. First, a discussion about optimizing CMO performance using gap analysis occurred. Presentations included information concerning identification of gaps related to monitoring provider adherence to the diabetes and asthma clinical practice guidelines. Second, aligning performance measure targets with disease management efforts was discussed. Presentations included information on obtaining a better understanding of the effective alignment of performance measure targets with disease management efforts.

Rapid-Cycle Technical Assistance

HSAG began working with the CMOs in February 2014 on using rapid-cycle techniques and incorporating quality improvement science into the PIP process. Technical assistance calls were held between February and May 2014 to provide guidance in determining each CMO's narrowed focus PIP topic and the study design for each of the rapid-cycle PIPs.

Centers for Medicare & Medicaid Services Quality Improvement 201 Project

The Quality Improvement (QI) 201 Project was a nine-month collaborative learning series to build state capacity for quality improvement. The series provided training and support to teams implementing QI projects related to maternity core set measures. Georgia's team, composed of DCH and the CMOs, partnered to improve postpartum visit rates and reproductive life plan discussions during the postpartum visit. After a review of the initial data collected for the project, the project's focus changed as described below.

Reproductive Life Plan Quality Improvement Project

The DCH leveraged the QI 201 Project focus into a quality improvement project designed to achieve a 5 percentage point increase over baseline in the number of pregnant women (within pilot practices) who had documentation in their medical charts of a reproductive life plan or a discussion about births and birth spacing. Each CMO selected and engaged two high-volume OB practices as pilot sites. Each CMO conducted face-to-face visits with the pilot practices to explain the project and encourage reproductive life planning during antenatal visits. The actual outcome achieved was a 30 percentage point increase over baseline.[2-2]

Adult Medicaid Quality Grant

This grant allows DCH the opportunity to collect and validate performance measure data on the Adult Medicaid population consistent with the Adult Core Set of Medicaid measures. CMS updated

[2-2] Medicaid/CHIP Health Care Quality: Strengthening Maternal and Infant Health. QI 201 Learning Session #8. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/qi-201-sharing-lessons-learned.pdf. Accessed on: January 9, 2015.

the Adult Core Set in May 2014, but the revisions will not be placed into production until the CY 2014 measurement period. These data will be used to compare Georgia's performance against other states' performance.

In partnership with the Division of Aging Services (DAS), which has oversight of the Area Agencies on Aging (AAA), the DCH conducted two PIPs. The first PIP focused on improving the screening and follow-up care for CCSP members with depression. The second PIP focused on the management of these members' antidepressant medications. In addition, the AAA's staff or contractors provided case management services to ensure CCSP members were compliant with their antidepressant medications.

Collaborative Improvement and Innovation Network to Reduce Infant Mortality

Georgia continued its participation in the Collaborative Improvement & Innovation Network (CoIIN) to Reduce Infant Mortality during this review period. 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

DCH implemented an early elective deliveries hard stop policy in October 2013 which clearly articulates that Georgia's Medicaid program will not pay for non-medically necessary elective inductions or deliveries prior to 39 weeks gestation. Georgia also reported on the Elective Deliveries Adult Core Set measure using CY 2012 and CY 2013 data and will work to refine the calculation of this measure during the upcoming reporting period. Issues arose during the calculation of the measure because Georgia's MMIS is not linked to the Department of Public Health's vital statistics database, making it difficult to calculate gestational age from claims data alone. Georgia reached out to the Designated Standards Maintenance Organization (DSMO) to request a modification to the CMS 1500 form and its electronic counterpart, the 837P, to allow the EDD to be recorded in Field 14 of the form instead of the last menstrual period. The DSMO extended its review period of the request, and the State is expecting a response during the spring of 2015.

The DCH also submitted a request to extend the 1115 Demonstration, the Planning for Healthy Babies® (P4HB®) program. The P4HB® inter-pregnancy care (IPC) component has been identified as a program that targets improvements in access to care and future birth outcomes for mothers of very low birth weight babies.

3. AMERIGROUP Community Care

Plan Overview

AMERIGROUP Community Care (AMERIGROUP) is a wholly-owned subsidiary of WellPoint, Inc. The CMO operates in the states of Florida, Georgia, Kansas, Louisiana, Maryland, Nevada, New Jersey, New Mexico, New York, Tennessee, Texas, and Washington. AMERIGROUP began operations in Georgia in 2006 and currently serves over 334,000 Georgia Families members.[3-1]

Georgia Families

The DCH held a contract with AMERIGROUP during the review period to provide services to GF members throughout the State of Georgia. In addition to providing medical and mental health Medicaid and CHIP-covered services to members, the CMO also provides a range of enhanced services, including dental and vision services for adults, disease management and education, and wellness/prevention programs.

Georgia Families 360°

Georgia Families (GF) 360° is the risk-based Medicaid managed care delivery program in Georgia for children, youth, and young adults in foster care; children and youth receiving adoption assistance; and select youth involved in the juvenile justice system. In March 2014, DCH contracted with AMERIGROUP to administer health benefits to the GF 360° managed care program.

Review of Compliance With Standards

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. During the review period, HSAG assessed the CMOs' performance in the following areas related to access to services:

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Emergency and Poststabilization Services

[3-1] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report. March 2015.

HSAG also conducted a re-review of all *Not Met* elements from the prior year's review.

In addition, HSAG performed a focused, case-specific file review of a sample of members enrolled in AMERIGROUP's case management and disease management programs. Appendix A contains a detailed description of HSAG's methodology for conducting the reviews.

Findings

HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about AMERIGROUP's performance in providing quality, accessible, and timely health care and services to its members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Summary Scores

Table 3-1 displays the standards and compliance scores for AMERIGROUP.

Table 3-1—Standards and Compliance Score for AMERIGROUP

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	17	17	17	0	0	100.0%
II	Furnishing of Services	22	22	20	2	0	90.9%
III	Cultural Competence	14	14	14	0	0	100.0%
IV	Coordination and Continuity of Care	21	21	18	3	0	85.7%
V	Coverage and Authorization of Services	25	25	22	3	0	88.0%
VI	Emergency and Poststabilization Services	20	20	20	0	0	100.0%
Varied	Follow-up From Previous Review Findings	5	5	1	4	0	20.0%
	***Total Compliance Score	124	124	112	12	0	90.3%

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

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

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

AMERIGROUP was fully compliant in three of the seven areas of review: Availability of Services, Cultural Competence, and Emergency and Poststabilization Services.

HSAG identified deficiencies in four of the seven areas of review as outlined below:

Furnishing of Services

- AMERIGROUP's network providers did not meet the 90 percent goal for the following timeliness of returning calls after hours.
- AMERIGROUP did not meet geographic access standards for:
  - PCPs
    - Urban areas: Two within eight miles.
    - Rural areas: Two within 15 miles.
  - Specialists
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - General dental providers
    - Rural areas: One within 45 minutes or 45 miles.
  - Dental subspecialty providers
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Mental health providers
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Pharmacies
    - Urban areas: One 24 hours a day, seven days a week within 15 minutes or 15 miles.
    - Rural areas: One 24 hours a day (or has an after-hours emergency phone number and pharmacist on call), seven days a week within 30 minutes or 30 miles.

Coordination and Continuity of Care

- HSAG was unable to identify that AMERIGROUP followed its process for discharge planning as described in its policy as an ongoing process throughout treatment and including member participation whenever possible. HSAG did not find documentation of discharge plans being completed for members being released from an inpatient setting, or of planning between the CMO and inpatient facility.
- AMERIGROUP's process for considering member consent to the care plan was not sufficient to be considered demonstration of members' inclusion as part of the care plan development process.

Coverage and Authorization of Services

- HSAG noted a pharmacy prior authorization request that was not decided within the 24-hour time frame.
- AMERIGROUP's utilization management (UM) policy on notice of action (NOA) for authorization requests that exceeded the required time frames conflicted with operational practice.

- AMERIGROUP did not provide a notice to members if an expedited request was denied.

Follow-Up Reviews

- AMERIGROUP's program evaluation does not ensure that all quality elements are addressed and that they are integrated in terms of overall program impact.
- AMERIGROUP did not demonstrate 90 percent of providers complying with the CMO's clinical practice guidelines.
- AMERIGROUP did not meet all DCH-established performance targets.

Strengths

AMERIGROUP demonstrated the following strengths:

- The CMO ensured that its contracted providers offered access to services for GF members consistent with Georgia Medicaid fee-for-service or commercial members.
- AMERIGROUP served its member population in a culturally competent manner by educating staff and providers on expected conduct. Its cultural competency plan was available in a PowerPoint format, and the full version was located on the AMERIGROUP Web site and was accessible to providers. Member materials were produced in English and Spanish, and each version was available on the Web site. The CMO offered free linguistic services to members and providers as needed.
- AMERIGROUP's Coordination and Continuity of Care program provided for prompt identification of members who were able to benefit from case management services; ensured the comprehensive assessment was completed in a timely manner; and addressed members' physical, behavioral, and psychosocial needs. Member care plans were linked to the comprehensive assessment, and members were stratified by the case manager for monitoring purposes.
- AMERIGROUP demonstrated strong knowledge and overall compliance with the requirements for processing prior authorization requests within the Utilization Management (UM) department. Delegation oversight and monitoring was evidenced with consistent reporting of utilization metrics to the Medical Advisory Committee.
- AMERIGROUP ensured that members were able to access emergency services 24 hours a day, seven days a week for the treatment of emergency medical conditions. The CMO did not deny payment for any emergency services regardless of network status and ensured payment for all triage/screening services. Medical records submitted were reviewed by appropriate clinical staff.

Recommendations for Improvement

Based on the identified deficiencies and opportunities for improvement, HSAG provides the following recommendations:

- Establish a process to reevaluate noncompliant providers on response times for returning calls after-hours until the providers meet the requirements.

- Continue provider recruitment efforts until geographic access standards are met.
- Maintain a formalized discharge planning program that includes a comprehensive evaluation of the member's health needs and identifies the services and supplies required for appropriate care following discharge.
- Ensure policies and procedures are consistent with operational activities including active participation in developing discharge plans for members being released from an inpatient setting and obtaining discharge plans for all members.
- Assess the process for considering member consent to care plan practices and ensure the member is an active participant in the care plan process.
- Review current pharmacy prior authorization processes and ensure turnaround times are calculated and reported accurately.
- Ensure policies and procedures related to notice of action (NOA) timeliness for authorization requests are congruent with daily practice.
- Provide notice to members if an expedited request was denied.
- Evaluate the process for developing the quality program description, workplan, and quality assessment and performance improvement evaluation report to ensure there is a strategic approach for integration and overall program impact. AMERIGROUP should ensure this process integrates its strategy for improving performance measure rates to meet DCH-established performance targets.
- Enhance training, monitoring, and accountability of providers to improve compliance with clinical practice guidelines. AMERIGROUP should continually work with non-compliant providers and establish an internal monitoring process until providers are brought into compliance. This process needs to be more frequent than an annual re-review of non-compliant providers.

Focused Review—Case and Disease Management

Case Management

HSAG performed case-specific file reviews that focused on members in case management. The reviews focused on assessment of the member's needs, the development of the care plan, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The review looked for gaps in the assessment, the care plan, monitoring and follow-up, presentation of the member in a multidisciplinary setting, and the process for handling transitions of care including discharge planning.

Observations

- Members were identified for case management through predictive modeling software (CI3), staff referral, member self-referral, and provider referral. Members were placed in either physical health case management, behavioral health case management, or emergency room case management and stratified based on need.

- The assessment was completed in a timely manner and addressed the member's physical, mental, and psychosocial needs to include cultural issues/concerns and linguistic needs.
- Care plans were developed based on the assessment and identified need. HSAG was unable to identify the member, family, and/or provider being included in the development of the care plan and staff reported that the member's agreement to the care plan showed that the care plan was member-centered. During the review of case files HSAG staff also noted that the care plan did not have a start date, review date(s), and/or date of change/update(s).
- Follow-up needs were identified by the case manager, and members were monitored based on the stratified risk level. Documentation showed that the case manager was in contact with the members and external providers. However, during the case file reviews HSAG noted that the CMO did not use a multidisciplinary team approach.
- During the file review, CMO staff reported that case managers monitor members' status while they are inpatient and consult with the "appropriate parties" to develop the discharge plan. HSAG identified one occurrence in which the case manager conducted a face-to-face visit with a member during the second inpatient stay and continued monitoring the member post-discharge. However, HSAG was unable to identify the following: consistent monitoring of members during inpatient stays; consultation with "appropriate parties" for discharge plan development; or discharge orders for the members being discharged.

Recommendations

- Individualize the care plan to the member. Member, family, and/or provider input should be included during development of the care plan.
- Ensure that the care plan is discussed with the provider(s) and that discussions are documented in the notes.
- Ensure that all care plans have a start date, review date(s), and/or date of change/update(s).
- Establish a multidisciplinary team review process to discuss and review current treatment and treatment options available to the member.
- Ensure monitoring of member status during inpatient stays.
- Ensure coordination of discharge planning with "appropriate parties."
- Ensure that discharge plans are obtained from inpatient stays.

Disease Management

HSAG performed case-specific file reviews which focused on members in disease management. Reviews focused on disease management identification, assessment, education, monitoring, and measureable outcomes.

Observations

- Good effort to use disease management as a mechanism to address HEDIS care gaps was observed for AMERIGROUP members. This was a special initiative directed by AMERIGROUP to its corporate office, which is responsible for disease management. Cases

identified for disease management were contacted in a timely manner for enrollment into the program.

- HSAG noted good improvement in aligning disease management programs with clinical practice guidelines (CPGs), which was identified as an area of concern during the previous audit.
- Education was provided using AMERITIPS; the disease manager also provided verbal education and coaching.
- Documentation indicated that many members had requested help to reach a healthier weight or had verbalized their weight loss goals. However, HSAG did not find evidence that care plan goals were created to help members achieve these goals. HSAG noted some issues with the CMO helping members obtain necessary durable medical equipment (DME). HSAG noted that disease management members experienced both denials and delays in obtaining DME, such as blood pressure cuffs. The CMO had difficulty engaging members beyond one or two contacts. Consequently, HSAG did not see evidence of members achieving goals. The CMO did not have the ability to or did not use metrics to manage and monitor members' progress. For members with diabetes and hypertension, HSAG expected that every discussion would involve blood glucose levels or blood pressure readings. The reviewer noted that lab results, medical record review, etc., appeared to overwrite what may have been self-reported by the member.
- AMERIGROUP had difficulty demonstrating measures of success for the disease management programs.

Recommendations

- Develop care plans that include small, manageable, and measureable steps to help members reach their care plan goals.
- Review and revise the CMO's internal process for providing DME for disease management members so that any barriers preventing members from receiving this equipment are removed.
- Explore strategies to increase member engagement in disease management.
- Incorporate a mechanism to track member indicators such as blood glucose and blood pressure readings over time.
- Develop measures of success for each disease management program.

Georgia Families 360°

The DCH requested that HSAG provide early feedback on AMERIGROUP's processes and procedures for the GF 360° program, which the CMO began administering in March 2014. HSAG limited its review to federal and State requirements covered under external quality review. The findings related to the GF 360° program were not considered in calculating AMERIGROUP's compliance scores because the program had only been in effect since March 2014.

HSAG provides the following observations and recommendations summary:

- The HSAG review team noted substantial resources dedicated to working with both traditional and non-traditional partners including various state agencies, community advocate groups, and

provider communities, to assist with the transition of members from Medicaid FFS to Medicaid managed care.

- AMERIGROUP was not meeting some contractual requirements due to external challenges. The CMO's staff members reported continued challenges concerning member eligibility, accuracy of the member's current PCP, accuracy of current placement information, and accuracy of the identification of the current DFCS case worker. Staff members also reported that during the first 8 to 10 weeks of the program, they were only able to complete health risk screenings for approximately 500 members due to an inability to contact members. At the time of the on-site audit, staff members reported that the health risk screenings were 65 to 70 percent completed. CMO staff members reported that they were working with DCH to revise the contract to better reflect expectations and lessons learned.
- No concerns were identified with receiving the eligibility file and processing members into AMERIGROUP systems. However, HSAG noted during the case file review that some members who were entered in case management on March 3, 2014, were not contacted, and did not have an assessment or a care plan developed by a case manager until July 2014. AMERIGROUP staff members reported that they were grouping members into levels for prioritization of contact and were just beginning to work with level one members. AMERIGROUP staff members reported that there was a 90-day transition period for incoming adoptive assistance members during which they could opt out of the plan; therefore, many of these families may not have benefitted from AMERIGROUP contacting them prior to the 90-day transition period.
- HSAG identified no concerns with AMERIGROUP's implemented process for allowing a 90-day transition period to ensure continuity of care for previously provided authorized services.
- AMERIGROUP is responsible for completing the EPSDT component of the Comprehensive Child and Family Assessment (CCFA) medical assessments, and the remainder of the components are completed or compiled by the agency contracted to complete the CCFA. As contractually written, AMERIGROUP is required to complete the CCFAs; however, staff members reported that CCFA medical assessments were not being completed by AMERIGROUP because it was unable to hold the providers to a standard since they were identified and contracted by the Division of Family and Children Services (DFCS). HSAG noted that the CMO was not meeting the timelines for conducting member health risk screenings within 30 days.
- AMERIGROUP provided documentation that outlined the process for conducting trauma assessments for foster care (FC) members. The policy stated that providers were to complete the trauma assessment within 15 calendar days of the notification to AMERIGROUP of the youth remaining in care beyond the preliminary placement hearing. This 15-calendar-day standard identified in AMERIGROUP's policy did not meet DCH's 10-calendar-day requirement. AMERIGROUP should revise its policy to be consistent with the requirement.
- Regarding AMERIGROUP's process for auto-assigning a PCP, HSAG identified some inconsistencies between staff members' descriptions of this process and AMERIGROUP policy. In addition, the policy as written did not meet the requirement to auto-assign a PCP within two business days. AMERIGROUP should update its policy and procedure in this area.
- AMERIGROUP provided a Scion Dental policy to meet the intent of selection of a primary care dentist for the adoption assistance, juvenile justice, and FC populations; however, HSAG determined that AMERIGROUP did not have its own policy for auto-assignment of a primary care dentist for GF 360° members, and Scion's policy did not identify the required time frames

for auto-assignment. AMERIGROUP should create its own policy to address the required time frames for auto-assignment of a primary care dentist and/or require the delegate to revise its time frames to meet the requirement.

- HSAG identified inconsistencies related to AMERIGROUP's case management policies for GF 360° members. This population is required to have case management for all members; however, AMERIGROUP did not follow the CMO's regular case management process for this population. The policies related to stratifying members need to be clear as to which members follow the regular case management process and which follow the GF 360° case management process.
- HSAG noted that the health risk assessment (HRA) was not comprehensive and primarily captured health history. AMERIGROUP needs to design an HRA for the GF 360° population to include all medical, behavioral, functional, cognitive, and social needs.
- Health risk screenings were not always fully completed. In several cases, questions were skipped, and it was unclear what was and was not completed.
- HSAG saw evidence that the CMO made good attempts to communicate with DFCS and treating providers to obtain medical and dental information.
- HSAG identified that some care plans were being developed before the health risk screening was completed. The care plan should be a dynamic document, but HSAG was not able to determine the start date or the goals of the care plan.

Performance Measures

The DCH annually selects a set of performance measures to evaluate the quality of care and services delivered by contracted CMOs to GF members. The DCH requires that the CMOs' performance measure rates are externally validated. Performance measure validation determines the extent to which plans followed specifications established by DCH for its performance measures when calculating rates. Appendix B includes a detailed methodology for the validation of performance measures.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about AMERIGROUP's performance in providing quality, accessible, and timely care and services to its GF members. Performance measures reflect all three domains of care—quality, access, and timeliness.

AMERIGROUP's Access Measure Results

Table 3-2—Access Measure Results				
	AMERIGROUP			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Children's and Adolescents' Access to Primary Care Providers				
Ages 12–24 Months	97.55%	97.03%	↓	
Ages 25 Months–6 Years	91.44%	91.19%	↔	
Ages 7–11 Years	92.26%	92.93%	↑	
Ages 12–19 Years	90.08%	90.55%	↑	91.59%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	83.84%	81.38%	↓	88.52%
Ages 45–64 Years	90.25%	89.37%	↔	
Ages 65+ Years	NA	NA	--	
Total	84.79%	82.58%	↓	
Oral Health (Annual Dental Visit Rate)				
Ages 2–3 Years	48.50%	48.59%	↔	
Ages 4–6 Years	77.44%	77.19%	↔	
Ages 7–10 Years	79.64%	79.60%	↔	
Ages 11–14 Years	72.39%	72.11%	↔	
Ages 15–18 Years	61.55%	60.92%	↔	
Ages 19–21 Years	35.70%	33.17%	↔	
Total	69.92%	69.67%	↔	69.07%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	41.87%	39.29%	↔	43.62%
Engagement	10.01%	9.62%	↔	18.56%
Annual HIV/AIDS Medical Visit*				
90 Days Apart	--	52.16%	--	
180 Days Apart	--	33.64%	--	
Care Transition—Transition Record Transmitted to Health Care Professional*				
Care Transition—Transition Record Transmitted to Health Care Professional	--	0.00%	--	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.

[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

The access measure results show that greater than 90 percent of AMERIGROUP's population of infants, children, and adolescents accessed care during 2014. AMERIGROUP had some gains in members 7–19 years of age accessing care, and the rate is moving in the right direction.

While over 97 percent of members ages 12–24 months accessed care in 2013, the rate for this population decreased between 2012 and 2013, and the decrease was significant. Access measure results for adults 20–64 years of age showed an overall decline when compared with 2012 rates. Oral health, and initiation and engagement of alcohol and other drug dependence treatment were unchanged during the measurement year.

AMERIGROUP's Children's Health Measure Results

Table 3-3—Children's Health Measure Results				
	AMERIGROUP			2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Well-Child/Well-Care Visits				
First 15 Months of Life: Six or More Visits	63.03%	63.59%	↔	70.70%
Third, Fourth, Fifth, and Sixth Years of Life	68.21%	72.98%	↑	72.26%
Adolescent Well-Care Visits	46.58%	52.55%	↑	49.65%
Immunization and Screening				
Childhood Immunization Status—Combination 3	82.64%	80.56%	↓	82.48%
Childhood Immunization Status—Combination 6*	40.97	41.20%	↔	
Childhood Immunization Status—Combination 10	31.94%	37.73%	↑	
Lead Screening in Children	74.06%	81.71%	↑	81.86%
Appropriate Testing for Children with Pharyngitis	77.44%	78.14%	↔	76.37%
Immunizations for Adolescents—Combination 1 Total	71.43%	78.70%	↑	80.91%

Table 3-3—Children's Health Measure Results				
	AMERIGROUP			2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile (Total)	40.74%	47.92%	↑	47.45%
Counseling for Nutrition (Total)	52.31%	54.63%	↑	54.88%
Counseling for Physical Activity (Total)	39.81%	47.22%	↑	43.29%
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	82.66%	83.78%	↑	85.34%
Developmental Screening in the First Three Years of Life				
Developmental Screening in the First Three Years of Life—Total*	--	34.03%	--	
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	50.75%	50.45%	↓	
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	24.11	23.20%	↓	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Overall, AMERIGROUP's rates related to children's health measures showed improvement over the prior year. Nine measures had statistically significant improvement over their CY 2012 rates. Of these nine improved rates, four were above their respective 2013 performance targets.

AMERIGROUP's Women's Health Measure Results

Table 3-4—Women's Health Measure Results				
	AMERIGROUP			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	2013 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening*	72.09%	69.34%	↓	78.51%
Breast Cancer Screening**	59.22%	75.70%	↑	56.58%
Chlamydia Screening—Ages 16–20 Years	53.93%	50.08%	↓	
Chlamydia Screening—Ages 21–24 Years	68.86%	64.04%	↓	
Chlamydia Screening—Total	56.98%	52.81%	↓	58.40%
Human Papillomavirus Vaccine for Female Adolescents***	16.71%	21.53%	--	22.27%
Prenatal Care and Birth Outcomes				
Timeliness of Prenatal Care	84.72%	75.92%	↓	90.39%
Postpartum Care	59.49%	60.78%	↑	71.05%
Cesarean Rate for Nulliparous Singleton Vertex *A lower rate indicates better performance*	18.14%	17.13%	↔	
Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance*	29.76%	29.60%	↔	28.70%
Rate of Infants With Low Birth Weight (Rate per 100) *A lower rate indicates better performance*	8.45%	8.84%	↔	8.10%
Behavioral Health Risk Assessment for Pregnant Women***	--	1.43%	--	
Elective Delivery*** *A lower rate indicates better performance*	--	5.11%	--	2.00%
Antenatal Steroids***	--	0.79%	--	
Frequency of Ongoing Prenatal Care				
< 21 Percent	10.65%	15.14%	↓	
21–40 Percent	4.17%	8.03%	↓	
41–60 Percent	7.64%	7.11%	↔	
61–80 Percent	11.11%	16.74%	↓	
81+ Percent	66.44%	52.98%	↓	72.99%

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
***This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Overall, AMERIGROUP demonstrated poor results related to women's health measures. Many measures had statistically significant declines in performance. Both the *Timeliness of Prenatal Care* and the *Frequency of Ongoing Prenatal Care* measures declined meaning that women are not receiving prenatal care as soon as is recommended, and approximately half of pregnant women are not receiving the recommended ongoing prenatal care visits. While the *Postpartum Care* measure rate improved slightly but significantly, approximately 40 percent of women who delivered a baby did not receive a postpartum visit consistent with clinical practice guidelines.

AMERIGROUP's Chronic Conditions Health Measure Results

Table 3-5—Physical Health Conditions: Chronic Conditions Measure Results				
	AMERIGROUP			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	79.37%	80.50%	↔	87.01%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	53.58%	57.62%	↔	41.68%
HbA1c Control (<8.0)	38.94%	35.11%	↔	48.72%
HbA1c Control (<7.0)	30.56%	27.71%	↔	36.72%
Eye Exam (Retinal) Performed	48.25%	43.97%	↓	52.88%
LDL-C Screening	73.21%	73.23%	↔	76.16%
LDL-C Control (<100 mg/dL)	27.29%	26.95%	↔	35.86%
Medical Attention for Nephropathy	74.38%	73.94%	↔	78.71%

Table 3-5—Physical Health Conditions: Chronic Conditions Measure Results				
	AMERIGROUP			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Blood Pressure Control (<140/80 mm/Hg)	32.61%	30.85%	↔	39.10%
Blood Pressure Control (<140/90 mm/Hg)	55.07%	53.19%	↔	63.50%
Diabetes Short-Term Complications Admission Rate†				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months) *A lower rate indicates better performance*	--	13	--	62.74
Respiratory Conditions				
Use of Appropriate Medications for People With Asthma				
5–11 Years	90.32%	91.72%	↔	
12–18 Years	88.69%	87.32%	↔	
19–50 Years	69.17%	60.68%	↔	
51–64 Years	NA	NA	--	
Total	89.03%	88.79%	↔	90.56%
Young Adult Asthma Admission Rate*				
Young Adult Asthma Admission Rate *A lower rate indicates better performance*	--	8.93	--	
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate†				
Per 100,000 Member Months (Total)	76.56	37	--	559.03
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate†				
Per 100,000 Member Months (Total)	29.64	6	--	380.70
Controlling High Blood Pressure				
Controlling High Blood Pressure	38.72%	48.36%	↑	57.52%
Adult BMI Assessment				
Adult BMI Assessment	62.70%	79.53%	↑	70.60%

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH

CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.
† The reporting metric for this measure has changed from 100,000 members to 100,000 member months. Therefore, trending comparisons with CY 2012 rates were not performed for all CMOs. It would also be inappropriate to compare the CMO CY 2013 rates with the performance target which was developed based on the prior year's reporting metric.

Regarding measures related to chronic conditions, the CMO's CY 2013 rates changed very little when compared to CY 2012 rates.

AMERIGROUP's Behavioral Health Measure Results

Table 3-6—Behavioral Health Measure Results				
	AMERIGROUP			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	CY 2013 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	42.32%	43.12%	↔	52.48%
Continuation and Maintenance Phase	58.15%	59.22%	↔	63.11%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	45.80%	50.85%	↑	69.57%
Follow-Up Within 30 Days	67.29%	72.40%	↑	84.28%
Antidepressant Medication Management				
Effective Acute Phase Treatment	54.16%	48.76%	↓	52.74%
Effective Continuation Phase Treatment	36.81%	34.39%	↔	37.31%
Screening for Clinical Depression and Follow-Up Plan*				
Screening for Clinical Depression and Follow-Up Plan	--	0.75%	--	
Adherence to Antipsychotics for Individuals With Schizophrenia*				
Adherence to Antipsychotics for Individuals With Schizophrenia	--	45.76%	--	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

AMERIGROUP did see statistically significant improvement over the CY 2012 rates for both *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 7 Days* and *Follow-up Within 30 Days* measures; however, the CMO did not meet the State CY 2013 goal for any behavioral health measure.

AMERIGROUP's Medication Management Measure Results

Table 3-7—Medication Management Measure Results				
	AMERIGROUP			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	CY 2013 Performance Target[3]
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions				
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions *A lower rate indicates better performance*	41.48%	40.94%**	↑	41.51%
Annual Monitoring for Patients on Persistent Medications				
Total	89.32%	88.42%	↔	88.55%
Medication Management for People With Asthma*				
50% Compliance—Total	43.64%	47.81%	↔	
75% Compliance—Total	20.07%	22.59%	↔	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Regarding measures related to medication management, one rate showed statistically significant improvement over the CY 2012 rate and met the CY 2013 performance goal.

Strengths

HSAG noted the following strengths in AMERIGROUP's CY 2013 performance measure rates:

- All rates reported by AMERIGROUP in CY 2013 were valid.
- Based on their CY 2013 performance, AMERIGROUP met nine performance targets (see Table 3-8). AMERIGROUP had half of its measures meeting the performance targets in the Children's Health domain.

Table 3-8—Number of Performance Targets Met by AMERIGROUP	
Measure Set	**Targets Met**
Access to Care	1
Children's Health	5
Women's Health	1
Chronic Conditions	1
Behavioral Health	0
Medication Management	1
Total	9

- AMERIGROUP showed improvement in care provided to its adolescent population with more adolescents accessing care than the prior year and more receiving the recommended immunizations.

Opportunities for Improvement

HSAG encourages the AMERIGROUP to perform the following:

- AMERIGROUP should pay special attention to the Women's Health measures. The CMO had six measures that had a statistically significant decline in performance. Four of the declining measures for AMERIGROUP are in the Prevention and Screening category.
- AMERIGROUP should focus quality improvement efforts on the *Comprehensive Diabetes Care* measure and identify opportunities to align provider's compliance with clinical practice guidelines and case management care plans and goals as an overarching strategy for improvement.
- AMERIGROUP should explore opportunities to solicit member feedback, through focus groups as an example, in areas of poor performance, such as women's health and chronic disease.

Performance Improvement Projects

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

HSAG reviews each PIP using CMS' validating protocol to ensure that the CMOs design, conduct, and report PIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DCH and interested parties can have confidence in reported improvements that result from a PIP.

PIP Validation Findings

HSAG organized, aggregated, and analyzed AMERIGROUP's PIP data to draw conclusions about the CMO's quality improvement efforts. The PIP validation process evaluated both the technical methods of the PIP (i.e., the study design) and the 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. The results are presented in Table 3-9. Appendix C provides additional detail on the methodology HSAG used for validating the PIPs.

Table 3-9—Performance Improvement Project Validation Scores for AMERIGROUP Community Care

PIP	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Validation Status
Adolescent Well-Care Visits	98%	100%	*Met*
Annual Dental Visits	71%	82%	*Not Met*
Appropriate Use of ADHD Medication	92%	91%	*Not Met*
Avoidable Emergency Room Visits	74%	73%	*Not Met*
Childhood Immunizations—Combo 10	98%	100%	*Met*
Childhood Obesity	94%	93%	*Not Met*
Comprehensive Diabetes Care	86%	86%	*Not Met*
Member Satisfaction	93%	100%	*Met*
Postpartum Care	88%	86%	*Not Met*
Provider Satisfaction	90%	86%	*Not Met*

Three of the 10 PIPs, *Adolescent Well-Care Visits, Childhood Immunizations—Combo 10*, and *Member Satisfaction* received an overall Met validation status. The remaining seven PIPs received a Not Met score for one or more critical evaluation elements, which resulted in a Not Met validation status.

Table 3-10 displays the combined validation results for all 10 AMERIGROUP PIPs validated. This table illustrates the CMO's application of the PIP process and its success in implementing all 10 projects. Each activity was composed of individual evaluation elements scored as *Met* or *Not Met*. Elements receiving a *Met* score satisfied the necessary technical requirements for a specific element. The validation results presented in Table 3-10 show the percentage of applicable evaluation elements that received a *Met* score by activity. Additionally, HSAG calculated an overall percentage of *Met* scores across all activities for all 10 PIPs.

Table 3-10—Performance Improvement Project Validation Results for AMERIGROUP Community Care (N=10 PIPs)

PIP Stage	Activity	Percentage of Applicable Elements	
		Met	*Not Met*
Design	Appropriate Study Topic	95% (54/57)	5% (3/57)
	Clearly Defined, Answerable Study Question(s)	100% (20/20)	0% (0/20)
	Correctly Identified Study Population	96% (27/28)	4% (1/28)
	Clearly Defined Study Indicator(s)	100% (58/58)	0% (0/58)
	Valid Sampling Techniques (if sampling was used)	100% (42/42)	0% (0/42)
	Accurate/Complete Data Collection	93% (77/83)	7% (6/83)
Design Total		**97% (278/288)**	**3% (10/288)**
Implementation	Sufficient Data Analysis and Interpretation of Results	90% (78/87)	10% (9/87)
	Appropriate Improvement Strategies	62% (23/37)	38% (14/37)
Implementation Total		**81% (101/124)**	**19% (23/124)**
Outcomes	Real Improvement Achieved	63% (25/40)	38% (15/40)
	Sustained Improvement Achieved	100% (2/2)	0% (0/2)
Outcomes Total		**64% (27/42)**	**36% (15/42)**
Percentage of Applicable Evaluation Elements Scored *Met*		**89% (406/454)**	

Overall, 89 percent of the evaluation elements across all 10 PIPs received a *Met* score. AMERIGROUP demonstrated strong performance in the Design stage; however, the CMO was less successful in the Implementation and Outcomes stages.

Design

AMERIGROUP met 97 percent of the requirements across all 10 PIPs for the six activities within the Design stage. The technical design of each PIP was sufficient to measure and monitor PIP outcomes. The solid foundation of the PIPs allowed the CMO to progress to the next stage of the PIP process.

Implementation

AMERIGROUP met 81 percent of the requirements for the two activities within the Implementation stage. The most common errors in the Sufficient Data Analysis and Interpretation of Results activity were incorrect, incomplete, or inconsistent documentation of the findings in the narrative interpretation. Additionally, the CMO reported inaccurate data components and performed statistical testing incorrectly in some of the PIPs. In the Appropriate Improvement Strategies activity, AMERIGROUP did not document sound and comprehensive causal/barrier analysis processes in most of its PIPs. The documented improvement strategies did not all appear to be system changes that were likely to induce long-term change in the study indicators. The CMO also did not consistently document that it revised interventions in response to the lack of statistically significant improvement in the study indicators.

Outcomes

This year, all 10 PIPs were evaluated for achieving statistically significant improvement over baseline. Four PIPs (*Adolescent Well-care Visits*, *Childhood Immunizations—Combo 10*, *Childhood Obesity*, and *Member Satisfaction*) achieved statistically significant improvement over baseline across all study indicators for the current measurement period. The *Annual Dental Visits* PIP achieved statistically significant improvement from baseline to Remeasurement 1 for two of the three study indicators. Only two of the 10 PIPs, *Childhood Immunizations—Combo 10* and *Childhood Obesity*, progressed to the point of being assessed for sustained improvement. Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the results of the most current measurement period must reflect improvement when compared to baseline results. Both PIPs assessed for sustained improvement achieved it for all study indicators during the current measurement period.

PIP-Specific Outcomes

Adolescent Well-Care

Table 3-11—Performance Improvement Project Outcomes for *Adolescent Well-Care Visits*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
The percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	43.9%	46.6%	52.5%	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.

For AMERIGROUP's *Adolescent Well-Care Visits* PIP, the rate of adolescents with at least one comprehensive well-care visit increased by 5.9 percentage points from Remeasurement 1 to Remeasurement 2. While the increase from Remeasurement 1 to Remeasurement 2 was not statistically significant, the Remeasurement 2 study indicator rate was a statistically significant improvement over baseline. The Remeasurement 2 rate exceeded the DCH 2013 target rate of 49.7 percent and was between the national Medicaid HEDIS 2012 50th and 75th percentiles.

A critical analysis of the CMO's improvement process for this PIP revealed that AMERIGROUP analyzed barriers to improving the *Adolescent Well-Care Visits* study indicator rate through multidisciplinary discussion, brainstorming, and review of rates. Identified barriers were summarized in an updated fishbone diagram. Barriers that the CMO believed it could realistically impact were identified as priorities: transportation issues, lack of awareness about when members are due for a well-care visit, and lack of member and provider incentives.

The CMO directed system-based interventions toward members and providers during the second remeasurement period to address priority barriers:

- Engagement and support of high-volume providers seeking the NCQA-Patient- Centered Medical Home (PCMH) Recognition; monitoring provider participation in the Provider Quality Incentive Program (PQIP) .
- My Health Direct program, which enabled internal member service associates to schedule well-visit appointments for noncompliant members.
- "Clinic Days" educational member events to promote completion of well-care visits.
- Member outreach via live telephone calls to noncompliant members to educate and offer transportation assistance for well-care visits.
- Transportation assistance for members due for a well-care visit.

AMERIGROUP documented quantitative, intervention-specific evaluation results as part of the PIP and used evaluations of effectiveness to guide decisions about continuing, revising, or discontinuing the interventions. The CMO planned revisions to ongoing interventions aimed at achieving further improvement following the second remeasurement.

Annual Dental Visits

Table 3-12—Performance Improvement Project Outcomes for *Annual Dental Visits*

Study Indicator	Baseline (10/1/2011–9/30/2012)	Remeasurement 1 (10/1/2012–9/30/2013)	Sustained Improvement^
1. The percentage of EPSDT eligible members ages 1–20 who received any dental services during the measurement period (CMS 416 12A).	54.2%	56.6%↑*	NA
2. The percentage of EPSDT eligible members ages 1–20 who received preventive dental services during the measurement period (CMS 416 12B).	51.1%	49.49%↓*	NA
3. The percentage of EPSDT eligible members ages 6–9 who received preventive dental services during the measurement period (CMS 416 12D).	22.4%	26.9%↑*	NA

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

For first remeasurement of the *Annual Dental Visits* PIP, AMERIGROUP achieved statistically significant improvement over baseline rates for Study Indicators 1 and 3, but there was a statistically significant decline in the rate of Study Indicator 2 at Remeasurement 1. The rate for Study Indicator 2 (preventive dental services) fell below the baseline rate and continued to fall below the DCH 2013 target rate of 58.0 percent.

A critical analysis of the CMO's quality improvement process and strategies for this PIP identified several factors which likely led to the mixed study indicator performance at the second remeasurement. While AMERIGROUP completed an annual causal/barrier analysis and documented some evaluation of intervention effectiveness, the PIP documentation suggested several deficiencies in the quality improvement process.

AMERIGROUP's internal interdisciplinary team discussed baseline study indicator results, reviewed further data analysis, and conducted process reviews to identify barriers, which were summarized using a fishbone diagram. The CMO identified priority areas for intervention by considering which barriers could be most effectively impacted with known resources.

While some interventions were strongly linked to the causal/barrier analysis and study indicators, other interventions were unlikely to have a significant impact on improvement. The stronger, system-based strategies included mobile dental units accompanied by member outreach for

appointment scheduling and Health Promotion coordinator visits with providers to support referrals for annual dental services. Other documented interventions, such as robotic calls to members and text messaging, may increase awareness of the importance of annual dental visits, but they would not address barriers to making and keeping dental appointments.

The CMO did not document any revision of the improvement strategies to address the statistically significant decline at Remeasurement 1 demonstrated by one of the three study indicators. Approximately six months had passed between the completion of the first remeasurement and the submission of the PIP for validation; during that time, the CMO should have conducted further drill-down analysis to determine why one study indicator declined while the other two indicators improved. The CMO should have documented follow-up analyses and implementation of new or revised interventions to address the performance decline.

The PIP documentation suggested some limitations to AMERIGROUP's methods for evaluating the effectiveness of its interventions. The CMO documented that it used the HEDIS *Annual Dental Visit* (ADV) measure as an interim, proxy measure for evaluating the effectiveness of the PIP's interventions. While the ADV measure may be similar to Study Indicator 1 (any dental service visit), it is substantially different from Study Indicators 2 (preventive dental visit) and 3 (receiving a dental sealant), which are both preventive dental services. Given the mixed performance of the study indicators, it is clear that interventions that may impact some of the study indicators will not necessarily impact all.

Appropriate Use of ADHD Medications

Table 3-13—Performance Improvement Project Outcomes for *Appropriate Use of ADHD Medications*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
1. 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%	43.1%	NA
2. 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%	59.2%	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.

Neither study indicator in the *Appropriate Use of ADHD Medications* PIP achieved statistically significant improvement over baseline at Remeasurement 2. While the rates of Study Indicator 1 (initiation phase follow-up visit) and Study Indicator 2 (continuation phase follow-up visit) increased from Remeasurement 1 to Remeasurement 2, the improvements were not statistically significant, and the rates of both study indicators remained below baseline. The Remeasurement 2 rates for Study Indicators 1 (initiation) and 2 (continuation) fell below the 2013 DCH target rates of 52.5 percent and 63.1 percent, respectively. In comparison with the national Medicaid HEDIS 2012 rates, the Remeasurement 2 rate for Study Indicator 1 fell between the 50th and 75th percentiles, and the rate for Study Indicator 2 was between the 75th and 90th percentiles.

An analysis of the CMO's improvement strategy for this PIP identified weaknesses which may have led to the lack of statistically significant improvement at Remeasurement 2. While the desired improvement was not achieved at the second remeasurement, the CMO documented follow-up analyses and revised improvement strategies in response to the insufficient improvement.

AMERIGROUP's interdisciplinary team discussed interim results and updated the fishbone analysis to identify barriers for the Remeasurement 2 period.

The CMO continued five provider- and member-focused interventions from the previous measurement period including e-mail of HEDIS report cards, face-to-face visits with providers, member focus groups, appointment reminder calls, and support of providers seeking the NCQA Patient-Centered Medical Home (PCMH) Recognition. During the current remeasurement period, AMERIGROUP initiated one new intervention in which a nurse practice consultant began face-to-face visits with low-performing providers. The face-to-face visits included review of the HEDIS report cards, sharing best practices to improve medication follow-up visit rates, and further follow-up with providers on specific members identified as having a "first fill" of ADHD medication.

The CMO acknowledged in the PIP Summary Form that the study indicator results demonstrated a lack of improvement and the need to redirect their improvement strategies. As a result, the CMO documented a new incentive program that was initiated in response to the lack of significant improvement during the Remeasurement 2 period. AMERIGROUP is piloting an incentive program for appointment schedulers to ensure that the ADHD medication follow-up appointments are scheduled and completed in the recommended time frames.

While AMERIGROUP documented evaluation processes and results for some interventions, the CMO stated that three interventions were continued without evaluation of effectiveness. Based on the lack of improvement over baseline demonstrated by the study indicators, it is clear that the interventions were not effectively addressing all of the critical barriers necessary for improvement in outcomes.

Childhood Immunizations—Combo 10

Table 3-14—Performance Improvement Project Outcomes for *Childhood Immunizations—Combo 10*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
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%↑*	37.7%	Yes

↑* Designates statistically significant improvement 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.

AMERIGROUP achieved sustained statistically significant improvement over the baseline rate at the second remeasurement for the *Childhood Immunizations—Combo 10* PIP. The Remeasurement 2 rate represented an increase of 5.8 percentage points over the Remeasurement 1 rate and an increase of 27.3 percentage points from baseline to Remeasurement 2. The Remeasurement 2 rate also surpassed the 90th percentile of the national Medicaid HEDIS 2012 rates.

A critical review of the quality improvement process used for this PIP identified the following:

- AMERIGROUP's team, including the medical director, medical management, quality management, and provider relations departments, reviewed data analysis results to identify barriers, which were summarized in an updated fishbone diagram. The team developed interventions based on the outcomes from the fishbone analysis and further discussion to determine priority barriers that could be most effectively impacted by the CMO.
- In CY 2013, AMERIGROUP continued member- and provider-focused interventions based on evaluation results and the improvement demonstrated during the previous measurement period. The CMO continued the PQIP provider incentive program for improving quality scores based partly on immunization rates; the distribution of corrective action plans to low-performing, high-volume providers; Health Promotion coordinator face-to-face visits with providers; live member outreach calls; "Clinic Days" events with member incentives to facilitate immunizations for noncompliant members; and the My Health Direct program, which enables internal member service associates to schedule well-visit appointments for noncompliant members.
- AMERIGROUP documented the revision of several interventions based directly on results of evaluations of effectiveness. For example, an evaluation of the "Clinic Days" events schedule determined that the event attendance rate varied by season; therefore, the CMO planned future events to occur during months with historically higher event attendance so that a greater percentage of "Clinic Days" appointments would be kept, leading to a greater number of

members receiving needed immunizations. Additionally, the CMO identified several planned revisions to its member outreach call intervention, based on evaluation results, which included increasing the gift cards available as member incentives, developing a new outreach database to track due/past-due members, and measuring the volume of appointments scheduled as part of member outreach associates' performance reviews.

Childhood Obesity

Table 3-15—Performance Improvement Project Outcomes for *Childhood Obesity*

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)	Remeasurement 4 (1/1/13–12/31/13)	Sustained Improvement^
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%↑*	47.9%↑*	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%	54.6%	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%	47.2%↑*	Yes

↑* Designates statistically significant improvement 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.

At Remeasurement 4, the AMERIGROUP *Childhood Obesity* PIP sustained statistically significant improvement over the baseline rate for all three study indicators. The Remeasurement 4 rates for Study Indicators 1 (BMI percentile documentation) and 3 (evidence of physical activity counseling) exceeded the 2013 DCH Target rates of 47.5 percent and 43.3 percent, respectively, while the rate for Study Indicator 2 (evidence of nutrition counseling) fell just below the 2013 DCH Target rate of 54.9 percent. In comparison to the national HEDIS 2012 rates, the rates for Study Indicators 1 and 3

were between their respective 50th and 75th percentiles, and the rate for Study Indicator 2 fell below the 50th percentile.

A critical review of AMERIGROUP's quality improvement process and improvement strategies for this PIP suggested that the CMO's causal/barrier analysis, evaluation of intervention effectiveness, and appropriate revision of improvement strategies helped to achieve sustained improvement across all three study indicators.

While some of the CMO's interventions clearly impacted the study indicators, the CMO continued to implement other interventions that were not directly related to the PIP's provider-based outcomes. Even though study indicators for this PIP were provider driven, AMERIGROUP continued its two-pronged approach, targeting both member and provider interventions. The study indicators, measuring provider documentation of BMI percentile and nutrition and physical activity counseling during a well-care visit, will not be impacted simply by ensuring members are compliant with well-care visits. The documented member-focused interventions that clearly will not impact the study indicators were:

- "Clinic Days" educational member events to promote completion of well-care visits.
- Transportation assistance for members due for a well-care visit.
- Text messages sent to member households via cellular phones provided by SafeLink.

To successfully impact the PIP's targeted outcomes, the CMO should work to improve physician compliance with these activities during well-care visits. AMERIGROUP's documented interventions that were physician-focused and could be directly linked to the study indicator performance through intervention-specific evaluation of effectiveness were:

- Distribution of corrective action plans (CAP) to physicians with noncompliant Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) medical records.
- Engagement and support of high-volume providers seeking the NCQA PCMH Recognition and monitoring through the PQIP provider incentive program.
- In-person consultation of Health Promotion coordinators with providers including review of the HEDIS report card showing performance on the study indicators and distribution of a HEDIS billing guide, which provided the correct coding for BMI documentation, nutrition counseling, and physical activity counseling.

Comprehensive Diabetes Care

Table 3-16—Performance Improvement Project Outcomes for *Comprehensive Diabetes Care*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
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%	27.7%	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%	27.0%	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%	53.2%	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.

None of the study indicators for the Comprehensive Diabetes Care PIP achieved statistically significant improvement over baseline rates at Remeasurement 2. The rates of all three study indicators declined from Remeasurement 1 to Remeasurement 2. Additionally, the rates of Study Indicators 1 (HbA1c control < 7.0%) and 3 (BP Control < 140/90 mmHg) remained below baseline at Remeasurement 2. The Remeasurement 2 rates for all three study indicators fell below the 25th percentiles of the national HEDIS 2012 rates and below the CY 2013 DCH targets of 36.7 percent (HbA1c control < 7.0%), 35.9 percent (LDL-C control < 100 mg/ml), and 63.5 percent (BP Control < 140/90 mmHg).

Through the critical analysis of AMERIGROUP's quality improvement processes and strategies, HSAG identified a number of deficiencies that contributed to the lack of performance improvement in the Comprehensive Diabetes Care PIP.

The CMO documented that its multidisciplinary team completed a causal/barrier analysis for the Remeasurement 2 period by reviewing and discussing prior results, summarizing barriers in a fishbone diagram. Although the Remeasurement 1 results did not demonstrate any statistically significant improvement, the CMO did not identify any new barriers in the fishbone diagram for Remeasurement 2. Consequently, the interventions implemented during the Remeasurement 2 period included only slight revisions from those implemented during the Remeasurement 1 period despite the lack of improvement.

In addition to continuing interventions during the Remeasurement 2 period that did not have a significant impact on outcomes at Remeasurement 1, the CMO implemented interventions that appeared to reach a relatively small proportion of the eligible member population and often targeted diabetic screening outcomes rather than the diabetic control outcomes measured by the PIP's study indicators. While increasing the number of screened members may help to improve the study

indicator rates, interventions need to go beyond simply getting members in for screening in order to significantly improve the rates of members with HbA1c, LCL-C, and BP levels in control. Some of the interventions which focused solely on screening, that did not directly impact the study indicators included:

- Robotic calls to diabetic members to remind them of diabetic screenings.
- Member incentive program that allowed for the distribution of $25 for every member who received an HbA1c, LDL-C, and BP screening.
- Engagement and support of high-volume providers seeking the NCQA recognized Patient Center Medical Home certification and monitoring through the PQIP provider incentive program.

Below are the member- and provider-focused interventions that AMERIGROUP implemented which could clearly impact members' control of their diabetes:

- Distributed HEDIS report cards showing providers' performance on HEDIS diabetes control measures.
- Enrolled members identified as having uncontrolled diabetes into nurse-led case management, disease management, and quality management programs.
- Held diabetes events targeting noncompliant members to provide nutritional counseling, blood pressure screening, LDL screening, and additional educational materials.

While the CMO's improvement strategies for the Remeasurement 2 period had a number of flaws, as described above, AMERIGROUP documented planned revisions for CY 2014 that were based on the study indicator findings and results of intervention-specific evaluations of effectiveness. The CMO acknowledged the lack of improvement to date and reported that they would be revisiting the causal/barrier analysis process and seeking out new improvement strategies to improve diabetes control in their members.

Avoidable Emergency Room Visits

Table 3-17—Performance Improvement Project Outcomes for *Avoidable Emergency Room Visits*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
1. 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 Healthcare of Atlanta facilities in the Atlanta region.	22.8%	23.3%	23.5%	NA
Study Indicator	**Baseline Period (1/1/13–12/31/13)**	**Remeasurement 1 (1/1/14–12/31/14)**	**Remeasurement 2 (1/1/15–12/31/15)**	**Sustained Improvement**
2. 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 selected hospitals in the CMO's expansion population.	22.3%			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.

In CY 2013, for the *Avoidable Emergency Room Visits* PIP, AMERIGROUP collected Remeasurement 2 data for Study Indicator 1 (the percentage of ER visits for avoidable diagnoses in select facilities in the Atlanta region) and collected baseline data for a new Study Indicator 2, which measured the percentage of ER visits for avoidable diagnoses in select hospitals in the CMO's expansion population. For the second remeasurement of Study Indicator 1, AMERIGROUP did not demonstrate statistically significant improvement over baseline; the rate increased from Remeasurement 1 to Remeasurement 2 by 0.2 percentage point. The Study Indicator 1 rate remained above baseline and also exceeded the DCH 2013 target rate of 21.69 percent. Because the avoidable ER visits rate was an inverse study indicator, for which a lower rate is better, the increase from Remeasurement 1 to Remeasurement 2 demonstrated a decline in performance.

AMERIGROUP reported baseline data for Study Indicator 2 (the percentage of ER visits for select avoidable diagnoses at select facilities in the expansion population). The baseline rate for Study Indicator 2 was 22.3 percent, which was below (better than) the DCH 2013 target rate of 23.38 percent.

The critical analysis of AMERIGROUP's quality improvement process and strategies for the *Avoidable Emergency Room Visits* PIP suggested several areas that need to be addressed in order to achieve statistically significant improvement in the avoidable ER visits rate. The CMO documented the multidisciplinary team that was involved in the quality improvement process and the cause and effect diagram that was used to summarize identified barriers. Team discussions included a review of prior study indicator results and considered all potential barriers. Priority barriers were identified based on whether they could be realistically impacted by the CMO. The interventions, targeting providers and members, addressed priority barriers such as lack of member knowledge about alternatives to ER care, lack of an established medical home for members, provider after-hours accessibility, and provider protocols for handling after-hours care needs and ER visit follow-up. Specific interventions implemented during CY 2013 were:

- Case management program for ER "ultra-utilizers."
- On-site visits to 20 PCPs who have high-utilizing members and providing materials on the value of PCMHs.
- Member outreach via automated telephone calls and mailings.

Based on the PIP documentation submitted for validation, the CMO did not tailor the interventions to specifically target the expansion population for the new Study Indicator 2. It appeared that the interventions were meant to address both the Metro Atlanta member population (Study Indicator 1) and the expansion population (Study Indicator 2).

Although AMERIGROUP implemented some system changes identified through causal/barrier analysis, such as the case management program for ER "ultra-utilizers" and on-site PCP visits promoting PCMHs, Study Indicator 1 did not demonstrate improvement and instead demonstrated a trend of performance decline at Remeasurement 1 and Remeasurement 2. The CMO documented that each intervention was individually effective but, considering the PIP results to date, the interventions did not result in any improvement in the study indicator rate. This pattern suggests that the causal/barrier analysis was incomplete. Either the CMO did not identify all of the critical barriers to improving the avoidable ER visits rate or the interventions implemented to date were not sufficient to address the barriers.

Member Satisfaction

Table 3-18—Performance Improvement Project Outcomes for *Member Satisfaction*

Study Indicator	Baseline (2/22/12–5/9/13)	Remeasurement 1 (2/7/14–5/2/14)	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%	90.7%↑*	NA

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

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.

AMERIGROUP achieved statistically significant improvement over baseline at Remeasurement 1 for the *Member Satisfaction* PIP. The study indicator rate from baseline to the first remeasurement increased by 4.9 percentage points.

A critical assessment of the quality improvement strategies applied to the *Member Satisfaction* PIP suggested some strengths and weaknesses in AMERIGROUP's approach. The CMO's quality improvement team reviewed processes, prior survey results, and additional data analyses, discussing all potential barriers to improving member satisfaction. The results of the causal/barrier analysis were summarized in an updated fishbone diagram.

The CMO used a three-pronged improvement strategy, implementing interventions focused on system changes, providers, and members. The CMO implemented 10 ongoing interventions to address physician awareness of member satisfaction, timeliness of care, member transportation issues, lack of access in rural areas, and member understanding of benefit coverage. Two new interventions implemented during the Remeasurement 1 period focused on improving provider understanding and awareness of member issues. To address lack of provider awareness of member dissatisfaction, the CMO presented member satisfaction results to all Provider Relations staff in an effort to help providers better understand and advocate for member needs. Additionally, AMERIGROUP distributed a provider tip sheet that covered the most commonly denied prescriptions and acceptable formulary replacements.

Although AMERIGROUP's causal/barrier analysis process appeared to be sound and the CMO implemented system changes that resulted in statistically significant improvement at the first remeasurement, the PIP documentation did not provide details on how interventions were evaluated for effectiveness. The CMO also did not describe how successful interventions would be standardized to promote and sustain further improvement in member satisfaction.

Postpartum Care

Table 3-19—Performance Improvement Project Outcomes for *Postpartum Care*

Study Indicator	Baseline (1/1/12–12/31/12)	Remeasurement 1 (1/1/13–12/31/13)	Sustained Improvement^
The percentage of deliveries of live births by members that were followed by a postpartum visit on or between 21 and 56 days after delivery.	59.5%	60.8%	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.

For the *Postpartum Care* PIP, there was a non-statistically significant increase in the study indicator rate of 1.3 percentage points from baseline to Remeasurement 1. The Remeasurement 1 rate fell below the 2013 DCH target rate of 71.1 percent. In comparison with the national HEDIS 2012 rates, the study indicator rate fell between the 25th and the 50th percentiles.

A critical review of the quality improvement processes and strategies used by AMERIGROUP for this PIP revealed several shortcomings that may have prevented the CMO from achieving the desired improvement in outcomes.

The CMO's quality improvement team reviewed baseline PIP results and identified priority barriers that could be realistically impacted during their causal/barrier analysis. The team documented the factors impacting postpartum care rates using a key driver diagram. While the diagram included a global goal and SMART Aim, the documented aim required revision in order to truly be SMART (specific, measurable, achievable, realistic, and time-bound). The key drivers documented by AMERIGROUP were eligibility issues, postpartum program design, quality improvement data processes, Medicaid administration and payment procedures, provider practices, and member knowledge and behaviors. The CMO's documented SMART Aim was "To statistically significantly improve the percentage of Medicaid eligible women who receive postpartum care within 21–56 days after their live birth." The SMART Aim should be revised to specify the amount of improvement in the postpartum rate being sought and should provide a date by which the improvement will be achieved.

To address the identified key drivers, AMERIGROUP implemented the following interventions:

- Member outreach via phone calls and text to schedule postpartum care visits
- Pilot incentive program for OB provider schedulers to ensure completion of postpartum visits among eligible members
- Member incentive program for completion of postpartum visit
- Nurse consultant visits to low-performing providers to share best practices and facilitate improvement of postpartum visit rate

In response to the lack of statistically significant improvement in the study indicator rate and intervention evaluation results, the CMO documented planned intervention specific revisions for the following measurement period. The revisions include contracting a new vendor to complete telephone outreach to members due for a postpartum visit, seeking enhanced member contact information through an outside vendor, and incorporating appointment scheduling rate into the performance reviews of member outreach associates.

While the CMO documented the use of intervention effectiveness evaluations to determine revisions needed to achieve the desired improvement in outcomes, the PIP documentation lacked detail on the methods used to evaluate some of the interventions and quantitative evaluation results were not documented for all interventions.

Provider Satisfaction

Table 3-20—Performance Improvement Project Outcomes for *Provider Satisfaction*

Study Indicator	Baseline (8/1/12–11/30/12)	Remeasurement 1 (7/1/13–9/30/13)	Sustained Improvement^
The percentage of providers who respond, "Very satisfied" or, "Somewhat satisfied" to Q48 – "Please rate your overall satisfaction with Amerigroup."	79.6%	84.2%	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.

In AMERIGROUP's *Provider Satisfaction* PIP, there was a non-statistically significant increase of 4.6 percentage points in the study indicator rate from baseline to Remeasurement 1.

The CMO's interdisciplinary quality improvement team conducted a causal/barrier analysis for the Remeasurement 1 period, utilizing both a cause and effect diagram and a key driver analysis. All identified barriers were discussed by the team, and barriers believed to be primarily under the CMO's control were identified as priorities. Priority barriers included claims payment accuracy, lack of staff support to the provider community, lack of responsiveness during claims payment dispute process, and helpfulness of clinical practice guidelines for patient management. To address these priority barriers, AMERIGROUP implemented the following interventions, each of which can impact overall provider satisfaction:

- Increased the use of a proactive claims audit process to ensure accuracy of claims payment.
- Hired additional staff in Provider Relations, Operations/Claims, and Quality Management departments to increase support for providers.
- Enhanced processes involved in claims processing, payments, and claims payment disputes such as processed claims monitoring and additional staff training.

- Created a centralized online claims and appeals tool and tutorial for the provider Web site.
- Revised the clinical practice guidelines (CPGs) to a shorter, more provider-friendly format and made the CPGs more accessible on the provider Web site.

Given the lack of statistically significant improvement in the study indicator at Remeasurement 1, and the timing of the PIP's measurement periods, the PIP should have also included a description of a drill-down analysis of the Remeasurement 1 results to identify barriers not addressed. Because the Remeasurement 1 period ended in September 2013, the CMO should have documented follow-up analysis on the Remeasurement 1 survey results and the causal/barrier analysis activities occurring during the remainder of CY 2013 and the first half of CY 2014, prior to the PIP submission. As a result of the lack of statistically significant improvement, new and/or revised interventions need to be implemented during the Remeasurement 2 period to achieve the desired outcomes.

Strengths

AMERIGROUP's performance suggests a thorough application of the PIP Design stage (Activities I through VI). The sound study design of the PIPs formed the foundation for AMERIGROUP to progress to subsequent PIP stages—implementing improvement strategies and achieving real and sustained study indicator outcomes.

Opportunities for Improvement

Although AMERIGROUP designed methodologically sound projects and implemented many interventions that were logically linked to barriers, only three of 10 PIPs demonstrated sustained statistically significant improvement over baseline. Critical examination of the CMO's quality improvement processes identified that AMERIGROUP's causal/barrier analyses were incomplete for some PIPs. The CMO reported quantitative evaluation results for some interventions but not for others. While some interventions were revised to address lack of significant improvement in the study indicators, others were not.

To achieve desired improvement in outcomes across all PIPs, the CMO should ensure that the following recommendations are addressed:

- Ensure that all data components reported in each PIP are accurate and consistently documented throughout the PIP, and align with the data reported in the CMO's final audit report.
- Review narrative interpretation of PIP findings to ensure accuracy of the interpretation and consistency with results presented in table format.
- Ensure that all statistical testing is done correctly, and the documentation of the statistical testing outcomes is accurate and consistent throughout the PIP.
- Conduct causal/barrier and drill-down analyses more frequently than annually and incorporate quality improvement science such as PDSA cycles into its improvement strategies and action plans.
- Ensure that the interventions implemented to address a specific barrier are directly linked to that barrier and will directly impact PIP outcomes.

- Evaluate the efficacy of each intervention to determine if it is being successfully implemented and achieving the desired goal. The results of each intervention's evaluation for each remeasurement period should be included in the PIP.
- Design small-scale tests coupled with analysis of results to determine the success of the intervention. If the small-scale test results suggest that the intervention has been unsuccessful, the CMO should determine: (1) if the true root cause was identified—if not, the CMO should conduct another causal/barrier analysis to isolate the true root cause or issue that is impacting improvement; and (2) if the interventions need to be revised because a new root cause was identified, or the intervention was unsuccessful. In evaluating the results of intervention testing, the CMO may find that the results of the test yield more information that directs the CMO to modify an existing intervention to yield a greater result. If the existing intervention is modified, the CMO should develop another test to evaluate the modified intervention's effectiveness if the current test is obsolete.
- Synthesize the results of intervention-specific evaluations with regular causal/barrier analyses to develop a complete picture of each PIP's progress toward improvement goals. If evaluation results suggest that individual interventions are successful but the study indicator rate(s) did not improve, the CMO should incorporate this information into further drill-down analyses to identify the true root causes of the lack of improvement.

Quality

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

The DCH uses the results of performance measures and PIPs to assess care delivered to members by a CMO in areas such as preventive screening and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DCH monitors aspects of a CMO's operational structures that promote the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

Based on AMERIGROUP's results across mandatory activities, HSAG found that the CMO's strengths were related to improving child health measures. In this area, the CMO had statistically significant improvement for many performance measure rates and achieved five performance targets.

Despite success in some areas of quality, overall, AMERIGROUP has opportunity for improvement in the quality domain. Many performance measure rates were below State targets, performance showed a statistically significant decline or no change in performance predominately in areas of women's health and chronic disease, and many PIPs did not yield improved outcomes.

The activities conducted by AMERGROUP appear to lack an overarching quality strategy for addressing deficiencies across the activities. Interventions initiated as part of a PIP were not evaluated intermittently during the process; therefore, the CMO only had opportunities to make mid-course corrections once annual data were available, making rapid change nearly impossible.

The CMO has an opportunity to design strategies that coordinate the work within its organization to generate improvement, such as improving providers' adherence to practice guidelines and using case and disease management programs as a vehicle to influence provider and member behavior. The CMO may consider soliciting member and provider feedback in areas of poor performance to better understand barriers in developing an overarching improvement strategy.

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 uses monitoring processes, including audits, to assess a CMO's compliance with access standards. These standards include an assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the GF program.

Performance measures, PIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, immunizations, timeliness of prenatal and postpartum care, cancer screening, and diabetes fall under the domains of quality and access because members rely on access to and the availability of the CMO's provider network and services to receive care according to generally accepted clinical guidelines.

AMERIGROUP's compliance review results show strength in contracting with all services required by DCH and in making culturally and linguistically appropriate service provisions to members in need of accessing services. The CMO demonstrated improvement in *Well-Child Visits* for both the PIP and performance measures as well as improvement in the *Childhood Immunization Status—Combination 10* measure. AMERIGROUP achieved sustained improvement for the *Childhood Immunization—Combo 10* PIP, increasing performance by 27.3 percentage points from baseline to Remeasurement 2 in the rate of eligible child members who had received all necessary immunizations by their second birthday. The Remeasurement 2 rate surpassed the 90th percentile of the national Medicaid HEDIS 2012 rates.

The greatest opportunities exist for AMERIGROUP in strengthening its care management program to better coordinate services for members, particularly during care transitions. HSAG could not find evidence that case managers were included in the discharge planning process or obtaining discharge plans for members upon discharge. The CMO should consider enhancing its process for care plan development to be more member- and family-centered by including the member, the member's family, and providers in the care plan development process. Care plan goals should be created with the member and be geared toward activities that can help members achieve better health care outcomes. The CMO may consider implementing a measure of success for care management efforts, such as the Patient Activation Measure survey. This type of survey provides baseline and remeasurement opportunities, and there are tailored coaching strategies that case managers can use to help activate members based on where they are along a continuum of activation.

HSAG's early review of AMERIGROUP's GF 360° population showed a tremendous effort on the CMO's part to carefully plan the transition of members moving from FFS to managed care. The CMO established partnerships with multiple state agencies to help streamline the continuity and coordination of care for members and to ensure that access to care was not disrupted. HSAG noted

similar opportunities for improvement related to care planning for the GF 360° population as it did for the GF population.

AMERIGROUP had some deficiencies with geo-access standards for some provider types and areas, and needs to continue its recruitment efforts to bring the CMO into compliance. Gaps in geo-access standards can be a barrier to members accessing care.

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.

AMERIGROUP had success in many areas of coverage and authorization decision standards. The CMO was strong in the area of emergency services, and its staff demonstrated good knowledge and compliance with prior authorization requests within the UM department.

In addition, the CMO had success in improving member satisfaction through its PIP.

AMERIGROUP has opportunities to address the few areas of deficiency related to pharmacy prior authorization time frames and its notice of action policy when decisions are not reached within the required time frame. Both areas had some inconsistency between the policy and operational practice.

AMERIGROUP had some challenges in completing timely assessments for the GF 360° population during the early months of the transition process. In addition, some contract requirements were outside of the CMO's control as they relied on services being provided by other agencies. These contract requirements should be revisited.

AMERIGROUP should focus efforts on exploring care for prenatal women. Both timeliness to and frequency of prenatal care were suboptimal.

4. Peach State Health Plan

Plan Overview

Peach State Health Plan (Peach State) is part of the multistate national parent company, Centene Corp. In Georgia, Peach State serves more than 380,000 Georgia Families members.[4-1]

Georgia Families

The DCH held a contract with Peach State during the review period and provided services to the State's GF members. In addition to providing medical and mental health Medicaid and CHIP-covered services to members, the CMO also provided a range of enhanced services, including dental and vision services, disease management and education, and wellness/prevention programs.

Review of Compliance With Standards

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. During the review period, HSAG assessed the CMOs' performance in the following areas related to access to services:

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Emergency and Poststabilization Services

HSAG also conducted a re-review of all *Not Met* elements from the prior year's review.

In addition, HSAG performed a focused, case-specific file review of a sample of members enrolled in Peach State's case management and disease management programs. Appendix A contains a detailed description of HSAG's methodology for conducting the reviews.

Findings

HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about Peach State's' performance in providing quality, accessible, and timely health care and services to its members. Compliance monitoring standards fall under the timeliness

[4-1] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report. March 2015.

and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Summary Scores

Table 4-1 displays the standards and compliance scores for Peach State.

Table 4-1—Standards and Compliance Scores for Peach State

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Availability of Services	**17**	**17**	**17**	**0**	**0**	**100.0%**
II	Furnishing of Services	**22**	**22**	**14**	**8**	**0**	**63.6%**
III	Cultural Competence	**14**	**14**	**14**	**0**	**0**	**100.0%**
IV	Coordination and Continuity of Care	**21**	**21**	**13**	**8**	**0**	**61.9%**
V	Coverage and Authorization of Services	**25**	**25**	**22**	**3**	**0**	**88.0%**
VI	Emergency and Poststabilization Services	**20**	**20**	**16**	**4**	**0**	**80.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**4**	**4**	**2**	**2**	**0**	**50.0%**
	Total Compliance Score	**123**	**123**	**98**	**25**	**0**	**79.7%**

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

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

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

Peach State was fully compliant in two of the seven areas of review: Availability of Services and Cultural Competence.

HSAG identified deficiencies in five of the seven areas of review as outlined below:

Furnishing of Services

- Peach State's network providers did not meet the 90 percent goal for the following appointment wait time targets:
  - Primary care provider (PCP) (Routine Visits)—not to exceed 14 calendar days
  - PCP (Adult Sick Visit)—not to exceed 24 hours
  - Non-emergency Hospital Stays—not to exceed 30 calendar days
  - Mental Health Providers—not to exceed 14 calendar days
  - Timeliness—Visits for Pregnant Women—Within 14 days of enrollment

- Peach State did not have adequate monitoring mechanisms in place to oversee provider office wait times or when a provider returned calls to Georgia Families' members. The monitoring activities in the following areas were not sufficient to ensure the requirements were met:
  - Scheduled in-office appointment wait times of not more than 60 minutes.
  - In-office work-in or walk-in appointment wait times of no more than 90 minutes.
  - After-hours urgent calls returned within 20 minutes and other calls within one hour.
- Peach State did not meet the following geographic access standards:
  - PCPs
    - Urban areas: Two within eight miles.
    - Rural areas: Two within 15 miles.
  - Specialists
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - General dental providers
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Dental subspecialty providers
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Mental health providers
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Pharmacies
    - Urban areas: One 24 hours a day, seven days a week within 15 minutes or 15 miles.
    - Rural areas: One 24 hours a day (or has an after-hours emergency phone number and pharmacist on call), seven days a week within 30 minutes or 30 miles.

Coordination and Continuity of Care

- Peach State's policy for members changing a PCP and its actual reported procedure were not congruent. The policy stated that members were able to switch PCPs every 30 days within the first 90 days of enrollment and every 6 months thereafter. However, staff reported that the member was allowed to change PCPs at any time.
- Staff indicated that case managers would not speak to the pregnant minor without the consent of the minor's parent/guardian. This was inconsistent with O.C.G.A. 31-9-2 (5) (2010) as any female, regardless of age or marital status, could consent for treatment herself when given in connection with pregnancy, or the prevention thereof, or childbirth.
- Peach State was unable to demonstrate documented instances of case managers either completing or receiving the discharge plan for members who were being discharged from an inpatient facility.
- Peach State was unable to identify how case managers included the member, the member's provider, and/or the caregiver/family member/guardian in care plan development.

- Staff members were unable to identify a formal process that would be used to identify any care gaps in the member's utilization of services.
- HSAG could not identify documentation of follow-up with the provider, member, or caregiver/guardian concerning a member's utilization of behavioral health services, diagnosis, medications, and/or progress. Once a referral for BH services was completed, the case manager did not complete any other care coordination for this service area.
- HSAG noted that Peach State's process for identifying members who have the greatest need for case management using Impact Pro was not evidenced during file review.

Coverage and Authorization of Services

- Peach State's policy and practice for untimely service requests were in conflict. Decisions not reached within the required time frames constituted a denial, as was noted in policy, but in practice CMO staff members stated they would provide an approval.
- Peach State staff indicated that if an expedited request was denied for not meeting criteria, the member was not notified of this action.
- Peach State did not always ensure that appropriate clinical staff members were reviewing medical records for requests for higher level reimbursement for triage/screening claims.

Emergency and Poststabilization Services

- Peach State had difficulty articulating assurance of coverage and payment for poststabilization services. While written policy supported coverage of poststabilization services, staff could not define the process in practice.

Follow-Up Reviews

- Peach State did not meet all DCH-established performance goals.
- Peach State did not ensure all quality elements were addressed and integrated in terms of overall program impact within its QAPI.

Strengths

Peach State demonstrated the following strengths.

- The CMO ensured that its contracted providers offered access to services for GF members consistent with Georgia Medicaid fee-for-service or commercial members. When an issue arose and a provider needed to be reminded about service goals, the CMO had a corrective action process to communicate needed improvement.
- Peach State served its members in a culturally competent manner by educating staff and providers on expected conduct. Its cultural competency plan was available on Peach State's Web site and was accessible to providers. Member materials were produced in English and Spanish, and members were able to call member services if materials were not easily understood. The CMO offered free linguistic services to members and providers as needed.
- Peach State's monitoring and follow-up of members in case management was focused and specific to the member's needs. The frequency of contact with members and providers was

robust in the outpatient setting. Peach State had a pharmacy lock-in program that provided an added layer of services to ensure that members were appropriately accessing medications.

- Peach State ensured that members were able to access emergency services 24 hours a day, seven days a week to treat emergency medical conditions. The CMO did not deny payment for any emergency services regardless of network status and ensured payment for all triage/screening services.

Recommendations for Improvement

Based on the identified deficiencies and opportunities for improvement, HSAG provides the following recommendations:

- Continually reevaluate noncompliant providers relative to timeliness standards until the providers meet the requirements.
- Establish a monitoring mechanism to oversee provider office wait times and when a provider returns calls to Georgia Families' members.
- Continue provider recruitment efforts until geographic access standards are met.
- Ensure the policy regarding members changing a PCP is congruent with operational practice.
- Implement policies to be consistent with member's privacy and confidentiality for pregnant members.
- Promote case managers participation in the discharge planning process and receive the discharge plan for members who are being discharged from an inpatient facility.
- Include the member, the member's provider, and/or the caregiver/family member/guardian in care plan development.
- Develop a formal process that would be used to identify any care gaps in the member's utilization of services.
- Document and follow-up with the provider, member, or caregiver/guardian concerning the coordination of member's utilization of behavioral health services, diagnosis, medications, and/or progress.
- Utilize Impact Pro, the CMO's predictive modeling software, to identify members as early as possible with the greatest need for case management.
- Ensure untimely service decision policies and practices are consistent with operational practice.
- Educate providers to ensure understanding of the definition of an urgent/expedited review and notify the member when an expedited request is denied for not meeting criteria.
- Ensure a clinician is reviewing reimbursement for triage/screening claims.
- Educate Peach State staff members on assurance of coverage and payment for poststabilization services consistent with written policy.
- Evaluate the process for developing the quality program description, workplan, and quality assessment and performance improvement evaluation report to ensure there is a strategic approach for integration and overall program impact. Peach State should ensure this process integrates its strategy for improving performance measure rates to meet DCH-established performance targets.

Focused Review—Case and Disease Management

Case Management

HSAG performed case-specific file reviews that focused on members in case management. The reviews focused on the assessment of the member's needs, the development of the care plans, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The review looked for gaps in the assessment, the care plan, monitoring and follow-up, presentation of the member in a multidisciplinary setting, and the process for handling transitions of care including discharge planning.

Observations

- Members identified for case management were referred by another internal CMO department via a "trigger list" that was typically based on inpatient admissions. Staff reported that members were also able to self-refer to case management or be referred by their provider. HSAG did not see evidence that members were identified for case management using the CMO's predictive modeling software, Impact Pro.
- Timely assessments were completed and included an assessment of the member's current physical/behavioral issues and concerns, social needs, support system, and linguistic and cultural needs and barriers. For child cases, caregiver and guardian involvement in the assessment was clearly understood. However, HSAG did not find evidence of the CMO involving the member's family and/or caregiver in the assessment process for adult members. In addition, HSAG identified limited or no inclusion of the adult member's provider and inconsistent contact and input from infant/child/adolescent providers during the assessment process.
- The care plan addressed the member's physical, social, and behavioral health issues identified during the assessment. The goals were member-centered, measurable, and achievable. However, for adult cases, the level of provider and family/caregiver involvement in care plan development was lacking.
- The intensity and frequency of monitoring and follow-up was tailored to the member's individual identified needs. There was communication between case management staff and the member concerning any changes in the contact frequency, with buy in from the member.
- The CMO had a pharmacy lock-in program to identify members who were using multiple controlled substances and used criteria to determine whether the member might benefit from coordination of medications by one pharmacy. HSAG identified this as a strength; however, while members who met the criteria for this program were notified of their enrollment, the CMO indicated that it no longer sent notification to the providers due to a high volume of returned mail for providers. CMO staff reported the reason for returned mail was incorrect provider mailing addresses.
- There was a lack of medication reconciliation by the case managers, with the exception of the pharmacy review, which was specific to controlled substances.
- There was fragmentation between physical health and behavioral health. For physical health, HSAG noted active monitoring of the members' progress and needs; however, for behavioral health, HSAG identified that a referral for behavioral health services was often given but there

was no monitoring or follow-up with the member or provider concerning the member's utilization of services, diagnosis, medications, or progress.

- A formal care gap analysis was not conducted to determine needed care versus provided care.
- HSAG noted inconsistency with use of a multidisciplinary team. Two of the eight cases reviewed were brought to the Integrated Care Model (ICM) rounds; however, the case notes lacked documentation of feedback from ICM rounds regarding member care or possible care options.
- Staff reported that discharge planning was completed for all members who had an inpatient stay. However, it was noted that discharge planning from an inpatient setting was limited to information gathered from the member or the member's guardian after the member had already been discharged or was about to be discharged. Gathering information from the member after the member had already been discharged was inadequate. HSAG noted that there was communication fragmentation between the utilization management and case management departments as it related to discharge planning and follow-up. Peach State indicated that discharge planning was a function of utilization management; however, HSAG was unable to identify formal discharge planning being conducted or communicated from the utilization management department to the case manager.

Recommendations

- Explore options for greater utilization of predictive modeling to identify members who could benefit from case management.
- Increase family/caregiver involvement in the assessment process for all members.
- Increase provider involvement in the assessment process for all members.
- Increase provider and family/caregiver involvement in care plan development.
- Implement a process to ensure that providers are notified of members enrolled in the pharmacy lock-in program to improve coordination of care.
- Explore ways to decrease fragmentation between Peach State's physical health and behavioral health programs.
- Train case managers on medication reconciliation and incorporate a process to ensure medication reconciliation is conducted for members in case management.
- Increase utilization of a multidisciplinary team approach for case consultation.
- Ensure documentation of the case presentation covers feedback from team members, inclusion of outside participants (e.g., family/caregivers, providers, and/or specialists and their feedback), treatment recommendations, and follow-up.
- Ensure coordination of discharge planning between utilization management and case management for members enrolled in case management.
- Obtain a copy of the discharge plan and/or document the discharge plan for all members transitioning between care settings that are enrolled in case management in the case management system.

Disease Management

HSAG performed case-specific file reviews that focused on members in disease management. The reviews focused on the identification for disease management, assessment, education, monitoring, and measureable outcomes.

Observations

- Peach State had an effective referral process for identifying members who could benefit from disease management. The target population consisted of individuals with a qualifying condition, evidence of poor control, or frequent utilization of care that could be more appropriately managed in a different setting. Members were referred to the program by CMO case managers and providers, or through a claims stratification process. Peach State also identified members through claims review of emergency department utilization.
- Despite the identification and referral process, the CMO had difficulty engaging members in the disease management program.
- Peach State and its delegated disease management partner, Nurtur, adopted disease management guidelines developed by national organizations. Peach State had well-developed assessment and disease management care plans. For several of the cases reviewed, the disease case managers lost contact with the member after the first or second contact for disease management.
- Members who agreed to be enrolled in disease management programs received enrollment education packets concerning their disease process. The packets had been developed to include both pediatric and adult content. Members referred to disease management, either through claims or referrals, but who had not agreed to be enrolled in disease management did not receive any educational materials about their disease process from Peach State or Nurtur.
- The case manager received communication about the member from Nurtur and the disease manager via an interface built between Nurtur and TruCare software systems. The telephonic disease management coaching program included disease-specific management by registered nurses, respiratory technicians, and community health workers. Once enrolled in the program, members received written educational materials, clinical review, coaching calls, and case manager follow-up regarding validated high alerts. In addition, the case manager provided fax/telephonic follow-up with providers.
- Coaching calls occurred at least every 30 days and often were more frequent based on the member's needs. The program's goal was to educate the member on his or her disease and how to control/manage it.
- Some cases reviewed showed that the disease case manager was not able to contact the member again and the case was closed.
- Peach State did not measure member outcomes using disease management data.

Recommendations

- Develop methods to improve initial engagement of members referred to disease management.
- Peach State should develop additional methods to improve the continued engagement of members after the baseline assessment is completed.

- Consider developing information that could be sent to members identified for disease management as a mechanism to engage members. The educational materials could summarize the information currently included in disease management enrollment packets.
- When follow-up has not been accomplished, at-risk members, particularly children, should be evaluated for a potential referral to case management or discussed in integrated care management rounds.

Performance Measures

The DCH annually selects a set of performance measures to evaluate the quality of care and services delivered by contracted CMOs to GF members. The DCH requires that the CMOs' performance measure rates are externally validated. Performance measure validation determines the extent to which plans followed specifications established by DCH for its performance measures when calculating rates. Appendix B includes a detailed methodology for the validation of performance measures.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about Peach State's performance in providing quality, accessible, and timely care and services to its GF members. Performance measures reflect all three domains of care—quality, access, and timeliness.

Peach State's Access Measure Results

Table 4-2—Access Measure Results				
	Peach State			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Children's and Adolescents' Access to Primary Care Providers				
Ages 12–24 Months	96.98%	96.97%	↔	
Ages 25 Months–6 Years	90.43%	90.45%	↔	
Ages 7–11 Years	90.81%	91.53%	↑	
Ages 12–19 Years	87.97%	88.51%	↑	91.59%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	84.94%	83.56%	↓	88.52%
Ages 45–64 Years	89.36%	89.77%	↔	
Ages 65+ Years	--	NA	--	
Total	85.23%	84.32%	↓	

Table 4-2—Access Measure Results				
	Peach State			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Oral Health (Annual Dental Visit Rate)				
Ages 2–3 Years	43.96%	44.28%	↔	
Ages 4–6 Years	76.01%	75.09%	↓	
Ages 7–10 Years	78.32%	78.08%	↔	
Ages 11–14 Years	70.02%	70.66%	↔	
Ages 15–18 Years	59.42%	59.81%	↔	
Ages 19–21 Years	38.85%	35.77%	↔	
Total	67.92%	68.13%	↔	69.07%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	37.74%	38.06%	↔	43.62%
Engagement	8.27%	7.08%	↔	18.56%
Annual HIV/AIDS Medical Visit*				
90 Days Apart	--	50.41%	--	
180 Days Apart	--	31.78%	--	
Care Transition—Transition Record Transmitted to Health Care Professional*				
Care Transition—Transition Record Transmitted to Health Care Professional	--	0.46%	--	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA Indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Peach State had five measures with statistically significant declines or improvements related to access measures; however, no rate was above the CY 2013 performance target.

Peach State's Children's Health Measure Results

Table 4-3—Children's Health Measure Results				
	Peach State			2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Well-Child/Well-Care Visits				
First 15 Months of Life: Six or More Visits	55.32%	57.64%	↑	70.70%
Third, Fourth, Fifth, and Sixth Years of Life	67.59%	69.44%	↑	72.26%
Adolescent Well-Care Visits	43.98%	45.14%	↑	49.65%
Immunization and Screening				
Childhood Immunization Status—Combination 3	76.74%	79.17%	↑	82.48%
Childhood Immunization Status—Combination 6*	33.26%	40.74%	↔	
Childhood Immunization Status—Combination 10	27.91%	36.34%	↑	
Lead Screening in Children	74.19%	76.85%	↑	81.86%
Appropriate Testing for Children with Pharyngitis	73.80%	76.33%	↑	76.37%
Immunizations for Adolescents—Combination 1 Total	71.30%	78.01%	↑	80.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile (Total)	47.69%	51.16%	↑	47.45%
Counseling for Nutrition (Total)	56.02%	58.10%	↑	54.88%
Counseling for Physical Activity (Total)	47.69%	54.63%	↑	43.29%
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	80.47%	81.26%	↑	85.34%
Developmental Screening in the First Three Years of Life*				
Developmental Screening in the First Three Years of Life—Total	--	42.82%	--	
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	48.06%	50.06%	↑	
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	23.14%	23.68%	↑	

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[2] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Peach State had 14 rates related to children's health measures with statistically significant improvement over their respective CY 2012 rates. While only three measures exceeded their 2013 performance targets, the rates are moving in the right direction with many rates nearing achievement of the DCH goals. Peach State demonstrated significant gains in children's health measure results during the CY 2013 year.

Peach State's *Women's Health Measure Results*

Table 4-4—Women's Health Measure Results

Measure	Peach State			2013 Performance Target[3]
	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Prevention and Screening				
Cervical Cancer Screening*	73.54%	73.84%	↔	78.51%
Breast Cancer Screening**	56.46%	72.96%	↑	56.58%
Chlamydia Screening—Ages 16–20 Years	54.68%	52.66%	↓	
Chlamydia Screening—Ages 21–24 Years	72.93%	72.11%	↔	
Chlamydia Screening—Total	59.60%	57.69%	↓	58.40%
Human Papillomavirus Vaccine for Female Adolescents***	17.82%	21.53%	↔	22.27%
Prenatal Care and Birth Outcomes				
Timeliness of Prenatal Care	86.71%	82.64%	↓	90.39%
Postpartum Care	71.56%	61.81%	↓	71.05%
Cesarean Rate for Nulliparous Singleton Vertex *A lower rate indicates better performance*	19.63%	18.08%	↑	
Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance*	30.01%	29.59%	↔	28.70%

Table 4-4—Women's Health Measure Results				
	Peach State			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	2013 Performance Target[3]
Rate of Infants With Low Birth Weight (Rate per 100) *A lower rate indicates better performance*	8.53%	8.73%	↔	8.10%
Behavioral Health Risk Assessment for Pregnant Women***	--	1.85%	--	
Elective Delivery*** *A lower rate indicates better performance*	--	0.00%	--	2.00%
Antenatal Steroids***	--	NA	--	
Frequency of Ongoing Prenatal Care				
< 21 Percent	8.62%	10.42%	↓	
21–40 Percent	4.43%	6.48%	↓	
41–60 Percent	6.99%	8.56%	↓	
61–80 Percent	14.92%	16.90%	↓	
81+ Percent	65.03%	57.64%	↓	72.99%

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
***This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Peach State had poor performance related to women's health measures. Most rates showed a statistically significant decline in performance. The CMO's performance for *Timeliness of Prenatal Care*, *Frequency of Ongoing Prenatal Care*, and *Postpartum Care* measures declined. Approximately 42 percent of pregnant women did not receive the recommended number of prenatal care visits, and approximately 39 percent of women who delivered a baby did not receive the appropriate follow-up during the postpartum period.

Peach State's Chronic Conditions Health Measure Results

Table 4-5—Physical Health Conditions: Chronic Conditions Measure Results				
	Peach State			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	79.83%	79.51%	↔	87.01%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	55.48%	63.19%**	↓	41.68%
HbA1c Control (<8.0)	39.13%	32.64%	↓	48.72%
HbA1c Control (<7.0)	27.61%	24.07%	↔	36.72%
Eye Exam (Retinal) Performed	57.22%	57.81%	↔	52.88%
LDL-C Screening	67.83%	68.92%	↔	76.16%
LDL-C Control (<100 mg/dL)	20.35%	23.44%	↔	35.86%
Medical Attention for Nephropathy	73.39%	70.83%	↔	78.71%
Blood Pressure Control (<140/80 mm/Hg)	27.30%	29.34%	↔	39.10%
Blood Pressure Control (<140/90 mm/Hg)	53.74%	53.65%	↔	63.50%
Diabetes Short-Term Complications Admission Rate†				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months) *A lower rate indicates better performance*	--	20	--	62.74
Respiratory Conditions				
Use of Appropriate Medications for People With Asthma				
5–11 Years	90.58%	92.92%	↑	
12–18 Years	88.40%	91.23%	↑	
19–50 Years	72.39%	73.43%	↔	
51–64 Years	NA	NA	--	
Total	89.22%	91.47%	↑	90.56%

Table 4-5—Physical Health Conditions: Chronic Conditions Measure Results				CY 2013 Performance Target[3]
	Peach State			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Young Adult Asthma Admission Rate*				
Young Adult Asthma Admission Rate *A lower rate indicates better performance*	--	4.63	--	
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate†				
Per 100,000 Member Months (Total)	71.03*	37	--	559.03
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate†				
Per 100,000 Member Months (Total)	25.53	3	--	380.70
Controlling High Blood Pressure				
Controlling High Blood Pressure	49.78%	44.15%	↓	57.52%
Adult BMI Assessment				
Adult BMI Assessment	66.59%	75.46%	↑	70.60%

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[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
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* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.
† The reporting metric for this measure has changed from 100,000 members to 100,000 member months. Therefore, trending comparisons with CY 2012 rates were not performed for all CMOs. It would also be inappropriate to compare the CMO CY 2013 rates with the performance target which was developed based on the prior year's reporting metric.

Regarding measures related to chronic conditions, Peach State had some success with medication management for children and adolescents with asthma, and with a documented BMI for adults.

Peach State did not perform strongly on adult chronic conditions for diabetes and high blood pressure.

Peach State's Behavioral Health Measure Results

Table 4-6—Behavioral Health Measure Results				
	Peach State			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	43.73%	43.04%	↔	52.48%
Continuation and Maintenance Phase	58.60%	57.73%	↔	63.11%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	52.52%	60.18%	↑	69.57%
Follow-Up Within 30 Days	70.79%	75.48%	↑	84.28%
Antidepressant Medication Management				
Effective Acute Phase Treatment	43.92%	39.64%	↔	52.74%
Effective Continuation Phase Treatment	28.13%	24.86%	↔	37.31%
Screening for Clinical Depression and Follow-Up Plan*				
Screening for Clinical Depression and Follow-Up Plan	--	0.00%	--	
Adherence to Antipsychotics for Individuals With Schizophrenia*				
Adherence to Antipsychotics for Individuals With Schizophrenia	--	16.98%	--	

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[2] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Peach State had two behavioral health measures with rates that showed statistically significant improvement over the CY 2012 rates. Otherwise, the rates showed little change from the previous year. No measure rates were above the CY 2013 performance target.

Peach State's Medication Management Measure Results

Table 4-7—Medication Management Measure Results				
	Peach State			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	CY 2013 Performance Target[3]
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions				
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions *A lower rate indicates better performance*	40.84%	39.98%**	↑	41.51%
Annual Monitoring for Patients on Persistent Medications				
Total	86.87%	86.42%	↔	88.55%
Medication Management for People With Asthma*				
50% Compliance—Total	40.08%	44.22%	↔	
75% Compliance—Total	18.44%	19.00%	↔	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

The rate for *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* showed statistically significant improvement over the CY 2012 rate, both rates were better than the CY 2013 performance target.

Strengths

Based on their CY 2013 performance, Peach State met nine performance targets (see Table 4-8). The CMO performed best within the Children's Health measures.

Table 4-8—Number of Performance Targets Met by Peach State	
Measure Set	**Targets Met**
Access to Care	0
Children's Health	3
Women's Health	2
Chronic Conditions	3
Behavioral Health	0
Medication Management	1
Total	9

Opportunities for Improvement

- Peach State should pay special attention to the Women's Health measures. The CMO had six measures that saw a statistically significant decline in performance.
- Peach State should focus quality improvement efforts on adult chronic conditions such as *Comprehensive Diabetes Care* and *Controlling Blood Pressure*.

Performance Improvement Projects

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

HSAG reviews each PIP using CMS' validating protocol to ensure that the CMOs design, conduct, and report PIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DCH and interested parties can have confidence in reported improvements that result from a PIP.

PIP Validation Findings

HSAG organized, aggregated, and analyzed Peach State's PIP data to draw conclusions about the CMO's quality improvement efforts. The PIP validation process evaluated both the technical methods of the PIP (i.e., the study design) and the 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. The results are presented in Table 4-9. Appendix C provides additional detail on the methodology HSAG used for validating the PIPs.

Table 4-9—Performance Improvement Project Validation Scores for Peach State Health Plan

PIP	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Validation Status
Adolescent Well-Care Visits	97%	100%	*Met*
Annual Dental Visits	79%	82%	*Not Met*
Appropriate Use of ADHD Medication	86%	82%	*Not Met*
Avoidable Emergency Room Visits	71%	64%	*Not Met*
Childhood Immunizations—Combo 10	92%	87%	*Not Met*
Childhood Obesity	96%	93%	*Not Met*
Comprehensive Diabetes Care	86%	79%	*Not Met*
Member Satisfaction	89%	86%	*Not Met*
Postpartum Care	82%	79%	*Not Met*
Provider Satisfaction	82%	86%	*Not Met*

Only one of the 10 PIPs, *Adolescent Well-Care Visits*, received an overall *Met* validation status. The remaining nine PIPs received a *Not Met* score for one or more critical evaluation elements, which resulted in a *Not Met* validation status.

Table 4-10 displays the combined validation results for all 10 Peach State PIPs validated. This table illustrates the CMO's application of the PIP process and its success in implementing all 10 projects. Each activity was composed of individual evaluation elements scored as Met or Not Met. Elements receiving a Met score satisfied the necessary technical requirements for a specific element. The validation results presented in Table 4-10 show the percentage of applicable evaluation elements that received a Met score by activity. Additionally, HSAG calculated an overall percentage of *Met* scores across all activities for all 10 PIPs. Appendix D provides the detailed scores from the validation tool for each of the 10 PIPs.

Table 4-10—Performance Improvement Project Validation Results for Peach State Health Plan (N=10 PIPs)

PIP Stage	Activity	Percentage of Applicable Elements	
		Met	***Not Met***
Design	Appropriate Study Topic	100% (57/57)	0% (0/57)
	Clearly Defined, Answerable Study Question(s)	100% (20/20)	0% (0/20)
	Correctly Identified Study Population	96% (27/28)	4% (1/28)
	Clearly Defined Study Indicator(s)	98% (56/57)	2% (1/57)
	Valid Sampling Techniques (if sampling was used)	97% (35/36)	3% (1/36)

Table 4-10—Performance Improvement Project Validation Results for Peach State Health Plan (N=10 PIPs)

PIP Stage	Activity	Percentage of Applicable Elements	
		Met	*Not Met*
	Accurate/Complete Data Collection	94% (74/79)	6% (5/79)
	Design Total	**97% (269/277)**	**3% (8/277)**
Implementation	Sufficient Data Analysis and Interpretation of Results	92% (79/86)	8% (7/86)
	Appropriate Improvement Strategies	35% (13/37)	65% (24/37)
	Implementation Total	**75% (92/123)**	**25% (31/123)**
Outcomes	Real Improvement Achieved	50% (20/40)	50% (20/40)
	Sustained Improvement Achieved	100% (3/3)	0% (0/3)
	Outcomes Total	**53% (23/43)**	**47% (20/43)**
Percentage of Applicable Evaluation Elements Scored *Met*		**87% (384/443)**	

Overall, 87 percent of the evaluation elements across all 10 PIPs received a *Met* score. While Peach State's strong performance in the Design stage indicated that each PIP was designed appropriately to measure outcomes and improvement, Peach State was less successful in the Implementation and Outcomes stages. The following subsections highlight HSAG's validation findings associated with each of the three PIP stages.

Design

Peach State met 97 percent of the requirements across all 10 PIPs for the six activities within the Design stage. The technical design of each PIP was sufficient to measure and monitor PIP outcomes. The solid foundation of the PIPs allowed for the CMO to progress to the next stage of the PIP process.

Implementation

Peach State met 75 percent of the requirements for the two activities within the Implementation stage. In the Sufficient Data Analysis and Interpretation of Results activity, the CMO's documentation included data inaccuracies and errors in statistical testing. In the Appropriate Improvement Strategies activity, most of the PIPs lacked sufficient documentation of the causal/barrier analysis process used to identify barriers and interventions. Some interventions were not linked to specific barriers or did not impact long-term change in the study indicators. For PIPs that achieved improvement in outcomes, the CMO did not sufficiently document monitoring,

evaluation of effectiveness, or the link between evaluation results and the status of the interventions going forward.

Outcomes

This year, all 10 PIPs were evaluated for achieving statistically significant improvement over baseline. Three PIPs, *Adolescent Well-Care Visits*, *Childhood Immunizations—Combo 10*, and *Childhood Obesity* achieved statistically significant improvement over baseline for all indicators at the current measurement period. The *Annual Dental Visits* PIP achieved statistically significant improvement from baseline to Remeasurement 1 for one of the three study indicators. Only three of the 10 PIPs, *Adolescent Well-Care Visits*, *Childhood Immunizations—Combo 10*, and *Childhood Obesity* progressed to the point of being assessed for sustained improvement. Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the results of the most current measurement period must reflect improvement when compared to baseline results. All three PIPs assessed for sustained improvement achieved it for all study indicators during the current measurement period.

PIP-Specific Outcomes Adolescent Well-Care

Table 4-11—Performance Improvement Project Outcomes for *Adolescent Well-Care Visits*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
The percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	38.5%	39.1%↑*	42.7%↑*	Yes

↑* Designates statistically significant improvement 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.

In the second remeasurement period of the *Adolescent Well-Care Visits* PIP, Peach State sustained 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 2 rate of 42.7 percent was a statistically significant improvement over both the baseline and Remeasurement 1 rates. The Remeasurement 2 rate fell below the 2013 DCH target of 49.7 percent and below the 25th percentile of national Medicaid HEDIS 2012 rates. The rates reported for this PIP were based on administrative data.

A critical analysis of the CMO's improvement strategies for this PIP demonstrated the following:

- Peach State identified barriers to improving the Adolescent Well-Care Visits indicator rate through monthly and quarterly analyses of data by a collaborative interdepartmental workgroup. The CMO summarized identified barriers in a fishbone diagram. The CMO also reported conducting "rapid-cycle analysis" of intervention effectiveness through a series of Plan-Do-Study-Act (PDSA) cycles.
- Peach State implemented interventions targeting member, provider, and system-based barriers identified in the fishbone diagram; however, some of the CMO's documented interventions were not linked to specific barriers in the PIP. During the Remeasurement 2 period, Peach State continued two ongoing interventions that were linked to member- and provider-based barriers:
  - Implementation of live telephonic outreach to assist noncompliant members in making well-care appointments to address member awareness of due well-care services.
  - Quarterly meetings with the CMO's medical record review vendor to ensure accurate and effective education of providers on adolescent well-care documentation requirements.
- The CMO initiated two new interventions during the second remeasurement period, targeting provider- and member-based barriers:
  - Large and small group provider education and engagement sessions, promoting the practice of completing due well-care services during sports physical appointments and sick visits, to address provider-missed opportunities for delivering well-care services.
  - Collaboration with an Atlanta FQHC to implement and facilitate the "Convenient Time" pilot program, which offered well-care appointments during after-school/work hours. The pilot program, targeting member schedule barriers, included transportation assistance and a gift card member incentive for completed appointments.

Peach State reported quantitative evaluation results for some interventions but not others. For example, the CMO documented evaluating the "Convenient Time" pilot program with data to support that the teens had well-care visits. In contrast, the CMO did not document quantitative evaluation results of the in-person provider education intervention, which prevented measuring the impact of this intervention on the well-care study indicator.

Annual Dental Visits

Table 4-12—Performance Improvement Project Outcomes for *Annual Dental Visits*

Study Indicator	Baseline (10/1/2011–9/30/2012)	Remeasurement 1 (10/1/2012–9/30/2013)	Sustained Improvement^
4. The percentage of EPSDT eligible members ages 1–20 who received any dental services during the measurement period (CMS 416 12A).	48.8%	48.2%↓*	NA
5. The percentage of EPSDT eligible members ages 1–20 who received preventive dental services during the measurement period (CMS 416 12B).	44.5%	45.0%↑*	NA

Table 4-12—Performance Improvement Project Outcomes for *Annual Dental Visits*

Study Indicator	Baseline (10/1/2011–9/30/2012)	Remeasurement 1 (10/1/2012–9/30/2013)	Sustained Improvement^
6. The percentage of EPSDT eligible members ages 6–9 who received preventive dental services during the measurement period (CMS 416 12D).	15.7%	14.9%↓*	NA

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

For first remeasurement of the *Annual Dental Visits* PIP, Peach State achieved statistically significant improvement over the baseline rate for Study Indicator 2, but there was a statistically significant decline in the rates of Study Indicators 1 and 3 at Remeasurement 1. The Remeasurement 1 rate for Study Indicator 2 did not reach the 2013 DCH target rate of 58.0 percent.

A critical review of Peach State's quality improvement processes revealed some issues that may have contributed to the mixed study indicator results. The CMO's collaborative workgroup completed a causal/barrier analysis and summarized the identified barriers in a fishbone diagram. The CMO initiated three interventions during the baseline measurement period to address provider and member barriers and continued these interventions during the Remeasurement 1 period. The CMO did not document any revised or new interventions during the Remeasurement 1 period. The three ongoing interventions are described below.

- Peach State implemented a provider-based intervention, "Preventistry Provider Sealant Program," to increase the frequency of sealants being placed on child and adolescent teeth. The intervention was targeted at changing provider practices of delaying the application of sealants and providing preventive and restorative care without applying sealants.
- To address lack of member awareness of dental benefits and recommended services, the CMO implemented a care gap alert system that notifies Member Services and other internal staff when a member is due or past-due for a preventive dental visit. Member Services staff are able to pass this information on to members during inbound and outbound telephone calls.
- Peach State implemented a secure member Web portal to improve member awareness of due/past-due preventive dental services. The Web portal notifies members who signed up to access their electronic health record when they are due for a dental visit.

In addition to the interventions described above, Peach State documented a number of ongoing "standardized interventions." The CMO did not document the specific barrier that each standardized intervention addressed and did not report evaluations of effectiveness for these interventions.

The mixed study indicator results for this PIP illustrate the importance of evaluating the impact of interventions on each study indicator. The CMO documented evaluations of effectiveness for some interventions but not others. The CMO did not report an evaluation for the care gap alert system or

for any of Peach State's "standardized interventions." The CMO should document the evaluation of the effectiveness for each intervention, and the link between evaluation results and decisions to continue, revise, or discontinue implementation should be documented.

Appropriate Use of ADHD Medications

Table 4-13—Performance Improvement Project Outcomes for *Appropriate Use of ADHD Medications*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
1. 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%	43.0%	NA
2. 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%	57.7%	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.

Neither study indicator in the *Appropriate Use of ADHD Medications* PIP achieved statistically significant improvement from baseline to Remeasurement 2. The rates of both study indicators, follow-up visits during the initiation phase (Study Indicator 1) and follow-up visits during the continuation and maintenance phases (Study Indicator 2), declined from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rates for Study Indicators 1 and 2 fell below the CY 2013 DCH targets of 52.5 percent and 63.1 percent, respectively. In comparison with the national Medicaid HEDIS 2012 rates, Peach State's CY 2013 rate for Study Indicator 1 fell between the 50th and 75th percentiles and its Study Indicator 2 rate fell between the 75th and 90th percentiles.

The critical analysis of Peach State's improvement processes and strategies revealed several factors that contributed to the decline in study indicator performance for this PIP. For the causal/barrier analysis, the CMO reported using a data-driven process and identifying priority barriers; however, the PIP documentation did not include any data supporting identified barriers or results of data analysis. Additionally, some of the documented interventions were not associated with specific

barriers. While some interventions were system changes to support long-term improvement, others were not.

Interventions implemented at the provider and member levels included:

- Continued Pharmacy Liaison education visits to non-psychiatric practitioners with high-volume ADHD prescriptions.
- Continued implementation of a clinical practice guideline (CPG) compliance program.
- Participated in an ongoing Quality Improvement and Public Relations collaboration to educate behavioral health providers on HEDIS measures and the ADHD CPG.
- Initiated live telephone calls to parents of members who were identified as having filled an ADHD medication prescription following a four-month negative medication history. The telephone calls served to verify that a follow-up appointment was scheduled, offer transportation assistance, and stress the importance of keeping the appointment.
- Conducted large and small group provider education and engagement sessions to ensure that providers understand the requirements for the HEDIS ADHD medication follow-up measures. At the sessions, the CMO distributed a HEDIS Quick Reference Book, which provides tips on ensuring that follow-up visits occur within the required time frames.

Peach State did not provide sufficient documentation on the evaluation and monitoring of intervention effectiveness.

Childhood Immunizations—Combo 10

Table 4-14—Performance Improvement Project Outcomes for *Childhood Immunizations—Combo 10*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
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%↑*	36.3%↑*	Yes

↑* Designates statistically significant improvement 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.

For the *Childhood Immunizations—Combo 10* PIP, Peach State sustained statistically significant improvement over baseline at the second remeasurement. From baseline to Remeasurement 2, the rate of eligible child members who had received all necessary immunizations by their second birthday

increased by 18.7 percentage points. The Remeasurement 2 rate of 36.3 percent exceeded the 90th percentile of the national Medicaid HEDIS 2012 rates.

Peach State's collaborative workgroup used a PDSA-based approach to improving the *Childhood Immunizations—Combo 10* indicator rate. The workgroup identified barriers using a fishbone diagram. While some of the documented interventions were linked to specific barriers in the fishbone diagram, other interventions were not clearly linked to specific barriers. The CMO's HEDIS Steering Committee collaborated with the PIP workgroup to develop and refine interventions to address identified member, provider, and system-based barriers including member awareness of the recommended immunization schedule, missed provider opportunities for administering vaccines, and provider awareness of the timing requirement for the HEDIS *Childhood Immunization Status—Combination 10* measure. The CMO implemented the following interventions to address identified barriers:

- Continued implementation of the care gap internal system alert accessible via secure portal to Peach State staff and members, letting them know about due or past due preventive services.
- Initiated large and small group provider education and engagement sessions to ensure that providers understand the vaccination timing requirements for the HEDIS *Childhood Immunization Status—Combination 10* measure. At the sessions, the CMO distributed a HEDIS Quick Reference Book, which provided tips to facilitate timely vaccinations.
- Conducted live telephone outreach to members who were due/past due for immunizations. Peach State staff offered assistance with appointment scheduling, transportation assistance, and a member gift card incentive for completed immunizations.

Peach State documented that a PDSA approach was used to implement, test, and continue or revise improvement strategies; however, the CMO did not fully document the results of specific PDSA cycles for each intervention. HSAG anticipated that the CMO would have documented a data-driven evaluation for each intervention.

Childhood Obesity

Table 4-15—Performance Improvement Project Outcomes for *Childhood Obesity*

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)	Remeasurement 4 (1/1/13–12/31/13)	Sustained Improvement^
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%↑*	51.2%	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	36.7%	45.5%↑*	40.7%	56.0%↑*	58.1%	Yes

Table 4-15—Performance Improvement Project Outcomes for *Childhood Obesity*

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)	Remeasurement 4 (1/1/13–12/31/13)	Sustained Improvement^
counseling for nutrition.						
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%↑*	54.6%	Yes

↑* 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.

The *Childhood Obesity* PIP demonstrated sustained improvement over baseline for all three study indicators at Remeasurement 4. The Remeasurement 4 rates for all three study indicators—BMI percentile documentation, evidence of nutrition counseling, and evidence of physical activity counseling—surpassed the respective CY 2013 DCH target rates of 47. 5 percent, 54.9 percent, and 43.3 percent. When compared to the national Medicaid HEDIS 2012 rates, the Remeasurement 3 rates for all three study indicators fell between the 50th and 75th percentiles.

Despite the sustained improvement in the study indicators, a critical review of the CMO's quality improvement strategies revealed some opportunities for improvement in its PIP processes.

- The CMO's collaborative workgroup and HEDIS Steering Committee contributed to the causal/barrier analysis and intervention development for the PIP. The analysis process included data analysis results, and workgroup findings were reviewed monthly to monitor the progress of interventions and assess barriers to improvement. Identified barriers were summarized in a fishbone diagram; however, specific data to support the barriers were not documented. Additionally, the PIP included some interventions that were not directly linked to specific barriers.
- Peach State's identified barriers were grouped into two categories: missed provider opportunities, and provider awareness and compliance with documentation requirements for the HEDIS *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* (WCC) measure.
- The CMO documented the implementation of several interventions aimed at improving member compliance with child/adolescent well-care visits, which were not directly related to the provider-driven study indicators. To address the provider-based barriers, Peach State implemented the following interventions:
  - Held 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.

- Initiated large and small group provider education and engagement sessions to ensure providers understood that the components of the HEDIS WCC measure should be addressed during well visits for all members, not just those members identified as obese. At the sessions, the CMO distributed a HEDIS Quick Reference Book, which provided tips to ensure that providers meet the documentation requirements for the HEDIS WCC measure.

While Peach State reported evaluating the effectiveness of interventions through monthly administrative rate review and provider feedback, the CMO did not document any quantitative, intervention-specific evaluation results for the PIP.

Comprehensive Diabetes Care

Table 4-16—Performance Improvement Project Outcomes for *Comprehensive Diabetes Care*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
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%	24.1%	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%↓*	23.4%	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%	53.6%	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 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.

None of the study indicators in the *Comprehensive Diabetes Care* PIP achieved statistically significant improvement over baseline at Remeasurement 2; all three study indicator rates remained below baseline. While there was a non-statistically significant increase in the rate for Study Indicator 2 (LDL-C < 100 mg/ml) from Remeasurement 1 to Remeasurement 2, the rates for Study Indicators 1 (HbA1c < 7.0%) and 3 (BP < 140/90 mmHg), declined. The rates for all three study indicators fell below the CY 2013 DCH targets of 36.7 percent (HbA1c control < 7.0%), 35.9 percent (LDL-C control < 100 mg/ml), and 63.5 percent (BP Control < 140/90 mmHg). The Remeasurement 2 rates for all three study indicators also fell below the 25th percentile of the respective national Medicaid HEDIS 2012 rates.

A critical analysis of the CMO's improvement strategies identified some weaknesses which may have led to the lack of improvement in this PIP's study indicator rates.

Peach State's collaborative workgroup reviewed administrative rates monthly as part of the causal/barrier analysis process. Identified barriers were summarized in a fishbone diagram. For

Remeasurement 2, the CMO prioritized member barriers, such as disease management knowledge and missing appointments, and the provider barrier, lack of knowledge about clinical practice guidelines and HEDIS requirements. While some of the interventions implemented during the second remeasurement period were system changes likely to impact the diabetic control study indicators, other interventions targeted diabetic screenings and would not directly improve diabetes control measures.

To address member barriers, the CMO continued implementation of the contractually required diabetes disease management program, conducted live telephone outreach to members due/past due for diabetes services, and offered member incentives for completing diabetes visits. Provider-focused interventions included a collaborative effort by the Quality Improvement and Provider Relations departments to enhance provider education on HEDIS specifications for the study indicators and educational provider mailings regarding diabetes service coding requirements.

While Peach State reported that it monitored monthly administrative rates to evaluate intervention effectiveness, the CMO did not link evaluation results to decisions about continuing, revising, or discontinuing the interventions.

Avoidable Emergency Room Visits

Table 4-17—Performance Improvement Project Outcomes for *Avoidable Emergency Room Visits*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
1. 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 Healthcare of Atlanta facilities in the Atlanta region.	22.4%	24.9%↑*	24.4%↓*	NA
Study Indicator	**Baseline Period (1/1/13–12/31/13)**	**Remeasurement 1 (1/1/14–12/31/14)**	**Remeasurement 2 (1/1/15–12/31/15)**	**Sustained Improvement^**
2. 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 selected hospitals in the CMO's expansion population.	23.8%			NA

↑* Designates statistically significant increase over the prior measurement period (*p* value < 0.05) in an inverse study indicator, indicating a performance decline.
↓* Designates statistically significant decrease from the prior measurement period (*p* value < 0.05) in an inverse study indicator, indicating performance improvement.

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.

In CY 2013, for the *Avoidable Emergency Room Visits* PIP, Peach State collected Remeasurement 2 data for Study Indicator 1 (the percentage of ER visits for avoidable diagnoses in select facilities in the Atlanta region) and collected baseline data for a new Study Indicator 2, which measured the percentage of ER visits for avoidable diagnoses in select hospitals in the CMO's expansion population. There was a statistically significant decrease in the Study Indicator 1 rate from Remeasurement 1 to Remeasurement 2. Because the avoidable ER visits rate was an inverse study indicator, for which a lower rate is better, the decrease demonstrated an improvement in performance from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rate remained above the baseline rate; therefore, the inverse study indicator has not demonstrated improvement over baseline.

Peach State reported baseline data for Study Indicator 2 (the percentage of ER visits for select avoidable diagnoses at select facilities in the expansion population). The baseline rate for Study Indicator 2 was 23.8 percent, which was higher (worse than) the DCH 2013 target rate of 23.38 percent.

The critical analysis of Peach State's improvement processes revealed several factors that contributed to the lack of statistically significant improvement over baseline in the avoidable ER visits rate. The CMO documented the results of its causal/barrier analysis in a fishbone diagram; however, the diagram included no new information compared to the fishbone diagram attached for the collaborative *Avoidable Emergency Room Visits* PIP submitted for validation last year. The PIP documentation also did not provide any specific data or analysis results supporting the identified barriers, and the barriers were not prioritized.

Peach State implemented three system-based interventions to improve the avoidable ER visit rate during calendar year 2013:

- An ER case management program, providing live outreach to members who frequent the emergency room.
- Distribution of an educational flyer in new member packets explaining when it is appropriate to seek care in an emergency room and providing information on contracted urgent care facilities.
- Face-to-face visits with six provider groups, identified through claims data, whose members had visited an emergency room for one of the six avoidable diagnoses targeted in the PIP. Medical Director and Provider Relations representatives visited the providers, presented the claims data, and discussed strategies for preventing future avoidable ER visits.

Peach State expanded implementation of interventions to the expansion population during calendar year 2013. The CMO implemented the same interventions in both the metro Atlanta area, measured by Study Indicator 1, and the expansion population areas, measured by Study Indicator 2. Peach State did not report modifying the interventions to specifically target the expansion populations.

While Peach State documented some intervention-specific evaluations of effectiveness, the CMO did not clearly document all evaluation results, linking implementation to performance in the study indicator. For example, the targeted face-to-face visits intervention with six providers was evaluated for effectiveness, showing a decrease in avoidable ER visits rates for the six selected providers. The CMO concluded, based on this evaluation, that this intervention was responsible for the study indicator rate decrease from Remeasurement 1 and Remeasurement 2. The CMO did not, however, document any data (e.g., a comparison of the avoidable ER visits rate with and without the participating providers' members included) illustrating the impact of the participating providers on the overall avoidable ER visits rate.

Member Satisfaction

Table 4-18—Performance Improvement Project Outcomes for *Member Satisfaction*

Study Indicator	Baseline Period (3/13/13–5/22/13)	Remeasurement 1 (2/25/14–5/1/14)	Sustained Improvement^
The percentage of respondents who rate the health plan an 8, 9, or 10 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%	84.9%	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.

At the first remeasurement for the *Member Satisfaction* PIP, Peach State reported a decline in the rate of member satisfaction. The rate of respondents giving Peach State a score of "8" or higher declined 2.1 percentage points from baseline to Remeasurement 1.

A critical assessment of the improvement strategies Peach State used for the *Member Satisfaction* PIP suggested several factors that contributed to the lack of improvement demonstrated at the first remeasurement. The CMO's multidisciplinary team reviewed data analysis results and completed a fishbone diagram to identify barriers impacting member satisfaction. The PIP documentation did not include a process for prioritizing barriers. The fishbone diagram included system and provider barriers; two barriers on the diagram, "Limited specialist participating with Medicaid/CMOs" and "Member difficulty in obtaining information/assistance from the Member Services Call Center" were circled, but the purpose of the circles was not documented.

Peach State documented the implementation of two interventions to address member perceptions:

- To address members' perceived lack of access to specialists, the CMO conducted outreach to specialists in the Metro Atlanta area to confirm participation and appointment availability.
- To address members' perceived difficulty obtaining assistance from the Member Services Call Center, the Member Services Department developed an internal program to improve call quality and customer service.

The CMO documented plans for new and revised interventions to address the decline in the study indicator at Remeasurement 1. Peach State is focused on developing a "culture of organization-wide quality involvement using front line and senior level staff."

Postpartum Care

Table 4-19—Performance Improvement Project Outcomes for *Postpartum Care*

Study Indicator	Baseline (1/1/12–12/31/12)	Remeasurement 1 (1/1/13–12/31/13)	Sustained Improvement^
The percentage of deliveries of live births by members that were followed by a postpartum visit on or between 21 and 56 days after delivery.	71.6%	61.8%↓*	NA

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

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.

There was a statistically significant decline in the study indicator rate for the *Postpartum Care* PIP at Remeasurement 1. The Remeasurement 1 rate declined by 9.8 percentage points from the baseline rate; the study indicator rate fell below the 2013 DCH target rate of 71.1 percent and below the 50th percentile of the national HEDIS 2012 rates.

Critical analysis of Peach State's improvement strategies revealed several deficiencies in the processes used, resulting in a lack of improvement in the study indicator. The PIP lacked sufficient documentation of the causal/barrier analyses conducted for the baseline and Remeasurement 1 periods. The CMO did not document the tools or step-by-step processes used for the baseline causal/barrier analysis process. Additionally, not all of the documented interventions were linked to specific barriers. Finally, in an analysis of the Remeasurement 1 study indicator performance, the CMO concluded that the rate decline was likely due to a difference in the composition of the samples for each measurement period. Given that the study indicator is an audited HEDIS measure, which followed HEDIS sampling methodologies, it was unlikely that the two samples would yield results that are not comparable. A more productive approach to the Remeasurement 1 drill-down analysis would be to revisit the causal/barrier analysis process and determine whether all relevant barriers have been identified and whether interventions need to be revised or added to address the root causes of lack of improvement.

To address barriers related to provider and member awareness and motivation, Peach State detailed the implementation of three system-wide interventions, in addition to numerous ongoing standardized interventions. The three interventions, specific to the *Postpartum Care* PIP, implemented during the first remeasurement period were:

- A collaborative partnership with the Obstetrics (OB) Society to increase provider awareness about the importance of completing postpartum visits between 21 and 56 days after delivery.

- A bonus program for providers who accurately code postpartum visits within the specified time frame, using appropriate ICD-9 codes.
- The Healthy Start Program, in which clinical staff met with members before they left the hospital, after giving birth, to provide education on postpartum care and assist with scheduling the postpartum visit.

Given the statistically significant decline in the study indicator rate, HSAG would have expected to see documentation of new or revised interventions to address the lack of improvement. Peach State reported that its team conducted a drill-down analysis in response to the Remeasurement 1 results; however, the PIP documentation did not include planned revisions to the improvement strategies. Additionally, while Peach State documented the evaluation of some interventions, the documentation was incomplete. Evaluations for some interventions, such as the Healthy Start program, used claims data. Other interventions, such as the provider bonus program and the OB Society partnership, did not have documented evaluation processes or results.

Provider Satisfaction

Table 4-20—Performance Improvement Project Outcomes for *Provider Satisfaction*

Study Indicator	Baseline Period (11/14/12–1/16/13)	Remeasurement 1 (9/1/13–10/31/13)	Sustained Improvement^
The percentage of providers answering, "very satisfied" or, "somewhat satisfied" to Q42 – "Overall satisfaction with Peach State Health Plan?"	76.3%	74.2%	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.

The rate for Peach State's *Provider Satisfaction* PIP declined 2.1 percentage points from baseline to Remeasurement 1.

A critical review of the PIP identified problems throughout the CMO's documented improvement process that contributed to the decline in provider satisfaction. Peach State's documented improvement process was inadequate. In addition to an unfinished causal/barrier analysis, the CMO did not clearly document the timing of intervention implementation or report any revision of the improvement strategies.

Based on the PIP's baseline results, Peach State identified barriers to provider satisfaction related to CMO-provider communication, access to provider representatives, and provider interest. In addition to ongoing, standardized interventions, the CMO documented two interventions that were initiated in "Q1 2013" and focused on improving the effectiveness of Provider Relations representatives:

- To ensure quality and consistency of services that providers received from Peach State's provider representatives (PRs), the CMO changed the PR training process. The new training process included a comprehensive assessment, mandatory biweekly internal PR meetings,

mandatory monthly PR training sessions, and dissemination of a monthly agenda and talking points for PR provider visits.

- To address provider awareness and access to PR field representatives, Peach State increased manager oversight of the field representatives. Manager oversight was increased through "quarterly ride-along field assessments," increased requirements for minimum field visit productivity, and improved laptop connectivity for all field representatives.

The PR representative interventions were implemented in addition to Peach State's ongoing standardized interventions; however, the interventions did not result in improvement of the study indicator. The CMO did not document a follow-up causal/barrier or drill-down analysis to address the decline in provider satisfaction at Remeasurement 1. Based on the PIP's measurement periods, with Remeasurement 1 ending in October 2013, Peach State would have had at least six months to revisit the causal/barrier analysis, identify barriers that were not addressed, and plan and implement new or revised interventions. The CMO also did not document evaluation processes or results for the PIP's interventions. To achieve meaningful improvement in provider satisfaction, Peach State should revisit the causal/barrier analysis, identify root causes that have not been addressed, implement revised interventions, and conduct ongoing evaluation of each intervention's effectiveness in impacting the study indicator.

Quality

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

The DCH uses the results of performance measures and PIPs to assess care delivered to members by a CMO in areas such as preventive screening and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DCH monitors aspects of a CMO's operational structures that promote the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

Peach State performed best in the area of children's health, with nearly all performance measures showing statistically significant improvement over the prior year. In addition, Peach State showed statistically significant and sustained improvement for its *Adolescent Well-Care Visits* PIP. While Peach State is managed under a larger corporate umbrella, the CMO had adequate resources dedicated at the local level with decision-making ability to align efforts to State-specific goals.

While several areas of success were noted, the CMO still has significant opportunity for improvement in the quality domain. Many performance measures were below State targets, and performance showed a statistically significant decline or no change, predominately in areas of women's health and chronic disease. With one exception, no PIPs yielded improved outcomes.

The CMO needs a new strategy for performance improvement as only one PIP demonstrated improvement and achieved an overall *Met* status. This suggests that while the CMO may be participating in quality improvement efforts, they are not resulting in change. The CMO could

benefit from narrowing its focus on quality efforts to initiate small tests of change to determine the effectiveness of process improvements and interventions prior to taking the interventions to scale. In addition, the CMO needs to develop a process to measure change rapidly so that annual measurements and a three-year cycle are not necessary to determine that the interventions implemented were not successful.

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 uses monitoring processes, including audits, to assess a CMO's compliance with access standards. These standards include an assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the GF's program.

Performance measures, PIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, immunizations, timeliness of prenatal and postpartum care, cancer screening, and diabetes fall under the domains of quality and access because members rely on access to and the availability of the CMO's provider network and services to receive care according to generally accepted clinical guidelines.

Peach State's compliance review results showed strength in contracting with all services required by DCH and in making culturally and linguistically appropriate service provisions to members in need of accessing services. The CMO demonstrated improvement in the *Adolescent Well-Care Visits* PIP.

The greatest opportunities exist for Peach State in the strengthening of its processes for care coordination and continuity of care, including improved integration of behavioral health and physical health services for members. HSAG could not find evidence that case managers were following up on behavioral health referrals to ensure members were linked. While performance measure rates showed success in the area of follow-up after mental health hospitalization, it is unclear how the member is receiving patient-centered care that integrates services for behavioral health and physical health needs. Cases reviewed involving members in case management revealed opportunities to improve the care planning process to include member and provider input. In addition, opportunities continue to exist with transitions of care.

Peach State had deficiencies with geo-access standards for some provider types and areas, and needs to continue its recruitment efforts to bring the CMO into compliance. Gaps in geo-access standards can be a barrier to members accessing care.

Timeliness

The timeliness domain of care relates to the CMO's 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.

Peach State had some areas of deficiency related to coverage and authorization decisions. To correct these deficiencies, the CMO should revise its policies and/or operational practices to ensure they are

consistent. In addition, the review found that the CMO did not always ensure appropriate clinical staff members were reviewing medical records for requests for higher-level reimbursement of triage/screening claims.

Peach State should create a process map depicting the stages of prenatal/postpartum care for pregnant members, and conduct a failure mode and effects analysis to identify potential barriers disrupting timeliness of care. The CMO may consider conducting a focus group study with pregnant women to better understand the process from their perspective and identify potential areas in need of improvement.

5. WellCare of Georgia, Inc.

Plan Overview

WellCare of Georgia, Inc. (WellCare), is part of the national corporation, WellCare Health Plans, Inc., a multistate provider of only government-sponsored health products. WellCare serves approximately 4 million members nationwide[5-1] and nearly 600,000 Georgia Families members in the State of Georgia.[5-2]

Georgia Families

The DCH held a contract with WellCare during the review period and provided services to the State's GF members. In addition to providing medical and mental health Medicaid and CHIP-covered services to members, the CMO also provided a range of enhanced services, including dental and vision services, disease management and education, and wellness/prevention programs.

Review of Compliance With Standards

According to federal requirements, the State or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the State related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. During the review period, HSAG assessed the CMOs' performance in the following areas related to access to services:

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care
- Coverage and Authorization of Services
- Emergency and Poststabilization Services

HSAG also conducted a re-review of all *Not Met* elements from the prior year's review.

In addition to the above-mentioned review areas, HSAG performed a focused, case-specific file review of a sample of members enrolled in WellCare's case management and disease management programs. Appendix A contains a detailed description of HSAG's methodology for conducting the reviews.

[5-1] https://georgia.wellcare.com/AboutUs/default. Accessed on: February 24, 2015.
[5-2] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report. March 2015.

Findings

HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about WellCare's performance in providing quality, accessible, and timely health care and services to its members. Compliance monitoring standards fall under the timeliness and access domains of care; however, standards related to measurement and improvement fall under the quality domain of care.

Summary Scores

Table 5-1 displays the standards and compliance scores for WellCare.

Table 5-1—Standards and Compliance Scores for WellCare

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Availability of Services	**17**	**17**	**17**	**0**	**0**	**100.0%**
II	Furnishing of Services	**22**	**22**	**19**	**3**	**0**	**86.4%**
III	Cultural Competence	**14**	**14**	**13**	**1**	**0**	**92.9%**
IV	Coordination and Continuity of Care	**21**	**21**	**17**	**4**	**0**	**81.0%**
V	Coverage and Authorization of Services	**25**	**25**	**22**	**3**	**0**	**88.0%**
VI	Emergency and Poststabilization Services	**20**	**20**	**20**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**6**	**6**	**0**	**6**	**0**	**0.0%**
	Total Compliance Score	**125**	**125**	**109**	**16**	**0**	**87.2%**

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

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

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

WellCare was fully compliant in two of the seven areas of review: Availability of Services and Emergency and Poststabilization Services.

HSAG identified deficiencies in five of the seven areas of review as outlined below:

<u>Furnishing of Services</u>

- WellCare's network providers did not meet the 90 percent goal for the following appointment wait time targets:
  - Scheduled in-office appointment wait times of no more than 60 minutes

  - Monitoring of in-office work-in or walk-in appointment wait times of no more than 90 minutes
  - Timeliness—Returning Calls After Hours
  - After-hours urgent calls returned within 20 minutes and other calls within one hour
- WellCare did not meet the following geographic access standards:
  - PCPs
    - Urban areas: Two within eight miles.
    - Rural areas: Two within 15 miles.
  - Specialists
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Dental subspecialty providers
    - Urban areas: One within 30 minutes or 30 miles.
    - Rural areas: One within 45 minutes or 45 miles.
  - Pharmacies
    - Urban areas: One 24 hours a day, seven days a week within 15 minutes or 15 miles.
    - Rural areas: One 24 hours a day (or has an after-hours emergency phone number and pharmacist on call), seven days a week within 30 minutes or 30 miles.

Cultural Competence

- The most current version of WellCare's cultural competency plan was not available to providers on the CMO's Web site.

Coordination and Continuity of Care

- HSAG identified that new case managers were not consistently adhering to the continuity of care procedure. In review of case management files, HSAG found evidence that for some members, the case managers failed to complete linkage for requested services.
- HSAG noted that the care plans were not consistently member-centered and measurable. In addition, problems identified in the care plans did not always match the member's currently reported diagnosis, and goals were often not linked to the identified interventions.
- HSAG found no documented follow-up by a case manager with the member's PCP or specialist after the care plan was faxed. In addition, there were instances where the case manager did not follow up with members or their families after receiving calls from them.

Coverage and Authorization of Services

- WellCare's policy for providing a notice of action (NOA) for authorization requests that had exceeded required time frames was inconsistent with operational practice.
- One pharmacy denial was reviewed, and no NOA was provided to the member.

Follow-Up Reviews

- The QAPI did not address and integrate all quality elements.

- The CMO did not meet all DCH-established performance goals.
- The CMO did not meet the clinical practice guideline (CPG) provider compliance goal.
- WellCare did not demonstrate evidence of ongoing monitoring of its staff related to discharge planning.
- WellCare also did not demonstrate that discharge plans were documented for all members discharged from an inpatient setting.

Strengths

- WellCare monitored providers to ensure they were accepting new patients and ensured continuity of care was maintained if and when a member needed to obtain services from other non-contracted providers. When out-of-network providers were needed, the CMO coordinated payment such that the member was not balance-billed and attempted to contract with those providers to make the provider network more robust.
- WellCare established expected standards and provided guidance for delivering services to its member population in a culturally competent manner by educating staff and providers on the diverse member population needs. WellCare provided a summary of its Cultural Competency Plan in the provider handbook. Provider contracts also included references on non-discrimination.
- Member materials were produced in English and Spanish, and alternative formats were stated as being available as needed. The Member Handbook provided information on accessing alternative formats, and members were able to call member services if they needed assistance in understanding the materials. The CMO contracted with linguistic services and made them available to members and providers as needed. These services were free to the member and provider.
- WellCare's obstetrics (OB) case management program monitoring and follow-up was focused and specific to the member's identified needs. OB case management case notes were comprehensive and specific to the services being provided to members.
- Overall, WellCare's staff demonstrated strong knowledge of UM policy and process, with consideration of both behavioral and medical health needs. There was strong evidence of medical director involvement and demonstration of Utilization Management Committee reporting and oversight.
- In the local facilities, WellCare's field staff members fostered positive provider relationships, which in turn supported the CMO's ability to understand and appropriately respond to local needs and identify appropriate community resources.
- WellCare ensured that members were able to access emergency services 24 hours a day, seven days a week to treat emergency medical conditions. The CMO provided payment, based on contractual agreements, for any emergency services regardless of network status and ensured payment for all triage/screening services.

Recommendations for Improvement

Based on the identified deficiencies and opportunities for improvement, HSAG provides the following recommendations:

- Establish a monitoring mechanism to oversee provider office wait times and when a provider returns calls to Georgia Families' members.
- Continue provider recruitment efforts until geographic standards are met.
- Ensure the most current version of WellCare's cultural competency plan is available to providers on the CMO's Web site.
- Ensure new case managers adhere to the continuity of care procedure.
- Ensure care plans are consistently member-centered and measurable.
- Ensure care plan goals are linked to the identified interventions.
- Conduct follow-up with the member's PCP or specialist after the care plan is submitted to the provider.
- Conduct case manager follow-up with members or their families after receiving calls from them.
- Ensure policies and operational practices are congruent when staff members address an NOA for an authorization request that exceeds the required time frame.
- Review the process for initiating an NOA to the member for a pharmacy denial and audit these cases until there is compliance.
- Evaluate the process for developing the quality program description, workplan, and quality assessment and performance improvement evaluation report to ensure there is a strategic approach for integration and overall program impact. WellCare should ensure this process integrates its strategy for improving performance measure rates to meet DCH-established performance targets.
- Enhance training, monitoring, and accountability of providers to improve compliance with clinical practice guidelines. WellCare should continually work with non-compliant providers and establish an internal monitoring process until providers are brought into compliance. This process needs to be more frequent than an annual re-review of non-compliant providers.
- Document discharge plans for cases involving member hospitalization.

Focused Review—Case and Disease Management

Case Management

HSAG performed case-specific file reviews that focused on members in case management. The reviews focused on assessment of the members' needs, the development of the care plans, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The review looked for gaps in the assessment, the care plan, monitoring and follow-up, presentation of the member in a multidisciplinary setting, and process for handling transitions of care including discharge planning.

Observations

- Members were identified for case management through data mining/predictive modeling, staff or utilization management (UM) referral, and provider or caregiver referral. Members were also able to self-refer. No issues with identification of members for case management were noted.
- The assessments and notes for pediatric, adult, and OB members in case management were completed within the appropriate time frames and provided documentation such as medical history, social history, and demographics. The initial assessment case notes that accompanied the system-generated comprehensive assessment results provided an overall comprehensive assessment of the members.
- Overall, HSAG noted that WellCare sent completed care plans to members' PCPs. In many cases, HSAG observed challenges with care plan development, including the following:
  - The care plan lacked member-centeredness.
  - Goals were not measurable.
  - The intent of the goal did not accurately represent the member's identified needs and did not link to the intervention(s) being provided by the case manager.
  - Problems identified by the case manager in the care plan did not accurately reflect the member's current diagnosis.
- HSAG noted during the case file reviews that monitoring of members aligned with the CMO's acuity levels assigned by the case manager. However, other than faxing of the care plan, HSAG noted limited contact with members' providers in the ongoing management of members. In one instance, HSAG identified that timely follow-up was not provided to a member's parent who had reached out for assistance. HSAG also noted that all reviewed cases lacked a multidisciplinary team approach.
- During the interview staff described the UM team's role and responsibility in developing and implementing the discharge planning process. However, during the file review, for cases involving member hospitalization, HSAG did not identify that any discharge planning was noted.

Recommendations

- Ensure that all care plans are member-centered, goals are measurable, the intent of the goal accurately represents the member's identified needs, and the interventions being provided to the member and problems identified in the care plan accurately represent the member's current diagnosis and needs.
- Engage members' providers throughout the monitoring and follow-up period to ensure members are following through with provider recommendations for care.
- Utilize a multidisciplinary team approach for consultation and review of services being provided to ensure all service options available to the member can be addressed.
- Follow up with members in a timely manner when they or their family/guardian/caregiver leave a message for the case manager. If the case manager is out of the office or unavailable, the case manager's team members should reach out to address member needs.
- Ensure that discharge planning is documented for all members discharged from an inpatient care setting.

Disease Management

HSAG performed case-specific file reviews which focused on members in disease management. The reviews focused on identification for disease management, assessment, education, monitoring, and measureable outcomes.

Observations

- The CMO's case and disease management system, Enterprise Medical Management Automation (EMMA), had limitations. HSAG found identification of members for disease management within the case documentation, but the system did not capture disease management episodes; therefore, the initial identification was always the date of enrollment and the date of assessment. This made reviewing the members' assessment needs and status with each episode difficult. Documentation related to the assessment date and most recent disease management episode did not always coincide.
- HSAG noted that, for all members in disease management, the CMO was moving toward active disease management instead of enrolling them into passive disease management; therefore, the leveling of members no longer appeared necessary since all members were contacted for active enrollment.
- HSAG found the disease management assessment process to be sufficient; the assessments captured appropriate elements of disease-specific conditions. A notification letter was typically sent to the PCP for members enrolled in the disease management program, and the letter content was noted as a strength. The provider notification letter included information about enrollment into the disease management program, and it solicited input from the provider specific to the member's condition.
- WellCare staff used *Living with Illness* workbooks as the primary mode of education. HSAG found evidence that the education provided in the workbook was reviewed with members telephonically to reinforce the educational message.
- HSAG noted that a care plan was developed for all members enrolled in active disease management; however, the review showed that most goals were standardized and primarily included a goal for educating members on the disease process and a goal for verbalization of signs and symptoms of exacerbations. Recently, the CMO began creating custom goals for members. While these goals still appeared to be somewhat broad, the customization was more likely to result in positive outcomes.
- Case note documentation indicated that much of the work that disease case managers were completing with members showed a connection to clinical guidelines.
- Member engagement was identified as a challenge for WellCare. Cases were opened with one-to-two contacts; members were usually then moved to passive enrollment after three unsuccessful contact attempts.
- One case reviewed was closed before goals were met.
- HSAG found strong evidence that asthmatic child members received hypoallergenic bedding, and confirmed that members received the appropriate durable medical equipment (DME) such as blood pressure cuffs, glucometers, scales, etc.
- The system had limitations for tracking progress indicators such as blood glucose levels, blood pressure readings, etc. The overall disease management program lacked ways to measure

success. For members enrolled in the disease management program, the CMO reported the percentage of members having each disease, with the CMO achieving a very low penetration level of members in active disease management. HSAG identified no measurement of health outcomes.

Recommendations

- The CMO should explore system enhancements to address the disease management system's identification practice.
- The CMO should consider reviewing and revising its process for stratification of members since it has implemented active management of all members identified for disease management, and the stratification process to determine who should receive passive versus active disease management is no longer necessary.
- Develop care plans that include customized goals, with input from the member.
- Consider care plan goals that focus on improved health outcomes and controlled management of chronic diseases.
- Ensure goals are met before the case is closed out.
- Consider system enhancements to enable member-level tracking of health indicators/status over time.
- Establish metrics to evaluate the overall effectiveness of the disease management program that focus on measuring health outcomes.

Performance Measures

The DCH annually selects a set of performance measures to evaluate the quality of care and services delivered by contracted CMOs to GF members. The DCH requires that the CMOs' performance measure rates are externally validated. Performance measure validation determines the extent to which plans followed specifications established by DCH for its performance measures when calculating rates. Appendix B includes a detailed methodology for the validation of performance measures.

Findings

HSAG organized, aggregated, and analyzed validated performance measure data to draw conclusions about WellCare's performance in providing quality, accessible, and timely care and services to its GF members. Performance measures reflect all three domains of care—quality, access, and timeliness.

WellCare's Access Measure Results

Table 5-2—Access Measure Results				
	WellCare			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Children's and Adolescents' Access to Primary Care Providers				
Ages 12–24 Months	97.56%	98.04%	↑	
Ages 25 Months–6 Years	91.63%	91.75%	↔	
Ages 7–11 Years	91.80%	92.62%	↑	
Ages 12–19 Years	89.57%	90.61%	↑	91.59%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	85.81%	85.05%	↓	88.52%
Ages 45–64 Years	91.21%	91.45%	↔	
Ages 65+ Years	--	NA	--	
Total	86.51%	85.86%	↓	
Oral Health (Annual Dental Visit Rate)				
Ages 2–3 Years	52.22%	49.95%	↓	
Ages 4–6 Years	77.61%	77.11%	↓	
Ages 7–10 Years	80.37%	79.94%	↓	
Ages 11–14 Years	73.72%	72.83%	↓	
Ages 15–18 Years	63.06%	62.56%	↔	
Ages 19–21 Years	41.88%	32.79%	↓	
Total	71.48%	70.73%	↓	69.07%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	48.28%	31.37%	↓	43.62%
Engagement	12.27%	9.38%	↓	18.56%
Annual HIV/AIDS Medical Visit*				
90 Days Apart	--	54.58%	--	
180 Days Apart	--	35.83%	--	
Care Transition—Transition Record Transmitted to Health Care Professional*				
Care Transition—Transition Record Transmitted to Health Care Professional	--	0.23%	--	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.

* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

WellCare had statistically significant improvement for children and adolescents accessing care in 2013 when compared to 2012. Ten rates had a statistically significant decline between CY 2012 and CY 2013. WellCare had only one rate that was above the CY 2013 performance target.

WellCare's Children's Health Measure Results

Table 5-3—Children's Health Measure Results				
	WellCare			2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Well-Child/Well-Care Visits				
First 15 Months of Life: Six or More Visits	66.58%	68.46%	↑	70.70%
Third, Fourth, Fifth, and Sixth Years of Life	68.46%	68.25%	↔	72.26%
Adolescent Well-Care Visits	51.58%	43.75%	↓	49.65%
Immunization and Screening				
Childhood Immunization Status—Combination 3	78.83%	84.95%	↑	82.48%
Childhood Immunization Status—Combination 6*	42.82%	43.06%	↔	
Childhood Immunization Status—Combination 10	38.44%	40.28%	↑	
Lead Screening in Children	75.34%	77.51%	↑	81.86%
Appropriate Testing for Children with Pharyngitis	75.70%	75.94%	↔	76.37%
Immunizations for Adolescents—Combination 1 Total	70.98%	74.59%	↑	80.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile (Total)	38.69%	49.07%	↑	47.45%
Counseling for Nutrition (Total)	55.47%	61.11%	↑	54.88%
Counseling for Physical Activity (Total)	42.09%	51.85%	↑	43.29%
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	79.95%	81.28%	↑	85.34%

Table 5-3—Children's Health Measure Results				
	WellCare			2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Developmental Screening in the First Three Years of Life*				
Developmental Screening in the First Three Years of Life—Total	--	40.51%	--	
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	52.52%	52.65%	↔	
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	24.32%	23.34%	↓	

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[2] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
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↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Regarding measures related to children's health, nine rates had a statistically significant improvement between CY 2012 and CY 2013; however, only four rates were above the 2013 performance targets.

WellCare's Women's Health Measure Results

Table 5-4—Women's Health Measure Results				
	WellCare			2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Prevention and Screening				
Cervical Cancer Screening*	72.51%	73.93%	↑	78.51%
Breast Cancer Screening**	55.78%	73.65%	↑	56.58%
Chlamydia Screening—Ages 16–20 Years	44.26%	45.76%	↑	
Chlamydia Screening—Ages 21–24 Years	62.42%	63.29%	↔	
Chlamydia Screening—Total	48.66%	49.83%	↔	58.40%

Table 5-4—Women's Health Measure Results				
	WellCare			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	2013 Performance Target[3]
Human Papillomavirus Vaccine for Female Adolescents***	--	21.30%	--	22.27%
Prenatal Care and Birth Outcomes				
Timeliness of Prenatal Care	84.18%	84.07%	↔	90.39%
Postpartum Care	62.53%	63.24%	↔	71.05%
Cesarean Rate for Nulliparous Singleton Vertex *A lower rate indicates better performance*	16.86%	15.23%	↑	
Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance*	29.10%	30.41%	↓	28.70%
Rate of Infants With Low Birth Weight (Rate per 100) *A lower rate indicates better performance*	8.02%	8.32%	↔	8.10%
Behavioral Health Risk Assessment for Pregnant Women***	--	6.45%	--	
Elective Delivery*** *A lower rate indicates better performance*	--	0.55%	--	2.00%
Antenatal Steroids***	--	0.69%	--	
Frequency of Ongoing Prenatal Care				
< 21 Percent	12.90%	11.52%	↑	
21–40 Percent	5.11%	6.86%	↓	
41–60 Percent	5.60%	5.64%	↔	
61–80 Percent	13.87%	10.05%	↑	
81+ Percent	62.53%	65.93%	↑	72.99%

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
***This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

Within women's health measures, seven measures demonstrated statistically significant improvement over the CY 2012 rate; however, only two rates were above the CY 2013 performance targets.

WellCare's Chronic Conditions Health Measure Results

Table 5-5—Physical Health Conditions: Chronic Conditions Measure Results				
	WellCare			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	78.47%	78.45%	↔	87.01%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	54.01%	52.47%	↔	41.68%
HbA1c Control (<8.0)	39.05%	39.64%	↔	48.72%
HbA1c Control (<7.0)	32.36%	30.08%	↔	36.72%
Eye Exam (Retinal) Performed	40.51%	34.87%	↓	52.88%
LDL-C Screening	69.71%	69.24%	↔	76.16%
LDL-C Control (<100 mg/dL)	28.10%	28.95%	↔	35.86%
Medical Attention for Nephropathy	72.81%	74.51%	↔	78.71%
Blood Pressure Control (<140/80 mm/Hg)	28.47%	33.55%	↑	39.10%
Blood Pressure Control (<140/90 mm/Hg)	51.64%	56.91%	↑	63.50%
Diabetes Short-Term Complications Admission Rate†				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months) *A lower rate indicates better performance*	--	17	--	62.74
Respiratory Conditions				
Use of Appropriate Medications for People With Asthma				
5–11 Years	90.56%	92.48%	↑	
12–18 Years	88.16%	88.72%	↔	
19–50 Years	75.65%	78.45%	↔	

Table 5-5—Physical Health Conditions: Chronic Conditions Measure Results				
	WellCare			CY 2013 Performance Target[3]
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	
51–64 Years	NA	NA	--	
Total	89.12%	90.45%	↑	90.56%
Young Adult Asthma Admission Rate*				
Young Adult Asthma Admission Rate *A lower rate indicates better performance*	--	6.03	--	
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate†				
Per 100,000 Member Months (Total)	--	44	--	559.03
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate†				
Per 100,000 Member Months (Total)	41.04	6	--	380.70
Controlling High Blood Pressure				
Controlling High Blood Pressure	49.64%	47.67%	↔	57.52%
Adult BMI Assessment				
Adult BMI Assessment	67.88%	75.78%	↑	70.60%

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[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
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* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.
† The reporting metric for this measure has changed from 100,000 members to 100,000 member months. Therefore, trending comparisons with CY 2012 rates were not performed for all CMOs. It would also be inappropriate to compare the CMO CY 2013 rates with the performance target which was developed based on the prior year's reporting metric.

For measures related to physical health chronic conditions, WellCare had five rates that showed statistically significant improvement and one rate with a statistically significant decline. Only one rate within the domain was above the CY 2013 performance target.

WellCare's Behavioral Health Measure Results

Table 5-6—Behavioral Health Measure Results				
	WellCare			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	CY 2013 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	39.39%	41.12%	↑	52.48%
Continuation and Maintenance Phase	53.10%	54.18%	↔	63.11%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	60.37%	52.39%	↓	69.57%
Follow-Up Within 30 Days	77.16%	72.63%	↓	84.28%
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.00%	44.15%	↓	52.74%
Effective Continuation Phase Treatment	32.74%	29.43%	↔	37.31%
Screening for Clinical Depression and Follow-Up Plan*				
Screening for Clinical Depression and Follow-Up Plan	--	1.07%	--	
Adherence to Antipsychotics for Individuals With Schizophrenia*				
Adherence to Antipsychotics for Individuals With Schizophrenia	--	40.40%	--	

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[2] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
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* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
-- Indicates this was not a required measure.
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↔ Indicates no statistically significant change.

Three of the eight measures related to behavioral health showed a statistically significant decline between CY 2012 and CY 2013. WellCare did not meet the CY 2013 performance target for any behavioral health measure.

WellCare's Medication Management Measure Results

Table 5-7—Medication Management Measure Results				
	WellCare			
Measure	CY 2012 Rate[1]	CY 2013 Rate[2]	Statistically Significant Increase/ Decline	CY 2013 Performance Target[3]
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions				
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions *A lower rate indicates better performance*	42.78%	41.89%**	↑	41.51%
Annual Monitoring for Patients on Persistent Medications				
Total	87.06%	87.01%	↔	88.55%
Medication Management for People With Asthma*				
50% Compliance—Total	43.85%	48.15%	↔	
75% Compliance—Total	20.55%	22.28%	↔	

[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 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[3] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
-- Indicates this was not a required measure.
↑ Indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ Indicates a statistically significant decline in performance between CY 2012 and CY 2013.
↔ Indicates no statistically significant change.

WellCare's rate for Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions showed statistically significant improvement over the CY 2012 rate; however, the CMO did not meet any of the CY 2013 performance targets for the Medication Management measures.

Strengths

Based on their CY 2013 performance, WellCare met eight performance targets (see Table 5-8). Half of WellCare's measures met the performance targets in the Children's Health domain.

Table 5-8—Number of Performance Targets Met by WellCare	
Measure Set	**Targets Met**
Access to Care	1
Children's Health	4
Women's Health	2
Chronic Conditions	1
Behavioral Health	0
Medication Management	0
Total	8

WellCare has opportunities for improvement related to achieving performance targets, especially for the Behavioral Health and Medication Management domains.

Opportunities for Improvement

HSAG encourages WellCare to perform the following:

- WellCare should focus on the Access measures, where there were 10 instances of statistically significant performance decline. Six of the seven *Oral Health (Annual Dental Visit Rate*) indicators contributed to this high number.
- WellCare should focus quality improvement efforts on the *Comprehensive Diabetes Care* measure.

Performance Improvement Projects

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

HSAG reviews each PIP using CMS' validating protocol to ensure that the CMOs design, conduct, and report PIPs in a methodologically sound manner and meet all State and federal requirements. As a result of this validation, DCH and interested parties can have confidence in reported improvements that result from a PIP.

PIP Validation Findings

HSAG organized, aggregated, and analyzed WellCare's PIP data to draw conclusions about the CMO's quality improvement efforts. The PIP validation process evaluated both the technical methods of the PIP (i.e., the study design) and the 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. The results are presented in Table 5-9. Appendix C provides additional detail on the methodology HSAG used for validating the PIPs.

Table 5-9—Performance Improvement Project Validation Scores for WellCare of Georgia, Inc.

PIP	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Validation Status
Adolescent Well-Care Visits	86%	93%	*Not Met*
Annual Dental Visits	71%	55%	*Not Met*
Appropriate Use of ADHD Medication	86%	82%	*Not Met*
Avoidable Emergency Room Visits	64%	45%	*Not Met*
Childhood Immunizations—Combo 10	92%	100%	*Met*
Childhood Obesity	94%	100%	*Met*
Comprehensive Diabetes Care	88%	86%	*Not Met*
Member Satisfaction	84%	86%	*Not Met*
Postpartum Care	88%	79%	*Not Met*
Provider Satisfaction	82%	79%	*Not Met*

Only two of the 10 WellCare PIPs, *Childhood Immunizations—Combo 10* and *Childhood Obesity*, received an overall *Met* validation status. The remaining eight PIPs received a *Not Met* score for one or more critical evaluation elements, which resulted in a *Not Met* validation status.

Table 5-10 displays the combined validation results for all 10 WellCare PIPs validated. This table illustrates the CMO's application of the PIP process and its success in implementing all 10 projects. Each activity was composed of individual evaluation elements scored as *Met* or *Not Met***.** Elements receiving a *Met* score satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-10 show the percentage of applicable evaluation elements that received a *Met* score by activity. Additionally, HSAG calculated an overall percentage of *Met* scores across all activities for all 10 PIPs. Appendix D provides the detailed scores from the validation tool for each of the 10 PIPs.

Table 5-10—Performance Improvement Project Validation Results for WellCare of Georgia, Inc. (N=10 PIPs)

PIP Stage	Activity	Percentage of Applicable Elements	
		Met	*Not Met*
Design	Appropriate Study Topic	100% (57/57)	0% (0/57)
	Clearly Defined, Answerable Study Question(s)	100% (20/20)	0% (0/20)
	Clearly Defined Study Indicator(s)	93% (26/28)	7% (2/28)
	Correctly Identified Study Population	91% (53/58)	9% (5/58)
	Valid Sampling Techniques (if sampling was used)	98% (41/42)	2% (1/42)
	Accurate/Complete Data Collection	99% (82/83)	1% (1/83)
Design Total		**97% (279/288)**	**3% (9/288)**
Implementation	Sufficient Data Analysis and Interpretation of Results	76% 66/87	24% 21/87
	Appropriate Improvement Strategies	53% 20/38	47% 18/38
Implementation Total		**69% 86/125**	**31% 39/125**
Outcomes	Real Improvement Achieved	48% 19/40	53% 21/40
	Sustained Improvement Achieved	50% 1/2	50% 1/2
Outcomes Total		**48% 20/42**	**52% 22/42**
Percentage of Applicable Evaluation Elements Scored *Met*		**85% (385/455)**	

Overall, 85 percent of the evaluation elements across all 10 PIPs received a *Met* score. WellCare demonstrated a strong performance in the Design stage; however, the CMO was considerably less successful in the Implementation and Outcomes stages. The following subsections highlight HSAG's validation findings associated with each of the three PIP stages.

Design

WellCare met 97 percent of the requirements across all 10 PIPs for the six activities within the Design stage. The technical design of each PIP was sufficient to measure and monitor PIP outcomes. The solid foundation of the PIPs allowed for the CMO to progress to the next stage of the PIP process.

Implementation

WellCare met 69 percent of the requirements for the two activities within the Implementation stage. The CMO did not report accurate data components in some of its PIPs, and not all of the statistical testing performed was completely accurate. Additionally, the CMO did not report an adequate and data-driven barrier identification process. The PIPs did not include specific data or analysis results to support identified barriers, and barriers were not prioritized. The PIPs also did not include evaluations of effectiveness for each intervention, and evaluation results were not reported. Overall, the improvement strategies were not successful in achieving statistically significant improvement across all study indicators for all PIPs and for sustaining any improvement achieved.

Outcomes

This year, all 10 PIPs were evaluated for achieving statistically significant improvement over baseline. Three PIPs, *Adolescent Well-Care Visits*, *Childhood Immunizations—Combo 10*, and *Childhood Obesity* achieved statistically significant improvement over baseline for all indicators at the current measurement period. Two of those PIPs, *Adolescent Well-Care Visits* and *Childhood Immunizations—Combo 10* progressed to the point of being assessed for sustained improvement with mixed results. Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the results of the most current measurement period must reflect improvement when compared to baseline results. While the *Childhood Immunizations—Combo 10* study indicator demonstrated sustained improvement, the *Adolescent Well-Care Visits* study indicator demonstrated a statistically significant decline in performance, resulting in a lack of sustained improvement over baseline.

PIP-Specific Outcomes

Adolescent Well-Care

Table 5-11—Performance Improvement Project Outcomes for *Adolescent Well-Care Visits*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
The percentage of members 12–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.	41.4%	51.6%↑*	43.8%↓*	No

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

There was a statistically significant decline in the study indicator rate from Remeasurement 1 to Remeasurement 2 for the *Adolescent Well-Care Visits* PIP. The percentage of eligible adolescent members who had at least one well-care visit during the measurement year declined 7.8 percentage points. The Remeasurement 2 rate was no longer a statistically significant improvement over the baseline rate; therefore, the PIP did not demonstrate sustained improvement. The Remeasurement 2 rate fell below the 2013 DCH target of 49.7 percent and was between the 25th and 50th percentiles of the national Medicaid HEDIS 2012 rates.

A critical analysis of WellCare's improvement processes revealed several factors contributing to the performance decline. The CMO's Utilization Management Medical Advisory Committee (UMAC) and Quality Improvement Committee (QIC) met quarterly to identify and address barriers. The CMO used a fishbone diagram to summarize identified barriers; however, WellCare did not describe the process used to identify or prioritize barriers for intervention. Specific data to support the barriers were not documented in the PIP.

WellCare continued ongoing interventions to address member and provider awareness of when an adolescent well-care appointment was due. The CMO revised one intervention for CY 2013, extending the hours of operation for the Centralized Telephonic Outreach outbound call unit to 7:00 p.m., in order to reach members after normal business hours and provide assistance with scheduling well-care appointments.

The ongoing interventions that the CMO continued during CY 2013 were:

- Telephone outreach to educate members on the importance of adolescent well-care visits and schedule appointments.
- Targeted Health Check schedule reminder letters sent at 120 days of plan enrollment and during the member's birthday month.
- Monthly provider membership lists that specified children eligible for health check visits who had not had an encounter within 120 days of joining the health plan or were not in compliance with the Health Check Program.

While WellCare initiated new interventions following the performance decline in Remeasurement 2, and reinstated the provider incentive program, the CMO did not describe the analysis results or processes used to guide decisions about making these changes. WellCare did not document any processes to evaluate the effectiveness of each intervention or any evaluation results. Without intervention-specific evaluations, the CMO does not have the information necessary to fully assess the causes for the decline in adolescent well-care visits. Quantitative assessment of each intervention is necessary to determine if interventions are being implemented effectively and to identify which strategies are having the greatest positive impact on targeted outcomes.

Annual Dental Visits

Table 5-12—Performance Improvement Project Outcomes for *Annual Dental Visits*

Study Indicator	Baseline (10/1/2011–9/30/2012)	Remeasurement 1 (10/1/2012–9/30/2013)	Sustained Improvement^
1. The percentage of EPSDT eligible members ages 1–20 who received any dental services during the measurement period (CMS 416 12A).	63.8%	64.7%↑*	NA
2. The percentage of EPSDT eligible members ages 1–20 who received preventive dental services during the measurement period (CMS 416 12B).	59.6%	45.4%↓*	NA
3. The percentage of EPSDT eligible members ages 6–9 who received preventive dental services during the measurement period (CMS 416 12D).	16.7%	16.1%↓*	NA

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

The study indicators demonstrated mixed results for the first remeasurement of WellCare's *Annual Dental Visits* PIP. There was a statistically significant increase in the rate for Study Indicator 1 (any dental service) but a statistically significant decline in the rates for Study Indicators 2 (preventive dental services) and 3 (dental sealant services). The Remeasurement 1 rate for Study Indicator 2 was also 12.6 percentage points below the 2013 DCH target rate of 58.0 percent.

A critical review of WellCare's quality improvement processes and strategies identified several reasons for the mixed study indicator performance.

- The CMO documented that barriers were identified through a collaborative approach including a drill-down analysis of the baseline data. WellCare summarized system, member, and provider barriers in a fishbone diagram. The PIP documentation, however, did not include any data to support identified barriers, and no specific step-by-step process was described for the causal/barrier analysis. Additionally, priority barriers were not identified in the PIP.
- WellCare did not adequately describe the interventions implemented for the PIP. Based on the documentation provided, some interventions, such as the case manager program and the community outreach program, were system interventions. Other interventions, such as the mailed member reminders and mailed noncompliant lists for providers, were not system changes likely to result in improvement of long-term outcomes.

- The CMO did not document any monitoring or evaluation of ongoing interventions. WellCare had no documented evaluation process, nor did it have results of evaluating the effectiveness for each intervention.

It is critical that WellCare implement and document processes to evaluate the effectiveness of each implemented intervention. To address the varied study indicator results, it is necessary to examine each intervention to determine if it is impacting some of the study indicators but not others.

Appropriate Use of ADHD Medications

Table 5-13—Performance Improvement Project Outcomes for *Appropriate Use of ADHD Medications*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
1. 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%	41.1%↑*	NA
2. 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%	54.2%	NA

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

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.

At the second remeasurement for WellCare's *Appropriate Use of ADHD Medications* PIP, neither study indicator achieved statistically significant improvement over baseline. The Remeasurement 2 rate for Study Indicator 1 (follow-up visits for the initiation phase) was a statistically significant improvement over Remeasurement 1 but not over baseline. The Remeasurement 2 rate for Study Indicator 2 (follow-up visits for the continuation phase) was a non-statistically significant improvement over Remeasurement 1, and the rate remained below baseline. The Remeasurement 2 rates for Study Indicators 1 and 2 fell below the CY 2013 DCH targets of 52.5 percent and 63.1

percent, respectively. In comparison with the national Medicaid HEDIS 2012 rates, the Remeasurement 2 rates for both study indicators fell between the 50th and 75th percentile rates.

A critical examination of WellCare's improvement processes and strategies determined several factors related to the lack of significant improvement in the study indicators for the *Appropriate Use of ADHD Medications* PIP.

- The CMO documented that "member and provider correspondence, data analysis, and process review" were used to identify barriers; however, the CMO did not report specific data or analysis results to support identified barriers. The CMO also did not identify priority barriers for the PIP. To thoroughly evaluate the root causes of noncompliance with ADHD follow-up visits, WellCare should have documented specific member/provider feedback, results from the survey of a sample of noncompliant members, and results from drill-down analyses for specific providers.
- To address member and provider awareness of the ADHD medication follow-up visit requirements, WellCare completed a number of educational and reminder mailings to members and providers. The mailings identified due follow-up visits and shared best practices. In addition to mailings, the CMO completed face-to-face visits with high-volume ADHD providers to review lists of noncompliant members and discuss best practices for completing timely follow-up visits.
- Despite the lack of significant improvement over baseline for the study indicator rates, the CMO documented that it would be continuing all interventions but provided no evaluation data to support this decision.

Childhood Immunizations—Combo 10

Table 5-14—Performance Improvement Project Outcomes for *Childhood Immunizations—Combo 10*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
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%↑*	40.3%	Yes

↑* Designates statistically significant improvement 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.

WellCare demonstrated sustained improvement in the *Childhood Immunizations—Combo 10* PIP, with an increase of 20.1 percentage points from baseline to Remeasurement 2 in the rate of eligible

child members who received the recommended vaccinations by their second birthday. The Remeasurement 2 rate of 40.3 percent exceeded the 90th percentile of the national Medicaid HEDIS 2012 rates.

WellCare's collaborative PIP team identified barriers and developed member, provider, and plan-level interventions through data analysis and process review. The CMO documented barriers such as members refusing assistance with appointments, member lack of awareness regarding immunization schedule, and lack of provider awareness of HEDIS requirements.

To address these barriers, WellCare implemented the following interventions:

- Pay for Performance (P4P) provider face-to-face visits to deliver lists of noncompliant members.
- Member incentive program for completed immunization visits.
- Outbound member reminder calls.
- Centralized telephonic outreach program with extended operating hours beyond normal business hours.
- Inbound care gap alert program to facilitate scheduling of visits for needed services when a member calls.
- Targeted periodicity letters sent to members annually.
- Targeted 120-day provider reminder letters with a list of noncompliant members.
- HEDIS Toolkits distributed during P4P visits.

Although the study indicator demonstrated sustained improvement, the CMO failed to document intervention evaluations. The PIP documentation included neither detail on methods for evaluating intervention effectiveness nor evaluation results.

Childhood Obesity

Table 5-15—Performance Improvement Project Outcomes For *Childhood Obesity*

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)	Remeasurement 4 (1/1/13–12/31/13)	Sustained Improvement^
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%↓*	49.1%↑*	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	42.3%	48.9%	50.4%↑*	55.5%	61.1%	NA

Table 5-15—Performance Improvement Project Outcomes
For *Childhood Obesity*

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)	Remeasurement 4 (1/1/13–12/31/13)	Sustained Improvement^
counseling for nutrition.						
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%	51.9%↑*	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.

All three study indicators for the *Childhood Obesity* PIP demonstrated improvements from Remeasurement 3 to Remeasurement 4, with the improvements for Study Indicators 1 (BMI percentile documentation) and 3 (evidence of counseling for physical activity) being statistically significant. Additionally, Study Indicator 3 demonstrated statistically significant improvement over baseline for the first time at Remeasurement 4. The Remeasurement 4 rates for all three study indicators—BMI percentile documentation, evidence of nutrition counseling, and evidence of physical activity counseling—exceeded the CY 2013 DCH target rates of 47.5 percent, 54.9 percent, and 43.3 percent, respectively. In comparison with the national Medicaid HEDIS 2012 benchmarks, WellCare's CY 2013 rates for all three study indicators were between their respective 50th percentile and 75th percentile rates.

For the *Childhood Obesity* PIP, WellCare gathered input from several sources: quarterly UMAC and QIC meetings; bimonthly HEDIS Steering Committee meetings; and staff input from member outreach, provider relations, and quality improvement departments. The CMO identified barriers through member and provider feedback, data analysis, and process review. Barriers documented in a fishbone diagram included the following: members not attending well-care visits during the measurement period, lack of provider awareness of documentation requirements, insufficient time for provider to meet documentation requirements, and lack of reimbursement for current procedural terminology (CPT) II codes.

To address these barriers, WellCare implemented the following interventions:

- Outreach to 13,732 members ages 3–6 years, reminding them of due well-child visits.

- Distribution of postcards outlining the Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC) measures to providers at a pediatric conference.
- Distribution of a DCH-approved BMI percentile documentation form for providers via their provider Web site and through fax.
- E-mail communication with independent practice associations (IPAs), providing BMI percentile forms and WCC postcards.
- Targeted face-to-face pediatric provider visits requesting the use of CPT II codes to document WCC services, despite the lack of reimbursement for these codes.

The CMO documented the evaluation of effectiveness for some interventions. One intervention, face-to-face provider visits requesting the use of CPT II codes, had a documented quantitative evaluation in which the CMO reported, "The providers that were asked to utilize the CPT II codes had higher rates of compliance for WCC than the providers who did not have a face-to-face visit."

Comprehensive Diabetes Care

Table 5-16—Performance Improvement Project Outcomes for *Comprehensive Diabetes Care*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
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%	30.1%	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%	28.9%	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%	56.9%	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.

There were no statistically significant changes in the study indicator rates at Remeasurement 2 for the *Comprehensive Diabetes Care* PIP. The rate for Study Indicator 1 (HbA1c control < 7.0%) decreased by 2.3 percentage points, the rate for Study Indicator 2 (LDL-C control < 100 mg/ml) increased by 0.8 percentage point, and Study Indicator 3 (BP control < 140/90 mmHg) increased by 5.3 percentage points. The CMO's rates fell below the CY 2013 DCH goals of 36.7 percent (HbA1c control < 7.0%), 35.9 percent (LDL-C control < 100 mg/ml), and 63.5 percent (BP control < 140/90 mmHg), respectively. The rate for Study Indicator 1 fell below the 25th percentile of the national

Medicaid HEDIS 2012 rates, and the rates for Study Indicators 2 and 3 were slightly higher than the 25th percentile.

A critical review of WellCare's quality improvement processes revealed several factors that contributed to a lack of significant improvement in the study indicators.

The CMO summarized barriers using a fishbone diagram; however, the PIP documentation did not include any quantitative data or specific data analysis results to support the identified barriers. The fishbone diagram included the following barriers: lack of member willingness, awareness, and skills to manage diabetes; lack of provider awareness of HEDIS requirements; lack of provider awareness of member noncompliance; inaccurate contact information for diabetic patients; and lack of provider incentive. WellCare did not describe a process for identifying high-priority barriers and did not rank barriers in order of priority.

WellCare implemented both member- and provider-focused interventions based on its causal/barrier analysis findings. The CMO implemented the following interventions:

- Laboratory follow-up by the QI Department to determine results of laboratory tests listed on the quarterly "labs with no result" lists.
- Distribution of noncompliant member lists to provider offices.
- HEDIS Education Screening Program—WellCare identified members with a care gap during the calendar year based on claims data. Registered nurses (RNs) across the company contacted those diabetic members with care gaps. During the call, the nurse provided education and assisted with making an appointment to visit the provider's office.
- A HEDIS care gap database and tracking tool, which alerts WellCare staff of any due/past due services during inbound/outbound telephone contact with the member.
- Training on glucometer use for members enrolled in the disease management program.
- Enhanced care plans implemented by the disease management program to support more individualized care and education, resulting in better self-management. These plans incorporate member-identified needs and identify specific, measurable, attainable, relevant, and time-bound (SMART) goals to facilitate self-management. The plans are shared with the member's provider.
- Contracted with AVESIS, an external vendor, to increase outreach capability through telephone calls and postcards.

While WellCare reported the implementation status of each intervention, the CMO did not document any intervention-specific results used to guide decisions about continuing or discontinuing the interventions. The documentation did not include any evaluation methods or results for the interventions. Although the PIP documentation included an additional intervention table with an "Analysis" column, the documentation in this column did not describe any evaluation linking intervention implementation to study indicator performance.

Avoidable Emergency Room Visits

Table 5-17—Performance Improvement Project Outcomes for *Avoidable Emergency Room Visits*

Study Indicator	Baseline Period (1/1/11–12/31/11)	Remeasurement 1 (1/1/12–12/31/12)	Remeasurement 2 (1/1/13–12/31/13)	Sustained Improvement^
1. 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 Healthcare of Atlanta facilities in the Atlanta region.	12.1%	14.8%	15.0%	NA
Study Indicator	**Baseline Period (1/1/13–12/31/13)**	**Remeasurement 1 (1/1/14–12/31/14)**	**Remeasurement 2 (1/1/15–12/31/15)**	**Sustained Improvement^**
2. 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 selected hospitals in the CMO's expansion population.*	*			NA

* The CMO did not report baseline data for Study Indicator 2.

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.

In CY 2013, for the *Avoidable Emergency Room Visits* PIP, WellCare collected Remeasurement 2 data for Study Indicator 1, the percentage of ER visits for avoidable diagnoses in select facilities in the Atlanta region. The CMO should have also collected baseline data for Study Indicator 2 (the percentage of ER visits for avoidable diagnoses in select hospitals in the CMO's expansion population) during CY 2013; however, WellCare did not report baseline data for Study Indicator 2. The rate for Study Indicator 1 increased from baseline to Remeasurement 1 and from Remeasurement 1 to Remeasurement 2. Because the avoidable ER visits rate was an inverse study indicator, for which a lower rate is better, the increases from baseline to Remeasurement 2 demonstrated a decline in performance.

A critical analysis of WellCare's improvement strategies identified several shortcomings in the PIP that resulted in a lack of improvement. The CMO's UMAC, QIC, and HEDIS Steering Committee collaborated to identify barriers. Barriers were summarized in a fishbone diagram; high-priority barriers were not distinguished in the PIP documentation. As with other WellCare PIPs, no analysis

results or quantitative data to support the barriers were identified for the *Avoidable Emergency Room Visits* PIP. The identified barriers included: lack of provider awareness of member emergency room (ER) visits, providers not offering members guidance on handling after-hours care needs, lack of member awareness of after-hours and urgent care facilities, and lack of member understanding of what conditions warrant an ER visit.

To address provider-based barriers, the CMO conducted a Webinar with providers to discuss the *Avoidable Emergency Room Visits* PIP and increase provider awareness of member ER usage. WellCare implemented three member-focused interventions including:

- Targeted distribution to members of a "Before the ER" step-by-step plan for when an emergency occurs.
  - Step 1: PCP information and a list of conditions appropriate for PCP care.
  - Step 2: Nurse advice line information and Web site to identify nearby urgent care facilities.
  - Step 3: Local urgent care facility information.
  - Step 4: Local ER facility information and a list of life-threatening conditions that warrant an ER visit.
- Distribution of "ER Tool Kits" through high-volume provider practices, to enhance member knowledge of when and where to seek urgent versus emergent care. The tool kits included:
  - Centers for Disease Control and Prevention (CDC) "Get Smart" materials: posters, prescription pads, and brochures.
  - Pre-populated flyers and posters providing office hours, local urgent care facility information, and local pharmacy information.
  - Materials providing advice for seeking care after-hours.
- Targeted outreach to members who visited the ER. Members were educated on their PCP contact information, benefits such as the nurse advice line, and what conditions warrant an ER visit. High ER utilizers were referred to field short-term case management and, when appropriate, members were referred to complex case management.

As WellCare did not report baseline data for the correct Study Indicator 2 (the percentage of ER visits for avoidable diagnoses in select hospitals in the CMO's expansion population), the CMO did not document any interventions that were tailored to the expansion population.

WellCare provided insufficient information on the impact of the interventions on the PIP outcomes. The CMO did not fully document evaluation processes and results used to evaluate intervention effectiveness. While the CMO provided some qualitative information about how the interventions were received by providers and how some interventions would be revised, the PIP documentation did not include any quantitative evaluation results. Additionally, the CMO provided no information on how the impact of one intervention, the "Before the ER" step-by-step member plan, was assessed and whether or not this strategy would be continued.

Member Satisfaction

Table 5-18—Performance Improvement Project Outcomes for *Member Satisfaction*

Study Indicator	Baseline Period (1/1/13–5/31/13)	Remeasurement 1 (1/1/14–5/31/14)	Sustained Improvement^
The percentage of respondents who rate the health plan an 8, 9, or 10 in response to the question "Using any number from 0–10, where 0 is the worst health plan and 10 is the best, what number would you use to rate your child's health plan?"	88.3%	87.5%	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.

At the first remeasurement for the *Member Satisfaction* PIP, WellCare reported a decline in the rate of member satisfaction. The rate of respondents giving WellCare a score of "8" or higher declined 0.8 percentage point from baseline to Remeasurement 1.

A critical assessment of the improvement strategies WellCare used for the *Member Satisfaction* PIP suggested several factors that contributed to the lack of improvement demonstrated at the first remeasurement. WellCare documented the involvement of its UMAC, QIC, HEDIS Steering Committee, and CAHPS Committee in the causal/barrier analysis process for the *Member Satisfaction* PIP. The committees identified barriers through data analysis and process review. The CMO used a Force Field Analysis to summarize identified barriers and interventions.

The CMO continued the following ongoing interventions:

- To address member care gaps, WellCare implemented HEDIS Tool Kits to provide member-centric talking points to Community Relations staff and outreach nurses who contact members identified as having due/past due services.
- To address a lack of in-network providers and specialists, WellCare continued year-round provider recruiting, worked with a vendor to identify specialists contracted with other payors, launched a partnership to provide telemedicine services, and removed prior authorization requirements for most procedures.
- To address WellCare not being a strong presence in the community, the CMO implemented Enhanced Community Outreach, a collaborative relationship with community advocacy partners.
- Lack of member awareness of recent CMO improvements.
- Member opinion of Customer Service courtesy and respect.

The CMO initiated four interventions during CY 2013, which included:

- Increased the number of open provider panels by 20 percent to enhance member access to providers.

- Sent out a letter to members to increase awareness of the changes WellCare implemented in order to improve member satisfaction.
- Provided "soft skill" training to customer service staff to meet members' expectations of courtesy and respect.
- Launched a series of member mailings to change member perceptions of the CMO's services.

Despite the many documented interventions, WellCare did not achieve improvement in overall member satisfaction. The CMO documented that the interventions would be discussed by the CAHPS Committee, in relation to the Remeasurement 1 results; however, WellCare did not document any planned or implemented intervention revisions.

Postpartum Care

Table 5-19—Performance Improvement Project Outcomes for *Postpartum Care*

Study Indicator	Baseline (1/1/12–12/31/12)	Remeasurement 1 (1/1/13–12/31/13)	Sustained Improvement^
The percentage of deliveries of live births by members that were followed by a postpartum visit on or between 21 and 56 days after delivery.	62.5%	63.2%	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.

For the first remeasurement of the *Postpartum Care* PIP, WellCare reported a non-statistically significant improvement of 0.7 percentage point. The Remeasurement 1 rate fell below the 2013 DCH target rate of 71.1 percent and below the 50th percentile of the national Medicaid HEDIS 2012 rates.

Critical examination of WellCare's quality improvement processes identified several deficiencies in the CMO's approach, leading to a lack of statistically significant improvement in the study indicator.

WellCare continued its practice of documenting barriers and interventions without providing quantitative data or analysis results to support conclusions for the *Postpartum Care* PIP. The CMO reported that it used a "fishbone analysis" for the causal/barrier analysis; however, the specific data and process used in this analysis were not identified. Additionally, no process for prioritizing barriers was described, and high-priority barriers were not distinguished from other barriers. Lastly, most of the interventions documented for the PIP were linked to barriers that were not listed on the fishbone diagram. The CMO documented the following interventions and associated barriers:

- To address lack of member awareness, WellCare implemented reminder calls for scheduled postpartum appointments.

- To provide members an incentive for completing a timely visit, the CMO offered a "maternity rewards program." Members could select a stroller or play yard after completion of a timely postpartum visit.
- To stress the importance of the postpartum visit, WellCare contracted with a vendor to conduct comprehensive outreach to members during and after the pregnancy.
- To address lack of coordination, WellCare issued a "Welcome Home Report" for each member recently discharged after delivery. Case managers and the High Risk Obstetrics (OB) team used these reports to plan transitional interventions, including scheduling the postpartum visit.
- To address social service needs and facilitate coordination of care, the CMO facilitated member outreach by OB social workers.
- To provide integrated care and meet individual member needs, WellCare offered OB short-term case management, which provided appropriate assessments and referrals.
- The Community Relations department hosted postpartum events to promote the importance of timely postpartum visits.
- To address provider awareness of HEDIS specifications for the timing of the postpartum visit, WellCare received assistance from the Obstetrics and Gynecology (OB/GYN) Society to provide education to specialists.

WellCare provided insufficient information about the interventions implemented. The CMO reported only the calendar year for the intervention implementation dates and did not provide specific start dates; it was unclear whether interventions were implemented for only part of the identified measurement period or for the entire year. Accurate and consistent documentation of implementation dates is important as part of the process to evaluate intervention effectiveness. Complete start and end dates allow the CMO to better link implementation of specific interventions to changes in the study indicators. Beyond incomplete implementation dates, WellCare failed to describe *any* evaluation methods or results for the *Postpartum Care* PIP interventions.

Provider Satisfaction

Table 5-20—Performance Improvement Project Outcomes for *Provider Satisfaction*

Study Indicator	Baseline Period (8/1/12–10/31/12)	Remeasurement 1 (6/1/13–8/31/13)	Sustained Improvement^
The percentage of providers answering, "Very satisfied" or "Somewhat satisfied" to Q42 - "Please rate your overall satisfaction with WellCare of Georgia."	81.0%	69.5%↓*	NA

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

In the *Provider Satisfaction* PIP, WellCare reported a statistically significant decline of 11.5 percentage points in the rate of overall provider satisfaction from baseline to Remeasurement 1.

A critical review of WellCare's PIP documentation yielded a number of areas of the quality improvement process that require further development to achieve the desired outcomes. Based on the PIP documentation, the CMO needs to revisit the processes used for causal/barrier analyses, intervention development and revision, and evaluation of intervention effectiveness.

The documentation for the causal/barrier analysis process used in the *Provider Satisfaction* PIP lacked detail on the processes and tools used. While the CMO attached the vendor's survey report for the baseline results, including a drill-down analysis, WellCare did not directly link the survey results to identified barriers. The CMO also did not describe a process for prioritizing or identifying high-priority barriers.

WellCare's interventions implemented during the Remeasurement 1 period to improve provider satisfaction included the following:

- To address provider awareness of HEDIS specifications for the timing of the postpartum visit, WellCare received assistance from the OB/GYN Society to provide education to specialists.
- WellCare developed "Closed Panel Procedures" to formalize the process of removing providers from the CMO's provider directory when they close their panels.
- The CMO created six Hospital Service Specialist positions, one in each region of the State, to improve customer service for hospitals.
- WellCare collected and verified e-mail addresses for high-volume PCPs to facilitate rapid dissemination of information to providers.
- To address unnecessary emergency room utilization by members, WellCare doubled its network of urgent care centers.
- The CMO completed in-person provider visits to deliver care gap reports; the visits helped to develop rapport with providers and make the care gap information more useful. The in-person visits included an explanation of how providers can use the report to address health concerns in the member population.

WellCare's omissions in the documented causal/barrier analysis process were accompanied by a lack of documented intervention-specific evaluation. The CMO's PIP documentation did not include a process for the evaluation of intervention effectiveness or quantitative evaluation results for each intervention. Process improvements, based on quality improvement science, in the areas of barrier identification and ongoing evaluation of intervention effectiveness are necessary before WellCare can expect to achieve the desired improvement in outcomes.

Quality

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

The DCH uses the results of performance measures and PIPs to assess care delivered to members by a CMO in areas such as preventive screening and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes.

In addition, DCH monitors aspects of a CMO's operational structures that promote the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

Based on WellCare's performance across the mandatory activities, HSAG found mixed results. The CMO demonstrated both strong and poor performance in the areas under review, without a dominant area of overall strength. WellCare had some success with aspects of chronic disease management for members with hypertension, while care for members with diabetes showed no change from the prior year. In addition, WellCare demonstrated statistically significant improvement in the number of women who received 81 percent or more of the recommended prenatal care visits, but many women's health measures remained unchanged or declined.

The review period revealed substantial organizational change for WellCare in relation to the quality assessment and performance improvement functions. Many staff members present for the compliance review were new, functioning in an interim role, or managing from the corporate office. While many organizational models can be successful, HSAG noted a lack of local staff presence with the ability to make decisions necessary to promote the local Georgia market's needs. HSAG observed that staff members responsible for revising performance improvement projects and performance measure rates were limited in their ability to move quickly or tackle initiatives deemed a priority by DCH because the corporate organization's priorities did not align with DCH priorities. The CMO has an opportunity to create a quality improvement strategy for Georgia Medicaid that builds on the strengths of its centralized functions and mission-driven goals, yet allows flexibility to address the needs of Georgia Medicaid.

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 uses monitoring processes, including audits, to assess a CMO's compliance with access standards. These standards include an assessment of network adequacy and availability of services, coordination and continuity of care, and access to covered services under the GF's program.

Performance measures, PIP outcomes, and member satisfaction results are used to evaluate access to care. Measures such as well-care visits for children and adolescents, immunizations, timeliness of prenatal and postpartum care, cancer screening, and diabetes fall under the domains of quality and access because members relay on access to and the availability of these services to receive care according to generally accepted clinical guidelines.

WellCare demonstrated mixed results within the access domain of care. The CMO demonstrated statistically significant improvement with at least 90 percent of children accessing care during 2013. Conversely, WellCare had statistically significant declines in most age categories for members accessing oral health services.

WellCare showed strength in its local OB case management program and improved its overall performance in measures related to pregnant women receiving the recommended number of prenatal visits.

Opportunities exist in the area of care coordination and continuity of care, with an emphasis on transitions of care, discharge planning, and follow-up. WellCare needs to explore strategies to engage members and providers to be more active in the care planning process.

WellCare had some deficiencies noted in the access to care timeliness standards.

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.

WellCare's performance related to timeliness of care was mixed. The CMO had statistically significant and sustained improvement in the area of childhood immunizations, suggesting that more children are receiving the recommended vaccines according to clinical practice guidelines. The CMO had some deficiencies in the area of coverage and authorization of services, and opportunities exist to align policies and procedures with operational practice.

In addition to the preceding report sections that assess each CMO's strengths and weaknesses, HSAG evaluated the GF's program across the CMOs to make an overall assessment about access, quality, and timeliness of care provided to the GF membership as a whole. Based on this assessment, HSAG provides additional recommendations to DCH to inform policy and oversight activities that may improve the delivery of care and services to the GF population.

Review of Compliance With 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 2014. The CMOs submitted documentation that covered the SFY 2014 review period of July 1, 2013, through June 30, 2014. HSAG provided detailed, final audit reports to the CMOs and DCH in December 2014.

Summary of SFY 2015 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 6-1 displays the standards and compliance scores.

Table 6-1—Standards and Compliance Score

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met****	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Availability of Services	17	17	A: 17 P: 17 W: 17	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 100% P: 100% W: 100%
II	Furnishing of Services	22	22	A: 20 P: 14 W: 19	A: 2 P: 8 W: 3	A: 0 P: 0 W: 0	A: 90.9% P: 63.6% W: 86.4%
III	Cultural Competence	14	14	A: 14 P: 14 W: 13	A: 0 P: 0 W: 1	A: 0 P: 0 W: 0	A: 100% P: 100% W: 92.9%
IV	Coordination and Continuity of Care	21	21	A: 18 P: 13 W: 17	A: 3 P: 8 W: 4	A: 0 P: 0 W: 0	A: 85.7% P: 61.9% W: 81.0%
V	Coverage and Authorization of Services	25	25	A: 22 P: 22 W: 22	A: 3 P: 3 W: 3	A: 0 P: 0 W: 0	A: 88.0% P: 88.0% W: 88.0%

Table 6-1—Standards and Compliance Score							
Standard #	**Standard Name**	**# of Elements***	**# of Applicable Elements****	**# *Met****	**# *Not Met***	**# *Not Applicable***	**Total Compliance Score**
VI	Emergency and Poststabilization Services	20	20	A: 20 P: 16 W: 20	A: 0 P: 4 W: 0	A: 0 P: 0 W: 0	A: 100% P: 80.0% W: 100%
Varied	Follow-up From Previous Review Findings	A: 5 P: 4 W: 6	A: 5 P: 4 W: 6	A: 1 P: 2 W: 0	A: 4 P: 2 W: 6	A: 0 P: 0 W: 0	A: 20.0% P: 50.0% W: 0.0%
	****Total Compliance Score	A: 124 P: 123 W: 125	A: 124 P: 123 W: 125	A: 112 P: 98 W: 109	A: 12 P: 25 W: 16	A: 0 P: 0 W: 0	A: 90.3% P: 79.7% W: 87.2%
*** 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*, 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 six standards and the follow-up reviews was sufficient to result in an overall *Met* score.

The CMOs had documentation describing their processes, practices, action plans, and performance results/outcomes related to each review requirement.

The statewide percentage-of-compliance score for AMERIGROUP was 90.3 percent, while WellCare received a score of 87.2 percent and Peach State received a score of 79.7 percent.

Findings

HSAG provides below the aggregated deficiencies across the CMOs for each of the standards reviewed.

Standard I: Availability of Services

- HSAG identified no opportunities for improvement for the Availability of Services standard.

Standard II: Furnishing of Services

- The State established a goal that 90 percent of providers must meet appointment wait time requirements. Overall, each CMO's network providers did not meet the 90 percent goal for one or more of the appointment wait time targets.

- Not all CMOs had a monitoring system to capture the wait times of each provider office or when a provider returns calls to GF members.
- Overall, the CMOs did not meet the geographic access requirements for many of the standards.

Standard III: Cultural Competence

- All three CMOs updated their cultural competency plans; however, one CMO's updated plan was not available to providers on its Web site.

Standard IV: Coordination and Continuity of Care

- Each CMO provided HSAG with various types of coordination and continuity of care policies, procedures, program descriptions, process work flows, and monitoring report examples. Overall, the CMOs' day-to-day activities were not congruent with these written policies.
- Case manager care plan monitoring was not consistent with the continuity of care procedures, and care plans were not consistently member-centered and measurable. Additionally, the care plans did not always match the member's current problem diagnosis and goals. HSAG also noted that the provider, caregiver, or member was not always included in the care plan development process and that discharge plans were not always completed or received from the inpatient facilities. HSAG noted during the file reviews that care plans were provided to the members' primary care providers (PCPs) but overall, case managers were not following up with the PCPs or the members.

Standard V: Coverage and Authorization of Services

- Each CMO provided HSAG with monitoring documents, policies, procedures, provider agreements, assessment forms, example letters, and processes as evidence of its coverage and authorization of services activities; however, the daily activities were contrary to the CMOs' policies.
- Overall, timeliness of decisions was monitored, but the turnaround times identified in the CMOs' policies were not consistently documented or conflicted with policy.

Standard VI: Emergency and Poststabilization Services

- Only one CMO had an identified deficiency, which involved not ensuring that appropriate medical staff members were available to review triage claims for emergency services.

Follow-Up Review

- None of the CMOs met or exceeded the DCH-established performance goals.
- Two CMOs did not meet their respective clinical practice guideline (CPG) goals.

- The CMOs did not demonstrate evidence of ongoing monitoring of formalized discharge planning or ensure that discharge plans included a comprehensive evaluation of the members' health needs.

Focused Reviews—Case Management and Disease Management

HSAG performed case-specific file reviews that focused on members in case management. The reviews focused on assessment of the members' needs, the development of the care plan, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The reviews looked for gaps in each of the above mentioned areas.

Common Themes From the CMOs' Key Findings

- The CMOs used similar methods to identify members for case management services, including predictive modeling software, staff referrals, self-referrals, data mining, and "trigger lists" that were based on inpatient admissions.
- The care management assessments were completed in a timely manner and addressed the member's physical, mental, and psychosocial needs to include cultural issues/concerns and linguistic needs.
- Care plans were not always individualized to the member, and the member or the caregiver was not always involved in the care plan creation process.
- Overall, the CMOs did not consistently use a multidisciplinary team approach when monitoring those members in case management.
- Discharge planning documentation was limited to information provided by the member or guardian after discharge.

Conclusions and Recommendations

Based on the aggregated results, HSAG recommends the following to DCH:

- Reevaluate the corrective action plan process for addressing the CMOs' deficiencies since the CMOs did not demonstrate compliance with most areas of deficiency that were reevaluated.
- Provide training for the CMOs related to the quality assessment and performance improvement evaluation. Training should focus on strategic planning principles that align the quality program description, workplan, and evaluation; training should also differentiate goals, objectives, and activities. Provide training in the area of transitions of care to the CMO case managers.
- Consider contract provisions for ensuring key staff positions are provided in the Georgia market.

Performance Measures

To facilitate rate comparisons, monitor waiver population performance, and prepare for reporting of data to CMS for the CHIPRA and adult core set measures, DCH contracted with Hewlett-Packard

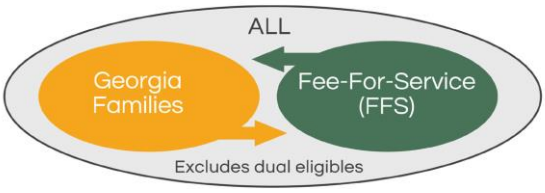
Enterprise Services (HP), its Medicaid Management Information System (MMIS) vendor, to calculate performance measure rates for the following populations:

- Georgia Families® Medicaid and PeachCare for Kids® managed care members (GF)
- Fee-for-Service (FFS)
- All Medicaid and PeachCare for Kids® (ALL)
- Medicaid Adult Only (MAO)
- Community Care Services Program (CCSP)
- Georgia Families 360° Managed Care for Foster Care, Adoption Assistance and Juvenile Justice Members (FC)

Georgia Families Managed Care (GF)—the GF population consisted of Medicaid and PeachCare for Kids® members enrolled in the three contracted CMOs:[6-1] 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.

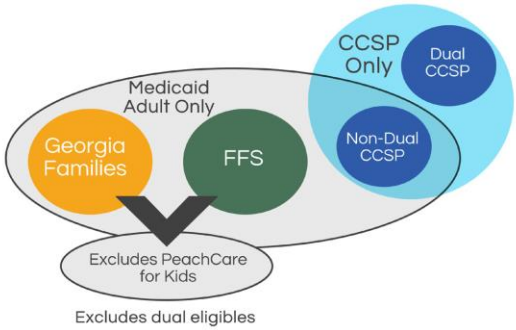
Fee-for-Service (FFS)—the FFS population included Medicaid and PeachCare for Kids® members not enrolled in the GF managed care program. To be included in the FFS rates, a member had to be continuously enrolled in the FFS population for the entire measurement period with no more than a 30-day break in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



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.

[6-1] 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.



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.

Foster Care (FC)—the FC population consists of children, youth, and young adults in foster care; children and youth receiving adoption assistance; and select youth involved in the juvenile justice system. As part of the redesign of the Georgia Medicaid program, DCH developed a new managed care program called Georgia Families 360°, which was launched on March 3, 2014. The DCH contracted with AMERIGROUP to provide services to improve care coordination and continuity of care, and to provide better health outcomes for these members. For CY 2013, the FC population included all FFS foster care, adoption assistance and certain juvenile justice members covered at any time during the measurement year.

Performance Measure Validation Results—HP

HSAG conducted performance measure validation on all of HP's reported rates across its populations.

Strengths

HSAG identified the following strengths related to performance measure validation:

- For CY 2013 data, the overall encounter data rejection rate was approximately 1.3 percent, down from 6.0 percent in 2012. HSAG found that the one outlying CMO had reduced its error rejection rate to less than 2.0 percent, from 9.6 percent in 2012. The CMOs were required by DCH to meet a 99 percent pass rate; significant progress toward the 99 percent pass rate was demonstrated.
- The State contracted with a pharmacy vendor, Catamaran, to administer pharmacy benefits to its FFS population. HP was able to demonstrate that, based on last year's feedback, HP

appropriately removed pharmacy reversals before the files were sent to HP's contracted software vendor to ensure that rates impacted by pharmacy data were not over-inflated.

- HP was able to report valid rates for all required measures.

Challenges

HSAG identified the following challenges related to performance measure validation:

- HP did not use a DRG grouper for CMO-submitted encounter data that did not contain DRGs; therefore, some measures that rely on DRGs, such as inpatient utilization measures, may be underreported for the GF and ALL populations.
- Although final rates were not biased and improvement was noted, a lack of consistency in capturing 4th- and 5th-digit specificity for ICD-9 codes continued to be an issue that impacted up to 12 reported measures.
- This was the first year for reporting rates for the FC population. A small population of members over the age of 21 was inappropriately included in the FC population.
- A few areas for improvement were identified regarding provider data:
  - Cardiologist and cardiovascular disease provider types were being pulled into the primary care practitioner bucket erroneously.
  - The eye care professional specialty contained eye care centers.
  - The Community Health Center provider type was listed under the behavioral health profession category, which does not meet the requirements of the specifications.
  - The DCH did not require the capture of rendering provider type on all claims, leading to greater reliance on medical record review for hybrid measures and potential underreporting of some administrative measures.
  - Federally qualified health centers (FQHCs) often submit the facility identification as the rendering provider on claims, also contributing to greater reliance on medical record review for hybrid measures and potential underreporting of some administrative measures.
- HSAG identified a few challenges that led to a high volume of medical record review errors:
  - Errors identified during HSAG's review of the convenience sample were not corrected during medical record review verification (MRRV).
  - The Georgia Medical Care Foundation (GMCF), HP's contracted medical record vendor, validated just 6 percent of the total volume of abstracted cases per abstractor for the Elective Delivery measure, which was a first-year measure.
  - Several files of supporting medical record documentation were not complete when uploaded to HSAG for review.
  - The chase logic used contributed to lower-than-expected hybrid rates for some measures. For example, Community Health Center providers were not included in the logic, possibly eliminating a high volume of measure-specific practitioners.

HSAG recommends that abstraction practices be corrected prior to the MRRV, based on any lessons learned during the convenience sample review. To help identify medical record review errors, a higher volume of quality assurance/interrater reliability (IRR) validation should be conducted

throughout the abstraction process. New measures may require more IRR than other measures. HSAG recommends adhering to the 10 percent validation rate. Because there is such a high volume of medical record documentation, referencing a page number in the abstraction tool is recommended. GMCF should review its medical record storage process to identify the issue that caused incomplete records to be forwarded to HSAG during the review. GMCF may want to work with the provider offices that supplied the overload of medical record documentation to find a better way to request the specific documentation needed. Lastly, HSAG recommends that GMCF use the abstraction errors for training purposes in the future.

Performance Measure Result Findings

Using the validated performance measure 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 members, and organized, aggregated, and analyzed the data provided from HP to draw conclusions about the delivery of care and services provided to FFS, ALL, MAO, CCSP, and FC member populations.

Table 6-2 through Table 6-7 present the GF, FFS, ALL, MAO, CCSP, and FC weighted averages for both administrative and hybrid measures. Table E-1 through Table E-6 display the individual CMO-specific performance measure rates.

Similar to groupings used in the GF Quality Strategy, HSAG grouped clinical performance measures 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 2013 GF rates with the prior year's rates. Additionally, for CY 2013, the GF rates were compared to the FFS rates, ALL, MAO, CCSP, and the FC population rates, and the CMOs' performance targets. In the tables below, the GF's rate is reflective of the rates calculated by HP; however, for GF hybrid measures, HSAG used the CMOs' reported rates and calculated a weighted average. For these hybrid measures, the population varies slightly from the definitions provided above since it does not capture members who changed CMOs during the measurement year.

The DCH required HP to use the hybrid methodology, when specified by the measure, to calculate rates for the FFS, MAO, CCSP, FC, and ALL populations for CY 2013 data, which allowed the State greater opportunity to compare rates across the CMOs and to compare rates between the managed care and 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 E 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, CCSP, and FC populations, HSAG displays CMO-specific rates for all CY 2013 required performance measures in the areas of access, children's health, women's health, chronic conditions, behavioral health, and medication management.

Access to Care

Table 6-2 displays 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, annual dental visits for people aged 2–21 years, and access to care for members that need alcohol and other drug dependence treatment, as well as Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS). All population groups included both administrative data and medical record data in the calculation of their rates.

Table 6-2—2013 Performance Measure Results—Access

	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
Children's and Adolescents' Access to Primary Care Providers							
Ages 12–24 Months	94.71%↑	93.36%	94.69%↑			91.42%	
Ages 25 Months–6 Years	87.18%↑	86.39%↑	86.74%↑			80.99%	
Ages 7–11 Years	88.76%	85.92%↑	88.34%↑			84.51%	
Ages 12–19 Years	86.10%↑	78.56%↑	84.82%↑			77.75%	91.59%
Total*	87.81%	82.70%	87.15%			80.77%	
Adults' Access to Preventive/Ambulatory Health Services							
Ages 20–44 Years	84.02%↓	78.27%↑	81.63%↑	81.63%↑	92.45%	49.72%	
Ages 45–64 Years	90.55%	89.04%↑	89.19%↑	89.19%↑	93.69%	NA	
Ages 65 Years and Above	NA	86.26%	86.26%	86.26%	85.51%	NA	
Total	84.89%↓	85.12%↑	85.20%↑	85.20%↑	88.01%	49.72%	88.52%
Oral Health (Annual Dental Visit Rate)							
Ages 2–3 Years	47.79%	42.20%	45.61%↓	NA	NA	42.48%	
Ages 4–6 Years	76.27%↓	64.03%	74.00%↓	NA	NA	70.50%	
Ages 7–10 Years	79.10%↓	65.98%	76.58%	NA	NA	70.99%	
Ages 11–14 Years	71.68%	59.54%	69.04%	NA	NA	65.88%	
Ages 15–18 Years	60.99%	50.34%	58.49%	47.70%↓	NA	57.50%	
Ages 19–21 Years	35.02%↓	29.55%	30.32%↓	28.97%↓	NA	30.53%	
All Members (Ages 2–21 Years)	69.47%↓	54.70%	66.35%↓	39.04%↓	NA	60.79%	69.07%
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment							
Initiation	35.62%↓	40.15%↓	38.65%↓	38.86%↓	37.97%	36.68%	43.62%
Engagement	7.65%	4.72%↓	5.67%↓	5.07%↓	0.00%	13.72%	18.56%
Annual HIV/AIDS Medical Visit							
90 Days Apart	39.02%↓	58.22%↑	55.46%	55.53%	65.85%	68.18%	
180 Days Apart	23.87%	43.69%	41.32%	41.37%	51.22%	31.82%	
Care Transition—Transition Record Transmitted to Health Care Professional							
Rate	0.15%	1.46%	0.73%	0.24%	0.97%	0.00%	

[1] CY 2013 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, 2013, through December 31, 2013, and 2013 rates are displayed where applicable. CY 2013 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 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement

year. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[3] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[4] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to report rates; no comparison with the prior year's rates was conducted. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[7] CY 2013 performance targets reflect the DCH-established CMO performance targets for CY 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* The Total age category was not a HEDIS indicator for this measure; comparisons with last year's rates were not performed.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.

Access Measure Results

For the *Children's and Adolescents' Access to Primary Care Providers* measure, all age groups within each population showed at least 75 percent of children and adolescents accessing care with their primary care providers. For all ages (the *Total* indicator), the performance measure rates from all applicable population groups ranged from 80.77 percent to 87.81 percent. Although none of the population groups met the DCH performance target for *Ages 12–19 Years*, GF, FFS, and ALL had significant improvements in the rates for three childhood age groups when compared with the CY 2012 rates.

For the *Adults' Access to Preventive/Ambulatory Health Services* measure, with the exception of FC, all population groups had at least 75 percent of adults receiving preventive/ambulatory health services. The *Total* indicator reported diverse performance from all population groups, ranging from 49.72 percent to 88.01 percent. Significant increases were noted in the *Ages 20–44 Years* and *Ages 45–64 Years* age groups for FFS, ALL, and MAO populations. A significant rate decline was observed for GF in the *Ages 20–44 Years* age group, though the decline was less than 1 percentage point. Although none of the population groups met the DCH performance target, the CCSP's rate was less than 1 percentage point below the target.

CY 2013 oral health performance also varied by population group, with GF's rate being the highest and meeting the DCH performance target (69.47 percent) and MAO's rate being the lowest (39.04 percent). Rates from GF, ALL, and MAO populations showed significant rate declines from CY 2012. Nonetheless, with the exception of the MAO population, these declines were less than 1 percent. For the MAO population, last year's rate inadvertently included children and adolescents in this population group. The decline from CY 2012 (25.05 percentage points) was due to the exclusion of age-inappropriate members from the denominator in this year's rate calculation.

For the *Initiation and Engagement of AOD Dependence Treatment* measure, at least one third of the eligible members in each population group received initiation services, with individual population performance ranging from 35.62 percent to 40.15 percent. The GF, FFS, ALL, and MAO

population groups reported significant rate declines for this indicator. Rates associated with the *Engagement* indicator showed wider variation among the population groups (0.0 percent–13.72 percent), with FFS, ALL, and MAO populations reporting significant rate declines. None of the population groups met the DCH performance targets established for the indicators under this measure.

The DCH did not establish performance targets for the *Annual HIV/AIDS Medical Visit* and *Care Transition* measures. For the *Annual HIV/AIDS Medical Visit* measure, with the exception of GF, all other population groups had at least 55 percent of their eligible members receiving medical visits that were at least 90 days apart within the measurement year. The GF population had a rate of 39.02 percent, a statistically significant decline from last year. Although the rates for the *180 Days Apart* indicator were generally lower than those for the *90 Days Apart* indicator, the differences were generally consistent (i.e., approximately 15 percentage points) across all population groups except the FC population. For the FC population, the difference was more than 35 percentage points (68.18 percent versus 31.82 percent). The CY 2013 rates for the *Care Transition* measure suggested a great potential for performance improvement for all populations. None of the population groups reported a rate above 1 percent.

Children's Health

Table 6-3 displays results for the children's health measures. These measures focus on well-child/well-care visits, immunization and screening, weight assessment and counseling for nutrition and physical activity for children/adolescents, and appropriate treatment for children with upper respiratory infection. MAO and CCSP were not required to report any of the measures in this domain.

Table 6-3—2013 Performance Measure Results—Children's Health

	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	FC Rate[4]	Performance Target[5]
Well-Child/Well-Care Visits					
First 15 Months of Life: Six or More Visits	64.32%↑	30.90%↑	58.39%↑	48.66%	70.70%
Third, Fourth, Fifth, and Sixth Years of Life	69.64%↑	57.32%	60.00%↑	56.30%	72.26%
Adolescent Well-Care Visits	46.24%↓	31.87%↑	40.15%	34.00%	49.65%
Immunization and Screening					
Childhood Immunization Status—Combination 3	82.38%↑	54.50%	34.55%↓	53.53%	82.48%
Childhood Immunization Status—Combination 6	42.01%↑*	34.06%↑	15.33%↓	31.14%	
Childhood Immunization Status—Combination 10	38.63%↑	23.60%↑	12.41%↓	20.44%	
Lead Screening in Children	78.32%↑	67.40%	72.99%↑	68.61%	81.86%

Table 6-3—2013 Performance Measure Results—Children's Health					
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	FC Rate[4]	Performance Target[5]
Appropriate Testing for Children with Pharyngitis	76.50%↓	72.75%	76.11%↑	75.44%	76.37%
Immunizations for Adolescents—Combination 1 Total	76.47%↑	60.39%↓	67.11%↓	63.70%	80.91%
Developmental Screening in the First Three Years of Life	38.43%↑	37.23↑	36.01%↑	34.55%	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
Body Mass Index (BMI) Percentile	49.36%↑	28.71%↑	30.17%↑	31.14%	47.45%
Counseling for Nutrition	58.82%↑	32.12%↓	44.28%↑	38.44%	54.88%
Counseling for Physical Activity	51.52%↑	24.82%↓	37.96%↑	31.87%	43.29%
Appropriate Treatment for Children With Upper Respiratory Infection					
Rate	81.95%↓	80.94%↓	81.91%↑	81.49%	85.34%

[1] CY 2013 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, 2013, through December 31, 2013, and 2013 rates are displayed where applicable. CY 2013 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 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[3] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
[4] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to report rates; no comparison with the prior year's rates was conducted. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
[5] CY 2013 performance targets reflect the DCH-established CMO performance targets for CY 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.
* CY 2012 rate (5.13 percent) listed in last year's EQR annual report was obtained from HP using administrative data. To provide accurate trending results, the CY 2012 CMO hybrid rate was generated (39.77 percent) and compared to the CY 2013 rate. Statistical significance result showed that GF had a significant improvement in this indicator.

Children's Health Measures Results

Only GF, FFS, ALL, and FC populations had reported rates for measures under the Children's Health domain. GF rates were the highest across all measures under this domain. Nonetheless, only one of its rates (*Appropriate Testing for Children with Pharyngitis*) met the DCH performance targets. Well-Child/Well-Care visit performance varied by age and population groups, but in general, at least 30 percent of members in each population group received well-child visits. For the *First 15 Months of Life with Six or More Visits* indicator, rates ranged from 30.90 percent to 64.32 percent—the widest range across populations for any Well-Child/Well-Care measure.

Performance related to immunization and screening differed by population group and measure. All population groups with CY 2012 rates reported significant rate increases for the *Developmental Screening in the First Three Years of Life* measure. For the *Immunizations for Adolescents* measure, GF's rate of 76.47 percent was over a five percentage-point improvement since last year. At least two population groups reported significant rate increases for the three indicators under *Childhood Immunization Status* and the *Lead Screening in Children* measures. CY 2013 rates for all groups were below the DCH performance target, suggesting great potential for improvement. *Appropriate Testing for Children with Pharyngitis* was the only measure with a population group (GF) meeting the DCH performance target.

Performance for the Weight Assessment and Counseling measures was diverse among the population groups, with GF having the highest rates for all three indicators. GF and ALL populations reported significant rate increases for all three indicators. Although the FFS population had significant rate declines in two of the three indicators, these declines were less than 5 percentage points. All three GF rates surpassed the DCH performance targets.

Performance associated with *Appropriate Treatment for Children With Upper Respiratory Infection* was very similar across all population groups (less than 1 percentage point difference). Although none of the population rates met the DCH performance target, at least 80 percent of eligible children received an appropriate treatment.

Women's Health

Table 6-4 displays 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 6-4—2013 Performance Measure Results—Women's Health

	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
Prevention and Screening							
Cervical Cancer Screening*	72.83%	35.77%↓	51.58%↑	52.55%↑	19.95%		78.51%
Breast Cancer Screening**	72.90%↑	31.49%	32.88%↓	32.88%↓	16.97%		56.58%
Chlamydia Screening—Ages 16–20 Years	46.09%	44.39%	47.52%↑	54.91%	NA	50.54%	
Chlamydia Screening—Ages 21–24 Years	63.66%↓	42.00%	60.80%	60.80%	NA	45.37%	
Chlamydia Screening—Total	50.11%↓	43.42%↑	51.55%↑	58.13%↑	NA	50.29%	58.40%
Human Papillomavirus Vaccine for Female Adolescents	21.41%↑	16.79%↑	20.44%↑			15.09%	22.27%
Prenatal Care and Birth Outcomes							
Timeliness of Prenatal Care	81.68%↓	48.42%↓	46.83%↓	51.34%↓		48.34%	90.39%
Postpartum Care	62.24%↓	34.06%↓	40.49%↓	37.41%↓		37.09%	71.05%
Cesarean Rate for Nulliparous Singleton Vertex *A lower rate indicates better*	18.02%↑	16.94%↓	18.11%↓	18.21%↓		21.36%	

Table 6-4—2013 Performance Measure Results—Women's Health							
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
performance							
Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance*	31.88	31.08↓	31.79↓	32.23↓		21.26	28.70
Infants With Low Birth Weight *A lower rate indicates better performance*	8.92%	10.34%↓	9.18%↓			28.63%	8.10%
Behavioral Health Risk Assessment for Pregnant Women	5.13%	12.41%	13.87%	11.92%		17.27%	
Elective Delivery*** *A lower rate indicates better performance*	2.07%	13.77%	18.52%	22.50%		25.00%	2.00%
Antenatal Steroids	0.73%↓†	18.82%↑	11.92%↑	10.95%↑		0.00%	
Frequency of Ongoing Prenatal Care**							
< 21 Percent *A lower rate indicates better performance*	12.11%↓	38.20%	48.66%↓	33.74%↑		32.00%	
21–40 Percent	7.05%	13.14%	15.65%	13.69%		15.33%	
41–60 Percent	6.79%	9.98%	7.33%	9.29%		15.33%	
61–80 Percent	13.55%	9.98%	5.87%	10.51%		18.00%	
81+ Percent	60.50%↓	28.71%↓	22.49%↓	32.76%↓		19.33%	72.99%

[1] CY 2013 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, 2013, through December 31, 2013, and 2013 rates are displayed where applicable. CY 2013 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 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[3] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[4] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to report rates; no comparison with the prior year's rates was conducted. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

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

↑ indicates a statistically significant improvement in performance between 2012 and 2013.

↓ indicates a statistically significant decline in performance between 2012 and 2013.

* Due to significant measure specification changes in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.

** Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
*** Rate comparison with CY 2012 data required the reported hybrid rates to be weighed by the eligible population. Since the eligible population includes individuals with gestation weeks yet to be confirmed during medical record abstraction, this process may yield inaccurate statistical significance test results. As such, statistical significance tests comparing the CY 2012 and CY 2013 rates were not performed for this measure.
****Rate comparison with CY 2012 data was performed only on the *<21 Percent* and *81+ Percent* indicators.
†The CY 2012 rate was calculated by HP using administrative data whereas the CY 2013 rate was calculated as an aggregate CMO hybrid rate. The significant rate decline could be due to this change in rate calculation methodology.

Women's Health Measures Results

Population-level performance on cervical and breast cancer screening showed a wide rate variation among all groups, with differences as large as 50 percentage points. Of all populations, GF performed the best and met the DCH performance target for multiple measures, including *Breast Cancer Screening*, *Cervical Cancer Screening*, *Chlamydia Screening—Ages 21–24 Years*, and *Human Papillomavirus Vaccine for Female Adolescents.* Performance variation was smaller among population groups on chlamydia screening and human papillomavirus vaccine (HPV).

CY 2013 population-level performance showed significant improvement by a few population groups on one or two prenatal care and birth outcomes measures; however, most measures reported significant declines. At least three population groups showed significant declines in performance in the *Timeliness of Prenatal Care*, *Postpartum Care*, *Cesarean Rate for Nulliparous Singleton Vertex*, and *Cesarean Delivery Rate* measures. Significant improvement from CY 2012 was observed for *Cesarean Rate for Nulliparous Singleton Vertex* (GF) and *Antenatal Steroids (*ALL, FFS, and MAO) measures.

For the *Frequency of Ongoing Prenatal Care* measure, significant declines were noted for GF, FFS, ALL, and MAO populations in the percentage of deliveries with at least 81 percent of expected visits. A wide rate variation was also observed across population groups (22.49 percent to 60.50 percent).

Chronic Conditions

Table 6-5 displays results for the chronic conditions measures.

Table 6-5—2013 Performance Measure Results—Chronic Conditions							
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
Diabetes							
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing	79.21%	67.88%↑	64.96%	66.06%↑	62.59%↑	62.75%	87.01%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	56.60%↓	72.99%↓	78.83%↓	77.74%↓	62.96%	76.47%	41.68%
HbA1c Control (<8.0)	36.69%↓	22.99%↓	17.70%↓	18.43%↓	30.47%	15.69%	48.72%
HbA1c Control (<7.0)	27.87%↓	20.51%↓	14.47%↓	14.40%↓	20.00%↓	8.33%	36.72%
Eye Exam (Retinal) Performed	43.20%↓	37.23%↓	39.42%↓	39.05%	40.51%	41.18%	52.88%
LDL-C Screening	70.09%	60.04%↑	58.21%↑	58.21%	53.83%↑	54.90%	76.16%
LDL-C Control (<100 mg/dL)	26.98%	15.88%↓	15.33%↓	13.87%↓	25.36%	13.73%	35.86%
Medical Attention for Nephropathy	73.37%	68.61%↓	65.15%↓	66.61%↓	72.26%	45.10%	78.71%
Blood Pressure Control (<140/80 mm/Hg)	31.77%↑	17.15%↓	14.96%↓	15.15%↓	32.48%	29.41%	39.10%
Blood Pressure Control (<140/90 mm/Hg)	55.14%↑	25.18%↓	25.00%↓	23.18%↓	43.80%	41.18%	63.50%
Diabetes, Short-Term Complications Admission Rate* (*A lower rate indicates better performance*)							
Rate Per 100,000 Member Months	16.66	38.99	30.90	31.39	24.58	4.92	62.74
Respiratory Conditions							
Use of Appropriate Medications for People With Asthma							
Ages 5–11 Years	92.32%↑	91.71%	91.80%↑	NA	NA	91.39%	
Ages 12–18 Years	88.67%	90.77%↑	88.48%↑	81.71%↓	NA	87.18%	
Ages 19–50 Years	72.77%	68.20%	70.06%	69.96%	NA	82.93%	
Ages 51–64 Years	81.13%	63.33%	64.17%	64.17%	NA	NA	
Total	90.06%↑	80.28%	87.31%↑	69.69%↓	NA	88.89%	90.56%
Medication Management for People With Asthma							
50 Percent Compliance (Total)	54.57%↑	64.75%↓	56.69%↑	62.42%↑	NA	64.66%	52.31%
75 Percent Compliance (Total)	30.65%↑	43.98%↓	33.58%	41.13%↑	NA	42.13%	29.14%

Table 6-5—2013 Performance Measure Results—Chronic Conditions							
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
Young Adult Asthma Admission Rate*							
Rate Per 100,000 Member Months *A lower rate indicates better performance*	6.36	16.84	10.49	10.92	0.00**	0.00**	
Pharmacotherapy Management of COPD Exacerbation							
Systemic Corticosteroid	76.21%	34.44%↓	35.65%↓	35.65%↓	2.29%↓		
Bronchodilator	82.04%	48.23%	49.26%↓	49.24%↓	9.92%↓		
Chronic Obstructive Pulmonary Disease (COPD) and Asthma in Older Adult Admission Rate*							
Rate Per 100,000 Member Months (Total)	39.63	404.29	366.85	366.78	369.71	24.00	559.03
Cardiovascular Conditions							
Congestive Heart Failure Admission Rate*							
Rate Per 100,000 Member Months (Total)	5.00	277.82	178.96	182.79	353.22	0.00**	380.70
Controlling High Blood Pressure							
Rate	46.92%	27.74%↓	30.17%↓	29.44%↑	29.20%↓	29.41%	57.52%
Adult BMI Assessment							
Rate	76.50%↑	55.23%↑	50.61%↑	51.82%↑	54.99%↑	40.15%	70.60%
Persistence of Beta-Blocker Treatment After a Heart Attack							
Persistence of Beta-Blocker Treatment After a Heart Attack		59.20%	60.45%	60.69%	NA		
Other Physical Health Conditions							
Colorectal Cancer Screening		28.22%↓	28.95%↓	26.03%↓	34.79%		
Plan All-Cause Readmission *A lower rate indicates better performance*	9.93%	10.11%↓	10.18%↓	10.17%↓	2.01%	11.57%	

[1] CY 2013 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, 2013, through December 31, 2013, and 2013 rates are displayed where applicable. CY 2013 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 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[3] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[4] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to

report rates; no comparison with the prior year's rates was conducted. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* Comparison with CY 2012 rates was not performed because the reporting metric changed from per 100,000 members to per 100,000 member months. Since the performance targets established for these measures were based on per 100,000 members, rate comparison against the targets was not recommended.
** The denominator for these rates consisted of fewer than 30 cases. Although NCQA requires HEDIS rates based on less than 30 cases to be denoted as "NA," CMS allows the rate to be reported.
↑ indicates a statistically significant improvement in performance between 2012 and 2013.
↓ indicates a statistically significant decline in performance between 2012 and 2013.

Chronic Conditions Health Measure Result Findings

All populations were reporting using hybrid methodology to calculate rates for measures related to comprehensive diabetes care and controlling high blood pressure. Regarding measures related to diabetes, significant declines in performance were observed for at least three population groups on all but two indicators under *Comprehensive Diabetes Care*. *HbA1c Testing*, *LDL-C Screening*, *Blood Pressure Control (<140/80 mm/Hg), and Blood Pressure Control (<140/90 mm/Hg)* were the only indicators where significant improvement was seen for at least one population group. No population groups met the DCH performance targets for the *Comprehensive Diabetes Care* indicators.

Population-level performance on measures related to respiratory conditions was mixed, with significant improvement in some measures for some population groups and significant declines for others. GF, FFS, and ALL groups reported significant improvement in at least one age group for the *Use of Appropriate Medications for People With Asthma* measure. GF, ALL, and MAO groups also reported significant improvement on at least one indicator under *Medication Management for People With Asthma*. Significant declines in performance were seen in at least three population groups for both indicators under *Pharmacotherapy Management of COPD Exacerbation*. All population groups met the performance targets established for the two indicators under *Medication Management for People With Asthma*.

Population-level performance on measures related to cardiovascular conditions was also mixed, with significant improvement for all population groups on *Adult BMI Assessment* and significant declines by three groups on *Controlling High Blood Pressure*. GF reached the DCH performance target for the *Adult BMI Assessment* measure.

Three population groups (FFS, ALL, and MAO) also reported declines in performance on the *Colorectal Cancer Screening* and *Plan All-Cause Readmission* measure.

Behavioral Health

Table 6-6 displays results for the behavioral health measures.

Table 6-6—2013 Performance Measure Results—Behavioral Health

	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
Screening for Clinical Depression and Follow-Up Plan							
Rate	0.95%	0.49%↑	0.00%↓	0.00%↓	0.24%↑	1.46%	
Adherence to Antipsychotics for Individuals With Schizophrenia							
Rate	37.55%	64.62%	63.64%	63.64%	NA	80.00%	
Follow-Up After Hospitalization for Mental Illness							
Follow-Up Within 7 Days	47.59%	40.69%	43.43%	38.23%↓	15.69%↓	56.56%	69.57%
Follow-Up Within 30 Days	65.89%	60.54%	62.74%	57.67%↓	37.25%	78.47%	84.28%
Follow-Up Care for Children Prescribed ADHD Medication							
Initiation Phase	35.74%	33.58%	35.21%			36.62%	52.48%
Continuation and Maintenance Phase	48.76%	45.32%	47.27%			45.08%	63.11%
Antidepressant Medication Management							
Effective Acute Phase Treatment	48.66%↓	51.63%↓	52.04%↓	52.10%↓	29.73%	62.20%	52.74%
Effective Continuation Phase Treatment	31.47%↓	38.15%↓	37.01%↓	37.17%↓	14.86%	40.24%	37.31%

[1] CY 2013 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, 2013, through December 31, 2013, and 2013 rates are displayed where applicable. CY 2013 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 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[3] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[4] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to report rates; no comparison with the prior year's rates was conducted. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

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

↑ indicates a statistically significant improvement in performance between 2012 and 2013.

↓ indicates a statistically significant decline in performance between 2012 and 2013.

Behavioral Health Measure Results

Performance across all applicable population groups varied notably for measures under the behavioral health domain. None of the population groups had rates reaching 2 percent for the *Screening for Clinical Depression and Follow-Up Plan* measure. Rate variation was the greatest in the *Adherence to Antipsychotics for Individuals With Schizophrenia* measure, where the difference between the population with the lowest rate (GF, 37.55 percent) and the highest rate (FC, 80.00 percent) was more than 40 percentage points. Significant declines in performance were observed across four population groups (GF, FFS, ALL, and MAO) for the *Antidepressant Medication Management* measure, with most declines exceeding 5 percentage points. Of all applicable groups, MAO reported the most significant declines. FC met both DCH performance targets established for the two indicators under *Antidepressant Medication Management*, while the FFS population met the performance target for the *Effective Continuation Phase Treatmen*t indicator. No other population groups met the DCH performance targets for any other measures in this domain.

Medication Management

Table 6-7 displays results for the medication management measures.

Table 6-7—2013 Performance Measure Results—Medication Management

	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	Performance Target[7]
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions*							
Rate *A lower rate indicates better performance*	41.17%↑	43.89%↑	41.82%↓	40.53%↓	49.65%	40.31%	41.51%
Annual Monitoring of Patients on Persistent Medications							
Rate	86.87%	87.10%↑	87.02%↑	87.04%↑	77.38%	70.59%	88.55%

[1] CY 2013 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, 2013, through December 31, 2013, and 2013 rates are displayed where applicable. CY 2013 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 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[3] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[4] CY 2013 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. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to report rates; no comparison with the prior year's rates was conducted. Where hybrid methodology was required for reporting, HP selected a random sample according to NCQA's HEDIS methodology and abstracted medical record data to supplement the administrative data rates.

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

* HP calculated the numerator and denominator but not the rate for this measure. The rates displayed here were computed by HSAG based on the validated numerators and denominators.

↑ indicates a statistically significant improvement in performance between 2012 and 2013.

↓ indicates a statistically significant decline in performance between 2012 and 2013.

Medication Management Measure Result Findings

Population-level performance showed mixed results for the *Antibiotic Utilization* measure. Although significant rate changes were noted for four population groups (two significant increases and two significant declines), the magnitude of change was less than 2 percentage points. Three population groups (GF, MAO, and FC) met the DCH performance target.

Compared to the prior year's rates, all population groups except GF and CCSP demonstrated significant improvement on the *Annual Monitoring of Patients on Persistent Medications* measure. Similar to the *Antibiotic Utilization* measure, the magnitude of increase was less than two percentage points. With the exception of FC, rate variation of this measure was similar to the *Antibiotic Utilization* measure.

Utilization Measures

In addition to clinical performance measures, DCH requires the CMOs to report utilization rates for *Mental Health, Ambulatory Care,* and *Inpatient Utilization.* This information can be helpful to the CMOs in reviewing patterns of suspected under- and overutilization of services. High or low rates of utilization do not necessarily indicate better or worse performance. Appendix E contains tables of 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 and rates associated with *Weeks of Pregnancy at Time of Enrollment* was reported by population and is displayed in Appendix E. Race variation was greatest between the MAO and CCSP populations, where the percentage of Whites was 31.24 percent for MAO and 56.62 percent for CCSP. The MAO population also had the highest proportion of members with race/ethnicity as "Unknown" (12.90 percent) or "Declined" (5.73 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 CMOs and HP were compliant with the required information system standards to report valid performance measure rates. The CMOs had the ability to process, receive, and enter medical and service data efficiently, accurately, completely, and on time.

CMOs

Several opportunities for improvement exist for the CMOs collectively. While the CMOs should improve their performance on all measures with rates not meeting the performance targets, the greatest opportunities for improvement were noted for the following measures: *Timeliness of*

Prenatal Care; Postpartum Care; Frequency of Ongoing Prenatal Care (81+ Percent); Comprehensive Diabetes Care (i.e., *HbA1c Testing* and all control levels, *LDL-C Control <100 mg/dL*, and the two *Blood Pressure Control* indicators)*; Controlling High Blood Pressure; Follow-Up Care for Children Prescribed ADHD Medication—Initiation;* and *Follow-Up After Hospitalization for Mental Illness*. For these measures, rates for all CMOs fell below the respective CY 2013 performance targets by at least 5 percentage points. For all CMOs, the *Ages 20–44 Years* and *Total* indicators under *Adults' Access to Preventive/Ambulatory Health Services* experienced a statistically significant decline in CY 2013.

Based on their CY 2013 performance, AMERIGROUP and Peach State met nine performance targets while WellCare met eight. All of the CMOs performed best within the Children's Health measures. Half of AMERIGROUP's measures met the performance targets in the Children's Health domain. Peach State had the highest number of measures meeting the targets in the Chronic Conditions domain. WellCare was the only CMO with no measures meeting the performance targets in the Medication Management domain.

Population-Specific Assessment

Access Measures

For the *Children's and Adolescents' Access to Primary Care Providers* measures, the GF, FFS, and ALL population rates showed statistically significant improvement over CY 2012 rates in both the *Ages 25 Months–6 Years* and the *Ages 12–19 Years* age groupings. The GF population performed best in this area with every rate being the highest among all populations.

Also of note were the *Adults' Access to Preventive/Ambulatory Health Services* rates for *Ages 20–44 Years, Ages 45–64 Years*, and *Total*. The FFS, ALL, and MAO populations showed statistically significant improvement over the CY 2012 rates.

Again, for the *Oral Health (Annual Dental Visit Rate)* measures, the GF population scored better than all other populations. Conversely, for the *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment: Initiation* measure, the GF, FFS, ALL, and MAO populations reported statistically significant declines from the CY 2012 rates.

The population showing the most improvement from its CY 2012 rates was the FFS population, with seven rates showing statistically significant improvement and only two rates showing a statistically significant decline. The GF population had eight rates that showed statistically significant declines from the CY 2012 rates.

Children's Health Measures

The GF, FFS, and ALL populations showed statistically significant improvement over their CY 2012 rates for the *Well-Child/Well-Care Visits: First 15 Months of Life: Six or More Visits* measure. Also of note, those populations showed statistically significant improvement in their rates for the *Developmental Screening in the First Three Years of Life* measure. The GF, FFS, and ALL

populations also showed statistically significant improvement for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: Body Mass Index (BMI) Percentile* measure.

Of the 14 rates included under Children's Health, 11 rates for the GF population were significantly improved over the CY 2012 rates, with only three showing statistically significant declines.

Women's Health Measures

Rates for the FFS, ALL, and MAO populations showed statistically significant improvement for the *Prevention and Screening: Chlamydia Screening—Total* measure. For the *Human Papillomavirus Vaccine for Female Adolescents* measure, rates for the GF, FFS, and ALL populations showed statistically significant improvement. For the *Prenatal Care and Birth Outcomes: Timeliness of Prenatal Care* and *Postpartum Care* measures, rates for the GF, FFS, ALL, and MAO populations showed statistically significant declines from the CY 2012 rates. For the *Frequency of Ongoing Prenatal Care: 81+ Percent* measure, rates for the GF, FFS, ALL, and MAO populations showed a statistically significant decline.

Chronic Conditions Measures

In the area of *Comprehensive Diabetes Care*, rates for the GF, FFS, ALL, MAO, and CCSP populations showed statistically significant declines for the *HbA1c Control (<7.0)* measure. Rates for all populations except CCSP and FC also showed statistically significant declines for the *HbA1c Control (<8.0)* measure. On a more positive note, for all populations except FC, rates for the *Adult BMI Assessment* measure showed statistically significant improvement over the CY 2012 rates. In nine of the 10 *Comprehensive Diabetes Care* measures, the GF rates were better than the rates for all other populations.

Behavioral Health Measures

For the GF, FFS, ALL, and MAO populations, rates for the *Antidepressant Medication Management* measure indicators showed statistically significant declines from the previous years' rates.

Medication Management Measures

Rates for the *Annual Monitoring of Patients on Persistent Medications* measure for the FFS, ALL, and MAO populations showed statistically significant improvement over the CY 2012 rates.

Recommendations

Based on the CY 2013 performance measure 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:

- Continue providing oversight of HP's performance measure rate generating process to include HP's oversight of GMCF's medical record retrieval and review process.
- Ensure that all provider types are accurately defined and grouped for measure specificity.
- Improve implementation of reporting ICD-9 codes to include the 4th- and 5th-digit specificity.
- Use a DRG grouper on CMO data to better capture data for measures.
- Continue chase logic improvement efforts.
- Specific to GMCF, the following areas need attention:
  - Immediately use any areas of concern identified during convenience sampling to minimize MRRV issues.
  - Increase the amount of validation conducted on the abstractors early into and throughout the MRRV process.
  - Investigate why medical record data sent to HSAG were incomplete on many occasions.
  - Confirm that GMCF is working toward improving communications with provider offices to improve the relevance and quantity of medical record data being procured.

Validation of Performance Improvement Projects

The June 30, 2014, through August 1, 2014, PIP submission included eight clinical PIPs (*Adolescent Well-Care Visits, Annual Dental Visits, Appropriate Use of ADHD Medications, Avoidable Emergency Room Visits, Childhood Immunizations—Combo 10, Childhood Obesity, Comprehensive Diabetes Care,* and *Postpartum Care*) as well as two nonclinical PIPs (*Member Satisfaction* and *Provider Satisfaction*).

Conclusions and Recommendations

As previously described, while there were some successes, the majority of the CMOs' PIP outcomes did not demonstrate the improvement expected (i.e., statistically significant improvement, meeting State goals, and performing above NCQA's 25th percentile). Less than half the PIPs completed by each CMO resulted in statistically significant improvement across all study indicators. Concentrated efforts geared toward intervention-specific evaluations of effectiveness and data-driven improvement strategies should bring greater success in achieving desired improvements in targeted outcomes.

HSAG recommends the following to DCH:

- Explore the EQRO's development of PIP tools that align with quality improvement science techniques, and provide training to the CMOs.
- Explore with the EQRO and CMS a revised approach for PIPs since the existing process has not yielded improvement.
- Consider prioritizing focus areas and reducing the number of formal PIPs that the CMOs are required to conduct to promote success.

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 its members as part of its process for evaluating the quality of health care services provided by plans to their members.

The DCH requires that CAHPS Surveys are administered to both adult members and parents or caretakers of child members. In 2014, 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., 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 6-8.

Table 6-8—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 6-9 displays the ratings for each global rating and composite measure.

Table 6-9—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	80.4%	★★★★★	89.3%	★★★★★	88.8%	★★★★★
Rating of Specialist Seen Most Often	82.7%	★★★★★	79.3%	★★★★★	84.4%	★★★★★
Rating of All Health Care	68.4%	★★★★★	84.9%	★★★★★	87.7%	★★★★★
Rating of Health Plan	72.6%	★★★★★	83.6%	★★★★★	86.0%	★★★★★
Composite Measures						
Getting Needed Care	82.3%	★★★	82.9%	★★	90.6%	★★★★★
Getting Care Quickly	82.9%	★★★	87.2%	★	91.9%	★★★
How Well Doctors Communicate	89.5%	★★★	92.3%	★★	95.7%	★★★★★
Customer Service	87.9%	★★★	85.7%	★	87.2%	★★
Shared Decision Making	46.7%	NA	51.6%	No comparison available	49.4%	No comparison available

All of the global ratings were "Excellent" when compared to national Medicaid data across all three surveyed populations. The results were less favorable for the composite ratings across all three populations. The Adult Medicaid population had all "Good" ratings across the five composite areas where comparable. The Child Medicaid population had "Fair" and "Poor" ratings across all five composite areas where comparable. The PeachCare for Kids® population ratings were mixed, with all but the Customer Service composite receiving at least a "Good" rating. While no national

comparisons are available for the Shared Decision Making composite, the scores across populations reveal an opportunity to improve communication as roughly half of respondents did not indicate being included in care and treatment decisions.

Performance Highlights

All global ratings for Adult Medicaid, Child Medicaid, and PeachCare for Kids® were at or above the 90th percentiles.

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 2014 CAHPS performance, there are opportunities to improve members' satisfaction with care and services. The Composite Measure results for the Child Medicaid population showed the most need for improvement efforts, with all composite measures showing poor or fair performance. 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 should consider conducting 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) for the Child Medicaid population as a formal quality improvement project and strategy for improving results.

7. 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 performance measure data on the Medicaid adult population consistent with the Adult Core Set of Medicaid measures released by CMS in February 2013. Several of the performance measures 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 7-1 summarizes the rates reported for the MAO population. Comparisons, where appropriate to other populations, are included in Section 4 of this report.

Table 7-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population

Measure	2012 Rate	2013 Rate
Cervical Cancer Screening	50.61%	52.55%
Breast Cancer Screening		
Ages 42–64 Years	36.74%	39.50%
Ages 65–69 Years	21.53%	24.02%
Prenatal and Postpartum Care		
Postpartum Care	64.96%	37.41%
Chlamydia Screening in Women		
Ages 21–24 Years	60.26%	60.80%
Comprehensive Diabetes Care		
LDL-C Screening		
Ages 18–64 Years	61.37%	61.10%
Ages 65–75 Years	46.03%	50.34%
Total	57.85%	58.21%
HbA1c Testing		
Ages 18–64 Years	68.25%	68.83%
Ages 65–75 Years	51.59%	58.50%
Total	64.42%	66.06%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up		
Ages 21–64 Years	38.61%	37.95%
Ages 65+ Years	18.67%	24.53%
30-Day Follow-Up		
Ages 21–64 Years	59.36%	57.90%
Ages 65+ Years	36.44%	41.04%

Table 7-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population		
Measure	**2012 Rate**	**2013 Rate**
Antidepressant Medication Management Effective Acute Phase Treatment Ages 18–64 Years Ages 65 and older Effective Continuation Phase Treatment Ages 18–64 Years Ages 65 and older	 60.00% 37.50% 44.43% 18.48%	 52.89% 31.41% 38.12% 15.31%
Diabetes, Short-term Complications Admission Rate Ages 18–64 Years Ages 65+ Years (For the 2012 rate, this was calculated per 100,000 members)	 305.83/100,000 members 383.58/100,000 members	 No comparable rate in 2013 No comparable rate in 2013
Diabetes, Short-term Complications Admission Rate Ages 18–64 Years Ages 65+ Years (For the 2013 rate, this was calculated per 100,000 member months)	 No comparable rate in 2012 No comparable rate in 2012	 34.50/100,000 member months 16.75/100,000 member months
Chronic Obstructive Pulmonary Disease (COPD) Admission Rate (Per 100,000) Ages 18–64 Years Ages 65+ Years	 1,139.94/100,000 members 19,892.07/100,000 members	 No comparable rate in 2013 No comparable rate in 2013
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate Ages 40–64 Years Ages 65+ Years	 No comparable rate in 2012 No comparable rate in 2012	 216.10/100,000 member months 642.41/100,000 member months
Congestive Heart Failure Admission Rate Ages 18–64 Years Ages 65+ Years (For the 2012 rate, this was calculated per 100,000 members)	 748.19/100,000 members 24,114.70/100,000 members	 No comparable rate in 2013 No comparable rate in 2013
Congestive Heart Failure Admission Rate Ages 18–64 Years Ages 65+ Years (For the 2013 rate, this was calculated per 100,000 member months)	 No comparable rate in 2012 No comparable rate in 2012	 71.65/100,000 member months 706.24/100,000 member months

Table 7-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population			
Measure		**2012 Rate**	**2013 Rate**
Controlling High Blood Pressure			
Ages 18–64 Years		31.60%	31.58%
Ages 65–85 Years		34.15%	24.60%
Total		32.36%	29.44%
Annual Monitoring for Patients on Persistent Medications			
ACE/ARB			
Ages 18–64 Years		89.78%	90.51%
Ages 65+ Years		78.57%	85.46%
Anticonvulsants			
Ages 18–64 Years		65.74%	66.14%
Ages 65+ Years		60.85%	76.24%
Digoxin			
Ages 18–64 Years		90.38%	91.18%
Ages 65+ Years		84.34%	86.21%
Diuretics			
Ages 18–64 Years		89.76%	90.46%
Ages 65+ Years		76.34%	86.56%
Total			
Ages 18–64 Years		86.19%	87.14%
Ages 65+ Years		76.36%	85.40%
Annual HIV/AIDS Medical Visit 180 Days Apart			
Ages 18–64 Years		40.65%	41.21%
Ages 65+ Years		44.52%	44.87%
Annual HIV/AIDS Medical Visit 90 Days Apart			
Ages 18–64 Years		53.91%	55.41%
Ages 65+ Years		57.14%	58.06%
Adult BMI Assessment			
Ages 18–64 Years		38.92%	51.27%
Ages 65+ Years		44.07%	55.36%
Elective Delivery *A lower rate indicates better performance*		33.81%	22.50%
Antenatal Steroids		4.02%	10.95%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		64.44%	63.64%
Flu Shots for Adults Ages 50–64		NR	NR
Medical Assistance With Smoking and Tobacco Use Cessation		NR	NR
Screening for Clinical Depression and Follow-Up Plan—Total		0.01%	0.00%

Table 7-1—Adult Core Set Measures and Rates for the Medicaid Adult Only (MAO) Population		
Measure	2012 Rate	2013 Rate
Plan All-Cause Readmission Rate		
Ages 18–44 Years	12.78%	12.90%
Ages 45–54 Years	12.28%	12.50%
Ages 55–64 Years	11.25%	11.78%
Ages 65+ Years	2.49%	2.12%
Total	9.42%	10.17%
Care Transition—Transition Record Transmitted to Health Care Professional	NR	0.24%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of Treatment		
Ages 18–64 Years	40.77%	38.74%
Ages 65+ Years	56.37%	40.57%
Engagement of Treatment		
Ages 18–64 Years	6.11%	5.25%
Ages 65+ Years	6.64%	2.47%

Many rates for the MAO population improved drastically over their respective 2012 rates. Of note, all rates for the *Annual Monitoring for Patients on Persistent Medications* increased over the 2012 rates. Most notable are the rates for *Anticonvulsants—Ages 65+ Years*, which increased 15.39 percentage points, and for *Total—Ages 65+ Years*, which increased 9.04 percentage points. The *Adult BMI Assessment—Ages 18–64 Years* rate increased from 38.92 percent to 51.27 percent, and the *Ages 65+ Years* rate increased from 44.07 percent to 55.36 percent. Also substantially improved was the *Elective Delivery* rate, which was 11.31 percentage points better than the 2012 rate.

Some rates showed substantial declines from the 2012 rates. For example, the *Controlling High Blood Pressure—Ages 65–85 Years* rate fell from 34.15 to 24.60 percent. The most significant rate decline was in the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of Treatment—Ages 65+ Years*, which fell 15.80 percentage points from the previous year.

Quality Improvement Projects

As part of the grant, DCH is working with the Division of Aging Services 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. Two quality improvement projects (QIPs) were implemented to improve the identification and treatment of depression among the CCSP population. The first QIP was specific to improvement in screening for clinical depression and follow-up, while the second was specific to improvement in the management of depression.

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.

The DCH contracted with HSAG to perform a review of the CMOs' compliance with standards, one of the three federally mandated activities. 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 2014.

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:

- Availability of Services
- Furnishing of Services
- Cultural Competence
- Coordination and Continuity of Care

- Coverage and Authorization of Services
- Emergency and Poststabilization Services
- Case and Disease Management Focused Review
- 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.

In addition to the above-mentioned review areas, HSAG performed a focused, case-specific file review of a sample of members enrolled in the CMO's case management and disease management programs.

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 documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of sample cases plus an oversample for case management, disease management, and service denial cases for the on-site CMO audit from the list of such members submitted to HSAG from the CMO.

[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: February 19, 2013.

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 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, 2013–June 30, 2014
Information obtained through interviews	July 1, 2013—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, 2013–June 30, 2014

Data Aggregation and Analysis

HSAG used scores of *Met* or *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:

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

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

Not Met indicates noncompliance defined as *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.
- 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* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

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

- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded 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 performance measure 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.

The DCH required the CMO's to report rates in SFY 2014 for 52 measure categories from the original required list of 54 measure categories. The measurement period was identified by DCH as calendar year (CY) 2013 for all measures except the two Child Core Set dental measures. The dental measures were reported for federal fiscal year (FFY) 2013, which covered the time frame of October 1, 2012, through September 30, 2013, according to CMS requirements. All performance measure rates were reported by the CMOs in June 2014. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information measures. Many of the 52 measure categories included multiple indicators or age stratifications. The DCH removed the *Annual Pediatric Hemoglobin (HbA1c) Testing* and *Annual Percentage of Asthma Patients with One or More Asthma-related ER Visit* measures based on CMS' decision to retire these from the Child Core Set.

For the CY 2013 data, DCH established performance targets for many of the required measure categories and their associated indicators. Fifty-four targets were established. These performance targets for CY 2013 data were based on NCQA national Medicaid percentiles and the Nationwide Inpatient Sample (NIS) for the AHRQ measures.

Objectives

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

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

HSAG began performance measure validation in February 2014 for the CMOs and completed validation in June 2014. The CMOs submitted performance measure data that reflected the period of January 1, 2013, through December 31, 2013. HSAG provided final performance measure validation reports to the CMOs and DCH in September 2014. HSAG began performance measure validation of HP in March 2014 and completed validation in December 2014. HSAG provided the final performance measure validation report to DCH in January 2015.

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.[B-1] 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 performance measures.

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

NCQA's HEDIS 2014 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 performance measures: 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 performance measure 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,

[B-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

and inpatient data. Additionally, the review evaluated the processes used to collect and calculate the performance measure 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 performance measure 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 performance measure 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 performance measure 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 Roadmap review 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.

The June 30, 2014, through August 1, 2014, PIP submissions included eight clinical PIPs (*Adolescent Well-Care Visits, Annual Dental Visits, Appropriate Use of ADHD Medications, Avoidable Emergency Room Visits, Childhood Immunizations—Combo 10, Childhood Obesity, Comprehensive Diabetes Care,* and *Postpartum Care)* as well as two nonclinical PIPs (*Member Satisfaction* and *Provider Satisfaction*).

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 seventh year of validating CMO PIPs, HSAG conducted PIP validation on 10 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—Combo 10.
- Childhood Obesity.
- Comprehensive Diabetes Care.
- Postpartum 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 activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. In consultation with DCH and in an effort to more clearly distinguish when evaluation criteria for each element were fulfilled, HSAG removed *Partially Met* from the scoring options for this year's validation cycle. HSAG designated some of the evaluation elements deemed pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements had to be scored *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall *Not Met* validation status for the PIP. The CMOs were also given a *Not Met* validation status if less than 80 percent of all evaluation elements were scored *Met*. HSAG provided a *Point of Clarification* when the CMOs fully met the evaluation element criteria and only minor documentation edits not critical to the validity of the PIP were recommended to the CMOs.

In addition to the overall validation status (e.g., *Met*) HSAG provided an overall percentage for all evaluation elements (including critical elements) scored *Met*. HSAG calculated the overall percentage by dividing the total number of elements scored *Met* by the total number of elements scored *Met* and *Not Met*. HSAG also calculated a critical element overall percentage by dividing the

[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. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

total number of critical elements scored *Met* by the sum of the critical elements scored *Met* and *Not Met*.

HSAG assessed the implications of the studies' findings on the validity and reliability of the results with one of the following two determinations of validation status:

- *Met*: High confidence/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 2014 and completed validation in August 2014. 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 2014.

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, 2013–December 31, 2013
	Annual Dentist Visits PIP	
	Appropriate Use of ADHD Medications PIP	
	Avoidable ER Visits Collaborative PIP	
	Childhood Immunizations—Combo 10 PIP	
	Childhood Obesity PIP	
	Comprehensive Diabetes Care PIP	
	Postpartum Care PIP	
AMERIGROUP	*Member Satisfaction* PIP	February 7, 2014–May 2, 2014
	Provider Satisfaction PIP	July 1, 2013–September 30, 2013
Peach State	*Member Satisfaction* PIP	February 25, 2014–May 1, 2014
	Provider Satisfaction PIP	September 1, 2013–October 31, 2013
WellCare	*Member Satisfaction* PIP	January 1, 2014–May 31, 2014
	Provider Satisfaction PIP	June 1, 2013–August 31, 2013

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.

Appendix D. PIP Summary Grid

Table D-1—Adolescent Well-Care Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
AMERIGROUP's rate of adolescents with at least one comprehensive well-care visit increased by 5.9 percentage points from Remeasurement 1 to Remeasurement 2. While the increase from Remeasurement 1 to Remeasurement 2 was not statistically significant, the Remeasurement 2 study indicator rate was a statistically significant improvement over baseline. The Remeasurement 2 rate exceeded the DCH 2013 target rate of 49.7 percent and was between the national Medicaid HEDIS 2012 50th and 75th percentiles.	◆ Engagement and support of high-volume providers seeking NCQA PCMH Recognition; monitoring of provider participation in the PQIP. ◆ The MyHealthDirect program, which enables internal Member Service associates to schedule well-visit appointments for noncompliant members. ◆ "Clinic Days" educational member events to promote completion of well-care visits. ◆ Member outreach via live telephone calls to noncompliant members to educate and address barriers to attending well-care visits. ◆ Transportation assistance for members due for a well-care visit.	Met	AMERIGROUP documented quantitative, intervention-specific evaluation results as part of the PIP and used evaluations of effectiveness to guide decisions about continuing, revising, or discontinuing implementation. The CMO planned revisions to ongoing interventions aimed at achieving further improvement following the second remeasurement. Going forward, the CMO should continue quantitative evaluation of effectiveness of each intervention. Conducting ongoing evaluations and regularly reviewing evaluation results will help the CMO refine improvement strategies to fully address barriers to improvement, which should result in sustained improvement in outcomes.

Table D-1—Adolescent Well-Care Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
Peach State			
In the second remeasurement period of the *Adolescent Well-Care Visits* PIP, Peach State sustained 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 2 rate of 42.7 percent was a statistically significant improvement over both the baseline and Remeasurement 1 rates. The Remeasurement 2 rate fell below the 2013 DCH target of 49.7 percent and below the 25th percentile of national Medicaid HEDIS 2012 rates. The rates reported for this PIP were based on administrative data.	◆ Implementation of live telephonic outreach to assist noncompliant members in making well-care appointments to address member awareness of due well-care services. ◆ Quarterly meetings with the CMO's medical record review vendor to ensure accurate and effective education of providers on adolescent well-care documentation requirements. ◆ Large and small group provider education and engagement sessions, promoting the practice of completing due well-care services during sports physical appointments and sick visits, to address provider-missed opportunities for delivering well-care services. ◆ Collaboration with an Atlanta FQHC to implement and facilitate the "Convenient Time" pilot program, which offered well-care appointments during after-	Met	Peach State reported quantitative evaluation results for some interventions but not others. For example, the CMO documented evaluating the "Convenient Time" pilot program with data to support that the teens had well-care visits. In contrast, the CMO did not document quantitative evaluation results of the in-person provider education intervention, which prevented measuring the impact of this intervention on the well-care study indicator. HSAG encourages Peach State to have processes in place to evaluate the effectiveness for each of its interventions. Without a method to evaluate the impact of each intervention on the study indicator, the CMO is less capable to make data-driven decisions about when to initiate, continue, modify, or discontinue interventions.

Table D-1—Adolescent Well-Care Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	school/work hours. The pilot program, targeting member schedule barriers, included transportation assistance and a gift card member incentive for completed appointments.		
WellCare			
For the WellCare PIP, the study indicator rate demonstrated a statistically significant decline from Remeasurement 1 to Remeasurement 2. The percentage of eligible adolescent members who had at least one well-care visit during the measurement year declined 7.8 percentage points. The Remeasurement 2 rate was no longer a statistically significant improvement over the baseline rate; therefore, the PIP did not demonstrate sustained improvement. The Remeasurement 2 rate fell below the 2013 DCH target of 49.7 percent and was between the 25th and 50th percentiles of the national Medicaid HEDIS 2012 rates.	◆ Telephone outreach to educate members on the importance of adolescent well-care visits and to schedule appointments. ◆ Targeted Health Check schedule reminder letters sent at 120 days of plan enrollment and during the member's birthday month. ◆ Monthly provider membership lists that specified children eligible for health check visits who had not had an encounter within 120 days of joining the health plan or were not in compliance with the Health Check Program.	Not Met	While WellCare initiated new interventions following the performance decline in Remeasurement 2, and reinstated the provider incentive program, the CMO did not describe the analysis results or processes used to guide decisions about making these changes. WellCare did not document any processes to evaluate the effectiveness of each intervention or any evaluation results. Without intervention-specific evaluations, the CMO does not have the information necessary to fully assess the causes for the decline in adolescent well-care visits. Quantitative assessment of each intervention is necessary to determine if interventions are being implemented effectively and to identify which strategies are having the greatest positive impact on targeted outcomes.

Table D-2—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
For first remeasurement of the *Annual Dental Visits* PIP, AMERIGROUP achieved statistically significant improvement over baseline rates for Study Indicators 1 and 3, but there was a statistically significant decline in the rate of Study Indicator 2 at Remeasurement 1. The rate for Study Indicator 2 (preventive dental services) fell below the baseline rate and continued to fall below the DCH 2013 target rate of 58.0 percent.	◆ Mobile dental units accompanied by member outreach for appointment scheduling. ◆ Health Promotion coordinator visits with providers to support referrals for annual dental services. ◆ Robotic calls to members ◆ Member reminder text messages.	Not Met	The CMO did not document any revision of the improvement strategies to address the statistically significant decline at Remeasurement 1 demonstrated by one of the three study indicators. Approximately six months had passed between completion of the first remeasurement and the submission of the PIP for validation; during that time, the CMO should have conducted further drill-down analysis to determine why one study indicator declined while the other two indicators improved. The CMO should have documented follow-up analyses and implementation of new or revised interventions to address the performance decline. The PIP documentation suggested some limitations to AMERIGROUP's methods for evaluating the effectiveness of its interventions. The CMO documented that it used the HEDIS *Annual Dental Visit* (ADV) measure as an interim, proxy measure for evaluating the effectiveness of the PIP's interventions. While the ADV measure may be similar to Study Indicator 1 (any dental service visit), it is substantially different from Study

Table D-2—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
			Indicators 2 (preventive dental visit) and 3 (receiving a dental sealant), which are both preventive dental services. Given the mixed performance of the study indicators, it is clear that interventions that may impact some of the study indicators will not necessarily impact all. The CMO should monitor the effectiveness of its interventions by using measures directly related to the study indicators.
Peach State			
For first remeasurement of the *Annual Dental Visits* PIP, Peach State achieved statistically significant improvement over the baseline rate for Study Indicator 2, but the rates for Study Indicators 1 and 3 at Remeasurement 1 demonstrated a statistically significant decline. The Remeasurement 1 rate for Study Indicator 2 did not reach the 2013 DCH target rate of 58.0 percent.	◆ Peach State implemented a provider-based intervention, "Preventistry Provider Sealant Program," to increase the frequency of sealants being placed on child and adolescent teeth. The intervention was targeted at changing provider practices of delaying the application of sealants and providing preventive and restorative care without applying sealants. ◆ To address lack of member awareness of dental benefits and recommended services, the CMO implemented the "CareGaps" alert system that notifies Member Services and	Not Met	The mixed study indicator results for this PIP illustrate the importance of evaluating the impact of interventions on each study indicator. The CMO documented evaluations of effectiveness for some interventions but not others. The CMO did not report an evaluation for the "CareGaps" intervention or for any of Peach State's "standardized interventions." The CMO should document the evaluation of the effectiveness for each intervention, and the link between evaluation results and decisions to continue, revise, or discontinue implementation should be documented. To achieve meaningful improvement across all study indicators, HSAG encourages

Table D-2—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	other internal staff when a member is due or past-due for a preventive dental visit. Member Services staff members are able to pass this information onto members during inbound and outbound telephone calls. ◆ Peach State implemented a secure member "CareGaps" Web portal to improve member awareness of due/past-due preventive dental services. The Web portal notifies members who signed up to access their electronic health record when they are due for a dental visit.		Peach State to implement ongoing, quantitative evaluations of each intervention and revise interventions, as needed, based on evaluations of effectiveness, study indicator performance, and causal/barrier analyses.
WellCare			
The study indicators demonstrated mixed results for the first remeasurement of WellCare's *Annual Dental Visits* PIP. The rate for Study Indicator 1 (any dental service) demonstrated a statistically significant increase, while the rates for Study Indicators 2 (preventive dental services) and 3 (dental sealant services) demonstrated a statistically significant decline. The Remeasurement 1 rate for	◆ Case management program. ◆ Community outreach program. ◆ Mailed member reminders. ◆ Mailed noncompliant lists to providers.	Not Met	The CMO did not document any monitoring or evaluation of ongoing interventions. WellCare had no documented evaluation process, nor did it have results of evaluating the effectiveness for each intervention. It is critical that WellCare implement and document processes to evaluate the effectiveness of each implemented intervention. To address the varied study indicator results, it is necessary to examine each intervention to determine if it is impacting some of

Table D-2—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
Study Indicator 2 was also 12.6 percentage points below the 2013 DCH target rate of 58.0 percent.			the study indicators but not others. The CMO should conduct further drill-down analyses to determine the root causes of noncompliance with the CMS 416 dental measures. Attention should be given to the differences between the three study indicators to determine why interventions positively impacted Study Indicator 1 but resulted in declines in Study Indicators 2 and 3.

Table D-3—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
AMERIGROUP did not achieve statistically significant improvement over baseline at Remeasurement 2. While the rates of Study Indicator 1 (initiation phase follow-up visit) and Study Indicator 2 (continuation phase follow-up visit) increased from Remeasurement 1 to Remeasurement 2, the improvements were not statistically significant, and the rates of both study indicators remained below baseline. The Remeasurement 2 rates for Study	◆ E-mailing HEDIS report cards to providers. ◆ Face-to-face visits with providers. ◆ Member focus groups. ◆ Appointment reminder calls. ◆ Support of providers seeking NCQA PCMH Recognition. ◆ Face-to-face visits with low-performing providers' nurse practice consultant.	Not Met	While AMERIGROUP documented evaluation processes and results for some interventions, the CMO stated that three interventions were continued without evaluation of effectiveness. Based on the lack of improvement over baseline demonstrated by the study indicators, it is clear that the interventions were not effectively addressing all of the critical barriers necessary for improvement in outcomes. The CMO should have an evaluation in place for each intervention to enable informed, data-driven decisions about

Table D-3—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
Indicators 1 (initiation) and 2 (continuation) fell below the 2013 DCH target rates of 52.5 percent and 63.1 percent, respectively. In comparison with the national Medicaid HEDIS 2012 rates, the Remeasurement 2 rate for Study Indicator 1 fell between the 50th and 75th percentiles, and the rate for Study Indicator 2 was between the 75th and 90th percentiles.			continuing, revising, or discontinuing interventions.
Peach State			
Neither study indicator in Peach State's PIP demonstrated statistically significant improvement from baseline to Remeasurement 2. The rates of both study indicators, follow-up visits during the initiation phase (Study Indicator 1) and follow-up visits during the continuation and maintenance phases (Study Indicator 2), declined from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rates for Study Indicators 1 and 2 fell below the CY 2013 DCH targets of 52.5 percent and 63.1 percent, respectively. In comparison with the national Medicaid HEDIS 2012 rates, Peach State's CY 2013	◆ Continued pharmacy liaison education visits to non-psychiatric practitioners with high-volume ADHD prescriptions. ◆ Continued implementation of a CPG compliance program. ◆ Participated in an ongoing Quality Improvement and Public Relations collaboration to educate behavioral health providers on HEDIS measures and the ADHD CPG. ◆ Initiated live telephone calls to parents of members who were identified as having filled an ADHD medication prescription following a four-month negative medication history. The telephone calls	Not Met	Peach State did not provide sufficient documentation on the evaluation and monitoring of intervention effectiveness. HSAG strongly recommends that Peach State implement a quantitative process to evaluate the effectiveness of each intervention's impact on the study indicator rates. The CMO should report the specific evaluation processes and results used during its documented PDSA cycles for the PIP and continue to revisit the evaluation and causal/barrier analyses until meaningful improvement is achieved. Effective evaluation and data analyses allow limited resources to be directed toward those interventions that will have the greatest positive impact on outcomes.

Table D-3—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
rate for Study Indicator 1 fell between the 50th and 75th percentiles and its Study Indicator 2 rate fell between the 75th and 90th percentiles.	served to verify that a follow-up appointment was scheduled, offer transportation assistance, and stress the importance of keeping the appointment. ◆ Conducted large and small group provider education and engagement sessions to ensure that providers understand the requirements for the HEDIS ADHD medication follow-up measures. At the sessions, the CMO distributed a HEDIS Quick Reference Book, which provides tips on ensuring the follow-up visits occur within the required time frames.		
WellCare			
At the second remeasurement for WellCare's *Appropriate Use of ADHD Medications* PIP, neither study indicator achieved statistically significant improvement over baseline. The Remeasurement 2 rate for Study Indicator 1 (follow-up visits for the initiation phase) was a statistically significant improvement over Remeasurement 1 but not over baseline. The Remeasurement 2	◆ Educational and reminder mailings to members about needed follow-up visits. ◆ Educational and reminder mailings to providers to share best practices. ◆ Face-to-face visits with high-volume ADHD providers to review lists of noncompliant members and discuss best practices for completing timely follow-up visits.	Not Met	Given the lack of significant improvement in outcomes, HSAG recommends that WellCare reevaluate its quality improvement processes, focusing on the documentation of data-driven analyses and results. The CMO should provide data to support identified barriers, and a detailed description of how the barriers were prioritized and how they were linked to the interventions. WellCare should also have processes in place to evaluate the effectiveness of each

Table D-3—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
rate for Study Indicator 2 (follow-up visits for the continuation phase) was a non-statistically significant improvement over Remeasurement 1, and the rate remained below baseline. The Remeasurement 2 rates for Study Indicators 1 and 2 fell below the CY 2013 DCH targets of 52.5 percent and 63.1 percent, respectively. In comparison with the national Medicaid HEDIS 2012 rates, the Remeasurement 2 rates for both study indicators fell between the 50th and 75th percentile rates.			implemented intervention, and combine evaluation results with causal/barrier drill-down analyses to illuminate the true root causes of the lack of significant improvement in outcomes. New or revised improvement strategies should be planned and implemented based on these follow-up analyses.

Table D-4—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
For the *Avoidable Emergency Room Visits* PIP, AMERIGROUP collected Remeasurement 2 data for Study Indicator 1 (the percentage of ER visits for avoidable diagnoses in select facilities in the Atlanta region) and collected baseline data for a new Study Indicator 2, which measured the percentage of ER visits for	◆ Case management program for ER "ultra-utilizers." ◆ On-site visits to 20 PCPs who have high-utilizing members and providing materials on the value of PCMHs. ◆ Member outreach via automated telephone calls and mailings.	Not Met	Although AMERIGROUP implemented some system changes identified through causal/barrier analysis, such as the case management program for ER "ultra-utilizers" and on-site PCP visits promoting PCMHs, Study Indicator 1 did not demonstrate improvement and instead demonstrated a trend of performance decline at Remeasurement 1 and

Table D-4—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
avoidable diagnoses in select hospitals in the CMO's expansion population. For the second remeasurement of Study Indicator 1, AMERIGROUP did not demonstrate statistically significant improvement over baseline; the rate increased from Remeasurement 1 to Remeasurement 2 by 0.2 percentage point. The Study Indicator 1 rate remained above baseline and also exceeded the DCH 2013 target rate of 21.69 percent. Because the avoidable ER rate was an inverse study indicator, for which a lower rate is better, the increase from Remeasurement 1 to Remeasurement 2 demonstrated a decline in performance.			Remeasurement 2. The CMO documented that each intervention was individually effective but, considering the PIP results to date, the interventions did not result in any improvement in the study indicator rate. This pattern suggests that the causal/barrier analysis was incomplete. Either the CMO did not identify all of the critical barriers to improving the avoidable ER visits rate or the interventions implemented to date were not sufficient to address the barriers. AMERIGROUP should revisit the causal/barrier analysis for this PIP, reviewing intervention evaluation results and performing additional drill-down analyses, to identify key drivers of avoidable ER visits that have not yet been addressed.
Peach State			
Peach State collected Remeasurement 2 data for Study Indicator 1 (the percentage of ER visits for avoidable diagnoses in select facilities in the Atlanta region) and collected baseline data for a new Study Indicator 2, which measured the percentage of ER visits for avoidable diagnoses in select hospitals in the CMO's	◆ An ER case management program, providing live outreach to members who frequent the emergency room. ◆ Distribution of an educational flyer in new member packets explaining when it is appropriate to seek care in an emergency room and providing information on	Not Met	While Peach State documented some intervention-specific evaluations of effectiveness, the CMO did not clearly document all evaluation results, linking implementation to performance in the study indicator. For example, the targeted face-to-face visits intervention with six providers was evaluated for effectiveness, showing a decrease in avoidable ER

Table D-4—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
expansion population. The Study Indicator 1 rate demonstrated a statistically significant decrease from Remeasurement 1 to Remeasurement 2. Because the avoidable ER rate was an inverse study indicator, for which a lower rate is better, the decrease demonstrated an improvement in performance from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rate remained above the baseline rate; therefore, the inverse study indicator has not demonstrated improvement over baseline.	contracted urgent care facilities. ◆ Face-to-face visits with six provider groups, identified through claims data, whose members had visited an emergency room for one of the six avoidable diagnoses targeted in the PIP. The Medical Director and Provider Relations representatives visited the providers, presented the claims data, and discussed strategies for preventing future avoidable ER visits.		rates for the six selected providers. The CMO concluded, based on this evaluation, that this intervention was responsible for the study indicator rate decrease from Remeasurement 1 and Remeasurement 2. The CMO did not, however, document any data (e.g., a comparison of the avoidable ER rate with and without the participating providers' members included) illustrating the impact of the participating providers on the overall avoidable ER rate. In the future, HSAG recommends that the CMO ensure that the evaluation process for each intervention be linked directly to overall study indicator performance to more effectively guide decisions about future implementation.
WellCare			
WellCare collected Remeasurement 2 data for Study Indicator 1, the percentage of ER visits for avoidable diagnoses in select facilities in the Atlanta region. The CMO should have also collected baseline data for Study Indicator 2 (the percentage of ER visits for avoidable diagnoses in select hospitals in the CMO's expansion population); however, WellCare did not report	◆ Targeted distribution to members of a "Before the ER" step-by-step plan for when an emergency occurs. ▪ Step 1: PCP information and a list of conditions appropriate for PCP care. ▪ Step 2: Nurse advice line information and Web site to identify nearby urgent care facilities. ▪ Step 3: Local urgent care	Not Met	WellCare provided insufficient information on the impact of the interventions on the PIP outcomes. The CMO did not fully document evaluation processes and results used to evaluate intervention effectiveness. While the CMO provided some qualitative information about how the interventions were received by providers and how some interventions would be revised, the PIP documentation did not include any

Table D-4—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
baseline data for Study Indicator 2. The rate for Study Indicator 1 increased from baseline to Remeasurement 1 and from Remeasurement 1 to Remeasurement 2. Because the avoidable ER rate was an inverse study indicator, for which a lower rate is better, the increases from baseline to Remeasurement 2 demonstrated a decline in performance.	facility information. ▪ Step 4: Local ER facility information and a list of life-threatening conditions that warrant an ER visit. ◆ Distribution of "ER Tool Kits" through high-volume provider practices, to enhance member knowledge of when and where to seek urgent versus emergent care. The tool kits included: ▪ CDC "Get Smart" materials: posters, prescription pads, and brochures. ▪ Pre-populated flyers and posters providing office hours, local urgent care facility information, and local pharmacy information. ▪ Materials providing advice for seeking care after-hours. ◆ Targeted outreach to members who visited the ER. Members were educated on their PCP contact information, benefits such as the nurse advice line, and what conditions warrant		quantitative evaluation results. Additionally, the CMO provided no information on how the impact of one intervention, the "Before the ER" step-by-step member plan, was assessed and whether or not this strategy would be continued. HSAG recommends WellCare investigate the reasons for the repeated decline in study indicator performance and, based on drill-down analyses and intervention-specific evaluation, identify and implement new strategies to improve performance.

Table D-4—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	an ER visit. High ER utilizers were referred to field short-term case management and, when appropriate, members were referred to complex case management.		

Table D-5—Childhood Immunizations—Combo 10			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
AMERIGROUP achieved sustained statistically significant improvement over the baseline rate at the second remeasurement for the *Childhood Immunizations—Combo 10* PIP. The Remeasurement 2 rate represented an increase of 5.8 percentage points over the Remeasurement 1 rate and an increase of 27.3 percentage points from baseline to Remeasurement 2. The Remeasurement 2 rate also surpassed the 90th percentile of the national Medicaid HEDIS 2012 rates.	◆ PQIP provider incentive program for improving quality scores based partly on immunization rates. ◆ The distribution of corrective action plans to low-performing, high-volume providers. ◆ Health Promotion coordinator face-to-face visits with providers. ◆ Live member outreach calls ◆ "Clinic Days" events with member incentives to facilitate immunizations for noncompliant members. ◆ The MyHealthDirect program, which enables internal Member Service associates to	Met	◆ Although AMERIGROUP achieved statistically significant improvement and sustained the improvement, the CMO has opportunities related to accurate documentation in its PIP. The CMO should document accurate percentage point differences between measurement period rates.

Table D-5—Childhood Immunizations—Combo 10			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	schedule well-visit appointments for noncompliant members.		
Peach State			
Peach State sustained statistically significant improvement over baseline at the second remeasurement for the *Childhood Immunizations—Combo10* PIP. From baseline to Remeasurement 2, the rate of eligible child members who had received all necessary immunizations by their second birthday increased by 18.7 percentage points. The Remeasurement 2 rate of 36.3 percent exceeded the 90th percentile of the national Medicaid HEDIS 2012 rates.	◆ Continued implementation of "CareGaps," an internal system alert accessible via secure portal to Peach State staff and members, letting them know about due or past-due preventive services. ◆ Initiated large and small group provider education and engagement sessions to ensure that providers understand the vaccination timing requirements for the HEDIS *Childhood Immunization Status—Combination 10* measure. At the sessions, the CMO distributed a HEDIS Quick Reference Book, which provided tips to facilitate timely vaccinations. ◆ Conducted live telephone outreach to members who were due/past-due for immunizations. Peach State staff offered assistance with appointment scheduling, transportation assistance, and a member gift card incentive for completed immunizations.	Not Met	Peach State documented that a PDSA approach was used to implement, test, and continue or revise improvement strategies; however, the CMO did not fully document the results of specific PDSA cycles for each intervention. HSAG anticipated that the CMO would have documented a data-driven evaluation for each intervention. HSAG recommends that Peach State more fully describe and document the evaluation of each intervention's effectiveness, to support ongoing sustained improvement in outcomes for this PIP.

Table D-5—Childhood Immunizations—Combo 10			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
WellCare			
WellCare demonstrated sustained improvement in the *Childhood Immunizations—Combo 10* PIP, with an increase of 20.1 percentage points from baseline to Remeasurement 2 in the rate of eligible child members who received the recommended vaccinations by their second birthday. The Remeasurement 2 rate of 40.3 percent exceeded the 90th percentile of the national Medicaid HEDIS 2012 rates.	◆ Pay for Performance (P4P) provider face-to-face visits to deliver lists of noncompliant members. ◆ A member incentive program for completed immunization visits. ◆ Outbound member reminder calls. ◆ Centralized telephonic outreach program with extended operating hours beyond normal business hours. ◆ Inbound Care Gap program to facilitate scheduling of visits for needed services when a member calls. ◆ Targeted periodicity letters sent to members annually. ◆ Targeted 120-day provider reminder letters with a list of noncompliant members. ◆ HEDIS Toolkits distributed during P4P visits.	Met	Although the study indicator demonstrated sustained improvement, the CMO failed to document intervention evaluations. The PIP documentation included neither detail on methods for evaluating intervention effectiveness nor evaluation results. To maintain and continue to improve the *Childhood Immunizations—Combo 10* study indicator rate, WellCare must implement ongoing, intervention-specific evaluations, based on quality improvement science, such as the PDSA cycle. Each intervention should be evaluated for effectiveness, and evaluation processes and results should be documented in the PIP and linked to decisions about future implementation.

Table D-6—Childhood Obesity			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
At Remeasurement 4, the AMERIGROUP *Childhood Obesity* PIP sustained statistically significant improvement over the baseline rate for all three study indicators. The Remeasurement 4 rates for Study Indicators 1 (BMI percentile documentation) and 3 (evidence of physical activity counseling) exceeded the 2013 DCH target rates of 47.5 percent and 43.3 percent, respectively, while the rate for Study Indicator 2 (evidence of nutrition counseling) fell just below the 2013 DCH target rate of 54.9 percent. In comparison to the national HEDIS 2012 rates, the rates for Study Indicators 1 and 3 were between their respective 50th and 75th percentiles, and the rate for Study Indicator 2 fell below the 50th percentile.	◆ "Clinic Days" educational member events to promote completion of well-care visits. ◆ Transportation assistance for members due for a well-care visit. ◆ Text messages sent to member households via cellular phones provided by SafeLink. ◆ Distribution of CAPs to physicians with noncompliant EPSDT medical records. ◆ Engagement and support of high-volume providers seeking NCQA PCMH Recognition, and monitoring through the PQIP provider incentive program. ◆ In-person consultation of Health Promotion coordinators with providers including review of the HEDIS report card showing performance on the study indicators and distribution of a HEDIS billing guide, which provided the correct coding for BMI documentation, nutrition counseling, and physical activity counseling.	Not Met	AMERIGROUP continued its two-pronged approach, targeting both member and provider interventions. The study indicators, measuring provider documentation of BMI percentile and nutrition and physical activity counseling during a well-care visit, will not be impacted simply by ensuring members are compliant with well-care visits. Going forward, AMERIGROUP should continue to use intervention-specific evaluation results, linked to study indicator performance, to guide decisions about continuing/expanding, revising, or discontinuing interventions for the PIP. This approach will not only support continued performance improvement but will also help to ensure that limited resources are targeted appropriately.

Table D-6—Childhood Obesity			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
Peach State			
Peach State's *Childhood Obesity* PIP demonstrated sustained improvement over baseline for all three study indicators at Remeasurement 4. The Remeasurement 4 rates for all three study indicators—BMI percentile documentation, evidence of nutrition counseling, and evidence of physical activity counseling—surpassed the respective CY 2013 DCH target rates of 47. 5 percent, 54.9 percent, and 43.3 percent. When compared to the national Medicaid HEDIS 2012 rates, the Remeasurement 3 rates for all three study indicators fell between the 50th and 75th percentiles.	◆ Held 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. ◆ Initiated large and small group provider education and engagement sessions to ensure providers understood that the components of the HEDIS WCC measure should be addressed during well visits for all members, not just those members who are identified as obese. At the sessions, the CMO distributed a HEDIS Quick Reference Book, which provided tips to ensure that providers meet the documentation requirements for the HEDIS WCC measure.	Not Met	◆ Peach State identified barriers in a fishbone diagram; however, specific data to support the barriers were not documented. Additionally, the PIP included some interventions that were not directly linked to specific barriers. ◆ While Peach State reported evaluating the effectiveness of interventions through monthly administrative rate review and provider feedback, the CMO did not document any quantitative, intervention-specific evaluation results for the PIP. The PIP documentation should include both the processes and results of each intervention's evaluation, to support ongoing sustained improvement in outcomes.
WellCare			
All three study indicators for WellCare's *Childhood Obesity* PIP demonstrated improvements from Remeasurement 3 to Remeasurement 4, with the	◆ Outreach to 13,732 members ages 3–6 years, reminding them of due well-child visits. ◆ Distribution of postcards outlining the *Weight*	Met	The CMO documented the evaluation of effectiveness for some interventions. One intervention, face-to-face provider visits requesting the use of CPT II codes, had a

Table D-6—Childhood Obesity			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
improvements for Study Indicators 1 (BMI percentile documentation) and 3 (evidence of counseling for physical activity) being statistically significant. Additionally, Study Indicator 3 demonstrated statistically significant improvement over baseline for the first time at Remeasurement 4. The Remeasurement 4 rates for all three study indicators—BMI percentile documentation, evidence of nutrition counseling, and evidence of physical activity counseling—exceeded the CY 2013 DCH target rates of 47.5 percent, 54.9 percent, and 43.3 percent, respectively. In comparison with the national Medicaid HEDIS 2012 benchmarks, WellCare's CY 2013 rates for all three study indicators were between their respective 50th percentile and 75th percentile rates.	*Assessment and Counseling for Nutrition and Physical Activity for Children/ Adolescents* (WCC) measures to providers at a pediatric conference. ◆ Distribution of a DCH-approved BMI percentile documentation form for providers via their provider Web site and through fax. ◆ E-mail communication with independent practice associations (IPAs), providing BMI percentile forms and WCC postcards. ◆ Targeted face-to-face pediatric provider visits requesting the use of CPT II codes to document WCC services, despite the lack of reimbursement for these codes.		documented quantitative evaluation in which the CMO reported, "The providers that were asked to utilize the CPT II codes had higher rates of compliance for WCC than the providers who did not have a face-to-face visit." This type of evaluation should be conducted and documented for each intervention. Documentation of evaluation results should include the specific subgroup rates compared as part of an evaluation. For example, for the provider visit intervention, the CMO should report the rate among providers who received the visit versus the rate among providers who did not receive the visit.

Table D-7—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
None of the study indicators for the AMERIGROUP PIP achieved statistically significant improvement over baseline rates at Remeasurement 2. The rates of all three study indicators declined from Remeasurement1 to Remeasurement 2. Additionally, the rates of Study Indicators 1 (HbA1c control < 7.0%) and 3 (BP Control < 140/90 mmHg) remained below baseline at Remeasurement 2. The Remeasurement 2 rates for all three study indicators fell below the 25th percentiles of the national HEDIS 2012 rates and below the CY 2013 DCH targets of 36.7 percent (HbA1c control < 7.0%), 35.9 percent (LDL-C control < 100 mg/ml), and 63.5 percent (BP Control < 140/90 mmHg).	◆ Robotic calls to diabetic members to remind them of diabetic screenings. ◆ Member incentive program that allowed for the distribution of $25 for every member who received an HbA1c, LDL-C, and BP screening. ◆ Engagement and support of high-volume providers seeking NCQA PCMH certification, and monitoring through the PQIP provider incentive program. ◆ Distributed HEDIS report cards showing providers their performance on HEDIS diabetes control measures. ◆ Enrolled members identified as having uncontrolled diabetes into nurse-led Case Management, Disease Management, and Quality Management programs. ◆ Held diabetes events (targeting noncompliant members) that provided nutritional counseling, blood pressure screening, LDL	Not Met	Although the Remeasurement 1 results did not demonstrate statistically significant improvement, the CMO did not identify any new barriers in the fishbone diagram for Remeasurement 2. Consequently, the interventions implemented during the Remeasurement 2 period included only slight revisions from those implemented during the Remeasurement 1 period despite the lack of improvement. In addition to continuing interventions during the Remeasurement 2 period that did not have a significant impact on outcomes at Remeasurement 1, the CMO implemented interventions that appeared to reach a relatively small proportion of the eligible member population and often targeted diabetic screening outcomes rather than the diabetic control outcomes measured by the PIP's study indicators. While increasing the number of screened members may help to improve the study indicator rates, interventions need to go beyond simply getting members in for screening in order to significantly improve the rates of members with HbA1c, LDL-C, and BP levels in control.

Table D-7—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	screening, and additional educational materials.		While the CMO's improvement strategies for the Remeasurement 2 period had a number of flaws, as described above, AMERIGROUP documented planned revisions for CY 2014 that were based on the study indicator findings and results of intervention-specific evaluations of effectiveness. The CMO acknowledged the lack of improvement to date and reported that it would revisit the causal/barrier analysis process and seek out new improvement strategies to improve members' diabetic control.
Peach State			
Peach State did not achieve statistically significant improvement over baseline at Remeasurement 2 for any of the study indicators; all three study indicator rates remained below baseline. While there was a non-statistically significant increase in the rate for Study Indicator 2 (LDL-C < 100 mg/ml) from Remeasurement 1 to Remeasurement 2, the rates for Study Indicators 1 (HbA1c < 7.0%) and 3 (BP < 140/90 mmHg), declined. The rates for all three study indicators fell below	◆ Continued implementation of the contractually required diabetes disease management program. ◆ Live telephone outreach to members due/past-due for diabetes services. ◆ Member incentives for completing diabetes visits. ◆ A collaborative effort by the Quality Improvement and Provider Relations departments to enhance provider education on HEDIS specifications for the study indicators and educational	Not Met	While some of the interventions implemented during the second remeasurement period were system changes likely to impact the diabetic control study indicators, other interventions targeted diabetic screenings and would not directly improve diabetes control measures. While Peach State reported that it monitored monthly administrative rates to evaluate intervention effectiveness, the CMO did not link evaluation results to decisions about continuing, revising, or discontinuing implementation. To achieve significant improvement in the study

Table D-7—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
the CY 2013 DCH targets of 36.7 percent (HbA1c control < 7.0%), 35.9 percent (LDL-C control < 100 mg/ml), and 63.5 percent (BP Control < 140/90 mmHg). The Remeasurement 2 rates for all three study indicators also fell below the 25th percentile of the respective national Medicaid HEDIS 2012 rates.	provider mailings regarding diabetes service coding requirements.		indicators, the CMO should ensure that decisions about future intervention implementation are closely based on intervention-specific evaluation results and ongoing causal/ barrier analyses.
WellCare			
There were no statistically significant changes in the study indicator rates at Remeasurement 2 for WellCare's *Comprehensive Diabetes Care* PIP. The rate for Study Indicator 1 (HbA1c control < 7.0%) decreased by 2.3 percentage points, the rate for Study Indicator 2 (LDL-C control < 100 mg/ml) increased by 0.8 percentage point, and Study Indicator 3 (BP control < 140/90 mmHg) increased by 5.3 percentage points. The CMO's rates fell below the CY 2013 DCH goals of 36.7 percent (HbA1c control < 7.0%), 35.9 percent (LDL-C control < 100 mg/ml), and 63.5 percent (BP control < 140/90 mmHg), respectively. The rate for Study Indicator 1 fell	◆ Laboratory follow-up by the QI Department to determine results of laboratory tests listed on the quarterly "labs with no result" lists. ◆ Distribution of noncompliant member lists to provider offices. ◆ 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 provided education and assisted with making an appointment to visit the provider's office.	Not Met	While WellCare reported the implementation status of each intervention, the CMO did not document any intervention-specific results used to guide decisions about continuing or discontinuing the interventions. The documentation did not include any evaluation methods or results for the interventions. Although the PIP documentation included an additional intervention table with an "Analysis" column, the documentation in this column did not describe any evaluation linking intervention implementation to study indicator performance. Each intervention should be accompanied by an effectiveness evaluation, with methods and quantitative results documented in the PIP.

Table D-7—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
below the 25th percentile of the national Medicaid HEDIS 2012 rates, and the rates for Study Indicators 2 and 3 were slightly higher than the 25th percentile.	◆ A HEDIS Care Gap database and tracking tool, which alerts WellCare staff of any due/past-due services during inbound/outbound telephone contact with the member. ◆ Training on glucometer use for members enrolled in the Disease Management program. ◆ Enhanced care plans implemented by the Disease Management program to support more individualized care and education, resulting in better self-management. These plans incorporate member-identified needs and identify specific, measurable, attainable, relevant, and time-bound (SMART) goals to facilitate self-management. The plans are shared with the member's provider. ◆ Contracted with Avesis, an external vendor, to increase outreach capability through telephone calls and postcards.		

Table D-8—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
AMERIGROUP achieved statistically significant improvement over baseline at Remeasurement 1 for the *Member Satisfaction* PIP. The study indicator rate from baseline to the first remeasurement increased by 4.9 percentage points.	◆ Implemented 10 ongoing interventions to address physician awareness of member satisfaction, timeliness of care, member transportation issues, lack of access in rural areas, and member understanding of benefit coverage. ◆ Presented member satisfaction results to all Provider Relations staff to help providers better understand and advocate for member needs. ◆ Distributed a provider tip sheet that covered the most commonly denied prescriptions and acceptable formulary replacements.	Met	Although AMERIGROUP's causal/ barrier analysis process appeared to be sound and the CMO implemented system changes that resulted in statistically significant improvement at the first remeasurement, the PIP documentation did not provide details on how interventions were evaluated for effectiveness. The CMO also did not describe how successful interventions would be standardized to promote and sustain further improvement in member satisfaction. Going forward, the CMO should ensure that each intervention is accompanied by ongoing evaluation of effectiveness. Evaluation results, in combination with repeated causal/barrier analyses, should be used to drive continuation, expansion, and/ or revision of improvement strategies. The ongoing assessment of effectiveness is necessary to achieve sustained significant improvement in outcomes.
Peach State			
At the first remeasurement for the *Member Satisfaction* PIP, Peach State reported a decline in the rate of member satisfaction. The rate	◆ The CMO conducted outreach to specialists in the Metro Atlanta area to confirm participation and appointment	Not Met	The CMO documented plans for new and revised interventions to address the decline in the study indicator at Remeasurement 1. Peach State is

Table D-8—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
of respondents giving Peach State a score of "8" or higher declined 2.1 percentage points from baseline to Remeasurement 1.	availability. ◆ The Member Services Department developed an internal program to improve call quality and customer service.		focused on developing a "culture of organizational-wide quality involvement using front line and senior level staff." Future interventions will emphasize customer service improvements and access to specialists. The CMO should also revisit the causal/barrier analysis process to determine if all relevant barriers have been identified and use analysis results to rank barriers by priority, to effectively address the key drivers of overall member satisfaction.
WellCare			
At the first remeasurement for the *Member Satisfaction* PIP, WellCare reported a decline in the rate of member satisfaction. The rate of respondents giving WellCare a score of "8" or higher declined 0.8 percentage point from baseline to Remeasurement 1.	◆ Implemented HEDIS Tool Kits to provide member-centric talking points to Community Relations staff and outreach nurses who contact members identified with due/past-due services. ◆ Continued year-round provider recruiting, worked with a vendor to identify specialists contracted with other payors, launched a partnership to provide telemedicine services, and removed prior authorization requirements for most procedures. ◆ Implemented Enhanced	Not Met	Despite the many documented interventions, WellCare did not achieve improvement in overall member satisfaction. The CMO documented that the interventions would be discussed by the CAHPS Committee, in relation to the Remeasurement 1 results; however, WellCare did not document any planned or implemented intervention revisions. HSAG recommends that the CMO determine an evaluation plan for each intervention and document evaluation results as part of the PIP. The evaluation results should be used to guide the CMO's decisions to continue, expand, revise, or abandon interventions.

Table D-8—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	Community Outreach, a collaborative relationship with community advocacy partners. ◆ Increased the number of open provider panels by 20 percent to enhance member access to providers. ◆ Sent out a letter to members to increase awareness of the changes WellCare implemented in order to improve member satisfaction. ◆ Provided "soft skill" training to customer service staff to meet members' expectations of courtesy and respect. ◆ Launched a series of member mailings to change member perceptions of the CMO's services.		

Table D-9—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
AMERIGROUP's *Postpartum Care* PIP demonstrated a non-statistically significant increase in the study indicator rate of 1.3 percentage points from baseline to Remeasurement 1. The Remeasurement 1 rate fell below the 2013 DCH target rate of 71.1 percent. In comparison with the national HEDIS 2012 rates, the study indicator rate fell between the 25th and the 50th percentiles.	◆ Member outreach via telephone calls and text messages to schedule postpartum care visits. ◆ Pilot incentive program for OB provider schedulers to ensure completion of postpartum visits among eligible members. ◆ Member incentive program for completion of postpartum visit. ◆ Nurse consultant visits to low-performing providers to share best practices and facilitate improvement of postpartum visit rates.	Not Met	In response to the lack of statistically significant improvement in the study indicator rate and intervention evaluation results, the CMO documented planned, intervention-specific revisions for the following measurement period. The revisions include contracting a new vendor to complete telephone outreach to members due for a postpartum visit, seeking enhanced member contact information through an outside vendor, and incorporating appointment scheduling rate into the performance reviews of member outreach associates. While the CMO documented the use of intervention effectiveness evaluations to determine revisions needed to achieve the desired improvement in outcomes, the PIP documentation lacked detail on the methods used to evaluate some of the interventions, and quantitative evaluation results were not documented for all interventions. Going forward, AMERIGROUP should ensure that each intervention is accompanied by an ongoing, quantitative evaluation of effectiveness so that improvement

Table D-9—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
			strategies can be refined, as needed, in order to successfully impact barriers and outcomes. Effectiveness evaluation results should be used in conjunction with the results of a revisited causal/barrier analysis process. After reviewing study indicator and evaluation data, the CMO should review all identified key drivers and secondary drivers impacting postpartum care rates to ensure the key driver diagram is comprehensive and the SMART Aim is specific, measurable, and time-bound.
Peach State			
There was a statistically significant decline in the study indicator rate for Peach State's *Postpartum Care* PIP at Remeasurement 1. The Remeasurement 1 rate declined by 9.8 percentage points from the baseline rate; the study indicator rate fell below the 2013 DCH target rate of 71.1 percent and below the 50th percentile of the national HEDIS 2012 rates.	◆ A collaborative partnership with the Obstetrics (OB) Society to increase provider awareness about the importance of completing postpartum visits between 21 and 56 days after delivery. ◆ A bonus program for providers who accurately code postpartum visits within the specified time frame, using appropriate ICD-9 codes. ◆ The Healthy Start Program, in which clinical staff met with members before they left the hospital, after giving birth, to	Not Met	The PIP lacked sufficient documentation of the causal/barrier analyses conducted for the baseline and Remeasurement 1 periods. The CMO did not document the tools or step-by-step processes used for the baseline causal/barrier analysis process. Additionally, not all of the documented interventions were linked to specific barriers. Given the statistically significant decline in the study indicator rate, HSAG would have expected to see documentation of new or revised interventions to address the lack of

Table D-9—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	provide education on postpartum care and assist with scheduling the postpartum visit.		improvement. Peach State reported that its team conducted a drill-down analysis in response to the Remeasurement 1 results; however, the PIP documentation did not include planned revisions to the improvement strategies. Additionally, while Peach State documented the evaluation of some interventions, the documentation was incomplete. Evaluations for some interventions, such as the Healthy Start program, used claims data. Other interventions, such as the provider bonus program and the OB Society partnership, did not have documented evaluation processes or results. The CMO should use both drill-down analyses and results of intervention evaluations to identify barriers that have not been addressed; new or revised interventions should be implemented to address persistent barriers to improvement.
WellCare			
For the first remeasurement of the *Postpartum Care* PIP, WellCare reported a non-statistically significant improvement of 0.7 percentage point. The Remeasurement 1 rate fell below the 2013 DCH target rate of 71.1 percent and below the 50th	◆ WellCare implemented reminder calls for scheduled postpartum appointments. ◆ The CMO offered a "maternity rewards program." Members could select a stroller or play yard after completion of a timely	Not Met	WellCare continued its practice of documenting barriers and interventions without providing quantitative data or analysis results to support conclusions for the *Postpartum Care* PIP. The CMO reported that it used a "fishbone analysis" for the causal/barrier

Table D-9—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
percentile of the national Medicaid HEDIS 2012 rates.	postpartum visit. ◆ WellCare contracted with a vendor to conduct comprehensive outreach to members during and after the pregnancy. ◆ WellCare issued a "Welcome Home Report" for each member recently discharged after delivery. Case managers and the High Risk OB team used these reports to plan transitional interventions, including scheduling the postpartum visit. ◆ The CMO facilitated member outreach by OB social workers. ◆ WellCare offered OB short-term case management, which provided appropriate assessments and referrals. ◆ The Community Relations department hosted postpartum events to promote the importance of timely postpartum visits. ◆ WellCare received assistance from the Obstetrics and Gynecology (OB/GYN) Society to provide education to specialists.		analysis; however, the specific data and process used in this analysis were not identified. Additionally, no process for prioritizing barriers was described, and high-priority barriers were not distinguished from other barriers. Lastly, most of the interventions documented for the PIP were linked to barriers that were not listed on the fishbone diagram. WellCare provided insufficient information about the interventions implemented. The CMO reported only the calendar year for the intervention implementation dates and did not provide specific start dates; it was unclear whether interventions were implemented for only part of the identified measurement period or for the entire year. Accurate and consistent documentation of implementation dates is important as part of the process to evaluate intervention effectiveness. Complete start and end dates allow the CMO to better link implementation of specific interventions to changes in the study indicators. Beyond incomplete implementation dates, WellCare failed to describe *any* evaluation methods or results for the *Postpartum Care* PIP interventions. The CMO must

Table D-9—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
			document an evaluation specific to each intervention, as part of ongoing causal/barrier analyses, to support data-driven decisions about future improvement strategies that will promote statistically significant improvement in outcomes.

Table D-10—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
AMERIGROUP			
In AMERIGROUP's *Provider Satisfaction* PIP, there was a non-statistically significant increase of 4.6 percentage points in the study indicator rate from 79.6 percent at baseline to 84.2 percent at Remeasurement 1.	◆ Increased the use of a proactive claims audit process to ensure accuracy of claims payment. ◆ Hired additional staff in Provider Relations, Operations/Claims, and Quality Management departments to increase support for providers. ◆ Enhanced processes involved in claims processing, payments, and claims payment disputes such as processed claims monitoring and additional staff training. ◆ Created a centralized online	Not Met	Given the lack of statistically significant improvement in the study indicator at Remeasurement 1, and the timing of the PIP's measurement periods, the PIP should have also included a description of a drill-down analysis of the Remeasurement 1 results to identify barriers not addressed. Because the Remeasurement 1 period ended in September 2013, the CMO should have documented follow-up analysis on the Remeasurement 1 survey results and the causal/barrier analysis activities occurring during the remainder of CY 2013 and the first half of CY 2014, prior to the PIP submission. As a result of the lack of

Table D-10—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	claims and appeals tool and tutorial for the provider Web site. ◆ Revised the CPGs to a shorter, more provider-friendly format and made the CPGs more accessible on the provider Web site.		statistically significant improvement, new and/or revised interventions need to be implemented during the Remeasurement 2 period to achieve the desired outcomes.
Peach State			
The study indicator rate for Peach State's *Provider Satisfaction* PIP declined 2.1 percentage points from 76.3 percent at baseline to 74.2 percent at Remeasurement 1.	◆ The CMO changed the PR training process. The new training process included a comprehensive assessment; mandatory, biweekly, internal PR meetings; mandatory, monthly PR training sessions; and dissemination of a monthly agenda and talking points for PR provider visits. ◆ Peach State increased manager oversight of the field representatives. Manager oversight was increased through "quarterly ride-along field assessments," increased requirements for minimum field visit productivity, and improved laptop connectivity for all field representatives.	Not Met	Peach State's documented improvement process was inadequate. In addition to an unfinished causal/barrier analysis, the CMO did not clearly document the timing of intervention implementation or report any revision of the improvement strategies. The CMO did not document a follow-up causal/barrier or drill-down analysis to address the decline in provider satisfaction at Remeasurement 1. Based on the PIP's measurement periods, with Remeasurement 1 ending in October 2013, Peach State would have had at least six months to revisit the causal/barrier analysis, identify barriers that were not addressed, and plan and implement new or revised interventions. The CMO also did not document evaluation processes or

Table D-10—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
			results for the PIP's interventions. To achieve meaningful improvement in provider satisfaction, Peach State should revisit the causal/barrier analysis, identify root causes that have not been addressed, implement revised interventions, and conduct ongoing evaluation of each intervention's effectiveness in impacting the study indicator.
WellCare			
In the *Provider Satisfaction* PIP, WellCare reported a statistically significant decline of 11.5 percentage points in the rate of overall provider satisfaction from 81 percent at baseline to 69.5 percent at Remeasurement 1.	◆ WellCare received assistance from the OB/GYN Society to provide education to specialists. ◆ WellCare developed "Closed Panel Procedures" to formalize the process of removing providers from the CMO's provider directory when they close their panels. ◆ The CMO created six hospital service specialist positions, one in each region of the State, to improve customer service for hospitals. ◆ WellCare collected and verified e-mail addresses for high-volume PCPs to facilitate rapid dissemination of information to providers.	Not Met	Based on the PIP documentation, the CMO needs to revisit the processes used for causal/barrier analyses, intervention development and revision, and evaluation of intervention effectiveness. The documentation for the causal/ barrier analysis process used in the *Provider Satisfaction* PIP lacked detail on the processes and tools used. While the CMO attached the vendor's survey report for the baseline results, including a drill-down analysis, WellCare did not directly link the survey results to identified barriers. The CMO also did not describe a process for prioritizing or identifying high-priority barriers. WellCare's omissions in the

Table D-10—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Rating**	**EQR Discussion and Recommendation**
	◆ WellCare doubled its network of urgent care centers. ◆ The CMO completed in-person provider visits to deliver Care Gap reports; the visits helped to develop rapport with providers and make the Care Gap information more useful. The in-person visits included an explanation of how providers can use the report to address health concerns in the member population.		documented causal/barrier analysis process were accompanied by a lack of documented, intervention-specific evaluation. The CMO's PIP documentation did not include a process for the evaluation of intervention effectiveness or quantitative evaluation results for each intervention. Process improvements, based on quality improvement science, in the areas of barrier identification and ongoing evaluation of intervention effectiveness are necessary before WellCare can expect to achieve the desired improvement in outcomes.

Appendix E. Performance Measure Results—CMO Comparison

CMO Comparisons

CMOs' Access Measure Results

Table E-1—Access Measures, CMO Comparison				CY 2013 Performance Target[2]
	AMERIGROUP	Peach State	WellCare	
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Children's and Adolescents' Access to Primary Care Providers				
Ages 12–24 Months	97.03%↓	96.97%	98.04%↑	
Ages 25 Months–6 Years	91.19%	90.45%	91.75%	
Ages 7–11 Years	92.93%↑	91.53%↑	92.62%↑	
Ages 12–19 Years	90.55%↑	88.51%↑	90.61%↑	91.59%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	81.38%↓	83.56%↓	85.05%↓	88.52%
Ages 45–64 Years	89.37%	89.77%	91.45%	
Ages 65+ Years	NA	NA	NA	
Total	82.58%↓	84.32%↓	85.86%↓	
Oral Health (Annual Dental Visit Rate)				
Ages 2–3 Years	48.59%	44.28%	49.95%↓	
Ages 4–6 Years	77.19%	75.09%↓	77.11%↓	
Ages 7–10 Years	79.60%	78.08%	79.94%↓	
Ages 11–14 Years	72.11%	70.66%	72.83%↓	
Ages 15–18 Years	60.92%	59.81%	62.56%	
Ages 19–21 Years	33.17%	35.77%	32.79%↓	
Total	69.67%	68.13%	70.73%↓	69.07%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	39.29%	38.06%	31.37%↓	43.62%
Engagement	9.62%	7.08%	9.38%↓	18.56%
Annual HIV/AIDS Medical Visit*				
90 Days Apart	52.16%	50.41%	54.58%	
180 Days Apart	33.64%	31.78%	35.83%	
Care Transition—Transition Record Transmitted to Health Care Professional*				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.46%	0.23%	

[1] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[2] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
NA indicates that the organization followed the specifications but the denominator was too small (<30) to report a valid rate.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.

CMOs' Children's Health Measures Results

Table E-2—Children's Health Measures, CMO Comparison				2013 Performance Target[2]
	AMERIGROUP	Peach State	WellCare	
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Well-Child/Well-Care Visits				
First 15 Months of Life: Six or More Visits	63.59%	57.64%↑	68.46%↑	70.70%
Third, Fourth, Fifth, and Sixth Years of Life	72.98%↑	69.44%↑	68.25%	72.26%
Adolescent Well-Care Visits	52.55%↑	45.14%↑	43.75%↓	49.65%
Immunization and Screening				
Childhood Immunization Status—Combination 3	80.56%↓	79.17%↑	84.95%↑	82.48%
Childhood Immunization Status—Combination 6*	41.20%	40.74%	43.06%	
Childhood Immunization Status—Combination 10	37.73%↑	36.34%↑	40.28%↑	
Lead Screening in Children	81.71%↑	76.85%↑	77.51%↑	81.86%
Appropriate Testing for Children with Pharyngitis	78.14%	76.33%↑	75.94%	76.37%
Immunizations for Adolescents—Combination 1 Total	78.70%↑	78.01%↑	74.59%↑	80.91%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile (Total)	47.92%↑	51.16%↑	49.07%↑	47.45%
Counseling for Nutrition (Total)	54.63%↑	58.10%↑	61.11%↑	54.88%
Counseling for Physical Activity (Total)	47.22%↑	54.63%↑	51.85%↑	43.29%
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	83.78%↑	81.26%↑	81.28%↑	85.34%
Developmental Screening in the First Three Years of Life*				
Developmental Screening in the First Three Years of Life—Total	34.03%	42.82%	40.51%	

Table E-2—Children's Health Measures, CMO Comparison				
	AMERIGROUP	Peach State	WellCare	2013 Performance Target[2]
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	50.45%↓	50.06%↑	52.65%	
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	23.20%↓	23.68%↑	23.34%↓	

[1] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[2] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.

CMOs' Women's Health Measures Results

Table E-3—Women's Health Measures, CMO Comparison				
	AMERIGROUP	Peach State	WellCare	2013 Performance Target[2]
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Prevention and Screening				
Cervical Cancer Screening*	69.34%↓	73.84%	73.93%↑	78.51%
Breast Cancer Screening**	75.70%↑	72.96%↑	73.65%↑	56.58%
Chlamydia Screening—Ages 16–20 Years	50.08%↓	52.66%↓	45.76%↑	
Chlamydia Screening—Ages 21–24 Years	64.04%↓	72.11%	63.29%	
Chlamydia Screening—Total	52.81%↓	57.69%↓	49.83%	58.40%
Human Papillomavirus Vaccine for Female Adolescents***	21.53%	21.53%	21.30%	22.27%
Prenatal Care and Birth Outcomes				
Timeliness of Prenatal Care	75.92%↓	82.64%↓	84.07%	90.39%
Postpartum Care	60.78%↑	61.81%↓	63.24%	71.05%
Cesarean Rate for Nulliparous Singleton Vertex *A lower rate indicates better performance*	17.13%	18.08%↑	15.23%↑	
Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance*	29.60%	29.59%	30.41%↑	28.70%

Table E-3—Women's Health Measures, CMO Comparison				
	AMERIGROUP	Peach State	WellCare	2013 Performance Target[2]
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Rate of Infants With Low Birth Weight (Rate per 100) *A lower rate indicates better performance*	8.84%	8.73%	8.32%	8.10%
Behavioral Health Risk Assessment for Pregnant Women***	1.43%	1.85%	6.45%	
Elective Delivery*** *A lower rate indicates better performance*	5.11%	0.00%	0.55%	2.00%
Antenatal Steroids***	0.79%	NA	0.69%	
Frequency of Ongoing Prenatal Care				
< 21 Percent	15.14%↑	10.42%↑	11.52%↓	
21–40 Percent	8.03%↑	6.48%↑	6.86%↑	
41–60 Percent	7.11%	8.56%↑	5.64%	
61–80 Percent	16.74%↑	16.90%↑	10.05%↓	
81+ Percent	52.98%↓	57.64%↓	65.93%↑	72.99%

[1] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[2] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.
*Due to significant measure specification changes in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
**Due to a change in the age criteria in this measure, rate changes from the prior year may not accurately reflect any real performance improvement or decline.
***This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.

CMOs' Chronic Conditions Health Measure Result Findings

Table E-4—Physical Health Conditions: Chronic Conditions Measures, CMO Comparison				CY 2013 Performance Target[2]
	AMERIGROUP	Peach State	WellCare	
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	80.50%	79.51%	78.45%	87.01%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	57.62%	63.19%↓**	52.47%	41.68%
HbA1c Control (<8.0)	35.11%	32.64%↓	39.64%	48.72%
HbA1c Control (<7.0)	27.71%	24.07%	30.08%	36.72%
Eye Exam (Retinal) Performed	43.97%↓	57.81%	34.87%↓	52.88%
LDL-C Screening	73.23%	68.92%	69.24%	76.16%
LDL-C Control (<100 mg/dL)	26.95%	23.44%	28.95%	35.86%
Medical Attention for Nephropathy	73.94%	70.83%	74.51%	78.71%
Blood Pressure Control (<140/80 mm/Hg)	30.85%	29.34%	33.55%↑	39.10%
Blood Pressure Control (<140/90 mm/Hg)	53.19%	53.65%	56.91%↑	63.50%
Diabetes Short-Term Complications Admission Rate†				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months) *A lower rate indicates better performance*	13	20	17	62.74
Respiratory Conditions				
Use of Appropriate Medications for People With Asthma				
5–11 Years	91.72%	92.92%↑	92.48%↑	
12–18 Years	87.32%	91.23%↑	88.72%	
19–50 Years	60.68%	73.43%	78.45%	
51–64 Years	NA	NA	NA	
Total	88.79%	91.47%↑	90.45%↑	90.56%

Table E-4—Physical Health Conditions: Chronic Conditions Measures, CMO Comparison				CY 2013 Performance Target[2]
	AMERIGROUP	Peach State	WellCare	
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Young Adult Asthma Admission Rate*				
Young Adult Asthma Admission Rate *A lower rate indicates better performance*	8.93	4.63	6.03	
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate†				
Per 100,000 Member Months (Total)	37	37	44	559.03
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate†				
Per 100,000 Member Months (Total)	6	3	6	380.70
Controlling High Blood Pressure				
Controlling High Blood Pressure	48.36%↑	44.15%↓	47.67%	57.52%
Adult BMI Assessment				
Adult BMI Assessment	79.53%↑	75.46%↑	75.78%↑	70.60%

[1] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[2] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013.
Shaded boxes are displayed when no DCH CY 2013 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
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.
*Specification for this measure was changed significantly such that trending comparisons with CY 2012 rates were not performed for all CMOs.
**Since a higher rate suggests poorer performance for this indicator, Peach State's CY 2013 statistically significantly higher rate means its performance had declined from CY 2012.
† The reporting metric for this measure has changed from 100,000 members to 100,000 member months. Therefore, trending comparisons with CY 2012 rates were not performed for all CMOs. It would also be inappropriate to compare the CMO CY 2013 rates with the performance target which was developed based on the prior year's reporting metric.

CMOs' Behavioral Health Measure Results

Table E-5—Behavioral Health Measures, CMO Comparison				
	AMERIGROUP	Peach State	WellCare	CY 2013 Performance Target[2]
Measure	CY 2013 Rate[1]	CY 2013 Rate[1]	CY 2013 Rate[1]	
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	43.12%	43.04%	41.12%↑	52.48%
Continuation and Maintenance Phase	59.22%	57.73%	54.18%	63.11%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	50.85%↑	60.18%↑	52.39%↓	69.57%
Follow-Up Within 30 Days	72.40%↑	75.48%↑	72.63%↓	84.28%
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.76%↓	39.64%	44.15%↓	52.74%
Effective Continuation Phase Treatment	34.39%	24.86%	29.43%	37.31%
Screening for Clinical Depression and Follow-Up Plan*				
Screening for Clinical Depression and Follow-Up Plan	0.75%	0.00%	1.07%	
Adherence to Antipsychotics for Individuals With Schizophrenia*				
Adherence to Antipsychotics for Individuals With Schizophrenia	45.76%	16.98%	40.40%	

[1] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[2] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.

CMOs' Medication Management Measure Result Findings

Table E-6—Medication Management Measure, CMO Comparison				
Measure	AMERIGROUP CY 2013 Rate[1]	Peach State CY 2013 Rate[1]	WellCare CY 2013 Rate[1]	CY 2013 Performance Target[2]
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions				
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions *A lower rate indicates better performance*	40.94%↑**	39.98%↑**	41.89%↑**	41.51%
Annual Monitoring for Patients on Persistent Medications				
Total	88.42%	86.42%	87.01%	88.55%
Medication Management for People With Asthma*				
50% Compliance—Total	47.81%	44.22%	48.15%	
75% Compliance—Total	22.59%	19.00%	22.28%	

[1] CY 2013 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2013, through December 31, 2013.
[2] CY 2013 performance targets reflect the DCH-established CMO performance targets for 2013. Shaded boxes are displayed when no DCH CY 2013 performance target was established.
↑ indicates a statistically significant improvement in performance between CY 2012 and CY 2013.
↓ indicates a statistically significant decline in performance between CY 2012 and CY 2013.
* This was a new measure required for CMO reporting in SFY 2014; no rates from the prior year were available for trending analysis.
**Since a higher rate suggests poorer performance for this indicator, CY 2013 statistically significantly lower rates for all CMOs meant that their performance had improved from CY 2012.

Appendix F. Utilization Measure Rates and Demographic Information

Table F-1—CY 2013 Performance Measure Results—Mental Health Utilization						
	0–12 Years	13–17 Years	18–64 Years	65+ Years	Unknown	Total
Georgia Families						
Any Services: Total	6.93%	12.19%	9.84%	4.98%	0.00%	8.33%
Inpatient: Total	0.13%	1.17%	0.89%	0.00%	0.00%	0.43%
Intensive Outpatient/ Partial: Total	0.06%	0.34%	0.14%	0.00%	0.00%	0.13%
Outpatient/ED: Total	6.91%	11.93%	9.50%	4.98%	0.00%	8.22%
Fee-For-Service						
Any Services: Total	14.40%	28.10%	21.19%	10.81%	0.00%	18.20%
Inpatient: Total	0.23%	1.66%	2.75%	6.61%	0.00%	2.61%
Intensive Outpatient/ Partial: Total	0.08%	0.25%	0.07%	0.00%	0.00%	0.08%
Outpatient/ED: Total	14.35%	27.81%	20.42%	5.01%	0.00%	16.82%
ALL						
Any Services: Total	8.03%	14.96%	16.19%	10.81%	0.00%	11.24%
Inpatient: Total	0.14%	1.26%	1.94%	6.61%	0.00%	1.08%
Intensive Outpatient/ Partial: Total	0.06%	0.33%	0.10%	0.00%	0.00%	0.11%
Outpatient/ED: Total	8.02%	14.76%	15.64%	5.01%	0.00%	10.78%
MAO						
Any Services: Total	0.00%	0.00%	16.47%	10.80%	0.00%	15.48%
Inpatient: Total	0.00%	0.00%	1.97%	6.60%	0.00%	2.78%
Intensive Outpatient/ Partial: Total	0.00%	0.00%	0.10%	0.00%	0.00%	0.08%
Outpatient/ED: Total	0.00%	0.00%	15.91%	5.01%	0.00%	14.00%
CCSP						
Any Services: Total	0.00%	20.00%	16.82%	8.49%	0.00%	11.07%
Inpatient: Total	0.00%	0.00%	1.50%	2.97%	0.00%	2.51%
Intensive Outpatient/ Partial: Total	0.00%	0.00%	0.05%	0.00%	0.00%	0.01%
Outpatient/ED: Total	0.00%	20.00%	16.31%	6.12%	0.00%	9.29%
FC						
Any Services: Total	40.26%	52.81%	20.21%	0.00%	0.00%	42.24%
Inpatient: Total	0.87%	4.46%	1.68%	0.00%	0.00%	2.08%
Intensive Outpatient/ Partial: Total	0.29%	0.68%	0.03%	0.00%	0.00%	0.39%
Outpatient/ED: Total	40.16%	52.58%	20.12%	0.00%	0.00%	42.09%

Table F-2—CY 2013 Performance Measure Results—Utilization							
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	CY 2013 Performance Target[7]
Ambulatory Care (Per 1,000 Member Months)							
ED Visits	58.91	91.38	68.58	112.64	96.44	35.20	52.45
OP Visits	342.10	457.75	376.54	495.88	667.55	263.93	388.71

[1] CY 2013 GF rates reflect data for members in the GF population during the measurement year (January 1, 2013–December 31, 2013) and included members who transitioned between CMOs during the measurement year. These rates were calculated and reported by HP using CMO-submitted administrative data pulled from the GA MMIS.
[2] CY 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year.
[3] CY 2013 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.
[4] CY 2013 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.
[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members.
[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care.

Table F-3—CY 2013 Performance Measure Results—Inpatient Utilization—General Hospital/Acute Care							
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]	CY 2013 Performance Target[7]
Days/1,000 Member Months							
Inpatient Total	19.92	94.39	42.09	114.54	173.42	20.21	
Medicine Total	4.22	45.32	16.46	43.02	107.99	8.19	
Surgery Total	3.94	45.37	16.27	41.08	65.39	10.68	
Maternity Total	25.10	5.94	18.24	36.65	0.12	2.33	

[1] CY 2013 GF rates reflect data for members in the GF population during the measurement year (January 1, 2013–December 31, 2013) and included members who transitioned between CMOs during the measurement year. These rates were calculated and reported by HP using CMO-submitted administrative data pulled from the GA MMIS.
[2] CY 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year.
[3] CY 2013 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.
[4] CY 2013 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.
[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members.
[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care.

Table F-4—2012 Performance Measure Results—Diversity of Membership						
	GF Rate[1]	FFS Rate[2]	ALL Rate[3]	MAO Rate[4]	CCSP Rate[5]	FC Rate[6]
Race/Ethnicity Diversity of Membership						
White	43.57%	36.01%	39.24%	31.24%	56.62%	44.89%
Black or African-American	46.63%	45.05%	45.32%	46.91%	42.10%	50.73%
American-Indian and Alaska Native	0.09%	0.11%	0.10%	0.12%	0.06%	0.17%
Asian	2.17%	2.09%	2.14%	2.12%	0.66%	0.29%
Native Hawaiian and Other Pacific Islanders	0.08%	0.07%	0.07%	0.05%	0.05%	0.14%
Some Other Race	3.42%	2.20%	2.99%	0.94%	0.15%	2.39%
Two or More Races	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%
Unknown	0.21%	9.47%	5.25%	12.90%	0.18%	0.57%
Declined	3.82%	4.99%	4.89%	5.73%	0.18%	0.81%
Weeks of Pregnancy at Time of Enrollment						
<0 Weeks	9.87%	21.65%	11.07%	18.89%	83.33%	79.10%
1-12 Weeks	10.33%	2.35%	9.52%	53.76%	0.00%	7.34%
13-27 Weeks	62.35%	9.21%	56.94%	18.18%	0.00%	7.91%
28+ Weeks	15.69%	61.36%	20.34%	7.36%	16.67%	4.52%
Unknown	1.75%	5.44%	2.13%	1.81%	0.00%	1.13%

[1] CY 2013 GF rates reflect data for members in the GF population during the measurement year (January 1, 2013–December 31, 2013) and included members who transitioned between CMOs during the measurement year. These rates were calculated and reported by HP using CMO-submitted administrative data pulled from the GA MMIS.
[2] CY 2013 FFS rates reflect data for members in the FFS population and were calculated based on claims data submitted to DCH for the measurement year.
[3] CY 2013 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.
[4] CY 2013 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.
[5] CY 2013 CCSP population rates reflect data for this Medicaid waiver program, including dual-eligible members.
[6] CY 2013 FC population rates reflect data for members in Georgia Families 360° Managed Care. CY 2013 was the first year for this program to report rates; no comparison with the prior year's rates was conducted.
NA indicates the organization followed the specifications but the denominator was too small (<30) to report a valid rate.