State of Georgia

Department of Community Health

2016 External Quality Review Annual Report

Including

Compliance Review Results

(Review Period: July 1, 2014–June 30, 2015)

CY 2014 Performance Measure Rates

CY 2014 Performance Improvement Project Results

CY 2015 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey Results

For the

Georgia Families (GF) and Georgia Families 360° (GF 360°) Care Management Organizations

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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®. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the Georgia Families 360° (GF 360°) managed care program. For the purposes of this report, "Georgia Families" refers to all other Medicaid and CHIP members enrolled in managed care, approximately 1.3 million beneficiaries.[1-1]

The DCH contracted with the following CMOs to provide services to the GF population: Amerigroup Community Care (Amerigroup), Peach State Health Plan (Peach State), and WellCare of Georgia, Inc. (WellCare). Amerigroup also has a contract with DCH to provide services to the GF 360° population and in these instances, Amerigroup is referred to as Amerigroup 360°.

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 technical report that describes the manner in which data from activities conducted, in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations provide.

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 performed by HSAG.

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 8/2015."

[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 healthcare 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.

Overview of the External Quality Review

This report includes HSAG's analysis of the following EQR activities.

- *Review of compliance with federal and State-specified operational standards*. HSAG evaluated the GF and GF 360° 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 2015. The CMOs submitted documentation that covered the state fiscal year (SFY) 2015 review period of July 1, 2014, through June 30, 2015. HSAG provided detailed, final audit reports to the CMOs and DCH in December 2015.
- *Validation of performance improvement projects (PIPs)*. HSAG validated PIPs for each GF CMO to ensure the CMOs designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocol for validating PIPs. Because the GF 360° program did not begin operations until March 2014, no CY 2014 PIPs were assigned to that program. Due to the transition to the new rapid cycle PIP approach that occurred throughout 2014, HSAG validated two types of PIPs during this validation cycle: rapid cycle PIPs and traditional outcome-focused PIPs. Each CMO submitted six new rapid cycle PIPs and two ongoing traditional outcome-focused PIPs for validation. HSAG assessed all 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, 2015, and August 26, 2015. 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 2015.
- *Validation of performance measures (PMs)*. HSAG validated the PM rates required by DCH to evaluate the accuracy of the PM results reported by the GF and GF 360° CMOs. The validation also determined the extent to which the DCH-specific PM rates followed specifications established by DCH. HSAG assessed the PM results and their impact on improving the health outcomes of members. HSAG conducted validation of the PM rates following the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1-4] Compliance Audit™ timeline, typically from January 2015 through July 2015. The final PM validation results generally reflected the measurement period of January 1, 2014, through December 31, 2014. HSAG provided final PM validation reports to the CMOs and DCH in August 2015.
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys*.[1-5] The DCH required that the three GF CMOs conduct CAHPS surveys of their adult and child populations

[1-4] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[1-5] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

to learn more about member satisfaction and experiences with care. HSAG did not conduct these surveys but included the results from the Adult and Child CAHPS surveys for all three CMOs in this report.

Overall Findings, Conclusions, and Recommendations

CMS has chosen the domains of quality, access, and timeliness as keys to evaluating CMO performance. HSAG used the following definitions to evaluate and draw conclusions about the performance of the CMOs in each of these domains:

- **Quality**—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows: "Quality, as it pertains to external quality review, means the degree to which an MCO [managed care organization] or PIHP [prepaid inpatient health plan] increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics and through provision of health services that are consistent with current professional knowledge." [1-6]
- **Access**—In the preamble to the Balanced Budget Act of 1997 (BBA) Rules and Regulations,[1-7] CMS discusses access and availability of services to Medicaid enrollees as the degree to which MCOs/PIHPs implement the standards set forth by the State to ensure that all covered services are available to enrollees. Access includes the availability of an adequate and qualified provider network that considers the needs and characteristics of the enrollees served by the MCO or PIHP.
- **Timeliness**—Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-8] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

For each activity, HSAG provides the following summary of its overall findings, conclusions, and recommendations regarding the CMOs' aggregate performance during the review period.

Review of Compliance

HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews to draw conclusions about each CMO's performance in providing quality, accessible, and timely healthcare and services to its members. The standards that were reviewed for all CMOs for the review period included (1) Provider Selection, Credentialing, and Recredentialing; (2) Subcontractual Relationships

[1-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction*, September 2012.
[1-7] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 67, No. 115, June 14, 2002.
[1-8] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

and Delegation; (3) Member Rights and Protections; (4) Member Information; (5) Grievance System; and (6) Disenrollment Requirements and Limitations. For the GF CMOs, HSAG also reviewed elements that were found to be noncompliant from the previous year's compliance review.

The three GF CMOs each received an overall compliance score between 93 and 95 percent for the six standards noted above, indicating that the CMOs had the policies, procedures, and operational structure in place to meet the majority of requirements. For the GF 360° program, Amerigroup received an overall compliance score of 89 percent. All standards fell within the quality domain, and the majority also crossed over into either the access or timeliness of care domain.

All CMOs (both GF and GF 360°) received a compliance score of 100 percent for the Subcontractual Relationships and Delegation standard and the Member Rights and Protections standard, demonstrating that the CMOs provide adequate oversight of delegated entities and provide appropriate education and information to members regarding their rights.

Overall, the CMOs performed well on the Provider Selection, Credentialing, and Recredentialing standard. For Amerigroup's GF and GF 360° populations and for WellCare, however, HSAG found that some credentialing decisions were not made in a timely manner. It should be noted that as of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, the CMOs will no longer be responsible for credentialing and recredentialing the majority of providers in their networks.

Overall, the Member Information standard and the Disenrollment Requirements and Limitations standard pertain to the quality and timeliness domains. Three of the CMOs (Amerigroup, WellCare, and Amerigroup 360°) were noncompliant with one or more elements for the Member Information standard, indicating that there is opportunity to improve communication with members to ensure they have adequate, timely information. In particular, each CMO must ensure that existing members receive notification of updates to the member handbook in a timely manner and that their policies reflect actual practice.

The Grievance System standard also falls within the quality and timeliness domains. Each CMO had opportunities for improvement in this area. All of the GF and GF 360° CMOs were found to be noncompliant with the requirement that information included in appeal resolution letters be written in easily understood language. In some cases, the rational for upholding a denial contained advanced medical terminology. Overall, the CMOs were compliant with timeliness requirements. However, through the review of policies, procedures, and other documents, other issues were identified that must be corrected to ensure consistency in the grievance system information available to members and providers.

PIPs

For this year's PIP validation cycle, each of the GF CMOs submitted six PIPs following HSAG's new rapid cycle PIP process and two ongoing, satisfaction-based PIPs following HSAG's traditional outcome-focused PIP process. The DCH identifies the general PIP focus areas, and the CMOs determine the specific PIP topics. Going forward, all PIPs implemented by the GF and GF 360° CMOs will follow the rapid cycle PIP process, which places greater emphasis on applying improvement

science to the PIP process and using rapid cycle evaluation through Plan-Do-Study-Act (PDSA) cycles to more efficiently achieve desired health outcomes. For the rapid cycle PIPs, the PIP outcomes reported were specific to the population and providers targeted under the new rapid cycle PIP process. The traditional PIPs continued to focus on the CMOs' broader member and provider populations. Performance by all three of the GF CMOs suggested that additional training and skill development in rapid cycle PIP techniques is necessary to achieve improved outcomes within the selected PIP topics. Overall, the CMOs did not achieve meaningful and sustained improvement in the PIPs related to the quality, access, and timeliness domains of care.

Because the purpose of a PIP is to achieve improvement in health outcomes through repeated measurements and interventions impacting the structural and/or operational characteristics of the CMO, all of the CMOs' PIPs fall under the quality domain of care, which relates to each CMO's ability to increase desired health outcomes for its members. As described in detail in Sections 3 through 5, the CMOs have considerable room for improvement to positively impact the quality domain of care. Out of 18 rapid cycle PIPs submitted for validation by the GF CMOs, only two PIPs submitted by one CMO, Amerigroup, achieved meaningful and sustained improvement in health outcomes. Of the six traditional outcome-focused PIPs submitted for validation by the GF CMOs, only one PIP demonstrated statistically significant improvement over baseline in the study indicator outcomes, none of the PIPs demonstrated sustained improvement in study indicator outcomes, and none of the PIPs received an overall *Met* validation finding. The PIP validation results suggest that the GF CMOs are not effectively applying quality improvement processes to identify, test, and refine interventions that lead to meaningful and sustained improvement of health outcomes in the population served.

Two of the GF CMOs' rapid cycle PIPs, *Annual Dental Visits* and *Bright Futures*, were also directly related to the access to care domain. The CMOs' PIPs focused on improving access to recommended preventive services such as those provided at annual preventive dental visits and annual well-care visits. Only one CMO's PIP related to this domain, Peach State's *Bright Futures* PIP, showed some promise in improving access to care. For this PIP, the CMO exceeded its SMART (specific, measurable, achievable, relevant, and time-bound) Aim goal and increased the rate of adolescent members who received an annual well-care visit by 11.1 percentage points, from 37.3 percent to 48.4 percent of adolescent members. The remaining PIPs related to this domain of care either did not achieve meaningful improvement of access to care (Peach State's *Annual Dental Visits* PIP) or were not methodologically sound and meaningful improvement could not be validated (Amerigroup's and WellCare's *Annual Dental Visits* and *Bright Futures* PIPs). Based on the validation results, the PIPs lacked the technical and methodological foundation to develop and evaluate interventions that will result in improved access-related outcomes.

Two of the GF CMOs' rapid cycle PIPs, *Appropriate Use of ADHD [Attention Deficit Hyperactivity Disorder] Medications* and *Postpartum Care*, related to the timeliness domain of care. Specifically, the PIPs addressed minimizing the disruption of follow-up care for members who had initiated medication to treat ADHD, and for members who had given birth, respectively. One of the CMOs, Amerigroup, demonstrated strength in addressing both PIPs related to the timeliness domain. Amerigroup achieved meaningful and sustained improvement in the *Appropriate Use of ADHD Medications* PIP by exceeding the PIP's goal for the ADHD 30-day follow-up visit compliance rate of 47.8 percent for four consecutive quarterly remeasurements. For the *Postpartum Care* PIP, Amerigroup achieved meaningful and sustained improvement by exceeding the PIP's goal for the

postpartum visit compliance rate of 76.05 percent for nine consecutive monthly remeasurements. Performance in this domain varied by CMO. While Amerigroup was successful in impacting the timeliness domain of care in its rapid cycle PIPs, the other GF CMOs were not successful and failed to demonstrate meaningful and sustained improvement for both of the timeliness-related PIPs.

The GF CMOs' performance regarding PIPs suggested opportunities for improvement in many areas of the new rapid cycle PIP process, such as ensuring a sound measurement methodology for the PIP outcomes, improving accuracy of reported key findings and interpretation of results, demonstrating meaningful and sustained improvement of outcomes through effective intervention testing and revision, planning for sustained improvement of outcomes, and documenting lessons learned and information gained at the conclusion of the PIP. Many of these opportunities for improvement applied across the individual CMOs and PIP topics.

Specific recommendations related to improving PIP performance are detailed in Sections 3, 4, 5, and 7 of the report. In general, HSAG recommends that the CMOs seek technical assistance as needed to further develop their capacity to apply sound improvement science in the rapid cycle PIP process. When developing plans for new rapid cycle PIPs, the CMOs should build a strong foundation for improvement by developing sound measurement methodology and quality improvement strategies to facilitate improvement of the targeted outcomes for each PIP. When planning a new rapid cycle PIP work plan and timeline, it is critical that the CMOs work backward from the anticipated end date of the PIP to ensure that sufficient time is allotted for all phases of the PIP. The DCH requires GF PIPs to be implemented annually; therefore, the CMOs should plan the timing of the four phases of the rapid cycle PIP on a 12-month cycle. The CMOs must efficiently complete the first (PIP Initiation and SMART Aim Data Collection) and second (Intervention Determination) phases of HSAG's rapid cycle PIP process to allow sufficient time for repeated PDSA cycles in the third phase as well as time at the end of the cycle to demonstrate sustained improvement as part of the fourth phase. Throughout the PIP process, the CMO should request technical assistance as needed to ensure adequate understanding and application of rapid cycle improvement techniques and principles.

Performance Measures

The greatest strength exhibited among all of the GF CMOs was in the care provided to children and adolescents across all three domains—access, quality, and timeliness. Most of the 2014 measure targets in the Children's Health measure set were achieved by all of the GF CMOs, and significant improvement was also exhibited, indicating positive progress. In fact, all of the GF CMOs exhibited significant improvement in the percentage of children with pharyngitis who received appropriate testing and in the percentage of children with an upper respiratory infection (URI) who were treated appropriately. However, dental care for children and adolescents was a general weakness across all of the GF CMOs. The GF CMOs not only failed to meet the 2014 performance target for any of the dental indicators, but they also exhibited significant decline in the percentage of members ages 2 to 21 years who had an annual dental visit. Two GF CMOs, Amerigroup and Peach State, exhibited significant improvement in providing preventive dental services and dental treatment services to child and adolescent members, indicating that positive progress was made.

Adults' access to preventive and ambulatory health services was a weakness exhibited by all of the GF CMOs, as none of these CMOs met the 2014 performance target and all exhibited a significant

decline in performance. None of the GF CMOs achieved the target for the number of emergency department (ED) visits per 1,000 member months, which represents an area for improvement.

An additional opportunity for improvement exists across all of the GF CMOs in providing care to women, including cervical cancer screening, chlamydia screening, prenatal care, and birth outcomes. However, all of the GF CMOs achieved the 2014 performance target for breast cancer screening, representing an area of strength.

Behavioral health and care provided to members with chronic conditions were areas of weakness for the GF CMOs, as a majority of the 2014 performance targets were not achieved. Specifically, Amerigroup and Peach State failed to meet any of the performance targets for measures in the Behavioral Health measure set, and WellCare only met one performance target in this measure set. There were, however, several strengths in the Chronic Conditions measure set, including two GF CMOs (Amerigroup and WellCare) that exhibited significant improvement in the percentage of members with diabetes who received a Hemoglobin A1c (HbA1c) test during the year, and two GF CMOs (Peach State and WellCare) that met the 2014 performance target for the percentage of adult members with a documented body mass index (BMI) assessment. Medication management was also an area of weakness as only one GF CMO, Peach State, achieved any of the 2014 performance targets in this measure set. However, it should be noted that all of the GF CMOs exhibited significant improvement in reducing the percentage of antibiotics of concern dispensed to members.

CY 2014 represents the first year results were reported for Amerigroup 360°; therefore, performance targets were not established for the first reporting year. Given that this was the baseline year for Amerigroup 360°, limited conclusions can be drawn related to its performance, but performance will continue to be evaluated as additional data become available for this population.

In general, Amerigroup 360° exhibited several strengths in providing care for children in the domains of quality and access. For instance, over 95 percent of children ages 12 to 24 months had at least one primary care practitioner (PCP) visit. Additionally, 75 percent of children with pharyngitis had appropriate testing when receiving antibiotics, and over 96 percent of children with a URI received appropriate treatment. Although Amerigroup 360° performed well in these areas related to children's health, a review of dental measures showed that while approximately 75 percent of all members received an annual dental visit, only 34 percent of members ages 2 to 3 years and 27 percent of members aged 19 to 21 years had an annual dental visit, representing an opportunity for improvement across these two age groups. Additional opportunities for improvement in the area of children's health include well-child visits in the first 15 months of life, documented weight assessments, counseling for nutrition, and counseling for physical activity for children and adolescents.

Amerigroup 360° demonstrated high performance in two of the three behavioral health-related measures and reported that nearly 80 percent of members hospitalized for mental illness had a follow-up visit within 30 days of discharge, and almost 60 percent received a follow-up visit within seven days of discharge. Amerigroup 360° also demonstrated high performance in the area of initiation and engagement of alcohol and other drug dependence treatment. For care provided to Amerigroup 360° members with chronic conditions, 0 percent of members with diabetes had documentation of adequate HbA1c control, and 0 percent of members with diabetes and cardiovascular conditions had documentation of appropriate blood pressure control. Further, less than 25 percent of adult members had a documented BMI assessment, representing an area of weakness.

CAHPS Surveys

Adult members' satisfaction with the quality of care, as measured through the CAHPS Adult Medicaid Health Plan Survey, revealed that the statewide average results for the Adult Medicaid population were above the NCQA national adult Medicaid average for two global ratings, *Rating of All Health Care* and *Rating of Specialist Seen Most Often*, and one composite measure, *How Well Doctors Communicate*. However, the statewide average results for the Adult Medicaid population were below the NCQA national adult Medicaid average for *Rating of Health Plan*, *Rating of Personal Doctor*, and *Customer Service*. These scores indicate that adult members were mostly satisfied with their healthcare and specialists; however, they were less satisfied with their health plan, personal doctor, and customer service.

Parents'/caretakers' satisfaction with the quality of care provided to child members, as measured through the CAHPS Child Medicaid Health Plan Survey, revealed that statewide average results for the child Medicaid population were above the NCQA national child Medicaid average for all four global ratings: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, and *Rating of Specialist Seen Most Often*. However, the statewide average results for the child Medicaid population also revealed that scores were below the NCQA national child Medicaid average for the *How Well Doctors Communicate* and *Customer Service* measures. These scores indicate that parents/caretakers of child members were mostly satisfied with their child's health plan, healthcare, specialists, and personal doctor; however, they were less satisfied with provider communication and customer service.

Members' satisfaction with receiving needed care and access to timely care (i.e., *Getting Needed Care* and *Getting Care Quickly* measures) both fall under the access domain of care. The *Getting Care Quickly* measure also falls under the timeliness domain of care. For the adult Medicaid population, for both *Getting Needed Care* and *Getting Care Quickly* measures, the statewide average rates were below the NCQA national adult Medicaid average. For the child Medicaid population, the statewide average rate for the *Getting Needed Care* measure was above the NCQA national child Medicaid average, while the rate for the *Getting Care Quickly* measure was below the NCQA national average. Based on the evaluation of the access-related CAHPS Survey measures, access to timely care is one area for improvement for both the adult and child Medicaid populations. Working with providers to implement an open access scheduling model may be one method for improving access to timely care, as open access scheduling allows for appointment flexibility and for patients to receive same-day appointments.

The Adult and Child Medicaid Statewide Average CAHPS scores revealed that, for both populations surveyed, the CMOs in aggregate scored above the NCQA national Medicaid average for *Rating of All Health Care* and *Rating of Specialist Seen Most Often* measures but below the NCQA national Medicaid average for *Getting Care Quickly* and *Customer Service* measures. These statewide average scores indicated that, overall, adult members/parents and caretakers of child members were satisfied with all of the healthcare received and with specialists seen, but were less satisfied when polled about the timeliness of care that was received and the help/information received from the health plan's customer service staff.

2. The Georgia Families Managed Care Program Overview

Georgia Medicaid Managed Care Service Delivery System Overview

The DCH was created in 1999 to serve as the lead agency for healthcare planning, purchasing, and oversight, and is designated as the single State agency for Medicaid in Georgia. With a mission to provide affordable quality healthcare, DCH is dedicated to a healthy Georgia.

As the largest DCH division, the Medical Assistance Plans Division administers the Medicaid and CHIP programs. The Medicaid program provides healthcare for low-income families; refugees; pregnant women; children; women under 65 who have breast or cervical cancer; and those who are aging, blind, and disabled. Georgia's standalone CHIP program is known as PeachCare for Kids®.

The DCH has administered a fee-for-service (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 enrolled members.

The GF program includes more than half of the State's Medicaid and PeachCare for Kids® populations. Enrollment in managed care 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. The following Medicaid eligibility categories have mandatory GF program enrollment:

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

In addition to the GF program, 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)

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 services to their enrolled Medicaid and CHIP members, the CMOs also provide a range of enhanced services, including dental and vision services, case and disease management and education, and wellness/prevention programs. The DCH's goals for care provided by the CMOs is that it be of acceptable quality; assure accessibility; provide for continuity; and promote efficiency.

The DCH also held a contract with Amerigroup for the GF 360° program during the review period. The goals for this program are to enhance the coordination of care and access to services; improve health outcomes; develop and utilize meaningful and complete electronic medical records; and comply fully with regulatory reporting requirements.

Quality Strategy

Federal regulations require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of healthcare services offered to their members. The written strategy must describe the standards the state and its contracted plans must meet for ensuring timely, accessible, and quality services to its members. 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 developed and submitted its GF Quality Strategic Plan for CMS' review and approval, receiving CMS approval on the initial plan in 2008. Updates to the plan were completed in January 2010 and again in November 2011.[2-1] During 2015, in collaboration with numerous stakeholders, DCH prepared a new quality strategic plan to coincide with the reprocurement of the GF and GF 360° managed care contractors. The plan was posted for public comment (December 2015) and recently submitted to CMS (in February 2016) for review and approval. This new Quality Strategic Plan is consistent with CMS' guidance in the 2013 Quality Strategy Toolkit for States,[2-2] and also aligns with the Department of Health and Human Services National Quality Strategy aims for better care, affordable care, and healthy people/healthy communities.[2-3] The State's revised plan describes:

- Quality performance measures with targets for the CMOs related to access, utilization, service quality, and appropriateness (beginning in the first full calendar year of CMO operations under the new contracts).

[2-1] Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: http://dch.georgia.gov/medicaid-quality-reporting. Accessed on: February 22, 2016.
[2-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: https://www.medicaid.gov/medicaid-chip-program-information/by-topics/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: February 25, 2016.
[2-3] Department of Health and Human Services, Agency for Healthcare Research and Quality. About the National Quality Strategy (NQS). Available at: http://www.ahrq.gov/workingforquality/about.htm#aims. Accessed on: February 25, 2016.

- Value-based purchasing performance metrics for the GF and GF360° programs that align with some of the State's key focus areas for improved care and member outcomes (e.g., low birth weight, diabetes, and ADHD).
- DCH's processes for assessing, monitoring, and reporting on the CMOs' performance, progress, and outcomes related to the State's strategic goals and areas of focus.
- Adoption of innovative quality improvement strategies, such as rapid cycle performance improvement projects, and ensuring DCH and the CMOs are in tune with the latest advances in quality improvement science through participation in quality improvement trainings and technical assistance sessions sponsored by CMS and/or hosted by the EQRO.
- Numerous collaborative efforts by DCH that include inter-agency coordination and participation of other key stakeholders, along with the CMOs and provider community, to leverage the talent and resources needed to address shared challenges that impede improved performance.

In its new Quality Strategic Plan, DCH also reported on progress and activities occurring since its last quality strategy update to CMS in November 2011. Among its more recent accomplishments relevant to the EQR review period, DCH:

- Completed participation in 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. After a six-month, no cost extension, the grant period and project ended in late June 2015, with several lessons learned about depression screening and care.
- Completed policy and Medicaid Management Information System (MMIS) activities to ensure mandated compliance with the International Classification of Diseases, 10th Edition (ICD-10) code sets within the Medical Assistance Plans Division. The requirement for ICD-10 coding was implemented effective October 1, 2015. The transition to ICD-10 coding was reported as being successful.
- Collaborated with CMS and HSAG to develop and implement a rapid cycle process improvement validation process for the CMOs' rapid cycle PIPs. HSAG provided training to the CMOs on the new rapid cycle process during web-based and in-person training in late 2014 and early 2015. All of the CMOs' 2015 PIPs will be validated using the rapid cycle PIP validation process. (Findings from validation of the CMOs' rapid cycle PIPs initiated in 2014 are described in this annual report.)
- Transitioned to a centralized credentialing verification organization (CVO) in 2015, to reduce the administrative burdens providers faced in their efforts to enroll in Medicaid and contract with a managed care plan to provide care to Medicaid eligible members. The new process also ensures high quality providers will serve both managed care and FFS members. CMO and DCH representatives serve on the CVO's credentials committee and the process meets NCQA's credentialing requirements.
- Facilitated the reprocurement of the GF and GF 360° managed care contractors. The Request for Proposal (RFP) process and contracts were used as a vehicle for promoting additional Medicaid delivery system reforms (e.g., performance incentives, value-based purchasing, and the

implementation of patient-centered medical homes [including integrated behavioral and physical health homes, and dental homes]).

- Initiated a collaborative effort involving DCH, the CMOs, and the Georgia Hospital Association's Care Coordination Council to address the Medicaid readmission rate. As a component of that collaboration, a new transition of care form was developed that aligns with the requirements for the CMS Adult Core Set's Care Transitions measure. The council believes the use of this form, in an electronic format, will improve the transition of a patient's medical information from the inpatient setting to the community setting and result in reduced hospital re-admissions and better patient outcomes. Several hospital systems in Georgia are pilot testing the new form in an electronic version and providing feedback to the Care Coordination Council.

Quality Initiatives Driving Improvement

Following are brief descriptions of some of DCH's 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.

Quality Improvement Conference

The DCH worked with HSAG to conduct a quality improvement conference, *The Improvement Journey—From Planning to Execution*, on January 9, 2015. The goal of the conference was to provide tools for the CMOs to strategize and plan for effective quality improvement.

The conference focused on two primary and interrelated topics. The first topic involved activities related to strategic planning principles, including strategic analysis, direction setting, and action planning for developing an effective quality improvement program specific to the GF and GF 360º populations and aligned with the state's Quality Strategic Plan. Second, introduction of Module 3 of the new rapid cycle PIP process focused on process mapping, failure modes and effects analysis, failure modes ranking, and intervention determination. The audience for the 2015 conference included CMO quality staff members, CMO senior leadership staff, clinical management and quality improvement staff, as well as DCH staff members involved in the GF and the GF 360º programs.

Rapid Cycle Technical Assistance

In December 2014, HSAG provided DCH and the CMOs with an in-depth companion guide, rapid cycle PIP submission forms, and updated PIP validation criteria to support the new rapid cycle PIP process developed by HSAG. This new PIP process was requested by, and developed in conjunction with, DCH to design and implement more effective improvement efforts by applying rapid cycle techniques and incorporating quality improvement science into the PIP process. HSAG delivered a series of webinars to the CMOs in late 2014 and early 2015 to provide training on the five modules of the rapid cycle PIP process. HSAG also facilitated one-on-one technical assistance conference calls with the CMOs throughout 2015 to offer guidance and assist in troubleshooting with the new process as the CMOs progressed toward completion of their first cycle of rapid cycle PIPs. As the CMOs worked through each of the five rapid cycle PIP modules for each PIP, HSAG reviewed each CMO's

activities as reported in module-specific submission forms and provided written feedback to guide the CMO through the rapid cycle process. Technical assistance conference calls were scheduled, as needed, for each module completed by the CMOs for all six rapid cycle PIPs.

The Centers for Medicare & Medicaid Services Quality Improvement (QI) 301 Project

The CMOs participated with DCH in the CMS QI 301 project that focused on improving the State's postpartum visit rate and increasing the utilization of long-acting reversible contraceptives using the rapid cycle PIP process. The interventions resulting from participation in this training informed the CMOs' postpartum care PIPs.

3. Description of EQR Activities

Results for the following four EQR activities were used for this annual evaluation and report. Brief descriptions of both mandatory and optional activities are provided below.

Mandatory Activities

In accordance with 42 CFR §438.356, DCH contracted with HSAG as the EQRO for the State of Georgia to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. In SFY 2015, HSAG conducted the following mandatory activities.

Review of compliance with federal and State-specified operational 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. The DCH contracted with HSAG 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. For the SFY 2015 review period, HSAG evaluated the degree to which the GF CMOs and the GF 360° CMO complied with federal Medicaid managed care regulations and the associated DCH contract requirements in six performance categories. The review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR §438.214–438.230. HSAG conducted the on-site compliance reviews in July 2015. The standards HSAG evaluated included:

- Provider Selection, Credentialing, and Recredentialing
- Subcontractual Relationships and Delegation
- Member Rights and Protections
- Member Information
- Grievance System
- Disenrollment Requirements and Limitations

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

HSAG provided detailed, final audit reports to the CMOs and DCH in November 2015. Appendix A contains a detailed description of HSAG's methodology for conducting the review.

Validation of performance improvement projects: HSAG reviews each PIP using CMS' validation protocol to ensure that the CMOs design, conduct, and report PIPs in a methodologically sound manner and meet all State and federal requirements

HSAG validated eight PIPs for each GF CMO. Six PIPs were validated using the new rapid cycle approach, and two PIPs were implemented using the traditional annual measurement approach. The transition from the traditional, outcome-focused PIP methodology to the new rapid cycle PIP

methodology and the unique characteristics of both processes are described in detail in Appendix B, Methodology for Conducting Validation of Performance Improvement Projects.

Because PIPs must meet CMS requirements, HSAG completed a crosswalk of the new rapid cycle framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-1] HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, a new approach was reasonable.

The CMOs submitted their CY 2014 PIP data that reflected varying time periods, depending on the PIP topic, in June and in August 2015. HSAG validated PIPs between July 1, 2015, and August 26, 2015. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in November 2015.

For the rapid cycle PIPs, DCH identified the general PIP focus area and the CMO selected the specific PIP topic. The CMO developed a SMART Aim measure that targeted a specific provider and member population to evaluate small tests of change. Appendix B, Methodology for Conducting Validation of Performance Improvement Projects, provides the necessary foundation for the rapid cycle PIP process and should be read prior to reading the CMO-specific PIP sections.

HSAG also began validation of the 2015 rapid cycle PIPs during calendar year (CY) 2015. All of these PIPs were implemented using the rapid cycle PIP methodology. Since the final validation of the CY 2015 PIPs will not be completed until 2016, the validation results for these PIPs will be presented in the next EQR annual report.

Validation of 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 and GF 360° members. The DCH requires that the CMOs submit externally validated performance measure rates. Performance measure validation determines the extent to which the CMOs followed specifications established by DCH for its performance measures when calculating the performance measure rates.

HSAG conducted validation of the PM rates following the NCQA HEDIS Compliance Audit timeline, typically from January 2015 through July 2015. The final PM validation results generally reflected the measurement period of January 1, 2014, through December 31, 2014. HSAG provided final PM validation reports to the CMOs and DCH in August 2015.

Appendix C includes a detailed methodology used by HSAG for performance measure validation.

[3-1] 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 22, 2016.

Optional Activities

In addition to conducting the mandatory EQR activities, HSAG reviewed the results of the CMOs' CAHPS Survey activities as described below.

Consumer Assessment of Healthcare Providers and Systems*:* The DCH periodically assesses the perceptions and experiences of members as part of its process for evaluating the quality of healthcare services provided by plans to their members. The administration of the CAHPS surveys is an optional Medicaid external quality review (EQR) activity to assess managed care members' satisfaction with their healthcare services. The DCH requires that the CMOs administer CAHPS surveys to both adult members and parents or caretakers of child members. In 2015, the three GF CMOs contracted with survey vendors to administer standardized survey instruments, CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys, to adult and child Medicaid members enrolled in their respective CMO. Amerigroup contracted with DSS Research, and Peach State and WellCare contracted with SPH Analytics (SPHA) to administer the Adult and Child Medicaid CAHPS Surveys on their behalf. HSAG included the results from these surveys for all three CMOs in this report. Appendix D includes a detailed methodology used by HSAG for its review of the CAHPS Survey results.

Plan Overview

Amerigroup Community Care (Amerigroup) is a wholly owned subsidiary of Anthem, Inc. Amerigroup 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 374,000 GF members statewide.[4-1] 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, case and disease management and education, and wellness/prevention programs.

Review of Compliance With Standards

Findings

Table 4-1 presents the standards and compliance scores for Amerigroup. For Standards I–VI, HSAG evaluated a total of 100 elements for the SFY 2015 review period. Each element was scored as *Met* or *Not Met*. A compliance score was calculated per standard as well as an overall compliance score for all standards.

Table 4-1—Standards and Compliance Scores

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	**10**	**9**	**1**	**90.0%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**0**	**100.0%**
IV	Member Information	**20**	**19**	**1**	**95.0%**
V	Grievance System	**47**	**43**	**4**	**91.5%**
VI	Disenrollment Requirements and Limitations	**10**	**9**	**1**	**90.0%**
	Total Number of Elements	**100**	**93**	**7**	
	Total Compliance Score				**93.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**12**	**3**	**9**	**25.0%**

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

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.

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

Amerigroup had a total compliance score of 93 percent, with two of the standards scoring 100 percent: Subcontractual Relationships and Delegation, and Member Rights and Protections.

Amerigroup scored 90 percent or higher in all other standards: Provider Selection, Credentialing, and Recredentialing; Member Information; Grievance System; and Disenrollment Requirements and Limitations. Grievance System had four *Not Met* elements while the other three standards each had one *Not Met* element.

HSAG also reviewed documentation provided by Amerigroup to determine whether the CMO had met the intent of the corrective action plans DCH had approved for *Not Met* elements from the previous noncompliant review findings. Twelve elements were re-reviewed within the following standards: Coverage and Authorization of Services, Furnishing of Services, Coordination and Continuity of Care, Clinical Practice Guidelines (CPGs), and Quality Assessment and Performance Improvement (QAPI). All elements related to Coverage and Authorization of Services were *Met* upon reevaluation. Nine elements within the remaining standards required continued corrective action.

Strengths and Weaknesses

Below is a discussion of the strengths and areas for improvement, by standard, that were identified during the compliance review.

Provider Selection, Credentialing, and Recredentialing: Amerigroup maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities were performed to industry and State requirements. Amerigroup monitored providers to ensure the provision of quality care. When quality issues were identified, the CMO implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status. The 10 recredentialing files that HSAG reviewed were complete and met timeliness requirements; however, HSAG identified two of 10 initial credentialing files in which the credentialing decision date exceeded the 120-day time frame requirement. As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, Amerigroup will no longer be responsible for credentialing and recredentialing the majority of providers in its network.

Subcontractual Relationships and Delegation: Amerigroup maintained its policies and procedures to ensure compliance with industry and State CMO standards. The CMO monitored delegate performance through ongoing assessment of individual delegate functions and took corrective action when deficiencies were identified. Amerigroup had an appointed CMO delegation designee who was responsible for providing findings and recommendations, identified by the corporate delegation designee, to the appropriate staff and committees.

Member Rights and Protections: Amerigroup had several mechanisms to inform members of their rights and responsibilities, such as the member handbook and CMO website. Member rights were also included in the provider manual as a method to keep providers informed regarding member rights.

Member Information: Member handbooks were provided to Amerigroup's members upon enrollment and were available online and in alternate formats, meeting the needs of the visually impaired, those with limited reading proficiency, and Spanish-speaking members. The DCH confirmed that for existing members the CMO is required to inform members via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request. The policies submitted for review did not reflect how Amerigroup complies with this requirement.

Grievance System: Amerigroup staff demonstrated a comprehensive understanding of the grievance system process. Although the CMO had detailed policies and procedures for grievances, administrative reviews, and administrative law hearings, there were two areas for improvement. The policies did not reflect that administrative review (appeal) acknowledgement letters are provided in writing within 10 working days of receipt in the member's primary language or that the CMO must provide information that advises the member of the limited time available for presenting evidence in the case of an expedited administrative review (appeal).

During the on-site visit, HSAG reviewed 10 grievance files and 10 appeal files. All cases were compliant with the applicable timeliness requirements. However, the appeal resolution letters for upheld denials were not written in a manner that could be easily understood. In some instances the rationale portion of the letter contained advanced medical terminology or a direct copy of the clinical reviewer's notes.

Disenrollment Requirements and Limitations: Although Amerigroup staff members demonstrated knowledge of the disenrollment requirements and assisted members with disenrollment paperwork if needed, the disenrollment policy and member handbook did not reflect a member's right to request disenrollment *for* cause at any time.

Recommendations for Improvement

Amerigroup received recommendations for improvement in the standard areas of Member Information, Disenrollment Requirements and Limitations, and Grievance System. The CMO has an opportunity to improve communication with its members to ensure they have adequate, timely information. HSAG's specific recommendations for Amerigroup are to:

- Revise its processes and policies to ensure that members receive administrative review appeal letters in their primary language.
- Develop and implement a mechanism that advises members of the limited time frame for presenting evidence in the case of an expedited appeal.
- Ensure that the rationale for upholding a denial is written in easily understood language in the appeal resolution letters.
- Update its disenrollment policy and member handbook to reflect a member's right to request disenrollment for cause at any time.
- Update its applicable policies to include a description of how the CMO notifies existing members that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy must also reflect how often existing members receive the notice.

Follow-Up Review: HSAG also conducted a follow-up review of the previous compliance review findings. Nine reevaluated elements within the following standards will require continued corrective action: Furnishing of Services, Coordination and Continuity of Care, CPGs, and QAPI standards. Below is a summary of the areas that require continued corrective actions.

- Amerigroup must address timely access issues to ensure providers return calls after-hours within the appropriate time frames. The CMO must continue to apply current and new interventions until the goal of returning urgent calls within 20 minutes and routine calls within one hour is achieved at least 90 percent of the time.
- Amerigroup must meet the minimum geographic access requirements in both urban and rural areas. Specifically, the CMO must have sufficient provider coverage for primary care physicians (PCPs), specialists, dental subspecialty providers, mental health providers, and pharmacies. Amerigroup must continue efforts to close its network adequacy gaps by implementing new network strategies, and keep DCH informed of its progress.
- Amerigroup must continue monthly auditing of case management files for members who were discharged from inpatient facilities to ensure current discharge procedures are followed. The CMO must develop a mechanism to evaluate the effectiveness of discharge documentation training with case managers. In addition, all auditing results should be documented and shared with applicable staff.
- Amerigroup must continue to monitor provider compliance and corrective action when providers fail the CMO's quarterly CPG monitoring audit to ensure that 90 percent of its providers use CPGs.
- Amerigroup must meet all DCH-established performance measure targets. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.
- Amerigroup must continue to incorporate DCH's suggested revisions and evaluate the overall effectiveness of its QAPI plan. The CMO should also ensure that it measures the effectiveness of the initiatives designed to improve the quality of care provided to its membership, assesses its evaluation methods, and implements modifications as needed.

Performance Improvement Projects

Findings

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 outcomes.

Rapid Cycle PIP Validation Results

Six of Amerigroup's eight PIPs were validated following the new rapid cycle methodology. Please refer to Appendix B, Methodology for Conducting Validation of Performance Improvement Projects,

for a detailed discussion regarding the rapid cycle PIP validation process and a description of HSAG's scoring criteria.

The overall validation findings (confidence levels) for the rapid cycle PIPs are presented in Table 4-2. HSAG's findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence*, *Confidence*, and *Low Confidence*.

Table 4-2—Rapid Cycle Performance Improvement Project Validation Findings for Amerigroup Community Care

PIP	Confidence Level
Annual Dental Visits	*Low Confidence*
Appropriate Use of ADHD Medications	*High Confidence*
Avoidable Emergency Room Visits	*Confidence*
Bright Futures	*Low Confidence*
Comprehensive Diabetes Care	*Confidence*
Postpartum Care	*High Confidence*

HSAG assigned a level of *High Confidence* in the quality improvement processes and outcomes for two of the six rapid cycle PIPs, *Appropriate Use of ADHD Medications* and *Postpartum Care*. HSAG assigned two other PIPs, *Avoidable Emergency Room Visits* and *Comprehensive Diabetes Care*, a level of *Confidence*. The remaining two PIPs, *Annual Dental Visits* and *Bright Futures*, were assigned a *Low Confidence* level.

Rapid Cycle PIP-Specific Outcomes

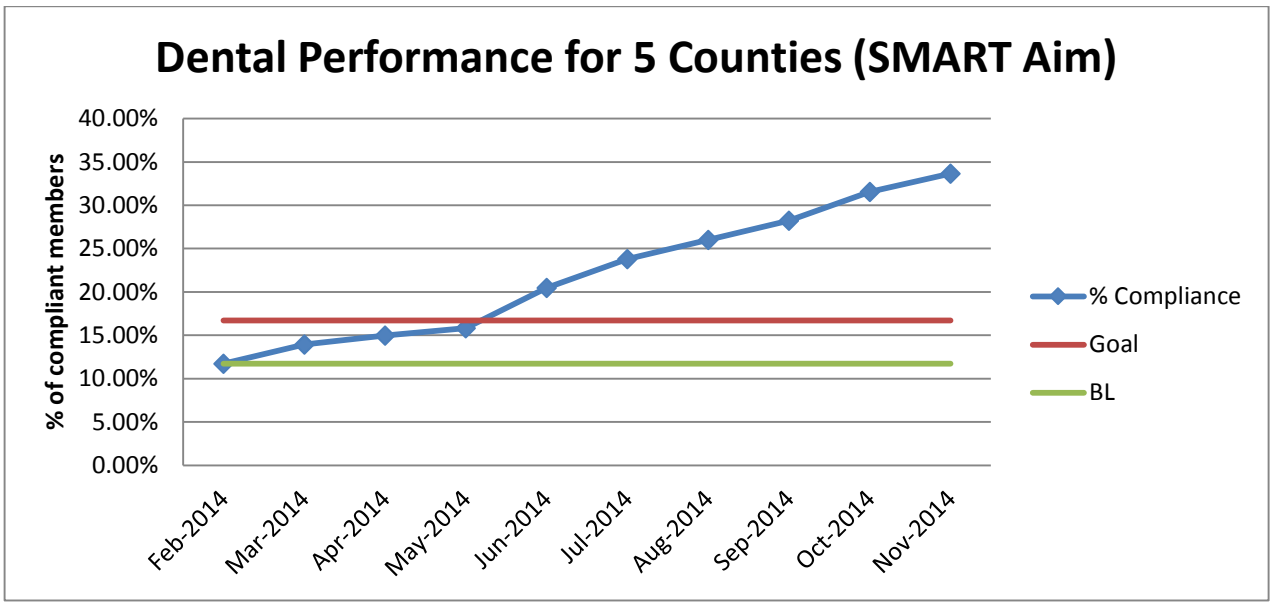
Amerigroup developed a SMART Aim statement and a SMART Aim measure for each rapid cycle PIP. Figure 4-1 through Figure 4-6 are run charts displaying the SMART Aim measurements for the rapid cycle PIPs, including the baseline and goal rates for each measure. The figures were constructed and submitted by Amerigroup as part of the PIP submissions; HSAG copied the figures for the purpose of reporting the PIP outcomes and did not alter the figures in any way.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements in comparison with reported baseline and goal rates. The data displayed in the SMART Aim run charts were used to determine whether each PIP demonstrated meaningful and sustained improvement in the SMART Aim measure.

A detailed discussion of Amerigroup's performance on each rapid cycle PIP, which includes the CMO's interventions and activities, is provided in the Performance Improvement Project Summary Grid in Appendix E. The grid also includes HSAG's recommendations to Amerigroup to improve performance.

Annual Dental Visits

Figure 4-1—SMART Aim Run Chart for *Annual Dental Visits*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Annual Dental Visits* PIP. For this PIP, Amerigroup defined the baseline rate (11.7 percent) as the monthly percentage of members, 1 to 20 years of age in the five targeted counties, who were compliant with having at least one annual preventive dental service in February 2014. The CMO's goal was to achieve an aggregate rate of 16.7 percent among the five counties included in the PIP, a 5 percentage point increase over the baseline rate. Because the CMO's measurement methodology was not sound, the reported PIP results were not credible.

The CMO's run chart tracked the cumulative monthly percentage of members who were compliant with having at least one annual preventive dental service from February to November 2014. In a cumulative rate, the CMO established the denominator, or the total number of all members due for the preventive dental service for the entire calendar year, and used this denominator for each monthly measurement. The numerator was calculated by adding the number of members who obtained the service during the current month to the number of members who had previously obtained the service during the prior months of the year. A cumulative rate, therefore, would inevitably increase throughout the life of the PIP, regardless of whether any true or meaningful improvement in the rate occurred.

Because the baseline rate was a monthly rate of an annually required service and the CMO tracked a cumulative rate over the course of the PIP, the baseline rate was not comparable with the remeasurement rates. Comparing cumulative monthly rates from one month to the next did not allow for a valid comparison; therefore, it was not possible for HSAG to determine whether meaningful or sustained improvement in the SMART Aim measure was achieved.

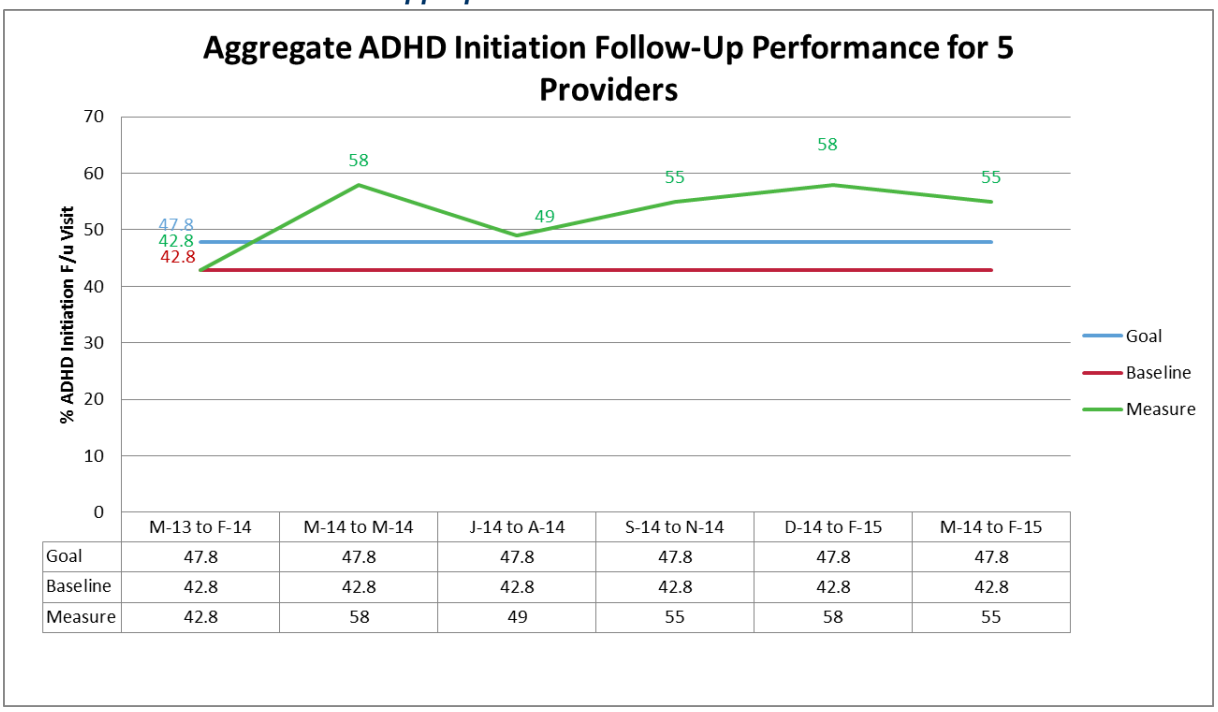
Amerigroup used a key driver diagram to summarize key drivers and potential interventions considered for the *Annual Dental Visits* PIP. The CMO tested two interventions during the life of the

PIP. First, the CMO contracted with a vendor to deploy mobile dental units to offer convenient locations for members to obtain preventive dental services. Outreach was conducted to educate members on the recommended and available services, to raise awareness of the mobile dental units, and to schedule preventive dental service appointments. Because the mobile dental unit vendor did not offer services in one of the counties targeted by the PIP, Amerigroup initiated a second intervention to address the identified gap in access. The CMO partnered with Federally Qualified Health Centers (FQHCs) that housed on-site dental providers. Through the FQHC partnerships, the CMO was able to offer members the choice of obtaining preventive dental services at one of the mobile dental units or from an on-site dental provider at an FQHC.

Amerigroup reported that both the mobile dental unit intervention and the FQHC partnership will be continued and expanded so that members will have multiple location options for obtaining preventive dental services. The CMO determined that a member's choice of location was influenced by geography; the mobile dental units were more successful in rural areas, while the FQHCs' dental services were in higher demand in urban areas. The CMO will continue to analyze results by geographic region and target its interventions accordingly.

Appropriate Use of ADHD Medications

Figure 4-2—SMART Aim Run Chart
for *Appropriate Use of ADHD Medications*



	M-13 to F-14	M-14 to M-14	J-14 to A-14	S-14 to N-14	D-14 to F-15	M-14 to F-15
Goal	47.8	47.8	47.8	47.8	47.8	47.8
Baseline	42.8	42.8	42.8	42.8	42.8	42.8
Measure	42.8	58	49	55	58	55

HSAG assigned a level of *High Confidence* to the validation findings for the *Appropriate Use of ADHD Medications* PIP. For this PIP, Amerigroup established the baseline rate for the five targeted providers of 42.8 percent based on a baseline measurement period of March 2013 to February 2014. The CMO set a goal of 47.8 percent for the five targeted providers, or an increase of 5 percentage points. The CMO's run chart included four quarterly remeasurements, following the baseline measurement, and one annual remeasurement (March 2014 to February 2015) corresponding to the

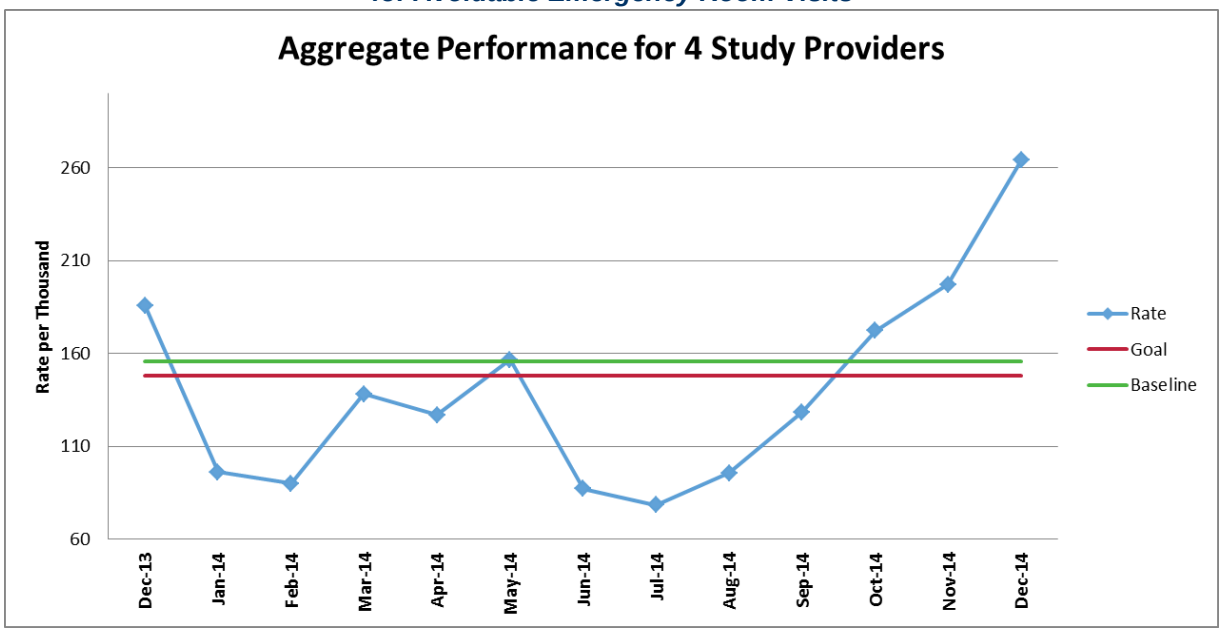
year following the baseline measurement period. The PIP's SMART Aim measure demonstrated meaningful and sustained improvement by exceeding the goal rate for all four quarterly remeasurements. The annual remeasurement of 55.0 percent also exceeded the goal of 47.8 percent by 7.2 percentage points.

Amerigroup used a key driver diagram to summarize key drivers and potential interventions considered for the *Appropriate Use of ADHD Medications* PIP. The CMO tested one intervention, offering clinical oversight by a nurse practice consultant, for five high-volume, low-performing providers. The clinical practice consultant (CPC) made face-to-face visits to the targeted ADHD provider offices. The provider visits involved education on best practices, identification of provider-specific barriers, and assistance in developing new processes in the provider offices to address identified barriers. The CPC made multiple visits to individual provider offices as necessary, depending on the receptiveness of the individual providers.

Amerigroup reported that it plans to refine, continue, and spread the CPC intervention. The CMO determined that the intervention was most effective when the provider was receiving multiple visits from the CPC. Therefore, the consultant will continue to offer assistance to targeted providers, keeping communication open and helping to motivate the providers to maintain improved performance.

Avoidable Emergency Room Visits

Figure 4-3—SMART Aim Run Chart for *Avoidable Emergency Room Visits*



HSAG assigned a level of *Confidence* to the validation findings for the *Avoidable Emergency Room Visits* PIP. For this PIP, Amerigroup established a baseline avoidable emergency room (ER) visit rate for the four targeted providers (an inverse rate where a lower rate indicates better performance) of 156 per 1,000, based on a baseline measurement period of CY 2013. The CMO set a goal to reduce the avoidable ER rate for the four targeted providers to 148 per 1,000. The CMO's run chart included monthly remeasurements from January to December 2014. The SMART Aim measure demonstrated

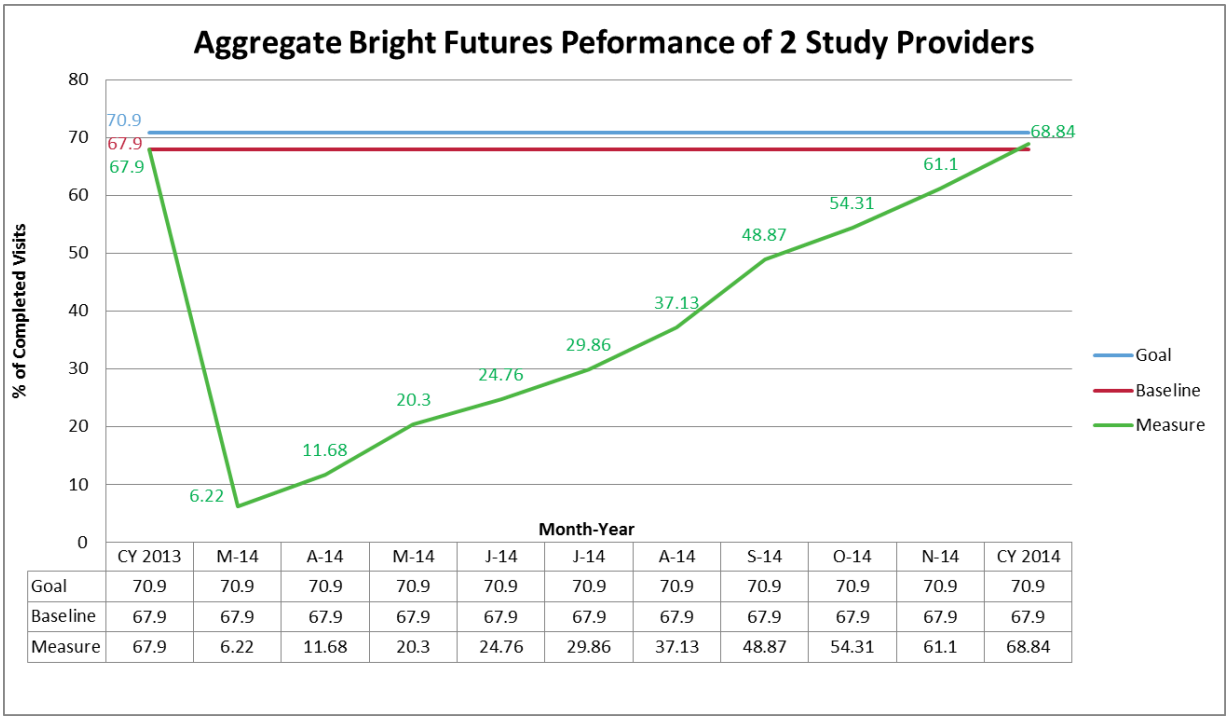
meaningful improvement by surpassing the goal for eight of the monthly remeasurements. The PIP did not provide evidence of sustained improvement, however, as shown by the final five monthly SMART Aim measurements. There was an increasing trend in the avoidable ER rate from August to December 2014, and the monthly avoidable ER rates for October, November, and December were higher (indicating worse performance) than both the baseline and goal avoidable ER rates.

Amerigroup used a key driver diagram to summarize key drivers and potential interventions considered for the *Avoidable Emergency Room Visits* PIP. To address identified barriers, the CMO tested two interventions with four high-volume, low-performing PCP practices. The first intervention was a face-to-face provider training session that illustrated best practices for early patient engagement and establishment of a medical home for members, including provider tools for member outreach, to prevent inappropriate ER utilization. The second intervention involved face-to-face visits with providers that included a demonstration of the inverse relationship between well visits and avoidable ER visits (the more completed well visits, the fewer avoidable ER visits). The second intervention also included a presentation of financial return on investment (ROI) data to support the use of additional practice resources for new member outreach to improve well visit and avoidable ER visit rates.

Amerigroup based plans for future improvement efforts on the qualitative feedback it received from providers participating in the PIP. Based on provider feedback, the CMO concluded that motivation to reduce the avoidable ER rate was driven by financial provider incentives and supported by face-to-face contact with the CMO. To that end, Amerigroup plans to have the chief medical officer follow up with targeted providers, develop additional provider education sessions, and potentially incorporate avoidable ER measures into the providers' shared savings incentive.

Bright Futures

Figure 4-4 SMART Aim Run Chart for *Bright Futures*



	CY 2013	M-14	A-14	M-14	J-14	J-14	A-14	S-14	O-14	N-14	CY 2014
Goal	70.9	70.9	70.9	70.9	70.9	70.9	70.9	70.9	70.9	70.9	70.9
Baseline	67.9	67.9	67.9	67.9	67.9	67.9	67.9	67.9	67.9	67.9	67.9
Measure	67.9	6.22	11.68	20.3	24.76	29.86	37.13	48.87	54.31	61.1	68.84

HSAG assigned a level of *Low Confidence* to the validation findings for the *Bright Futures* PIP. For this PIP, Amerigroup established a baseline rate of 67.9 percent for the two targeted providers based on a baseline measurement period of CY 2013. The CMO set a goal of 70.9 percent for the two targeted providers, an improvement of 3 percentage points in the rate of completed annual well-child visits for members 3 to 6 years of age. The CMO's run chart included nine monthly measurements from March to November 2014 and an annual measurement for CY 2014, the year following the baseline measurement period. The SMART Aim measure did not meet the goal of 70.9 percent. The final monthly rate reported for November 2014 was 61.1 percent, and the CY 2014 rate was 68.8 percent.

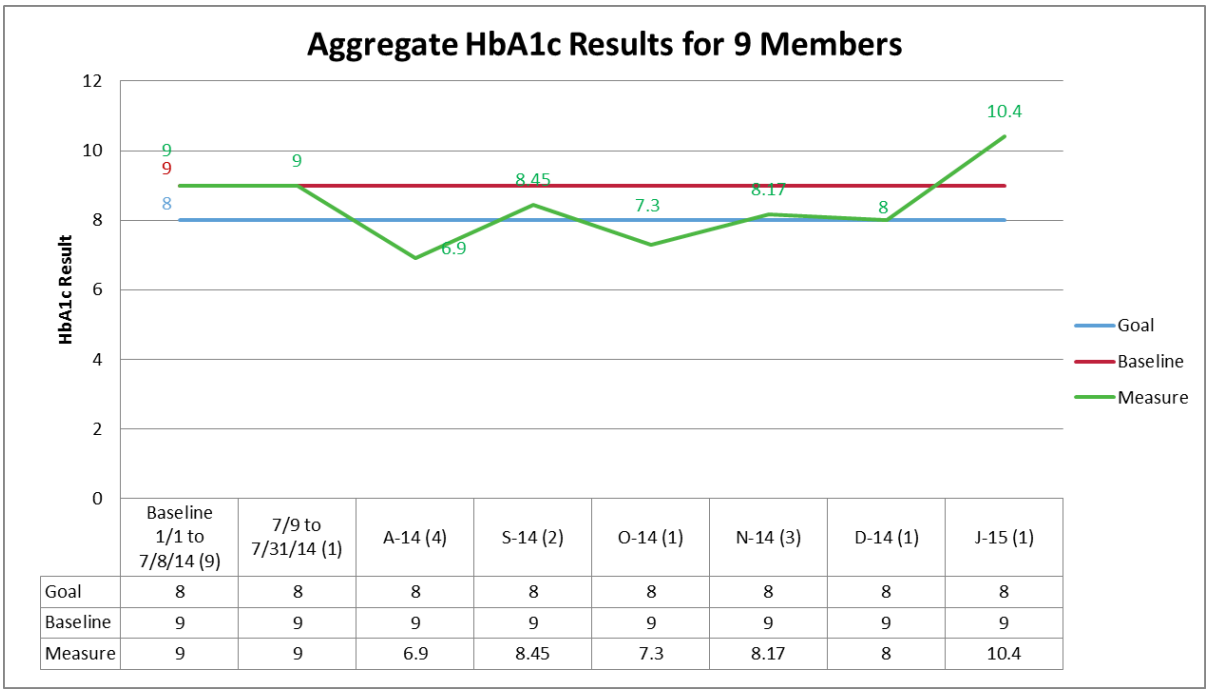
The CMO's measurement methodology for this PIP was not sound. The CMO's run chart tracked the cumulative monthly percentage of eligible members who had at least one annual well visit from March to November 2014. In a cumulative rate, the CMO established the denominator, or the total number of all members due for a well-child visit for the entire calendar year, and used this denominator for each monthly measurement. The numerator was calculated by adding the number of members who obtained the service during the current month to the number of members who had previously obtained the service during the prior months of the year. A cumulative rate would therefore inevitably increase throughout the life of the PIP, regardless of whether any true or meaningful improvement in the rate occurred. Because the baseline rate was a monthly rate of an annually required service and the CMO tracked a cumulative rate over the course of the PIP, the baseline rate was not comparable with the remeasurement rates. Comparing cumulative monthly rates from one month to the next did not allow for a valid comparison; therefore, it was not possible for HSAG to determine whether meaningful or sustained improvement in the SMART Aim measure was achieved.

Amerigroup used a key driver diagram to summarize key drivers and potential interventions considered for the *Bright Futures* PIP. The CMO tested one intervention, Clinic Days events, with two targeted providers. One provider had hosted Clinic Days events in the previous year and had already improved its well-child visit performance; the second provider had never hosted a Clinic Days event and had more room for improvement in its well-child visit rate at the start of the PIP. Amerigroup wanted to determine whether the intervention could help the first provider sustain its improved performance, or improve further, as well as enable the second provider to achieve improvement. The Clinic Days intervention entailed partnering with high-volume providers to set aside time slots on a specific day for Amerigroup to schedule appointments for their members. Amerigroup also offered a gift card incentive to members for completing their well-child visit during the Clinic Days events. The Clinic Days events were scheduled around the local school calendar to provide opportunities for members to obtain a well-child visit without missing school.

Amerigroup documented lessons learned from the variation in performance among the two targeted providers who participated in the PIP. The CMO plans to share the PIP results with the participating providers and continue to conduct barrier analysis to identify additional areas for improvement.

Comprehensive Diabetes Care

Figure 4-5—SMART Aim Run Chart for *Comprehensive Diabetes Care*



	Baseline 1/1 to 7/8/14 (9)	7/9 to 7/31/14 (1)	A-14 (4)	S-14 (2)	O-14 (1)	N-14 (3)	D-14 (1)	J-15 (1)
Goal	8	8	8	8	8	8	8	8
Baseline	9	9	9	9	9	9	9	9
Measure	9	9	6.9	8.45	7.3	8.17	8	10.4

Run Chart Note: Parentheses denote how many results were in the denominator for that remeasurement period. For example, A-14 (4) means that four results had values recorded in August 2014. Overall, a total of nine members participated in this study, but not all members were required to complete HbA1c testing in each month. When these members had tests completed varied.

HSAG assigned a level of *Confidence* to the validation findings for the *Comprehensive Diabetes Care* PIP. For this PIP, Amerigroup defined the SMART Aim measure as the average HbA1c test result (an inverse measure, where a lower rate indicates better performance) for diabetic members assigned to the targeted provider. The CMO established a baseline average value of 9.0 percent for members assigned to the targeted provider based on a baseline measurement period of January 1, 2014–July 8, 2014. The goal was to decrease the monthly average HbA1c test result to 8.0 for members assigned to the targeted provider. The CMO's run chart included seven monthly SMART Aim measurements following the baseline period, from July 2014 through January 2015. The SMART Aim measure demonstrated meaningful improvement by meeting or exceeding the goal of 8.0 for three of the monthly remeasurements, including the month of August, which included the greatest number of members (four) with an HbA1c test result. The SMART Aim measure did not provide clear evidence of sustained improvement because the monthly average HbA1c result fluctuated between values above and below the goal rate throughout the life of the PIP.

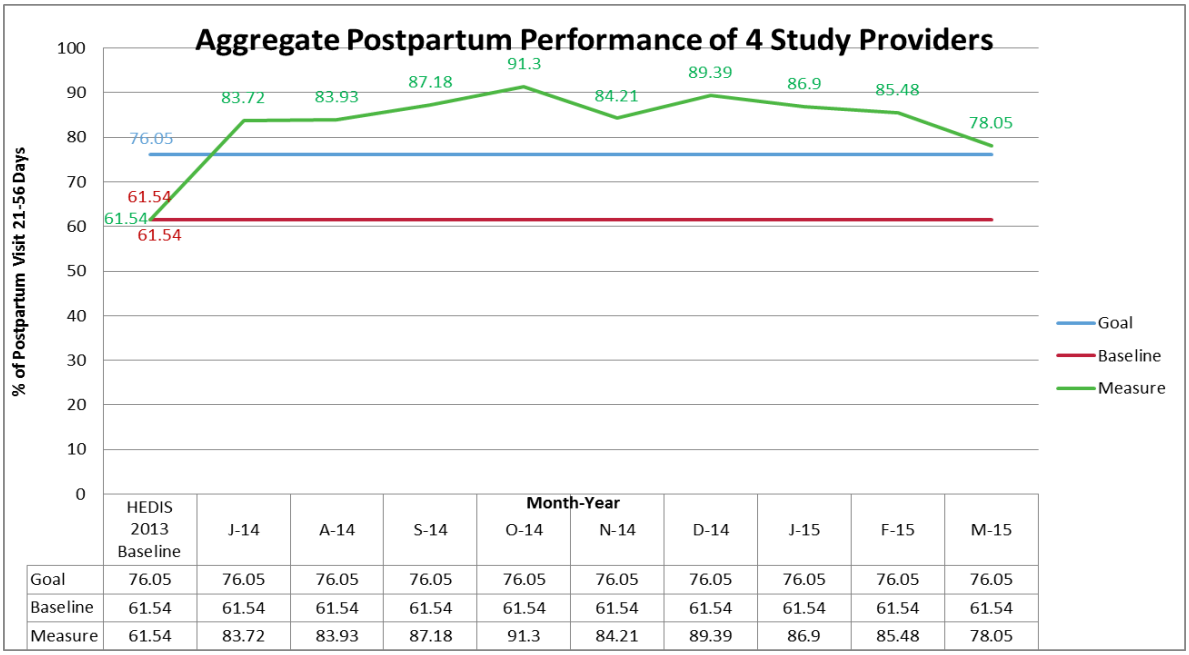
Amerigroup used a key driver diagram to summarize key drivers and potential interventions considered for the *Comprehensive Diabetes Care* PIP. The CMO tested one intervention, offering a high dollar amount incentive to diabetic members seen by the targeted provider. The targeted provider offered comprehensive diabetes care and allowed members access to diabetic screenings and other needed services in one location. Eligible members could earn a total of $100 in incentives by fulfilling the following requirements: (1) obtain a repeat HbA1c blood test with a decrease of at least 1 percentage point, (2) use a glucometer and refill test strips as prescribed, (3) take and refill

medications as prescribed, and (4) talk with a registered dietician about healthy diet and nutrition. Members could earn a $25 incentive for each of the four components, for a total of $100 in incentives. Eligible members received information about the incentive program through verbal communication and a printed brochure.

The CMO documented a number of lessons learned and considerations for future improvement efforts related to this PIP. Amerigroup reported individual, member-related factors that impacted the outcomes including office visit adherence, comorbidities, medical complexity, and psychosocial issues. The CMO also reported that HbA1c control was difficult to assess and improve in a rapid cycle format because of the sporadic timing of HbA1c testing and the length of time required for the behavioral changes needed to improve control.

Postpartum Care

Figure 4-6—SMART Aim Run Chart for *Postpartum Care*



	HEDIS 2013 Baseline	J-14	A-14	S-14	O-14	N-14	D-14	J-15	F-15	M-15
	Month-Year									
Goal	76.05	76.05	76.05	76.05	76.05	76.05	76.05	76.05	76.05	76.05
Baseline	61.54	61.54	61.54	61.54	61.54	61.54	61.54	61.54	61.54	61.54
Measure	61.54	83.72	83.93	87.18	91.3	84.21	89.39	86.9	85.48	78.05

HSAG assigned a level of *High Confidence* to the validation findings for the *Postpartum Care* PIP. For this PIP, Amerigroup used its annual HEDIS 2013 rate for the baseline rate of postpartum care visits completed within 21 to 56 days after delivery, among the four targeted providers, which was 61.5 percent. The CMO set a goal of increasing the rate for the four targeted providers by 14.5 percentage points. The CMO's run chart included nine monthly SMART Aim measurements from July 2014 through March 2015. The SMART Aim measure demonstrated meaningful and sustained improvement in the postpartum care rate by exceeding the goal for all nine monthly measurements. While the highest monthly rate (91.3 percent) was reported for October 2014 and the lowest monthly rate (78.05 percent) was reported for March 2015, all of the monthly remeasurement rates exceeded the goal.

Amerigroup used a key driver diagram to summarize key drivers and potential interventions considered for the *Postpartum Care* PIP. The CMO tested one intervention, a postpartum care

schedule incentive program, with four targeted providers. The CMO's CPC introduced the incentive program to the targeted providers during face-to-face meetings and incorporated input and feedback from the providers prior to launching the program. The incentive program was focused on the providers' office staff members because they controlled the scheduling of postpartum care appointments and could therefore more directly impact the timing of appointments to occur during the required time frame after delivery.

Based on the demonstrated success of the scheduler incentive program, Amerigroup plans to continue and expand this intervention. Because the claims and medical record review process used to confirm postpartum visit completion for the incentive program proved to be time-consuming, the CMO explored new methods of coding and claims processing for the postpartum services as well as additional provider incentives for postpartum care. The CMO has hired additional staff and is planning to expand the incentive program to other high-volume, low-performing providers.

Traditional Outcome-Focused PIP Validation Results

Amerigroup's two satisfaction-based PIPs were validated using HSAG's outcome-focused PIP validation methodology, based on annual study indicator measurements. Table 4-3 displays the validation findings for the ongoing, satisfaction-based PIPs.

Table 4-3—Traditional Outcome-Focused Performance Improvement Project Validation Findings for Amerigroup Community Care

PIP	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Validation Findings
Member Satisfaction	91%	93%	*Not Met*
Provider Satisfaction	76%	57%	*Not Met*

Both of the traditional outcome-focused satisfaction-based PIPs received an overall validation finding of *Not Met.* For both PIPs, the *Not Met* validation finding resulted from a *Not Met* score for one of the critical evaluation elements in the Outcomes stage.

Traditional Outcome-Focused PIP-Specific Outcomes

Table 4-4 and Table 4-5 display the study indicator rates for each measurement period of the two traditional outcome-focused, satisfaction-based PIPs, including the baseline period and each subsequent annual measurement period. In these tables, statistically significant changes between remeasurement periods are noted with an upward or downward arrow followed by an asterisk. Statistical significance is based on the *p* value calculated from a statistical test comparing measurement period rates. Differences in these rates that resulted in a *p* value less than 0.05 were considered statistically significant. It is possible for a percentage point difference between measurement period rates to appear large without being statistically significant. In certain instances, the study indicator denominators may not be large enough to have sufficient power to detect statistically significant difference. Similarly, the reverse may also occur: a *small* percentage point difference between measurement period rates with *large* denominators may result in a small percentage point difference that is statistically

significant because larger denominators have greater power to detect statistically significant differences.

If the PIP achieved statistically significant improvement over the baseline rate during a previous measurement period, it was then reviewed for sustained improvement. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators. PIPs that did not achieve statistically significant improvement (i.e., did not meet the criteria to be assessed for sustained improvement) were not assessed (NA).

A detailed discussion of Amerigroup's performance on each traditional PIP, which includes the CMO's interventions and activities, is provided in the Performance Improvement Project Summary Grid in Appendix E. The grid also includes HSAG's recommendations to Amerigroup to improve performance.

Member Satisfaction

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

Study Indicator	Baseline (2/22/12–5/9/13)	Remeasurement 1 (2/7/14–5/2/14)	Remeasurement 2 (3/1/15–5/1/15)	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%↑*	86.8%↓*	No

↑* 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).
^ 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 increased from baseline to the first remeasurement by 4.9 percentage points. Amerigroup did not demonstrate sustained improvement at the second remeasurement. There was a statistically significant decline in the study indicator rate from Remeasurement 1 to Remeasurement 2, and the Remeasurement 2 rate of 86.8 percent was no longer a statistically significant improvement over the baseline rate.

The CMO's collaborative quality improvement team reviewed processes, prior survey results, and additional data analyses, discussing all potential barriers to improving member satisfaction. The barrier identification process included analysis of member complaint data in addition to the CAHPS member satisfaction survey results. The results of the causal/barrier analyses were summarized in a fishbone diagram. The CMO also ranked identified barriers by priority level.

Amerigroup targeted interventions toward both providers and members. The CMO continued five ongoing interventions to address physician awareness of member satisfaction, lack of access to providers in rural areas, member awareness of telemedicine options, and member understanding of billing procedures. In addition to the five ongoing interventions, the CMO sent out an educational provider newsletter focusing on the "teach back technique" method of provider communication with patients. This method has been demonstrated to assess health literacy of a patient and to empower patients to take initiative for their care.

Provider Satisfaction

Table 4-5—Performance Improvement Project Outcomes for *Provider Satisfaction*								
Study Indicator				**Baseline (7/1/13–9/30/13)**		**Remeasurement 1 (7/1/14–9/30/14)**		**Sustained Improvement^**
1. The percentage of providers who respond, "Very satisfied" or, "Somewhat satisfied" to Q34B – "Please rate your experience with…Satisfaction with helpfulness of staff providing DMCCU services."				33.9%		37.3%		NA
Study Indicator	**Quarter 1**	**Quarter 2**	**Quarter 3**	**Quarter 4**	**Quarter 5**	**Quarter 6**	**Quarter 7**	**Sustained Improvement^**
2. The percentage of members with asthma and/or diabetes admitted into the Disease Management (DM) program who were actively managed by DM staff.	5.6%	8.1%	4.2%	7.4%	2.8%	3.9%	15.0%	NA

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

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

In Amerigroup's *Provider Satisfaction* PIP, there was a non-statistically significant increase of 3.4 percentage points in the rate of Study Indicator 1 from baseline to Remeasurement 1. Because Study Indicator 2 results were reported as six quarterly measurements, HSAG was unable to compare annual baseline and remeasurement rates to determine if there was a statistically significant change in the second study indicator. The CMO-defined quarterly remeasurement periods for Study Indicator 2 did not align with the required annual measurement periods for the PIP. Because requirements for this PIP followed HSAG's outcome-focused methodology and not the rapid cycle PIP methodology, quarterly remeasurement periods were not acceptable. The CMO should have included only study indicators with annual measurement periods for this PIP and should have documented only annual remeasurement results. The quarterly rates for Study Indicator 2 fluctuated over the six measurements, with the lowest rate, 2.8 percent, reported for the fifth quarterly measurement and the highest rate, 15.0 percent, reported for the sixth quarterly measurement. There was no clear trend in the reported rates for Study Indicator 2.

The CMO's interdisciplinary quality improvement team conducted a causal/barrier analysis for the PIP using a fishbone diagram. All identified barriers were discussed by the team, and barriers believed to be primarily under the CMO's control were identified as priorities. Amerigroup focused on a single

high-priority barrier for the Remeasurement 1 period, which was the lack of effective communication between provider field associates and disease management (DM) staff. Based on Amerigroup's Provider Satisfaction survey results, the survey vendor had identified provider satisfaction with services provided by DM staff as an opportunity for improvement that was associated with overall provider satisfaction and was an area that could be impacted by the CMO. The CMO reported that its approach to improving provider satisfaction was to ensure that the communication providers received from both provider field representatives and DM staff was consistent and clear. By ensuring clear and consistent communication with providers about DM services for their members, the CMO believed it could improve provider satisfaction. The CMO initiated two interventions to address the primary identified barrier:

- Deployed a new DM model focused on asthma- and diabetes-specific HEDIS gaps in care.
- Enhanced communication processes to inform provider field associates and nurse practice consultants about asthma and diabetes initiatives that aligned with DM activities.

Strengths and Weaknesses

This was the first year that Amerigroup submitted for validation PIPs using the new rapid cycle PIP framework. The learning curve necessary for transitioning to the new rapid cycle approach was evidenced by Amerigroup's performance on the six rapid cycle PIPs. Amerigroup's performance suggests that the CMO has substantial room for improvement in the application of the new rapid cycle PIP process. While HSAG determined *High Confidence* in the results for two of the CMO's six rapid cycle PIPs, as many PIPs received a *Low Confidence* level. Each of the rapid cycle PIPs was validated, and assigned a confidence level, based on six criteria defined by HSAG to represent successful completion of a valid PIP. Amerigroup demonstrated strength in one area, documenting lessons learned and information gained from the PIP, by achieving this criterion across all six rapid cycle PIPs. None of the remaining five criteria were achieved across all six PIPs. HSAG identified these opportunities for improvement in implementing the new rapid cycle PIP process: improving the accuracy of reported key findings and interpretation of results, demonstrating meaningful and sustained improvement of outcomes through effective intervention testing and revision, and planning for sustained improvement of outcomes.

Amerigroup's two satisfaction-based PIPs that used the traditional annual study indicator measurements were validated with HSAG's established, outcome-focused PIP validation methodology. Amerigroup's performance in the *Member Satisfaction* PIP suggests that the PIP's study design, established in the Design stage (Steps I through VI), was valid and appropriate for measuring the study indicator outcomes. The *Member Satisfaction* PIP had weaknesses in the Implementation stage, most notably the lack of intervention-specific evaluations to determine the impact of the many individual interventions on the PIP outcomes. Amerigroup's selection of a new narrowed focus for the *Provider Satisfaction* PIP, using a hybrid design with one annually measured study indicator and one quarterly measured study indicator, led to problems with the PIP's study design and data analysis activities. The PIP did not conform to the outcome-focused PIP methodology and did not follow DCH's requirement to continue the previous year's *Provider Satisfaction* PIP by reporting Remeasurement 2 results. Finally, in the Outcomes stage, there was a statistically significant decline in the study indicator rate for the *Member Satisfaction* PIP from Remeasurement 1 to Remeasurement 2, and the increase in the study indicator rate for the *Provider Satisfaction* PIP was

not statistically significant. Neither satisfaction-based PIP has achieved sustained improvement over the baseline results.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the improvement strategies used must be methodologically sound and based on solid improvement science. Amerigroup's PIP performance suggested a number of areas of opportunity that applied across the various PIP topics. Because all ongoing and future PIPs will be using the rapid cycle PIP process, all of the recommendations for future projects are related to the rapid cycle PIP design. HSAG recommends the following for Amerigroup:

- At the start of a new rapid cycle PIP, the CMO should carefully consider the end date specified in the SMART Aim statement and work backwards when planning the execution of the five rapid cycle PIP modules. Careful planning is critical to allow sufficient time to test and refine interventions that will result in meaningful and sustained improvement of outcomes during the limited time frame of the PIP.
- The CMO should ensure that the SMART Aim measure for each PIP is methodologically sound and appropriate for the PIP topic. The numerator and denominator of the SMART Aim measure should be clearly and accurately defined. The baseline measurement period should be comparable to the planned SMART Aim measurement intervals. Additionally, for future rapid cycle PIPs, SMART Aim measurements should occur monthly or more frequently, as appropriate.
- For rapid cycle PIPs focused on annual services (e.g., well-child visits and diabetic screenings), Amerigroup should seek technical assistance from HSAG to ensure that the SMART Aim measure is appropriate and that meaningful improvement is detectable from one measurement interval to the next.
- The CMO should carefully and thoroughly execute all steps in the PDSA cycle for each intervention. Each step in the PDSA process is necessary to maintain the focus of limited resources on the most impactful improvement strategies and to achieve optimal outcomes.
- The CMO should 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.
- If meaningful improvement is achieved, the CMO should formulate and document plans for ensuring that the improvement is sustained over time and include consideration for how successful interventions can be spread beyond the targeted population of the PIP in the future.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the current measure rates as compared to those of last year. The performance targets reflect the DCH-established performance targets for 2014. When possible, changes in rates were tested for statistical

significance. However, caution should be exercised when interpreting the results of the significance testing given that statistically significant changes may not necessarily be clinically significant.

Access to Care

Amerigroup's Access to Care performance measure results are shown in Table 4-6.

Table 4-6—Amerigroup Access to Care Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12–24 Months	97.03%	97.00%	↔	
Ages 25 Months–6 Years	91.19%	90.85%	↔	
Ages 7–11 Years	92.93%	92.99%	↔	
Ages 12–19 Years	90.55%	90.68%	↔	91.85%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	81.38%	79.69%	↓	88.32%
Oral Health (Annual Dental Visit)				
Ages 2–3 Years	48.59%	47.54%	↓	55.78%
Ages 4–6 Years	77.19%	75.89%	↓	
Ages 7–10 Years	79.60%	78.32%	↓	
Ages 11–14 Years	72.11%	71.65%	↔	
Ages 15–18 Years	60.92%	60.07%	↓	
Ages 19–21 Years	33.17%	30.58%	↔	
Total	69.67%	68.78%	↓	69.92%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	39.29%	52.57%	↑	43.43%
Engagement	9.62%	12.84%	↑	16.17%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.00%	NT	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
NT Indicates that statistical significance testing was not performed because reported rates were 0.00% for CY 2013 (0/432) and CY 2014 (0/432).
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

Within the Access to Care measure set, Amerigroup showed significant improvement for the two *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure indicator rates. Additionally, the *Initiation of Alcohol and Other Drug Dependence Treatment* indicator exceeded the 2014 performance target. Conversely, Amerigroup showed a significant decline for the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* measure indicator, which also fell below the 2014 performance target. Further, Amerigroup showed significant declines in five of the seven performance indicators reported as part of the *Oral Health (Annual Dental Visit)* measure.

Children's Health

Amerigroup's Children's Health performance measure results are shown in Table 4-7.

Table 4-7—Amerigroup Children's Health Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	63.59%	65.97%	↔	65.50%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Third, Fourth, Fifth, and Sixth Years of Life	72.98%	73.84%	↔	70.46%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	52.55%	53.01%	↔	50.20%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	80.56%	79.12%	↔	82.64%
Combination 6	41.20%	43.39%	↔	
Combination 10	37.73%	38.05%	↔	35.44%
Lead Screening in Children				
Lead Screening in Children	81.71%	78.70%	↔	75.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	78.14%	80.92%	↑	77.97%
Immunization for Adolescents				
Combination 1—Total	78.70%	80.20%	↔	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	47.92%	54.40%	↔	43.30%
Counseling for Nutrition—Total	54.63%	58.80%	↔	56.44%
Counseling for Physical Activity—Total	47.22%	53.47%	↔	43.05%
Developmental Screening in the First Three Years of Life				
Total	34.03%	38.19%	↔	45.00%

Table 4-7—Amerigroup Children's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	50.45%	53.21%	↑	58.00%
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	23.20%	24.13%	↑	31.50%
Upper Respiratory Infection				
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	83.78%	85.92%	↑	85.86%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014, with the exception of *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services*, which is October 1, 2013, through September 30, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

Amerigroup exceeded the 2014 performance targets for 11 of the 15 measures in the Children's Health measure set. Two measures exceeded the performance measure target and had significant improvement: *Appropriate Testing for Children with Pharyngitis* and *Appropriate Treatment for Children with URI.* Amerigroup made significant improvements in two of the measure rates that fell below the performance target, *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services.* None of the measures in this measure set showed significant decline.

Women's Health

Amerigroup's Women's Health performance measure results are shown in Table 4-8. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex, Cesarean Delivery Rate, Percentage of Live Births Weighing Less Than 2,500 Grams, and Early Elective Delivery*.

Table 4-8—Amerigroup Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	69.34%	66.40%	↔	76.64%
Breast Cancer Screening				
Breast Cancer Screening	75.70%	69.04%	↓	62.88%
Chlamydia Screening in Women				
Total	52.81%	56.96%	↑	57.25%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	21.53%	19.72%	↔	22.14%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	75.92%	79.02%	↔	89.72%
Postpartum Care	60.78%	62.94%	↔	70.20%
Cesarean Section for Nulliparous Singleton Vertex				
Cesarean Section for Nulliparous Singleton Vertex[4]	17.13%	NR	NT	15.23%
Cesarean Delivery Rate				
Cesarean Delivery Rate[4]	29.60%	28.59%	↔	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams				
Percentage of Live Births Weighing Less Than 2,500 Grams[4]	8.84%	8.87%	↔	7.99%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	1.43%	4.57%	↑	10.42%
Early Elective Delivery				
Early Elective Delivery[4]	5.11%	NR	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	0.79%	NR	NT	
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
81+ Percent	52.98%	48.02%	↔	73.97%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.

Table 4-8—Amerigroup Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
NR Indicates the CMO produced a rate that was materially biased or chose not to report results for this measure; therefore, the rates were not included in the performance calculation. The auditors confirmed that although Amerigroup calculated these measures properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population. NT Indicates that statistical significance testing was not performed due to the lack of an appropriate rate for CY 2014. ↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014. ↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014. ↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.				

Amerigroup's performance on most of the Women's Health measure rates did not change significantly. However, two measures exhibited significant improvement: *Chlamydia Screening in Women* and *Behavioral Health Risk Assessment for Pregnant Women*. *Chlamydia Screening in Women* almost met the 2014 performance target; however, *Behavioral Health Risk Assessment for Pregnant Women* fell well below the performance target. The performance measure rates for the *Cervical Cancer Screening, Timeliness of Prenatal Care, Postpartum Care,* and *Frequency of Ongoing Prenatal Care—≥81 Percent* also fell well below the 2014 performance targets. Although *Breast Cancer Screening* exhibited a significant decline in performance, this measure exceeded the 2014 performance target.

Chronic Conditions

Amerigroup's Chronic Conditions performance measure results are shown in Table 4-9. Note that a lower rate is better for the following performance measures: *HbA1c Poor Control (>9.0), Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months), Young Adult Asthma Admission Rate, COPD and Asthma Admission Rate—Total (Per 100,000 Member Months),* and *Congestive Heart Failure Admission Rate—Total (Per 100,000 Member Months).*

Table 4-9—Amerigroup Chronic Conditions Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	80.50%	85.37%	↑	87.32%
HbA1c Poor Control (>9.0)[4]	57.62%	58.54%	↔	43.02%
HbA1c Control (<8.0)	35.11%	35.02%	↔	48.57%
HbA1c Control (<7.0)	27.71%	25.21%	↔	34.76%
Eye Exam (Retinal) Performed	43.97%	46.86%	↔	54.43%
Medical Attention for Nephropathy	73.94%	76.66%	↔	79.28%

Table 4-9—Amerigroup Chronic Conditions Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Blood Pressure Control (<140/90 mm/Hg)	53.19%	36.93%	↓	60.93%
Diabetes Short-Term Complications Admission Rate				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]	12.80	14.87	NT	--
Respiratory Conditions				
Use of Appropriate Medications for People with Asthma				
Ages 5–11 Years	91.72%	92.99%	↔	
Ages 12–18 Years	87.32%	86.73%	↔	
Total	88.79%	89.23%	↔	89.76%
Young Adult Asthma Admission Rate				
Young Adult Asthma Admission Rate[4]	8.93	7.39	NT	--
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate				
COPD and Asthma Admission Rate—Total (Per 100,000 Member Months)[4]	36.77	37.71	NT	--
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate				
Congestive Heart Failure Admission Rate—Total (Per 100,000 Member Months)[4]	6.21	6.44	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	48.36%	29.07%	↓	56.20%
Adult BMI Assessment				
Adult BMI Assessment	79.53%	66.51%	↓	78.71%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NT Indicates that statistical significance testing was not performed.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.
-- Indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2013 and CY 2014, and previous years were reported as per 100,000 members. Since the 2014 performance target was developed based on previous years' reporting metrics, the 2014 performance target is not presented and caution should be used if comparing the CY 2014 rate to the 2014 performance target for this measure.

None of Amerigroup's Chronic Conditions measure rates met the 2014 performance targets, although its rate for *Use of Appropriate Medications for People with Asthma* almost met the performance target. Of note, the rate for *Comprehensive Diabetes Care (CDC)—HbA1c Testing* improved significantly, by nearly 5 percentage points, but still did not meet the 2014 performance target. Performance on three Chronic Conditions measures worsened significantly and fell well below the 2014 performance target: *CDC—Blood Pressure Control (<140/90 mm Hg)*, *Controlling High Blood Pressure*, and *Adult BMI Assessment*.

Behavioral Health

Amerigroup's Behavioral Health performance measure results are shown in Table 4-10.

Table 4-10—Amerigroup Behavioral Health Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	43.12%	45.04%	↔	51.86%
Continuation and Maintenance Phase	59.22%	59.36%	↔	63.75%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	50.85%	51.01%	↔	68.79%
Follow-Up Within 30 Days	72.40%	70.29%	↔	81.98%
Antidepressant Medication Management				
Effective Acute Phase Treatment	48.76%	46.99%	↔	56.17%
Effective Continuation Phase Treatment	34.39%	31.83%	↔	40.17%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	0.75%	2.33%	↔	
Adherence to Antipsychotics for Individuals with Schizophrenia				
Adherence to Antipsychotics for Individuals with Schizophrenia	45.76%	44.57%	↔	61.34%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

None of Amerigroup's Behavioral Health measure rates met the 2014 performance targets or exhibited significant changes in performance. In addition, both indicators within the *Follow-Up After Hospitalization for Mental Illness* measure were below the 2014 performance target by more than 10

percentage points. The *Adherence to Antipsychotics for Individuals with Schizophrenia* rate was more than 15 percentage points below the 2014 performance measure target.

Medication Management

Amerigroup's Medication Management performance measure results are shown in Table 4-11. Note that a lower rate is better for the *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* performance measure.

Table 4-11—Amerigroup Medication Management Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 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[4]	40.94%	39.10%	↑	39.06%
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	89.61%	88.67%	↔	
Diuretics	89.74%	89.47%	↔	
Total	88.42%	88.86%	↔	
Medication Management for People with Asthma				
Medication Compliance 50%—Ages 5–11 Years	48.59%	47.33%	↔	
Medication Compliance 50%—Ages 12–18 Years	46.26%	42.68%	↔	
Medication Compliance 50%—Ages 19–50 Years	53.52%	50.00%	↔	
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	
Medication Compliance 50%—Total	47.81%	45.73%	↔	
Medication Compliance 75%—Ages 5–11 Years	22.88%	21.27%	↔	29.46%
Medication Compliance 75%—Ages 12–18 Years	22.18%	19.60%	↔	
Medication Compliance 75%—Ages 19–50 Years	21.13%	21.43%	↔	
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	
Medication Compliance 75%—Total	22.59%	20.80%	↔	

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

Table 4-11—Amerigroup Medication Management Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**

[2] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NA Indicates that the rate was withheld because the denominator was less than 30.
NT Indicates that statistical significance testing was not performed due to suppression of rates with a denominator less than 30.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

None of Amerigroup's Medication Management measure rates met the 2014 performance targets. However, one measure improved significantly, *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions*, and nearly met the 2014 performance target.

Utilization

Amerigroup's Utilization performance measure results are shown in Table 4-12. Note that a lower rate is better for the *Ambulatory Care (Per 1,000 Member Months)—ED Visits* performance measure. Significance testing was not performed on the Utilization measure set since variances are not reported to NCQA.

Table 4-12—Amerigroup Utilization Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Ambulatory Care (Per 1,000 Member Months)				
ED Visits[4]	58.54	56.83	NT	53.98
Outpatient Visits	345.73	314.23	NT	
Inpatient Utilization— General Hospital/Acute Care				
Total Inpatient Average Length of Stay	3.32	3.42	NT	
Total Medicine Average Length of Stay	3.67	3.62	NT	
Total Surgery Average Length of Stay	7.05	7.96	NT	
Total Maternity Average Length of Stay	2.75	2.70	NT	
Mental Health Utilization				
Any Services—Total	8.75%	9.14%	NT	
Inpatient Services—Total	0.47%	0.52%	NT	
Intensive Outpatient Services—Total	0.13%	0.14%	NT	

Table 4-12—Amerigroup Utilization Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Ambulatory/ED Visits—Total	8.65%	9.04%	NT	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NT Indicates that statistical significance testing was not performed.

Although significance testing was not performed, Amerigroup's rate for *Ambulatory Care (Per 1,000 Member Months)—ED Visits* showed improvement, but it did not meet the 2014 performance target.

Strengths and Weaknesses

The number of performance targets met by Amerigroup is shown in Table 4-13.

Table 4-13—Number of Performance Targets Met by Amerigroup			
Measure Set	**Number of Measures With Performance Target***	**Number of Measures That Met Performance Target**	**Percentage of Targets Met**
Access to Care	6	1	**16.7%**
Children's Health	15	11	**73.3%**
Women's Health	10	2	**20.0%**
Chronic Conditions	10	0	**0.0%**
Behavioral Health	7	0	**0.0%**
Medication Management	2	0	**0.0%**
Utilization	1	0	**0.0%**
Total	51	14	**27.5%**

**Excludes measures that were not comparable to performance targets.*

Based on Amerigroup's 2014 performance, Amerigroup met 27.5 percent of its performance targets overall. Performance measure targets were met in the Access to Care, Children's Health, and Women's Health measure sets only. HSAG has highlighted specific strengths and areas for improvement below.

Amerigroup's greatest strength was in the care it provided to children and adolescents. As illustrated in Table 4-13 above, over 73 percent of the measures in the Children's Health measure set exceeded the 2014 performance measure target. Notably, over 90 percent of children and adolescents visited PCPs at least once during the year, with 97 percent of children ages 12 to 24 months having at least

one visit. In addition, Amerigroup exceeded the 2014 performance targets by more than 10 percentage points in the areas of weight assessment and counseling for physical activity. Amerigroup showed significant improvement by more than 13 percentage points and exceeded the 2014 performance target by more than 9 percentage points for initiating alcohol and drug dependence treatment.

Although Amerigroup performed well in the Children's Health measure set, a review of dental measures across both the Children's Health and Access to Care measure sets indicated that the CMO needs to establish methods to improve in this area since none of these performance measures met the 2014 performance targets. However, two of the indicators, *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services*, demonstrated significant improvement.

Measures related to Women's Health presented several opportunities for improvement as only two of the 10 measures met the performance measure targets. One of the measures, *Breast Cancer Screening*, met the 2014 performance target but showed a significant decline from 2013 to 2014. Less than half of Amerigroup's pregnant members received at least 81 percent of the recommended prenatal care visits, which was more than 25 percentage points below the 2014 performance target.

Amerigroup did not meet any 2014 performance targets for the Chronic Conditions, Behavioral Health, Medication Management, or Utilization measure sets. The following measures showed significant decline in performance:

- Measures of blood pressure control for members with diabetes and cardiovascular conditions showed significant declines from 2013 to 2014 and fell short of the 2014 performance targets by more than 20 percentage points.
- The percentage of adults with a documented BMI assessment significantly declined from 2013 to 2014, which was more than 12 percentage points below the 2014 performance target.

Approximately 50 percent of members hospitalized for mental illness had a follow-up visit within seven days of discharge, which was more than 17 percentage points below the 2014 performance target. Despite low performance in 2013 for this and other behavioral health measures, these rates remained relatively unchanged in 2014.

Recommendations for Improvement

Amerigroup performed well in the Children's Health measure set; however, all other measure sets require innovative, targeted interventions to improve performance. Therefore, HSAG recommends the following:

- Amerigroup should analyze the improvement strategies that can be linked to the overall success with the Children's Health measure set. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.
- Amerigroup currently has rapid cycle PIPs in place which are related to some of the performance measures. Amerigroup should continue to assess the impact of its PIPs on related

measures and refine its rapid cycle approach to positively impact health outcomes for its membership.

- Amerigroup should analyze all performance measure rates that fell below the DCH-required target and either implement new PIPs or adjust the focus of existing PIPs as needed.
- Amerigroup should prioritize focusing on performance measures that had a statistically significant decline, such as oral health measures and breast cancer screening.

In addition to the specific recommendations above, Amerigroup should focus efforts on the following measure topics in its quality improvement efforts.

Access to Care and Children's Health

- Pediatric and adolescent dental care (2 to 21 years)

Women's Health

- Women's health vaccination and screenings
- Prenatal and postpartum care

Chronic Conditions

- Comprehensive diabetes care
- Blood pressure control for members with diabetes and cardiovascular conditions

Behavioral Health

- Behavioral health and timely follow-up visits following a mental health-related hospital discharge

CAHPS Surveys

Findings

To assess the overall performance of Amerigroup, HSAG compared the calculated question summary rates for each global rating and global proportions for each composite measure (i.e., the percentage of respondents offering a positive response) to 2015 NCQA national Medicaid averages, where applicable.[4-2] The calculated question summary rates and global proportions represent the percentage of top-level responses (i.e., CAHPS top-box scores) for each global rating and composite measure, respectively. Comparisons of the 2015 CAHPS top-box scores to 2015 NCQA national Medicaid data were performed for Amerigroup's adult and child Medicaid populations.[4-3] Further, for Amerigroup's

[4-2] Quality Compass® 2015 data serve as the source for the NCQA national averages contained in this publication and are used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[4-3] The CAHPS Survey results presented throughout this section for Amerigroup are the CAHPS Survey measure results calculated by the CMO's survey vendor and provided to HSAG for purposes of reporting.

CMO-specific findings, a substantial difference is noted when a CAHPS Survey measure's rate is 5 percentage points higher or lower than the 2015 NCQA national average. Additional methodology information can be found in Appendix D.

The four global rating measures and five composite measures evaluated through the CAHPS surveys are as follows:

CAHPS Global Rating Measures:

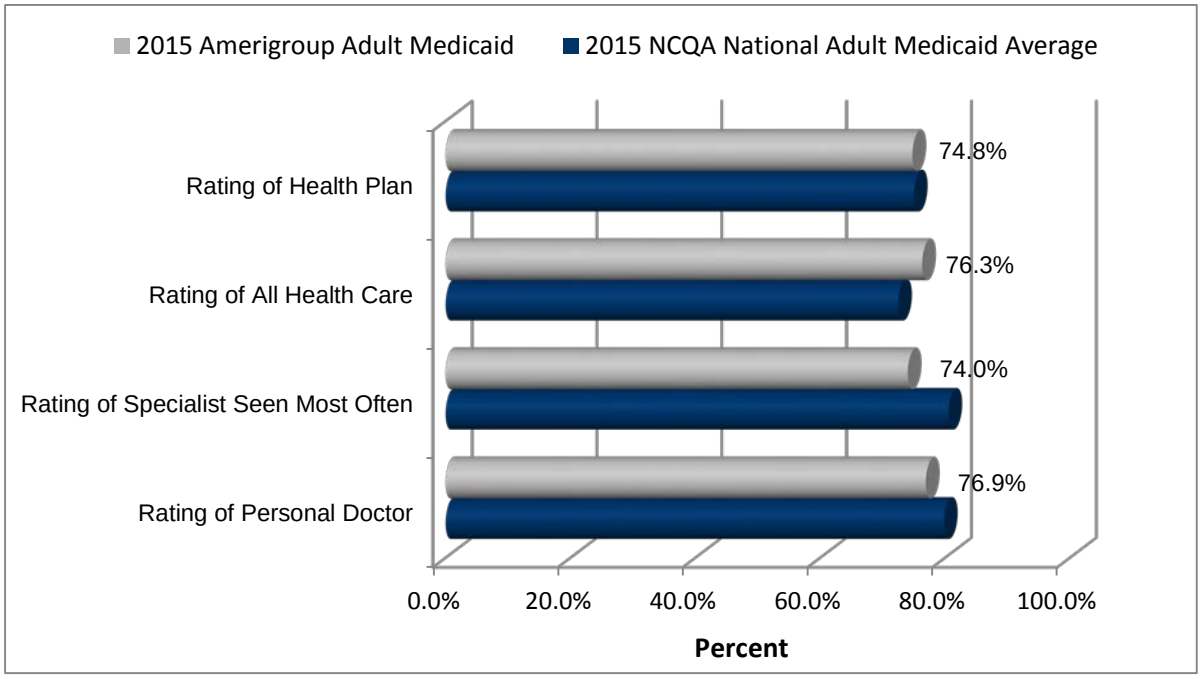
- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Personal Doctor*

CAHPS Composite Measures:

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

Figure 4-7 below depicts Amerigroup's adult Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national adult Medicaid average for each of the global ratings. The grey bars represent Amerigroup's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 4-7—Amerigroup Adult Medicaid CAHPS Survey Results for Global Ratings

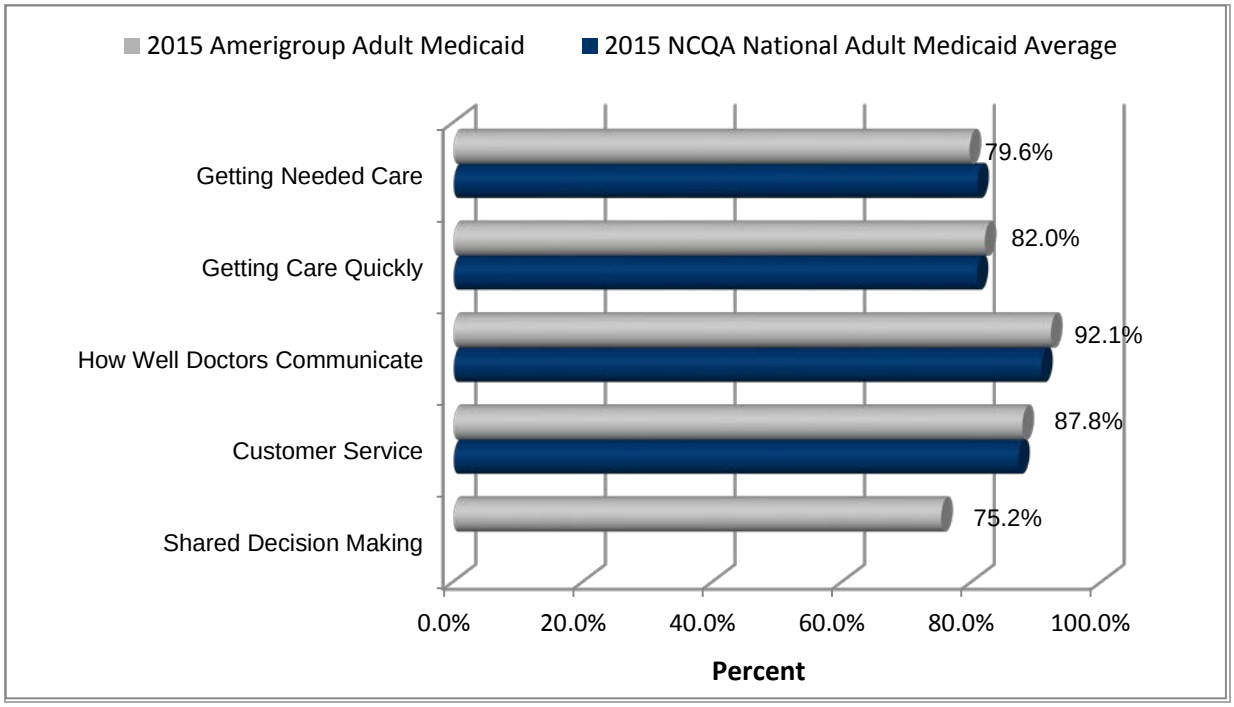


The top-box scores for the adult Medicaid global ratings indicate the following:

- Amerigroup scored between 74 and 77 percent on all four global rating measures.
- Amerigroup scored at or above the 2015 NCQA national adult Medicaid average for one measure—*Rating of All Health Care*.
- Amerigroup scored below the 2015 NCQA national adult Medicaid average for the remaining three measures—*Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.

Figure 4-8 below depicts Amerigroup's adult Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national adult Medicaid average for each of the composite measures. The grey bars represent Amerigroup's top-box scores and the blue bars represent the 2015 NCQA national averages

Figure 4-8—Amerigroup Adult Medicaid CAHPS Survey Results for Composite Measures



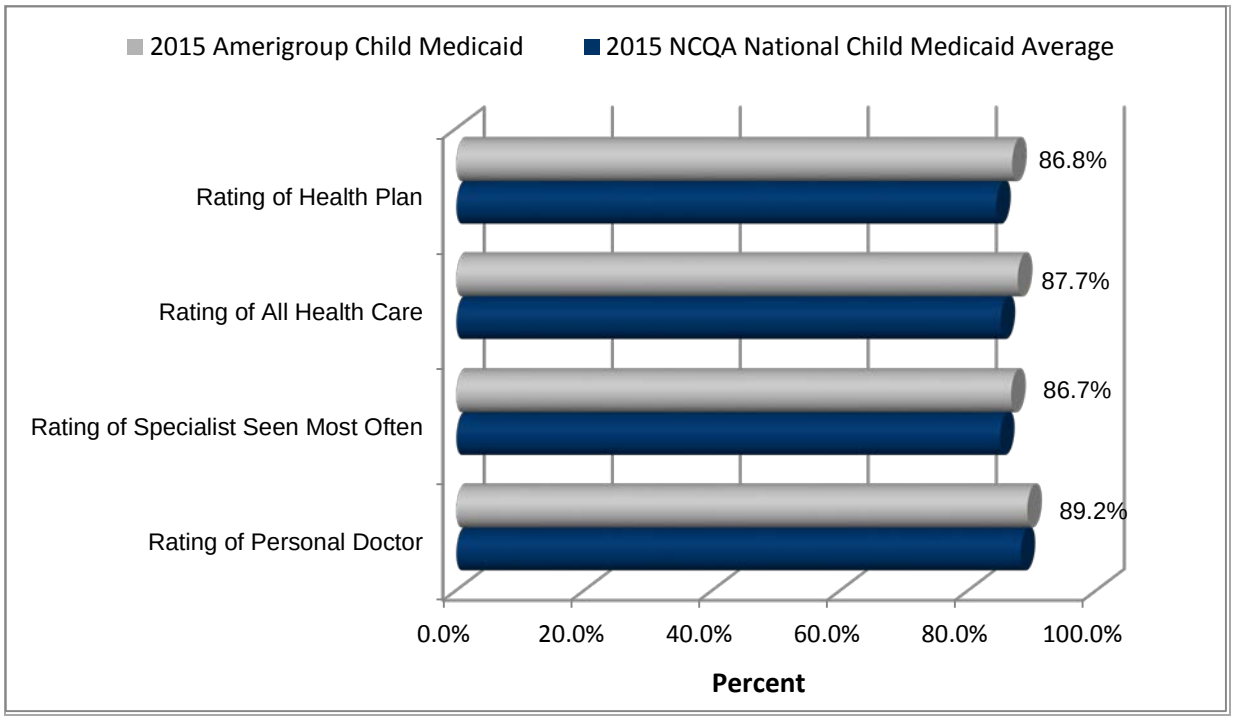
Please note: Due to changes to the Shared Decision Making composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015

The top-box scores for the adult Medicaid composite measures indicate the following:

- Amerigroup scored between 75 and 92 percent on the five composite measures.
- Amerigroup scored at or above the 2015 NCQA national adult Medicaid average for three measures—*Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.
- Amerigroup scored below the 2015 NCQA national adult Medicaid average for one measure—*Getting Needed Care*.

Figure 4-9 below depicts Amerigroup's child Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national child Medicaid average for each of the global ratings. The grey bars represent Amerigroup's top-box scores and the blue bars represent the 2015 NCQA national averages

Figure 4-9—Amerigroup Child Medicaid CAHPS Survey Results for Global Ratings

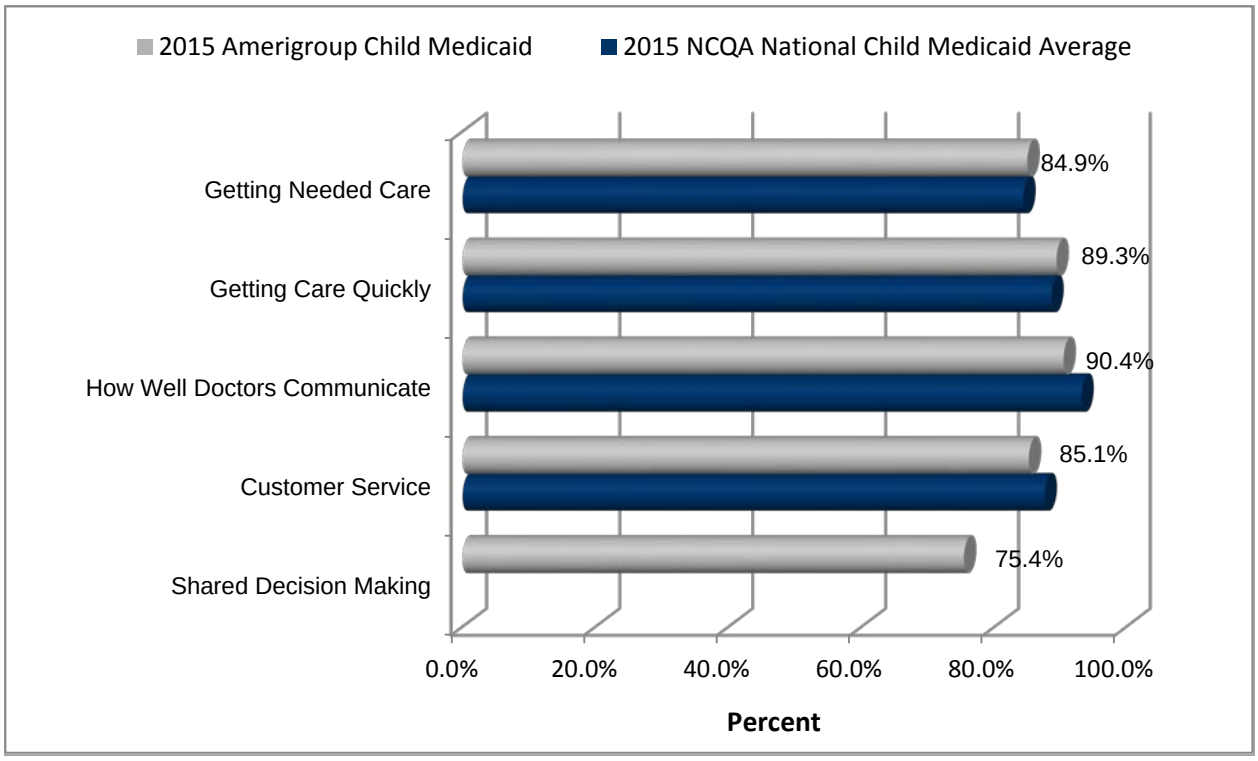


The top-box scores for the child Medicaid global ratings indicate the following:

- Amerigroup scored between 87 and 89 percent on all four global rating measures.
- Amerigroup scored at or above the 2015 NCQA national child Medicaid average for all four measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.
- Amerigroup did not score below the 2015 NCQA national child Medicaid average for any of the global rating measures.

Figure 4-10 below depicts Amerigroup's child Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national child Medicaid average for each of the composite measures.[4-4] The grey bars represent Amerigroup's top-box scores and the blue bars represent the 2015 NCQA national averages.

Figure 4-10—Amerigroup Child Medicaid CAHPS Survey Results for Composite Measures



The top-box scores for the child Medicaid composite measures indicate the following:

- Amerigroup scored between 75 and 90 percent on the five composite measures.
- Amerigroup scored at or above the 2015 NCQA national child Medicaid average for two measures—*Getting Needed Care* and *Getting Care Quickly*.
- Amerigroup scored below the 2015 NCQA national child Medicaid average for two measures—*How Well Doctors Communicate* and *Customer Service*.

Strengths and Weaknesses

For Amerigroup's adult Medicaid population, the 2015 top-box rates for four of the eight comparable CAHPS Survey measures, *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care*, were lower than the 2015 NCQA adult Medicaid national average. Further, the top-box rate for *Rating of Specialist Seen Most Often* was lower than the 2015 NCQA adult Medicaid national average by 5 percentage points or more. For the remaining four measures, *Rating of All Health Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and

[4-4] As previously noted, due to changes to the *Shared Decision Making* composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

Customer Service, Amerigroup's 2015 top-box rates were higher than the 2015 NCQA adult Medicaid national averages.

For Amerigroup's child Medicaid population, the 2015 top-box rates for two of the eight comparable CAHPS Survey measures, *How Well Doctors Communicate* and *Customer Service*, were lower than the 2015 NCQA child Medicaid national average. For the remaining six comparable measures, *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly*, the 2015 top-box rates for the child population were higher than the 2015 NCQA child Medicaid national average.

Recommendations for Improvement

Based on an evaluation of Amerigroup's 2015 adult Medicaid CAHPS Survey results, HSAG recommends that the CMO focus quality improvement (QI) initiatives on enhancing members' experiences with *Rating of Health Plan*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Getting Needed Care*, since the rates for these measures were lower than NCQA's 2015 CAHPS adult Medicaid national average. For Amerigroup's child Medicaid population, HSAG recommends that the CMO focus QI initiatives on *How Well Doctors Communicate* and *Customer Service*, given that the rates for these measures were below the 2015 NCQA national child Medicaid average.

HSAG has made general recommendations based on the information found in the CAHPS literature. (See Appendix G for an explanation of these recommendations.) The recommendations are intended to address those areas for which CAHPS measure scores were lower than the NCQA national Medicaid average.

Amerigroup should conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network. HSAG recommends that the CMO review the CAHPS literature and other relevant sources to assist with developing applicable interventions and process improvement activities.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about Amerigroup's performance in providing quality, accessible, and timely healthcare and services to its members. Overall, HSAG's evaluation showed that Amerigroup has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The CMO demonstrated moderately strong compliance review results (93 percent of federal and contract requirements for structure and operations were *Met*) and overall member satisfaction with the care members received (*Rating of All Health Care* exceeded the Medicaid national average). The CMO's quality measurement and performance improvement processes also demonstrated strength, with Amerigroup's achievement of *High Confidence* and measureable, meaningful, sustained improvement on two of its six rapid cycle performance improvement projects—the only CMO to do so. Amerigroup showed improved outcomes and success in meeting or exceeding the quality targets established for more than 73 percent of performance

indicators in the area of children's health. Going forward, Amerigroup is well positioned to capitalize on these strengths and continue to achieve improved outcomes in additional areas of care and service.

In addition, two key themes emerged in HSAG's assessment of Amerigroup's overall performance, indicating significant opportunities for improvement in these areas. While a variety of other findings also indicate a need for improvement, HSAG advises the CMO to focus its quality initiatives on key areas with interrelated findings. Concentrated improvement efforts that achieve success in these areas can be spread, with greater potential to also affect performance in other similar population/program areas over time. These areas, and resulting recommendations, are described below and include:

- Network sufficiency.
- Care for members with chronic conditions.

Network Sufficiency

Although members' perception of providers' availability and the care they provide was relatively positive (Child CAHPS Survey results for *Getting Needed Care* and *Getting Care Quickly* and Adult CAHPS Survey results for *Getting Care Quickly* exceeded the Medicaid national averages), the CMO's performance in the HEDIS measure domain of access to care showed that less than 17 percent of access indicators met DCH's targets. Moreover, during the two most recent reviews of compliance, Amerigroup did not meet certain provider access and availability requirements (to ensure providers return calls after-hours within the appropriate time frames) or minimum geographic access standards in both urban and rural areas (to ensure adequate provider coverage for appointments with and access to primary care physicians, specialists, dental subspecialty providers, mental health providers, and pharmacies).

The CMO should investigate whether inadequate availability of PCPs and dental providers is among the key drivers of Amerigroup's poor performance, as evidenced by an increasing rate of avoidable ER visits over a six-month period (a current PIP) and decreasing rates of adults' access to preventive care and annual dental visits for children (performance measure results with comparison to prior year measurement period). Additional barrier analysis regarding provider availability and access issues would provide the CMO with information it could use to select appropriate interventions that may result in improved performance in these areas. For example, if appointment availability was assessed as a driver, the CMO could evaluate whether extended-hours and "immediate care" in-office appointments might be implemented in select offices in each geographic area. Improvement activities of this nature have the potential of increasing both access and timely provision of an appropriate level of care, as well as preventing avoidable use of emergency services.

The DCH has recently implemented a centralized credentialing process for providers, contracting with a credentials verification organization, with a goal of preventing unnecessary duplication and reducing individual provider and CMO burden for credentialing shared providers. This initiative has promise for improving provider participation in CMO networks, thereby potentially improving access, if providers' participation was hindered by the requirement to complete duplicate credentialing processes across the CMOs. Future provider surveys could be used to assess provider opinions about satisfaction with this new, centralized process.

In addition, through its contracts with the CMOs and as an effort to reform and improve the delivery system, DCH promotes the implementation of patient-centered medical homes. In part, this evidence-based approach furthers the goal of effective management of chronic conditions to achieve improved quality and health outcomes, including dental and mental health outcomes. Through use of the medical/dental home model, there is also increased likelihood of improved member access to appropriate healthcare and services, and member perceptions and satisfaction may also improve. On its most recent adult consumer survey, Amerigroup scored below the NCQA national average for four such measures of satisfaction, including *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, and *Getting Needed Care*.

Care for Members With Chronic Conditions

Amerigroup's performance on the group of measures related to care for chronic conditions demonstrated that it did not meet any of DCH's targets on any of the indicators, and also had the lowest performance rates of the three CMOs in this domain. In addition, for at least two successive years Amerigroup did not meet the required level of provider adherence to clinical practice guidelines (CPGs), scoring below the target of 90 percent. CPGs are required for certain chronic conditions, such as care for ADHD, diabetes, and asthma, to ensure providers maintain quality care and services at a level consistent with current best and proven practices and to achieve desired health outcomes.

While Amerigroup has disease management (DM) programs for an array of chronic conditions, findings from a case and disease management study performed by HSAG in 2014 revealed that the CMO may not be adequately engaging members, parents/caregivers, and providers during the treatment planning process that follows the assessment for participation in the DM program. This is further supported by member perception of *Shared Decision Making*, as Amerigroup scored the lowest of the three CMOs on this CAHPS measure. Member engagement in treatment planning decisions is important to ensure treatment adherence and member empowerment to participate as a partner in healthcare practices, especially disease self-management.

Although Amerigroup's *Appropriate Use of ADHD Medications* PIP interventions did show promise for ADHD CPG adherence, the CMO's *Comprehensive Diabetes Care* PIP failed to show sustained improvement in member self-management. Results of related HEDIS diabetes measure indicators (*HbA1c Control*) further support that the member and/or provider interventions did not appear to be effective. HSAG strongly recommends that Amerigroup revisit the causal/barrier assessment process to determine key drivers of its low performance in the area of care and management of chronic conditions. This assessment should target key impact areas and health plan processes in the CMO's DM programs (member engagement, member education, and case management) and for its CPGs for chronic conditions (dissemination to and adherence by providers). The CMO should discover, through drill-down analysis of member and provider data, specific areas for maximum impact and interventions for future rapid cycle improvement testing.

Conclusions

Overall, although Amerigroup's performance results indicate some areas of strength, they are mixed. With certain exceptions in children's health outcomes, the CMO must implement mechanisms to

improve quality, access, and timeliness of care for its members. Amerigroup should continue to assess areas for targeted interventions in care for chronic conditions and to improve access to care through maintaining an adequate provider network. The CMO should ensure that its methodologies for determining and tracking any measureable improvements are sound and can be relied upon to link the success of its interventions to the improved outcome. Amerigroup should further ensure that it integrates a review of the related organizational and operational processes as part of its continuous quality improvement efforts.

The CMO's quality assessment and performance improvement (QAPI) plan and process must provide a comprehensive roadmap for the organization's priorities for improvement, include the timelines and steps it will take, and provide for sufficient monitoring and tracking of results. HSAG has provided recent, formal quality improvement technical assistance to the CMOs, and DCH has provided written guidance and reporting requirements for the CMOs' annual QAPI evaluation process. Amerigroup should use these tools and request additional process improvement assistance as needed to move its quality program toward success.

Plan Overview

Peach State Health Plan (Peach State) is part of a 23-state parent company, Centene Corporation. In Georgia, Peach State serves more than 380,000 GF members.[5-1] The DCH held a contract with Peach State during the review period and Peach State 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, case and disease management and education, and wellness/prevention programs.

Review of Compliance With Standards

Findings

Table 5-1 presents the standards and compliance scores for Peach State. For Standards I–VI, HSAG evaluated a total of 100 elements for the SFY 2015 review period. Each element was scored as *Met* or *Not Met*. A compliance score was calculated per standard as well as an overall compliance score for all standards.

Table 5-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# *Met*	# *Not Met*	Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	**10**	**10**	**0**	**100.0%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**0**	**100.0%**
IV	Member Information	**20**	**18**	**2**	**90.0%**
V	Grievance System	**47**	**43**	**4**	**91.5%**
VI	Disenrollment Requirements and Limitations	**10**	**10**	**0**	**100.0%**
	Total Number of Elements	**100**	**94**	**6**	
	Total Compliance Score				**94.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**25**	**21**	**4**	**84.0%**

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

***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.

[5-1] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report. August 2015.

Peach State had a total compliance score of 94 percent, with four standards scoring 100 percent: Provider Selection, Credentialing and Recredentialing; Subcontractual Relationships and Delegation; Member Rights and Protections; and Disenrollment Requirements and Limitations.

Peach State scored 90 percent or higher in the two remaining standards: Member Information and Grievance System. Member Information had two *Not Met* elements while Grievance System had four *Not Met* elements.

HSAG also reviewed documentation provided by Peach State to determine whether the CMO had met the intent of the corrective action plans DCH had approved for *Not Met* elements from the previous noncompliant review findings. Twenty-five elements were re-reviewed within the following standards: Coordination and Continuity of Care, Coverage and Authorization of Services, Emergency and Poststabilization Services, Furnishing of Services, and Quality Assessment and Performance Improvement. All elements related to Coordination and Continuity of Care, Coverage and Authorization of Services, and Emergency and Poststabilization Services were *Met* upon reevaluation. Four elements within the remaining standards require continued corrective action.

Strengths and Weaknesses

Below is a discussion of the strengths and areas for improvement, by standard, that were identified during the compliance review.

Provider Selection, Credentialing, and Recredentialing: Peach State maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities were performed according to industry and State requirements. Peach State monitored providers to ensure the provision of quality care. When quality issues were identified, the CMO implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status. During the on-site audit, HSAG reviewed 10 credentialing files and 10 recredentialing files. All files reviewed were identified as compliant with all case review elements.

Subcontractual Relationships and Delegation: Peach State identified a delegation designee who worked with the corporate delegation designee to review "national delegates" providing services for the CMO. The CMO's designee was responsible for providing findings and recommendations to the appropriate staff and committees, as well as monitoring the delegates' performance on an ongoing basis. The CMO documented annual monitoring of delegate performance that outlined findings and any identified deficiencies.

Member Rights and Protections: Peach State had several mechanisms to inform members of their rights and responsibilities, such as the member handbook and CMO website. Member rights were also included in the provider manual as a method to keep providers informed regarding member rights.

Member Information: Member handbooks were provided to Peach State's members upon enrollment and were available online and in alternative formats. The DCH confirmed that for existing members the CMO is required to inform members via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request. Although Peach State was in compliance with this requirement, the policies submitted for review did not reflect actual practice. In addition, although DCH granted Peach State a waiver from providing a hard copy provider

directory to newly enrolled members, the Distribution of Member Handbook policy and procedure indicated that Peach State provided all new members a provider directory with the new member packet and therefore did not reflect actual practice.

Grievance System: Peach State had designated staff at the local level who demonstrated a comprehensive understanding of the grievance system process. Although Peach State had detailed policies and procedures regarding grievances, administrative reviews, and administrative law hearings, in some instances, the CMO's documents contained inaccurate or conflicting information. For example, the grievance acknowledgment letter contained a statement that Peach State may exceed the 90-day time frame to resolve a grievance.

During the on-site visit, HSAG reviewed 10 grievance files and 10 appeal files. All cases were compliant with the applicable timeliness requirements. However, the appeal resolution letters for upheld denials were not written in a manner that could be easily understood. In some instances the rationale portion of the letter contained advanced medical terminology or a direct copy of the clinical reviewer's notes. Two grievance records contained resolution letters that did not address all issues contained in the members' original complaints.

Disenrollment Requirements and Limitations: Peach State ensured that members could request disenrollment for cause at any time and provided assistance to members to coordinate disenrollment with DCH.

Recommendations for Improvement

Peach State received recommendations for improvement in the standard areas of Member Information and Grievance System; four of the recommendations were within the Grievance System standard. HSAG's specific recommendations for Peach State are to:

- Review its grievance system policies, procedures, and other documents to ensure consistency in the grievance system information available to members and providers.
- Ensure that all documents accurately provide members access to the appeal process when Peach State fails to meet required time frames for resolution of grievances and appeals.
- Ensure that the rational for upholding a denial is written in easily understood language in the appeal resolution letters.
- Ensure that grievance resolution letters address all issues identified by the member in his/her complaint.
- Update its applicable policies to include a description of how the CMO notifies existing members that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy must also reflect how often existing members receive the notice.
- Update its applicable policies to reflect the CMO's practice regarding informing members of the availability of the provider directory.

Follow-Up Review: HSAG also conducted a follow-up review of the previous compliance review findings. Four reevaluated elements within the Furnishing of Services and Quality Assessment and Performance Improvement standards will require continued corrective action as follows:

- Peach State must address timely access issues to ensure providers return after-hours calls within the appropriate time frames. Urgent calls must be returned within 20 minutes and other calls within one hour.
- Peach State must meet the minimum geographic access requirements in both rural and urban areas. Specifically, the CMO must have sufficient provider coverage for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies.
- Peach State must meet the DCH-established targets for all performance measures. The CMO should evaluate the effectiveness of its interventions and apply new interventions as needed.
- Peach State must continue to evaluate the effectiveness of its QAPI program. The CMO should also ensure that it measures the effectiveness of the initiatives designed to improve the quality of care provided to its membership, assesses its evaluation methods, and implements modifications as needed.

Performance Improvement Projects

Findings

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 outcomes.

Rapid Cycle PIP Validation Results

Six of Peach State's eight PIPs were validated following the new rapid cycle methodology. Please refer to Appendix B, Methodology for Conducting Validation of Performance Improvement Projects, for a detailed discussion regarding the rapid cycle PIP validation process and a description of HSAG's scoring criteria.

The overall validation findings (confidence levels) for the rapid cycle PIPs are presented in Table 5-2. HSAG's findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*.

Table 5-2—Rapid Cycle Performance Improvement Project Validation Findings for Peach State Health Plan

PIP	Confidence Level
Annual Dental Visits	*Low Confidence*
Appropriate Use of ADHD Medications	*Low Confidence*
Avoidable Emergency Room Visits	*Low Confidence*
Bright Futures	*Confidence*
Comprehensive Diabetes Care	*Confidence*
Postpartum Care	*Low Confidence*

HSAG did not assign a level of *High Confidence* to any of Peach State's rapid cycle PIPs. HSAG determined *Confidence* in the quality improvement processes and outcomes for two of the six PIPs, *Bright Futures* and *Comprehensive Diabetes Care*. The remaining four PIPs were assigned a *Low Confidence* level due to lack of meaningful improvement.

Rapid Cycle PIP-Specific Outcomes

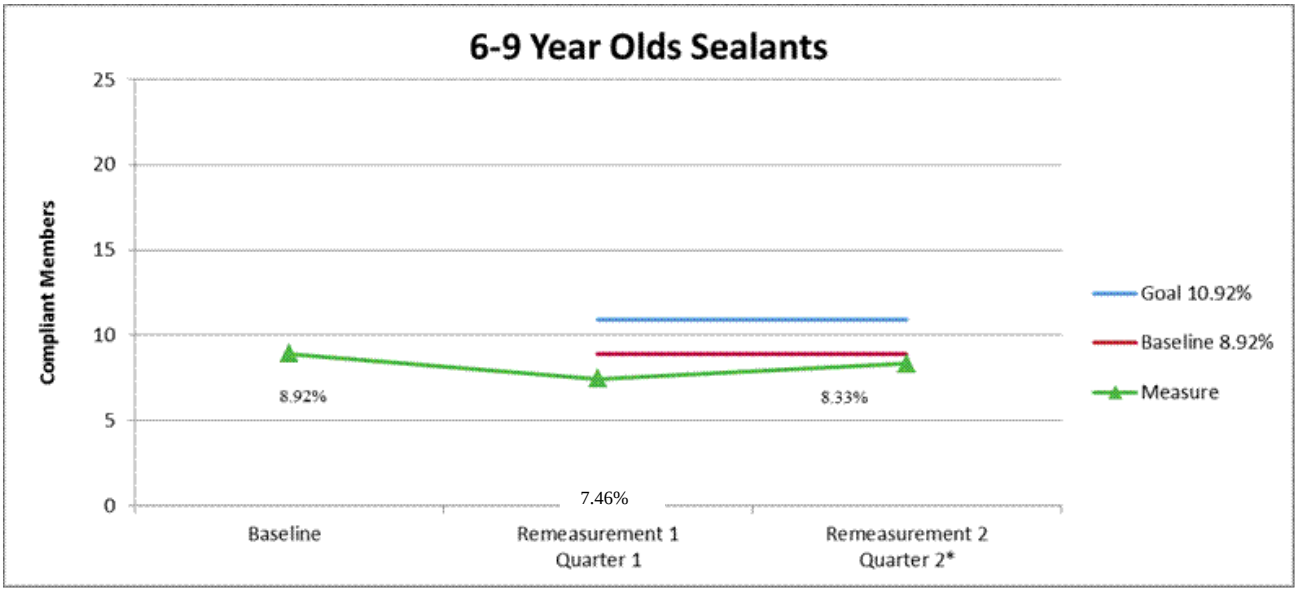
Peach State developed a SMART Aim statement and a SMART aim measure for each rapid cycle PIP. Figure 5-1 through Figure 5-6 are run charts displaying the SMART Aim measurements for the rapid cycle PIPs, including the baseline and goal rates for each measure. The figures were constructed and submitted by Peach State as part of the PIP submissions; HSAG copied the figures for the purpose of reporting the PIP outcomes and did not alter the figures in any way.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements in comparison with reported baseline and goal rates. The data displayed in the SMART Aim run charts were used to determine whether each PIP demonstrated meaningful and sustained improvement in the SMART Aim measure.

A detailed discussion of Peach State's performance on each rapid cycle PIP, which includes the CMO's interventions and activities, is provided in the Performance Improvement Project Summary Grid in Appendix E. The grid also includes HSAG's recommendations to Peach State to improve performance.

Annual Dental Visits

Figure 5-1—SMART Aim Run Chart for *Annual Dental Visits*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Annual Dental Visits* PIP. For this PIP, Peach State established the baseline sealant rate for 6-to-9-year-olds (8.9 percent) assigned to one targeted provider based on the baseline measurement period of January through June 2014. The CMO set a goal of 10.9 percent for the eligible members assigned to the targeted provider, an increase

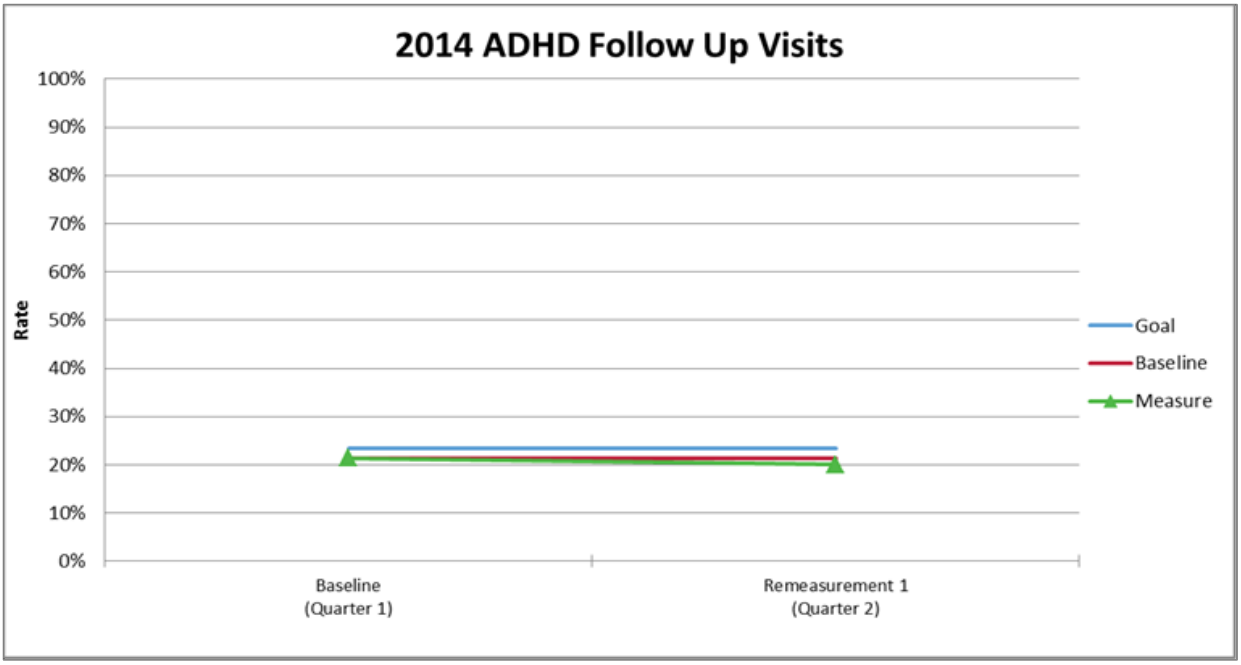
of 2 percentage points. The run chart included two quarterly remeasurements following the baseline measurement. The PIP's SMART Aim measure did not meet the goal; therefore, there was no evidence of meaningful or sustained improvement. The second remeasurement was 0.6 percentage point below the baseline rate.

Peach State used a key driver diagram to summarize key drivers and potential interventions considered for the *Annual Dental Visits* PIP. The CMO tested four interventions with one targeted dental provider office. The interventions were both provider- and member-focused. The CMO doubled the reimbursement rate for sealant placement for eligible members among all dental providers, including the targeted provider. The CMO also sent the targeted provider eligible member rosters and requested that the dental provider reach out to members to schedule sealant/preventive service appointments. Peach State's dental vendor, DentaQuest, implemented the member-based interventions, which included educational mailings on the importance of dental sealants sent to Peach State members and automated calls to eligible members, promoting the scheduling and keeping of preventive dental appointments.

Because the CMO saw an increase in the aggregate annual dental sealant rate across all providers from 2013 to 2014, after the reimbursement rate for sealants was doubled, Peach State concluded that financial provider incentives were an effective improvement strategy. Additionally, Peach State concluded that, for financial incentives to reach their full potential as improvement strategies, it is crucial to implement the incentive early in the PIP, and to clearly communicate the incentive to providers in a timely manner to raise awareness and increase provider participation.

Appropriate Use of ADHD Medications

Figure 5-2—SMART Aim Run Chart for *Appropriate Use of ADHD Medications*



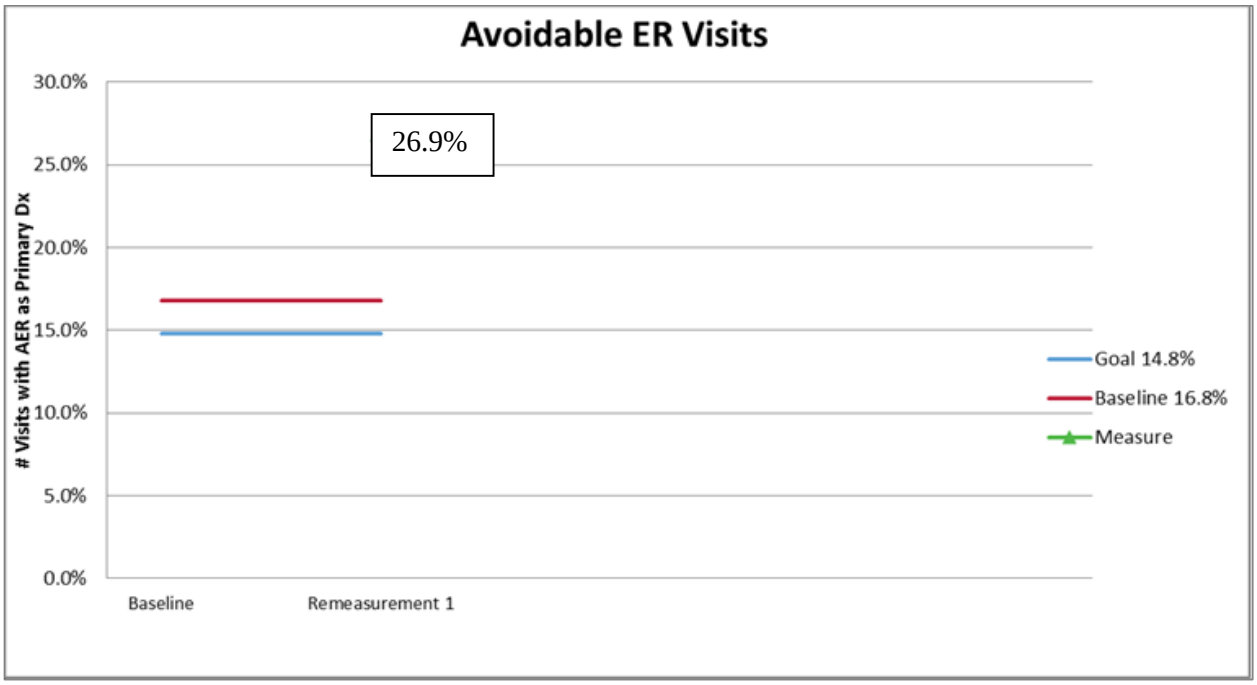
HSAG assigned a level of *Low Confidence* to the validation findings for the *Appropriate Use of ADHD Medications* PIP. For this PIP, Peach State established the baseline rate of 21.4 percent for the three targeted PCPs based on third quarter 2014 data (July through September). The CMO set a goal for the three targeted PCPs of a 2 percentage point increase over baseline, or 23.4 percent. The CMO's run chart included one quarterly remeasurement, which fell 1.4 percentage points below the baseline measurement. Because the goal was not achieved at the remeasurement, the SMART Aim measure did not provide evidence of meaningful or sustained improvement in the appropriate use of ADHD medications for members 6 to 12 years of age.

Peach State used a key driver diagram to summarize key drivers and potential interventions considered for the *Appropriate Use of ADHD Medications* PIP. The CMO tested one intervention, peer-to-peer physician outreach and education, for three targeted PCPs with a high volume of members receiving ADHD medication prescriptions. Peach State's behavioral health management sister company, Cenpatico, initiated the intervention by sending out clinical practice guidelines (CPGs) for ADHD medication management to the targeted providers. Cenpatico's chief executive officer (CEO) then reached out to the targeted providers individually to offer peer-to-peer review of ADHD medication management via phone call. While the CMO approached five targeted providers, only three providers agreed to the peer-to-peer review. During the peer-to-peer review phone call, Cenpatico's CEO offered technical assistance, clarified the clinical practice guidelines, discussed the HEDIS ADHD medication management requirements, and collected qualitative feedback from the targeted providers.

Based on the lack of improvement in the SMART Aim measure and the feedback received from participating providers, Peach State reported that it would be discontinuing the peer-to-peer physician outreach intervention. Feedback from the targeted providers suggested that physicians were aware of, and supported, the recommended 30-day follow-up visit for ADHD medication management; however, the consensus among participating physicians was that the major barriers to completing the 30-day follow-up were member-based. The CMO revisited its barrier analysis for the PIP, incorporating lessons learned, and reported that member-based barriers such as "member medication 'holidays,' lack of attendance at follow-up appointments, and lack of family/guardian understanding of medication side effects" were more likely the root causes related to ADHD follow-up visit noncompliance.

Avoidable Emergency Room Visits

Figure 5-3—SMART Aim Run Chart for *Avoidable Emergency Room Visits*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Avoidable Emergency Room Visits* PIP. For this PIP, Peach State established a baseline avoidable emergency room (ER) visit rate for members ages 0 to 21 years assigned to five Atlanta region PCPs (an inverse rate where a lower rate indicates better performance) of 16.8 percent based on a quarterly measurement period of July through September 2014. The CMO set a goal to decrease the avoidable ER visit rate among the eligible members assigned to the five targeted PCPs by 2 percentage points to 14.8 percent. The SMART Aim run chart included one quarterly remeasurement of 26.9 percent that was 10.1 percentage points higher (indicating worse performance) than the baseline rate. The SMART Aim measure demonstrated a decline in performance; there was no evidence of meaningful or sustained improvement.

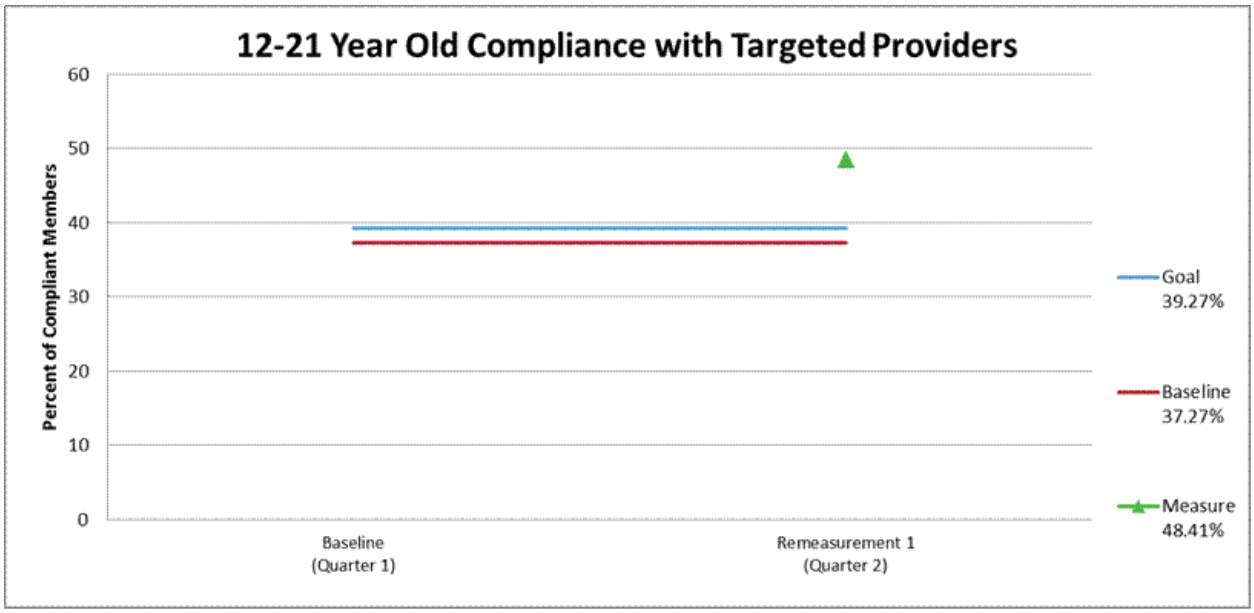
Peach State used a key driver diagram to summarize key drivers and potential interventions considered for the *Avoidable Emergency Room Visits* PIP. To address identified barriers, the CMO tested one intervention with five Atlanta region PCPs who had a high volume of members who visited the ER. The CMO's medical director and Provider Relations staff visited the targeted providers and shared the Avoidable ER Collaborative presentation. During the visits, the targeted providers received patient educational materials and were instructed on how to tailor Web page content for educating members on appropriate ER utilization. The targeted providers responded favorably to the CMO's presentation and indicated they were willing to incorporate the educational materials and tools into their practices.

Peach State documented a number of lessons learned from the PIP. The CMO believed that the intervention did not have sufficient time to demonstrate effectiveness during the one quarterly remeasurement and that at least two years were needed to assess improvement. While the provider-

focused intervention may impact the avoidable ER rate over time, the CMO considered that a member-focused intervention may be more impactful if members can be educated on appropriate alternatives before they have an avoidable ER visit.

Bright Futures

Figure 5-4—SMART Aim Run Chart for *Bright Futures*



HSAG assigned a level of *Confidence* to the validation findings for the *Bright Futures* PIP. For this PIP, Peach State established a baseline well-visit rate for the targeted providers of 37.3 percent based on a baseline measurement period of July through September 2014. The CMO set a goal to increase the rate among the targeted providers by 2 percentage points to 39.3 percent. The run chart included one quarterly remeasurement at 48.4 percent, which was an increase of 11.1 percentage points over the baseline rate. The SMART Aim measure demonstrated meaningful improvement by exceeding the goal by 9.1 percentage points. Because the PIP had only one remeasurement, the PIP did not include sufficient remeasurement data to demonstrate sustained improvement.

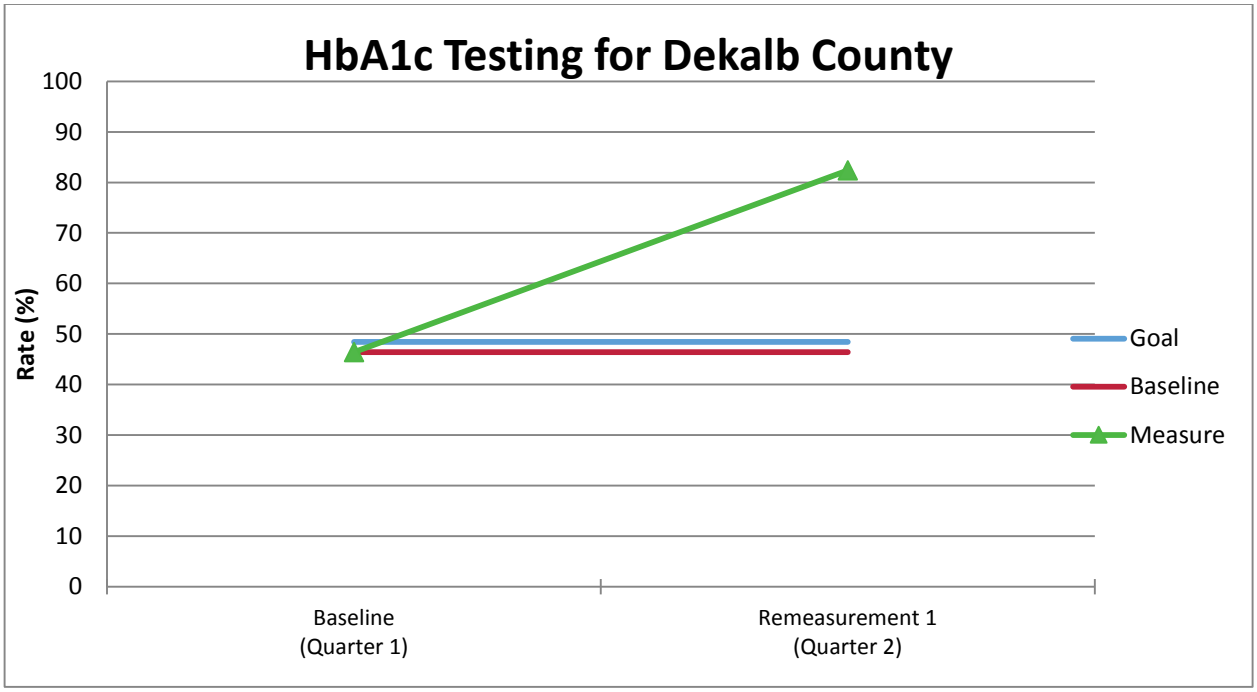
Peach State used a key driver diagram to summarize key drivers and potential interventions considered for the *Bright Futures* PIP. To address identified barriers, the CMO tested one primary intervention—on-site partnering with targeted providers to optimize member encounters to deliver any due/past due well-visit services, even when the appointment was scheduled for other services. In addition to the primary intervention, the CMO also offered targeted member incentives to schedule and keep a due/past due well visit beginning in October 2014; conducted live and automated telephone outreach to members to promote and schedule well visits beginning in July 2014; and mailed postcard reminders to members who were due/past due for a well visit beginning in November 2014.

Because the primary intervention, optimizing member encounters, was resource-intensive and difficult to evaluate, Peach State reported that it would not be continuing this improvement effort. The participating providers who tested this intervention reported that primary barriers to optimizing encounters for well visits were the additional time required and seasonal surges in patient volume.

The CMO reported that collecting data for the SMART Aim measure was more time-consuming and less effective than anticipated. Given the lessons learned, Peach State concluded that the primary intervention, partnering with provider offices to optimize encounters, was not sustainable.

Comprehensive Diabetes Care

Figure 5-5—SMART Aim Run Chart for *Comprehensive Diabetes Care*



HSAG assigned a level of *Confidence* to the validation findings for the *Comprehensive Diabetes Care* PIP. For this PIP, Peach State established a baseline HbA1c testing rate for DeKalb County of 46.4 percent based on a baseline measurement period of July through September 2014. The CMO set a goal to increase the rate in DeKalb County by 2 percentage points, to 48.4 percent. The CMO's run chart included one quarterly remeasurement at 82.4 percent, which was 36 percentage points above the baseline rate and 34 percentage points above the goal. The SMART Aim measure demonstrated meaningful improvement by exceeding the goal. Because the PIP had only one remeasurement, the PIP did not include sufficient remeasurement data to demonstrate sustained improvement.

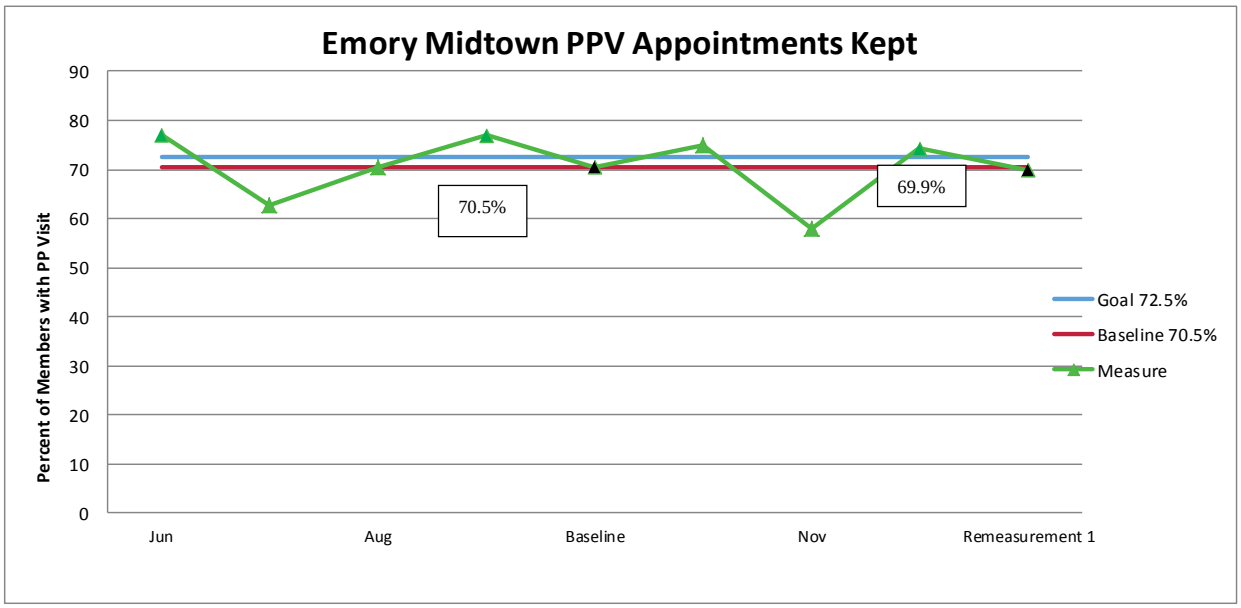
Peach State used a key driver diagram to summarize key drivers and potential interventions considered for the *Comprehensive Diabetes Care* PIP. The CMO tested one intervention, live outreach to members with diabetes, in one targeted county. Peach State identified members who had a diagnosis of diabetes but who had not had an HbA1c test, based on claims received. Peach State's disease management sister company, Nurtur, mailed educational material to all identified members and followed up with each member via live phone calls to provide further education and assist the member with scheduling an HbA1c test.

Due to the early success demonstrated by the SMART Aim measure, Peach State is planning to continue its live outreach to diabetic members. The CMO will continue to monitor the intervention

and assess for sustained improvement in the HbA1c testing rate; given the short duration of the PIP, additional measurements are required to determine long-term sustainability. The CMO is also considering expansion of the intervention to one or more similar high-volume, low-performing counties and believes this expansion is feasible.

Postpartum Care

Figure 5-6—SMART Aim Run Chart for *Postpartum Care*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Postpartum Care* PIP. For this PIP, Peach State established the baseline postpartum visit compliance rate, for Emory Midtown, of 70.5 percent based on a quarterly baseline measurement period of July through September 2014. The CMO set a goal for Emory Midtown to increase the rate by 2 percentage points to 72.5 percent. The CMO plotted both monthly and quarterly measurements on the run chart. The green triangles on the chart represent the seven monthly measurements from June through December 2014. The black triangles on the run chart represent the quarterly baseline (July through September 2014) and Remeasurement 1 (October through December 2014) measurements. The postpartum visit rate declined from 70.5 percent at baseline to 69.9 percent at Remeasurement 1. The SMART Aim measure did not demonstrate evidence of meaningful or sustained improvement because the goal was not met at Remeasurement 1.

Peach State used a key driver diagram to summarize key drivers and potential interventions considered for the *Postpartum Care* PIP. The CMO tested one intervention, on-site postpartum visit scheduling support and outreach, for one high-volume hospital in the Atlanta region. Peach State staff members were placed at the hospital three days per week to assist members with scheduling a postpartum visit at the time of delivery and to help establish a PCP for newborns. The on-site scheduling support was increased to four days per week, upon request from the hospital. The schedulers attempted to schedule the postpartum visits between 21 and 45 days after delivery to allow time to reschedule the visit prior to the 56th day, HEDIS-based time frame, if needed. The intervention

also included telephone outreach to remind the member of the scheduled postpartum visit, and provider follow-up to confirm when the postpartum visit occurred.

The CMO continued to implement the on-site scheduler intervention after the PIP ended and reported that it believed the intervention can be successful if more time is allowed to evaluate effectiveness. Peach State reported several strategies learned from the PIP process that can be used to enhance future improvement efforts. One lesson was the value of documenting and analyzing changes in a process to facilitate implementation and expansion of improvement strategies. A second lesson was the benefit of sharing best practices of one facility with other similar facilities to expedite and optimize improved outcomes.

Traditional Outcome-Focused PIP Validation Results

Peach State's two satisfaction-based PIPs were validated using HSAG's outcome-focused PIP validation methodology, based on annual study indicator measurements. Table 5-3 displays the validation findings for the ongoing, satisfaction-based PIPs.

Table 5-3—Traditional Outcome-Focused Performance Improvement Project Validation Findings for Peach State Health Plan

PIP	Percentage of Evaluation Elements Scored *Met*	Percentage of Critical Elements Scored *Met*	Validation Finding
Member Satisfaction	94%	93%	*Not Met*
Provider Satisfaction	84%	93%	*Not Met*

Both of the traditional outcome-focused satisfaction-based PIPs received an overall *Not Met* validation finding. Both PIPs were scored down in the Outcomes stage for a critical evaluation element in Step IX because of a lack of statistically significant improvement in the study indicator, which resulted in an overall *Not Met* validation finding.

Traditional Outcome-Focused PIP-Specific Outcomes

Table 5-4 and Table 5-5 display the study indicator rates for each measurement period of the two traditional outcome-focused satisfaction-based PIPs, including the baseline period and each subsequent annual measurement period. In these tables, statistically significant changes between remeasurement periods are noted with an upward or downward arrow followed by an asterisk. Statistical significance is based on the *p* value calculated from a statistical test comparing measurement period rates. Differences in these rates that resulted in a *p* value less than 0.05 were considered statistically significant. It is possible for a percentage point difference between measurement period rates to appear large without being statistically significant. In certain instances, the study indicator denominators may not be large enough to have sufficient power to detect statistically significant difference. Similarly, the reverse may also occur: a *small* percentage point difference between measurement period rates with *large* denominators may result in a small percentage point difference that is statistically

significant because larger denominators have greater power to detect statistically significant differences.

If the PIP achieved statistically significant improvement over the baseline rate during a previous measurement period, it was then reviewed for sustained improvement. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators. PIPs that did not achieve statistically significant improvement (i.e., did not meet the criteria to be assessed for sustained improvement) were not assessed (NA).

A detailed discussion of Peach State's performance on each traditional PIP, which includes the CMO's interventions and activities, is provided in the Performance Improvement Project Summary Grid in Appendix E. The grid also includes HSAG's recommendations to Peach State to improve performance.

Member Satisfaction

Table 5-4—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)	Remeasurement 2 (3/20/15–5/29/15)	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%	88.5%	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, 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. The study indicator rate increased 3.6 percentage points from Remeasurement 1 to Remeasurement 2; however, the increase was not statistically significant. The Remeasurement 2 rate was 1.5 percentage points higher than the baseline rate, but the difference was not statistically significant.

The CMO's multidisciplinary team reviewed results of drill-down analyses of the CAHPS member survey, and of customer service call quality audit data, and gathered input based on the experiences of subject matter experts. Key barriers identified by the CMO included a member-perceived lack of access to specialist providers, difficulty obtaining information and assistance through the customer call center, and perceived lack of staff courtesy.

To address key barriers, Peach State implemented several new interventions. To improve call center staff members' ability to respond to customer inquiries, the CMO revised its customer service representative training program to include modified call scripts, additional educational content, and enhanced staff monitoring. To address member access to specialists, the CMO continued outreach efforts to specialist providers to confirm participation and appointment availability.

Provider Satisfaction

Table 5-5—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)	Remeasurement 2 (9/1/14–10/31/14)	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%	71.6%	NA

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

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

The rate for Peach State's *Provider Satisfaction* PIP declined 2.1 percentage points from baseline to Remeasurement 1. The study indicator rate declined an additional 2.6 percentage points from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rate of 71.6 percent fell 4.7 percentage points below the baseline rate. The PIP has not yet demonstrated statistically significant or sustained improvement in overall provider satisfaction.

Peach State's collaborative team completed a barrier analysis that incorporated brainstorming and data analyses. Peach State's causal/barrier analysis for the Remeasurement 2 period identified new key barriers to overall provider satisfaction, which included a lack of timely and consistent communication by Provider Services representatives and insufficient information provided to providers on the CMO's HEDIS-based initiatives. To address the lack of timely and consistent information shared with providers, Peach State implemented quarterly intensive training sessions for their Provider Services staff and held collaborative training sessions with the Provider Services representatives and Provider Services call center staff. The CMO also conducted provider focus groups to obtain feedback on practice-specific needs and held several large group provider education sessions to disseminate information. To improve HEDIS information sharing with providers, a report of applicable HEDIS/ Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) data was provided during each Provider Services interaction.

Strengths and Weaknesses

This was the first year that Peach State submitted for validation PIPs using the new rapid cycle PIP framework. The learning curve necessary for transitioning to the new rapid cycle approach was evidenced by Peach State's performance on the six rapid cycle PIPs. Peach State's performance suggests that the CMO has substantial room for improvement in the application of the new rapid cycle PIP process. HSAG was unable to determine *High Confidence* in the results of any of the rapid cycle PIPs. Two of the CMO's six rapid cycle PIPs received a level of *Confidence,* and the remaining four PIPs received a *Low Confidence* level. Opportunities for improvement in implementing the new rapid cycle PIP process include demonstrating meaningful and sustained improvement of outcomes through effective intervention testing and revision based on intervention-specific evaluation results, planning for sustained improvement of outcomes, and documenting lessons learned at the conclusion of a PIP.

Peach State's two satisfaction-based PIPs that used the traditional annual study indicator measurements were validated with HSAG's established outcome-focused PIP validation methodology. Peach State's performance on the two traditional outcome-focused PIPs suggests that the PIP's study design, established in the Design stage (Steps I through VI), was valid and appropriate for measuring the study indicator outcomes; the CMO showed strength in the Design stage by meeting 100 percent of the evaluation elements for this stage in both PIPs. The CMO's strengths in the Design stage for these two PIPs included accurately and appropriately defining the PIP's study question, study population, and study indicators; and using sound data collection methods. The solid study design of the two PIPs formed the foundation for progressing to the subsequent PIP stages—implementing improvement strategies and achieving real and sustained study indicator outcomes. In the Implementation stage, the CMO failed to conduct intervention-specific evaluations of effectiveness. The lack of evaluation and data-driven refinement of improvement strategies resulted in a lack of improvement in study indicator outcomes for both PIPs.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the quality improvement processes used must be methodologically sound and based on solid improvement science. Peach State's PIP performance suggested a number of areas of opportunity that applied across the various PIP topics. Because all ongoing and future PIPs will be using the rapid cycle PIP process, all of the recommendations for future projects are related to the rapid cycle PIP design. HSAG recommends the following for Peach State:

- At the start of a new rapid cycle PIP, the CMO should carefully consider the end date specified in the SMART Aim statement and work backwards when planning the execution of the five rapid cycle PIP modules. Careful planning is critical to allow sufficient time to test and refine interventions that will result in meaningful and sustained improvement of outcomes during the limited time frame of the PIP.
- The CMO should ensure that the SMART Aim measure for each PIP is methodologically sound and appropriate for the PIP topic. The numerator and denominator of the SMART Aim measure should be clearly and accurately defined. The baseline measurement period should be comparable to the planned SMART Aim measurement intervals. Additionally, for future rapid

cycle PIPs, SMART Aim measurements should occur monthly or more frequently, as appropriate.

- For rapid cycle PIPs focused on annual services (e.g., well-child visits and diabetic screenings), Peach State should seek technical assistance from HSAG to ensure that the SMART Aim measure is appropriate and that meaningful improvement is detectable from one measurement interval to the next.
- The CMO should carefully and thoroughly execute all steps in the PDSA cycle for each intervention. Each step in the PDSA process is necessary to maintain the focus of limited resources on the most impactful improvement strategies and to achieve optimal outcomes.
- If meaningful improvement is achieved, the CMO should formulate and document plans for ensuring that the improvement is sustained over time and include consideration for how successful interventions can be spread beyond the targeted population of the PIP in the future.
- At the conclusion of the PIP, Peach State should ensure that the lessons learned from completed PDSA cycles, the final process map, the final failure modes and effects analysis (FMEA), and the final SMART Aim run chart are synthesized and documented by the PIP team so that the PIP outcomes can be used as the foundation of future improvement efforts. The CMO should document lessons learned as part of its Module 5 submission for each PIP.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the current measure rates as compared to those of last year. The performance targets reflect the DCH-established performance targets for 2014. When possible, changes in rates were tested for statistical significance. However, caution should be exercised when interpreting the results of the significance testing given that statistically significant changes may not necessarily be clinically significant.

Access to Care

Peach State's Access to Care performance measure results are shown in Table 5-6.

Table 5-6—Peach State Access to Care Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12–24 Months	96.97%	97.26%	↔	
Ages 25 Months–6 Years	90.45%	89.96%	↓	
Ages 7–11 Years	91.53%	91.50%	↔	
Ages 12–19 Years	88.51%	88.63%	↔	91.85%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	83.56%	81.17%	↓	88.32%

Table 5-6—Peach State Access to Care Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Oral Health (Annual Dental Visit)				
Ages 2–3 Years	44.28%	45.07%	↔	55.78%
Ages 4–6 Years	75.09%	74.66%	↔	
Ages 7–10 Years	78.08%	77.15%	↓	
Ages 11–14 Years	70.66%	69.94%	↓	
Ages 15–18 Years	59.81%	59.32%	↔	
Ages 19–21 Years	35.77%	33.62%	↔	
Total	68.13%	67.67%	↓	69.92%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	38.06%	39.65%	↔	43.43%
Engagement	7.08%	8.24%	↔	16.17%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

Within the Access to Care measure set, none of Peach State's measure rates met the 2014 performance targets. Additionally, Peach State showed significant declines in three of the seven performance indicators reported as part of the *Oral Health (Annual Dental Visit)* measure. Peach State showed a significant decline for the *Children and Adolescents' Access to Primary Care Practitioners—Ages 25 Months–6 Years* and *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* measure indicators.

Children's Health

Peach State's Children's Health performance measure results are shown in Table 5-7.

Table 5-7—Peach State Children's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	57.64%	65.05%	↑	59.81%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Third, Fourth, Fifth, and Sixth Years of Life	69.44%	69.91%	↔	69.64%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	45.14%	49.07%	↔	45.42%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	79.17%	79.63%	↔	78.52%
Combination 6	40.74%	43.52%	↔	
Combination 10	36.34%	40.28%	↔	33.43%
Lead Screening in Children				
Lead Screening in Children	76.85%	79.40%	↔	75.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	76.33%	80.31%	↑	77.97%
Immunization for Adolescents				
Combination 1 Total	78.01%	76.39%	↔	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	51.16%	69.21%	↑	51.39%
Counseling for Nutrition—Total	58.10%	64.81%	↑	58.30%
Counseling for Physical Activity—Total	54.63%	60.19%	↔	49.54%
Developmental Screening in the First Three Years of Life				
Total	42.82%	46.28%	↔	45.00%
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	50.06%	52.17%	↑	58.00%
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	23.68%	24.53%	↑	31.50%

Table 5-7—Peach State Children's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Upper Respiratory Infection				
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	81.26%	83.50%	↑	85.86%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014, with the exception *of Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services*, which is October 1, 2013 through September 30, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

Peach State exceeded the 2014 performance targets for 12 of the 15 measures in the Children's Health measure set. Of those 12 measures, four showed significant improvements. Of the Children's Health measures that fell below the performance target, *Percentage of Eligibles that Received Preventive Dental Services, Percentage of Eligibles that Received Dental Treatment Services,* and *Appropriate Treatment for Children with URI,* all three showed significant improvements. None of the measures in this measure set showed significant decline.

Women's Health

Peach State's Women's Health performance measure results are shown in Table 5-8. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex, Cesarean Delivery Rate, Percentage of Live Births Weighing Less Than 2,500 Grams,* and *Early Elective Delivery*.

Table 5-8—Peach State Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	73.84%	68.53%	↔	76.64%
Breast Cancer Screening				
Breast Cancer Screening	72.96%	71.02%	↔	62.88%
Chlamydia Screening in Women				
Total	57.69%	56.71%	↔	57.25%

Table 5-8—Peach State Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	21.53%	24.54%	↔	22.14%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.64%	82.13%	↔	89.72%
Postpartum Care	61.81%	70.30%	↑	70.20%
Cesarean Section for Nulliparous Singleton Vertex				
Cesarean Section for Nulliparous Singleton Vertex[4]	18.08%	NR	NT	15.23%
Cesarean Delivery Rate				
Cesarean Delivery Rate[4]	29.59%	29.84%	↔	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams				
Percentage of Live Births Weighing Less Than 2,500 Grams[4]	8.73%	9.04%	↔	7.99%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	1.85%	0.00%	↓	10.42%
Early Elective Delivery				
Early Elective Delivery[4]	0.00%	NR	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	3.85%	NR	NT	
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
81+ Percent	57.64%	57.77%	↔	73.97%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NR indicates the CMO produced a rate that was materially biased or chose not to report results for this measure; therefore, the rates were not included in the performance calculation. The auditors confirmed that although Peach State calculated these measures properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.
NT Indicates that statistical significance testing was not performed.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

Peach State's performance on most of the Women's Health measure rates did not change significantly. However, one measure exhibited significant improvement, *Prenatal and Postpartum Care—Postpartum Care*, and also exceeded the 2014 performance target. Two other performance measures also exceeded the 2014 performance target, *Breast Cancer Screening* and *Human Papillomavirus Vaccine for Female Adolescents*. The remaining performance measure rates did not meet the 2014 performance targets or exhibit significant improvement.

Chronic Conditions

Peach State's Chronic Conditions performance measure results are shown in Table 5-9. Note that a lower rate is better for the following performance measures: *HbA1c Poor Control (>9.0)*, *Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)*, *Young Adult Asthma Admission Rate*, *COPD and Asthma Admission Rate—Total (Per 100,000 Member Months)*, and *Congestive Heart Failure Admission Rate—Total (Per 100,000 Member Months)*.

Table 5-9—Peach State Chronic Conditions Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	79.51%	83.63%	↔	87.32%
HbA1c Poor Control (>9.0)[4]	63.19%	53.17%	↑	43.02%
HbA1c Control (<8.0)	32.64%	37.32%	↔	48.57%
HbA1c Control (<7.0)	24.07%	27.73%	↔	34.76%
Eye Exam (Retinal) Performed	57.81%	58.63%	↔	54.43%
Medical Attention for Nephropathy	70.83%	77.82%	↑	79.28%
Blood Pressure Control (<140/90 mm/Hg)	53.65%	53.17%	↔	60.93%
Diabetes Short-Term Complications Admission Rate				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]	20.00	18.15	NT	--
Respiratory Conditions				
Use of Appropriate Medications for People with Asthma				
Ages 5–11 Years	92.92%	93.83%	↔	
Ages 12–18 Years	91.23%	89.67%	↔	
Total	91.47%	91.42%	↔	89.76%
Young Adult Asthma Admission Rate				
Young Adult Asthma Admission Rate[4]	4.63	4.55	NT	--

Table 5-9—Peach State Chronic Conditions Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate				
COPD and Asthma Admission Rate—Total (Per 100,000 Member Months)[4]	37.00	28.70	NT	--
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate				
Congestive Heart Failure Admission Rate—Total (Per 100,000 Member Months)[4]	3.00	5.45	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	44.15%	36.64%	↓	56.20%
Adult BMI Assessment				
Adult BMI Assessment	75.46%	80.56%	↔	78.71%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NT Indicates that statistical significance testing was not performed.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.
-- Indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2013 and CY 2014, and previous years were reported as per 100,000 members. Since the 2014 performance target was developed based on previous years' reporting metrics, the 2014 performance target is not presented and caution should be used if comparing the CY 2014 rate to the 2014 performance target for this measure.

The majority of Peach State's Chronic Conditions measure rates were below the 2014 performance targets. One measure had a statistically significant decline, *Controlling High Blood Pressure*. The rates for *Comprehensive Diabetes Care (CDC)—HbA1c Poor Control (>9.0)* and *CDC—Medical Attention for Nephropathy* improved significantly but did not meet the 2014 performance targets. Peach State met the 2014 performance targets for three Chronic Conditions measures: *CDC—Eye Exam (Retinal) Performed, Use of Appropriate Medications for People with Asthma—Total,* and *Adult BMI Assessment*.

Behavioral Health

Peach State's Behavioral Health performance measure results are shown in Table 5-10.

Table 5-10—Peach State Behavioral Health Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	43.04%	43.58%	↔	51.86%
Continuation and Maintenance Phase	57.73%	58.19%	↔	63.75%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	60.18%	56.78%	↔	68.79%
Follow-Up Within 30 Days	75.48%	72.79%	↔	81.98%
Antidepressant Medication Management				
Effective Acute Phase Treatment	39.64%	39.57%	↔	56.17%
Effective Continuation Phase Treatment	24.86%	24.86%	↔	40.17%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	0.00%	2.86%	↑	
Adherence to Antipsychotics for Individuals with Schizophrenia				
Adherence to Antipsychotics for Individuals with Schizophrenia	16.98%	33.33%	↑	61.34%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

None of Peach State's Behavioral Health measure rates met the 2014 performance targets. However, the *Adherence to Antipsychotics for Individuals with Schizophrenia* measure exhibited significant improvement.

Medication Management

Peach State's Medication Management performance measure results are shown in Table 5-11. Note that a lower rate is better for the *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* performance measure.

Table 5-11—Peach State Medication Management Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 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[4]	39.98%	38.49%	↑	39.06%
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	88.32%	87.24%	↔	
Diuretics	87.41%	86.63%	↔	
Total	86.42%	86.74%	↔	
Medication Management for People with Asthma				
Medication Compliance 50%—Ages 5–11 Years	46.50%	44.06%	↔	
Medication Compliance 50%—Ages 12–18 Years	39.47%	39.67%	↔	
Medication Compliance 50%—Ages 19–50 Years	54.81%	44.19%	↔	
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	
Medication Compliance 50%—Total	44.22%	42.56%	↔	
Medication Compliance 75%—Ages 5–11 Years	20.71%	18.82%	↔	29.46%
Medication Compliance 75%—Ages 12–18 Years	15.56%	16.03%	↔	
Medication Compliance 75%—Ages 19–50 Years	24.04%	23.26%	↔	
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	
Medication Compliance 75%—Total	19.00%	18.03%	↔	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NA Indicates that the rate was withheld because the denominator was less than 30.
NT Indicates that statistical significance testing was not performed.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

One of Peach State's measures in the Medication Management measure set improved significantly and met the 2014 performance target, *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions.* The performance rate for *Medication Management for People with Asthma—Medication Compliance 75 Percent—Ages 5–11 Years* fell below the 2014 performance target.

Utilization

Peach State's Utilization performance measure results are shown in Table 5-12. Note that a lower rate is better for the *Ambulatory Care (Per 1,000 Member Months)—ED Visits* performance measure. Significance testing was not performed on the Utilization measure set since variances are not reported to NCQA.

Table 5-12—Peach State Utilization Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)				
ED Visits[4]	55.87	54.10	NT	53.98
Outpatient Visits	332.51	309.79	NT	
Inpatient Utilization— General Hospital/Acute Care				
Total Inpatient Average Length of Stay	3.27	3.39	NT	
Total Medicine Average Length of Stay	3.29	3.43	NT	
Total Surgery Average Length of Stay	7.90	8.43	NT	
Total Maternity Average Length of Stay	2.71	2.75	NT	
Mental Health Utilization				
Any Services—Total	8.46%	8.01%	NT	
Inpatient Services—Total	0.37%	0.38%	NT	
Intensive Outpatient Services—Total	0.13%	0.13%	NT	
Ambulatory/ED Visits—Total	8.40%	7.93%	NT	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NT Indicates that statistical significance testing was not performed.

Although significance testing was not performed, Peach State's rate for *Ambulatory Care (Per 1,000 Member Months)—ED Visits* exhibited improvement, but it did not meet the 2014 performance target.

Strengths and Weaknesses

The number of performance targets met by Peach State is shown in Table 5-13.

Table 5-13—Number of Performance Targets Met by Peach State			
Measure Set	**Number of Measures With Performance Target***	**Number of Measures That Met Performance Target**	**Percentage of Targets Met**
Access to Care	6	0	**0.0%**
Children's Health	15	12	**80.0%**
Women's Health	10	3	**30.0%**
Chronic Conditions	10	3	**30.0%**
Behavioral Health	7	0	**0.0%**
Medication Management	2	1	**50.0%**
Utilization	1	0	**0.0%**
Total	51	19	**37.3%**
**Excludes measures that were not comparable to performance targets.*			

Based on Peach State's CY 2014 performance, Peach State met 37.3 percent of its performance targets overall. Performance targets were met in the Children's Health, Women's Health, Chronic Conditions, and Medication Management measure sets. HSAG has highlighted specific strengths and areas for improvement below.

Peach State's greatest strength was in the care it provided to children and adolescents. As illustrated in Table 5-13 above, 80 percent of the measures in the Children's Health measure set met the 2014 performance measure target. Over 65 percent of children received six or more well-child visits in their first 15 months of life, which met the 2014 performance target and showed a significant improvement from 2013 to 2014. In addition, Peach State exceeded the 2014 performance target by more than 17 percentage points for weight assessment (BMI) and also exceeded the 2014 performance target for counseling for nutrition for children and adolescents, which were both significant improvements between 2013 and 2014. Further, Peach State exceeded the 2014 performance target by more than 10 percentage points in the area of counseling for physical activity.

Although Peach State performed well in the Children's Health measure set, a review of dental measures across both the Children's Health and Access to Care measure sets indicates that the CMO needs to establish methods to improve in this area since none of these performance measures met the 2014 performance targets. However, two of the indicators, *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services*, demonstrated significant improvement.

Measures related to Women's Health presented several opportunities for improvement as only three of 10 measures met the performance measure targets. One measure, *Timeliness of Prenatal and Postpartum Care—Postpartum Care*, showed statistically significant improvement and met the 2014 performance target. However, less than 60 percent of Peach State's pregnant members received at least 81 percent of the recommended prenatal care visits, which was more than 16 percentage points

below the 2014 performance target. Similarly, Peach State also fell below the 2014 performance target by almost 8 percentage points in the area of providing timely prenatal care.

Within the Chronic Conditions measure set, although Peach State met only one performance measure target for the *Comprehensive Diabetes Care (CDC)* indicators, the CMO significantly reduced the percentage of members with diabetes who had documentation of poor HbA1c control by 10 percentage points from 2013 to 2014. However, documented blood pressure control for members with cardiovascular conditions and diabetes is an area for improvement for Peach State, as the performance in these areas was almost 20 percentage points below (among members with cardiovascular conditions) and almost 8 percentage points below (among members with diabetes) the 2014 performance targets.

Peach State did not meet any 2014 performance targets for the Behavioral Health measure set, as indicated below.

- Approximately 57 percent of members hospitalized for mental illness had a follow-up visit within seven days of discharge, which is around 12 percentage points below the 2014 performance target.
- Peach State's performance in the area of antidepressant medication management remained steady from 2013 to 2014; however, both the effective acute and continuation phase rates were greater than 15 percentage points below the 2014 performance targets.
- Although the percentage of members with schizophrenia who adhered to their antipsychotic medications significantly improved in 2014, this rate was approximately 28 percentage points below the 2014 performance target.

Peach State also did not meet any of the performance measure targets for Access to Care or Utilization measure sets.

- Performance in the area of providing oral healthcare to members ages 2 to 3 was approximately 10 percentage points below the 2014 performance target.

Recommendations for Improvement

Peach State performed well in the Children's Health measure set; however, all other measure sets require innovative, targeted interventions to improve performance. Therefore, HSAG recommends the following:

- Peach State should analyze the improvement strategies that can be linked to the overall success of the Children's Health measure set. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.
- Peach State currently has rapid cycle PIPs in place which are related to some of the performance measures. Peach State should continue to assess the impact of its PIPs on related measures and refine their rapid cycle approach to positively impact health outcomes for its membership.
- Peach State should analyze all performance measure rates that fell below the DCH-required target and either implement new PIPs or adjust the focus of existing PIPs, as needed.

- Peach State should prioritize its focus on performance measures that had a statistically significant decline, such as controlling high blood pressure and oral health.

In addition to the specific recommendations above, Peach State should focus efforts on the following measure topics in its quality improvement efforts.

Women's Health

- Prenatal care

Chronic Conditions

- HbA1c control
- Blood pressure control for members with diabetes and cardiovascular conditions

Behavioral Health

- Timely follow-up visits following a mental health-related hospital discharge
- Medication management for members on antidepressants
- Adherence to antipsychotics for members with schizophrenia

CAHPS Surveys

Findings

To assess the overall performance of Peach State, HSAG compared the calculated question summary rates for each global rating and global proportions for each composite measure (i.e., the percentage of respondents offering a positive response) to 2015 NCQA national Medicaid averages, where applicable.[5-2] The calculated question summary rates and global proportions represent the percentage of top-level responses (i.e., CAHPS top-box scores) for each global rating and composite measure, respectively. Comparisons of the 2015 top-box scores to 2015 NCQA national Medicaid data were performed for Peach State's adult and child Medicaid populations.[5-3] Further, for Peach State's CMO-specific findings, a substantial difference is noted when a CAHPS Survey measure's rate is 5 percentage points higher or lower than the 2015 NCQA national average. Additional methodology information can be found in Appendix D.

The four global rating measures and five composite measures evaluated through the CAHPS surveys are as follows:

[5-2] Quality Compass® 2015 data serve as the source for the NCQA national averages contained in this publication and are used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[5-3] The CAHPS Survey results presented throughout this section for Peach State are the CAHPS Survey measure results calculated by the CMO's survey vendor and provided to HSAG for purposes of reporting.

CAHPS Global Rating Measures

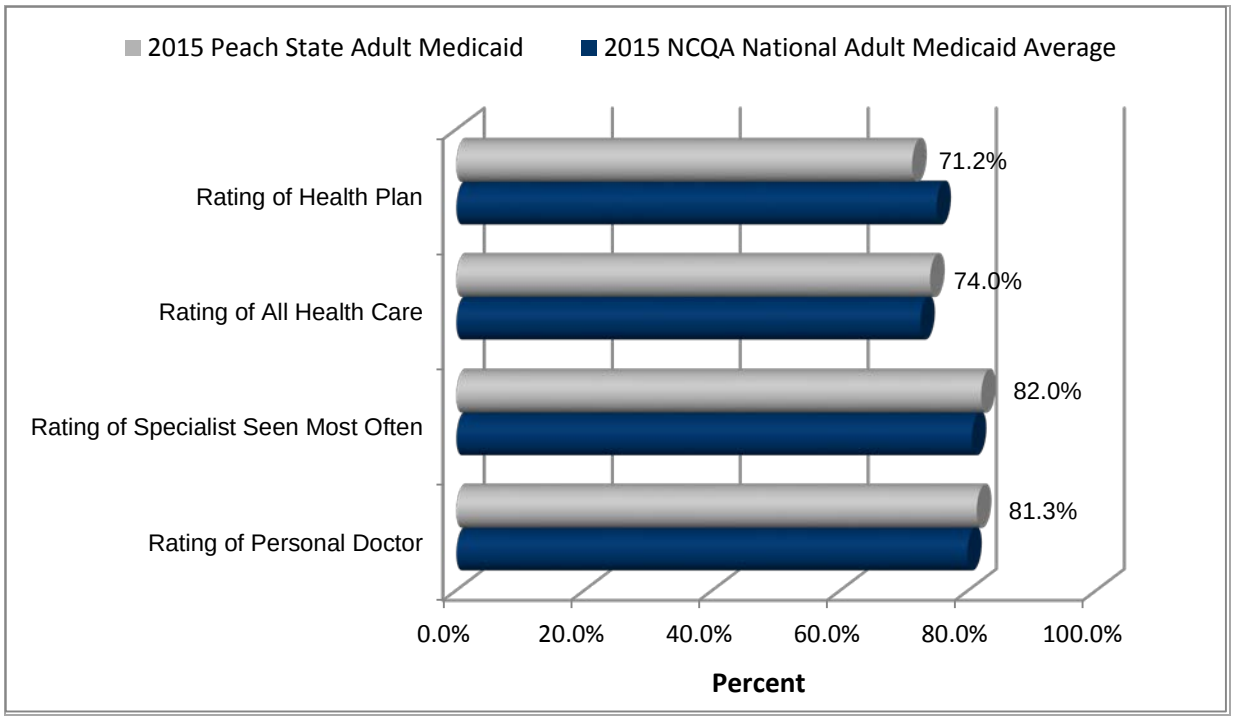
- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Personal Doctor*

CAHPS Composite Measures

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

Figure 5-7 below depicts Peach State's adult Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national adult Medicaid average for each of the global ratings. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 5-7—Peach State Adult Medicaid CAHPS Survey Results for Global Ratings



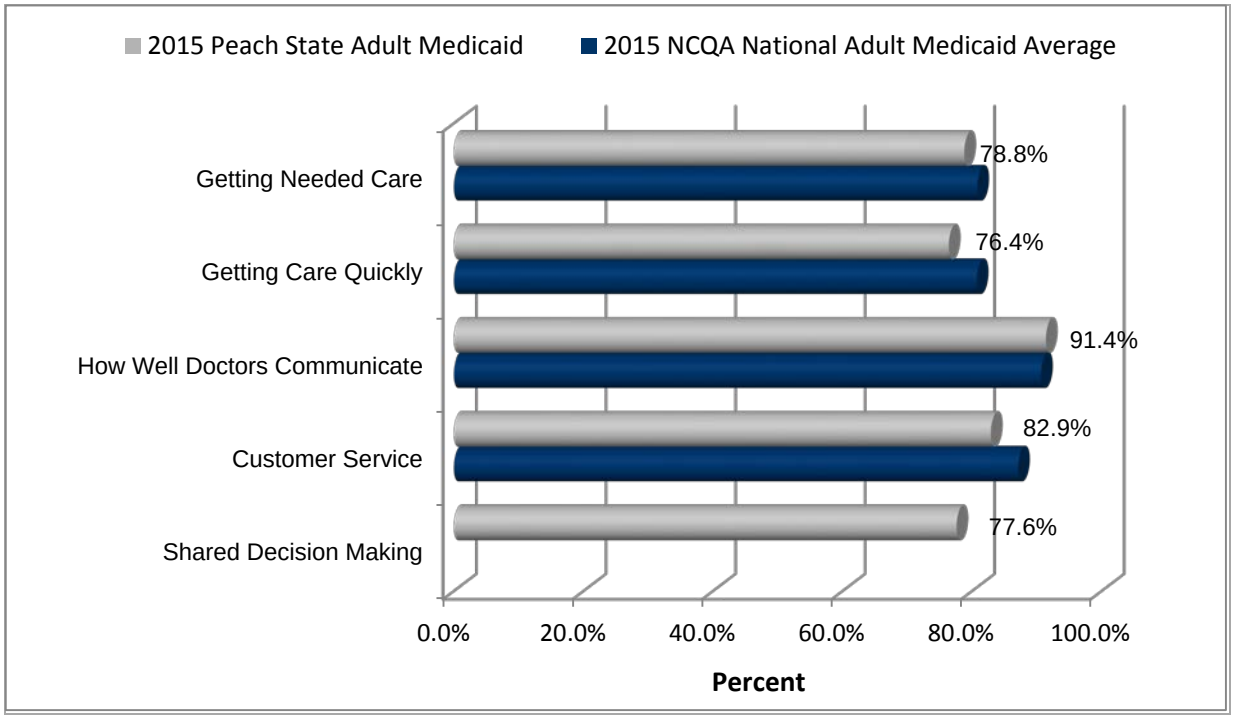
The top-box scores for the adult Medicaid global ratings indicate the following:

- Peach State scored between 71 and 82 percent on the four global rating measures.

- Peach State scored at or above the 2015 NCQA national adult Medicaid average for three measures—*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.
- Peach State scored below the 2015 NCQA national adult Medicaid average for one measure—*Rating of Health Plan*.

Figure 5-8 below depicts Peach State's adult Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national adult Medicaid average for each of the composite measures. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 5-8—Peach State Adult Medicaid CAHPS Survey Results for Composite Measures



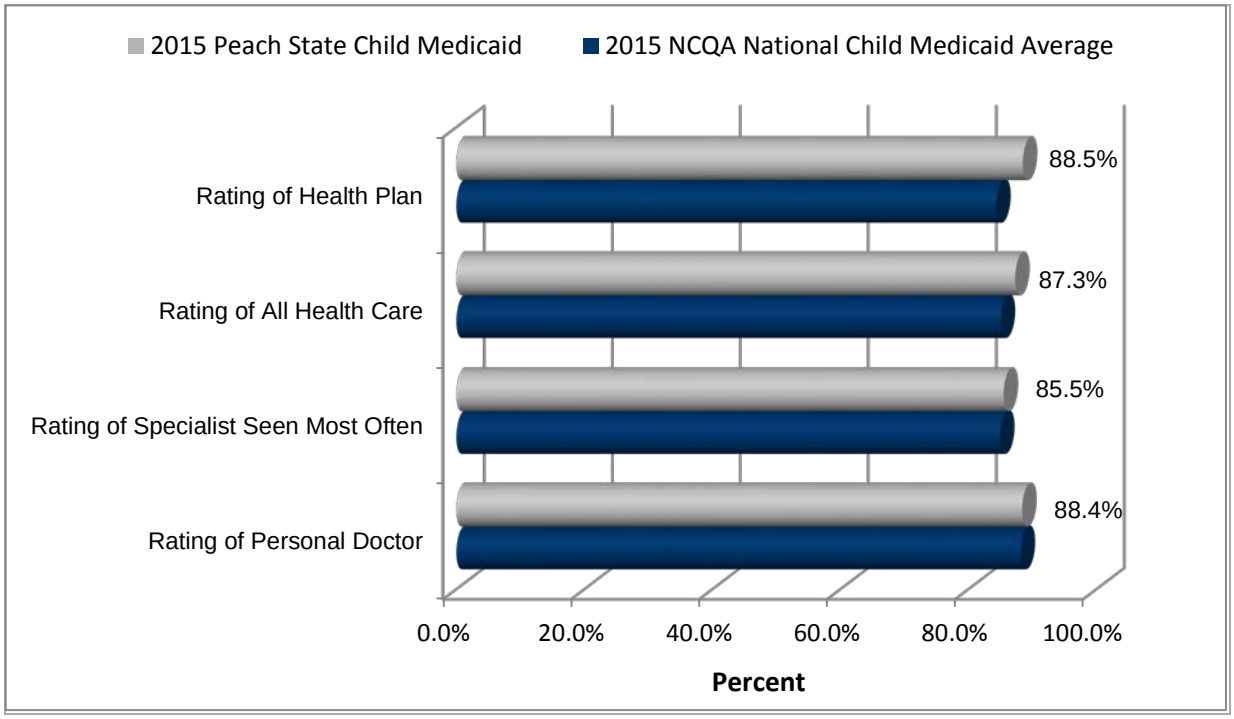
Please note: Due to changes to the Shared Decision Making composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

The top-box scores for the adult Medicaid composite measures indicate the following:

- Peach State scored between 76 and 91 percent on the five composite measures.
- Peach State scored at or above the 2015 NCQA national adult Medicaid average for one measure—*How Well Doctors Communicate.*
- Peach State scored below the 2015 NCQA national adult Medicaid average for three measures—*Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.

Figure 5-9 below depicts Peach State's child Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national child Medicaid average for each of the global ratings. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 5-9—Peach State Child Medicaid CAHPS Survey Results for Global Ratings

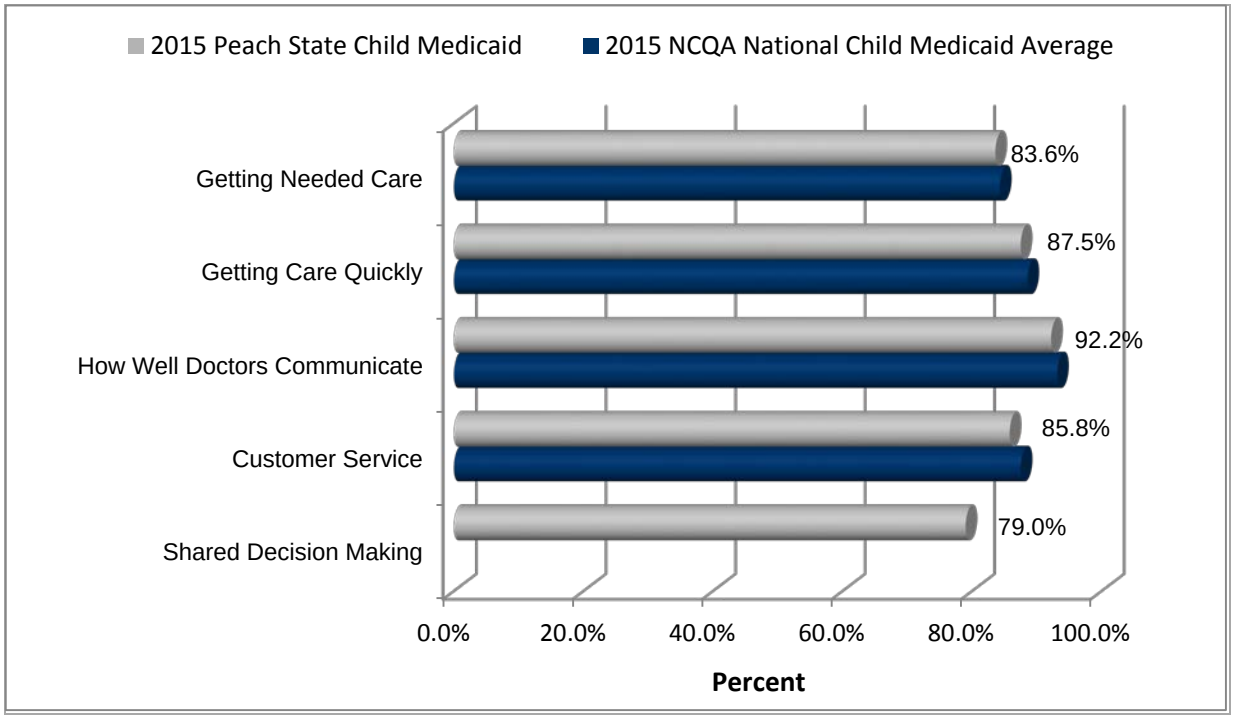


The top-box scores for the child Medicaid global ratings indicate the following:

- Peach State scored between 86 and 89 percent on all four global rating measures.
- Peach State scored at or above the 2015 NCQA national child Medicaid average for all four measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.
- Peach State did not score below the 2015 NCQA national child Medicaid average on any of the global rating measures.

Figure 5-10 below depicts Peach State's child Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national child Medicaid average for each of the composite measures. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 5-10—Peach State Child Medicaid CAHPS Survey Results for Composite Measures



Please note: Due to changes to the Shared Decision Making composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

The top-box scores for the child Medicaid composite measures indicate the following:

- Peach State scored between 79 and 92 percent on the five composite measures; each was below the 2015 NCQA national child Medicaid average.
- Peach State scored below the 2015 NCQA national child Medicaid average for all four comparable composite measures—*Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.

Strengths and Weaknesses

For Peach State's adult Medicaid population, the 2015 top-box rates for four of the eight comparable CAHPS Survey measures, *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*, were lower than the 2015 NCQA adult Medicaid national averages. The four remaining comparable measures' 2015 top-box rates, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*, exceeded the 2015 NCQA adult Medicaid national averages.

For Peach State's child Medicaid population, the 2015 top-box rates for four of the eight comparable measures were lower than the 2015 NCQA child Medicaid national averages: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*. The 2015 top-box rates for the four remaining comparable measures were higher than the 2015 NCQA child Medicaid national average: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.

Recommendations for Improvement

Based on an evaluation of Peach State's 2015 adult Medicaid CAHPS Survey results, HSAG recommends that the CMO focus quality improvement (QI) initiatives on enhancing members' experiences with *Rating of Health Plan*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service* since the rates for these measures were lower than NCQA's 2015 CAHPS adult Medicaid national averages. For Peach State's child Medicaid population, HSAG recommends that the CMO focus QI initiatives on *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service* since the rates for these measures were below the 2015 NCQA national child Medicaid average.

HSAG has made general recommendations based on the information found in the CAHPS literature. (See Appendix G for an explanation of these recommendations.) The recommendations are intended to address those areas for which CAHPS measure scores were lower than the NCQA national Medicaid average.

Peach State should conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network. HSAG recommends that the CMO review the CAHPS literature and other relevant sources to assist with developing applicable interventions and process improvement activities.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about Peach State's performance in providing quality, accessible, and timely healthcare and services to its members. Overall, HSAG's evaluation showed that Peach State has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The CMO demonstrated moderately strong compliance review results (94 percent of federal and contract requirements for structure and operations were *Met*) and also demonstrated its commitment to quality process improvement, by closing 21 of the 25 corrective action plans from the previous year's compliance review, and with two of its PIPs receiving a level of *Confidence*.

Members' satisfaction with the care they received was high, with three CAHPS scores exceeding the Medicaid national average (*Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*).

Peach State showed improved outcomes and success in meeting or exceeding the quality targets established for more than 80 percent of performance indicators in the area of children's health—the highest percentage of any CMO for this measure set. Additionally, the three children's health performance measures that did not meet the target showed statistically significant improvement. Going forward, Peach State is well positioned to capitalize on these strengths and to continue to achieve improved outcomes in additional areas of care and service.

In addition, two key themes emerged in HSAG's assessment of Peach State's overall performance, indicating significant opportunities for improvement in these areas. While a variety of other findings also indicate a need for improvement, HSAG advises the CMO to focus its quality initiatives on key areas with interrelated findings. Concentrated improvement efforts that achieve success in these areas can be spread, with greater potential to also affect performance in other similar population/program areas over time. These areas, and resulting recommendations, are described below and include:

- Network sufficiency.
- Behavioral health.

Network Sufficiency

Results from three EQR activities illustrate that Peach State has an opportunity to improve its network adequacy and availability for both child and adult members. In addition to not meeting any of the DCH performance measure targets in the HEDIS measure domain of access to care, the CMO's CAHPS Survey results for both *Getting Needed Care* and *Getting Care Quickly* were below the Medicaid national average. In addition, during the two most recent reviews of compliance, Peach State did not meet all provider availability requirements (to ensure providers return calls after-hours within the appropriate time frames) or minimum standards for geographic access in both urban and rural areas (to ensure adequate provider coverage for appointments with and access to primary care physicians, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies).

The CMO should investigate whether gaps in its PCP and dental network are among the key drivers of the decline in performance measure rates (e.g., adults' access to preventive care and annual dental visits for children) and the cause of an increasing rate of avoidable emergency room visits for members 0 to 21 years (a current PIP). Additional barrier analysis regarding provider availability and access issues, and more robust rapid cycle testing of interventions, would provide the CMO with information it could use to select and refine appropriate interventions that may result in improved performance in these areas.

For example, the CMO's *Bright Futures* PIP (to improve the rate of adolescents who received a well-child visit) demonstrated meaningful improvement; however, the CMO was unable to determine which of the interventions, if any, had impacted the well-visit rate for the targeted population.

For one of the interventions related to performance measures, Peach State collaborated with a federally qualified health center (FQHC) to provide after-hours clinic appointments for adolescents. If a key driver is appointment availability, the CMO should determine if further collaborative efforts of this type would improve rates.

The DCH has recently implemented a centralized credentialing process for providers, contracting with a credentials verification organization, with a goal of preventing unnecessary duplication and reducing individual provider and CMO burden for credentialing shared providers. This initiative has promise for improving provider participation in CMO networks, thereby potentially improving access, if providers' participation was hindered by the requirement to complete duplicate credentialing requirements across the CMOs. Future provider surveys could be used to assess provider opinions about satisfaction with this new, centralized process.

In addition, through its contracts with the CMOs and as an effort to reform and improve the delivery system, DCH promotes the implementation of patient-centered medical homes. In part, this evidence-based approach furthers the goal of effective management of chronic conditions to achieve improved quality and health outcomes, including dental and mental health outcomes. Through use of the medical/dental home model, there is also increased likelihood of improved member access to appropriate healthcare and services, and member perceptions and satisfaction may also improve. On its most recent consumer survey, Peach State scored below the NCQA national average for *Customer Service* (both child and adult surveys) and *Rating of Health Plan* (adult survey only).

Behavioral Health

Peach State's performance on the behavioral health measure set demonstrated that, although two of eight measures showed a statistically significant increase, the CMO did not meet any of the DCH targets for any of the indicators.

As a result of findings during the 2014 compliance review, Peach State received several recommendations related to case management, disease management, and furnishing of services. Although Peach State made significant progress in updating policies, training staff, and conducting internal audits, it is possible that the full impact of these quality improvement processes has not been seen in performance measure results. Of particular note is HSAG's recommendation from the prior year regarding the importance of the CMO decreasing fragmentation between physical health and behavioral health programs, as well as increasing family/caregiver involvement in the case management process. Member engagement and integration of physical and behavioral health treatment planning is important to ensure member adherence to treatment planning and to positively impact both physical and behavioral health outcomes. Therefore, HSAG recommends that Peach State continue to explore opportunities to: (1) integrate its physical and behavioral health programs within the organization; and (2) provide patient-centered medical homes for the members.

The CMO's PIP, *Appropriate Use of ADHD Medications* (ADHD 30-day follow-up visit rate), did not demonstrate meaningful or sustained improvement in the appropriate use of ADHD medications for members 6 to 12 years of age. Perhaps more importantly, while the selected intervention focused on provider awareness and education, the final conclusions were that member-based barriers, not provider-based barriers, were the primary factors impacting members' follow-up visit compliance. Therefore, HSAG recommends that Peach State review the barrier analysis and intervention development steps used for this PIP to identify gaps in its quality improvement processes. The CMO should pursue further drill-down analyses of member-based barriers and should more carefully prioritize identified barriers so that improvement efforts can be focused in an area that is more likely to see improvement.

This recommendation may be broadened and applied to the CMO's overall performance in the area of behavioral health; Peach State should revisit the causal/barrier assessment process to determine key drivers of its low performance. The assessment should target key impact areas and processes in the CMO's behavioral health program (member engagement, member education, and case management) and the link to network sufficiency (need for patient-centered medical homes). The CMO should discover, through drill-down analysis of member and provider data, specific areas for maximum impact and interventions for future rapid cycle improvement testing.

Conclusions

Overall, although Peach State's performance results indicate some areas of strength, these results are mixed. With certain exceptions in children's health outcomes, the CMO must implement mechanisms to improve quality, access, and timeliness of care for its members. Peach State should continue to assess areas for targeted interventions in care for members with behavioral health diagnoses and to improve access to care through maintaining an adequate provider network. The CMO should ensure that its methodologies for determining and tracking any measureable improvements are sound and can be relied upon to link the success of its interventions to the improved outcome. Peach State should further ensure that it integrates a review of the related organizational and operational processes as part of its continuous quality improvement efforts.

The CMO's quality assessment and performance improvement (QAPI) plan and process must provide a comprehensive roadmap for the organization's priorities for improvement, include the timelines and steps it will take, and provide for sufficient monitoring and tracking of results. HSAG has provided recent, formal quality improvement technical assistance to the CMOs, and DCH has provided written guidance and reporting requirements for the CMOs' annual QAPI evaluation process. Peach State should use these tools and request additional process improvement assistance as needed to move its quality program toward success.

6. WellCare of Georgia, Inc.

Plan Overview

WellCare of Georgia, Inc. (WellCare), is part of the national corporation, WellCare Health Plans, Inc., a multistate provider targeting government-sponsored health products. WellCare began operations in Georgia in 2005 and currently serves over 692,000 GF members in the State of Georgia.[6-1] 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, case and disease management and education, and wellness/prevention programs.

Review of Compliance With Standards

Findings

Table 6-1 presents the standards and compliance scores for WellCare. For Standards I–VI, HSAG evaluated a total of 100 elements for the SFY 2015 review period. All elements were scored as *Met* or *Not Met*. A compliance score was calculated per standard as well as an overall compliance score for all reviewed standards.

Table 6-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# *Met*	# *Not Met*	Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	**10**	**9**	**1**	**90.0%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**0**	**100.0%**
IV	Member Information	**20**	**20**	**0**	**100.0%**
V	Grievance System	**47**	**43**	**4**	**91.5%**
VI	Disenrollment Requirements and Limitations	**10**	**10**	**0**	**100.0%**
	Total Number of Elements	**100**	**95**	**5**	
	Overall Compliance Score				**95%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**17**	**12**	**5**	**70.6%**

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

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.

[6-1] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report. August 2015.

WellCare had an overall compliance score of 95 percent. Four standards were at 100 percent compliance: Subcontractual Relationships and Delegation, Member Rights and Protections, Member Information, and Disenrollment Requirements and Limitations.

WellCare scored 90 percent or higher in the two remaining standards: Provider Selection, Credentialing, and Recredentialing; and Grievance System. The Grievance System standard was noncompliant in four elements while the other standard had one element that was *Not Met*.

HSAG also reviewed documentation provided by WellCare to demonstrate that the CMO had met the intent of the corrective action plans DCH had approved for *Not Met* elements from the previous noncompliant review findings. Seventeen elements were re-reviewed within the following standards: Coordination and Continuity of Care, Coverage and Authorization of Services, Furnishing of Services, Clinical Practice Guidelines (CPGs), and Quality Assessment and Performance Improvement (QAPI) standards. All elements related to Coordination and Continuity of Care, and Coverage and Authorization of Services were *Met* upon reevaluation. Five elements within the remaining standards required continued corrective action.

Strengths and Weaknesses

Below is a discussion of the strengths and areas for improvement, by standard, that were identified during the compliance review.

Provider Selection, Credentialing, and Recredentialing: WellCare monitored its providers to ensure the provision of quality care. When quality issues were identified, the CMO implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status. The 10 recredentialing files that were reviewed by HSAG were complete and met timeliness requirements; however, HSAG identified two of 10 initial credentialing files in which the credentialing decision date exceeded the 120-day time frame requirement. As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, WellCare will no longer be responsible for credentialing and recredentialing the majority of providers in its network.

Subcontractual Relationships and Delegation: The CMO maintained its policies and procedures to ensure compliance with industry and State standards. WellCare delegated functions based on quality, efficiency, and cost-effective healthcare solutions with a focus on enhancing members' health and quality of life. WellCare monitored delegate performance through ongoing assessment of individual delegate functions and took corrective action when deficiencies were identified.

Member Rights and Protections: WellCare submitted several policies, procedures, and the member handbook as evidence that the CMO and its providers took into account member rights while providing care. All of the member rights included in both the federal regulations and the State contract were included in these documents.

Member Information: WellCare provided materials to members within the contractually required time frame. Materials were available in alternative languages when needed and at a reading level appropriate for the member.

Grievance System: WellCare staff demonstrated knowledge of grievance and appeal processes. Although the CMO had detailed policies and procedures for grievances, administrative review, and administrative law hearings, there were areas for improvement. HSAG noted that descriptions of contract requirements were not always consistent with actual practice or did not include all contractually required information.

During the on-site audit, HSAG reviewed 10 grievance files and 10 administrative review (appeal) files. With regard to timeliness, all appeal files met the applicable timeliness requirements for standard and expedited cases, and all grievance resolution letters were mailed within 90 days. However, the appeal resolution letters were not always written in easily understood language. In some cases, procedure codes and advanced medical terminology were used. In addition, three grievance acknowledgement letters were not mailed to members within 10 days.

Disenrollment Requirements and Limitations: The disenrollment policies, procedures, work flows, and processes were well structured and easily understood. The possible reasons for disenrollment, either for cause or without cause, were appropriately documented.

Recommendations for Improvement

WellCare received recommendations for improvement for the Grievance System standard only. HSAG's specific recommendations for improvement for WellCare are:

- Revise the Administrative Review procedure to include the "intended effective date of the proposed action" in its timely filing description when the proposed action is to terminate, reduce, or suspend previously authorized services.
- Revise the Notice of Proposed Action form letter to indicate that the member must exhaust WellCare's internal administrative review process.
- Revise the Georgia Medicaid Grievance procedure to include the provision that the member acknowledgment letter must be available in the member's primary language.
- Acknowledge all grievances within 10 working days.
- Ensure that appeal resolution letters are written in a manner that is understandable to members.

Follow-Up Review: HSAG also conducted a follow-up review of the previous compliance review findings. Five reevaluated elements within the following standards will require continued corrective action: Furnishing of Services, CPGs, and QAPI standards. Below is a summary of the areas that require continued corrective action.

- WellCare must address timely access issues to ensure providers return calls after hours within the appropriate time frames. Urgent calls must be returned within 20 minutes and other calls within one hour.
- WellCare must meet the geographic access standards in both urban and rural areas for primary care physicians (PCPs), specialists, dental subspecialty providers, and pharmacies.
- WellCare must ensure that 90 percent of its providers use CPGs.
- WellCare must meet all DCH-established performance measure targets.

- WellCare must continue to incorporate DCH's feedback on its QAPI plan. The CMO should also ensure it measures the effectiveness of the quality initiatives on the care provided to its membership.

Performance Improvement Projects

Findings

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 outcomes.

Rapid Cycle PIP Validation Results

Six of WellCare's eight PIPs were validated following the new rapid cycle methodology. Please refer to Appendix B, Methodology for Conducting Validation of Performance Improvement Projects, for a detailed discussion regarding the rapid cycle PIP validation process and a description of HSAG's scoring criteria.

The overall validation findings (confidence levels) for the rapid cycle PIPs are presented in Table 6-2. HSAG's findings are based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence*, *Confidence*, and *Low Confidence*.

Table 6-2—Rapid Cycle Performance Improvement Project Validation Findings for WellCare of Georgia, Inc.

PIP	Confidence Level
Annual Dental Visits	*Low Confidence*
Appropriate Use of ADHD Medications	*Low Confidence*
Avoidable Emergency Room Visits	*Low Confidence*
Bright Futures	*Low Confidence*
Comprehensive Diabetes Care	*Confidence*
Postpartum Care	*Low Confidence*

HSAG did not determine *High Confidence* in the quality improvement processes and outcomes for any of the six rapid cycle PIPs. HSAG assigned one PIP, *Comprehensive Diabetes Care*, a level of *Confidence*. The remaining five PIPs were assigned a *Low Confidence* level.

Rapid Cycle PIP-Specific Outcomes

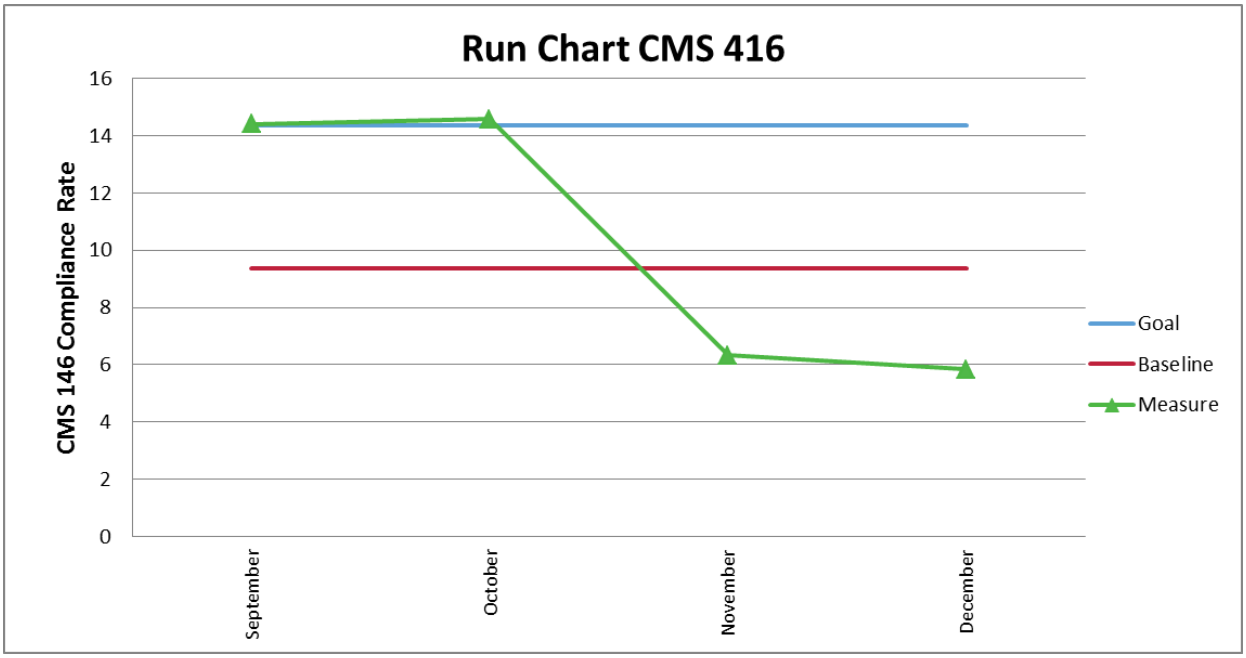
WellCare developed a SMART Aim statement and a SMART Aim measure for each rapid cycle PIP. Figure 6-1 through Figure 6-9 are run charts displaying the SMART Aim measurements for the rapid cycle PIPs, including the baseline and goal rates for each measure. The figures were constructed and submitted by WellCare as part of the PIP submissions; HSAG copied the figures for the purpose of reporting the PIP outcomes and did not alter the figures in any way.

For each PIP, HSAG evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements in comparison with reported baseline and goal rates. The data displayed in the SMART Aim run charts were used to determine whether each PIP demonstrated meaningful and sustained improvement in the SMART Aim measure.

A detailed discussion of WellCare's performance on each rapid cycle PIP, which includes the CMO's interventions and activities, is provided in the Performance Improvement Project Summary Grid in Appendix E. The grid also includes HSAG's recommendations to WellCare to improve performance.

Annual Dental Visits

Figure 6-1—SMART Aim Run Chart for *Annual Dental Visits*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Annual Dental Visits* PIP. For this PIP, WellCare established the baseline preventive dental rate for 6-to-9-year-old members assigned to one targeted dental provider (9.4 percent) based on the baseline measurement period of June through August 2014. The CMO set a goal rate for eligible members assigned to the targeted provider of 14.4 percent, an increase of 5 percentage points. The run chart included four monthly remeasurements for September through December 2014; however, the CMO compared the baseline measurement to the average of the four monthly measurements to assess for meaningful improvement. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible; therefore, the

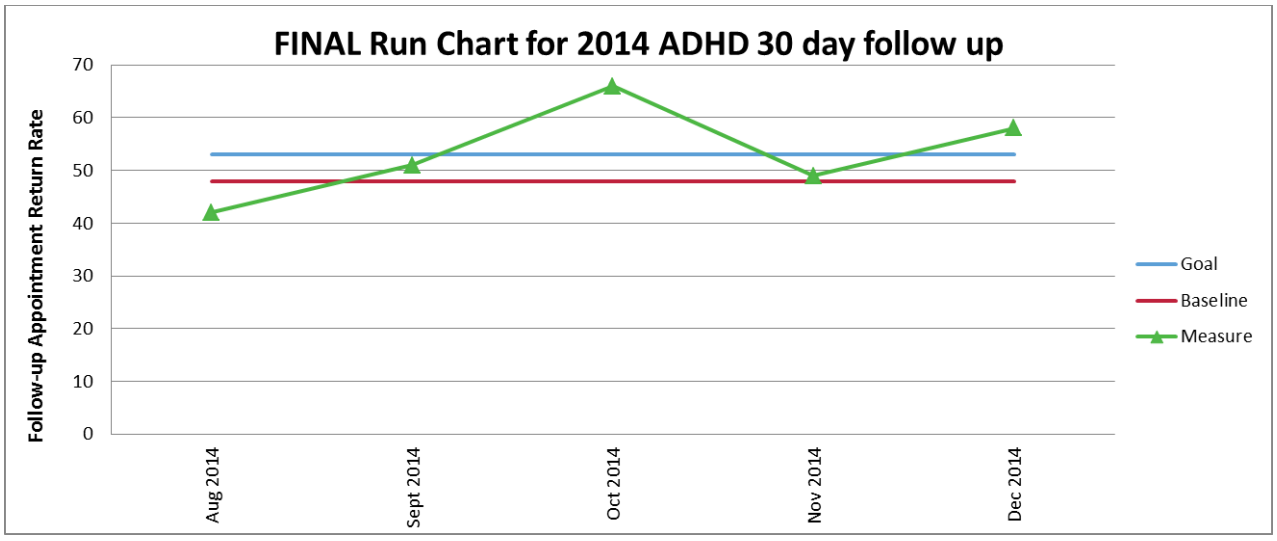
results displayed in the run chart should be interpreted with caution. HSAG determined that the CMO incorrectly calculated the baseline rate and the remeasurement rate. Rather than averaging monthly rates to establish a baseline rate, the numerators and denominators of each monthly measurement should have been summed, and the numerator total should have then been divided by the denominator total. Because the PIP results reported by the CMO were not credible, HSAG could not validate whether the PIP demonstrated meaningful or sustained improvement.

WellCare used a key driver diagram to summarize key drivers and potential interventions considered for the *Annual Dental Visits* PIP. The CMO tested one intervention with one targeted dental provider office. For the intervention, WellCare's dental vendor, Avesis, conducted telephonic outreach to eligible members who had had a visit with the targeted dental provider prior to CY 2014. Avesis provided education on preventive dental visits to eligible members who were reached by telephone.

WellCare determined that seasonality and timing impacted the ability to improve preventive dental visit rates among the targeted age group. Because the PIP was initiated at the end of summer, concurrent with the start of the school year, the CMO believed that competing with the school schedule resulted in the decline in the preventive dental visit rate during the PIP. The intervention did not include a follow-up component for those members who missed a scheduled dental appointment; therefore, an opportunity was missed to assist members in completing the preventive dental visit. The CMO reported that future improvement efforts will include follow-up phone calls for members who miss a scheduled appointment.

Appropriate Use of ADHD Medications

Figure 6-2—SMART Aim Run Chart for *Appropriate Use of ADHD Medications*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Appropriate Use of ADHD Medications* PIP. For this PIP, WellCare established the baseline rate (48 percent) of completed 30-day follow-up appointments for eligible members prescribed ADHD medications by the three targeted PCPs based on the baseline measurement period of August through December 2013. The CMO set a goal of an increase of 5 percentage points over the baseline rate for members prescribed ADHD medications by the three targeted PCPs. The run chart included five monthly remeasurements for August through December 2014; however, the CMO compared the baseline measurement to the average of the five

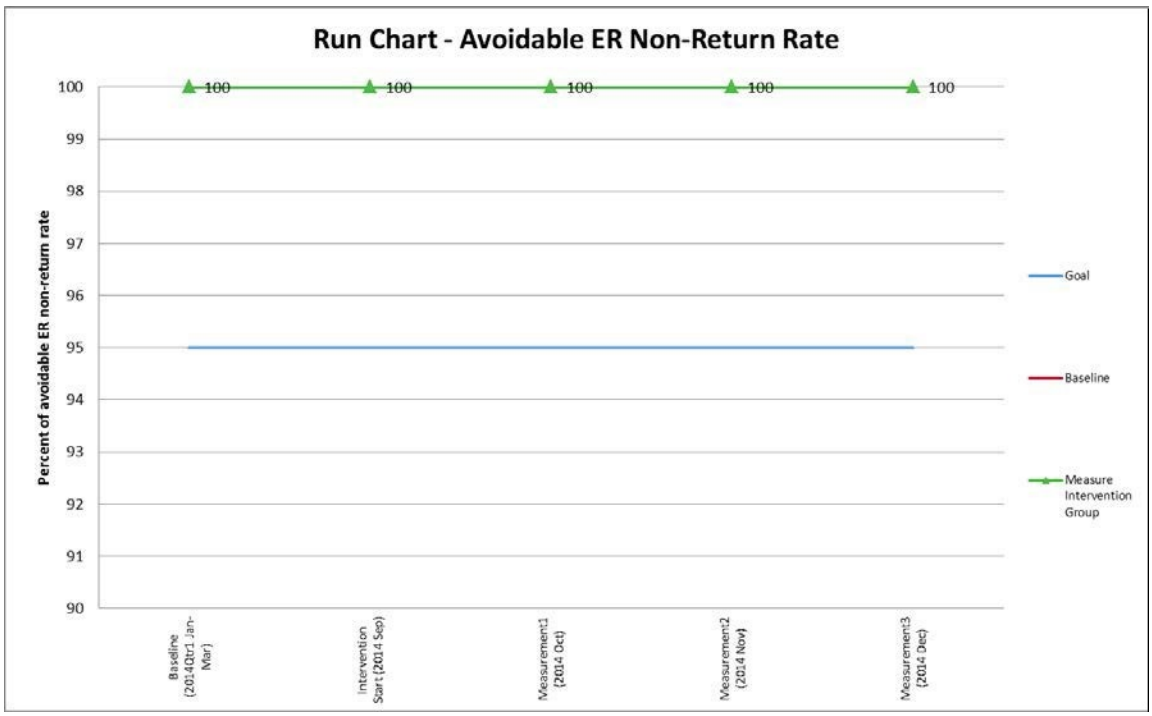
monthly measurements to assess for meaningful improvement. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible; therefore, the results displayed in the run chart should be interpreted with caution. HSAG determined that the CMO incorrectly calculated the baseline rate and the remeasurement rate. Rather than taking an average of monthly rates to establish a baseline rate, the numerators and denominators of each monthly measurement should have been summed, and the numerator total should have then been divided by the denominator total. Because the CMO's reported PIP results were not credible, HSAG could not use the PIP's SMART Aim measure to evaluate meaningful or sustained improvement.

WellCare used a key driver diagram to summarize key drivers and potential interventions considered for the *Appropriate Use of ADHD Medications* PIP. To address identified barriers, the CMO tested one intervention with three targeted PCPs who were high-volume and low-performing in relation to 30-day ADHD follow-up appointment completion. The intervention entailed an outreach telephone call placed by the WellCare Quality Department that occurred within seven days of the initial ADHD medication fill date. The telephone outreach included confirmation that the follow-up appointment had been scheduled, as well as education about the importance of the visit.

Despite the lack of evidence that the intervention was successful, WellCare reported that it will continue to outreach members for the targeted providers and will work with the targeted providers to overcome identified barriers. The CMO will also engage its Member Outreach and Community Advocacy teams to assist with overcoming the member-based barriers to attending follow-up visits. In anticipation of the increase in ADHD medication fills in August and September, the CMO will begin working with members and providers in July to improve follow-up visit compliance.

Avoidable Emergency Room Visits

Figure 6-3—SMART Aim Run Chart for *Avoidable Emergency Room Visits*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Avoidable Emergency Room Visits* PIP. For this PIP, WellCare defined the SMART Aim measure, the ER Non-Return rate, as the percentage of eligible members who had a previous avoidable ER visit, received the intervention, and did not return to the ER for an avoidable diagnosis within 90 days of receiving the intervention. WellCare established a baseline ER Non-Return rate for eligible members enrolled with either of the two targeted medical practices of 100 percent based on a baseline measurement period of January through March 2014. Because the baseline rate was 100 percent, and the SMART Aim measure was not an inverse rate, there was no room for improvement in this PIP. WellCare set an ER Non-Return rate goal of 95 percent for eligible members enrolled with either of the two targeted medical practices, which represented a decline of 5 percentage points from the baseline rate. The CMO's run chart included four monthly remeasurements, following the baseline measurement, from September through December 2014. All four monthly remeasurements remained at 100 percent; however, the SMART Aim measure did not provide any evidence of improvement because the baseline rate was also 100 percent.

WellCare used a key driver diagram to summarize key drivers and potential interventions considered for the *Avoidable Emergency Room Visits* PIP. The CMO tested one intervention with members who were enrolled with one of two targeted medical practices. The CMO conducted telephone outreach to parents of members ages 0 to 5 years who had previously had an avoidable ER visit. These parents were educated on the importance of developing a relationship with a PCP and on having post-ER visits with the PCP. Additionally, information on WellCare's 24-hour nurse advice line and nonemergency transportation services was provided as part of the outreach phone call.

Regardless of the lack of meaningful improvement, the CMO believed the intervention was successful and reported that it would be incorporating telephone follow-up for avoidable ER visits into the regular operating procedures of the Member Outreach department. WellCare plans to continue to monitor ER Non-Return rates as a measure of performance going forward.

Bright Futures

WellCare reported the results of three SMART Aim measures for its *Bright Futures* PIP. Figure 6-4, Figure 6-5, and Figure 6-6 display the SMART Aim measure results as reported by WellCare.

Figure 6-4—SMART Aim Run Chart for *Bright Futures*—Adolescent Well-Care Visits

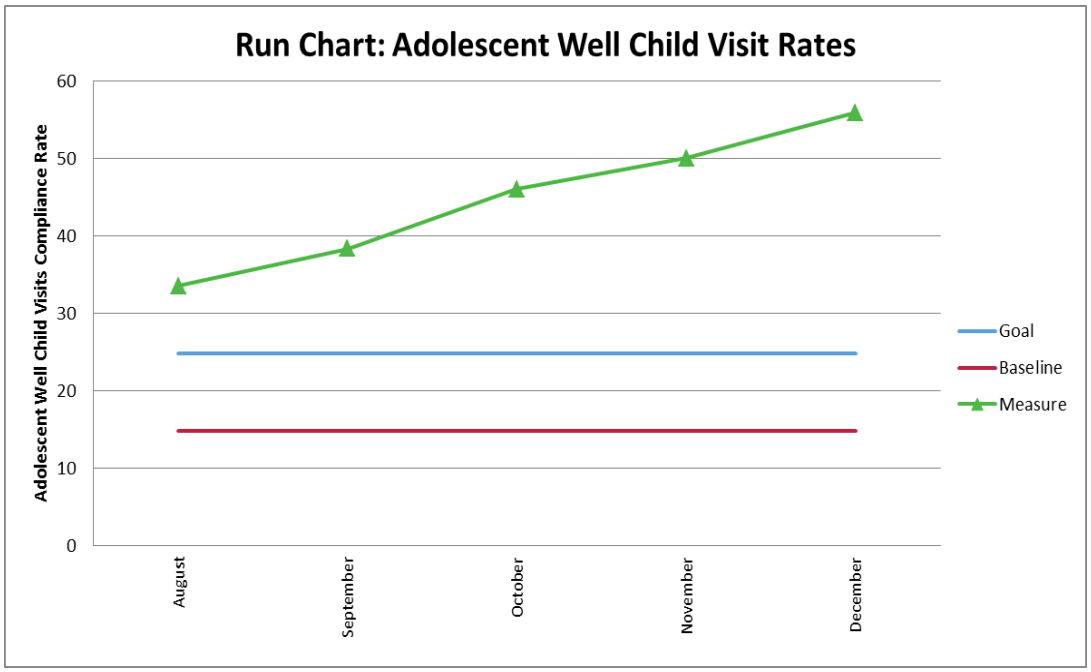


Figure 6-5—SMART Aim Run Chart for *Bright Futures*—Well-Child Visits in the First 15 Months of Life (6+)

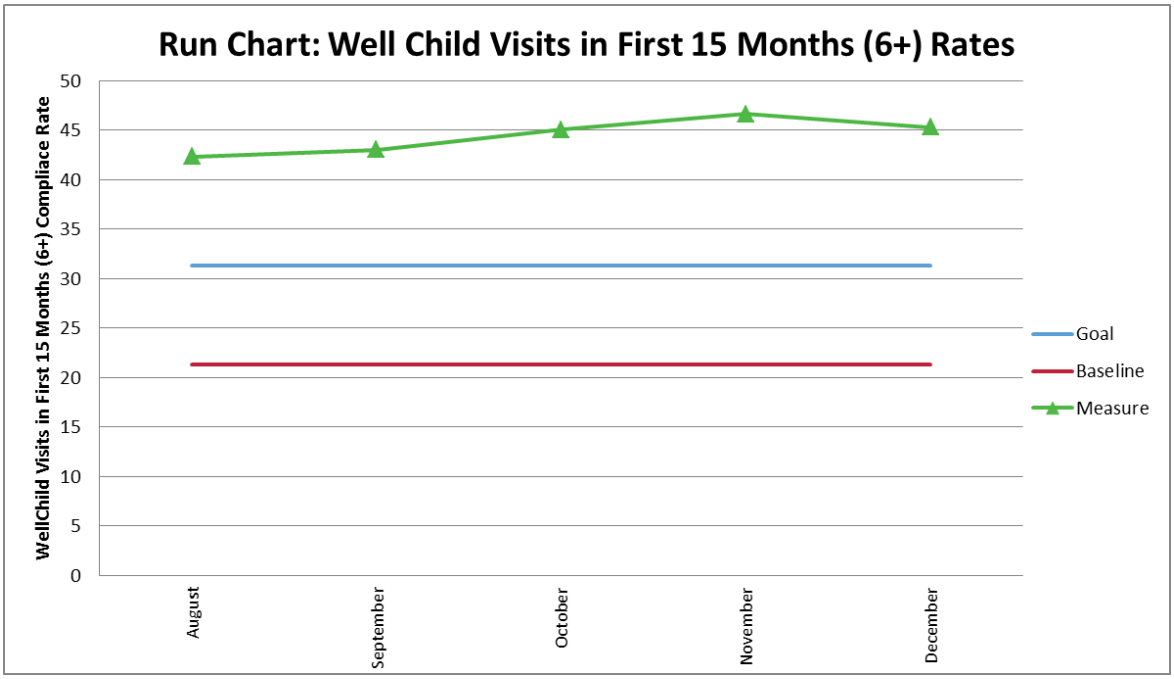
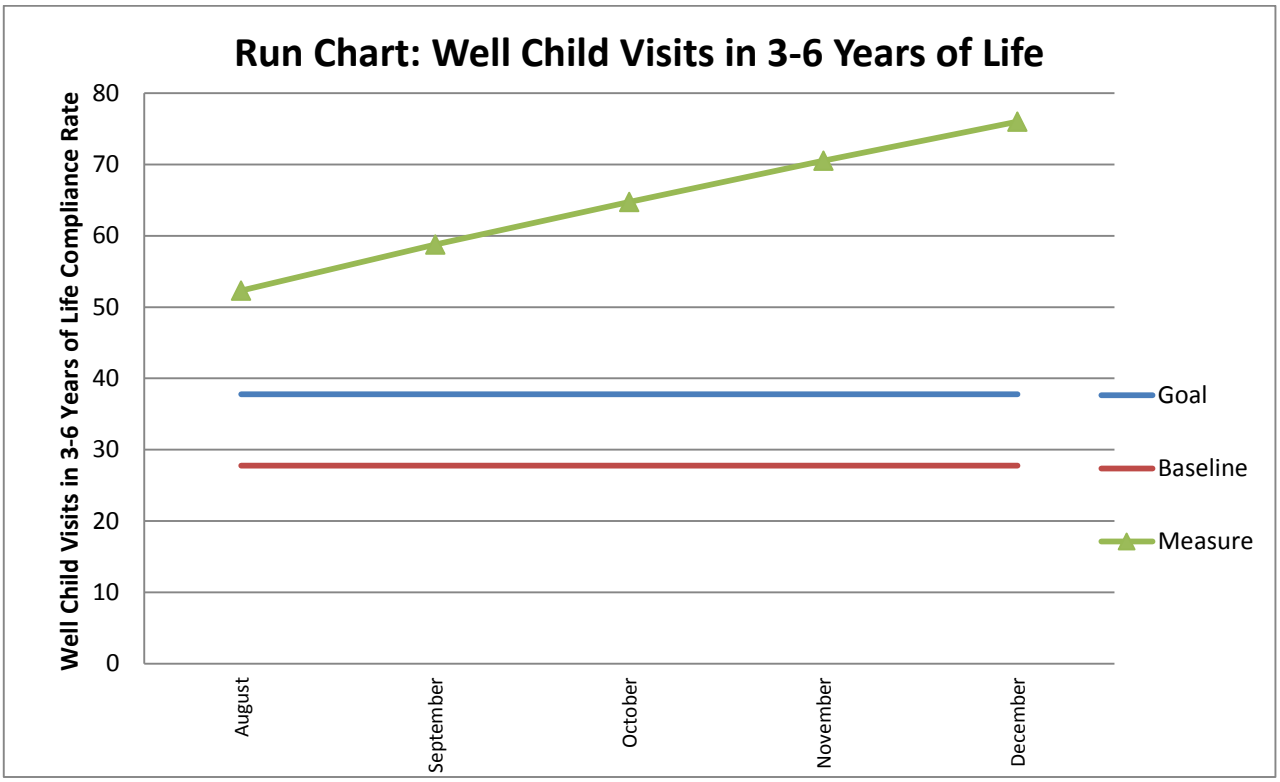


Figure 6-6—SMART Aim Run Chart
for *Bright Futures*—Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life



HSAG assigned a level of *Low Confidence* to the validation findings for the *Bright Futures* PIP. For this PIP, WellCare defined three SMART Aim measures, as displayed in Figure 6-4, Figure 6-5, and Figure 6-6, to measure the rate of well-child visits among adolescent members, members 15 months of age, and members 3 to 6 years of age, respectively. The baseline measurement period for each measure was January through February 2014. The CMO's baseline measurements for the two targeted PCP offices were as follows: 14.8 percent of adolescents had an annual well visit; 21.3 percent of members 15 months of age had six or more well visits; and 27.8 percent of members 3 to 6 years of age had an annual well visit. WellCare set a goal for the targeted PCP offices to increase each rate by 10 percentage points over the respective baseline rate.

The results displayed in the three run charts should be interpreted with caution because WellCare's SMART Aim measurement methodology was not sound. HSAG determined that the CMO plotted a cumulative well-visit rate for each of the SMART Aim measures. For each cumulative rate, the CMO established the denominator, or the total number of all members due for well-visit services for the entire calendar year, and used this denominator for each monthly measurement. The numerator was calculated by adding the number of members who obtained the service during the current month to the number of members who had previously obtained the service during the prior months of the year. A cumulative rate, therefore, would inevitably increase throughout the life of the PIP, regardless of whether any true or meaningful improvement in the rate occurred. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible; therefore, the results displayed in the run charts should be interpreted with caution. The CMO should have used a monthly or rolling annual rate for the SMART Aim measures to allow for a valid assessment of improvement.

WellCare used a key driver diagram to summarize key drivers and potential interventions considered for the *Bright Futures* PIP. The CMO tested two interventions, a member incentive program and a provider pay-for-performance (P4P) incentive program, with two PCP offices to address barriers to improving well-child visit rates. For the member incentive, eligible members received a brochure explaining the monetary incentive for obtaining well-child services. After receiving the service, the member (or member's parent) was instructed to have the provider sign a form, and submit the form to the CMO. Only one of the two targeted providers was eligible for the provider P4P incentive. The eligible provider received a monetary incentive "for meeting set metrics."

WellCare determined that well-child interventions should be implemented earlier in the PIP or calendar year, to allow time for the interventions to reach members and providers and to impact the well-visit rates. The CMO plans to implement the interventions earlier in the calendar year following the conclusion of this PIP, to allow more time for the interventions to have an effect and to provide a greater opportunity for demonstrating meaningful and sustained improvement.

Comprehensive Diabetes Care

WellCare reported the results of three SMART Aim measures for its *Comprehensive Diabetes Care* PIP. Figure 6-7 and Figure 6-8 display the SMART Aim measure results as reported by WellCare.

Figure 6-7—SMART Aim Run Chart for *Comprehensive Diabetes Care*—HbA1c Control

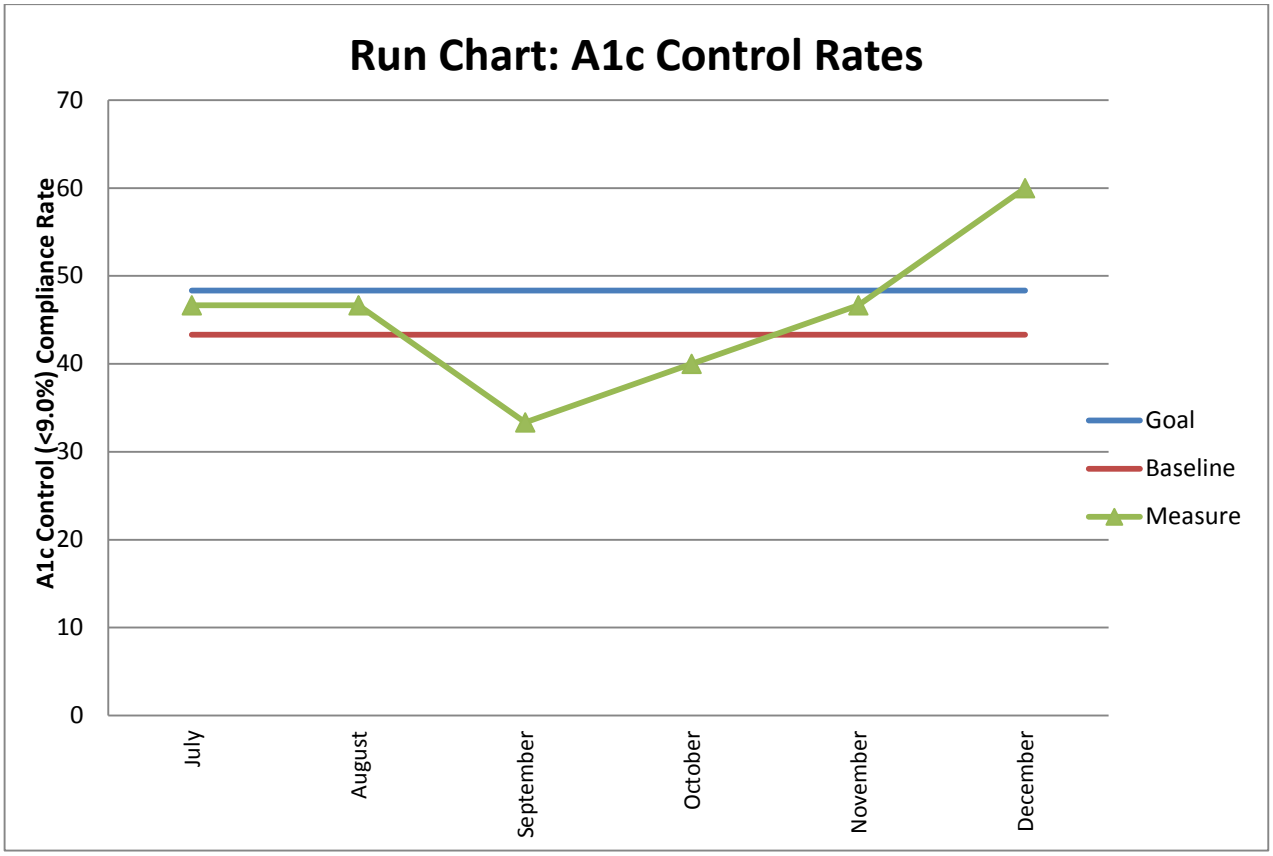
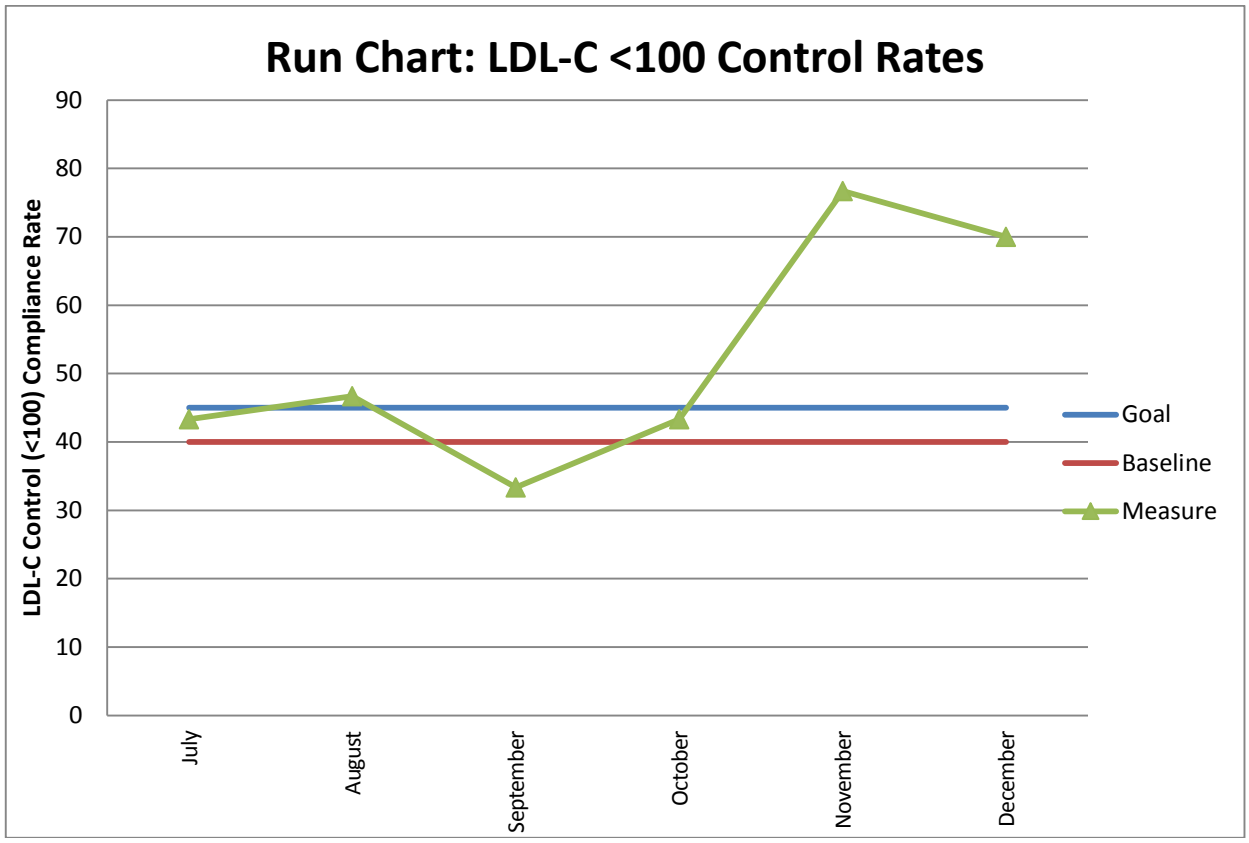


Figure 6-8—SMART Aim Run Chart
for *Comprehensive Diabetes Care*—LDL-C Control



HSAG assigned a level of *Confidence* to the validation findings for the *Comprehensive Diabetes Care* PIP. For this PIP, WellCare defined two SMART Aim measures, as displayed in Figure 6-7 and Figure 6-8, to measure the percentage of members with diabetes whose most recent HbA1c level was less than 9.0 percent and the percentage of members with diabetes whose most recent LDL-C level was less than 100 mg/dL. The baseline measurement period for both measures was January through February 2014. The baseline measurements for the targeted endocrinologists were as follows: 43.3 percent of members had a most recent HbA1c level less than 9.0 percent, and 40.0 percent of members had a most recent LDL-C level less than 100 mg/dL. The CMO set a goal for the targeted endocrinologists to increase each rate by 5 percentage points over the respective baseline rate. Both run charts included six monthly remeasurements for July through December 2014.

Although WellCare reported that the SMART Aim goal for members' HbA1c level was not met, HSAG determined that the December 2014 measurement of 60.0 percent was 16.7 percentage points above the baseline rate of 43.3 percent. The increase of 16.7 percentage points exceeded the goal of increasing the rate by 5 percentage points; therefore, the SMART Aim goal was met. Similarly, the SMART Aim goal for LDL-C control, an increase of 5 percentage points above the baseline rate of 40.0 percent, was met for the August (46.7 percent), November (76.7 percent), and December (70.0 percent) measurements for that measure, which were all more than 5 percentage points above the baseline rate. Because the SMART Aim goal was met for HbA1c and LDL-C, both SMART Aim measures demonstrated meaningful improvement. Only the LDL-C SMART Aim measure

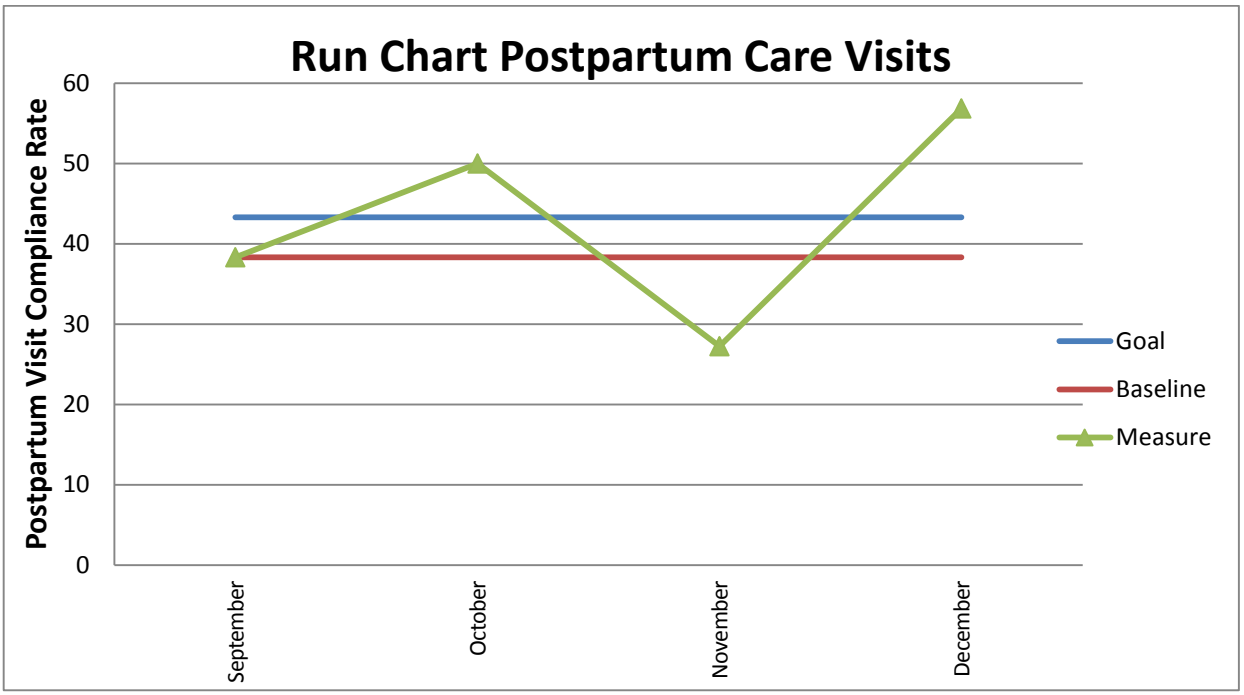
demonstrated sustained improvement, with more than one consecutive measurement exceeding the SMART Aim goal.

WellCare used a key driver diagram to summarize key drivers and potential interventions considered for the *Comprehensive Diabetes Care* PIP. The CMO tested one intervention, face-to-face visits with two low-performing endocrinologists, to address identified barriers to improving HbA1c and LDL-C control. WellCare Quality Improvement (QI) representatives met with each provider and a member of the provider's office staff during the face-to-face visits. The QI representatives discussed the Diabetes Clinical Practice Guidelines (CPGs) and provided details of members who were noncompliant with the diabetes control outcomes. The providers had an opportunity to share known member-specific barriers and any concerns about the PIP. Additionally, the QI representatives introduced the PIP tracking tool to the providers, which recorded member demographics, dates of service, and diabetes lab results. The tracking tool was used for real-time tracking of the SMART Aim measures.

WellCare documented that it will continue the intervention and monitor rates to determine if sustained improvement can be achieved for both SMART Aim measures. The CMO also reported lessons learned from the provider visits. The providers reported a lack of continuity of care when members switch from one provider to another as a barrier. WellCare is considering how the lack of member motivation and continuity of care can be addressed through additional interventions by its case management and disease management departments.

Postpartum Care

Figure 6-9—SMART Aim Run Chart for *Postpartum Care*



HSAG assigned a level of *Low Confidence* to the validation findings for the *Postpartum Care* PIP. For this PIP, WellCare established the baseline rate of completed postpartum care visits (38.3 percent) for the targeted women's healthcare provider group based on the baseline measurement period of June through August 2014. The CMO set a goal for the targeted provider group to increase the postpartum visit rate by 5 percentage points over the baseline rate. The run chart included four monthly remeasurements from September through December 2014; however, the CMO compared the baseline measurement to the average of the four monthly measurements to assess for meaningful improvement. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible; therefore, the results displayed in the run chart should be interpreted with caution. HSAG determined that the CMO incorrectly calculated the baseline rate and the remeasurement rate. Rather than taking an average of monthly rates to establish a baseline rate, the numerators and denominators of each monthly measurement should have been summed, and the numerator total should have then been divided by the denominator total. Because the PIP results reported by the CMO were not credible, HSAG could not validate whether the PIP demonstrated meaningful or sustained improvement.

WellCare used a key driver diagram to summarize key drivers and potential interventions considered for the *Postpartum Care* PIP. To address identified barriers, the CMO tested two interventions, a member incentive program and a provider incentive program, for members assigned to one women's healthcare provider group. The Healthy Postpartum Behavior incentive program was communicated to members through a brochure that encouraged them to complete a postpartum care appointment three to eight weeks after delivery. To obtain the incentive reward, members were required to fill in their information on a portion of the brochure and mail it back to the CMO. For the Postpartum Provider incentive program, WellCare provided to the targeted provider a weekly list of members who had recently delivered. The provider outreached members on the list to schedule the postpartum care visit within 21 to 56 days after the delivery date. After the visit was completed, the provider was responsible for sending medical records documenting the postpartum care visit to the CMO. WellCare paid a monetary incentive to the provider for each qualifying completed postpartum care appointment that was documented.

While the CMO did not collect sufficient data to determine which incentive program had a greater impact on the SMART Aim measure, WellCare concluded that the provider incentive may have had a greater likelihood for impacting the postpartum care visit rate. The CMO will continue to research best practices to further improve future outcomes.

Traditional Outcome-Focused PIP Validation Results

WellCare's two satisfaction-based PIPs were validated using HSAG's outcome-focused PIP validation methodology, based on annual study indicator measurements. Table 6-3 displays the validation findings for the ongoing satisfaction-based PIPs.

Table 6-3—Satisfaction-Based Performance Improvement Project Validation Findings for WellCare of Georgia, Inc.			
PIP	**Percentage of Evaluation Elements Scored *Met***	**Percentage of Critical Elements Scored *Met***	**Validation Findings**
Member Satisfaction	80%	71%	*Not Met*
Provider Satisfaction	71%	71%	*Not Met*

Both of the satisfaction-based PIPs received a *Not Met* score for one or more critical evaluation elements, which resulted in an overall *Not Met* validation finding.

Traditional Outcome-Focused PIP-Specific Outcomes

Table 6-4 and Table 6-5 display the study indicator rates for each measurement period of the two traditional outcome-focused, satisfaction-based PIPs, including the baseline period and each subsequent annual measurement period. In these tables, statistically significant changes between remeasurement periods are noted with an upward or downward arrow followed by an asterisk. Statistical significance is based on the *p* value calculated from a statistical test comparing measurement period rates. Differences in these rates that resulted in a *p* value less than 0.05 were considered statistically significant. It is possible for a percentage point difference between measurement period rates to appear large without being statistically significant. In certain instances, the study indicator denominators may not be large enough to have sufficient power to detect statistically significant difference. Similarly, the reverse may also occur: a *small* percentage point difference between measurement period rates with *large* denominators may result in a small percentage point difference that is statistically significant because larger denominators have greater power to detect statistically significant differences.

If the PIP achieved statistically significant improvement over the baseline rate during a previous measurement period, it was then reviewed for sustained improvement. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators. PIPs that did not achieve statistically significant improvement (i.e., did not meet the criteria to be assessed for sustained improvement) were not assessed (NA).

A detailed discussion of WellCare's performance on each traditional PIP, which includes the CMO's interventions and activities, is provided in the Performance Improvement Project Summary Grid in Appendix E. The grid also includes HSAG's recommendations to WellCare to improve performance.

Member Satisfaction

Table 6-4—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)**	**Remeasurement 2 (1/1/15–5/31/15)**	**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%	88.1%	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. The study indicator rate increased from Remeasurement 1 to Remeasurement 2 by 0.6 percentage point, but the Remeasurement 2 rate remained below the baseline rate.

WellCare did not use a causal/barrier analysis process that clearly linked the interventions implemented for the *Member Satisfaction* PIP with identified barriers. The CMO submitted a "2015 Force Field Analysis" document as part of the PIP documentation; however, the content of this document did not appear to have been updated from the prior year's PIP submission. WellCare reported new interventions for the second remeasurement period. One new intervention, a cultural competency plan to increase case manager knowledge and comfort in addressing cultural and spiritual needs of members, could clearly impact member satisfaction. It was unclear how two other new interventions, described below, would directly impact member satisfaction:

- Creation of the HealthConnections Model to catalogue available social services that WellCare staff can use when working with communities to address unique local social service needs.
- Creation of the Healthy Behaviors Rewards Program, which offered members a financial incentive to complete health behavior services.

Provider Satisfaction

Table 6-5—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)**	**Remeasurement 2 (6/1/14–8/31/14)**	**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%↓*	70.9%	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. There was an increase of 1.4 percentage points in the study indicator rate from Remeasurement 1 to Remeasurement 2, but the Remeasurement 2 rate remained below the baseline rate.

The 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 did not document any new interventions for the Remeasurement 2 period. The Remeasurement 1 interventions that were continued for the Remeasurement 2 period included the following:

- 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 email 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.

Strengths and Weaknesses

This was the first year that WellCare submitted for validation PIPs using the new rapid cycle PIP framework. The learning curve necessary for transitioning to the new rapid cycle approach was evidenced by WellCare's performance on the six rapid cycle PIPs. WellCare's performance on the six rapid cycle PIPs suggests that the CMO has substantial room for improvement in the application of the new rapid cycle PIP process. HSAG was unable to determine *High Confidence* in the results of any of the rapid cycle PIPs. Only one of the CMO's six rapid cycle PIPs, *Comprehensive Diabetes Care*, received a level of *Confidence*, and the remaining five PIPs received a *Low Confidence* level. Based on their performance across the six rapid cycle PIPs, WellCare has opportunities for improvement in implementing the new rapid cycle PIP process in the following areas: accuracy of reported key findings and interpretation of results, demonstrating meaningful and sustained improvement of outcomes through effective intervention testing and revision, planning for sustained improvement of outcomes, and documenting lessons learned and information gained at the conclusion of the PIP.

WellCare's two satisfaction-based PIPs that used the traditional annual study indicator measurements were validated with HSAG's established, outcome-focused PIP validation methodology. WellCare's performance revealed flaws in the PIP Design stage (Steps I through VI). The CMO incorrectly documented the study indicator title and measurement period dates for the *Member Satisfaction* PIP and failed to include the survey tool, telephone script, and cover letter used for the *Provider Satisfaction* PIP. In the Implementation stage, the CMO did not complete all of the required statistical testing, incorrectly interpreted study indicator results, and failed to conduct intervention-specific evaluations of effectiveness. The lack of evaluation and data-driven refinement of improvement strategies resulted in a lack of improvement in study indicator outcomes for both PIPs.

Recommendations for Improvement

For a PIP to successfully improve the three domains of care and health outcomes, the technical design of the project and the quality improvement processes used must be methodologically sound and based on solid improvement science. WellCare's PIP performance suggested a number of areas of opportunity that applied across the various PIP topics. Because all ongoing and future PIPs will be using the rapid cycle PIP process, all of the recommendations for future projects are related to the rapid cycle PIP design. HSAG recommends the following for WellCare:

- At the start of a new rapid cycle PIP, the CMO should carefully consider the end date specified in the SMART Aim statement and work backwards when planning the execution of the five rapid cycle PIP modules. Careful planning is critical to allow sufficient time to test and refine interventions that will result in meaningful and sustained improvement of outcomes during the limited time frame of the PIP.
- WellCare should involve qualified analysts from the start of the PIP process, and throughout the life of the PIP, to ensure that the SMART Aim measure definition and measurements are methodologically sound. Measurement rates cannot be collapsed across multiple measurement intervals by simply taking an average of the monthly percentages. Involving analysts in every step of the design, data collection, analysis, and results interpretation for the PIP will ensure that measurements and analyses are accurate, appropriate, and methodologically sound.

- The CMO should ensure that the SMART Aim statement for each PIP is structured correctly and includes all of the required components.
- The CMO should ensure that the SMART Aim measure for each PIP is methodologically sound and appropriate for the PIP topic. The numerator and denominator of the SMART Aim measure should be clearly and accurately defined. The baseline measurement period should be comparable to the planned SMART Aim measurement intervals. Additionally, for future rapid cycle PIPs, SMART Aim measurements should occur monthly or more frequently, as appropriate.
- For rapid cycle PIPs focused on annual services (e.g., well-child visits and diabetic screenings), WellCare should seek technical assistance from HSAG to ensure that the SMART Aim measure is appropriate and that meaningful improvement is detectable from one measurement interval to the next.
- The CMO should carefully and thoroughly execute all steps in the PDSA cycle for each intervention. Each step in the PDSA process is necessary to maintain the focus of limited resources on the most impactful improvement strategies and achieve optimal outcomes.
- If meaningful improvement is achieved, the CMO should formulate and document plans for ensuring that the improvement is sustained over time and include consideration for how successful interventions can be spread beyond the targeted population of the PIP in the future.
- At the conclusion of the PIP, WellCare should ensure that the lessons learned from completed PDSA cycles, the final process map, the final FMEA, and the final SMART Aim run chart are synthesized and documented by the PIP team so that the outcomes of the PIP can be used as the foundation of future improvement efforts.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the current measure rates as compared to those of last year. The performance targets reflect the DCH-established performance targets for 2014. When possible, changes in rates were tested for statistical significance. However, caution should be exercised when interpreting the results of the significance testing given that statistically significant changes may not necessarily be clinically significant.

Access to Care

WellCare's Access to Care performance measure results are shown in Table 6-6.

Table 6-6—WellCare Access to Care Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12–24 Months	98.04%	97.51%	↓	
Ages 25 Months–6 Years	91.75%	91.23%	↓	
Ages 7–11 Years	92.62%	92.61%	↔	
Ages 12–19 Years	90.61%	90.35%	↔	91.85%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	85.05%	81.76%	↓	88.32%
Oral Health (Annual Dental Visit)				
Ages 2–3 Years	49.95%	46.94%	↓	55.78%
Ages 4–6 Years	77.11%	72.25%	↓	
Ages 7–10 Years	79.94%	75.14%	↓	
Ages 11–14 Years	72.83%	69.30%	↓	
Ages 15–18 Years	62.56%	58.65%	↓	
Ages 19–21 Years	32.79%	31.96%	↔	
Total	70.73%	66.64%	↓	69.92%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	31.37%	32.34%	↔	43.43%
Engagement	9.38%	7.02%	↓	16.17%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.23%	0.00%	↔	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

WellCare showed significant declines in 10 out of 15 Access to Care performance measures and did not meet any of the 2014 performance targets.

Children's Health

WellCare's Children's Health performance measure results are shown in Table 6-7.

Table 6-7—WellCare Children's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	68.46%	66.93%	↔	67.98%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Third, Fourth, Fifth, and Sixth Years of Life	68.25%	66.93%	↔	69.60%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	43.75%	49.54%	↔	53.47%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	84.95%	84.03%	↔	80.30%
Combination 6	43.06%	43.06%	↔	
Combination 10	40.28%	38.66%	↔	38.94%
Lead Screening in Children				
Lead Screening in Children	77.51%	81.35%	↔	77.00%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	75.94%	79.09%	↑	77.97%
Immunization for Adolescents				
Combination 1 Total	74.59%	76.33%	↔	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	49.07%	63.43%	↑	42.00%
Counseling for Nutrition—Total	61.11%	59.49%	↔	57.70%
Counseling for Physical Activity—Total	51.85%	54.63%	↔	44.20%
Developmental Screening in the First Three Years of Life				
Total	40.51%	44.91%	↔	45.00%
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	52.65%	49.93%	↓	58.00%

Table 6-7—WellCare Children's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	23.34%	21.76%	↓	31.50%
Upper Respiratory Infection				
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	81.28%	82.81%	↑	85.86%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014, with the exception *of Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services*, which is October 1, 2013, through September 30, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

WellCare exceeded the 2014 performance targets for 7 out of 15 measures in the Children's Health measure set and showed significant improvement in three rates, *Appropriate Testing for Children with Pharyngitis*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, and *Appropriate Treatment for Children with URI*. WellCare showed significant declines for the *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services* measure indicators, which also fell below the 2014 performance targets.

Women's Health

WellCare's Women's Health performance measure results are shown in Table 6-8. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex*, *Cesarean Delivery Rate*, *Percentage of Live Births Weighing Less Than 2,500 Grams*, and *Early Elective Delivery*.

Table 6-8—WellCare Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	73.93%	74.56%	↔	76.64%
Breast Cancer Screening				
Breast Cancer Screening	73.65%	72.17%	↔	62.88%

Table 6-8—WellCare Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Chlamydia Screening in Women				
Total	49.83%	50.26%	↔	57.25%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	21.30%	20.37%	↔	22.14%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.07%	81.27%	↔	89.72%
Postpartum Care	63.24%	64.56%	↔	70.20%
Cesarean Section for Nulliparous Singleton Vertex				
Cesarean Section for Nulliparous Singleton Vertex[4]	15.23%	NR	NT	15.23%
Cesarean Delivery Rate				
Cesarean Delivery Rate[4]	30.41%	29.73%	↔	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams				
Percentage of Live Births Weighing Less Than 2,500 Grams[4]	8.32%	9.21%	↓	7.99%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	6.45%	9.95%	↔	10.42%
Early Elective Delivery				
Early Elective Delivery[4]	0.55%	NR	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	0.69%	NR	NT	
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
81+ Percent	65.93%	58.48%	↓	73.97%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NR Indicates the CMO produced a rate that was materially biased or chose not to report results for this measure; therefore, the rates were not included in the performance calculation. The auditors confirmed that although WellCare calculated these measures properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.
NT Indicates that statistical significance testing was not performed.

Table 6-8—WellCare Women's Health Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014. ↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014. ↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.				

WellCare only exceeded the 2014 performance target for one of the Women's Health measures, *Breast Cancer Screening*. Two measures exhibited significant declines and were below the performance target, *Percentage of Live Births Weighing Less than 2,500 Grams* and *Frequency of Ongoing Prenatal Care—Greater than 81 Percent*.

Chronic Conditions

WellCare's Chronic Conditions performance measure results are shown in Table 6-9. Note that a lower rate is better for the following performance measures: *HbA1c Poor Control (> 9.0)*, *Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)*, *Young Adult Asthma Admission Rate*, *COPD and Asthma Admission Rate—Total (Per 100,000 Member Months)*, and *Congestive Heart Failure Admission Rate—Total (Per 100,000 Member Months)*.

Table 6-9—WellCare Chronic Conditions Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	78.45%	83.19%	↑	87.32%
HbA1c Poor Control (>9.0)[4]	52.47%	48.75%	↔	43.02%
HbA1c Control (<8.0)	39.64%	43.26%	↔	48.57%
HbA1c Control (<7.0)	30.08%	32.43%	↔	34.76%
Eye Exam (Retinal) Performed	34.87%	35.44%	↔	54.43%
Medical Attention for Nephropathy	74.51%	76.71%	↔	79.28%
Blood Pressure Control (<140/90 mm/Hg)	56.91%	55.74%	↔	60.93%
Diabetes Short-Term Complications Admission Rate				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]	17.02	18.36	NT	--
Respiratory Conditions				
Use of Appropriate Medications for People with Asthma				
Ages 5–11 Years	92.48%	91.95%	↔	
Ages 12–18 Years	88.72%	88.52%	↔	

Table 6-9—WellCare Chronic Conditions Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Total	90.45%	89.67%	↔	89.76%
Young Adult Asthma Admission Rate				
Young Adult Asthma Admission Rate[4]	6.03	5.52	NT	--
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate				
COPD and Asthma Admission Rate—Total (Per 100,000 Member Months)[4]	43.71	41.00	NT	--
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate				
Congestive Heart Failure Admission Rate—Total (Per 100,000 Member Months)[4]	5.64	4.28	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	47.67%	43.24%	↔	56.20%
Adult BMI Assessment				
Adult BMI Assessment	75.78%	79.94%	↔	78.71%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NT Indicates that statistical significance testing was not performed.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.
-- Indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2013 and CY 2014, and previous years were reported as per 100,000 members. Since the 2014 performance target was developed based on previous years' reporting metrics, the 2014 performance target is not presented and caution should be used if comparing the CY 2014 rate to the 2014 performance target for this measure.

WellCare only exceeded the 2014 performance target for one of the Chronic Conditions measures, *Adult BMI Assessment*. The rate for *Comprehensive Diabetes Care (CDC)—HbA1c Testing* improved significantly, but it did not meet the 2014 performance target.

Behavioral Health

WellCare's Behavioral Health performance measure results are shown in Table 6-10.

Table 6-10—WellCare Behavioral Health Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 Performance Target[3]
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	41.12%	48.92%	↑	51.86%
Continuation and Maintenance Phase	54.18%	63.78%	↑	63.75%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	52.39%	50.77%	↔	68.79%
Follow-Up Within 30 Days	72.63%	69.72%	↓	81.98%
Antidepressant Medication Management				
Effective Acute Phase Treatment	44.15%	46.92%	↔	56.17%
Effective Continuation Phase Treatment	29.43%	30.37%	↔	40.17%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	1.07%	0.49%	↔	
Adherence to Antipsychotics for Individuals with Schizophrenia				
Adherence to Antipsychotics for Individuals with Schizophrenia	40.40%	33.85%	↔	61.34%

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.
↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.

WellCare only exceeded the 2014 performance target for one of the Behavioral Health measures, *Follow-Up of Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*. This measure, along with *Follow-Up of Care for Children Prescribed ADHD Medication—Initiation Phase*, exhibited significant improvement from 2013 to 2014. Conversely, *Follow-Up After Hospitalization for Mental Illness—Follow-Up Within 30 Days* exhibited a significant decline in performance.

Medication Management

WellCare's Medication Management performance measure results are shown in Table 6-11. Note that a lower rate is better for the *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* performance measure.

Table 6-11—WellCare Medication Management Measure Results

Measure	CY 2013 Rate[1]	CY 2014 Rate[2]	Statistically Significant Improvement or Decline	2014 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[4]	41.89%	40.54%	↑	39.06%
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	89.24%	86.72%	↓	
Diuretics	87.89%	87.27%	↔	
Total	87.01%	86.86%	↔	
Medication Management for People with Asthma				
Medication Compliance 50%—Ages 5–11 Years	49.08%	45.62%	↓	
Medication Compliance 50%—Ages 12–18 Years	45.61%	42.00%	↓	
Medication Compliance 50%—Ages 19–50 Years	53.60%	57.79%	↔	
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	
Medication Compliance 50%—Total	48.15%	44.91%	↓	
Medication Compliance 75%—Ages 5–11 Years	22.81%	21.93%	↔	29.46%
Medication Compliance 75%—Ages 12–18 Years	21.00%	18.25%	↓	
Medication Compliance 75%—Ages 19–50 Years	22.97%	33.61%	↑	
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	
Medication Compliance 75%—Total	22.28%	21.17%	↔	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.

Table 6-11—WellCare Medication Management Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
[4] A lower rate indicates better performance for this measure. NA Indicates that the rate was withheld because the denominator was less than 30. NT Indicates that statistical significance testing was not performed. ↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014. ↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014. ↔ Indicates no statistically significant change in performance between CY 2013 and CY 2014.				

None of WellCare's Medication Management measure rates met the 2014 performance targets. However, two measures improved significantly, *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* and *Medication Management for People with Asthma—Medication Compliance 75 Percent—Ages 19–50 Years*. WellCare showed significant declines in four of the eight performance indicators trended as part of the *Medication Management for People with Asthma* measure. In addition, WellCare showed a significant decline for the *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs* measure indicator.

Utilization

WellCare's Utilization performance measure results are shown in Table 6-12. Note that a lower rate is better for the *Ambulatory Care (Per 1,000 Member Months)—ED Visits* performance measure. Significance testing was not performed on the Utilization measure set since variances are not reported to NCQA.

Table 6-12—WellCare Utilization Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Ambulatory Care (Per 1,000 Member Months)				
ED Visits[4]	62.21	61.04	NT	53.98
Outpatient Visits	361.52	334.03	NT	
Inpatient Utilization—General Hospital/Acute Care				
Total Inpatient Average Length of Stay	3.12	2.99	NT	
Total Medicine Average Length of Stay	3.10	3.02	NT	
Total Surgery Average Length of Stay	7.25	5.84	NT	
Total Maternity Average Length of Stay	2.56	2.53	NT	
Mental Health Utilization				
Any Services—Total	9.30%	8.88%	NT	
Inpatient Services—Total	0.48%	0.50%	NT	

Table 6-12—WellCare Utilization Measure Results				
Measure	**CY 2013 Rate[1]**	**CY 2014 Rate[2]**	**Statistically Significant Improvement or Decline**	**2014 Performance Target[3]**
Intensive Outpatient Services—Total	0.14%	0.14%	NT	
Ambulatory/ED Visits—Total	9.21%	8.77%	NT	

[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 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[3] CY 2014 performance targets reflect the DCH-established CMO performance targets for 2014. Shaded boxes are displayed when no DCH CY 2014 performance target was established.
[4] A lower rate indicates better performance for this measure.
NT Indicates that statistical significance testing was not performed.

Although significance testing was not performed, WellCare's rate for the *Ambulatory Care (Per 1,000 Member Months)—ED Visits* exhibited improvement, but it did not meet the 2014 performance target.

Strengths and Weaknesses

The number of performance targets met by WellCare is shown in Table 6-13.

Table 6-13—Number of Performance Targets Met by WellCare			
Measure Set	**Number of Measures With Performance Target**	**Number of Measures That Met Performance Target**	**Percentage of Targets Met**
Access to Care	6	0	**0.0%**
Children's Health	15	7	**46.7%**
Women's Health	10	1	**10.0%**
Chronic Conditions	10	1	**10.0%**
Behavioral Health	7	1	**14.3%**
Medication Management	2	0	**0.0%**
Utilization	1	0	**0.0%**
Total	51	10	**19.6%**
**Excludes measures that were not comparable to performance targets.*			

Based on WellCare's 2014 performance, WellCare met 19.6 percent of its performance targets overall. Performance measure targets were met in Children's Health, Women's Health, Chronic Conditions, and Behavioral Health measure sets. HSAG has highlighted specific strengths and areas for improvement below.

WellCare's greatest strength was in the care it provided to children and adolescents. As illustrated in Table 6-13 above, over 46 percent of the measures in the Children's Health measure set exceeded the

2014 performance measure target. WellCare exceeded the 2014 performance target by more than 21 percentage points in the area of weight assessments (BMI) for children and adolescents, and also significantly improved performance by approximately 14 percentage points between 2013 and 2014. Further, WellCare exceeded the 2014 performance target by more than 10 percentage points in the area of counseling for physical activity.

A review of dental measures across both the Children's Health and Access to Care measure sets indicates that the CMO needs to establish methods to improve in this areas since none of the measures met the performance measure targets and all but one measure had significant declines from 2013 to 2014.

Measures related to Women's Health presented several opportunities for improvement as only one of the 10 measures, *Breast Cancer Screening*, met the performance measure target. Less than 60 percent of WellCare's pregnant members received at least 81 percent of the recommended prenatal care visits, which was more than 15 percentage points below the 2014 performance target, and represented a significant decline from 2013 to 2014.

WellCare did not meet any of the Access to Care 2014 performance targets. Performance significantly declined in children and adolescents' access to primary care practitioners (ages 12 months to 6 years), adults' access to preventative and ambulatory health services, and engagement of alcohol and other drug dependence treatment. Although the percentage of members who received timely initiation of alcohol and other drug dependence treatment services slightly improved, the rate was greater than 11 percentage points below the 2014 performance target.

WellCare also did not meet any 2014 performance targets for the Medication Management or Utilization measure sets. The percentage of members with asthma who remained on an asthma controller medication for at least 75 percent of their treatment period significantly improved among members ages 19 to 50 years. However, the percentage of members with asthma who remained on an asthma controller medication for at least 50 percent of their treatment period significantly declined among members ages 5 to 18 years. Further, WellCare's rate fell almost 8 percentage points below the 2014 performance target for members ages 5 to 11 years who remained on an asthma controller medication for at least 75 percent of their treatment period.

For the Behavioral Health measure set, approximately 51 percent of members hospitalized for mental illness had a follow-up visit within seven days of discharge, which is about 18 percentage points below the 2014 performance target. Additionally, approximately 70 percent of members hospitalized for mental illness had a follow-up visit within 30 days of discharge, which is more than 12 percentage points below the 2014 performance target. The percentage of members with schizophrenia who adhered to their antipsychotic medications fell approximately 27 percentage points below the 2014 performance target.

Within the Chronic Conditions measure set, the percentage of members with diabetes who received an eye exam remained steady from 2013 to 2014 but was nearly 19 percentage points below the 2014 performance target. Documented blood pressure control for members with cardiovascular conditions was nearly 13 percentage points below the 2014 performance target.

Recommendations for Improvement

WellCare met approximately half of the performance measure targets in the Children's Health measure set. This and all other measure sets require innovative, targeted interventions to improve performance. Therefore, HSAG recommends the following:

- WellCare currently has rapid cycle PIPs in place which are related to some of the performance measures. Because the majority of the CY 2014 PIPs did not use a sound measurement methodology, it was not possible for the CMO to evaluate the impact of interventions on the PIP outcomes or related performance measures. The CMO must ensure a sound measurement methodology for its PIPs (as described in the WellCare PIP recommendations section of this report) in order to produce valid PIP results that can be assessed for impact on related performance measures.
- WellCare should analyze the improvement strategies that can be linked to improvement in performance measure rates (for those performance measures that had a statistically significant increase). The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.
- WellCare should analyze all performance measure rates that fell below the DCH-required target and either implement new PIPs or adjust the focus of existing PIPs as needed.
- WellCare should prioritize its focus on performance measures that demonstrated a statistically significant decline, such as oral health and access to care.

In addition to the specific recommendations above, WellCare should focus efforts on the following measure topics in its quality improvement efforts.

Access to Care and Children's Health

- Access to care for children, adolescents, and adults

Women's Health

- Prenatal care

Chronic Conditions

- Blood pressure control for members with cardiovascular conditions
- Eye exams for members with diabetes

Behavioral Health

- Timely follow-up visits following a mental health-related hospital discharge
- Adherence to antipsychotics for members with schizophrenia

Medication Management

- Medication management

CAHPS Surveys

Findings

To assess the overall performance of WellCare, HSAG compared the calculated question summary rates for each global rating and global proportions for each composite measure (i.e., the percentage of respondents offering a positive response) to 2015 NCQA national Medicaid averages, where applicable.[6-2] The calculated question summary rates and global proportions represent the percentage of top-level responses (i.e., CAHPS top-box scores) for each global rating and composite measure, respectively. Comparisons of the 2015 top-box scores to 2015 NCQA national Medicaid data were performed for WellCare's adult and child Medicaid populations.[6-3] Further, for WellCare's CMO-specific findings, a substantial difference is noted when a CAHPS Survey measure's rate is 5 percentage points higher or lower than the 2015 NCQA national average. For purposes of this report, CAHPS measures are reported even when the NCQA minimum reporting threshold of 100 respondents was not met. Additional methodology information can be found in Appendix D.

The four global rating measures and five composite measures evaluated through the CAHPS Surveys are as follows:

CAHPS Global Rating Measures

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

CAHPS Composite Measures

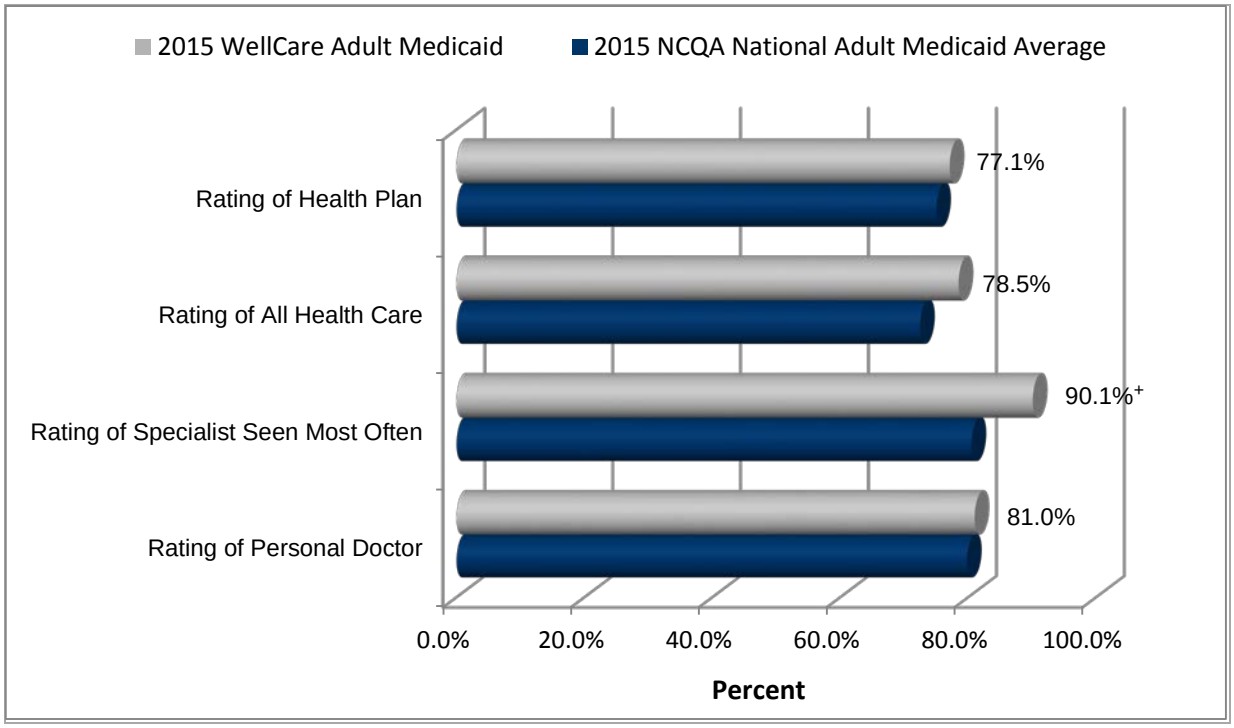
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

[6-2] Quality Compass® 2015 data serve as the source for the NCQA national averages contained in this publication and are used with the permission of the National Committee for Quality Assurance (NCQA). Quality Compass 2015 includes certain CAHPS data. Any data display, analysis, interpretation, or conclusion based on these data is solely that of the authors, and NCQA specifically disclaims responsibility for any such display, analysis, interpretation, or conclusion. Quality Compass® is a registered trademark of NCQA. CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

[6-3] The CAHPS Survey results presented throughout this section for WellCare are the CAHPS Survey measure results calculated by the CMO's survey vendor and provided to HSAG for purposes of reporting.

Figure 6-10 below depicts WellCare's adult Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national adult Medicaid average for each of the global ratings. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 6-10—WellCare Adult Medicaid CAHPS Survey Results for Global Ratings



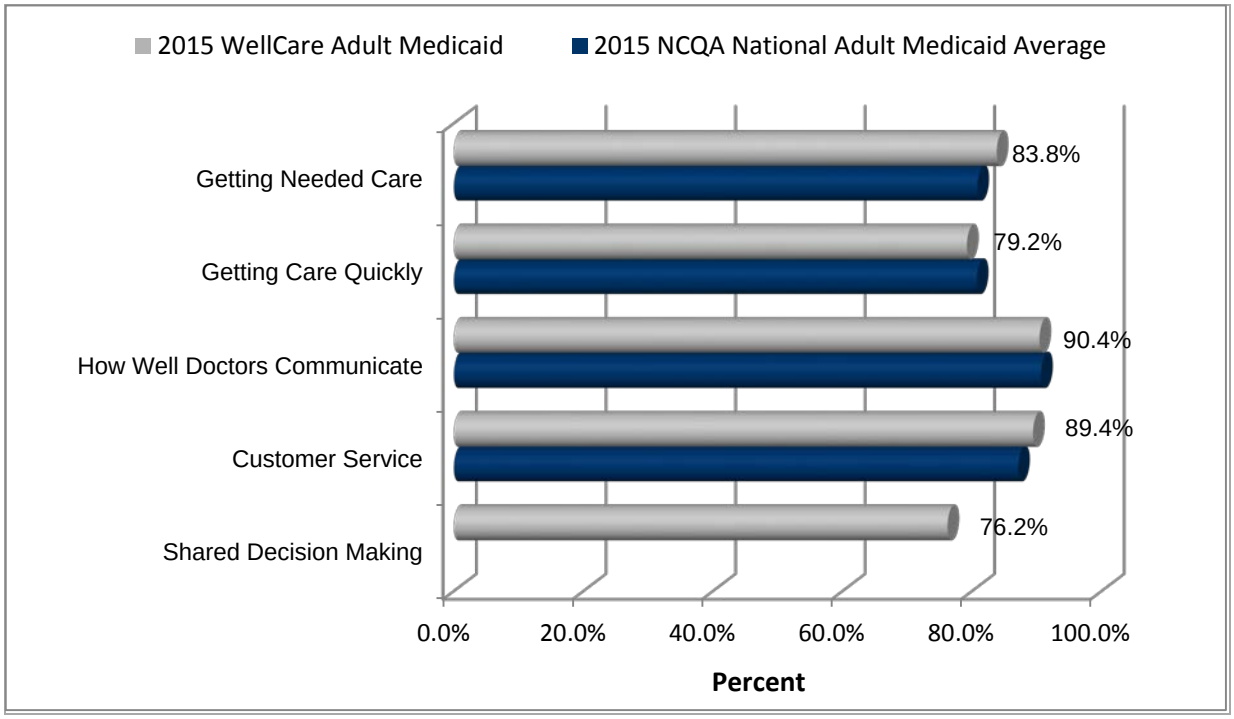
Please note: CAHPS measures with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a measure, caution should be exercised when interpreting the results.

The top-box scores for the adult Medicaid global ratings indicate the following:

- WellCare scored between 77 and 90 percent on the four global rating measures.
- WellCare scored at or above the 2015 NCQA national adult Medicaid average for all four global rating measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.
- WellCare did not score below the 2015 NCQA national adult Medicaid average on any of the global rating measures.

Figure 6-11 below depicts WellCare's adult Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national adult Medicaid average for each of the composite measures. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 6-11—WellCare Adult Medicaid CAHPS Survey Results for Composite Measures



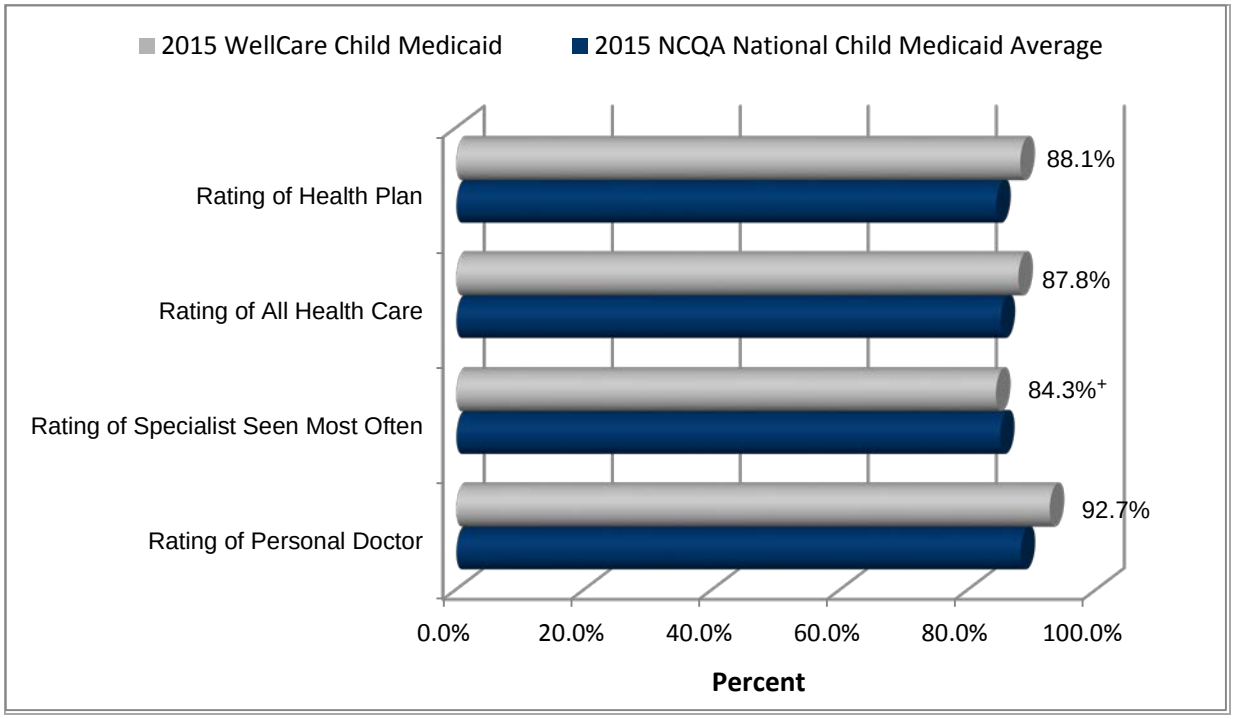
Please note: Due to changes to the Shared Decision Making composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

The top-box scores for the adult Medicaid composite measures indicate the following:

- WellCare scored between 76 and 90 percent on the five composite measures.
- WellCare scored at or above the 2015 NCQA national adult Medicaid average for two measures—*Getting Needed Care* and *Customer Service*.
- WellCare scored below the 2015 NCQA national adult Medicaid average for two measures—*Getting Care Quickly* and *How Well Doctors Communicate*.

Figure 6-12 below depicts WellCare's child Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national child Medicaid average for each of the global ratings. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2015 NCQA national averages.

Figure 6-12—WellCare Child Medicaid CAHPS Survey Results for Global Ratings



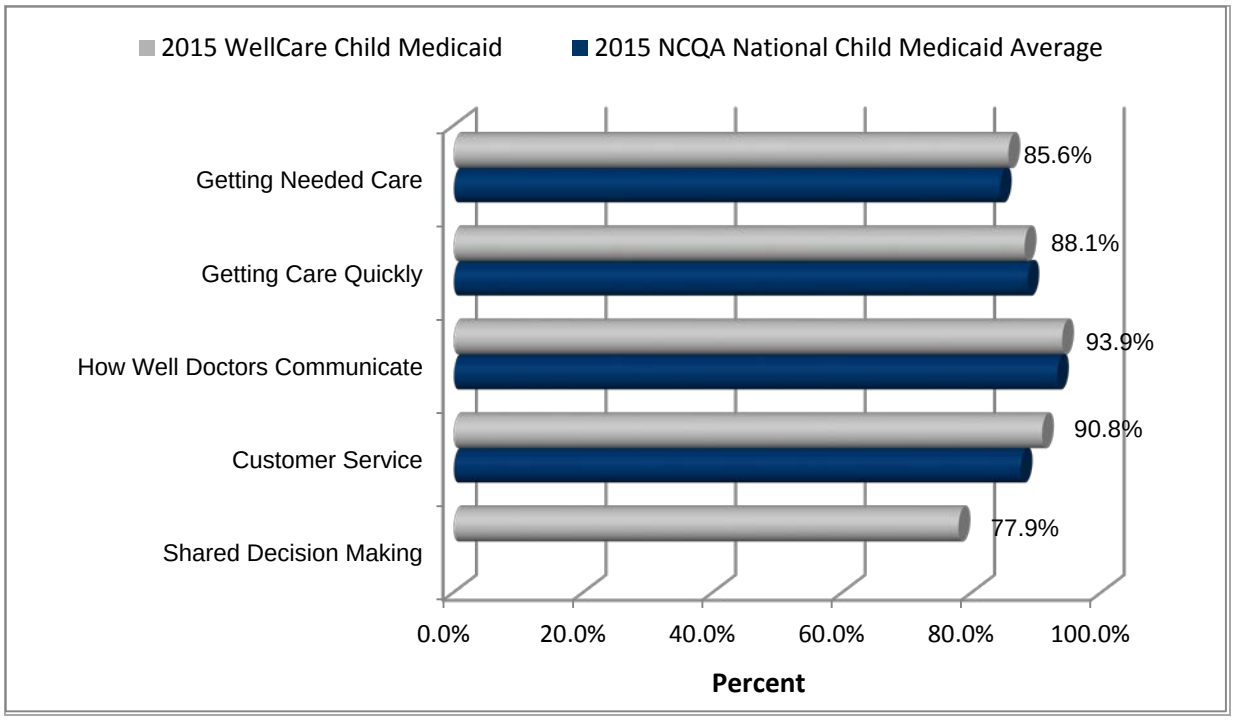
Please note: CAHPS measures with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a measure, caution should be exercised when interpreting the results.

The top-box scores for the child Medicaid global ratings indicate the following:

- WellCare scored between 84 and 93 percent on the four global rating measures.
- WellCare scored at or above the 2015 NCQA national child Medicaid average for three measures—*Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- WellCare scored below the 2015 NCQA national child Medicaid average for one measure—*Rating of Specialist Seen Most Often*.

Figure 6-13 below depicts WellCare's child Medicaid 2015 CAHPS top-box scores and the 2015 NCQA national child Medicaid average for each of the composite measures.

Figure 6-13—WellCare Child Medicaid CAHPS Survey Results for Composite Measures



Please note: Due to changes to the Shared Decision Making composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

The top-box scores for the child Medicaid composite measures indicate the following:

- WellCare scored between 78 and 94 percent on the five composite measures.
- WellCare scored at or above the 2015 NCQA national child Medicaid average for three measures—*Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.
- WellCare scored below the 2015 NCQA national child Medicaid average for one measure—*Getting Care Quickly*.

Strengths and Weaknesses

For WellCare's adult Medicaid population, the 2015 top-box rates for two of the eight comparable measures, *Getting Care Quickly* and *How Well Doctors Communicate*, were lower than the 2015 NCQA adult Medicaid national average. For the remaining six comparable measures, the 2015 top-box rates for the adult population were higher than the 2015 NCQA adult Medicaid national average; of these, the top-box rates for *Rating of All Health Care* and *Rating of Specialist Seen Most Often* were higher than the 2015 NCQA adult Medicaid national average by at least 5 percentage points or more.

For WellCare's child Medicaid population, the 2015 top-box rates for two of the eight comparable measures were lower than the 2015 NCQA child Medicaid national averages: *Rating of Specialist Seen Most Often* and *Getting Care Quickly*. The remaining six comparable measures' 2015 top-box rates were higher than the 2015 NCQA child Medicaid national averages: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.

Recommendations for Improvement

Based on an evaluation of WellCare's 2015 adult Medicaid CAHPS Survey results, HSAG recommends that the CMO focus quality improvement (QI) initiatives on enhancing members' experiences with *Getting Care Quickly* and *How Well Doctors Communicate*, since the rates for these measures were lower than NCQA's 2015 CAHPS adult Medicaid national averages. For WellCare's child Medicaid population, HSAG recommends that the CMO focus QI initiatives on *Rating of Specialist Seen Most Often* and *Getting Care Quickly* since the rates for these measures were below the 2015 NCQA national child Medicaid average.

HSAG has made general recommendations based on the information found in the CAHPS literature. (See Appendix G for an explanation of these recommendations.) The recommendations are intended to address those areas for which CAHPS measure scores were lower than the NCQA national Medicaid average.

WellCare should conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network. HSAG recommends that the CMO review the CAHPS literature and other relevant sources to assist with developing applicable interventions and process improvement activities.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about WellCare's performance in providing quality, accessible, and timely healthcare and services to its members. Overall, HSAG's evaluation showed that WellCare has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. The CMO demonstrated strong compliance review results (95 percent of federal and contract requirements for structure and operations were *Met*) and also demonstrated its commitment to quality process improvement, by closing 12 of the 17 corrective action plans from the previous year's compliance review. In addition, member satisfaction was high, both in the care received and the service provided by the CMO (CAHPS Survey results at or above the Medicaid national average for five measures, including *Rating of All Health Care, Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Customer Service*).

Three key themes emerged in HSAG's assessment of WellCare's overall performance, indicating significant opportunities for improvement in these areas. While a variety of other findings also indicate a need for improvement, HSAG advises the CMO to focus its quality initiatives on key areas with interrelated findings. Concentrated improvement efforts that achieve success in these areas can

be spread, with greater potential to also affect performance in other similar population/program areas over time. These areas, and resulting recommendations, are described below and include:

- Network sufficiency.
- Children's health.
- Care for members with chronic conditions.

Network Sufficiency

Results from three EQR activities illustrate that WellCare has an opportunity to improve its network adequacy and availability for both child and adult members. In addition to not meeting any of the DCH performance measure targets in the HEDIS measure domain of access to care, 10 of the 15 measures showed statistically significant decline. Although the CMO's CAHPS Survey results were positive, the rates for *Getting Care Quickly* were below the Medicaid national average. In addition, findings from the two most recent reviews of compliance showed that WellCare did not meet all provider availability requirements (to ensure providers return calls after-hours within the appropriate time frames) and minimum geographic access standards in both urban and rural areas (to ensure adequate provider coverage for appointments with and access to primary care physicians, specialists, dental subspecialty providers, and pharmacies).

The CMO should investigate whether gaps in its PCP network are among the key drivers of the decline in performance measure rates (such as child and adults access to preventive care and annual dental visits for children). The CMO also may want to consider conducting member focus groups to assess the apparent disconnect between its high member satisfaction rates related to access to care (*Getting Needed Care* and *Rating of All Health Care*) versus actual access to care performance measure results. Additional barrier analysis regarding provider availability and access issues would provide the CMO with information it could use to select appropriate interventions that may result in improved performance in these areas. For example, if appointment availability was assessed as a driver, the CMO could evaluate whether extended-hours and "immediate care" in-office appointments might be implemented in select offices in each geographic area.

As one of the interventions in its compliance corrective action plan, WellCare included the development of a pilot program to promote telemedicine in a school setting, and also partnered with a public health department. The CMO noted that it is expanding the use of telemedicine to increase access in areas for which there is a shortage of PCPs and/or specialists. If a key driver is appointment availability, the CMO should determine if further collaborations of this type would improve access rates.

The DCH has recently implemented a centralized credentialing process for providers, contracting with a credentials verification organization, with the goal of preventing unnecessary duplication and reducing individual provider and CMO burden for credentialing shared providers. This initiative has promise for improving provider participation in CMO networks, thereby potentially improving access, if providers' participation was hindered by the requirement to complete duplicate credentialing requirements across the CMOs. Future provider surveys could be used to assess provider opinions about satisfaction with this new, centralized process.

In addition, through its contracts with the CMOs and as an effort to reform and improve the delivery system, DCH promotes the implementation of patient-centered medical homes. In part, this evidence-based approach furthers the goal of effective management of chronic conditions to achieve improved quality and health outcomes, including dental and mental health outcomes. Through use of the medical/dental home model, there is also increased likelihood of improved member access to appropriate healthcare and service.

Children's Health

Although member satisfaction with care received was high, the results of the Children's Health measure set demonstrated that the CMO met only 46.7 percent of the DCH targets for these indicators, which was substantially lower than the other two CMOs' results. Coupled with the children's related measures in the Access to Care measure set (rates for nine of the 11 measures in the Access to Care measure set related to children's and adolescents' access to primary care practitioners and oral health showed statistically significant declines), WellCare's results related to children's health demonstrate that the CMO must evaluate methods to ensure children receive needed care.

WellCare met one of the performance measure targets related to *Follow-Up of Care for Children Prescribed ADHD Medication* and was the only CMO to do so. However, the CMO's ADHD-related PIP could not be evaluated for improvement because an incorrect rate calculation yielded PIP results that were not credible. Without accurate and meaningful data, the CMO can neither effectively implement rapid cycle evaluation for the PIPs nor monitor progress toward meeting the PIP SMART Aim goal and impact on the corresponding performance measure rate. Two other PIPs related to children's health (*Annual Dental Visits* and *Bright Futures*) also had measurement methodologies that were not sound; therefore, results for these PIPs were also not credible.

For WellCare to positively impact children's health performance measure rates, HSAG recommends that the CMO assess its PIP development process (as described in the WellCare PIP recommendations section of this report) and make the necessary changes. Further, the CMO should conduct causal/barrier analyses to determine the root causes that have resulted in the declines in performance measure rates and develop the necessary interventions. Due to the CMO's performance in the children's health area, quality improvement strategies beyond the specific rapid cycle PIPs should be evaluated and implemented.

Care for Members With Chronic Conditions

WellCare's performance on the group of measures related to care for chronic conditions demonstrated that it met only one of DCH's targets for these indicators. In addition, for at least two successive years, WellCare did not meet the required level of provider adherence to clinical practice guidelines (CPGs), scoring below the target of 90 percent. CPGs are required for certain chronic conditions, such as care for ADHD, diabetes, and asthma, in order to ensure providers maintain quality care and services at a level consistent with current best and proven practices and to achieve desired health outcomes.

During the 2014 compliance review, WellCare received several recommendations related to case and disease management. Although the CMO made significant progress so that related corrective action plans could be closed, it is possible that the full impact of these quality improvement processes has not been seen in performance measure results. Of particular note is HSAG's recommendation from the prior year regarding the importance of the CMO developing care plans that include customized goals with input from the member. Member engagement in treatment planning decisions is important to ensure treatment adherence and member empowerment to participate as a partner in healthcare practices, especially disease self-management.

Although WellCare's self-audit results showed that provider adherence to many CPGs improved greatly, the rate of adherence to the diabetes CPG was only 67 percent (as reported in the 2015 compliance review). The CMO's *Comprehensive Diabetes Care* PIP demonstrated meaningful improvement (HbA1c level); however, none of the related performance measures (the three *Comprehensive Diabetes Care—HbA1c Control* indicators) showed statistically significant improvement, nor did they meet the DCH-established targets. Conversely, the diabetes performance measure indicator that showed statistically significant improvement (*Comprehensive Diabetes Care—Hemoglobin A1c Testing*) was not part of the narrow focus of the CMO's *Comprehensive Diabetes Care* PIP. Therefore, it is not possible to ascertain which CMO improvement strategies are linked to this positive outcome.

HSAG strongly recommends that WellCare revisit the causal/barrier assessment process to determine root causes of its low performance in the area of care and management of chronic conditions. This assessment should target key impact areas and health plan processes in the CMO's case and disease management programs (member engagement, member education, and case management) and for its diabetes CPG (dissemination to and adherence by providers). The CMO should discover, through drill-down analysis of member and provider data, specific areas for maximum impact and interventions for future rapid cycle improvement testing.

Conclusions

Overall, although performance results indicate that members' perception of WellCare is positive, the CMO must implement mechanisms to improve quality, access, and timeliness of care for its members. WellCare should continue to assess areas for targeted interventions in the care for children and members with chronic conditions and to improve access to care through maintaining an adequate provider network. The CMO should ensure that its methodologies for determining and tracking any measureable improvements are sound and can be relied upon to link the success of its interventions to the improved outcome. WellCare should further ensure that it integrates a review of the related organizational and operational processes as part of its continuous quality improvement efforts.

The CMO's quality assessment and performance improvement (QAPI) plan and process must provide a comprehensive roadmap for the organization's priorities for improvement, include the timelines and steps it will take, and provide for sufficient monitoring and tracking of results. HSAG has provided recent, formal quality improvement technical assistance to the CMOs, and DCH has provided written guidance and reporting requirements for the CMOs' annual QAPI evaluation process. WellCare should use these tools and request additional process improvement assistance as needed to move its quality program toward success.

Plan Overview

As part of the redesign of the Georgia Medicaid program, DCH developed a new managed care program called GF 360°, which was launched on March 3, 2014. The DCH transitioned children in State custody, children receiving adoption assistance (AA), and certain children in the juvenile justice system from the FFS delivery system into the GF 360° managed care program. The DCH contracted with Amerigroup to provide services on a state-wide basis, to improve care coordination and continuity of care, and to provide better health outcomes for these members. Within this report, the three populations served by this program are collectively referred to as the GF 360° program. There are currently 27,000 members enrolled in the program.

The DCH requires its CMOs to undergo annual compliance reviews that cover a third of the federal standards each year. This ensures that within a three-year period, a full comprehensive assessment is conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2014–June 30, 2015. Although this is the second year of a three-year cycle of external quality reviews for the three GF CMOs, this is the first year that HSAG evaluated and completed a separate external quality review report for Amerigroup's contract for the GF 360° program.

Review of Compliance With Standards

Findings

Table 7-1 presents the standards and compliance scores for Amerigroup 360°. HSAG reviewed a total of 119 elements. Each element was scored as *Met* or *Not Met*. A compliance score was calculated per standard as well as an overall compliance score for all standards.

Table 7-1—Standards and Compliance Scores

Standard #	Standard Name	Total # of Elements	# *Met*	# *Not Met*	Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	**18**	**16**	**2**	**88.9%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**0**	**100.0%**
IV	Member Information	**27**	**25**	**2**	**92.6%**
V	Grievance System	**47**	**43**	**4**	**91.5%**
VI	Disenrollment Requirements and Limitations	**14**	**9**	**5**	**64.3%**
	Total Number of Elements	**119**	**106**	**13**	
	Total Compliance Score				**89.1%**

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

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.

Amerigroup 360° had an overall compliance score of 89.1 percent, with two standards scoring 100 percent: Subcontractual Relationships and Delegation, and Member Rights and Protections. Two standards scored greater than 90 percent: Member Information and Grievance System.

The standard with the greatest opportunity for improvement was Disenrollment Requirements and Limitations, with a compliance score of 64.3 percent.

Strengths and Weaknesses

Below is a discussion of the strengths and areas for improvement, by standard, that were identified during the compliance review.

Provider Selection, Credentialing, and Recredentialing: Amerigroup 360° maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities were performed according to industry and State requirements. Amerigroup 360° monitored providers to ensure the provision of quality care. When quality issues were identified, the CMO implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status. The 10 recredentialing files that HSAG reviewed were complete and met timeliness requirements, however, HSAG identified four initial credentialing files for which credentialing decisions were made greater than 120 days from the attestation date. As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization. Therefore, Amerigroup 360° will no longer be responsible for credentialing and recredentialing the majority of providers in its network.

Amerigroup 360° developed a training plan for law enforcement officials, judges, and other key stakeholders. Although all entities were provided access to the training, Amerigroup 360° did not develop tracking tools to identify which training modules were being completed, who was completing the training, and when it was completed.

Subcontractual Relationships and Delegation: Amerigroup 360° maintained its policies and procedures to ensure compliance with industry and State CMO standards. The CMO monitored delegate performance through ongoing assessment of individual delegate functions and took corrective action when deficiencies were identified. Amerigroup 360° had an appointed CMO delegation designee who was responsible for providing findings and recommendations to the appropriate staff and committees.

Member Rights and Protections: Amerigroup 360° submitted policies, procedures, and the member handbook as evidence that the CMO and its providers took into consideration member rights while providing care. All of the member rights included in both the federal standard and the State contract were included in these documents.

Member Information: Member materials were available in alternative languages when needed and at a reading level appropriate for the member. The online provider directory was easy to use and contained the mandated information. The DCH confirmed that for existing members the CMO is required to inform members via a member newsletter or other mechanism that the handbook is

available on the CMO's website and that a hard copy will be mailed upon request. The policies submitted for review did not reflect how Amerigroup 360° complies with this requirement.

Grievance System: Amerigroup 360° staff demonstrated a comprehensive understanding of the grievance system process. Although the CMO had detailed policies and procedures for grievances, administrative review, and administrative law hearings, there were areas for improvement. The policies did not reflect that administrative review (appeal) acknowledgement letters are provided in writing within 10 working days of receipt in the member's primary language or that the CMO must provide information that advises the member of the limited time available for presenting evidence in the case of an expedited administrative review (appeal).

During the on-site visit, HSAG reviewed 10 grievance files and 10 appeal files. All cases were compliant with the applicable timeliness requirements. However, the appeal resolution letters for upheld denials were not written in a manner that could be easily understood. In some instances the rationale portion of the letter contained advanced medical terminology or a direct copy of the clinical reviewer's notes.

Disenrollment Requirements and Limitations: Although Amerigroup 360° staff members demonstrated knowledge of the disenrollment requirements, the applicable policies and procedures did not include all of the required contractual information pertaining to a member's right to request disenrollment with and without cause.

Recommendations for Improvement

Amerigroup 360° received recommendations for improvement in the standard areas of Provider Selection, Credentialing and Recredentialing, Member Information, Disenrollment Requirements and Limitations, and Grievance System. The CMO has an opportunity to improve communication with its members to ensure they have adequate, timely information. HSAG's specific recommendations for Amerigroup 360° are to:

- Develop GF 360° training plan tracking tools to capture which training modules are being completed by key stakeholders.
- Update its applicable policies to include a description of how the CMO notifies members that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy must also reflect how often existing members receive the notice.
- Revise its processes and policies to ensure that members receive administrative review (appeal) letters in their primary language.
- Develop and implement a mechanism that advises members of the limited time available for presenting evidence in the case of an expedited administrative review (appeal).
- Ensure that the rationale for upholding a denial is written in easily understood language in the administrative review (appeal) resolution letters.
- Update its applicable disenrollment policies to include the required contractual information, including (but not limited to) a member's right to request disenrollment for cause at any time.

Performance Measures

Findings

The following table of results is organized by measure sets, or domains of care, and shows the current measure rates. Of note, 2014 was the first year rates were reported for Amerigroup 360°; therefore, only one year of results is presented and targets have not yet been established. Data will be trended and additional analyses performed in future years as more information becomes available. Rates with denominators composed of less than 11 members were withheld from reporting. Further, due to the unique characteristics of the GF 360° population, the continuous enrollment requirements for the HEDIS 2015 measures could not be applied and therefore were waived by DCH for rate calculation. This should be taken into consideration when interpreting the findings from the GF 360° population.

Access to Care

Amerigroup 360°'s Access to Care performance measure results are shown in Table 7-2.

Table 7-2—Amerigroup 360° Access to Care Measure Results

Measure	CY 2014 Rate[1]
Children and Adolescents' Access to Primary Care Practitioners	
Ages 12–24 Months	95.69%
Ages 25 Months–6 Years	85.62%
Ages 7–11 Years	83.98%
Ages 12–19 Years	79.43%
Total	82.55%
Adults' Access to Preventive/Ambulatory Health Services	
Ages 20–44 Years*	51.18%
Oral Health (Annual Dental Visit)	
Ages 2–3 Years	33.70%
Ages 4–6 Years	82.03%
Ages 7–10 Years	87.70%
Ages 11–14 Years	86.55%
Ages 15–18 Years	82.52%
Ages 19–21 Years	27.27%
Total	75.48%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	
Initiation	51.72%
Engagement	15.17%
Care Transition—Transition Record Transmitted to Health Care Professional	
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.

* The eligible population for this measure indicator includes all adult members between the ages of 20–44; however, the GF 360° population consists of children, youth, and young adults up to age 26.

For Amerigroup 360°'s *Children and Adolescents' Access to Primary Care Practitioners* measure, the 12–24 months age group had the highest percentage of members who had a visit with their PCP. The performance rates for *Oral Health (Annual Dental Visit)* ranged from 27.27 percent to 87.70 percent.

Children's Health

Amerigroup's Children's Health performance measure results are shown in Table 7-3.

Table 7-3—Amerigroup 360° Children's Health Measure Results

Measure	CY 2014 Rate[1]
Well-Child/Well-Care Visits	
Well-Child Visits in the First 15 Months of Life	
Six or More Visits	42.82%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Third, Fourth, Fifth, and Sixth Years of Life	70.14%
Adolescent Well-Care Visits	
Adolescent Well-Care Visits	45.83%
Prevention and Screening	
Childhood Immunization Status	
Combination 3	45.37%
Combination 6	23.61%
Combination 10	17.59%
Lead Screening in Children	
Lead Screening in Children	63.89%
Appropriate Testing for Children with Pharyngitis	
Appropriate Testing for Children with Pharyngitis	75.00%
Immunization for Adolescents	
Combination 1 Total	76.16%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	39.35%
Counseling for Nutrition—Total	34.95%
Counseling for Physical Activity—Total	32.41%
Developmental Screening in the First Three Years of Life	
Total	23.84%
Percentage of Eligibles that Received Preventive Dental Services	
Percentage of Eligibles that Received Preventive Dental Services	53.25%
Percentage of Eligibles that Received Dental Treatment Services	
Percentage of Eligibles that Received Dental Treatment Services	21.35%

Table 7-3—Amerigroup 360° Children's Health Measure Results	
Measure	**CY 2014 Rate[1]**
Upper Respiratory Infection	
Upper Respiratory Infection	
Appropriate Treatment for Children With URI	96.45%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014, with the exception of *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services*, which is October 1, 2013, through September 30, 2014.

Amerigroup 360°'s rates for *Childhood Immunization Status* ranged from 17.59 percent to 45.37 percent. The measure indicator rates for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* ranged from 32.41 percent to 39.35 percent.

Women's Health

Amerigroup 360°'s Women's Health performance measure results are shown in Table 7-4. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex, Cesarean Delivery Rate, Percentage of Live Births Weighing Less Than 2,500 Grams,* and *Early Elective Delivery*.

Table 7-4—Amerigroup 360° Women's Health Measure Results	
Measure	**CY 2014 Rate[1]**
Prevention and Screening	
Chlamydia Screening in Women	
Total	52.93%
Human Papillomavirus Vaccine for Female Adolescents	
Human Papillomavirus Vaccine for Female Adolescents	15.78%
Prenatal Care and Birth Outcomes	
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	46.81%
Postpartum Care	34.04%
Cesarean Section for Nulliparous Singleton Vertex	
Cesarean Section for Nulliparous Singleton Vertex[2]	NR
Cesarean Delivery Rate	
Cesarean Delivery Rate[2]	21.31%
Percentage of Live Births Weighing Less Than 2,500 Grams	
Percentage of Live Births Weighing Less Than 2,500 Grams[2]	NA
Behavioral Health Risk Assessment for Pregnant Women	
Behavioral Health Risk Assessment for Pregnant Women	3.64%
Early Elective Delivery	
Early Elective Delivery[2]	NR
Antenatal Steroids	
Antenatal Steroids	NR

Table 7-4—Amerigroup 360° Women's Health Measure Results	
Measure	**CY 2014 Rate[1]**
Frequency of Ongoing Prenatal Care	
Frequency of Ongoing Prenatal Care	
81+ Percent	19.15%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[2] A lower rate indicates better performance for this measure.
NR Indicates the CMO produced a rate that was materially biased or chose not to report results for this measure; therefore, the rates were not included in the performance calculation. The auditors confirmed that although Amerigroup 360° calculated these measures properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.
NA Indicates that the rate was withheld because the denominator was less than 11.

Amerigroup 360°'s rate for *Prenatal and Postpartum Care—Timeliness of Prenatal Care* was 46.81 percent, while the rate for *Frequency of Ongoing Prenatal Care— ≥ 81 Percent* was 19.15 percent.

Chronic Conditions

Amerigroup 360°'s Chronic Conditions performance measure results are shown in Table 7-5. Note that a lower rate is better for the following performance measures: *HbA1c Poor Control (>9.0), Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months),* and *Young Adult Asthma Admission Rate.*

Table 7-5—Amerigroup 360° Chronic Conditions Measure Results	
Measure	**CY 2014 Rate[1]**
Diabetes	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	76.92%
HbA1c Poor Control (>9.0)[2]	100.00%
HbA1c Control (<8.0)	0.00%
HbA1c Control (<7.0)	0.00%
Eye Exam (Retinal) Performed	30.77%
Medical Attention for Nephropathy	30.77%
Blood Pressure Control (<140/90 mm/Hg)	0.00%
Diabetes Short-Term Complications Admission Rate	
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[2]	4.96
Respiratory Conditions	
Use of Appropriate Medications for People with Asthma	
Ages 5–11 Years	NA
Ages 12–18 Years	NA
Total	72.73%
Young Adult Asthma Admission Rate	
Young Adult Asthma Admission Rate[2]	NA

Table 7-5—Amerigroup 360° Chronic Conditions Measure Results	
Measure	**CY 2014 Rate[1]**
Cardiovascular Conditions	
Controlling High Blood Pressure	
Controlling High Blood Pressure	0.00%
Adult BMI Assessment	
Adult BMI Assessment	24.89%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[2] A lower rate indicates better performance for this measure.
NA Indicates that the rate was withheld because the denominator was less than 11.

Amerigroup 360°'s performance measure rates revealed that none of its members had adequate HbA1c control documented. Similarly, rates for *Comprehensive Diabetes Care—Blood Pressure Control* and *Controlling High Blood Pressure* revealed that none of its members with diabetes or cardiovascular conditions had adequately controlled blood pressure documented.

Behavioral Health

Amerigroup 360°'s Behavioral Health performance measure results are shown in Table 7-6.

Table 7-6—Amerigroup 360° Behavioral Health Measure Results	
Measure	**CY 2014 Rate[1]**
Follow-Up of Care for Children Prescribed ADHD Medication	
Initiation Phase	NA
Continuation and Maintenance Phase	NA
Follow-Up After Hospitalization for Mental Illness	
Follow-Up Within 7 Days	58.88%
Follow-Up Within 30 Days	78.46%
Antidepressant Medication Management	
Effective Acute Phase Treatment	NA
Effective Continuation Phase Treatment	NA
Screening for Clinical Depression and Follow-Up Plan	
Screening for Clinical Depression and Follow-Up Plan	0.51%
Adherence to Antipsychotics for Individuals with Schizophrenia	
Adherence to Antipsychotics for Individuals with Schizophrenia	NA

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
NA Indicates that the rate was withheld because the denominator was less than 11.

Amerigroup 360°'s rates for *Follow-Up After Hospitalization for Mental Illness* were 58.88 percent (follow-up within seven days) and 78.46 percent (follow-up within 30 days).

Medication Management

Amerigroup 360°'s Medication Management performance measure results are shown in Table 7-7. Note that a lower rate is better for the *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* performance measure.

Table 7-7—Amerigroup 360° Medication Management Measure Results	
Measure	**CY 2014 Rate[1]**
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions	
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions[2]	40.88%
Annual Monitoring for Patients on Persistent Medications	
Total	NA
Medication Management for People with Asthma	
Medication Compliance 50%—Ages 5–11 Years	NA
Medication Compliance 50%—Ages 12–18 Years	NA
Medication Compliance 50%—Ages 19–50 Years*	NA
Medication Compliance 50%—Total	NA
Medication Compliance 75%—Ages 5–11 Years	NA
Medication Compliance 75%—Ages 12–18 Years	NA
Medication Compliance 75%—Ages 19–50 Years*	NA
Medication Compliance 75%—Total	NA

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[2] A lower rate indicates better performance for this measure.
NA Indicates that the rate was withheld because the denominator was less than 11.
* The eligible population for this measure indicator includes all adult members between the ages of 19–50; however, the GF 360° population consists of children, youth, and young adults up to age 26.

There was an insufficient number of members included in the Medication Management measure results for any of the measure rates to be reported, with the exception of *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions.*

Utilization

Amerigroup 360°'s Utilization performance measure results are shown in Table 7-8. Note that a lower rate is better for the *Ambulatory Care (Per 1,000 Member Months)—ED Visits* performance measure.

Table 7-8—Amerigroup 360° Utilization Measure Results	
Measure	**CY 2014 Rate[1]**
Ambulatory Care (Per 1,000 Member Months)	
ED Visits[2]	35.79
Outpatient Visits	265.85
Inpatient Utilization— General Hospital/Acute Care	
Total Inpatient Average Length of Stay	4.88

Table 7-8—Amerigroup 360° Utilization Measure Results	
Measure	**CY 2014 Rate[1]**
Total Medicine Average Length of Stay	4.03
Total Surgery Average Length of Stay	7.52
Total Maternity Average Length of Stay	2.52
Mental Health Utilization	
Any Services—Total	63.23%
Inpatient Services—Total	4.52%
Intensive Outpatient Services—Total	1.03%
Ambulatory/ED Visits—Total	62.72%
Plan All-Cause Readmissions	
Total[2,3]	25.84%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[2] A lower rate indicates better performance for this measure.
[3] The rate displayed is the observed readmission rate.

Amerigroup 360°'s rate for *Ambulatory Care (Per 1,000 Member Months)—ED Visits* was 35.79. The *Plan All-Cause Readmissions* rate was 25.84 percent.

Strengths and Weaknesses

Amerigroup 360° had several notable strengths in the area of Children's Health and Access to Care for children. Its high performance in this area was noted across the quality and access domains. As illustrated in Table 7-2, over 95 percent of children ages 12 to 24 months had at least one primary care practitioner visit. Table 7-3 shows that 75 percent of members ages 2 to 18 years with pharyngitis had appropriate testing when receiving antibiotics, and over 96 percent of members ages 3 months to 18 years who had a URI received appropriate treatment.

Although Amerigroup 360° performed well in the area of Children's Health and Access to Care for children, a review of dental measures in the Access to Care measure set showed that approximately 75 percent of all members received an annual dental visit; however, only 34 percent of members ages 2 to 3 years and 27 percent of members ages 19 to 21 years had an annual dental visit, representing an opportunity for improvement across these two age groups.

Further, a review of the well-child visits and weight assessment and counseling measures in the Children's Health measure set showed that just over 40 percent of members received six or more well-child visits in the first 15 months of life, as noted in Table 7-3. Additionally, less than 40 percent of children and adolescents had a documented weight assessment, counseling for nutrition, or counseling for physical activity. Measures related to Women's Health presented several opportunities for improvement. Table 7-4 shows that less than 50 percent of members who were pregnant received timely prenatal care, and less than 20 percent received at least 81 percent of the recommend prenatal visits. Further, less than 35 percent of members who delivered a live birth received postpartum care.

Amerigroup 360° also demonstrated high performance in two of the Behavioral Health indicators across the domains of access and timeliness. As noted in Table 7-6, nearly 80 percent of members hospitalized for mental illness had a follow-up visit within 30 days of discharge, and almost 60 percent received a follow-up visit within seven days of discharge.

Several opportunities for improvement were noted in the Chronic Conditions measure set. As presented in Table 7-5, 0 percent of members with diabetes had documentation of adequate HbA1c control, and 0 percent of members with diabetes and cardiovascular conditions had documentation of appropriate blood pressure control. Further, less than 25 percent of adult members received a documented BMI assessment.

Recommendations for Improvement

Amerigroup 360° reported performance measure rates for measurement year 2014 and this was its first full year of data available. The DCH did not yet set performance measure targets for Amerigroup 360°; therefore, 2014 will be the baseline measurement year.

HSAG recommends that Amerigroup 360° develop PIPs that address areas of weak performance identified in its performance measure results. Executing a robust rapid cycle system of change and incorporating a sound methodology for measurement may assist the CMO in improving the quality, access, and timeliness of healthcare delivery to its membership.

In addition to formal PIPs, Amerigroup 360° should focus its quality improvement efforts on the following measure topics:

Access to Care and Children's Health

- Annual dental visits for members ages 2 to 3 years and 19 to 21 years
- Children's health
  - Well-child visits in the first 15 months of life
  - Weight assessment and counseling for nutrition and physical activity

Women's Health

- Prenatal and postpartum care

Chronic Conditions

- HbA1c control among members with diabetes
- Blood pressure control among members with diabetes and cardiovascular conditions
- Adult BMI assessment

Overall Assessment of Quality, Access, and Timeliness of Care

As this was a baseline year for compliance and performance measure results, and PIPs and CAHPS activities were not conducted for Amerigroup 360°, HSAG had a limited amount of information from

which to draw conclusions regarding Amerigroup 360°'s performance in providing quality, accessible, and timely healthcare and services to its members.

However, based on HSAG's evaluation and as evidenced by the 2015 on-site compliance review results, Amerigroup 360° showed that it has systems, policies, and staff in place to ensure the CMO's structure and operations support core processes for providing care and services and promoting quality outcomes.

As indicated by the compliance review results, the CMO has an opportunity to improve its communication with members (i.e., appeal resolution letters for upheld denials), which is critical to ensure members' understanding of healthcare services. With regard to performance measure results, the CMO should conduct a causal/barrier analysis to determine key drivers of low rates (as identified in the Strengths and Weaknesses section above) and develop targeted, appropriate interventions to improve performance.

Moving forward, and as more performance information becomes available, Amerigroup 360°'s quality assessment and performance improvement (QAPI) plan and process must provide a comprehensive roadmap for the organization's priorities for improvement, include the timelines and steps it will take, and provide for sufficient monitoring and tracking of results. HSAG has provided recent, formal quality improvement technical assistance to the CMOs, and DCH has provided written guidance and reporting requirements for the CMOs' annual QAPI evaluation process. Amerigroup 360° should use these tools and request additional process improvement assistance as needed to move its quality program toward success.

8. Comparative Analysis of the Georgia Families and the Georgia Families 360° CMOs

Comparative Analysis of the CMOs

This section provides a comparison of the CMOs for each activity.

Compliance With Standards

The following table provides information that can be used to compare the GF CMOs and the CMO for the GF 360° program for each of the six compliance standard areas selected for review this year.

Table 8-1—Standards and Compliance Scores

Standard #	Standard Name	Amerigroup	Peach State	WellCare	Amerigroup 360°
I	Provider Selection, Credentialing, and Recredentialing	**90.0%**	**100%**	**90.0%**	**88.9%**
II	Subcontractual Relationships and Delegation	**100%**	**100%**	**100%**	**100%**
III	Member Rights and Protections	**100%**	**100%**	**100%**	**100%**
IV	Member Information	**95.0%**	**90.0%**	**100%**	**92.6%**
V	Grievance System	**91.5%**	**91.5%**	**91.5%**	**91.5%**
VI	Disenrollment Requirements and Limitations	**90.0%**	**100%**	**100%**	**64.3%**
	Total Compliance Score	**93.0%**	**94.0%**	**95%**	**89.1%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**25.0%**	**84.0%**	**70.6%**	**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.

The three GF CMOs each received an overall compliance score between 93 and 95 percent indicating that these CMOs have the policies, procedures, and operational structures in place to meet the majority of requirements. Amerigroup, for the GF 360° program, received an overall compliance score of 89.1 percent. The greatest variance across the GF CMOs occurred with the follow-up results on the previous review's noncompliant findings. Amerigroup met 25 percent of the re-reviewed elements, whereas WellCare and Peach State met 70.6 percent and 84 percent, respectively.

A comparison of the individual standards across CMOs indicates the following:

- For the GF program, two areas of strong performance were identified during the compliance review of the Structure and Operations standards. All CMOs received a compliance score of 100 percent in two standard areas—Subcontractual Relationships and Delegation, and Member Rights and Protections.

- All CMOs received a compliance score of 91.5 percent on the Grievance System standard, demonstrating consistency in performance across the CMOs but also scoring as one of the lowest performance areas overall.
- The greatest variance in results was for compliance with the Disenrollment Requirements and Limitations standard. Both Peach State and WellCare scored 100 percent. Amerigroup (for the GF population) was noncompliant for one element, resulting in a score of 90 percent. Amerigroup 360° received a score of 64.3 percent.
- For five of the six standards, Amerigroup 360° had the same score or was within 3 percentage points of Amerigroup for the GF program. As noted above, the only substantial difference in scores was for the Disenrollment Requirements and Limitations standard. There are additional contract requirements for this standard related to the GF 360° program, and the lower score indicates that Amerigroup must establish process improvements in this area.

With the exception of the Grievance System standard, the GF CMOs collectively performed well on the six standards reviewed for this year's compliance review. Amerigroup 360° also needs to improve its results for the Grievance System standard, as well as the Disenrollment Requirements and Limitations standard. In addition, each GF CMO must evaluate the effectiveness of its corrective action process and implement new strategies to bring the CMO into compliance with areas from the previous year's review that were scored *Not Met*.

Performance Improvement Projects

CMO Comparison of Rapid Cycle PIPs

Table 8-2 summarizes HSAG's key validation findings for the six rapid cycle PIPs conducted by each CMO. The key findings for the rapid cycle PIPs include whether each PIP achieved its SMART Aim goal, whether the PIP demonstrated sustained improvement in the SMART Aim measure, and the overall confidence level HSAG assigned to each PIP. The first two findings, achieving the SMART Aim goal and sustaining improvement, represent the PIP outcomes, whether the PIP demonstrated meaningful improvement and sustained that improvement over time. The third finding, the confidence level, represents HSAG's overall validation findings based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence, Confidence,* and *Low Confidence*, depending on the performance of the PIP.

Table 8-2—PIP Validation Findings Across the GF Program

PIP Topic	Amerigroup			Peach State			WellCare		
	SMART Aim Goal	*Sustained Improvement*	*Confidence Level*	*SMART Aim Goal*	*Sustained Improvement*	*Confidence Level*	*SMART Aim Goal*	*Sustained Improvement*	*Confidence Level*
Annual Dental Visits	*Failed*	*Failed*	*Low Confidence*	*Failed*	*Failed*	*Low Confidence*	*Failed*	*Failed*	*Low Confidence*
Appropriate Use of ADHD Medications	*Achieved*	*Achieved*	*High Confidence*	*Failed*	*Failed*	*Low Confidence*	*Failed*	*Failed*	*Low Confidence*
Avoidable Emergency Room Visits	*Achieved*	*Failed*	*Confidence*	*Failed*	*Failed*	*Low Confidence*	*Failed*	*Failed*	*Low Confidence*

Table 8-2—PIP Validation Findings Across the GF Program									
PIP Topic	**Amerigroup**			**Peach State**			**WellCare**		
	SMART Aim Goal	*Sustained Improvement*	*Confidence Level*	*SMART Aim Goal*	*Sustained Improvement*	*Confidence Level*	*SMART Aim Goal*	*Sustained Improvement*	*Confidence Level*
Bright Futures	*Failed*	*Failed*	*Low Confidence*	*Achieved*	*Failed*	*Confidence*	*Failed*	*Failed*	*Low Confidence*
Comprehensive Diabetes Care	*Achieved*	*Failed*	*Confidence*	*Achieved*	*Failed*	*Confidence*	*Achieved*	*Failed*	*Confidence*
Postpartum Care	*Achieved*	*Achieved*	*High Confidence*	*Failed*	*Failed*	*Low Confidence*	*Failed*	*Failed*	*Low Confidence*
Percentage *Achieved* Across PIP Topics*	**66.7%**	**33.3%**	**33.3%**	**33.3%**	**0%**	**0%**	**16.7%**	**0%**	**0%**

*The Percentage *Achieved* Across PIP Topics row displays the percentage of each CMO's PIPs that achieved the SMART Aim goal, achieved sustained improvement, and achieved a *High Confidence* level.

Overall, the CMOs' performance on the six rapid cycle PIPs demonstrates the need for further training and skill development around the new rapid cycle PIP process to ensure that improvement strategies are being effectively developed, tested, and refined, and that desired outcomes are being achieved. The findings suggest that the CMOs are in an elementary stage of implementing rapid cycle PIPs. The three types of findings presented in Table 8-2, achieving the SMART Aim goal, achieving sustained improvement, and achieving a level of *High Confidence*, will naturally be accomplished in a sequential order as the CMOs' capacity for rapid cycle improvement progresses: each CMO first needs to achieve the SMART Aim goal before sustained improvement can be achieved, and both types of outcomes need to be achieved in order for the PIP to be assigned a level of *High Confidence*. As summarized in the Percentage *Achieved* Across PIP Topics row at the bottom of the table, the CMOs were more successful in achieving the SMART Aim goal, with a higher percentage of PIPs achieving this outcome, than achieving sustained improvement or a level of *High Confidence*. Each CMO has opportunities for improvement in fundamental areas of the rapid cycle PIP process such as appropriate and accurate SMART Aim measurement and effective execution of the PDSA cycle for testing and refining interventions.

A comparison of the CMOs' performance across the six PIP topics indicates the following:

- Amerigroup was the highest-performing CMO with regard to PIPs, with the highest percentage of PIPs that achieved the SMART Aim goal (66.7 percent), sustained improvement in the SMART Aim measure (33.3 percent), and achieved a level of High Confidence overall (33.3 percent).
- Peach State had the second highest percentage of PIPs that achieved the SMART Aim goal (33.3 percent).
- WellCare had only 16.7 percent of its PIPs achieving the SMART Aim goal.
- Amerigroup was the only CMO that achieved sustained improvement and that received a level of High Confidence for any of its PIPs.
- The *Annual Dental Visits* PIP was the most challenging PIP for the three CMOs. None of the CMOs were able to achieve the SMART Aim goal, sustained improvement, or a confidence level higher than Low Confidence for the *Annual Dental Visits* PIP.

- The *Comprehensive Diabetes Care* PIP was the only PIP for which all CMOs met their SMART Aim goals; however, none of the CMOs achieved sustained improvement for this topic.
- There was not a clear pattern of performance across all three CMOs for the remaining rapid cycle PIP topics.

Given the CMOs' performance across the six rapid cycle PIPs, there is ample opportunity to improve the execution of the new rapid cycle PIP process. HSAG recommends further training and technical assistance in the fundamental areas of the process, including SMART Aim measurement methodology, identification of appropriate and innovative interventions, and effective implementation of the PDSA cycle to refine and improve interventions and achieve meaningful and sustained improvement of health outcomes.

CMO Comparison of Traditional Outcome-Focused PIPs

Table 8-3 summarizes HSAG's key validation findings for the two traditional outcome-focused PIPs conducted by each CMO. The key findings for the traditional outcome-focused PIPs include the percentage of evaluation elements that received a *Met* score in the three stages of the PIP: Design, Implementation, and Outcomes. The table also presents specific information on whether each PIP achieved statistically significant improvement of outcomes and sustained improvement of outcomes. Finally, the bottom row of the table presents the overall validation findings, an overall finding of either *Met* or *Not Met* based on the overall performance of the PIP in meeting validation requirements in the three PIP stages and in achieving statistically significant and sustained improvement in study indicator outcomes.

Table 8-3—Traditional Outcome-Focused Performance Improvement Project Validation Findings for GF Program

	Amerigroup		Peach State		WellCare	
	Member Satisfaction	*Provider Satisfaction*	*Member Satisfaction*	*Provider Satisfaction*	*Member Satisfaction*	*Provider Satisfaction*
Design Stage (Steps I – VI)	100%	86%	100%	100%	89%	86%
Implementation Stage (Steps VII & VIII)	92%	62%	92%	69%	69%	46%
Outcomes Stage (Steps IX & X)	40%	50%	50%	25%	50%	50%
Statistically Significant Improvement Over Baseline Achieved	Yes	No	No	No	No	No
Sustained Improvement Achieved	No	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*
Validation Finding	***Not Met***	***Not Met***	***Not Met***	***Not Met***	***Not Met***	***Not Met***

As evidenced by the overall Validation Finding row, the CMOs' performance on the traditional outcome-focused PIPs, *Member Satisfaction* and *Provider Satisfaction*, left considerable room for improvement; all of the PIPs were assigned a *Not Met* finding for their overall performance. A comparison of the CMOs' performance across these two PIP topics indicates the following:

- In general, the CMOs were most successful in the Design stage of the PIPs, receiving a *Met* score for 86 percent to 100 percent of the evaluation elements in this stage. Peach State excelled in this area, receiving a score of 100 percent for the Design stage on both of its PIPs.
- In the Implementation stage, the percentage of evaluation elements receiving a *Met* score was mixed, ranging from 46 percent in WellCare's *Provider Satisfaction* PIP to 92 percent in both Amerigroup's and Peach State's *Member Satisfaction* PIP. Opportunities exist for all CMOs for implementing sound interventions to improve provider satisfaction.
- The greatest opportunities for improvement were in the Outcomes stage, where the percentage of evaluation elements scored *Met* was the lowest overall and ranged from 25 percent in Peach State's *Provider Satisfaction* PIP to 50 percent in the following PIPs: *Provider Satisfaction* (Amerigroup), *Member Satisfaction* (Peach State), and both *Member* and *Provider Satisfaction* (WellCare).

The CMOs struggled with effectively implementing improvement strategies in the Implementation stage and achieving desired improvement of health outcomes in the Outcomes stage. The challenges in the Implementation and Outcomes stages correlate with the challenges the CMOs experienced in effectively identifying, testing, and refining interventions for the rapid cycle PIPs. The end result is the same for both types of PIPs: the PIPs were not successful in achieving the desired improvement in outcomes.

In the Outcomes stage, only Amerigroup's *Member Satisfaction* PIP was able to achieve statistically significant improvement over baseline in the study indicator outcomes. The PIP did not, however, achieve sustained improvement in *Member Satisfaction* outcomes. None of the other PIPs achieved statistically significant improvement over baseline and, therefore, were not assessed for sustained improvement.

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 submit externally validated performance measure rates. Performance measure validation determines the extent to which the CMOs followed the DCH specifications for their performance measures when calculating rates. For reference, Appendix F presents detailed performance measure rates for Amerigroup, Peach State, WellCare, and Amerigroup 360° for reporting year 2015. Caution should be exercised when making comparisons between the GF CMOs and Amerigroup 360° given the differences in populations (e.g., ages of members covered).

Table 8-4 illustrates the percentage of performance targets met by measure set for each GF CMO. Of note, since 2014 was a baseline measurement year for Amerigroup 360°, the CMO did not have DCH-established performance targets for 2014. As such, Amerigroup 360° results are not represented in this table.

Table 8-4—Percentage of Performance Targets Met by GF CMOs*			
Measure Set	**Amerigroup**	**Peach State**	**WellCare**
Access to Care	16.7%	0.0%	0.0%
Children's Health	73.3%	80.0%	46.7%
Women's Health	20.0%	30.0%	10.0%
Chronic Conditions	0.0%	30.0%	10.0%
Behavioral Health	0.0%	0.0%	14.3%
Medication Management	0.0%	50.0%	0.0%
Utilization	0.0%	0.0%	0.0%
Total	**27.5%**	**37.3%**	**19.6%**
**Excludes measures that were not comparable to performance targets.*			

A comparison of the CMOs' performance measure results in Table 8-4 and in Appendix F indicates the following:

- Peach State was the highest-performing CMO, meeting 37.3 percent of its performance measure targets. Peach State also had the highest percentage of performance measure targets met for four of the six measure sets.
- Amerigroup was the second-highest-performing CMO, meeting 27.5 percent of its performance measure targets. Amerigroup was also the only CMO that met any of its performance measure targets for the Access to Care measure set.
- Of the three CMOs, WellCare demonstrated the lowest performance, meeting 19.6 percent of its performance measure targets. WellCare had a significantly lower number of performance measure targets met for the Children's Health measure set than Amerigroup and Peach State. However, it should be noted that WellCare was the only CMO to meet any of its targets for the Behavioral Health measure set.

Based on the GF CMOs' results presented in Table 8-4 above and in Appendix F, the Children's Health measure set exhibited the highest percentage of targets achieved across all GF CMOs. This measure set also demonstrated significant improvement, indicating positive progress. All of the GF CMOs exhibited significant improvement in the percentage of children with pharyngitis who received appropriate testing and in the percentage of children with a URI who were treated appropriately. Additionally, all of the GF CMOs met the 2014 performance target for *Lead Screening in Children; Immunization for Adolescents—Combination 1 Total;* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Assessment—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total.* However, dental care for children and adolescents was a general weakness across all of the GF CMOs. The GF CMOs failed to meet the 2014 performance target for any of the dental indicators and also exhibited significant performance decline in the percentage of members ages 2 to 21 years who had an annual dental visit. Although none of the GF CMOs met the 2014 performance targets for the dental indicators, two GF CMOs, Amerigroup and Peach State, exhibited significant improvement in the *Percentage of Eligibles that Received Preventive Dental Services* and *Percentage of Eligibles that Received Dental Treatment Services* measures, while one GF CMO, WellCare, exhibited significant decline in both measures.

Within the Access to Care measure set, *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* was a weakness exhibited by all of the GF CMOs, as none of the GF CMOs met the 2014 performance target and all exhibited a significant decline in performance. Further, none of the GF CMOs achieved the target for the number of ED visits per 1,000 member months, which represents an area for improvement. An additional opportunity for improvement exists across all of the GF CMOs in the Women's Health measure set, including cervical cancer screening, chlamydia screening, prenatal care, and birth outcomes. However, all of the GF CMOs met the 2014 performance target for the *Breast Cancer Screening* measure, representing an area of strength.

The Behavioral Health and Chronic Conditions measure sets were areas of weakness for the GF CMOs, as a majority of the 2014 performance targets were not achieved. There were, however, several strengths in these measure sets, including two GF CMOs (Amerigroup and WellCare) that exhibited significant improvement in the percentage of members with diabetes who received an HbA1c test during the year. Also, two GF CMOs (Peach State and WellCare) met the 2014 performance target for *Adult BMI Assessment*, but the remaining GF CMO (Amerigroup) exhibited significant decline.

Similarly, several weaknesses were noted in the Medication Management measure set, as only one GF CMO, Peach State, achieved either of the 2014 performance targets. For the Medication Management measure set, all GF CMOs exhibited significant improvement for the *Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions* measure.

In general, Amerigroup 360° exhibited several strengths in providing care for children in the domains of quality and access. For instance, over 95 percent of children ages 12 to 24 months had at least one PCP visit. Additionally, 75 percent of children with pharyngitis had appropriate testing when receiving antibiotics. Amerigroup 360°'s performance indicated that more than 96 percent of children with a URI received appropriate treatment, which was approximately 10 percentage points higher than the rate for the highest-performing GF CMO, Amerigroup. Although Amerigroup 360° performed well in these areas of the Children's Health measure set, a review of dental measures showed that while approximately 75 percent of all members received an annual dental visit, only 34 percent of members ages 2 to 3 years and 27 percent of members ages 19 to 21 years had an annual dental visit, representing an opportunity for improvement across these two age groups. Additional opportunities for improvement in the area of children's health include the *Well-Child Visits in the First 15 Months of Life—Six or More Visits*, *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* measures.

Amerigroup 360° demonstrated high performance in two of the three behavioral health-related measures and reported that nearly 80 percent of members hospitalized for mental illness had a follow-up visit within 30 days of discharge, and almost 60 percent received a follow-up visit within seven days of discharge. Amerigroup 360° also demonstrated high performance for the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure. For the *Ambulatory Care (Per 1,000 Member Months)—ED Visits* indicator, Amerigroup 360° had 18 fewer ED visits per 1,000 member months compared to the highest-performing GF CMO.

The Women's Health and Chronic Conditions measure sets revealed several opportunities for improvement for Amerigroup 360°. For instance, less than 50 percent of members who were pregnant

received timely prenatal care, and less than 20 percent received at least 81 percent of the recommended prenatal visits. Further, less than 35 percent of members who delivered a live birth received postpartum care. With regard to chronic conditions, 0 percent of Amerigroup 360°'s members with diabetes had documentation of adequate HbA1c control, and 0 percent of members with diabetes and cardiovascular conditions had documentation of appropriate blood pressure control. Additionally, less than 25 percent of adult members had a documented BMI assessment, which was approximately 42 percentage points lower than the rate for the lowest-performing GF CMO.

CAHPS Surveys

CAHPS Survey results for both adult and child Medicaid populations were compared across CMOs. HSAG compared the CMOs' top-box scores for the four CAHPS global rating measures and five composite measures. Additionally, HSAG compared the CMOs' CAHPS Survey results to the 2015 NCQA national Medicaid averages, where applicable.

Adult Medicaid CAHPS Survey Results

Table 8-5 displays the statewide average and the CMOs' 2015 adult Medicaid CAHPS top-box scores (i.e., percentage of top-level responses) for each global rating measure and composite measure. Cells highlighted in yellow represent top-box scores that were equal to or greater than the 2015 NCQA national adult Medicaid average.

Table 8-5—Adult Medicaid CAHPS Survey Results

Measure	Statewide Average	Amerigroup	Peach State	WellCare
Global Ratings				
Rating of Health Plan	74.4%	74.8%	71.2%	77.1%
Rating of All Health Care	76.3%	76.3%	74.0%	78.5%
Rating of Specialist Seen Most Often	82.0%	74.0%	82.0%	90.1%+
Rating of Personal Doctor	79.7%	76.9%	81.3%	81.0%
Composite Measures				
Getting Needed Care	80.7%	79.6%	78.8%	83.8%
Getting Care Quickly	79.2%	82.0%	76.4%	79.2%
How Well Doctors Communicate	91.3%	92.1%	91.4%	90.4%
Customer Service	86.7%	87.8%	82.9%	89.4%
Shared Decision Making	76.3%	75.2%	77.6%	76.2%

CAHPS scores are reported even when the NCQA minimum reporting threshold of 100 respondents was not met. Scores based on fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting these results.

Due to changes to the *Shared Decision Making* composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

Comparisons across the CMOs' adult Medicaid CAHPS top-box scores revealed the following:

- Amerigroup scored highest among the three CMOs on two measures: *Getting Care Quickly* and *How Well Doctors Communicate*. However, Amerigroup also scored lowest among the CMOs on three measures: *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, and *Shared Decision Making*.
- Peach State scored highest among the three CMOs on two measures: *Rating of Personal Doctor* and *Shared Decision Making*. However, Peach State also scored lowest among the CMOs on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, and *Customer Service*.
- WellCare scored highest among the three CMOs on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Customer Service*. However, WellCare also scored lowest among the CMOs on one measure: *How Well Doctors Communicate*.

Comparisons of Amerigroup's, Peach State's, and WellCare's adult Medicaid CAHPS top-box scores to the 2015 NCQA national adult Medicaid averages revealed the following:

- Amerigroup scored at or above the NCQA national adult Medicaid average on four of the eight comparable measures: *Rating of All Health Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Customer Service*.
- Peach State scored at or above the NCQA national adult Medicaid average on four of the eight comparable measures: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, and *How Well Doctors Communicate*.
- WellCare scored at or above the NCQA national adult Medicaid average on six of the eight comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Customer Service*.

Child Medicaid CAHPS Survey Results

Table 8-6 displays the statewide average and CMOs' 2015 child Medicaid CAHPS top-box scores (i.e., percentage of top-level responses) for each global rating measure and composite measure. Cells highlighted in yellow represent top-box scores that were equal to or greater than the 2015 NCQA national child Medicaid average.

Table 8-6—Child Medicaid CAHPS Survey Results				
Measure	**Statewide Average**	**Amerigroup**	**Peach State**	**WellCare**
Global Ratings				
Rating of Health Plan	87.8%	86.8%	88.5%	88.1%
Rating of All Health Care	87.6%	87.7%	87.3%	87.8%
Rating of Specialist Seen Most Often	85.5%	86.7%	85.5%	84.3%+
Rating of Personal Doctor	90.1%	89.2%	88.4%	92.7%
Composite Measures				
Getting Needed Care	84.7%	84.9%	83.6%	85.6%
Getting Care Quickly	88.3%	89.3%	87.5%	88.1%
How Well Doctors Communicate	92.2%	90.4%	92.2%	93.9%
Customer Service	87.2%	85.1%	85.8%	90.8%
Shared Decision Making	77.4%	75.4%	79.0%	77.9%

CAHPS scores are reported even when the NCQA minimum reporting threshold of 100 respondents was not met. Scores based on fewer than 100 respondents are denoted with a cross (+). Caution should be exercised when interpreting these results.

Due to changes to the *Shared Decision Making* composite measure, comparisons to 2015 NCQA national averages could not be performed for this CAHPS measure for 2015.

Comparisons across the CMOs' child Medicaid CAHPS Survey scores revealed the following:

- Amerigroup scored highest among the three CMOs on two measures: *Getting Needed Care* and *Getting Care Quickly*. However, Amerigroup also scored lowest among the CMOs on four measures: *Rating of Health Plan*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.
- Peach State scored highest among the three CMOs on two measures: *Rating of Health Plan* and *Shared Decision Making*. However, Peach State also scored lowest among the CMOs on three measures: *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly*.
- WellCare scored highest among the three CMOs on five measures: *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*. However, WellCare also scored lowest among the CMOs on one measure: *Rating of Specialist Seen Most Often*.

Comparisons of Amerigroup's, Peach State's, and WellCare's CAHPS top-box scores to the 2015 NCQA national child Medicaid averages revealed the following:

- Amerigroup scored at or above the NCQA national child Medicaid average on six of the eight comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly*.
- Peach State scored at or above the NCQA national child Medicaid average on four of the eight comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.

- WellCare scored at or above the NCQA national child Medicaid average on six of the eight comparable measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service*.

Conclusions

Overall, the CMOs demonstrated compliance with the majority of the structure and operations standards reviewed. Improvement efforts should be focused on the grievance system for all CMOs, as well as disenrollment requirements for Amerigroup 360°. Additionally, two CMOs closed the majority of their corrective action plans from the previous year's review. All CMOs should continue to enhance and develop new interventions, as needed, to improve performance and close the remaining corrective action plans.

To optimize the improvement of outcomes achieved through PIPs, the CMOs need to further develop their capacity to apply sound improvement science in the rapid cycle PIP process. The CMOs should seek technical assistance when planning for new rapid cycle PIPs to ensure that the measurement methodology and quality improvement strategies form a solid foundation to facilitate improvement of the outcomes for each PIP. When planning a new rapid cycle PIP, the CMOs must start with the end date of the PIP in mind, working backwards from this date to develop a work plan and timeline that allows sufficient time for all phases of the PIP. The DCH requires GF PIPs to be conducted annually; therefore, the CMOs should plan the timing of the four phases of the rapid cycle PIP on a 12-month cycle. The CMOs must efficiently complete the first (PIP Initiation and SMART Aim Data Collection) and second (Intervention Determination) phases of HSAG's rapid cycle PIP process to allow sufficient time for repeated PDSA cycles in the third phase as well as time at the end of the cycle to demonstrate sustained improvement as part of the fourth phase.

Despite minor variations in PIP performance among the CMOs, the validation findings described earlier exemplify that all CMOs need further training on the fundamental processes involved in a successful rapid cycle PIP.

The performance measure results indicate that each CMO must implement mechanisms to improve quality, access, and timeliness of care for its members. Areas of focus were noted for each CMO in Sections 4 through 7 of this report. Overall, the GF CMOs should target the following performance areas as quality improvement initiatives:

Access to Care

- Adults' access to preventive and ambulatory health services
- Oral health
- Children and adolescents' access to primary care practitioners (ages 12 to 19 years)

Women's Health

- Cervical cancer screening
- Chlamydia screening
- Prenatal care

Chronic Conditions

- Comprehensive diabetes care
- Controlling high blood pressure among members with cardiovascular conditions

Behavioral Health

- Initiation of follow-up of care for children who were prescribed ADHD medications
- Follow-up after hospitalization for mental illness
- Antidepressant medication management
- Adherence to antipsychotics for members with schizophrenia

Medication Management

- Medication management for members with asthma ages 5 to 11 years

Utilization

- ED utilization

With regard to CAHPS Survey results, all CMOs met or exceeded the Medicaid national average for the following measures:

- *Rating of All Health Care*—child and adult
- *Rating of Health Plan*—child only
- *Rating of Personal Doctor*—child only

For all other CAHPS measures, at least one of the CMOs met or exceeded the Medicaid national average.

As noted previously in this report, each CMO should conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network. The CMOs may also want to consider conducting focus groups to determine, in more detail, members' perception of areas for improvement.

Recommendations for the GF and GF 360° Programs

Based on a comparative review of findings for all activities, HSAG recommends the following to DCH:

- Reevaluate the CMOs' corrective action plan activities resulting from the compliance reviews. Because the CMOs' recent reevaluation scores showed that only 25 to 84 percent of the corrective actions were successful in bringing the CMO into compliance, DCH should consider implementing an ongoing monitoring process to ensure that the corrective actions are successfully completed within the time period specified in the corrective action plans.

- Review samples of each CMO's grievance and appeal letters annually to ensure all federal and State requirements are met; this includes evaluating letters for reading grade level and understandability of any customized, inserted text.
- Provide clarification to all CMOs regarding State requirements and the periodicity for distributing the member handbook to existing members.
- Ensure all CMOs are informed of updates to or clarifications about State requirements in a timely manner. Consider development of a communication system to ensure all CMOs receive the same information at the same time.
- Determine (based on the results of the 2016 PIPs, and in conjunction with the CMOs) if the CMOs were more successful when they were able to focus their improvement efforts on fewer PIP topics. If so, DCH should consider prioritizing fewer focus areas for the CMOs' statewide quality improvement efforts (i.e., required PIP topics), while allowing additional, formal PIPs that the CMOs may conduct in other areas of identified poor performance.
- Provide additional guidance documents that detail DCH's requirements for the CMOs' QAPI plans.

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 DCH GF CMOs addresses HSAG's:

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

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

Objective of Conducting the Review of Compliance With Standards

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

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

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

- Standard I—Provider Selection, Credentialing, and Recredentialing
- Standard II—Subcontractual Relationships and Delegation
- Standard III—Member Rights and Protections
- Standard IV—Member Information
- Standard V—Grievance System
- Standard VI—Disenrollment Requirements and Limitations
- Follow-up on areas of noncompliance from the prior year's review

The DCH and the CMOs will use the information and findings that resulted from HSAG's review to:

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

The review was the second year of the current three-year cycle of CMO compliance reviews.

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

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DCH and the CMOs, as they related to the scope of the review. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[A-1] for the following activities:

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the two-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate their preparation for HSAG's review.
- Conducting a pre-on-site desk review of 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 grievances, appeals, credentialing, and recredentialing cases for the on-site CMO audit from the list submitted to HSAG from the CMO.

On-site review activities: HSAG 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 and files HSAG requested that the CMOs have available on-site.

[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.

- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

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

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, 2014–June 30, 2015
Information obtained through interviews	July 30, 2015—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, 2014–June 30, 2015

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

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 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 standards and an overall percentage-of-compliance score across the 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 the 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 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 step.
- Transition to the Rapid Cycle PIP process.
- 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 PIP.

The June 30, 2015, through August 3, 2015, PIP submissions included:

- Six new PIPs with a narrowed focus, which followed HSAG's new rapid cycle approach (*Annual Dental Visits, Appropriate Use of ADHD Medications, Avoidable Emergency Room Visits, Bright Futures, Comprehensive Diabetes Care,* and *Postpartum Care*).
- Two ongoing, nonclinical, satisfaction-based PIPs, which followed HSAG's outcome-focused PIP process: *Member Satisfaction* and *Provider Satisfaction.*

The methodologies used for validating the two types of PIPs are described below. The objective of PIP validation was the same regardless of PIP type.

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.

Transition to the Rapid Cycle PIP Process

In January 2014, DCH requested that HSAG incorporate a new rapid cycle improvement approach into the existing PIP process, to fuel more effective improvement efforts by the CMOs in Georgia. In response to DCH's request, HSAG added the following components to the guidance provided to the CMOs for six of the PIPs conducted in 2014:

- Narrow the study topic for each PIP. The CMOs were expected to conduct drill-down data analyses to identify a subgroup of their members or providers that could benefit from improvement efforts.

- Measure data on study indicator results more frequently than the previously accepted annual measurement periods. HSAG instructed the CMOs to measure and document results at least quarterly.
- Develop a SMART (specific, measureable, achievable, relevant, and time-bound) Aim statement for each PIP. The CMOs were to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the date by which the goal was targeted.

The DCH and HSAG instructed the CMOs to proceed with Plan-Do-Study-Act (PDSA) cycles and intervention testing for the six 2014 rapid cycle PIPs while a more comprehensive rapid cycle PIP process was being designed. The CMOs were directed to continue the two ongoing satisfaction-based PIPs, *Member Satisfaction* and *Provider Satisfaction*, using annual study indicator measurements and following HSAG's established, outcome-focused PIP methodology.

In July 2014, HSAG began to fully develop a new rapid cycle PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and applied to healthcare quality activities by the Institute for Healthcare Improvement.[B-1] The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The new methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement.

Because PIPs must meet CMS requirements, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[B-2] HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, a new approach was reasonable and approved the use of the new rapid cycle framework to be piloted in the State of Georgia.

The key concepts of the new PIP framework include the formation of a PIP team, setting aims, establishing measures, determining interventions, testing and refining interventions, and spreading successful changes. The core component of the new approach involves testing changes on a small scale—using a series of PDSA cycles and applying rapid cycle learning principles over the course of the improvement project to adjust intervention strategies, so that improvement can occur more efficiently and lead to long-term sustainability. For the State of Georgia, DCH established a 12-month calendar year (CY) time frame for the duration of the rapid cycle PIPs.

[B-1] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: September 24, 2015.

[B-2] 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.

For the formalized rapid cycle PIP framework, HSAG developed five modules with an accompanying companion guide.

- Module 1—PIP Initiation: Outlines the framework for the project. The framework includes the topic rationale and supporting data, building a PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- Module 2—SMART Aim Data Collection: The SMART Aim measure is outlined, and the data collection methodology is described. SMART Aim data are displayed using a run chart.
- Module 3—Intervention Determination: The quality improvement activities that can impact the SMART Aim are identified. Through the use of process mapping, failure modes and effects analysis (FMEA), and failure mode priority ranking, interventions are selected to test in Module 4.
- Module 4—Plan-Do-Study-Act: The interventions selected in Module 3 are tested and evaluated through a series of PDSA cycles.
- Module 5—PIP Conclusions: Summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

Technical Methods of Data Collection and Analysis

In this eighth year of validating CMO PIPs, HSAG conducted PIP validation on eight DCH-required PIPs for each CMO, six required PIPs following a new rapid cycle PIP process, and two PIPs following HSAG's outcome-focused methodology. The rapid cycle PIPs are listed below:

- *Annual Dental Visits*
- *Appropriate Use of ADHD Medications*
- *Avoidable Emergency Room Visits*
- *Bright Futures*
- *Comprehensive Diabetes Care*
- *Postpartum Care*

The following DCH-required PIPs were evaluated with traditional annual study indicator measurements and validated with HSAG's existing outcome-focused PIP validation methodology:

- *Member Satisfaction*
- *Provider Satisfaction*

Both the methodology used to validate the rapid cycle PIPs and the methodology used to validate the traditional outcome-focused PIPs were 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.[B-3] Using this protocol, HSAG, in

[B-3] 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.

collaboration with DCH, developed the PIP Submission Form for rapid cycle PIPs and the PIP Summary Form for traditional outcome-focused PIPs, to ensure uniform validation of the PIPs. These forms standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

Rapid Cycle PIP Data Collection and Analysis Methodology

For 2014, a transition year when the CMOs began the rapid cycle PIPs as HSAG's modules were being developed, the CMOs submitted a modified Module 5 Submission Form for validation that incorporated elements of Modules 1 through 4 of the rapid cycle PIP process, to capture the key design, implementation, and outcomes for the annual validation of each rapid cycle PIP. The submissions were scored on the following Module 5 criteria necessary for successful completion of a valid PIP:

- The narrative summary of overall key findings and interpretation of results was accurate.
- The CMO documented evidence of achieving the SMART Aim.
- The CMO documented evidence of meaningful improvement.
- The CMO documented evidence that the achieved improvement was sustained.
- The CMO documented its plan for sustaining the improvement achieved, if applicable.
- The CMO documented lessons learned and information gained from failed interventions and/or lack of improvement.

HSAG assigned a score of *Achieved* or *Failed* for each of the criteria in Module 5. If one of the Module 5 criteria was not applicable to a PIP, the criterion was not scored. HSAG used the findings for the Module 5 criteria for each PIP to determine a confidence level representing the validity and reliability of the PIP findings and outcomes.

The scoring methodology for the rapid cycle PIPs evaluates whether the CMO achieved all of the criteria in Module 5, which represent the synthesis of all of the requirements in the CMS protocols at the conclusion of a PIP, including whether a sound quality improvement process was used, whether meaningful improvement was achieved, and whether the improvement was sustained.

Using the PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved meaningful improvement for the SMART Aim measure, and the demonstrated improvement was clearly linked to the quality improvement processes conducted.
- *Confidence* = the PIP was methodologically sound; achieved meaningful improvement for the SMART Aim measure; and some of the quality improvement processes were clearly linked to the demonstrated improvement, but there was not a clear link between all quality improvement processes and the demonstrated improvement.
- *Low confidence* = (A) the PIP was not methodologically sound; (B) the PIP was methodologically sound, but improvement was not achieved for the SMART Aim measure; or

(C) improvement was achieved for the SMART Aim measure, but the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.

Traditional Outcome-Focused PIP Data Collection and Analysis Methodology

For the traditional outcome-focused PIPs, HSAG developed a PIP Validation Tool using the CMS PIP validation protocol as its guide, which was approved by DCH. This tool ensured the uniform assessment of PIPs across all CMOs and contained the following validation steps:

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

Each required step was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given step 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 did not assign a score of *Partially Met* for any evaluation elements in 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 finding for the PIP. The CMOs were also given a *Not Met* validation finding 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 finding (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 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 and assigned one of the following two determinations of validation findings:

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

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validation from the CMOs' PIP Submission Forms (for rapid cycle PIPs) and PIP Summary Forms (for satisfaction-based PIPs). These forms provided detailed information about the CMOs' completed PIP steps.

To validate the PIPs, HSAG obtained and reviewed information from each CMO's PIP Submission Form or PIP Summary Form. The CMOs were required to submit for validation a PIP Submission Form for the each of the six rapid cycle PIP topics and a PIP Summary Form, for each of the two traditional outcome-focused, satisfaction-based PIP topics. The PIP Submission Forms and PIP Summary Forms contained detailed information about each PIP and the activities completed for the validation cycle. HSAG began PIP validation in July 2015 and completed validation in August 2015. 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.

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 B–1—Description of Data Sources

CMO	Data Obtained	Time Period to Which the Data Applied
Amerigroup Peach State WellCare	*Annual Dentist Visits* PIP	January 1, 2014–December 31, 2014
	Appropriate Use of ADHD Medications PIP	
	Avoidable Emergency Room Visits PIP	
	Bright Futures PIP	
	Comprehensive Diabetes Care PIP	
	Postpartum Care PIP	
Amerigroup	*Member Satisfaction* PIP	March 1, 2015–May 1, 2015
	Provider Satisfaction PIP	July 1, 2014–September 30, 2014
Peach State	*Member Satisfaction* PIP	March 20, 2015–May 29, 2015
	Provider Satisfaction PIP	September 1, 2014–October 31, 2014
WellCare	*Member Satisfaction* PIP	January 1, 2015–May 31, 2015
	Provider Satisfaction PIP	June 1, 2014–August 31, 2014

HSAG provided CMO-specific PIP validation reports to DCH and the CMOs that detailed information about the PIP validation process and findings.

Appendix C. **Methodology for Conducting Validation of Performance Measures**

The following is a description of how HSAG conducted the validation of performance measure activity associated with the GF population and the GF 360° population. 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 CMOs to report GF rates in SFY 2015 for 50 HEDIS and non-HEDIS measures. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information measures.[C-1] Many of the measures included multiple indicators or age stratifications. The measurement period was identified by DCH as CY 2014 for all measures except the two Child Core Set dental measures. The dental measures were reported for federal fiscal year (FFY) 2014, which covered the time frame of October 1, 2013, through September 30, 2014, according to CMS requirements. All performance measure rates were reported by the CMOs in June 2015.

The DCH allowed the CMOs to contract with individual licensed organizations to conduct NCQA HEDIS Compliance Audits. As such, the HEDIS measure rates were validated by the CMOs' contracted licensed organizations, and the non-HEDIS measure rates were validated by HSAG.

For the CY 2014 data, DCH established performance targets for many of the required measures and their associated indicators. These performance targets for CY 2014 data were based on the NCQA national Medicaid percentiles and the Nationwide Inpatient Sample (NIS) for the Agency for Healthcare Research and Quality (AHRQ) measures. Fifty-seven targets were established. Targets established for nine hybrid indicators were CMO-specific, meaning that CMOs have their own targets to achieve.

For the GF 360° population, DCH required Amerigroup to report 34 HEDIS measures and 13 non-HEDIS measures for SFY 2015. Similar to the GF rate reporting, DCH allowed Amerigroup to contract with an individual licensed organization to conduct an NCQA HEDIS Compliance Audit for the GF 360° population. However, due to the unique characteristics of the GF 360° population, the continuous enrollment requirements for the HEDIS measures could not be applied and therefore were waived by DCH for rate calculation. In addition, Amerigroup 360° measures with denominators less than 30 were not suppressed by the licensed organization that conducted the audit as would typically take place according to NCQA's audit designation results assignment guidelines. Therefore, HSAG applied a suppression threshold for Amerigroup 360°'s population, and suppressed rates comprised of less than 11 members to protect member confidentiality. The 13 non-HEDIS measure rates for this population were validated by HSAG.

[C-1] The health plan descriptive information measures were not presented in this report.

Objectives

HSAG validated 15 non-HEDIS measures calculated and reported by the CMOs for the GF program and 13 non-HEDIS measures calculated and reported by Amerigroup for the GF 360° program. Most of the non-HEDIS measures were Adult or Child Core Set measures; a few were AHRQ measures. The primary objectives of HSAG's performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the CMOs.
- Determine the extent to which the specific performance measures calculated by the CMOs followed the specifications established for each performance measure.

HSAG began performance measure validation of the non-HEDIS measures and completed validation in June 2015. The CMOs submitted performance measure data that reflected the period of January 1, 2014, through December 31, 2014, with the exception of the two Child Core Set dental measures, which covered the time frame of October 1, 2013, through September 30, 2014. HSAG provided final performance measure validation reports to the CMOs and DCH in August 2015. These reports contain validation findings generated by HSAG with regard to its performance measure validation of the non-HEDIS measures and the corresponding validated rates. In addition, these reports also contain the validated HEDIS rates obtained from the CMOs' licensed organizations.

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.[C-2] Pre-on-site activities and document review were conducted, followed by an on-site visit to each CMO that included interviews with key staff and system demonstrations. Finally, post-review follow-up was conducted with each CMO 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 2015 Roadmap: The CMOs 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

[C-2] 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: October 26, 2015.

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. 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, 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.

Post-On-Site Activities

HSAG conducted post-review follow-up with each CMO to ensure that any issues identified during the site visit were resolved. Additionally, HSAG also reviewed the final measure rates calculated by each CMO. The review included comparison of this year's rates to those from prior years, as well as rate comparison across all CMOs, to ensure reasonableness.

Description of Data Obtained

For all the HEDIS rates, HSAG obtained the audited GF CMO rate files from each of the CMOs and the audited GF 360° rate file from Amerigroup 360°. All the HEDIS rates were audited by individual licensed organizations other than HSAG. HSAG did not independently audit any of the HEDIS measures displayed in this technical report. For the non-HEDIS rates displayed in this technical report, since HSAG conducted the performance measure validation for all the GF CMOs and for Amerigroup 360°, the audited rate files were obtained from the individual performance measure validation reports.

Data Aggregation, Analysis, and How Conclusions Were Drawn

Based on all validation activities, HSAG determined results for each performance measure. As set forth in the CMS protocol, HSAG assigned a validation finding of *Reportable*, *Not Reportable*, or *Not Applicable* to each performance measure. HSAG based each validation finding on the magnitude of errors detected for the measure's evaluation elements, not by the number of elements determined to be noncompliant. Consequently, it was possible that an error for a single element resulted in a designation of *Not Reportable* because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it was also possible that errors for several elements had little impact on the reported rate, and the indicator was given a designation of *Reportable*.

After completing the validation process, HSAG prepared a report of the performance measure validation findings and recommendations for each CMO reviewed. HSAG forwarded these reports to the State and the appropriate CMO.

Results of HSAG's performance measure validation showed that all CMOs followed the required measure specifications to calculate and report the non-HEDIS measures for the GF and GF 360° programs. Nonetheless, three measures received the NR (*Not Reportable*) designation for the audit results: *Antenatal Steroids*, *Cesarean Section for Nulliparous Singleton Vertex*, and *Elective Delivery*. The CMOs calculated these measures properly, and according to the CMS specifications. However, due to limitations with the CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)—Surveys

Objectives

The primary objective of the Adult and Child CAHPS Surveys was to effectively and efficiently obtain information on the levels of satisfaction of adult and child Medicaid members enrolled in Amerigroup, Peach State, and WellCare with their CMO and healthcare experiences.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through the administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to adult Medicaid members, and the CAHPS 5.0H Child Medicaid Health Plan Survey (without the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid members enrolled in Amerigroup, Peach State, and WellCare. Each CMO was responsible for contracting with its own NCQA-certified survey vendor to conduct CAHPS surveys of its adult and child Medicaid populations, including survey analysis and reporting of CAHPS Survey results. Amerigroup contracted with DSS Research, while Peach State and WellCare both contracted with SPH Analytics to conduct the CAHPS Survey activities. Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2014; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2014.

The surveys administered by each CMO's vendor include a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the CCC measurement set) that assess members' perspectives on care. To support the reliability and validity of the findings, the CMOs' vendors followed standardized sampling and data collection procedures to select members and distribute surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis by each CMO's vendor. The CAHPS Survey results, produced by each CMO's survey vendor, were provided to HSAG for purposes of inclusion in this report.

Based on the information provided to HSAG, the analysis of the CAHPS 5.0H Adult and Child Medicaid Health Plan Survey results was conducted by each CMO's vendor following NCQA HEDIS Specifications for Survey Measures.[D-1] NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS Survey result; however, for purposes of this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100

[D-1] National Committee for Quality Assurance. *HEDIS® 2015, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2014.

respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into nine measures of satisfaction. These measures included four global ratings and five composite scores. The global ratings reflected members' overall satisfaction with their health plans, all healthcare, specialists, and personal doctors. The composite scores were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care* and *How Well Doctors Communicate*). The following are the four global rating measures and five composite measures evaluated through the CAHPS 5.0 Surveys:

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*

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 8, 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate. For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. Response choices for the CAHPS composite questions in the adult and child Medicaid surveys fell into one of the following two categories: (1) "Never," "Sometimes," "Usually," and "Always;" or (2) "No" and "Yes." A positive or top-box response for the composites was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite scores.

For each CMO, the 2015 adult and child CAHPS scores were compared to 2015 NCQA national adult and child Medicaid averages, respectively. In addition to the CMO-specific results, HSAG provided an overall statewide average score for the adult and child Medicaid populations and compared the scores to 2015 NCQA national Medicaid averages.[D-2] These comparisons were performed on the four global ratings and four composite measures. With the release of the 2015 CAHPS 5.0H Medicaid Health Plan Surveys, changes were made to the survey question language and response options for the *Shared Decision Making* composite measure; therefore, comparisons to NCQA national average data could not be performed for this measure for 2015.

[D-2] Quality Compass® 2015 data serve as the source for the 2015 NCQA national adult and child Medicaid averages.

Description of Data Obtained

The CAHPS Survey asks members to report on and to evaluate their experiences with healthcare. The survey covers topics important to members, such as the communication skills of providers and the accessibility of services. The CAHPS Survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least one question was answered. Eligible members included the entire random sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, they were invalid (they did not meet the eligible population criteria), they had a language barrier, or they were mentally or physically incapacitated (adult population only). Ineligible members were identified during the survey process. This information was recorded by the CMOs' survey vendors, and a summary of the final survey dispositions was provided to HSAG in the data (i.e., CAHPS reports) received.

The CMO-specific results of the Adult and Child CAHPS Surveys are summarized in the CMO-specific sections of this report; and in Section 7, a statewide comparison of all CMO results is provided.

Appendix E. **Performance Improvement Project Summary Grid**

Table E-1—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup defined the baseline rate (11.7 percent) for the PIP as the monthly percentage of members 1 to 20 years of age who were compliant with having at least one annual preventive dental service in February 2014. The CMO's goal was to achieve a rate of 16.7 percent, a 5 percentage point increase over the baseline rate. The CMO's final cumulative rate for November 2014 was 33.7 percent. While the goal was met and surpassed for the six final monthly measurements, the PIP did not demonstrate meaningful or sustained improvement because the measurement methodology was not sound. Because the baseline rate was a monthly rate of an annually required service and the CMO tracked a cumulative rate over the course of the PIP, the baseline rate was not comparable with the remeasurement rates. Comparing cumulative monthly rates from	◆ Amerigroup contracted with a mobile dental unit vendor to offer convenient locations for members to obtain preventive dental services ◆ Amerigroup partnered with Federally Qualified Health Centers (FQHCs) that offered on-site dental providers to provide additional locations for members to obtain preventive dental services.	Low Confidence	The measurement methodology for this PIP was not sound; therefore, HSAG assigned a *Low Confidence* validation finding. Because the SMART Aim measure could not represent meaningful improvement over the life of the PIP, the PIP's run chart did not provide any useful data to evaluate the CMO's interventions or the overall success of the PIP. HSAG recommends that Amerigroup seek technical assistance when identifying, defining, and tracking SMART Aim measures for ongoing and future PIPs to ensure a sound measurement methodology. The SMART Aim measurement methodology must ensure that baseline and remeasurement data points are comparable in order for the data to be useful for evaluating intervention effectiveness and planning future improvement efforts. Especially in PIPs focused on

Table E-1—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
one month to the next did not allow for a valid comparison; therefore, it was not possible for HSAG to determine whether meaningful or sustained improvement in the SMART Aim measure was achieved.			improving a service or outcome that occurs annually, such as an annual dental visit, SMART Aim measurement can be methodologically complex. By seeking necessary assistance and ensuring a sound technical structure of the measure, the CMO will be able to monitor the true impact of the interventions, effectively conduct PDSA cycles, and determine if meaningful improvement is being achieved or whether a new improvement strategy is needed.
Peach State			
Peach State established the baseline sealant rate for 6-to-9-year-olds (8.9 percent) based on the baseline measurement period of January through June 2014. The CMO set a goal of 10.9 percent, an increase of 2 percentage points. The run chart included two quarterly remeasurements following the baseline measurement. The PIP's SMART Aim measure did not meet the goal; therefore, there was no evidence of meaningful or sustained improvement (*Low Confidence* validation finding). The second remeasurement was 0.6	◆ Peach State doubled the sealant placement reimbursement rate for eligible members among all dental providers, including the targeted provider. ◆ Peach State sent the targeted provider eligible member rosters and requested that the dental provider reach out to members to schedule sealant/preventive service appointments. ◆ Peach State partnered with the dental vendor to send educational mailings on the importance of dental sealants.	Low Confidence	The targeted provider selected by the CMO was inappropriate for the focus of the PIP because the provider primarily performed surgical procedures and did not focus on preventive dental services. This oversight suggested that Peach State did not carefully evaluate and select the targeted provider. Going forward, the CMO should ensure that the targeted population selected for each PIP is an appropriate fit with the PIP's focus and intended outcomes. The poorly selected targeted provider likely contributed to the lack of meaningful improvement. Because Peach State implemented multiple interventions simultaneously

Table E-1—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
percentage point below the baseline rate.	◆ Peach State partnered with the dental vendor to place automated calls to eligible members, promoting the scheduling and keeping of preventive dental appointments.		and did not implement sufficient, intervention-specific evaluations, the CMO could not determine the unique impact of each intervention on the PIP outcomes. Meaningful knowledge about the four interventions was not gained because of the lack of sound intervention evaluation processes. For all ongoing and future rapid cycle PIPs, Peach State must ensure adequate planning of intervention timing and measurement of intervention-specific effectiveness by following sound PDSA cycle methodologies for each intervention.
WellCare			
WellCare established the baseline preventive dental rate for 6-to-9-year-olds (9.4 percent) based on the baseline measurement period of June through August 2014. The CMO set a goal of 14.4 percent, an increase of 5 percentage points. The run chart included four monthly remeasurements for September through December 2014; however, the CMO compared the baseline measurement to the average of the four monthly measurements to assess for meaningful improvement. Because the SMART Aim measurement methodology	◆ WellCare partnered with a dental vendor to conduct telephonic outreach to eligible members who had had a visit with the targeted dental provider prior to CY 2014. The dental vendor provided education on preventive dental visits to eligible members who were reached by telephone.	Low Confidence	Because the quarterly SMART Aim measurements were incorrectly calculated, the PIP's run chart did not provide accurate data to evaluate the CMO's interventions or the overall success of the PIP. The SMART Aim measurement methodology must ensure that baseline and remeasurement data points are comparable and calculated accurately in order for the data to be useful for evaluating intervention effectiveness and planning future improvement efforts. Especially in PIPs focused on improving a service or outcome that occurs annually, such

Table E-1—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
was not sound, the reported PIP results were not credible. There was no evidence that the PIP's SMART Aim measure achieved meaningful or sustained improvement.			as an annual dental visit, SMART Aim measurement can be methodologically complex. By seeking necessary assistance and ensuring a sound technical structure of the measure, the CMO will be able to monitor the true impact of the interventions, effectively conduct PDSA cycles, and determine if meaningful improvement is being achieved or whether a new improvement strategy is needed. In addition to ensuring that the SMART Aim measurement is methodologically sound, HSAG recommends that WellCare approach new rapid cycle PIPs by first considering the required end date of the life of the PIP, working backwards from that date to develop a realistic and comprehensive plan for PIP activities to ensure that sufficient time is allotted to address all five modules of HSAG's rapid cycle PIP process. For example, the PDSA cycle process in Module 4 of HSAG's process is an iterative process that usually requires multiple testing cycles to refine interventions so that they can reach their full potential to impact PIP outcomes. Having only four monthly data points for the SMART Aim measure, as displayed in the *Annual*

Table E-1—Annual Dental Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			Dental Visits PIP run chart, was not sufficient to achieve meaningful and sustained improvement. Careful planning of the timing of all five rapid cycle PIP modules at the start of the PIP will also help to allow adequate time to follow sound quality improvement processes when identifying barriers and developing a comprehensive key driver diagram. WellCare noted that its primary outreach intervention for the *Annual Dental Visits* PIP did not include follow-up on missed appointments. Because missed appointments are a common and well-known issue, it appears that a well-planned intervention would have included a plan for addressing this barrier during the PIP. Additionally, although WellCare plans to include a follow-up phone call for missed appointments in the future, the CMO should also conduct further drill-down analyses to determine the root causes of missed appointments and consider whether a follow-up phone call will be a sufficient revision in the improvement strategy to achieve the desired improvement in dental visit rates.

Table E-2—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup established the baseline rate of 42.8 percent based on a baseline measurement period of March 2013 to February 2014. The CMO set a goal of 47.8 percent, or an increase of 5 percentage points. The CMO's run chart included four quarterly remeasurements following the baseline measurement and one annual remeasurement (March 2014 to February 2015) corresponding to the year following the baseline measurement period. The PIP's SMART Aim measure demonstrated meaningful and sustained improvement by exceeding the goal rate for all four quarterly remeasurements. The annual remeasurement of 55.0 percent also exceeded the goal of 47.8 percent by 7.2 percentage points.	◆ Amerigroup offered clinical oversight by a nurse practice consultant to five high-volume, low-performing providers. The clinical practice consultant (CPC) made face-to-face visits to the targeted ADHD provider offices. The provider visits involved education on best practices, identification of provider-specific barriers, and assistance in developing new processes in the provider offices to address identified barriers. The CPC made multiple visits to individual provider offices as necessary, depending on the receptiveness of the individual providers.	High Confidence	The CMO used a sound SMART Aim measurement methodology and effective improvement strategies, which resulted in meaningful and sustained improvement. HSAG recommends that Amerigroup continue its efforts toward sustaining the improvement already achieved and strategically evaluate if and how it is appropriate to spread improvement strategies beyond the original scope of the PIP. The CMO should share PIP results with senior leadership and consider developing a plan to spread the successful improvement strategies. Planning to spread interventions beyond the original scope of the PIP should not be taken lightly and should include considerations for communication of planned changes, measurement of spread effectiveness, and a work plan detailing how spread will be managed. In addition to plans to sustain and spread the improvement demonstrated by the *Appropriate Use of ADHD Medications* PIP, the CMO should consider how the successful approach to the technical design of the PIP, the barrier analysis techniques used, and the improvement strategies could be applied or translated to

Table E-2—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			improve the CMO's less successful PIPs.
Peach State			
Peach State established a baseline ADHD 30-day follow-up visit rate of 21.4 percent based on third quarter 2014 data (July through September). The CMO set a goal of a 2 percentage point increase over baseline, or 23.4 percent. The CMO's run chart included one quarterly remeasurement, which fell 1.4 percentage points below the baseline measurement. Because the goal was not achieved at the remeasurement, the SMART Aim measure did not provide evidence of meaningful or sustained improvement in the appropriate use of ADHD medications for members 6 to 12 years of age.	◆ Peach State partnered with a behavioral health sister company to offer peer-to-peer physician outreach and education for three targeted PCPs with a high volume of members receiving ADHD medication prescriptions. ◆ Peach State sent out clinical practice guidelines (CPGs) for ADHD medication management to the targeted providers. ◆ During the peer-to-peer review phone call, the physician/CEO offered technical assistance, clarified the CPGs, discussed the HEDIS ADHD medication management requirements, and collected qualitative feedback from the targeted providers.	Low Confidence	The conclusions from the PIP suggested that the CMO's processes for identifying barriers, prioritizing barriers, and/or selecting a priority intervention to test were flawed. While the selected intervention was focused on provider awareness and education, the final conclusions were that member-based barriers, not provider-based barriers, were the primary factors impacting ADHD medication follow-up visit compliance. HSAG recommends that Peach State review the barrier analysis and intervention development steps used for the PIP to identify gaps in its quality improvement processes. The CMO should pursue further drill-down analyses of the member-based barriers identified by the providers participating in the PIP so that improvement efforts can be focused in an area that is more likely to lead to improvement. Going forward, in ongoing and future PIPs, the CMO should ensure that adequate time is allowed during the life of the PIP for multiple, consecutive PDSA cycles to

Table E-2—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			occur prior to the end of the PIP. Starting with the goal date in mind, the CMO should plan the timing of the PDSA cycles so that, once lessons have been learned from one cycle, they can be applied to refine the improvement strategies during the life of the PIP and increase the likelihood that meaningful improvement will be achieved.
WellCare			
WellCare established the baseline rate (48 percent) of completed 30-day follow-up appointments for eligible members prescribed ADHD medications based on the baseline measurement period of August through December 2013. The CMO set a goal of an increase of 5 percentage points over the baseline rate. The run chart included five monthly remeasurements for August through December 2014; however, the CMO compared the baseline measurement to the average of the five monthly measurements to assess for meaningful improvement. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible. Based on	◆ Telephone outreach by the WellCare Quality Department occurring within seven days of the initial ADHD medication fill date to members assigned to three targeted high-volume, low-performing PCPs. The telephone outreach included confirmation that the follow-up appointment had been scheduled, as well as education about the importance of the visit.	Low Confidence	The CMO's conclusions from the PIP, including the decision to continue the intervention and plans for addressing additional barriers, could not be supported by the SMART Aim data because the measurement calculation was not methodologically sound and the reported rates were inaccurate. HSAG recommends that the CMO seek technical assistance when developing and calculating the SMART Aim measures for future PIPs. Accurate measurement of improvement processes and PIP outcomes, and sufficient data points, are critical to achieving meaningful and sustained improvement. Without accurate and meaningful data, the CMO can neither evaluate and refine improvement strategies nor monitor progress toward the PIP's SMART

Table E-2—Appropriate Use of ADHD Medications			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
the CMO's definition of "meaningful improvement" and HSAG's calculations, using the monthly numerators and denominators reported in the PIP, there was no evidence that the PIP's SMART Aim measure achieved meaningful or sustained improvement.			Aim goal. Additionally, HSAG recommends that the CMO plan for earlier initiation of interventions in the life of future PIPs so that sufficient data points can be measured, allowing time for sufficient impact on key drivers of improvement, and ultimately meaningful and sustained improvement of the targeted health outcome. Finally, the CMO should ensure that barriers identified during the course of the PIP, and lessons learned, are clearly and completely communicated to key stakeholders, and are included as part of the PIP submission so that concrete evidence is available to support future improvement efforts.

Table E-3—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup established a baseline avoidable emergency room (ER) visit rate (an inverse rate where a lower rate indicates better performance) of 156 per 1,000, based on a baseline measurement period of CY 2013. The CMO set a goal to reduce the avoidable ER rate to 148 per 1,000. The CMO's run chart included monthly remeasurements from January to December 2014. The SMART Aim measure demonstrated meaningful improvement by surpassing the goal for eight of the monthly remeasurements. The PIP did not provide evidence of sustained improvement, however, as shown by the final five monthly SMART Aim measurements. There was an increasing trend in the avoidable ER rate from August to December 2014, and the monthly avoidable ER rates for October, November, and December were higher (indicating worse performance) than both the baseline and goal avoidable ER rates.	◆ A face-to-face provider training session that illustrated best practices for early patient engagement and establishment of a medical home for members, including provider tools for member outreach, to prevent inappropriate ER utilization. ◆ Face-to-face visits with providers that included a demonstration of the inverse relationship between well visits and avoidable ER visits (the more completed well visits, the fewer avoidable ER visits) and a presentation of financial return on investment (ROI) data to support the use of additional practice resources for new member outreach to improve well visit and avoidable ER visit rates.	Confidence	The SMART Aim measure demonstrated meaningful improvement by surpassing the goal for eight of the monthly remeasurements; therefore, HSAG assigned a *Confidence* validation finding. The CMO documented that future improvement efforts will assess the readiness and willingness of providers to make process changes prior to selecting them for targeted improvement efforts. Because the interventions tested as part of the rapid cycle PIP should have the potential to be expanded beyond the initial narrowed focus, it is not sufficient for Amerigroup to focus improvement efforts only on providers who are already willing and ready to make changes. Instead, the CMO should determine what would motivate providers and consider testing strategies that can incentivize providers to change their processes and engage them in the process of reducing avoidable ER visits.

Table E-3—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Peach State			
Peach State established a baseline avoidable ER visit rate for members ages 0 to 21 years (an inverse rate where a lower rate indicates better performance) of 16.8 percent based on a quarterly measurement period of July through September 2014. The CMO set a goal to decrease the avoidable ER visit rate by 2 percentage points to 14.8 percent. The SMART Aim run chart included one quarterly remeasurement of 26.9 percent that was 10.1 percentage points higher (indicating worse performance) than the baseline rate. The SMART Aim measure demonstrated a decline in performance; there was no evidence of meaningful or sustained improvement.	◆ The CMO's medical director and Provider Relations staff visited the targeted providers and shared the Avoidable ER Collaborative presentation. During the visits, the targeted providers received patient educational materials and were instructed on how to tailor Web page content for educating members on appropriate ER utilization.	Low Confidence	The SMART Aim measure demonstrated a decline in performance and there was no evidence of meaningful or sustained improvement; therefore, HSAG assigned a *Low Confidence* validation finding. The CMO reported that a longer time period was needed to fully evaluate the effectiveness of the intervention. Going forward, HSAG highly recommends that Peach State consider the time frame of the rapid cycle PIP and develop each PIP's narrowed focus and SMART Aim with that time frame in mind. Given the shorter length of the rapid cycle PIP, it is critical that the CMO use an effective, data-driven barrier analysis process to uncover and prioritize key root causes. Additionally, the CMO should conduct the barrier analysis and intervention development process early enough in the life of the PIP to allow sufficient time for an effective series of PDSA cycles, allowing for actionable data to be collected and applied in the refinement of interventions before testing occurs again. This iterative process requires

Table E-3—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			sufficient time, which is dependent on careful planning, starting with the end date of the PIP and working backwards, to develop a realistic goal and timeline for PIP activities.
WellCare			
WellCare defined the SMART Aim measure, the ER Non-Return rate, as the percentage of eligible members who had a previous avoidable ER visit, received the intervention, and did not return to the ER for an avoidable diagnosis within 90 days of receiving the intervention. WellCare established a baseline ER Non-Return rate of 100 percent based on a baseline measurement period of January through March 2014. Because the baseline rate was 100 percent, and the SMART Aim measure was not an inverse rate, there was no room for improvement in this PIP. WellCare set an ER Non-Return rate goal of 95 percent, which represented a decline of 5 percentage points from the baseline rate. The CMO's run chart included four monthly remeasurements following the baseline measurement, from September through December	◆ Telephone outreach to parents of members ages 0 to 5 years who had previously had an avoidable ER visit. Parents were educated on the importance of developing a relationship with a PCP and on having post-ER visits with the PCP. Additionally, information on WellCare's 24-hour nurse advice line and nonemergency transportation services was provided as part of the outreach phone call.	Low Confidence	The CMO's selected, narrowed focus for the *Avoidable Emergency Room Visits* PIP was not supported by data and was an inappropriate focus for the PIP topic. WellCare reported a baseline avoidable ER non-return rate of 100 percent, leaving no room for improvement. The foundation of any PIP should be a thorough and accurate analysis of CMO-specific data to identify a quantitative health outcome measure that demonstrates the need for improvement. Going forward, WellCare should ensure that CMO-specific data are used to support the selection of each PIP topic's narrowed focus. For this PIP, it appeared that because WellCare had selected a narrowed focus with such a high baseline rate, the CMO's goal was essentially to maintain a high level of performance that was near the baseline rate. This approach was incorrect. The CMO should select a narrowed focus that is supported by a

Table E-3—Avoidable Emergency Room Visits			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
2014. All four monthly remeasurements remained at 100 percent; however, the SMART Aim measure did not provide any evidence of improvement because the baseline rate was also 100 percent.			baseline rate which has room for improvement. Given the lack of evidence that improvement was achieved in this PIP, the short duration of the PIP, and that the PIP's primary intervention only reached 33 percent of the targeted population, HSAG recommends that WellCare review its conclusions about this project. The CMO should conduct further drill-down analyses of its members' avoidable ER visits to develop a comprehensive picture of the CMO-specific drivers of this issue. The selected focus of the PIP did not appear to be an area that needed improvement. The CMO's limited resources should be directed toward areas where the need for improvement is clearly demonstrated by data. Likewise, decisions to continue and/or spread interventions more widely should be based on improvement demonstrated through the SMART Aim measure and other measurable outcomes.

Table E-4—Bright Futures			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup established a baseline rate of 67.9 percent based on a baseline measurement period of CY 2013. The CMO set a goal of 70.9 percent, an improvement of 3 percentage points in the rate of completed annual well-child visits for members 3 to 6 years of age. The CMO's run chart included nine monthly measurements from March to November 2014 and an annual measurement for CY 2014, the year following the baseline measurement period. The SMART Aim measure did not meet the goal of 70.9 percent. The final monthly rate reported for November 2014 was 61.1 percent, and the CY 2014 rate was 68.8 percent.	◆ Amerigroup partnered with targeted providers to host Clinic Days events. The Clinic Days intervention entailed partnering with high-volume providers to set aside time slots on a specific day for Amerigroup to schedule appointments for their members. Amerigroup also offered a gift card incentive to members for completing their well visit during the Clinic Days events. The Clinic Days events were scheduled around the local school calendar and scheduled to provide opportunities for members to obtain a well visit without missing school.	Low Confidence	The inappropriate SMART Aim measurement methodology compromised the credibility of the PIP results and the CMO's ability to make sound decisions about future quality improvement efforts related to annual well-child visits. Because the SMART Aim measure could not represent meaningful improvement over the life of the PIP, the PIP's run chart did not provide any useful data to evaluate the CMO's interventions or the overall success of the PIP. The CMO could not provide a clear rationale for future planned improvement activities because the flawed SMART Aim measure did not provide meaningful data. For example, the CMO's decision to continue and spread the Clinic Days intervention beyond the initial scope of the PIP was unfounded because the SMART Aim measure did not provide meaningful data for support. HSAG recommends that Amerigroup seek technical assistance to ensure ongoing and future PIPs are based on a sound SMART Aim measurement methodology, which is critical to obtaining accurate and actionable data to drive improvement efforts.

Table E-4—Bright Futures			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Peach State			
Peach State established the baseline adolescent well-visit rate of 37.3 percent based on a baseline measurement period of July through September 2014. The CMO set a goal to increase the rate by 2 percentage points to 39.3 percent. The run chart included one quarterly remeasurement at 48.4 percent, which was an increase of 11.1 percentage points over the baseline rate. The SMART Aim measure demonstrated meaningful improvement by exceeding the goal by 9.1 percentage points. Because the PIP had only one remeasurement, the PIP did not include sufficient remeasurement data to demonstrate sustained improvement.	◆ Peach State partnered with targeted providers on-site to optimize member encounters to deliver any due/past due well-visit services, even when the appointment is scheduled for other services. ◆ Peach State offered targeted member incentives to schedule and keep a due/past due well visit. ◆ Peach State conducted live and automated telephone outreach to members to promote and schedule well visits. ◆ Peach State mailed postcard reminders to members who were due/past due for a well visit.	Confidence	The SMART Aim measure demonstrated meaningful improvement by exceeding the goal by 9.1 percentage points; therefore, HSAG assigned a *Confidence* validation finding. While meaningful improvement over the baseline rate was achieved for one remeasurement data point, the PIP included only two quarterly SMART Aim measurements occurring in the second half of 2014, one baseline measurement and one subsequent remeasurement. There were not sufficient data to demonstrate sustained improvement. Additionally, not all of the CMO's quality improvement processes were clearly linked to improvement in the SMART Aim measure. While the CMO reported the implementation dates of various interventions, the intervention dates overlapped and the CMO did not conduct adequate evaluations of the individual interventions; therefore, the CMO was unable to determine which of the interventions had impacted the well-visit rate for the targeted population. HSAG recommends that Peach State develop a more comprehensive and

Table E-4—Bright Futures			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			thoughtful plan for the timing of future PIP activities, seeking technical assistance if necessary. The CMO should develop a plan prior to the initiation of a new PIP that starts with the PIP end date, working backwards to determine a realistic goal for improvement, given the time frame, as well as documenting when specific activities will need to occur in order to reach the goal of meaningful and sustained improvement during the life of the PIP. Planning for success of the PIP should address all five of the PIP modules outlined in HSAG's rapid cycle PIP process. Of specific importance, given Peach State's performance on this PIP and others, is the plan for evaluating each intervention using the PDSA cycle. The plan should ensure that sufficient data specific to each intervention are collected so that the individual impact of the intervention can be determined. Sufficient time should be allotted to conduct multiple PDSA cycles, applying results to enhance improvement strategies, in an effort to ultimately meet the PIP's SMART Aim goal.

Table E-4—Bright Futures			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
WellCare			
WellCare defined three SMART Aim measures to measure the rate of well-care visits among adolescent members, members 15 months of age, and members 3 to 6 years of age, respectively. The baseline measurement period for each measure was January through February 2014. The CMO's baseline measurements were as follows: 14.8 percent of adolescents had an annual well visit; 21.3 percent of members 15 months of age had six or more well visits; and 27.8 percent of members 3 to 6 years of age had an annual well visit. WellCare set a goal to increase each rate by 10 percentage points over the respective baseline rate. WellCare's SMART Aim measurement methodology was not sound. HSAG determined that the CMO plotted a cumulative well-visit rate for each of the SMART Aim measures. For each cumulative rate, the CMO established the denominator, or the total number of all members due for well-visit services for the	◆ Member incentive program, where eligible members received a brochure explaining the monetary incentive for obtaining well-child services. After receiving the service, the member (or member's parent) was instructed to have the provider sign a form, and submit the form to the CMO. ◆ Provider pay-for-performance (P4P) incentive program where the eligible provider received a monetary incentive "for meeting set metrics" related to well-care visits.	Low Confidence	Because the SMART Aim measurement methodology was flawed, no true evidence of meaningful improvement was demonstrated for the *Bright Futures* PIP. Given the lack of evidence of improvement, HSAG recommends that WellCare revisit the barrier analysis activities for the PIP to ensure that sound methods, based on improvement science, were used to identify the root causes for this PIP topic. Going forward, the CMO should use tools such as FMEA and process mapping to ensure that the highest-priority barriers are being identified and that resources are being directed to address high-priority barriers first. For example, while member and provider financial incentives may serve to engage the member and provider populations in improving well-child visit rates, the CMO should consider whether these strategies alone will result in sustained improvement in this area or whether other types of barriers also need to be addressed in order to achieve long-term improvement.

Table E-4—Bright Futures			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
entire calendar year, and used this denominator for each monthly measurement. The numerator was calculated by adding the number of members who obtained the service during the current month to the number of members who had previously obtained the service during the prior months of the year. A cumulative rate, therefore, would inevitably increase throughout the life of the PIP, regardless of whether any true or meaningful improvement in the rate occurred. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible; therefore, the results displayed in the run charts should be interpreted with caution. The CMO should have used a monthly or rolling annual rate for the SMART Aim measures to allow for a valid assessment of improvement.			

Table E-5—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup defined the SMART Aim measure as the average HbA1c test result (an inverse measure, where a lower rate indicates better performance) for diabetic members assigned to the targeted provider. The CMO established a baseline average value of 9.0 percent based on a baseline measurement period of January 1, 2014–July 8, 2014. The goal was to decrease the monthly average HbA1c test result to 8.0 for members assigned to the targeted provider. The CMO's run chart included seven monthly SMART Aim measurements following the baseline period, from July 2014 through January 2015. The SMART Aim measure demonstrated meaningful improvement by meeting or exceeding the goal of 8.0 for three of the monthly remeasurements, including the month of August, which included the greatest number of members (four) with an HbA1c test result. The SMART Aim measure did not provide clear evidence of sustained improvement because the monthly	◆ A high dollar amount incentive offered to diabetic members seen by the targeted provider. The targeted provider offered comprehensive diabetes care and allowed members access to diabetic screenings and other needed services in one location. Eligible members could earn a total of $100 in incentives by fulfilling the following requirements: (1) obtain a repeat HbA1c blood test with a decrease of at least 1 percentage point, (2) use a glucometer and refill test strips as prescribed, (3) take and refill medications as prescribed, and (4) talk with a registered dietician about healthy diet and nutrition. Members could earn a $25 incentive for each of the four components, for a total of $100 in incentives. Eligible members received information about the incentive program through verbal communication and a printed brochure.	Confidence	The SMART Aim measure demonstrated meaningful improvement by meeting or exceeding the goal; therefore, HSAG assigned a *Confidence* validation finding. Amerigroup's selection of a member financial incentive for the PIP's primary intervention did not appear to address member-based root causes of poor HbA1c control. While the financial incentive may have generated member interest, the CMO did not provide a clear rationale for how this intervention would support members in making long-term behavioral changes that would improve their long-term diabetes control. One benefit of a narrowed PIP focus with such a small targeted population (less than 15 members at one provider office) is that in-depth barrier analysis activities such as focus groups or patient interviews are more feasible. It appeared that, given the small targeted population of members, Amerigroup should have conducted an in-depth barrier assessment of the targeted member population to determine common root causes.

Table E-5—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
average HbA1c result fluctuated between values above and below the goal rate throughout the life of the PIP.			Rather than focusing the PIP on HbA1c control among members within the rapid cycle PIP time frame, it may have been more effective to select one of the specific, member-based barriers to improve as the focus of the PIP. Going forward, Amerigroup should ensure that it selects PIP topics that can realistically be improved during the rapid cycle time frame. Additionally, the CMO should consider more in-depth barrier analysis techniques, such as focus groups and interviews, especially when the PIP's eligible population is so small, in order to drill down and identify the most important and feasible barriers to address for the rapid cycle PIP.
Peach State			
Peach State established a baseline HbA1c testing rate of 46.4 percent based on a baseline measurement period of July through September 2014. The CMO set a goal to increase the rate by 2 percentage points, to 48.4 percent. The CMO's run chart included one quarterly remeasurement at 82.4 percent that was 36 percentage points above the baseline rate and 34 percentage points above the	◆ Peach State partnered with a disease management sister company to conduct live telephone outreach to members with diabetes, in one targeted county. Peach State identified members who had a diagnosis of diabetes but who had not had an HbA1c test, based on claims received. Peach State's disease management sister company,	Confidence	The SMART Aim measure demonstrated meaningful improvement by exceeding the goal; therefore, HSAG assigned a *Confidence* validation finding. The PIP demonstrated meaningful improvement from baseline to the first remeasurement; however, the PIP did not include sufficient data to demonstrate sustained improvement. The SMART Aim run chart included

Table E-5—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
goal. The SMART Aim measure demonstrated meaningful improvement by exceeding the goal. Because the PIP had only one remeasurement, the PIP did not include sufficient remeasurement data to demonstrate sustained improvement.	Nurtur, mailed educational material to all identified members and followed up with each member via live phone calls to provide further education and assist the member with scheduling an HbA1c test.		only two data points. Going forward, the CMO should ensure that the timing of PIP activities is well planned and based on the PIP's end date, in order to build in sufficient time to evaluate and refine interventions and to achieve meaningful and sustained improvement. HSAG recommends that Peach State not take the expansion of the intervention beyond the original targeted population lightly, even if meaningful improvement has been demonstrated in the PIP. Given the lack of sufficient data points to demonstrate sustained improvement, the CMO should first seek to demonstrate sustained improvement in the PIP's targeted population. The decision to spread an intervention widely should be preceded by careful evaluation and planning. Peach State should work with its senior leadership to develop a plan for spreading successful strategies. The CMO should research best practices for spread and should draw upon resources for technical assistance in this area. For example, HSAG's Rapid Cycle PIP Companion Guide describes a framework for spread based on Everett Rogers' definition of "diffusion" which includes components such as

Table E-5—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			responsibilities for leadership, communication, measurement and feedback, and knowledge management.[E-1] Planning for spread should include planning for effective communication, planning to measure effectiveness, and a work plan to manage the steps involved with spread.
WellCare			
WellCare defined two SMART Aim measures to measure the percentage of members with diabetes whose most recent HbA1c level was less than 9.0 percent and the percentage of members with diabetes whose most recent LDL-C level was less than 100 mg/dL, respectively. The baseline measurement period for both measures was January through February 2014. The baseline measurements were as follows: 43.3 percent of members had a most recent HbA1c level less than 9.0 percent, and 40.0 percent of members had a most recent LDL-C level less than 100 mg/dL. The CMO set a goal to increase each rate by 5 percentage points over the respective baseline	◆ Face-to-face visits with two low-performing endocrinologists, to address identified barriers to improving HbA1c and LDL-C control. WellCare Quality Improvement (QI) representatives met with each provider and a member of the provider's office staff during the face-to-face visits. The QI representatives discussed the Diabetes CPGs and provided details of members who were noncompliant with the diabetes control outcomes. The providers had an opportunity to share known member-specific barriers and any concerns about the PIP. Additionally, the QI	Confidence	Because the SMART Aim goal was met for HbA1c and LDL-C, both SMART Aim measures demonstrated meaningful improvement; therefore, HSAG assigned a *Confidence* validation finding. Based on the PIP submission, it appeared that WellCare will continue to test the provider-focused intervention while also pursuing approaches to address member-based barriers such as member motivation and behaviors. HSAG recommends that the CMO use tools such as process mapping, FMEA, and/or a logic model to more fully analyze how provider- and member-based barriers interact to impact diabetes control measures. By following sound quality improvement processes, the CMO can

[E-1] Rogers E: Diffusion of Innovations, 4th ed. New York: The Free Pres, 1995.

Table E-5—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
rate. Both run charts included six monthly remeasurements for July through December 2014. Because the SMART Aim goal was met for HbA1c and LDL-C, both SMART Aim measures demonstrated meaningful improvement. Only the LDL-C SMART Aim measure demonstrated sustained improvement, with more than one consecutive measurement exceeding the SMART Aim goal.	representatives introduced the PIP tracking tool to the providers, which recorded member demographics, dates of service, and diabetes lab results. The tracking tool was used for real-time tracking of the SMART Aim measures.		develop a comprehensive improvement approach that addresses all root causes and key drivers of diabetes control. Whether WellCare is seeking to change provider behavior or member behavior, changing behavior can be a challenging improvement strategy. HSAG recommends that the CMO review and select a specific model to follow for interventions focused on behavioral change. HSAG is available to provide assistance if WellCare would like further information on methods and strategies to promote and manage change at the organizational level. As with other PIP topics, HSAG recommends that the CMO ensure that the timing of future rapid cycle PIP activities is carefully planned, based on the end date of the PIP, to ensure adequate time to identify and test interventions based on sound improvement science, and that interventions are tested early enough in the life of the PIP to have sufficient SMART Aim measure data points to demonstrate both meaningful and sustained improvement. For example, meaningful improvement needs to be achieved early enough in the life of the PIP that subsequent data points

Table E-5—Comprehensive Diabetes Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			can be plotted to demonstrate sustained improvement prior to the PIP's end date. Additionally, the CMO should review HSAG's Rapid Cycle PIP Companion Guide to ensure that all PIP team members understand the definitions of "meaningful improvement" and "sustained improvement." The CMO's PIP team must have a clear foundation of understanding of the rapid cycle PIP process so that PIP outcomes are correctly interpreted and accurately communicated to key stakeholders such as DCH, HSAG, and the CMO's members and providers.

Table E-6—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup used its annual HEDIS 2013 rate for the baseline rate of postpartum care visits completed within 21 to 56 days after delivery, which was 61.5 percent. The CMO set a goal of increasing the rate by 14.5 percentage points. The CMO's run chart included nine monthly SMART Aim measurements from July 2014 through March 2015. The SMART Aim measure demonstrated meaningful and sustained improvement in the postpartum care rate by exceeding the goal for all nine monthly measurements. The monthly rates ranged from 78.1 percent in March 2015 to 91.3 percent in October 2014.	◆ A postpartum care scheduling incentive program was offered to four targeted providers. The CMO's CPC introduced the incentive program to the targeted providers during face-to-face meetings and incorporated input and feedback from the providers prior to launching the program. The incentive program was focused on the providers' office staff members because they controlled the scheduling of postpartum care appointments and could therefore more directly impact the timing of appointments to occur during the required time frame after delivery.	High Confidence	The CMO used a sound SMART Aim measurement methodology and effective improvement strategies for the PIP, which resulted in meaningful and sustained improvement. Amerigroup did not provide details on how it would be expanding the successful intervention. HSAG recommends that Amerigroup put in place a thoughtful plan for gradual expansion that includes continued evaluation of the effectiveness of the obstetric scheduler incentive among the original targeted providers. Additionally, the CMO should conduct additional analyses of the participating provider offices to determine if there were unique characteristics of these practices, such as practice size, location, number of support staff, and patient load that supported the intervention's effectiveness or drove the development of the intervention. When the CMO considers expanding the intervention to other obstetric practices, it will need to evaluate each new practice to determine if the intervention can be successful as it was originally implemented with the

Table E-6—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			targeted providers or if the intervention will need to be adapted. To effectively spread a successful intervention, the CMO must first carefully evaluate if and how the intervention should be expanded to a wider population. Care should be taken to maintain the improvement achieved among the original providers targeted for the PIP while gradually assessing expansion to additional provider practices. Planning to spread the intervention should address how changes will be communicated to key stakeholders, how the effectiveness of the intervention will continue to be measured at the individual provider and member level, and a work plan detailing how expansion of the intervention will be managed by all parties involved.
Peach State			
Peach State established the baseline postpartum visit compliance rate of 70.5 percent based on a quarterly baseline measurement period of July through September 2014. The CMO set a goal to increase the rate by 2 percentage points to 72.5 percent. The postpartum visit rate declined from 70.5 percent at	◆ On-site postpartum visit scheduling support and outreach for one high-volume hospital in the Atlanta Region. Peach State staff members were placed at the hospital three days per week to assist members with scheduling a postpartum visit at the time of delivery and to help establish	Low Confidence	The SMART Aim goal was not met; therefore, HSAG assigned a *Low Confidence* validation finding. The PIP did not achieve meaningful improvement in the postpartum visit rate for the targeted facility. The CMO's SMART Aim run chart was difficult to interpret because it

Table E-6—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
baseline to 69.9 percent at Remeasurement 1; therefore, the goal was not met and the SMART Aim measure did not demonstrate evidence of meaningful or sustained improvement.	a PCP for newborns. The on-site scheduling support was increased to four days per week at the hospital's request. The schedulers attempted to schedule the postpartum visits between 21 and 45 days after delivery to allow time to reschedule the visit prior to the 56-day, HEDIS-based time frame, if needed. The intervention also included telephone outreach to remind the member of the scheduled postpartum visit and provider follow-up to confirm when the postpartum visit occurred.		included both monthly and quarterly measurements for the same time period. Going forward, the CMO should select only one measurement interval to display on the run chart. In general, plotting data from more frequent measurement intervals (monthly rather than quarterly) is preferable. Peach State's continuation of the PIP's primary intervention at the targeted facility, despite a lack of meaningful improvement achieved during the life of the PIP, appeared to be based on the CMO's experience of achieving improvement using the intervention at a different facility. HSAG recommends that Peach State do an in-depth comparative analysis of the two facilities where the intervention has been implemented to determine whether certain facility characteristics are associated with more success. The process of spreading an intervention from one facility to another should be executed with caution and should include an evaluation of facility similarities and differences. It is likely that a "one-size-fits-all" approach will not be appropriate and that certain adaptations of the intervention, tailoring it to each individual facility,

Table E-6—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			will need to occur in order to achieve optimal improvement. Finally, regular evaluation of the impact of the intervention at each facility should continue in order to inform decisions about continuing, revising, or discontinuing the intervention at each facility.
WellCare			
WellCare established the baseline rate of completed postpartum care visits (38.3 percent) based on the baseline measurement period of June through August 2014. The CMO set a goal to increase the postpartum visit rate by 5 percentage points over the baseline rate. The run chart included four monthly remeasurements from September through December 2014; however, the CMO compared the baseline measurement to the average of the four monthly measurements to assess for meaningful improvement. Because the SMART Aim measurement methodology was not sound, the reported PIP results were not credible. HSAG determined that the CMO incorrectly calculated the baseline rate and the	◆ The Healthy Postpartum Behavior member incentive program was communicated to members through a brochure that encouraged them to complete a postpartum care appointment three to eight weeks after delivery. To obtain the incentive reward, members were required to fill in their information on a portion of the brochure and mail it back to the CMO. ◆ For the Postpartum Provider incentive program, WellCare provided to the targeted provider a weekly list of members who had recently delivered. The provider outreached members on the list to schedule the postpartum care visit within 21 to 56 days	Low Confidence	WellCare had challenges with correctly calculating the quarterly SMART Aim measurements. Because the quarterly SMART Aim measurements were incorrectly calculated, the PIP's run chart did not provide accurate data to evaluate the CMO's interventions or the overall success of the PIP. The lack of accurate data in the run chart resulted in a lack of valid PIP results, which, in turn, compromised the CMO's ability to make sound, data-driven decisions about future improvement activities. HSAG again recommends that WellCare seek technical assistance to ensure that SMART Aim measurement data collection and calculation methodologies are sound at the outset of the PIP so that meaningful data can be captured to drive the project toward achieving the desired improvement.

Table E-6—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
remeasurement rate. Rather than taking an average of monthly rates to establish a baseline rate, the numerators and denominators of each monthly measurement should have been summed, and the numerator total should have then been divided by the denominator total. There was no evidence that the PIP's SMART Aim measure achieved meaningful or sustained improvement.	after the delivery date. After the visit was completed, the provider was responsible for sending medical records documenting the postpartum care visit to the CMO. WellCare paid a monetary incentive to the provider for each qualifying completed postpartum care appointment that was documented.		In addition to ensuring accurate and appropriate data collection and measurement of outcomes, HSAG recommends that WellCare plan future PIP PDSA cycles more strategically to avoid being unable to distinguish the individual effects of two simultaneous interventions, as it reported for this PIP. One approach to this issue is to initiate PIP activities well enough in advance of the end date of the PIP to allow time for staggered initiation of interventions. Staggering the timing of the interventions can help to distinguish impact on the SMART Aim measure. Additionally, the CMO must develop a comprehensive evaluation plan for each individual intervention that should distinguish effectiveness, even if the timing of multiple interventions overlaps. WellCare should include in the evaluation plan process-level data to assess how well each intervention was conducted and identify specific areas of implementation that may need refinement. Additionally, whenever possible, the CMO should collect and track individual, member-level data linking the intervention to achieving the desired health outcome. Collecting and analyzing both process- and outcome-level data to evaluate the

Table E-6—Postpartum Care			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
			effectiveness of the interventions will result in a more comprehensive picture of progress toward the SMART Aim goal. Finally, when each intervention is adequately evaluated, data can be used to clearly direct future improvement efforts and next steps after the completion of a PIP. The results and conclusions from one well-designed PIP should naturally guide goals and strategies for the next PIP.

Table E-7—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
Amerigroup did not demonstrate sustained improvement at the PIP's second remeasurement. There was a statistically significant decline in the study indicator rate from Remeasurement 1 to Remeasurement 2, and the Remeasurement 2 rate of 86.8 percent was no longer a statistically significant improvement over the baseline rate of 85.8 percent.	◆ An educational provider newsletter focusing on the "teach back technique" method of provider communication with patients was distributed to providers. This method has been demonstrated to assess health literacy of a patient and to empower patients to take initiative for their care. ◆ Provider notification of member complaints and PCP change requests. ◆ Member education on "balance billing" and reimbursement billing. ◆ Recruitment of new providers to address areas of need. ◆ Expansion of telemedicine equipment to PCP offices and communication of telemedicine options to members. ◆ A cultural competency initiative for providers was implemented after the Remeasurement 2 period. ◆ A new follow-up process to address member PCP change	Not Met	Amerigroup did not demonstrate sustained improvement at the PIP's second remeasurement; therefore, the PIP was assigned a validation finding of *Not Met*. The CMO's collaborative quality improvement team reviewed processes, prior survey results, and additional data analyses, discussing all potential barriers to improving member satisfaction. The barrier identification process included analysis of member complaint data in addition to the CAHPS member satisfaction survey results. The results of the causal/barrier analyses were summarized in a fishbone diagram. The CMO also ranked identified barriers by priority level. Although Amerigroup's causal/barrier analysis process appeared to be sound and the CMO continued implementation of system changes that resulted in the statistically significant improvement at the first remeasurement, the improvement strategies did not result in sustained improvement at Remeasurement 2. The greatest weakness of the CMO's quality improvement approach was

Table E-7—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
	requests was implemented after the Remeasurement 2 period.		the lack of intervention-specific evaluations of effectiveness. Some of the evaluation plans relied on tracking the same measures for different interventions and did not generate results at the individual member/provider level. Not only were many interventions implemented simultaneously, the CMO did not collect intervention-specific evaluation data that could be used to determine the impact of each intervention. Amerigroup should develop an evaluation plan for each intervention that allows the CMO to determine intervention-specific effectiveness on improving the study indicator. The ongoing assessment of effectiveness is necessary to achieve significant and sustained 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 of respondents giving Peach State a score of "8" or higher declined 2.1 percentage points from baseline to Remeasurement 1. The study indicator rate increased 3.6 percentage points from	◆ To improve call center staff members' ability to respond to customer inquiries, the CMO revised its customer service representative training program to include modified call scripts, additional educational content, and enhanced staff monitoring.	Not Met	Peach State did not document evaluation plans or results for the individual interventions implemented during the Remeasurement 2 period. Without ongoing evaluation of effectiveness, the CMO cannot determine which interventions are worth sustaining and which need to be refined or replaced to achieve optimal improvement in outcomes. Each

Table E-7—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Remeasurement 1 to Remeasurement 2; however, the increase was not statistically significant. The Remeasurement 2 rate was 1.5 percentage points higher than the baseline rate, but the difference was not statistically significant.	◆ To address member access to specialists, the CMO continued outreach efforts to specialist providers to confirm participation and appointment availability.		intervention should be accompanied by an evaluation plan that allows the CMO to determine intervention-specific effectiveness on improving the study indicator. The ongoing assessment of effectiveness is necessary to achieve significant and sustained improvement in outcomes. Peach State should carefully select only those interventions that are most likely to directly impact the study indicator, rather than implementing many interventions without a specific rationale for what each intervention will add to improvement efforts. In addition to linking interventions to specific barriers, the CMO should carefully plan the timing of intervention initiation and ensure that each intervention is evaluated for its specific impact on the study indicator throughout the PIP.
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. The study indicator rate increased from	◆ A cultural competency plan to increase case manager knowledge and comfort in addressing cultural and spiritual needs of members. ◆ Creation of the HealthConnections Model to catalogue available social services that WellCare staff	Not Met	WellCare's causal/barrier analysis process did not clearly link the interventions implemented for the *Member Satisfaction* PIP with identified barriers. The CMO submitted a "2015 Force Field Analysis" document as part of the PIP documentation; however, the content of this document did not appear to

Table E-7—Member Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Remeasurement 1 to Remeasurement 2 by 0.6 percentage point, but the Remeasurement 2 rate remained below the baseline rate.	can use when working with communities to address unique local social service needs. ◆ Creation of the Healthy Behaviors Rewards Program, which offered members a financial incentive to complete health behavior services.		have been updated from the prior year's PIP submission. Despite HSAG's feedback regarding last year's *Member Satisfaction* PIP submission, WellCare failed to describe any evaluation methods or results to assess intervention effectiveness for this year's PIP submission. The CMO should 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 E-8—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Amerigroup			
There was a non-statistically significant increase of 3.4 percentage points in the rate of Study Indicator 1 from baseline to Remeasurement 1. Because Study Indicator 2 results were reported as six quarterly measurements, HSAG was unable to compare annual baseline and remeasurement rates to determine if there was a statistically significant change in the second study indicator. The CMO-defined quarterly remeasurement periods for Study Indicator 2 did not align with the required annual measurement periods for the PIP. Because requirements for this PIP followed HSAG's outcome-focused methodology and not the rapid cycle PIP methodology, quarterly remeasurement periods were not acceptable. The CMO should have included only study indicators with annual measurement periods for this PIP and should have documented only annual remeasurement results. The quarterly rates for Study Indicator 2 fluctuated over the six measurements, with the lowest	◆ Deployed a new disease management (DM) model focused on asthma- and diabetes-specific HEDIS gaps in care. ◆ Enhanced communication processes to inform provider field associates and nurse practice consultants about asthma and diabetes initiatives that aligned with DM activities.	Not Met	The PIP did not achieve statistically significant improvement over baseline at the first remeasurement; therefore, the PIP received a validation finding of *Not Met*. The CMO's interdisciplinary quality improvement team conducted a causal/barrier analysis for the PIP using a fishbone diagram. All identified barriers were discussed by the team, and barriers believed to be primarily under the CMO's control were identified as priorities. Amerigroup focused on a single high-priority barrier for the Remeasurement 1 period, which was the lack of effective communication between provider field associates and DM staff. Based on Amerigroup's Provider Satisfaction survey results, the survey vendor had identified provider satisfaction with services provided by DM staff as an opportunity for improvement that was associated with overall provider satisfaction and was an area that could be impacted by the CMO. The CMO chose to revise the structure of the PIP to include elements of the rapid cycle PIP process, including a

Table E-8—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
rate, 2.8 percent, reported for the fifth quarterly measurement and the highest rate, 15.0 percent, reported for the sixth quarterly measurement. There was no clear trend in the reported rates for Study Indicator 2.			new narrowed focus, an aim statement, and a new study indicator with quarterly measurements. This PIP should have been continued from the previous year, using the previous outcome-focused approach, with annual study indicator measurement periods. The CMO lost sight of the original intent of the PIP to improve overall provider satisfaction and instead chose to focus on a narrow area of provider experience—experience with services provided by DM staff. In the future, Amerigroup should ensure that each PIP is addressing the State's requirements for topic and structure. The CMO should be able to demonstrate a clear link between the focus of the PIP and the State's quality strategy.
Peach State			
The rate for Peach State's *Provider Satisfaction* PIP declined 2.1 percentage points from baseline to Remeasurement 1. The study indicator rate declined an additional 2.6 percentage points from Remeasurement 1 to Remeasurement 2. The Remeasurement 2 rate of 71.6 percent fell 4.7 percentage points below the baseline rate. The PIP	◆ To address the lack of timely and consistent information shared with providers, Peach State implemented quarterly intensive training sessions for their Provider Services staff and held collaborative training sessions with the Provider Services representatives and Provider Services call center staff.	Not Met	Peach State's collaborative team completed a barrier analysis that incorporated brainstorming and data analyses; however, the improvement strategies implemented to address identified barriers were inadequate. The CMO did not clearly document the timing of intervention implementation, so it was unclear whether the interventions were implemented early enough to allow

Table E-8—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
has not yet demonstrated statistically significant or sustained improvement in overall provider satisfaction.	◆ Peach State conducted provider focus groups to obtain feedback on practice-specific needs and held several large group provider education sessions to disseminate information. ◆ To improve HEDIS information sharing with providers, a report of applicable HEDIS/EPSDT data was provided during each Provider Services interaction.		sufficient time to impact the study indicator. The CMO did not document evaluation processes or results for the PIP's interventions. Additionally, despite the ongoing decline in provider satisfaction during the life of the PIP, Peach State reported that all interventions were ongoing and were expected to be effective. There was no evidence that ongoing interventions would be revised. To achieve meaningful improvement in provider satisfaction, Peach State should conduct ongoing evaluation of each intervention's effectiveness in impacting the study indicator and implement revised interventions based on intervention-specific evaluation results.
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 baseline to Remeasurement 1. There was an increase of 1.4 percentage points in the study indicator rate from Remeasurement 1 to	◆ 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	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 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-

Table E-8—Provider Satisfaction			
Summary of Performance	**PIP Intervention and Activities**	**EQR Validation Finding**	**EQR Discussion and Recommendation**
Remeasurement 2, but the Remeasurement 2 rate remained below the baseline rate.	State, to improve customer service for hospitals. ◆ WellCare collected and verified email 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.		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 did not update any of the documentation of the causal/barrier analysis process for this year's PIP submission and did not address any of HSAG's feedback from last year.

Care Management Organization (CMO) Detailed Results Comparison

The following tables display the detailed performance measure rates for Amerigroup, Peach State, WellCare, and Amerigroup 360° for reporting year 2015. The rates were calculated by each CMO and audited by either HSAG or the CMO's NCQA HEDIS compliance auditor. Where applicable, a statistical significance rate comparison was performed and the results are displayed with ↓ **(significant decline)** or ↑ **(significant increase)**. The DCH established CMO-specific performance targets for six hybrid measures with nine indicators. (These measure names are located in cells shaded **orange**.) Names of other measures for which DCH established a single performance target across all CMOs are located in cells shaded **green**. Individual CMO rates are located in cells shaded **orange** or **green** if they met the performance targets. Of note, performance targets were not applied to Amerigroup 360°'s rates. Comparisons of Amerigroup 360°'s rates to the other CMOs' rates are not recommended due to differences between this plan's and other CMOs' plan and population characteristics; therefore, Amerigroup 360°'s rates are located in cells shaded gray in the tables below.

Access to Care

A comparison of CY 2014 Access to Care performance measure results across CMOs is shown in Table F-1.

Table F-1—CMO Comparison of CY 2014 Access to Care Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Children and Adolescents' Access to Primary Care Practitioners				
Ages 12–24 Months	97.00%	97.26%	97.51%↓	95.69%
Ages 25 Months–6 Years	90.85%	89.96%↓	91.23%↓	85.62%
Ages 7–11 Years	92.99%	91.50%	92.61%	83.98%
Ages 12–19 Years	90.68%	88.63%	90.35%	79.43%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	79.69%↓	81.17%↓	81.76%↓	51.18%
Oral Health (Annual Dental Visit)				
Ages 2–3 Years	47.54%↓	45.07%	46.94%↓	33.70%
Ages 4–6 Years	75.89%↓	74.66%	72.25%↓	82.03%
Ages 7–10 Years	78.32%↓	77.15%↓	75.14%↓	87.70%
Ages 11–14 Years	71.65%	69.94%↓	69.30%↓	86.55%
Ages 15–18 Years	60.07%↓	59.32%	58.65%↓	82.52%
Ages 19–21 Years	30.58%	33.62%	31.96%	27.27%
Total	68.78%↓	67.67%↓	66.64%↓	75.48%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation	52.57%↑	39.65%	32.34%	51.72%
Engagement	12.84%↑	8.24%	7.02%↓	15.17%

Table F-1—CMO Comparison of CY 2014 Access to Care Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.23%	0.00%	0.00%

↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.

Children's Health

A comparison of CY 2014 Children's Health performance measure results across CMOs is shown in Table F-2.

Table F-2—CMO Comparison of CY 2014 Children's Health Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Visits	65.97%	65.05%↑	66.93%	42.82%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Third, Fourth, Fifth, and Sixth Years of Life	73.84%	69.91%	66.93%	70.14%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	53.01%	49.07%	49.54%	45.83%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	79.12%	79.63%	84.03%	45.37%
Combination 6	43.39%	43.52%	43.06%	23.61%
Combination 10	38.05%	40.28%	38.66%	17.59%
Lead Screening in Children				
Lead Screening in Children	78.70%	79.40%	81.35%	63.89%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	80.92%↑	80.31%↑	79.09%↑	75.00%
Immunization for Adolescents				
Combination 1 Total	80.20%	76.39%	76.33%	76.16%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	54.40%	69.21%↑	63.43%↑	39.35%
Counseling for Nutrition—Total	58.80%	64.81%↑	59.49%	34.95%
Counseling for Physical Activity—Total	53.47%	60.19%	54.63%	32.41%
Developmental Screening in the First Three Years of Life				
Total	38.19%	46.28%	44.91%	23.84%

Table F-2—CMO Comparison of CY 2014 Children's Health Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Percentage of Eligibles that Received Preventive Dental Services				
Percentage of Eligibles that Received Preventive Dental Services	53.21%↑	52.17%↑	49.93%↓	53.25%
Percentage of Eligibles that Received Dental Treatment Services				
Percentage of Eligibles that Received Dental Treatment Services	24.13%↑	24.53%↑	21.76%↓	21.35%
Upper Respiratory Infection				
Upper Respiratory Infection				
Appropriate Treatment for Children With URI	85.92%↑	83.50%↑	82.81%↑	96.45%

↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.

Women's Health

A comparison of CY 2014 Women's Health performance measure results across CMOs is shown in Table F-3. Additionally, although Amerigroup followed CMS specifications and calculated the rates for *Cesarean Section for Nulliparous Singleton Vertex*, *Early Elective Delivery*, and *Antenatal Steroids* properly, due to the limitation of CMS specifications, the calculated rates were not representative of the eligible populations for the measures and were considered biased. Since this finding applied to all three CMOs, HSAG recommends that the CMOs work with DCH to revisit whether these measures should be a part of the reporting set prior to any revision of CMS specifications.

Table F-3—CMO Comparison of CY 2014 Women's Health Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	66.40%	68.53%	74.56%	—
Breast Cancer Screening				
Breast Cancer Screening	69.04%↓	71.02%	72.17%	—
Chlamydia Screening in Women				
Total	56.96%↑	56.71%	50.26%	52.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	19.72%	24.54%	20.37%	15.78%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.02%	82.13%	81.27%	46.81%
Postpartum Care	62.94%	70.30%↑	64.56%	34.04%

Table F-3—CMO Comparison of CY 2014 Women's Health Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Cesarean Section for Nulliparous Singleton Vertex				
Cesarean Section for Nulliparous Singleton Vertex[1]	NR	NR	NR	NR
Cesarean Delivery Rate				
Cesarean Delivery Rate[1]	28.59%	29.84%	29.73%	21.31%
Percentage of Live Births Weighing Less Than 2,500 Grams				
Percentage of Live Births Weighing Less Than 2,500 Grams[1]	8.87%	9.04%	9.21%↓	NA
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	4.57%↑	0.00%↓	9.95%	3.64%
Early Elective Delivery				
Early Elective Delivery[1]	NR	NR	NR	NR
Antenatal Steroids				
Antenatal Steroids	NR	NR	NR	NR
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
81+ Percent	48.02%	57.77%	58.48%↓	19.15%

[1] A lower rate indicates better performance for this measure.
NR indicates that the CMO produced a rate that was materially biased or chose not to report results for this measure; therefore, the rates were not included in the performance calculations.
NA indicates that the rate was withheld because the denominator was less than 30 or 11 (for Amerigroup 360° only).
— Indicates the rate was not analyzed for Amerigroup 360°.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.

Chronic Conditions

A comparison of CY 2014 Chronic Conditions performance measure results across CMOs is shown in Table F-4.

Table F-4—CMO Comparison of CY 2014 Chronic Conditions Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	85.37%↑	83.63%	83.19%↑	76.92%
HbA1c Poor Control (>9.0)[1]	58.54%	53.17%↑	48.75%	100.00%
HbA1c Control (<8.0)	35.02%	37.32%	43.26%	0.00%
HbA1c Control (<7.0)	25.21%	27.73%	32.43%	0.00%
Eye Exam (Retinal) Performed	46.86%	58.63%	35.44%	30.77%

Table F-4—CMO Comparison of CY 2014 Chronic Conditions Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Medical Attention for Nephropathy	76.66%	77.82%↑	76.71%	30.77%
Blood Pressure Control (<140/90 mm/Hg)	36.93%↓	53.17%	55.74%	0.00%
Diabetes Short-Term Complications Admission Rate				
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[1, 2]	14.87	18.15	18.36	4.96
Respiratory Conditions				
Use of Appropriate Medications for People with Asthma				
Ages 5–11 Years	92.99%	93.83%	91.95%	NA
Ages 12–18 Years	86.73%	89.67%	88.52%	NA
Total	89.23%	91.42%	89.67%	72.73%
Young Adult Asthma Admission Rate				
Young Adult Asthma Admission Rate[1,2]	7.39	4.55	5.52	NA
Chronic Obstructive Pulmonary Disease (COPD) and Asthma Admission Rate				
Per 100,000 Member Months—Total[1,2]	37.71	28.70	41.00	—
Cardiovascular Conditions				
Congestive Heart Failure Admission Rate				
Per 100,000 Member Months—Total[1,2]	6.44	5.45	4.28	—
Controlling High Blood Pressure				
<140/90 mm/Hg	29.07%↓	36.64%↓	43.24%	0.00%
Adult BMI Assessment				
Adult BMI Assessment	66.51%↓	80.56%	79.94%	24.89%

[1] A lower rate indicates better performance for this measure.
[2] Indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2013 and CY 2014, and previous years were reported as per 100,000 members. The 2014 performance target was developed based on previous years' reporting metrics; therefore, comparisons were not made to the 2014 performance target.
NA indicates that the rate was withheld because the denominator was less than 30 or 11 (for Amerigroup 360° only).
— Indicates the rate was not analyzed for Amerigroup 360°.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.

Behavioral Health

A comparison of CY 2014 Behavioral Health performance measure results across CMOs is shown in Table F-5.

Table F-5—CMO Comparison of CY 2014 Behavioral Health Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Follow-Up of Care for Children Prescribed ADHD Medication				
Initiation Phase	45.04%	43.58%	48.92%↑	NA
Continuation and Maintenance Phase	59.36%	58.19%	63.78%↑	NA
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	51.01%	56.78%	50.77%	58.88%
Follow-Up Within 30 Days	70.29%	72.79%	69.72%↓	78.46%
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.99%	39.57%	46.92%	NA
Effective Continuation Phase Treatment	31.83%	24.86%	30.37%	NA
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.33%	2.86%↑	0.49%	0.51%
Adherence to Antipsychotics for Individuals with Schizophrenia				
Adherence to Antipsychotics for Individuals with Schizophrenia	44.57%	33.33%↑	33.85%	NA

NA indicates that the rate was withheld because the denominator was less than 30 or 11 (for Amerigroup 360° only).
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.

Medication Management

A comparison of CY 2014 Medication Management performance measure results across CMOs is shown in Table F-6.

Table F-6—CMO Comparison of CY 2014 Medication Management Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions				
Antibiotic Utilization—Percentage of Antibiotics of Concern for All Antibiotic Prescriptions[1]	39.10%↑	38.49%↑	40.54%↑	40.88%
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	88.67%	87.24%	86.72%↓	—
Diuretics	89.47%	86.63%	87.27%	—
Total	88.86%	86.74%	86.86%	NA
Medication Management for People with Asthma				
Medication Compliance 50%—Ages 5–11 Years	47.33%	44.06%	45.62%↓	NA

Table F-6—CMO Comparison of CY 2014 Medication Management Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Medication Compliance 50%—Ages 12–18 Years	42.68%	39.67%	42.00%↓	NA
Medication Compliance 50%—Ages 19–50 Years	50.00%	44.19%	57.79%	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	—
Medication Compliance 50%—Total	45.73%	42.56%	44.91%↓	NA
Medication Compliance 75%—Ages 5–11 Years	21.27%	18.82%	21.93%	NA
Medication Compliance 75%—Ages 12–18 Years	19.60%	16.03%	18.25%↓	NA
Medication Compliance 75%—Ages 19–50 Years	21.43%	23.26%	33.61%↑	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	—
Medication Compliance 75%—Total	20.80%	18.03%	21.17%	NA

[1] A lower rate indicates better performance for this measure.
NA indicates that the rate was withheld because the denominator was less than 30 or 11 (for Amerigroup 360° only).
— Indicates the rate was not analyzed for Amerigroup 360°.
↑ Indicates a statistically significant improvement in performance between CY 2013 and CY 2014.
↓ Indicates a statistically significant decline in performance between CY 2013 and CY 2014.

Utilization

A comparison of CY 2014 Utilization performance measure results across CMOs is shown in Table F–7.

Table F–7—CMO Comparison of CY 2014 Utilization Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Ambulatory Care (Per 1,000 Member Months)				
ED Visits[1]	56.83	54.10	61.04	35.79
Outpatient Visits	314.23	309.79	334.03	265.85
Inpatient Utilization— General Hospital/Acute Care				
Total Inpatient Average Length of Stay	3.42	3.39	2.99	4.88
Total Medicine Average Length of Stay	3.62	3.43	3.02	4.03
Total Surgery Average Length of Stay	7.96	8.43	5.84	7.52
Total Maternity Average Length of Stay	2.70	2.75	2.53	2.52

Table F–7—CMO Comparison of CY 2014 Utilization Measure Rates				
Measure	**Amerigroup**	**Peach State**	**WellCare**	**Amerigroup 360°**
Mental Health Utilization				
Any Services—Total	9.14%	8.01%	8.88%	63.23%
Inpatient Services—Total	0.52%	0.38%	0.50%	4.52%
Intensive Outpatient Services—Total	0.14%	0.13%	0.14%	1.03%
Ambulatory/ED Visits—Total	9.04%	7.93%	8.77%	62.72%

[1] A lower rate indicates better performance for this measure.

Appendix G. CAHPS Survey Recommendations

The following are general recommendations based on the information found in the CAHPS literature. The recommendations are intended to address those areas for which CAHPS measure performance was lower than the NCQA national Medicaid average. Each CMO should evaluate these general recommendations in the context of its own operational and QI activities.

Rating of Health Plan

- **Alternatives to One-on-One Visits**—The CMO should engage in efforts that assist providers in examining and improving their systems' abilities to manage patient demand. As an example, the CMO could test alternatives to traditional one-on-one visits, such as telephone consultations, telemedicine, or group visits for certain types of healthcare services and appointments. Alternatives to traditional one-on-one, in-office visits can assist in improving physician availability and ensuring patients receive immediate medical care and services.
- **Health Plan Operations**—It is important for health plans to view their organization as a collection of microsystems (such as providers, administrators, and other staff that provide services to members) that provide the health plan's healthcare "products." The goal of the microsystems approach is to focus on small, replicable, functional service systems that enable health plan staff to provide high-quality, patient-centered care. Once the microsystems are identified, new processes that improve care should be tested and implemented. Effective processes can then be rolled out throughout the health plan.
- **Promote Quality Improvement Initiatives**—Implementation of organization-wide QI initiatives is most successful when health plan staff members at every level are involved. Methods for achieving this can include aligning QI goals to the mission and goals of the health plan organization, establishing plan-level performance measures, clearly defining and communicating collected measures, and offering provider-level support and assistance in implementing QI initiatives. Further, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

Rating of Personal Doctor

- **Maintain Truth in Scheduling**—The CMO could request that all providers monitor appointment scheduling to ensure that scheduling templates accurately reflect the amount of time it takes to provide patient care during a scheduled office visit, as well as provide assistance or instructions to those physicians unfamiliar with this type of assessment. One method for evaluating appropriate scheduling of various appointment types is to measure the amount of time it takes to complete the scheduled visit. This type of monitoring will allow providers to identify if adequate time is being scheduled for each appointment type to ensure patients are receiving prompt, adequate care. Patient wait times for routine appointments should also be recorded and monitored to ensure that scheduling can be optimized to minimize these wait times. Additionally, by measuring the amount of time it takes to provide care, both health plans and physician offices can identify where streamlining opportunities exist.

- **Direct Patient Feedback**—The CMO should explore options for obtaining direct patient feedback to improve patient satisfaction. Comment cards have been utilized and found to be a simple method for engaging patients and obtaining rapid feedback on their recent physician office visit experiences. Asking patients to describe what they liked most about the care they received during their recent office visit, what they liked least, and one thing they would like to see changed can be an effective means for gathering feedback (both positive and negative). Comment card questions may also prompt feedback regarding other topics, such as providers' listening skills, wait time to obtaining an appointment, customer service, and other items of interest. This direct feedback can be helpful in gaining a better understanding of the specific areas that are working well and areas that can be targeted for improvement.
- **Physician-Patient Communication**—The CMO should encourage physician-patient communication to improve patient satisfaction and outcomes. Health plans can also create specialized workshops focused on enhancing physicians' communication skills, relationship building, and the importance of physician-patient communication. Training sessions can include topics such as improving listening techniques, patient-centered interviewing skills, collaborative communication that involves allowing the patient to discuss and share in the decision-making process, as well as effectively communicating expectations and goals of healthcare treatment. In addition, workshops can include training on the use of tools that improve physician-patient communication.
- **Improving Shared Decision Making**—The CMO should encourage skills training in shared decision making for all physicians. Implementing an environment of shared decision making and physician-patient collaboration requires physician recognition that patients have the ability to make choices that affect their healthcare. One key to a successful shared decision-making model is ensuring that physicians are properly trained. Training should focus on providing physicians with the skills necessary to facilitate the shared decision-making process, ensuring that physicians understand the importance of taking each patient's values into consideration, and understanding patients' preferences and needs. Effective and efficient training methods include seminars and workshops.

Getting Needed Care

- **Appropriate Healthcare Providers**—The CMO should ensure that patients are receiving care from physicians most appropriate to treat their condition. Tracking patients to ascertain they are receiving effective, necessary care from those appropriate healthcare providers is imperative to assessing quality of care. The health plan should actively attempt to match patients with appropriate healthcare providers and engage providers in their efforts to ensure appointments are scheduled for patients to receive care in a timely manner.
- **Interactive Workshops**—The CMO should engage in promoting health education, health literacy, and preventive healthcare among its membership. The health plan can develop community-based interactive workshops and educational materials to provide information on general health or specific needs. Free workshops can vary by topic (e.g., women's health, specific chronic conditions) to address and inform the needs of different populations.
- **"Max-Packing"**—The CMO can assist and encourage providers in implementing strategies within their system that allow for as many of the patient's needs to be met during one office visit when feasible—a process called "max-packing." Max-packing is a model designed to

maximize each patient's office visit, which in many cases eliminates the need for extra appointments. Max-packing strategies could include using a checklist of preventive care services to anticipate the patient's future medical needs and guide the process of taking care of those needs during a scheduled visit, whenever possible.

- **Referral Process**—Streamlining the referral process allows health plan members to more readily obtain the care they need. A referral expert can assist with this process and expedite the time from physician referral to the patient receiving needed care. An electronic referral system, such as a web-based system, can improve the communication mechanisms between PCPs and specialists to determine which clinical conditions require a referral, and allows providers access to a standardized referral form to ensure all necessary information is collected from all parties involved (i.e., plan, patients, and provider).

Getting Care Quickly

- **Decrease No-Show Appointments**—Reducing the demand for unnecessary appointments and increasing availability of physicians can result in decreased no-shows and improve members' perceptions of timely access to care. The CMO can assist providers in examining patterns related to no-show appointments in order to determine if there are specific contributing factors (e.g., lack of transportation) or appointment types (e.g., follow-up visits) that account for a large percentage of patient no-shows. This analysis could assist the CMO in determining targeted, potential resolutions.
- **Electronic Communication**—Electronic forms of communication between patients and providers can help alleviate the demand for in-person visits and provide prompt care to patients who may not require an appointment with a physician. Electronic communication can also be used when scheduling appointments, requesting referrals, providing prescription refills, answering patient questions, educating patients on health topics, and disseminating lab results.
- **Open Access Scheduling**—An open access scheduling model can be used to match the demand for appointments with physician supply. This type of scheduling model allows for appointment flexibility and for patients to receive same-day appointments. Instead of booking appointments weeks or months in advance, an open access scheduling model includes leaving part of a physician's schedule open for same-day appointments.
- **Patient Flow Analysis**—A patient flow analysis involves tracking a patient's experience throughout a visit or clinical service (i.e., the time it takes to complete various parts of the visit/service). Examples of steps that are tracked include wait time at check-in, time to complete check-in, wait time in waiting room, wait time in exam room, and time with provider. This type of analysis can help providers identify "problem" areas, including steps that can be eliminated or steps that can be performed more efficiently.

How Well Doctors Communicate

- **Communication Tools for Patients**—The CMO can encourage patients to take a more active role in the management of their healthcare by providing them with the necessary tools to effectively communicate with physicians. This can include items such as "visit preparation" handouts, sample symptom logs, and healthcare goals and action planning forms that facilitate physician-patient communication. Further, educational literature and information on medical conditions specific to their needs can encourage patients to communicate with their physicians any questions, concerns, or expectations they may have regarding their healthcare and/or treatment options. CMOs could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care.
- **Health Literacy**—Often, health information is presented to patients in a way that is too complex and technical, which can result in patient noncompliance with suggested care and poor health outcomes. To address this issue, the CMO should consider revising existing and creating new print materials that are easy to understand based on patients' needs and preferences. Materials such as patient consent forms and disease education materials on various conditions can be revised and developed in new formats to aid patients' understanding of the health information that is being presented. Further, providing training for healthcare workers on how to use these materials with their patients and ask questions to gauge patient understanding can help improve patients' level of satisfaction with provider communication. Additionally, health literacy coaching can be implemented to ease the inclusion of health literacy into physician practice.
- **Language Barriers**—The CMO could consider hiring interpreters who serve as full-time staff members at provider offices with a high volume of non-English-speaking patients to ensure accurate communication among patients and physicians. Offering an in-office interpretation service promotes the development of relationships between the patient and family members with their physician. With an interpreter present to translate, the physician will have a clearer understanding of how to best address the appropriate health issues and the patient will feel more at ease. Having an interpreter on-site is also more time efficient for both the patient and physician, allowing the physician to stay on schedule.

Customer Service

- **Call Centers**—An evaluation of current CMO call center hours and practices can be conducted to determine if the hours and resources meet members' needs. If it is determined that the call center is not meeting members' needs, an after-hours customer service center can be implemented to assist members after normal business hours and/or on weekends. Additionally, asking members to complete a short survey at the end of each call can assist in determining if members are getting the help they need and identify potential areas for customer service improvement.
- **Creating an Effective Customer Service Training Program**—The CMO could consider implementing a training program to meet the needs of its unique work environment. Recommendations from employees, managers, and business administrators could be used and serve as guidance when constructing the training program. The customer service training program should be geared toward teaching the fundamentals of effective communication. By

reiterating basic communication techniques, employees will have the skills to communicate in a professional and friendly manner. Training topics could also include conflict resolution and service recovery to ensure staff members feel competent in their ability to deal with difficult patient/member encounters. The key to ensuring that employees carry out the skills they learned in training is to not only provide motivation, but implement a support structure when they are back on the job.

- **Customer Service Performance Measures**—Establishing plan-level customer service standards can assist in addressing areas of concern and serve as domains for which health plans can evaluate and modify internal customer service performance measures. Collected measures should be communicated with providers and staff members, tracked, reported, and modified as needed.

Rating of Specialist Seen Most Often

- **Planned Visit Management**—The CMO could work with providers to encourage the implementation of systems that enhance efficiency and effectiveness of specialist care. For example, by identifying patients with chronic conditions who have routine appointments, a reminder system could be implemented to ensure that these patients are receiving the appropriate attention at the appropriate time. This triggering system could be used to prompt general follow-up contact or specific interaction with patients to ensure that they have necessary tests completed before an appointment or various other prescribed reasons.
- **Skills Training for Specialists**—The CMO could create specialized workshops or seminars that focus on training specialists in the skills they need to effectively communicate with patients to improve physician-patient communication. Training seminars may include sessions for improving communication skills with different cultures and handling challenging patient encounters. In addition, workshops might include case studies to illustrate the importance of communicating with patients and offer insight into specialists' roles as both managers of care and educators of patients.
- **Telemedicine**—Telemedicine models allow for the use of electronic communication and information technologies to provide specialty services to patients in varying locations. Telemedicine, such as live, interactive videoconferencing, allows providers to offer care from a remote location. Physician specialists located in urban settings can diagnose and treat patients in communities where there are shortages of specialists. Telemedicine consultation models allow for the local provider to both present the patient at the beginning of the consult and to participate in a case conference with the specialist at the end of the teleconference visit. Further, the local provider is more involved in the consultation process and more informed about care the patient is receiving.