State of Georgia

Department of Community Health

2017 External Quality Review Annual Report

Including

Compliance Review Results
(Review Period: July 1, 2015–June 30, 2016)
CY 2015 Performance Measure Rates
CY 2015 Performance Improvement Project Results
CY 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Results

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

April 2017

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. The State refers to its CHIP program as PeachCare for Kids®. Both programs include FFS and managed care components and deliver services through a statewide provider network. The FFS program has been in place since the inception of Medicaid in Georgia. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to certain categories of members enrolled in the State's Medicaid and PeachCare for Kids® programs. 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. The Georgia Families (GF) program, implemented in 2006, serves all other Medicaid and PeachCare for Kids® managed care members not enrolled in the GF 360° program. Approximately 1.3 million beneficiaries are enrolled in the GF program.[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°. For ease of reporting information relevant to both GF and GF 360° populations, HSAG uses the term "CMOs" in the remainder of this report to refer to Amerigroup, Peach State, WellCare, and Amerigroup 360° results collectively.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[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]

[1-1] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report June 2016.

[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: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-toolkit.pdf. Accessed on: Jan 5, 2017.

This report provides:

- An overview of the GF and GF 360° programs.
- A description of the scope of EQR activities performed by HSAG.
- 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 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 August 2016. The CMOs submitted documentation that covered the state fiscal year (SFY) 2016 review period of July 1, 2015, through June 30, 2016. HSAG provided detailed, final audit reports to the CMOs and DCH in December 2016.
- *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. This was the first year that HSAG also validated PIPs for the GF 360° program. Amerigroup, Peach State, and WellCare submitted eight PIPs for validation. Amerigroup GF 360° submitted three PIPs for validation. All of the PIPs were based on the rapid cycle PIP framework, which includes five modules that were submitted by the CMOs for each PIP, reviewed by HSAG, and used to provide feedback from HSAG to the CMOs, throughout the 12-month PIP cycle. 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. The CMOs submitted Modules 1 through 3 for each PIP at varying times throughout calendar year (CY) 2015. The CMOs submitted Modules 4 and 5 to HSAG on February 29, 2016, for annual validation. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in August 2016.
- *Validation of performance measures (PMs)*. HSAG validated the PM rates required by DCH to evaluate the accuracy of the PM results reported by the CMOs. The validation also determined the extent to which the DCH-specific PM rates 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 2016 through July 2016. The final PM validation results generally reflect the measurement period of January 1, 2015, through December 31, 2015. HSAG provided final PM validation reports to the CMOs and DCH in September 2016.

- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys*.[1-5] The DCH required that the CMOs conduct CAHPS surveys of their adult and child populations 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 four 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 enrollees through its structural and operational characteristics and through the 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.

[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).
[1-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality of Care External Quality Review (EQR). Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Apr 7, 2017.
[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.

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) Practice Guidelines, (2) Quality Assessment and Performance Improvement (QAPI), and (3) Health Information Systems. HSAG also reviewed elements that were found to be noncompliant from the previous year's compliance review.

Each of the three GF CMOs received an overall compliance score between 67.3 and 75.4 percent for the standards reviewed, indicating that the CMOs generally had the policies, procedures, and operational structure in place to meet the requirements. For the GF 360° program, Amerigroup received an overall compliance score of 75.4 percent. All standards fell within the quality domain. The Health Information Systems standard crossed over into the timeliness of care domain. Several of the standards reviewed also crossed over into the access to care domain.

The CMOs received their highest compliance score (100 percent for two GF CMOs and the GF 360° program, and 87.5 percent for the third GF CMO) for the Health Information Systems standard, demonstrating that the CMOs maintained health information systems that supported business intelligence needs and allowed for the collection, integration, tracking, analysis, and reporting of data.

Overall, the CMOs performed well on the Clinical Practice Guidelines standard, demonstrating that their clinical practice guidelines (CPGs) were developed, implemented, and disseminated appropriately and supported the quality of services provided to members. Two of the three GF CMOs were noncompliant with the element that focuses on ensuring staff decisions related to utilization management were made consistent with the guidelines. The results identified an opportunity to strengthen processes to ensure that decisions involving utilization management and coverage of services, made by the CMOs' staff, are consistent with the CPGs.

The Quality Assessment and Performance Improvement (QAPI) standard received the lowest scores for all CMOs. Areas in which all CMOs failed to demonstrate compliance included the DCH-established performance targets, mechanisms to detect underutilization and to assess quality of care, processes for evaluating the impact and effectiveness of the QAPI Program, processes for provider profiling, and patient safety plans. All CMOs demonstrated a need to continue to develop comprehensive QAPI program descriptions and QAPI program evaluations that described the CMOs' QAPI stories. All CMOs were challenged in developing the QAPI program description and the QAPI program evaluation according to DCH specifications.

All CMOs showed evidence of active involvement of executive leadership in their QAPI programs. One CMO, Amerigroup, described involvement of its CEO in all levels of quality improvement work within the organization. All CMOs were in the process of implementing the Institute for Healthcare

Improvement's Science of Quality Improvement principles, and some had staff trained in Lean Six Sigma.

Specific recommendations related to improving compliance with standards are detailed in Sections 4, 5, 6, 7, and 8 of the report. In general, HSAG recommends that the CMOs seek technical assistance as needed to further develop their QAPI programs to ensure compliance with State and federal requirements. The CMOs should adhere to the guidance and resources developed and used by DCH in developing plans and evaluations.

PIPs

For this year's PIP validation cycle, each of the GF CMOs (Amerigroup, Peach State, and WellCare) submitted eight PIPs following HSAG's rapid cycle PIP process, which emphasizes 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. Using the rapid cycle framework, reported PIP outcomes were specific to a targeted population and to targeted providers. The DCH identified the general PIP focus areas, and the CMOs determined the specific PIP topics and targeted areas. Performance by the GF CMOs suggested that additional skill development in the application and documentation of rapid cycle PIP techniques, especially related to the planning and execution of PDSA cycles, is necessary to achieve improved PIP results. Overall, while the CMOs were generally successful in achieving the SMART Aim goal for each PIP, the improvement strategies were not clearly linked to the demonstrated improvement in quality, access, and timeliness domains of care. As a result, few PIPs were assigned a level of *High Confidence*.

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 4 through 7, the CMOs have considerable room for improvement to positively impact the quality domain of care. Out of 24 PIPs submitted for validation by the three GF CMOs, only two PIPs submitted by one CMO, WellCare, achieved meaningful improvement in health outcomes and were assigned a level of *High Confidence*.

Two of the three PIPs submitted for validation by Amerigroup GF 360° for the GF 360° program achieved desired outcomes defined by the SMART Aim goal and were assigned a *High Confidence* level. The Amerigroup GF 360° program applied quality improvement processes for planning, testing, and evaluating interventions more effectively than the GF CMOs.

Two of the GF CMOs' PIPs, *Annual Dental Visits* and *Bright Futures*, and one of the GF 360° PIPs, *Adolescent Well-Child Visits*, 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. None of the PIPs related to this domain demonstrated meaningful improvement in access to care that could be validated with a level of *High Confidence*. While some PIPs achieved the desired outcomes defined by the SMART Aim goal, none of

the PIPs clearly linked the demonstrated improvement to the tested interventions. Without a clear linkage between the interventions tested and the observed improvement in outcomes, the PIPs did not yield meaningful results to support improvement on a broader or sustained scale.

Two of the GF CMOs' PIPs, *Appropriate Use of ADHD [Attention Deficit Hyperactivity Disorder] Medications* and *Postpartum Care*, related to the timeliness domain of care. Amerigroup GF 360° also conducted an *Appropriate Use of ADHD Medications* PIP and one other PIP, *7-Day Inpatient Discharge Follow-up*, which related to timeliness of care. Specifically, the PIPs addressed minimizing the disruption of follow-up care for members who had initiated medication to treat ADHD, for members who had given birth, and for members who were discharged from inpatient care for treatment of a mental illness, respectively. Amerigroup GF 360° demonstrated strength in addressing both of its PIPs related to the timeliness domain. Amerigroup GF 360° achieved the desired outcomes defined by the SMART Aim goal for both the *7-Day Inpatient Discharge Follow-up* and *Appropriate Use of ADHD Medications* PIPs, and HSAG assigned a level of *High Confidence* to the results of both PIPs. The three GF CMOs were not as successful at improving timeliness of care in their PIPs. None of the GF CMOs' *Appropriate Use of ADHD Medications* PIPs achieved meaningful improvement that could be validated with a level of *High Confidence*. For each GF CMO's *Postpartum Care* PIP, the SMART Aim goal was achieved; however, only some of the improvement strategies could be linked to the demonstrated improvement. HSAG assigned each GF CMO's *Postpartum Care* PIP a level of *Confidence*.

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; maintaining the integrity of approved measurement methodology throughout the PIP process; identifying the true root causes of barriers to improvement; and planning and executing effective PDSA cycles to test and refine interventions that will result in meaningful, sustained, and spreadable improvement strategies. Many of these opportunities for improvement applied across the individual CMOs and their PIP topics.

Specific recommendations related to improving PIP performance are detailed in Sections 4, 5, 6, 7, and 8 of this 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 selecting interventions to test for each PIP, each CMO should allow sufficient opportunities for the PIP teams to fully develop and update the process maps and failure modes and effects analyses (FMEAs) to ensure appropriate use of data and input from all relevant team members. The accuracy and completeness of the process map and FMEA will serve as the foundation for identifying and developing impactful improvement strategies. As the CMOs move through the quality improvement process and conduct additional PDSA cycles, each CMO's PIP team should ensure that it is communicating the theory about changes that will lead to improvement. Without a common understanding of the theory, the CMO's PIP team may be working on changes for various perceived reasons. During the testing of interventions, each CMO should ensure that it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved. Additionally, the CMOs should ensure that the evaluation plan for each intervention includes appropriate process data, to support refinement of the intervention throughout testing, and adequate outcome data to support rapid learning. Throughout the PIP process,

the CMOs should request technical assistance as needed to ensure adequate understanding and application of rapid cycle improvement techniques and principles.

Performance Measures

In the Children's Health measure set, all GF CMOs collectively met or exceeded approximately 57 percent of the performance targets. This measure set demonstrated the highest performance across all CMOs when compared to all other measure sets; all GF CMOs exhibited improvement in the percentage of children with pharyngitis who received appropriate testing as well as the percentage of adolescents who had documentation of receiving the Combination 1 (Meningococcal, Tdap/Td) immunization. However, the percentage of members receiving preventive dental services was a general weakness across two of the three GF CMOs as neither met the CY 2015 performance target, and both CMOs' rates demonstrated a statistically significant decline since CY 2014. On the other hand, Amerigroup 360°'s rate for members receiving preventive dental services met or exceeded the CY 2015 performance target, and WellCare's rate demonstrated statistically significant improvement.

Another general strength among some of the CMOs was in the management of medications. For Amerigroup and WellCare, 75 percent of targets were met within this measure set when compared to the other measure sets. Both CMOs met or exceeded the CY 2015 DCH-defined performance targets for the *Annual Monitoring for Patients on Persistent Medications* measure (i.e., angiotensin converting enzyme [ACE] inhibitors, angiotensin receptor blockers [ARBs], and diuretics). Additionally, two of WellCare's rates for this measure demonstrated statistically significant improvement since CY 2014. Furthermore, the majority of rates for the *Medication Management for People with Asthma* measure demonstrated statistically significant improvement for Amerigroup.

Across the CMOs, measures within the Women's Health, Chronic Conditions, and Behavioral Health measure sets all presented opportunities for improvement. Additionally, the Access to Care measure set presented opportunities for improvement for the three GF CMOs, while the GF 360° CMO achieved almost 67 percent of the CY 2015 Access to Care measure set's performance targets. For the GF CMOs collectively, approximately 26 percent of the rates within the Access to Care measure set met or exceeded the CY 2015 performance targets. All three GF CMOs met or exceeded the CY 2015 performance target for the percentage of annual dental visits for members between the ages of 19 and 20. However, in CY 2014 and prior years, members 2 to 21 years of age were included in the *Annual Dental Visit* measure, and beginning in CY 2015 only members 2 to 20 years of age were included. Therefore, caution should be exercised when comparing rates between years and to performance targets.

The remaining measures in the Access to Care measure set presented opportunities for improvement as none of them met the performance targets across the three GF CMOs.

For the GF CMOs collectively, approximately 19 percent of the CY 2015 performance targets within the Women's Health measure set were met, presenting opportunities to improve the rates for the *Cervical Cancer Screening*, *Prenatal and Postpartum Care*, and *Percentage of Live Births Weighing Less Than 2,500 Grams* measures. However, within this measure set, Amerigroup met or exceeded the performance targets for the percentage of members who turned 13 years of age and who received the

human papillomavirus vaccine, while WellCare met or exceeded the breast cancer screening performance target. Amerigroup, WellCare, and Amerigroup 360° met or exceeded the performance targets for *Cesarean Delivery Rate, Uncomplicated*. Peach State met or exceeded the *Chlamydia Screening in Women* performance target.

Approximately 23 percent of the CY 2015 performance targets within the Chronic Conditions measure set were met for the GF CMOs collectively, presenting opportunities to improve the rates for various components of comprehensive diabetes care and care for members with respiratory and/or cardiovascular conditions. Amerigroup, Peach State, and WellCare met or exceeded the performance target for medical attention to nephropathy in the care for diabetic members. However, for CY 2015, updates to the technical specifications were made to the requirements for meeting the testing criteria for nephropathy. In addition, the classification of diabetes changed significantly between International Classification of Diseases, 9th (ICD-9) and 10th (ICD-10) editions. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Comprehensive Diabetes Care* measure.

Additionally, Amerigroup met or exceeded the performance targets for hemoglobin A1c (HbA1c) testing for diabetic members and the timely dispensing of systemic corticosteroids for members with chronic obstructive pulmonary disease (COPD). Peach State met or exceeded the performance targets for eye exams performed for diabetic members, as well as the timely dispensing of systemic corticosteroids for members with COPD.

Approximately 19 percent of the CY 2015 performance targets within the Behavioral Health measure set were met by the GF CMOs collectively, presenting opportunities to increase the rates for initiating the follow-up care for children prescribed ADHD medication, the follow-up care for those hospitalized for mental illness, and the adherence to antipsychotic medications for individuals with schizophrenia. Within this measure set, however, Amerigroup and Amerigroup 360° met or exceeded both performance targets for the management of antidepressant medications, and WellCare met or exceeded the performance target for the continuation and maintenance phase of providing follow-up care to children prescribed ADHD medication.

Overall, several areas of improvement were identified through analysis of the CY 2015 performance measure rates. For most of the measure sets, only a minority of the CY 2015 performance targets were met. The only exceptions were the Children's Health and Medication Management measure sets. The GF CMOs should focus on those measures for which the performance targets were not met, as well as any measure that demonstrated a statistically significant decline from its CY 2014 performance.

CAHPS Surveys

Adult members' satisfaction with their healthcare experiences, 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 adult Medicaid national average for three global ratings, *Rating of Health Plan, Rating of All Health Care*, and *Rating of Specialist Seen Most Often*, and two composite measures: *Getting Needed Care* and *How Well Doctors Communicate*. However, the statewide average

results for the Adult Medicaid population were below the NCQA adult Medicaid national average for four measures: *Rating of Personal Doctor, Getting Care Quickly, Customer Service,* and *Shared Decision Making*. These scores indicate that adult members were mostly satisfied with their health plan, overall healthcare, specialists, getting the care they needed, and provider communication. However, they were less satisfied with their personal doctor, timeliness of care, customer service, and shared decision making.

Parents'/caretakers' satisfaction with their children's healthcare experiences, as measured through the CAHPS Child Medicaid Health Plan Survey, revealed that statewide average results for the child Medicaid population were above the NCQA child Medicaid national average for all four global ratings: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often,* and *Rating of Personal Doctor*, and three of the composite measures: *Getting Needed Care, Getting Care Quickly,* and *Customer Service*. However, the statewide average results for the child Medicaid population also revealed that scores were below the NCQA child Medicaid national average for the *How Well Doctors Communicate* and *Shared Decision Making* measures. These scores indicate that parents/caretakers of child members were mostly satisfied with their child's health plan, overall healthcare, specialists, personal doctors, getting the care they needed and in a timely fashion, and their plan's customer service. However, they were less satisfied with provider communication and shared decision making.

The Adult Medicaid CAHPS scores revealed that all three GF CMOs scored above the NCQA adult Medicaid national average for *Rating of All Health Care* and *Getting Needed Care*. These findings suggest that adult members were satisfied with all healthcare received and getting the care they needed.

The Child Medicaid CAHPS scores revealed that all four CMOs scored above the NCQA child Medicaid national average for one measure, *Rating of Personal Doctor*. These findings suggest that the parents/caretakers of child members were satisfied with their child's personal doctor.

In addition to the CAHPS Health Plan Surveys the CMOs administered, DCH conducted a statewide CAHPS survey for Georgia's standalone CHIP program, PeachCare for Kids®. The DCH surveyed parents or caretakers of child members in this program to satisfy CHIPRA Reauthorization Act requirements; however, the results are not presented in this report.

2. The Georgia Families Managed Care Program Overview

Georgia Medicaid Managed Care Service Delivery Systems 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 PeachCare for Kids® 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 aged (65 and over), blind, and disabled.

The GF program includes more than half of the Georgia'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 (e.g., children enrolled in the Children's Medical Services 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 medical, mental health, vision, dental, and case and disease management services to their enrolled Medicaid and CHIP members, plus a range of

enhanced services, including dental and vision services for adults, wellness/prevention programs, and incentives. The DCH's goals for the care provided by the CMOs are that:

- The care be of acceptable quality.
- Access to care is assured.
- Continuity of care is provided.
- Efficient care is promoted.

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 managed care 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, November 2011, and again in February 2016.[2-1] The 2016 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).
- Value-based purchasing performance metrics for the GF and GF 360° 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).

[2-1] Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: http://dch.georgia.gov/medicaid-quality-reporting. Accessed on: Jan 5, 2017.
[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/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Jan 5, 2017.
[2-3] Department of Health and Human Services, Agency for Healthcare Research and Quality. About the National Quality Strategy (NQS). Available at: https://www.ahrq.gov/workingforquality/about.htm. Accessed on: Jan 5, 2017.

- The 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 February 2016 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 policy and Medicaid Management Information System (MMIS) activities to ensure mandated compliance with 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 were validated using the rapid cycle PIP validation process. (Findings from validation of the CMOs' rapid cycle PIPs initiated in 2015 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.
- Reprocured the GF and GF 360^{o} contracts through the Georgia Department of Administrative Services Request for Proposal (RFP) process. The RFP process and contract awards 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 behavioral health, physical health, 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 aligned 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 readmissions and better patient outcomes. One hospital system in Georgia pilot tested the new form in an electronic version and provided feedback to the Care Coordination Council.

- Initiated work to expand telemedicine originating sites to include local education agencies (i.e., school districts), thus improving members' access to providers, especially in Georgia's rural counties.
- Implemented a policy for the DCH and CMOs to deny payment for non-medically necessary labor inductions and Cesarean sections for women less than 39 weeks' gestation. Birth outcomes metrics and elective delivery (ED) rates were being monitored to track the effectiveness of this policy.
- Identified a new administrative method for determining gestational age. This will inform the calculations for the EDs, antenatal steroids, and Cesarean sections for nulliparous singleton vertex Adult Core Set measures and assist with the strategies to reduce the State's low birth weight rate. The DCH recommended that the CMOs adopt this or other equivalent methodologies to identify gestational age and parity for the CY 2016 performance measure rate generation process.

Quality Initiatives Driving Improvement

The following are some of DCH's initiatives during the review period that supported the improvement of quality of care and services for GF and GF 360° members, as well as activities that supported the CMOs' improvement efforts.

- Implemented preventive health visits for all Medicaid enrolled adults ages 21 years and over effective January 1, 2016.
- Updated, in February 2016, the Quality Strategic Plan (QSP) for the GF program and included the GF 360° program. The QSP was posted for public comment and, following the public comment period, was sent to CMS for review and comment. CMS stated the QSP aligned with the template that it provided to states for their QSPs.
- Collaborated with the Georgia Department of Public Health (DPH) regarding the management of asthma and diabetes. The DCH adopted the asthma action plan in use by DPH as the asthma action plan the CMOs' providers will use in conjunction with their asthma clinical practice guideline (CPG). This collaboration included the implementation of collaborative performance improvement projects to improve asthma self-management through education and to identify home triggers for asthma through a standardized home assessment for the CMOs' patients diagnosed with poorly controlled asthma. The projects were implemented in February and March 2017.
- Approved the CMOs' collaborative Asthma, ADHD, and Diabetes CPGs to ensure consistency across all three of the Georgia Families managed care plans. The focus of this collaboration was to reduce administrative burden for the providers.
- Finalized revisions of the new quarterly medical record audit (MRA) tools for the Asthma, ADHD, and Diabetes CPGs to capture more meaningful data. The CMOs trained their staff on these new audit tools to ensure consistency when conducting audits.
- Engaged the CMOs in an ongoing process of reviewing report specifications for several DCH required reports. The review process identified areas needing additional modifications for some of the reports.

- Finalized the revisions of the CMOs' quarterly Case Management, Disease Management, and Utilization Claims Management Report templates and specifications to capture more meaningful data.
- Engaged with the Department of Public Health (DPH) in the Centers for Disease Control and Prevention's (CDC's) 6|18 Initiative, focusing on the treatment of asthma and reducing unintended pregnancies. The DCH staff participated in both state-only and multistate calls with the CDC and its partners regarding this initiative and participated in the in-person meeting held in December 2016. The meeting goals were to celebrate states' progress and accomplishments, discuss strategies to overcome challenges and barriers, support states' abilities to track progress, and demonstrate and develop plans for 6|18 sustainability and expansion. The assistant chief for performance, quality and outcomes also made a presentation in February 2017 during one of the CDC's and the American College of Preventive Medicine's (ACPM's) 6|18 Initiative Listening Sessions about the work that Georgia had performed relative to managing asthma and reducing unintended pregnancies.
- Began conducting readiness reviews in late summer 2016 for each of the four CMOs that will be operational effective July 1, 2017. These reviews require the DCH staff to review the CMOs' policies and procedures relative to contractual requirements along with member and provider materials to ensure alignment with contractual requirements and the 2016 managed care rules. On-site readiness reviews were initiated in February 2017.
- Conducted training sessions for the CMOs on those sections within the 2016 managed care rules related to quality and performance. Provided the CMOs with the comparisons between the 2015 and 2016 CFRs.
- Completed reprocurement for the State's 1115 Demonstration evaluation contract.
- Participated with CMS and other states in the Postpartum Action Learning Series to improve the State's postpartum visit rate and increase the utilization of long-acting reversible contraceptives.
- Initiated the Perinatal Case Management (PCM) project in August 2016. This project is a collaborative initiative between DPH, the DPH case management system vendor, DCH, and the CMOs to automate the delivery and processing of the perinatal case management assessment, the reproductive life plan, and the plan of care for Georgia Medicaid members who apply for Medicaid presumptive eligibility as pregnant women.
- Continued ongoing engagement of the Improving Birth Outcomes Workgroup, which comprises representatives from DCH, the State Health Benefit Plan's contractors, the CMOs, DPH, and Healthy Mothers Healthy Babies.
- Continued ongoing participation in the CMS Quality Technical Advisory Group as one of the Region IV representatives.
- Engaged the CMOs in a collaborative project to reduce avoidable ED utilization. The CMOs identified actionable interventions along with barriers to be overcome in order to achieve success.
- Collaborated with DPH in the Human Immunodeficiency Virus (HIV) Health Improvement Affinity Group supported by CMS, Health Resources and Services Administration (HRSA), CDC, the Health and Human Services (HHS) Office of Human Immunodeficiency Virus (HIV) and Infectious Disease Policy, and in partnership with the National Academy for State Health Policy (NASHP). The HIV Health Improvement Affinity Group supports states' efforts to improve health outcomes, including rates of viral load suppression, for Medicaid and CHIP beneficiaries living with HIV.

Quality Improvement Conference

The DCH worked with HSAG to conduct a quality improvement conference, Building Excellence in Quality Improvement: *Leadership, Culture, and Capability,* on February 9, 2016. The goal of the conference was to provide resources and tools for the CMOs to use for effective quality improvement.

The conference focused on three interrelated topics. The first topic, the cost of poor quality (COPQ), built the case for why high quality is essential for maximizing profits and sustaining a competitive healthcare business advantage. The discussion explained why the roles of the CMOs' leaders were critical to developing and sustaining a culture of high quality. Information was also provided regarding why leaders were often unaware that a major share of the COPQ was invisible because the contributing factors were often neither measured nor reported. Once leaders recognized the COPQ, they were more likely to address issues and implement actions for improvement.

The second topic focused on the fundamentals of quality improvement necessary to build and sustain capability, culture, and leadership support. The discussion described CMS' strategic framework for developing, implementing, and sustaining an effective Quality Assessment and Performance Improvement (QAPI) program to support a culture of quality. Discussion emphasis was on leadership responsibility and accountability, characteristics of an effective quality improvement team, self-assessment for a QAPI program evaluation, and leverage points for change.

The final topic focused on thinking critically about key drivers, interventions, and outcomes for performance improvement. The discussion centered around applying content theory for performance improvement, techniques to analyze and improve key driver diagrams, using different strategies such as logical and critical thinking, benchmarking, technology, use of change concepts, and the importance of building a stronger foundation for improvement before selecting interventions to test. Following the presentation, each CMO worked on skill building exercises with HSAG staff.

The audience for the 2016 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 360^{o} programs.

Rapid Cycle Technical Assistance

Throughout CY 2015, HSAG facilitated one-on-one technical assistance conference calls at the CMOs' request to provide guidance and to answer any questions as they completed each rapid cycle PIP module. In addition to the technical assistance calls, HSAG provided comprehensive, written feedback for the modules completed and submitted for review. The CMOs also had the rapid cycle PIP Companion Guide, prepared by HSAG, to reference as they completed their PIPs. This guide outlines the requirements for each module and the steps in the rapid cycle process.

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 EQR 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 2016 and 2017, 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 2016 review period, HSAG evaluated the degree to which the CMOs complied with federal Medicaid managed care regulations and the associated DCH contract requirements in three performance categories. The review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR §438.236–438.330. 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.[3-1] HSAG conducted the on-site compliance reviews in August 2016. The standards HSAG evaluated included:

- Practice Guidelines
- Quality Assessment and Performance Improvement (QAPI)
- Health Information Systems

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 December 2016. 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 uses a rapid cycle PIP process, which places an

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2016.

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.

HSAG validated eight PIPs for each GF CMO and three PIPs for the GF 360° program. The PIPs were validated using the rapid cycle approach. The rapid cycle PIP methodology is 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 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.[3-2] 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, the new approach was reasonable.

The CMOs submitted their CY 2015 PIP data that reflected varying time periods, depending on the PIP topic, in June and in August 2016. HSAG validated PIPs between July 1, 2016, and August 26, 2016. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in November 2016.

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 [specific, measureable, attainable, relevant and time-bound] 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 2016 rapid cycle PIP modules during CY 2016. All of these PIPs were implemented using the rapid cycle PIP methodology. The validation of the final CY 2016 PIP modules (Modules 4 and 5) will be completed and results provided to DCH in late spring 2017.

Validation of performance measures: The DCH annually selects a set of performance measures to evaluate the quality of care and services delivered by its 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 2016 through July 2016. The final PM validation results generally reflected the measurement period of January 1, 2015, through December 31, 2015. HSAG provided final PM validation reports to the CMOs and DCH in September 2016.

[3-2] 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: Feb 22, 2016.

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

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 the CMOs to their members. Administration of the CAHPS surveys is an optional Medicaid 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 2016, the 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 four CMOs in this report. Appendix D includes a detailed methodology HSAG used to review the CAHPS Survey results.

Auto-Assignment Algorithm: For members who do not select a CMO and are not otherwise assigned to one based on the DCH default algorithm, one is automatically assigned to them via a quality-based auto-assignment algorithm. HSAG calculated the quality-based auto-assignment scores for each CMO for the two 2016 DCH quality-based auto-assignment periods (January through June and July through December). The auto-assignment calculation was conducted according to the methodology determined by DCH, which includes both a cost component (30 percent of the total score) and a quality component (70 percent of the total score). The quality component was calculated using the CMOs' CY 2014 performance measure rates reported to DCH in June 2015. The CMO with the highest auto-assignment score for each period received all GF managed care members who did not select a CMO and who were not otherwise assigned one based on the default algorithm.

4. Amerigroup Community Care

Plan Overview

Amerigroup Community Care (Amerigroup) is a wholly owned subsidiary of Anthem, Inc. Amerigroup operates in the states of Florida, Georgia, Iowa, Kansas, Louisiana, Maryland, Nevada, New Jersey, Tennessee, Texas, and Washington. Amerigroup began operations in Georgia in 2006 and currently serves over 351,000 GF members statewide.[4-1] Amerigroup provides medical, mental health, vision, dental, and case and disease management services to its enrolled Medicaid and CHIP members, plus a range of enhanced services, including dental and vision services for adults, wellness/prevention programs, and incentives.

Review of Compliance With Standards

Table 4-1 presents the standards and compliance scores for Amerigroup. For Standards I–III and follow-up on previously noncompliant review findings, HSAG evaluated a total of 63 elements for the FY 2016 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	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Clinical Practice Guidelines	**11**	**11**	**11**	**0**	**0**	**100.0%**
II	Quality Assessment and Performance Improvement (QAPI)	**32**	**30**	**16**	**14**	**2**	**53.3%**
III	Health Information Systems	**8**	**8**	**8**	**0**	**0**	**100.0%**
	Follow-up Reviews From Previous Noncompliant Review Findings	**12**	**12**	**9**	**3**	**0**	**75.0%**
	Total Compliance Score	**63**	**61**	**44**	**17**	**2**	**72.1%**

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

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

***** 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. June 2016.

Findings

Amerigroup had a total compliance score of 72.1 percent, with two of the standards scoring 100 percent: Clinical Practice Guidelines and Health Information Systems. The Quality Assessment and Performance Improvement (QAPI) standard was noncompliant with 14 elements.

HSAG also reviewed documentation provided by Amerigroup to determine whether the CMO had met the intent of the corrective action plans DCH approved for *Not Met* elements from the previous noncompliant review findings. Twelve elements were re-reviewed within the following standards: Member Information, Grievance System, Disenrollment Requirements and Limitations, Furnishing of Services, and Coordination and Continuity of Services. All elements related to Member Information and Disenrollment Requirements and Limitations were *Met* upon reevaluation. Three 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.

Clinical Practice Guidelines: Amerigroup adopted clinical practice guidelines (CPGs) from evidence-based, professional association recommendations for care and treatment, considered demographic and epidemiological profiles of its population, and analyzed utilization data. Amerigroup disseminated the CPGs through outreach materials for providers, included components of the guidelines in member materials, and made the CPGs available to members and providers on the CMO's website. Amerigroup provided training for CMO clinical staff involved in disease management and case management regarding guideline recommendations and implemented provider monitoring activities to ensure provider compliance with CPGs.

Quality Assessment and Performance Improvement: The CMO's chief executive officer and the chief medical officer, in addition to executive and senior-level staff, were actively involved in QAPI program activities. Amerigroup continued to expand current quality improvement (QI) knowledge and training, including the Institute for Healthcare Improvement's (IHI's) Science of Quality Improvement and Lean Six Sigma, throughout its organization. Amerigroup developed strong processes to measure provider network accessibility, using provider surveys to determine availability of appointments and after-hours care. Amerigroup also had processes to monitor complaints and grievances in relation to access to care concerns and used monitoring results to identify opportunities for improvement. Amerigroup developed provider report cards, as well as a performance measurement report card that displayed provider year-over-year performance and variance. The report cards were used to facilitate discussions with providers about performance and opportunities for improvement.

Amerigroup's QAPI program description was not comprehensive and did not meet the DCH guidelines. The QAPI program description did not detail the QI processes the CMO had developed and implemented, and had described in other CMO documents. The CMO did not document its use of the latest available research in the area of quality assurance/improvement in its QAPI program. The QAPI

program evaluation did not provide a complete summary of how the QI goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered (and implemented); how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured in order to provide a comprehensive story of the effectiveness of Amerigroup's QAPI work. Amerigroup's documentation did not fully describe how Amerigroup monitored or evaluated its own processes for quality management and performance improvement and reflected limited engagement of members' caregivers/representatives in meetings focused on QI. The QAPI or QM program description also did not address implementation or use of provider profiling information.

Health Information Systems: The Amerigroup Management Information System (MIS) included five integrated components, which collectively allowed for the collection, integration, tracking, analysis, and reporting of data. The MIS included (1) the core operating system that hosted provider, member, claims, and authorizations data; (2) the care management system, CareCompass, which included member utilization data such as claims history, authorizations, immunizations, lab, and case and disease management data; (3) the data warehouse that supported processes and functions, which was populated from source systems such as the core operating system; (4) supplemental applications to support overall functionality and produce business intelligence reports such as dashboards and analytical reporting; and (5) member and provider websites that were used to communicate, share, and deliver vital information.

Recommendations for Improvement

Amerigroup received recommendations for improvement in the Clinical Practice Guidelines and Quality Assessment and Performance Improvement (QAPI) standards. HSAG's specific recommendations for Amerigroup are as follows:

- Write the QAPI program evaluation based on DCH specifications. The QAPI program evaluation must be approved by DCH. The QAPI program description must also include the comprehensive process used for QI activities, beginning with a review of information and data available to the CMO (e.g., claims/encounters, grievance and appeals, quality of care cases, disease management, case management, care coordination, member and provider input). In addition, the CMO must include the identification of QI opportunities and gaps in care or service delivery. QI initiatives must meet regulatory requirements and also reflect an understanding of the population served; use data to understand where opportunities exist; and include the results of research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members. The QAPI program evaluation must provide a complete summary of how the QI goals, objectives, and related initiatives were identified, which data were used in the selection process, which interventions were considered (and implemented), how the initiatives were resourced, and the results or outcomes of the QI work. The QAPI program evaluation must document the story of the effectiveness of Amerigroup QAPI work.
- Describe in QAPI program descriptions and program evaluations the linkage between monitoring activities, the analysis and evaluation of the activities, and how the analysis and evaluations are used to

develop and implement interventions specifically focused on improving the delivery, quality, and appropriateness of healthcare furnished to all members, including those with special healthcare needs.

- Document its use of the latest available research in the area of quality assurance/improvement in its QAPI program description and program evaluation.
- Develop policies and procedures that support the implementation of the scope, goals, and objectives of the QAPI program including quality assessment, utilization management, and continuous QI.
- Continue to monitor and evaluate its service delivery system and provider network to ensure that DCH requirements for access to care are met.
- Continue to monitor and evaluate that its own processes for quality management and performance improvement are met.
- Define mechanisms to assess the quality and appropriateness of care furnished to its members with special healthcare needs.
- Develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction.
- Identify additional opportunities to engage members, parents, guardians, and family members in activities focused on QI.
- Work with community organizations and resources related to QI, in addition to its current processes that are focused on care coordination.
- Meet all DCH-established performance targets.
- Structure the QM Patient Safety Plan according to DCH guidelines and obtain DCH approval of this plan. The QM Patient Safety Plan must clearly distinguish between grievances and the grievance system.

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

- Amerigroup must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters. The CMO should write a separate letter for the provider and a separate letter for the member.
- Amerigroup must continue to apply current and new interventions with providers until the goal of returning urgent calls within 20 minutes and routine calls within one hour is achieved 90 percent of the time.
- Amerigroup must meet the geographic standards for both urban and rural areas for PCPs, specialists, oral health 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.

Performance Improvement Projects

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. Amerigroup followed the rapid cycle PIP methodology as identified by HSAG in the Companion Guide sent to the CMO in January 2015. 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 the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving improved outcomes. The rapid cycle PIP methodology, including module descriptions, is described in detail in Appendix B, Methodology for Conducting Validation of Performance Improvement Projects.

Findings

For each PIP, Amerigroup was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. Amerigroup developed a SMART Aim statement that quantified the improvement sought for each PIP and used a process map and FMEA to identify one or more interventions that had the potential to impact the SMART Aim goal.

HSAG organized and analyzed Amerigroup's PIP data to draw conclusions about the CMO's QI efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal. Table 4-2 outlines the PIP topics, final CMO-reported SMART Aim statements, and the overall validation findings for the eight PIPs.

HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation findings were based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. Confidence levels included *High Confidence*, *Confidence*, and *Low Confidence*. If the CMO did not execute the PIP according to the approved SMART Aim measure methodology, a confidence level was not assigned because HSAG determined that the reported PIP results were not credible.

Table 4-2—PIP Titles, SMART Aim Statements, and Confidence Levels

PIP Title	SMART Aim Statement	Confidence Level
Annual Dental Visits	To increase the percentage of unique children <21 years old receiving a preventive dental visit by 10% (41.7% to 45.87%) who are assigned to Family Health Care Centers of Georgia, by December 31, 2015	*Low Confidence*
Appropriate Use of ADHD Medications	To increase the percentage of children, 6 to 12 years of age, who fill an initial prescription used to treat ADHD and return within 30 days for a follow-up office visit at Medical Specialists from 23.68% to 28.68% by December 31, 2015	*Low Confidence*

PIP Title	SMART Aim Statement	Confidence Level
Avoidable Emergency Room Visits	To decrease the rate of avoidable ER utilization by 5 percentage points from 21% to 16% for members less than 21 years of age assigned to Nuestros Niños practice by December 31, 2015	*Low Confidence*
Bright Futures	Increase the percentage of children assigned to Kaiser who complete their 6th visit on or before 15 months of age from 59.58% to 69.58% by December 31, 2015	*Low Confidence*
Comprehensive Diabetes Care	To increase the number of diabetic prescriptions refilled on time, during the measurement month by 12 percentage points (from 28% to 40%) for diabetic patients age 18 and older, assigned to Absolute Care from February 1, 2015, and December 31, 2015	*Confidence*
Member Satisfaction	Decrease calls by Amerigroup Georgia Members to the National Contact Center for PCP changes by 5% (from 191/1000 to 181/1000) by December 31, 2015	*Confidence*
Postpartum Care	Increase the percentage of women who had a postpartum visit with an Eagle's Landing OB/GYN Associates provider between 21–56 days from 67% to 72% by June 30, 2015	*Confidence*
Provider Satisfaction	Decrease the percentage of providers terminated due to failure to recredential by 10% (from 32% to 28.8%) by December 31, 2015	*Low Confidence*

HSAG assigned a level of *Confidence* to three of Amerigroup's eight PIPs and a level of *Low Confidence* for the remaining five PIPs. HSAG did not assign a level of *High Confidence* for any of Amerigroup's PIPs.

HSAG determined *Confidence* in the results for three PIPs: *Comprehensive Diabetes Care*, *Member Satisfaction*, and *Postpartum Care*. A level of *Confidence* was assigned to each of these PIPs because the SMART Aim goal was achieved; however, some but not all of the CMO's QI processes could be linked to the demonstrated improvement.

HSAG assigned a level of *Low Confidence* for five of Amerigroup's PIPs: *Annual Dental Visits*, *Appropriate Use of ADHD Medications*, *Avoidable Emergency Room Visits*, *Bright Futures*, and *Provider Satisfaction*. For each of the five PIPs, the SMART Aim goal was achieved; however, the QI processes could not be clearly linked to the demonstrated improvement.

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 the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

Annual Dental Visits

Amerigroup's goal for the *Annual Dental Visits* PIP was to identify and test interventions to improve the preventive dental visit rates for members 21 years of age and younger who were assigned to Family

Health Care Centers of Georgia. Although the PIP's SMART Aim goal was exceeded, the QI processes were not clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 4-3 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 4-3—SMART Aim Measure Results for *Annual Dental Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of members, 0 to 21 years of age, who were assigned to Family Health Care Centers of Georgia and completed a preventive dental visit.	41.7%	45.9%	64.7%	*Low Confidence*

HSAG validated Amerigroup's *Annual Dental Visits* PIP SMART Aim measure rates based on the rates the CMO plotted on the SMART Aim run chart. It should be noted that the CMO had discrepancies in the SMART Aim measure baseline and goal rates. The CMO established a goal of improving the preventive dental visit rate for members 21 years of age and younger assigned to Family Health Care Centers of Georgia by 4.2 percentage points (10 percent), from 41.7 percent to 45.9 percent. On the final SMART Aim measure run chart, the CMO plotted the baseline and goal rates as 47.0 percent and 57.0 percent, respectively. Because the highest SMART Aim rate achieved (64.7 percent) exceeded both goal rates, HSAG determined the SMART Aim goal was achieved. The details of the improvement processes used and the intervention tested for the *Annual Dental Visits* PIP are presented in Table 4-4 and in the narrative description below.

Table 4-4—Intervention Testing for *Annual Dental Visits*

Intervention	Key Drivers Addressed	Failure Mode Addressed	Conclusions
Dental clinic events with scheduling assistance	• Identification of children who need a preventive dental visit • Appointment follow-up/coordination of care • Provider education and awareness • Member education and awareness	Parents do not schedule dental appointments for their children during school and work hours	The CMO chose to adopt the intervention and pursue expansion.

The CMO identified eligible members assigned to Family Health Care Centers of Georgia who were due or past due for a preventive dental visit and reached out to those members and their parents/caregivers to schedule an appointment during the dental clinic event. The CMO followed up with members 24 hours prior to the scheduled appointment to remind and encourage members to attend.

Although Amerigroup designed an evaluation plan to test the intervention with an intervention-specific measure of effectiveness (the percentage of members who received the intervention that also received preventive dental services at a dental event), the CMO did not report the results of this metric. Instead, the CMO plotted and analyzed the SMART Aim measure results and did not report how many eligible members assigned to the targeted provider actually received the intervention; therefore, the specific impact of the intervention could not be determined. The CMO chose to adopt the intervention and was exploring the possibility of expanding it to an additional provider. Amerigroup did not provide a strong rationale for adopting and expanding the intervention because the run chart for the intervention testing results was not appropriate and did not meaningfully measure the impact of the intervention.

Appropriate Use of ADHD Medications

Amerigroup's goal for the *Appropriate Use of ADHD Medications* PIP was to identify and test interventions to improve the 30-day follow-up appointment compliance rate among members 6–12 years of age who received an initial ADHD medication prescription from a provider in the Medical Specialists provider group. Although the SMART Aim goal was achieved, the improvement could not be clearly linked to the documented QI processes; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 4-5 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 4-5—SMART Aim Measure Results for *Appropriate Use of ADHD Medications*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of members, 6 to 12 years of age, who receive an initial ADHD medication prescription and return within 30 days for a follow-up visit at Medical Specialists.	23.7%	28.7%	60.0%	*Low Confidence*

The CMO established a goal of improving the ADHD medication follow-up visit rate at Medical Specialists by 5 percentage points, from 23.7 percent to 28.7 percent. Six of the PIP's monthly SMART Aim measurements met or exceeded the goal rate of 28.7 percent. The details of the improvement processes used and the interventions tested are presented in Table 4-6 and in the subsequent narrative description.

Table 4-6—Intervention Testing for *Appropriate Use of ADHD Medications*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Clinical practice consultant	• Appointment follow-up/ Coordination of Care • Provider Education/ Awareness	• Lack of Provider office procedure for scheduling ADHD follow-up appointments within 30 days of initiating ADHD medication • Coordination issues between practitioners and schedulers	The CMO chose to abandon the intervention because improvement was not sustained and the intervention was too resource-intensive.
Member outreach and incentive	Member Education/Awareness	Parent does not understand need for ADHD follow-up evaluation within 30 days of starting medication	The CMO chose to expand the intervention to a new provider based on the SMART Aim measure results.

The CMO identified two interventions: the provider-focused clinical practice consultant intervention and the member-focused outreach and incentive intervention.

The purpose of the clinical practice consultant intervention was to train staff at the targeted provider's practice on the importance of the 30-day follow-up visit and to assist in developing strategies for facilitating member compliance with a timely follow-up visit. The CMO described a methodologically sound data collection process and data sources used for monthly measurements of intervention effectiveness. Because the clinical practice consultant intervention was provider-based and the SMART Aim measure was based on data from one targeted provider who received the intervention, it was appropriate for the CMO to use the SMART Aim measure to evaluate the effectiveness of the intervention. The SMART Aim measure run chart indicated that the clinical practice consultant intervention was initially successful at improving the follow-up visit rate among members assigned to the targeted provider; however, the improvement was not sustained and performance declined toward the end of the PIP. The CMO reported that it chose to abandon the intervention for three reasons:

- There was a downward trend (decline) on the run chart for the final three months the intervention was tested.
- The CMO identified two additional barriers, appointment "no-shows" and the provider prioritizing walk-in appointments over scheduled follow-up appointments, as issues that could not be addressed by the intervention.
- The targeted provider could not sustain the resources needed for the intervention partnership because the provider's resources were directed toward electronic medical record (EMR) implementation.

The purpose of the member outreach and incentive intervention was to educate members and their parents/caregivers on the importance of attending a follow-up visit with the targeted provider within 30 days of initiating ADHD medication. The incentive was offered to increase member motivation to schedule and attend the follow-up appointment. The CMO's use of the SMART Aim measure to

evaluate the effectiveness of the intervention was not appropriate because the SMART Aim measure included all members assigned to the targeted provider and was not limited to the specific members reached by the intervention. The CMO did not document how many members assigned to the targeted provider were reached by the intervention; unless 100 percent of eligible members received the member outreach and incentive offer, the SMART Aim measure could not meaningfully evaluate the impact of the intervention. Because the CMO used an inappropriate measure to evaluate the effectiveness of the intervention, the run chart results did not provide a meaningful metric to evaluate the success of the intervention. The CMO, therefore, did not provide a sound rationale for the decision to expand the intervention to a new provider.

Avoidable Emergency Room Visits

Amerigroup's goal for the *Avoidable Emergency Room Visits* PIP was to identify and test interventions to reduce the avoidable ER visit rate for members less than 21 years of age assigned to Nuestros Niños (Our Kids) pediatric primary care practice. Although the SMART Aim goal was achieved, the improvement could not be clearly linked to the documented QI processes; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 4-7 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 4-7—SMART Aim Measure Results for *Avoidable Emergency Room Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The monthly avoidable ER rate for members less than 21 years of age assigned to Nuestros Niños (Our Kids) pediatric primary care practice	21.0%	16.0%	9.0%	*Low Confidence*

* The Lowest Rate Achieved is reported for the *Avoidable Emergency Room Visits* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

The CMO established a goal of reducing the avoidable ER rate for members assigned to the Nuestros Niños practice by 5 percentage points, from 21.0 percent to 16.0 percent. The SMART Aim measure run chart included five monthly data points from July, September, October, November, and December, when the avoidable ER visit rate for members assigned to the targeted primary care provider (PCP) was lower (better) than the goal of 16.0 percent. The details of the improvement processes used and the intervention tested for the *Avoidable Emergency Room Visits* PIP are presented in Table 4-8 and in the narrative description below.

Table 4-8—Intervention Testing for *Avoidable Emergency Room Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Primary care-based member education about appropriate emergency care utilization and alternative care options	Access to alternate care levels/walk-in appointments	Parent/member not aware that they can go to Urgent Care facilities	The CMO did not provide a sound rationale for the decision to expand the intervention.

The CMO identified one intervention for the PIP: primary care-based member education about alternative care options and how to appropriately use after-hours, urgent care, and emergency room services.

Amerigroup used the SMART Aim measure (the percentage of avoidable ER visits for members assigned to the targeted primary care provider) to evaluate the intervention's effectiveness; however, the SMART Aim measure was not specific to those members who received the intervention. To evaluate the impact of the intervention, the CMO should have tracked those members who received the intervention to determine how many sought care at the urgent care facility and how many visited the ER for an avoidable diagnosis. Amerigroup did not use a metric that allowed the CMO to determine the specific impact of the intervention on the SMART Aim measure. In addition to using an inappropriate measure to evaluate intervention effectiveness, the CMO reported several potential, confounding factors that may have contributed to some of the low avoidable ER visit rates plotted on the SMART Aim run chart. Specifically, the CMO reported that the summer school break may have resulted in the low rate in July, and unseasonably warm weather from October through December may have contributed to the avoidable ER visit rate being zero during these three months. Given the lack of intervention-specific evaluation results and the CMO's reported confounding factors, it is not possible to draw an accurate conclusion of the impact of the intervention on the SMART Aim measure.

The SMART Aim measure demonstrated an improvement in the avoidable ER rate by performing better than the goal rate (16 percent) for five of the monthly measurements. The CMO concluded that the intervention was successful, chose to adopt the intervention, and described a plan for expanding it to additional providers. The CMO did not, however, provide a strong rationale for adopting and expanding the intervention because the findings did not include intervention-specific results and could not meaningfully establish the impact of the intervention.

Bright Futures

Amerigroup's goal for the *Bright Futures* PIP was to identify and test interventions to improve the rate of members assigned to the Southeastern Permanente (Kaiser) practice who received six or more well-child visits on or before 15 months of age. Although the SMART Aim goal was achieved, the improvement could not be clearly linked to the documented QI processes; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 4-9 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 4-9—SMART Aim Measure Results for *Bright Futures*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of members assigned to Southeastern Permanente (Kaiser) who complete their sixth well child visit on or before 15 months of age	59.6%	69.6%	88.9%	*Low Confidence*

The CMO established a goal of improving the well-child visit rate for members 0–15 months of age at Southeastern Permanente (Kaiser) by 10 percentage points, from 59.6 percent to 69.6 percent. The PIP's SMART Aim measurements met or exceeded the goal rate of 69.6 percent for eight consecutive months during intervention testing. The details of the improvement processes used and the intervention tested are presented in Table 4-10 and in the subsequent narrative description.

Table 4-10—Intervention Testing for *Bright Futures*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Member Outreach Coordinator	Member engagement and encouragement to schedule well-baby visits	Coordination and consistency of scheduling the next routine well-baby visit prior to leaving the office	The provider concluded the intervention was effective based on the SMART Aim measure results, and planned to share the PIP results with other high-volume, low-performing providers.

The CMO identified one intervention for the PIP: initiation of a Member Outreach Coordinator position at the targeted provider office. The CMO partnered with Southeastern Permanente to test the Member Outreach Coordinator position, to facilitate member engagement and proactive well-visit appointment scheduling, and improve the rate of members assigned to the targeted provider who have six or more well visits by 15 months of age.

The member outreach coordinator directed the following four primary activities: (1) asking members to schedule their next well-baby visit prior to leaving the office for the current well visit; (2) working with the CMO to identify members by birthdate, and the anchor date for receiving at least six well visits by 15 months of age, for appointment scheduling outreach; (3) making reminder phone calls to eligible members 24–48 hours prior to scheduled appointments; and, (4) working with the CMO to reach out to members who were past due for a well-visit appointment or who missed an appointment.

Amerigroup's intervention evaluation plan was not sufficient to determine the impact of the individual components of the complex member outreach coordinator intervention. The data sources and data collection processes documented for the evaluation plan did not demonstrate how all of the intervention components would be evaluated for impact on the SMART Aim measure. Because of the complexity of the intervention, the CMO needed to clearly document how each component would be tracked to determine its contribution to any demonstrated improvement in the SMART Aim measure. For example, the following questions illustrate gaps in the CMO's documentation:

- How did the provider track which members were asked to schedule the next visit and how many members successfully scheduled a visit prior to leaving the office?
- For reminder calls prior to scheduled appointments, how did the provider track whether the member was successfully reached and whether the member completed the well visit?
- For the outreach to members who were past due for an appointment or missed an appointment, how did the CMO track whether the member was successfully reached and whether the member subsequently completed six or more visits by the anchor date?

Based on the SMART Aim measure results, Amerigroup concluded that the intervention was effective at improving the well-visit rate for members 0–15 months of age and planned to share the PIP results with other high-volume, low-performing providers. HSAG determined that Amerigroup did not provide a sound rationale for the CMO's conclusions about intervention effectiveness. As described previously, the SMART Aim measure was not an appropriate measure for evaluating the complex member outreach coordinator intervention. Amerigroup's summary of findings did not include a discussion of any process measures related to how many members were reached for each of the four components of the intervention (scheduling prior to leaving the office; outreach calls for scheduling, reminder calls, or follow-up for past due/missed well visits). Additionally, the CMO did not discuss the issue of exceeding the SMART Aim goal for the first three months of the year, prior to initiation of the intervention. This result suggests that meaningful improvement occurred prior to the intervention and therefore could not be attributed to the intervention.

Comprehensive Diabetes Care

Amerigroup's goal for the *Comprehensive Diabetes Care* PIP was to identify and test interventions to improve the timely medication refill rate among diabetic members assigned to Absolute Care. The PIP's SMART Aim goal was achieved; however, some but not all of the QI processes could be linked to the improvement; therefore, the PIP was assigned a level of *Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 4-11 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 4-11—SMART Aim Measure Results for *Comprehensive Diabetes Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of diabetic medications for members assigned to Absolute Care that were refilled on time	28.0%	40.0%	55.0%	*Confidence*

The CMO established a goal of improving the timely diabetic medication refill rate for members assigned to Absolute Care by 12 percentage points, from 28.0 percent to 40.0 percent. Three of the monthly SMART Aim measurements exceeded the goal of a timely diabetic medication refill rate of 40 percent. The details of the improvement processes used and the intervention tested are presented in Table 4-12 and in the subsequent narrative description.

Table 4-12—Intervention Testing for *Comprehensive Diabetes Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Clinical practice consultant partnership with Absolute Care	• Provider processes • Patient engagement and education • Member compliance with medication	• No timely communication with practitioner office to request refill before the member runs out of medication • Member did not request refill at pharmacy to allow time to obtain prior to running out of medication • Member did not schedule or keep follow-up office visit for medication evaluation	The CMO provided a sound rationale for abandoning the intervention based on the intervention evaluation results.

The CMO identified one intervention for the PIP: a clinical practice consultant (CPC) partnership with the targeted practice to provide member follow-up for missed appointments and reminders of when diabetic medications were due to be refilled. For the intervention, the Amerigroup CPC identified diabetic members assigned to the targeted primary care provider and worked with the provider and the on-site pharmacy to follow up with members who missed appointments, remind members prior to the scheduled medication refill date, and educate members about the provider's on-site pharmacy and medication delivery options.

The CMO clearly described a methodologically sound data collection process and data sources to track the monthly SMART Aim measure (the monthly percentage of diabetic medication refills for members assigned to the targeted PCP that were refilled with "no gap in fill"). The CMO partnered with the

targeted PCP to complete a manual tracking tool and used real-time pharmacy data to determine the rate of timely medication refills. The CMO also tracked the percentage of medications that were filled with only a one- or two-day gap in fill. Additionally, the CMO tracked and analyzed HbA1c levels of diabetic members assigned to the targeted PCP.

During the testing of the CPC intervention, the rate of timely diabetic medication refills for the targeted group exceeded the goal rate of 40 percent for three monthly measurements, but the rate fluctuated throughout the PIP, with three subsequent monthly measurements falling below the baseline rate. Based on the SMART Aim measure results, the CMO provided a sound rationale for abandoning the intervention.

Member Satisfaction

Amerigroup's goal for the *Member Satisfaction* PIP was to identify and test interventions to improve member satisfaction with the CMO by reducing the need for members to request a new PCP assignment through improved provider information accuracy. The CMO accurately summarized the overall key findings, linking the QI processes to improvement in the SMART Aim measure, but inconsistently documented the number of SMART Aim measurements in the PIP; therefore, the PIP was assigned a level of *Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 4-13 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 4-13—SMART Aim Measure Results for *Member Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The monthly PCP change request call rate	191/1,000 member months	181/1,000 member months	131/1,000 member months	*Confidence*

* The Lowest Rate Achieved is reported for the *Member Satisfaction* PIP's SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

The CMO's SMART Aim statement established a goal of reducing the PCP change request call rate from 191/1,000 member months to 181/1,000 member months. The SMART Aim goal was achieved for six consecutive monthly SMART Aim measurements. A total of eight monthly measurements during the PIP indicated better performance (had rates lower) than the goal of 181 PCP change request calls per 1,000 member months. The details of the improvement processes used and the intervention tested are presented in Table 4-14 and in the subsequent narrative description.

Table 4-14—Intervention Testing for *Member Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Timely updates and corrections to the provider network database	• Identification of high-volume PCPs requested for change to a new PCP. • Provider Data/Information	• Provider does not notify health plan of demographic changes (address/phone/move). • Provider data are correct; however, status is not correct (age range, panel closed but designated open, or open designated closed).	The CMO chose to adopt the intervention based on the intervention evaluation results.

The CMO identified one intervention for the PIP: timely updates to the provider network database with corrected provider information to reduce the member's need to request a PCP change. The intervention entailed timely provider outreach to identify and update provider network participation and demographic information. The CMO's goal was to reduce PCP change requests and delays in care resulting from PCP assignments based on out-of-date provider information. The CMO completed the following steps to test the intervention:

- Generated a monthly report of PCP change request calls to the CMO's National Contact Center.
- Identified PCPs on the change request report with more than 10 change requests.
- Reached out to the identified providers to determine any network participation or demographic changes.
- Updated the provider database to reflect updated provider network participation and demographic information.

The CMO used a methodologically sound data collection process and data sources to evaluate the intervention. Specifically, the CMO used a monthly report generated from the call center database that identified calls for PCP change requests. The CMO tracked the monthly rate of PCP change request calls per 1,000 member months to account for month-to-month shifts in membership volume.

Amerigroup reported that the monthly call rate for PCP change requests was better than the goal rate of 181 calls per 1,000 member months for eight of the months the intervention was tested. There was a spike in the change request call rate in August and September, but the CMO noted several factors (staffing changes, competing projects, etc.) unrelated to the intervention that likely caused the increase. The CMO concluded that the intervention enabled a rapid recovery in the change request call rate, with the rate nearly reaching the goal in October and exceeding the goal in November and December. The CMO chose to adopt the intervention based on the analysis of the findings.

While Amerigroup's *Member Satisfaction* PIP achieved the SMART Aim goal and the QI processes were linked to the demonstrated improvement, minor inaccuracies in the CMO's reporting of overall PIP results led to HSAG assigning the PIP a level of *Confidence.*

Postpartum Care

Amerigroup's goal for the *Postpartum Care* PIP was to identify and test interventions to improve the postpartum visit rate among members who delivered a live birth with an Eagle's Landing Obstetrics/Gynecology (OB/GYN) Associates provider. The PIP's SMART Aim goal was achieved; however, some but not all of the QI processes could be linked to the demonstrated improvement. As a result, the PIP was assigned a level of *Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 4-15 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 4-15—SMART Aim Measure Results for *Postpartum Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of members who completed a postpartum visit with an Eagle's Landing OB/GYN Associates provider 21–56 days after delivering a live birth	67.0%	72.0%	81.0%	*Confidence*

The CMO established a goal of improving the percentage of women who completed a postpartum visit with an Eagle's Landing provider within 21–56 days post-delivery by 5 percentage points, from 67.0 percent to 72.0 percent. Three of the monthly SMART Aim measurements exceeded the goal of 72 percent. The details of the improvement processes used and the intervention tested are presented in Table 4-16 and in the subsequent narrative description.

Table 4-16—Intervention Testing for *Postpartum Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Scheduler incentive program for Eagle's Landing OB/GYN Associates	Provider/scheduler engagement	No appointment being scheduled	The CMO chose to abandon the intervention because testing revealed that it was too resource-intensive to sustain or expand.

The CMO identified one intervention for the PIP: a scheduler incentive program for the targeted obstetrics practice. The incentive program offered a monthly reward of $50 for every 5 percentage points that the

targeted provider's monthly postpartum visit rate exceeded the goal rate. A total of $450 was paid out to the targeted provider during the six months of intervention testing.

To evaluate the intervention, the CMO tracked the monthly percentage of eligible members who completed a postpartum visit within 21–56 days after delivering a live birth with one of the targeted practice providers. The CMO appropriately used the SMART Aim measure to evaluate intervention effectiveness because the scheduler incentive was tested at the practice level and all members delivering to a practice provider would have been impacted by the incentive. To test the intervention, the CMO worked collaboratively with the targeted provider to identify members who had delivered a live birth with one of the targeted practice providers each month, using both internal practice records and claims data. The CMO gave the provider a manual tracking tool that included the eligible members in need of a postpartum visit. Both medical records and claims were used to identify postpartum visits that occurred, to complete the manual tracking tool.

Amerigroup reported that the rate of postpartum visits within 21–56 days among members who delivered with an Eagle's Landing provider fluctuated during the six months of testing, from January through June. Three of the six monthly measurements exceeded the SMART Aim goal of 72.0 percent. Although the SMART Aim goal was exceeded for three monthly measurements, the CMO determined that the intervention process was too resource-intensive for both the CMO and the targeted provider. The process, which required manual tracking by the targeted provider and a hybrid data collection process—reviewing both claims and medical records—was not sustainable.

Provider Satisfaction

Amerigroup's goal for the *Provider Satisfaction* PIP was to identify and test interventions to reduce the percentage of providers who were terminated from the provider network for failure to complete the CMO's provider recredentialing process. Although the SMART Aim goal was achieved, the CMO's QI processes could not be clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 4-17 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved (lower is better) for the SMART Aim measure.

Table 4-17—SMART Aim Measure Results for *Provider Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The monthly percentage of providers who were terminated from the Amerigroup provider network because of failure to complete the recredentialing process	32.0%	28.8%	6.0%	*Low Confidence*

* The Lowest Rate Achieved is reported for the *Provider Satisfaction* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

The CMO established a goal of reducing the percentage of providers terminated from the network because of recredentialing issues by 3.2 percentage points (10 percent), from 32.0 percent to 28.8

percent. The SMART Aim measure (an inverse measure, where lower is better) indicated better performance than the goal rate of 28.8 percent for 10 of the PIP's monthly measurements. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 4-18 and in the narrative description below.

Table 4-18—Intervention Testing for *Provider Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Provider outreach	Provider Awareness	Provider does not receive termination letter	The CMO based its decision to adopt the intervention on the analysis of findings and conclusions, which indicated that the intervention was successful at positively impacting the SMART Aim measure.

The CMO identified one intervention for the PIP: outreach to providers who were due for recertification. The outreach included information on the recredentialing process and the consequences of not meeting the recredentialing deadline (termination from the provider network). The CMO's provider relations representatives reached out to identified providers by phone and email to ensure that the providers were aware of the need to complete the recredentialing process and the consequences of failing to do so (termination from the provider network). The outreach also allowed the CMO to determine why the provider had not submitted the recredentialing application.

Based on Amerigroup's PIP documentation, the CMO did not select an appropriate data collection process and data sources to evaluate the effectiveness of the intervention. The CMO reported that the monthly rate of providers terminated for failure to complete the recredentialing process was used to measure effectiveness. While the CMO also tracked the number of providers who were identified for the outreach intervention, the CMO did not report the percentage of providers who received the intervention or whether those who received the intervention successfully completed the recredentialing process. The CMO should have tracked and reported the number of office managers and providers who were reached by phone or email. Without this information, the evaluation data collection process did not link receiving the outreach intervention to the recredentialing outcome; therefore, the CMO could not directly measure the impact of the intervention on the SMART Aim measure.

In addition to the flaws in the intervention evaluation design, HSAG identified gaps in Amerigroup's interpretation of overall SMART Aim measure results. While the CMO accurately summarized the improvement in the annual rate of provider terminations due to recredentialing from 2014 to 2015, the CMO did not discuss the trends in the monthly SMART Aim measurements. Because the SMART Aim measure had better rates than the goal prior to initiation of the intervention, the CMO's interpretation of results should have included consideration of factors other than the intervention that may have impacted the SMART Aim measure.

The CMO based its decision to adopt the intervention on the analysis of findings and conclusions. The findings and conclusions indicated that the intervention was successful at positively impacting the SMART Aim measure.

Amerigroup did not use an appropriate intervention evaluation design and did not accurately interpret the overall key PIP findings; therefore, the rationale provided for adopting the intervention was not sound.

Strengths and Weaknesses

This was the second year that Amerigroup submitted PIPs for validation using the rapid cycle PIP framework. For Amerigroup's eight PIPs, HSAG assigned a level of *Confidence* to three PIPs and a level of *Low Confidence* to the remaining five PIPs. HSAG did not assign a level of *High Confidence* for any of the PIPs. Amerigroup reported that the SMART Aim goal was achieved for each PIP; however, the PIP documentation did not clearly link all of the QI processes to the demonstrated improvement in each PIP.

Amerigroup's performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing the rapid cycle PIP process. Some of the PIPs, such as the *Annual Dental Visits* PIP, had documentation flaws and inconsistencies across the five PIP modules. For other PIPs, such as the *Bright Futures* PIP, the CMO executed complex, multi-component interventions but failed to design appropriate PDSA cycles that could measure and evaluate the impact of the various intervention components. Without accurate documentation and well-designed, well-executed PDSA cycles, the CMO was unable to achieve a *High Confidence* level for any of its 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 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. HSAG recommends the following for Amerigroup:

- Ensure detailed, accurate, and consistent documentation of the SMART Aim statement, SMART Aim measure definition, and baseline and goal rates to ensure consistency across all modules.
- Institute centralized oversight of the data analysis and results reporting for all PIPs so that all rates are reported accurately and consistently. SMART Aim measure baseline and goal rates, and rate results should be reported to the same number of decimal places for all PIPs. HSAG recommends reporting all PIP rates to one decimal place.
- Revisit and update the key driver diagram and FMEA throughout the improvement process. Each version of the key driver diagram and FMEA should be dated to document when it was last revised.
- As Amerigroup moves through the QI process and conducts additional PDSA cycles, the CMO's PIP team should ensure that it is communicating Amerigroup's theory about changes that will lead to

improvement. Without a common understanding of the theory, the CMO's PIP team may be working on changes for various perceived reasons.

- As Amerigroup tests new interventions, the CMO should ensure that it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep everyone involved in the project focused on the theory for improvement.
- Incorporate detailed, process-level data into the intervention evaluation plan to further the CMO's understanding of intervention effects.
- Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- When planning to test an intervention with multiple steps or components, consider staggering the initiation of the individual steps or components so that the impact of each step or component can be distinguished. A staggered approach to intervention testing may require shorter data collection intervals so that the multiple intervention components can be introduced and tested within the life of the PIP.
- When planning a test of change, Amerigroup should think proactively (future tests and implementation).
- Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the current year's rates as compared to last year's rates. Some performance measures include multiple indicators; therefore, some measures may have more than one rate reported. For purposes of this report, measure and measure indicator rates have been evaluated separately and are generally referred to as "rates."

The performance targets reflect the DCH-established performance targets for CY 2015. 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

Within the Access to Care measure set, seven measures yielded 17 individual rates. Of those 17, DCH established CY 2015 performance targets for seven rates. Amerigroup's Access to Care performance measure results are shown in Table 4-19.

Table 4-19—Amerigroup Access to Care Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.00%	96.61%	↔	NC
25 Months–6 Years	90.85%	89.42%	↓	NC
7–11 Years	92.99%	92.23%	↓	NC
12–19 Years	90.68%	89.92%	↓	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	79.69%	79.48%	↔	88.52%
Annual Dental Visit				
2–3 Years	47.54%	46.51%	↓	54.20%
4–6 Years	75.89%	75.11%	↓	NC
7–10 Years	78.32%	78.48%	↔	NC
11–14 Years	71.65%	71.85%	↔	NC
15–18 Years	60.07%	60.80%	↔	NC
*19–20 Years**	30.58%	39.47%	↑	34.04%[4]
*Total**	68.78%	68.81%	↔	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total	52.57%	36.94%	↓	43.48%
Engagement of AOD Treatment—Total	12.84%	8.23%	↓	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.00%	↔	NC
Colorectal Cancer Screening				
Colorectal Cancer Screening	^	45.24%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	66.51%	71.46%	↔	85.23%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members ages 19–21 years rather than 19–20 years.

** Due to changes in the technical measure specifications, where the CY 2014 measure included members ages 2–21 years and CY 2015 included members ages 2–20 years, use caution when comparing rates for this measure between CY 2014 and 2015 and to performance targets.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

^ indicates that this is a newly reported rate for CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Access to Care measure set, one of the seven rates with a performance target for CY 2015, *Annual Dental Visit—19–20 Years*, met or exceeded the target and also demonstrated statistically significant improvement when compared to CY 2014. However, caution should be exercised when comparing the CY 2015 rate for the *Annual Dental Visit—19–20 Years* measure to the performance target and to the previous CY 2014 rates due to changes to the technical measure specifications. In CY 2014, the measure included members between the ages of 19 and 21, while the CY 2015 measure included members between the ages of 19 and 20. Additionally, the CY 2015 performance target was derived from the HEDIS 2014 percentiles, which included members between the ages of 19 and 21.

Of the remaining six rates that did not meet the performance targets, four rates demonstrated a statistically significant decline from CY 2014 to CY 2015, including *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*, *Annual Dental Visit—2–3 Years*, and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total.* Additionally, three rates that did not have established performance targets also demonstrated a statistically significant decline since CY 2014.

Children's Health

Within the Children's Health measure set, 12 measures yielded 16 individual rates. Of those 16, DCH established CY 2015 performance targets for 15 rates. Amerigroup's Children's Health performance measure results are shown in Table 4-20.

Table 4-20—Amerigroup Children's Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	65.97%	68.52%	↔	67.98%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.84%	73.04%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	53.01%	56.02%	↔	53.47%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	79.12%	76.16%	↔	80.30%
Combination 6	43.39%	39.35%	↔	59.37%
Combination 10	38.05%	35.42%	↔	38.94%
Lead Screening in Children				
Lead Screening in Children	78.70%	80.09%	↔	75.34%
Appropriate Testing for Children with Pharyngitis				

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Appropriate Testing for Children with Pharyngitis	80.92%	82.38%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	80.20%	90.49%	↑	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	54.40%	67.75%	↑	45.86%
Counseling for Nutrition—Total	58.80%	63.57%	↔	60.58%
*Counseling for Physical Activity—Total**	53.47%	56.84%	↔	46.30%
Developmental Screening in the First Three Years of Life				
Total	38.19%	48.38%	↑	46.36%
Percentage of Eligibles Who Received Preventive Dental Services				
Percentage of Eligibles Who Received Preventive Dental Services	53.21%	52.34%	↓	58.00%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	^	24.81%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	85.92%	86.82%	↑	86.11%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

^ indicates that this is a newly reported rate for CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Children's Health measure set, 10 of the 15 rates with performance targets for CY 2015 met or exceeded the targets. Furthermore, four of these rates demonstrated statistically significant improvement from CY 2014 to CY 2015, including *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td), Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Developmental Screening in the First Three Years of Life—Total,* and *Appropriate Treatment for Children with Upper Respiratory Infection.*

Of the five remaining rates that did not meet performance targets, the *Percentage of Eligibles Who Received Preventive Dental Services* rate fell below the 2015 performance target and represented a statistically significant decline from CY 2014. While the *Appropriate Testing for Children with Pharyngitis* rate did not meet its performance target, the rate demonstrated statistically significant improvement from CY 2014.

Women's Health

Within the Women's Health measure set, 12 measures yielded 13 individual rates. Of those 13, DCH established CY 2015 performance targets for 11 rates. Amerigroup's Women's Health performance measure results are shown in Table 4-21. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex; Cesarean Delivery Rate, Uncomplicated; Percentage of Live Births Weighing Less Than 2,500 Grams;* and *Elective Delivery.*

Table 4-21—Amerigroup Women's Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	66.40%	64.49%	↔	76.64%
Breast Cancer Screening				
Breast Cancer Screening	69.04%	67.84%	↔	71.35%
Chlamydia Screening in Women				
Total	56.96%	53.71%	↓	54.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	19.72%	29.17%	↑	23.62%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.02%	78.09%	↔	89.62%
Postpartum Care	62.94%	64.10%	↔	69.47%
Cesarean Section for Nulliparous Singleton Vertex[4]				
Cesarean Section for Nulliparous Singleton Vertex	NR	NR	NT	18.08%
Cesarean Delivery Rate, Uncomplicated[4]				
Cesarean Delivery Rate, Uncomplicated	28.59%	21.59%	↑	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[4]				
Percentage of Live Births Weighing Less Than 2,500 Grams	8.87%	9.34%	↔	8.02%

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	4.57%	11.00%	↑	NC
Elective Delivery[4]				
Elective Delivery	NR	NR	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	NR	NR	NT	NC
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	48.02%	49.65%	↔	60.10%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that Cesarean Section for Nulliparous Singleton Vertex, Elective Delivery, and Antenatal Steroids received the NR designation for the audit results. The CMO used a software vendor to produce the denominator for these measures; however, the vendor was not able to identify the gestational age using administrative data, which resulted in false positives in the denominator. Since the gestational age was not determined prior to drawing the sample, the rate was considered materially biased and an audit result of Not Reportable was assigned.

Within the Women's Health measure set, two of the 11 rates with performance targets for CY 2015 were not reportable. Of the remaining nine reportable rates, two rates met or exceeded the performance targets, *Human Papillomavirus Vaccine for Female Adolescents* and *Cesarean Delivery Rate, Uncomplicated*. Additionally, both of these rates demonstrated statistically significant improvement when compared to CY 2014. Although the *Behavioral Health Risk Assessment for Pregnant Women* rate did not have an established performance target, this measure demonstrated statistically significant improvement when compared to CY 2014.

Of the remaining seven rates reported that did not meet the performance targets, only the *Chlamydia Screening in Women—Total* rate demonstrated a statistically significant decline from CY 2014.

Chronic Conditions

Within the Chronic Conditions measure set, eight measures yielded 15 individual rates. Of those 15, DCH established CY 2015 performance targets for 10 rates. Amerigroup's Chronic Conditions performance measure results are shown in Table 4-22. Note that a lower rate is better for the following

performance measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0), Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months), Asthma in Younger Adults Admission Rate (Per 100,000 Member Months), Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months),* and *Heart Failure Admission Rate (Per 100,000 Member Months).*

Table 4-22—Amerigroup Chronic Conditions Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care*				
Hemoglobin A1c (HbA1c) Testing	85.37%	88.35%	↔	87.59%
HbA1c Poor Control (>9.0%)[4]	58.54%	53.22%	↔	44.69%
HbA1c Control (<8.0%)	35.02%	38.96%	↔	46.43%
HbA1c Control (<7.0%)	25.21%	28.93%	↔	36.27%
Eye Exam (Retinal) Performed	46.86%	49.74%	↔	54.14%
Medical Attention for Nephropathy	76.66%	92.87%	↑	80.05%
Blood Pressure Control (<140/90 mm Hg)	36.93%	50.78%	↑	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]				
Diabetes Short-Term Complications Admission Rate	14.87	13.46	NT	--
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]				
Asthma in Younger Adults Admission Rate	7.39	4.42	NT	--
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]				
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	37.71	30.22	NT	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	69.01%	79.07%	↔	74.94%
Bronchodilator	70.42%	83.72%	↑	83.82%
Cardiovascular Conditions				
Heart Failure Admission Rate (Per 100,000 Member Months)[4]				
Heart Failure Admission Rate	6.44	4.11	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	29.07%	42.72%	↑	56.46%
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	93.75%	NT	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this year's technical report.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Chronic Conditions measure set, three of the 10 rates with a performance target for CY 2015 met or exceeded the targets: *Comprehensive Diabetes Care—Hemoglobin A1c (HbA1c) Testing* and *Medical Attention for Nephropathy*, and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid*. Additionally, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* rate demonstrated statistically significant improvement from CY 2014 to CY 2015. However, caution should be exercised when comparing rates for the *Comprehensive Diabetes Care* measure from CY 2014 to CY 2015 due to changes to the technical measure specifications.

The *Pharmacotherapy Management of COPD Exacerbation—Bronchodilator* rate was only 0.1 percentage points below the CY 2015 performance target, and the rate also demonstrated statistically significant improvement when compared to CY 2014.

Behavioral Health

Within the Behavioral Health measure set, six measures yielded nine individual rates. Of those nine, DCH established CY 2015 performance targets for seven rates. Amerigroup's Behavioral Health performance measure results are shown in Table 4-23.

Table 4-23—Amerigroup Behavioral Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	45.04%	46.42%	↔	53.03%
Continuation and Maintenance Phase	59.36%	61.59%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	51.01%	50.40%	↔	63.21%

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
30-Day Follow-Up	70.29%	67.73%	↔	80.34%
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.99%	57.03%	↑	54.31%
Effective Continuation Phase Treatment	31.83%	39.89%	↑	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.33%	2.34%	↔	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	44.57%	40.57%	↔	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	3.26%	2.82%	↔	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Behavioral Health measure set, two of the seven rates with a performance target for CY 2015 met or exceeded their performance targets, *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Antidepressant Medication Management—Effective Continuation Phase Treatment*. Moreover, both rates demonstrated statistically significant improvement from CY 2014.

Of the remaining five rates that did not meet performance targets, the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* rate fell below its target by more than 20 percentage points. However, for CY 2015, updates to the technical specifications extended the index prescription start date by three months. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure.

Medication Management

Within the Medication Management measure set, two measures yielded 13 individual rates. Of those 13, DCH established CY 2015 performance targets for four rates. Amerigroup's Medication Management performance measure results are shown in Table 4-24.

Table 4-24—Amerigroup Medication Management Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	88.67%	88.67%	↔	88.00%
Annual Monitoring for Members on Diuretics	89.47%	88.14%	↔	87.90%
Total	88.86%	88.32%	↔	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	47.33%	53.31%	↑	NC
Medication Compliance 50%—Ages 12–18 Years	42.68%	50.69%	↑	NC
Medication Compliance 50%—Ages 19–50 Years	50.00%	53.25%	↔	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 50%—Total	45.73%	52.54%	↑	NC
Medication Compliance 75%—Ages 5–11 Years	21.27%	27.16%	↑	32.32%
Medication Compliance 75%—Ages 12–18 Years	19.60%	24.22%	↑	NC
Medication Compliance 75%—Ages 19–50 Years	21.43%	33.73%	↑	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 75%—Total	20.80%	26.58%	↑	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Medication Management measure set, three of the four rates with performance targets for CY 2015 met or exceeded the targets: *Annual Monitoring for Patients on Persistent Medications—Annual Monitoring for Members on ACE Inhibitors or ARBs*, *Annual Monitoring for Members on Diuretics*, and *Total*. Additionally, six measures without established performance targets demonstrated statistically significant improvement since CY 2014.

While the *Medication Management for People With Asthma— Medication Compliance 75%—Ages 5–11 Years* rate was the only rate with a performance target that was not met, the rate demonstrated statistically significant improvement from CY 2014.

Utilization

Within the Utilization measure set, four measures yielded 21 individual rates. Of those 21, DCH established CY 2015 performance targets for one rate. Amerigroup's Utilization measure results are shown in Table 4-25. Note that lower rates are better for the *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total* and *Plan All-Cause Readmission Rate* measures. Significance testing was not performed on the Utilization measure set since variances are not reported to NCQA.

Table 4-25—Amerigroup Utilization Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	56.83	56.35	NT	52.31
Outpatient Visits—Total	314.23	306.89	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	3.42	3.36	NT	NC
Total Inpatient—Average Length of Stay—<1 Year	9.45	8.05	NT	NC
Medicine—Average Length of Stay—Total	3.62	3.54	NT	NC
Medicine—Average Length of Stay—<1 Year	4.80	4.59	NT	NC
Surgery—Average Length of Stay—Total	7.96	7.44	NT	NC
Surgery—Average Length of Stay—<1 Year	19.65	16.53	NT	NC
Maternity—Average Length of Stay—Total	2.70	2.77	NT	NC
Mental Health Utilization—Total				
Any Service—Total—Total	9.14%	9.69%	NT	NC
Inpatient—Total—Total	0.52%	0.54%	NT	NC
Intensive Outpatient or Partial Hospitalization—Total—Total	0.14%	0.14%	NT	NC
Outpatient or ED—Total—Total	9.04%	9.59%	NT	NC
Plan All-Cause Readmission Rate[4]				
Age 18–44	^	11.26%	NT	NC
Age 45–54	^	17.07%	NT	NC
Age 55–64	^	6.58%	NT	NC
Age 18–64—Total	^	12.11%	NT	NC
Age 65–74	^	NA	NT	NC
Age 75–84	^	NA	NT	NC

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Age 85 and Older	^	NA	NT	NC
Age 65 and Older—Total	^	NA	NT	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

^ indicates that this is a newly reported rate for CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Utilization measure set, the only rate with a performance target for CY 2015, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total*, did not meet the performance target.

Health Plan Descriptive Information

Amerigroup's Health Plan Descriptive Information measure results are shown in Table 4-26.

Table 4-26—Amerigroup Health Plan Descriptive Information Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.32%	10.70%	⇔	NC
1–12 Weeks	7.35%	13.68%	↑	NC
13–27 Weeks	57.47%	52.53%	↓	NC
28+ Weeks	16.74%	15.03%	↓	NC
Unknown	8.11%	8.06%	⇔	NC
Race/Ethnicity Diversity of Membership				
Total—White	46.67%	47.41%	↑	NC
Total—Black or African American	44.67%	44.87%	⇔	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ indicates a statistically significant rate increase between CY 2014 and CY 2015.

↓ indicates a statistically significant rate decrease between CY 2014 and CY 2015.

⇔ indicates no statistically significant change between CY 2014 and CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Health Plan Descriptive Information rates are presented for information purposes only. HSAG recommends that Amerigroup review these results and identify whether a rate is higher or lower than expected.

Strengths and Weaknesses

The number of performance targets met by Amerigroup is shown in Table 4-27.

Table 4-27—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	7	1	14.29%
Children's Health	15	10	66.67%
Women's Health	9	2	22.22%
Chronic Conditions	10	3	30.00%
Behavioral Health	7	2	28.57%
Medication Management	4	3	75.00%
Utilization	1	0	0.00%
Total	**53**	**21**	**39.62%**

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

Based on Amerigroup's performance in CY 2015, nearly 40 percent of the rates met or exceeded the performance targets overall. Amerigroup's rates met or exceeded a majority of the performance targets in the Medication Management and Children's Health measure sets. Select rates in the Access to Care, Women's Health, Chronic Conditions, and Behavioral Health measure sets also met or exceeded performance targets. HSAG has highlighted specific strengths and areas for improvement below.

Amerigroup's greatest strength was in the management of medication for members. As illustrated in the table above, Amerigroup met or exceeded 75 percent of the performance targets within the Medication Management measure set. Additionally, Amerigroup's rates demonstrated statistically significant improvement for seven of the 11 rates within this measure set that were reportable for CY 2015 and comparable to CY 2014 rates. All three rates for the *Annual Monitoring for Patients on Persistent Medications* measure met or exceeded performance targets.

Measures within the Access to Care measure set presented several opportunities for improvement as only one of seven rates met or exceeded the performance measure target for CY 2015, and the remaining rates did not meet the targets. Most notably, Amerigroup's reported rate for *Adult BMI Assessment* was more than 13 percentage points below the CY 2015 performance target. Additionally, seven of the rates demonstrated a statistically significant decline, including three of four rates for the *Children and Adolescents' Access to Primary Care Practitioners* measure, two rates for the *Annual Dental Visit*

measure, and both rates for the *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment* measure.

For the Utilization measure set, only one rate, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total,* was compared to performance targets because most of the rates in this measure set are displayed for information purposes only. Amerigroup's rate for this measure did not meet the performance target, indicating opportunities for improvement related to reducing the number of potentially preventable/avoidable or non-emergent ED visits that could be treated in a primary care setting.

Recommendations for Improvement

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

- Analyze the improvement strategies that can be linked to the overall success within the Medication Management and Children's Health measure sets. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.
- Analyze all performance measure rates that fell below the DCH-required performance target and either implement new PIPs or adjust the focus of existing PIPs as needed.
- Prioritize focusing on performance measures that demonstrated a statistically significant decline, such as access to care for children and adolescents and treatment of drug dependence measures.

In addition to the specific recommendations above, Amerigroup should focus efforts on the following measure topics in its QI efforts. The measure topics below were derived based on comparisons to the CY 2015 performance targets.

Access to Care

- Primary care for members 12 to 19 years of age and preventive/ambulatory services for adults
- Annual dental visits for members 2 to 3 years of age
- Treatment for members for alcohol and other drug dependence
- BMI assessments for adults

Children's Health

- Immunizations for children
- Testing for children with pharyngitis
- Preventive dental services for children

Women's Health

- Screenings for cervical cancer, breast cancer, and chlamydia
- Prenatal care and postpartum care
- Live births with low birth weight

Chronic Conditions

- HbA1c control, eye exams, and blood pressure control for members with diabetes
- Timely dispensing of bronchodilators for members with COPD
- Blood pressure control for members with hypertension

Behavioral Health

- Follow-up care for children with ADHD
- Follow-up care for members after hospitalization for mental illness
- Members with schizophrenia who remained on antipsychotic medications

Medication Management

- Appropriate medication management for members with asthma

Utilization

- Emergency department usage

CAHPS Surveys

Findings

To assess Amerigroup's overall performance, 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 2016 NCQA Medicaid national averages.[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 2016 CAHPS

[4-2] Quality Compass® 2016 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 2016 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).

top-box scores to 2016 NCQA Medicaid national data were performed for Amerigroup's adult and child Medicaid populations.[4-3] 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*

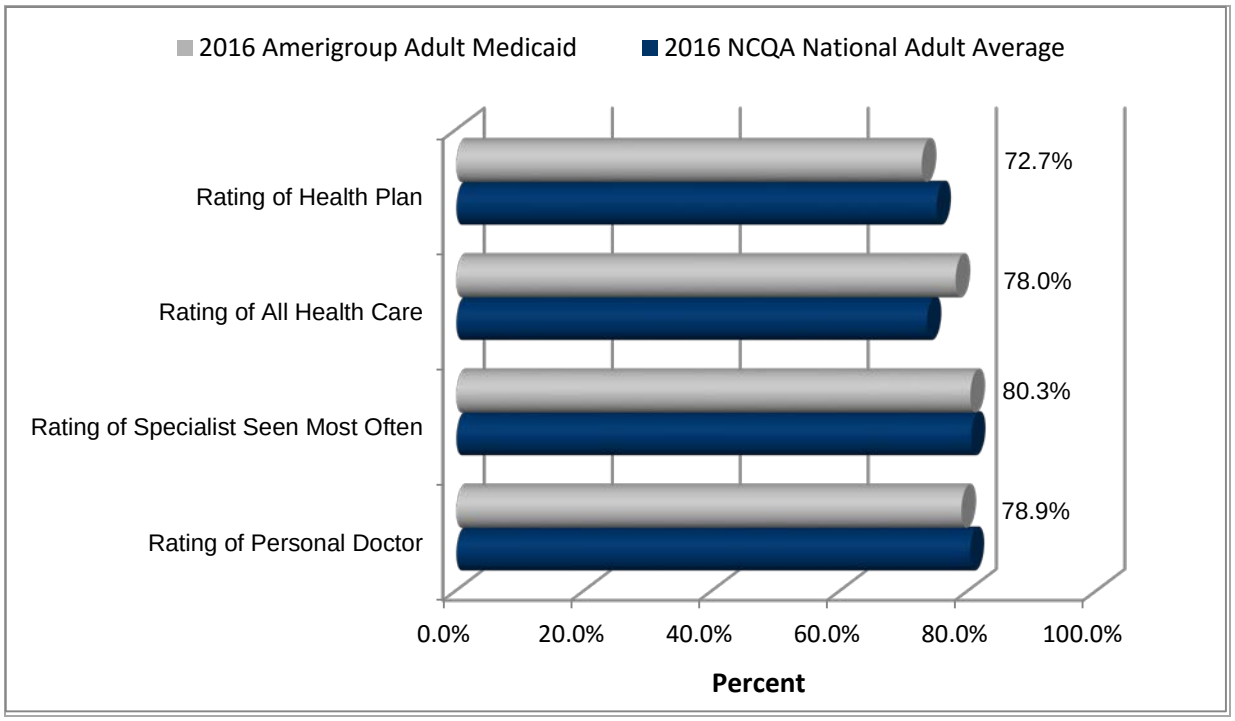
CAHPS Composite Measures

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

[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 reporting purposes.

Figure 4-1 below depicts Amerigroup's adult Medicaid 2016 CAHPS top-box scores and the 2016 NCQA adult Medicaid national average for each of the global ratings. The grey bars represent Amerigroup's top-box scores, and the blue bars represent the 2016 NCQA adult Medicaid national averages.

Figure 4-1—Amerigroup Adult Medicaid CAHPS Survey Results for Global Ratings

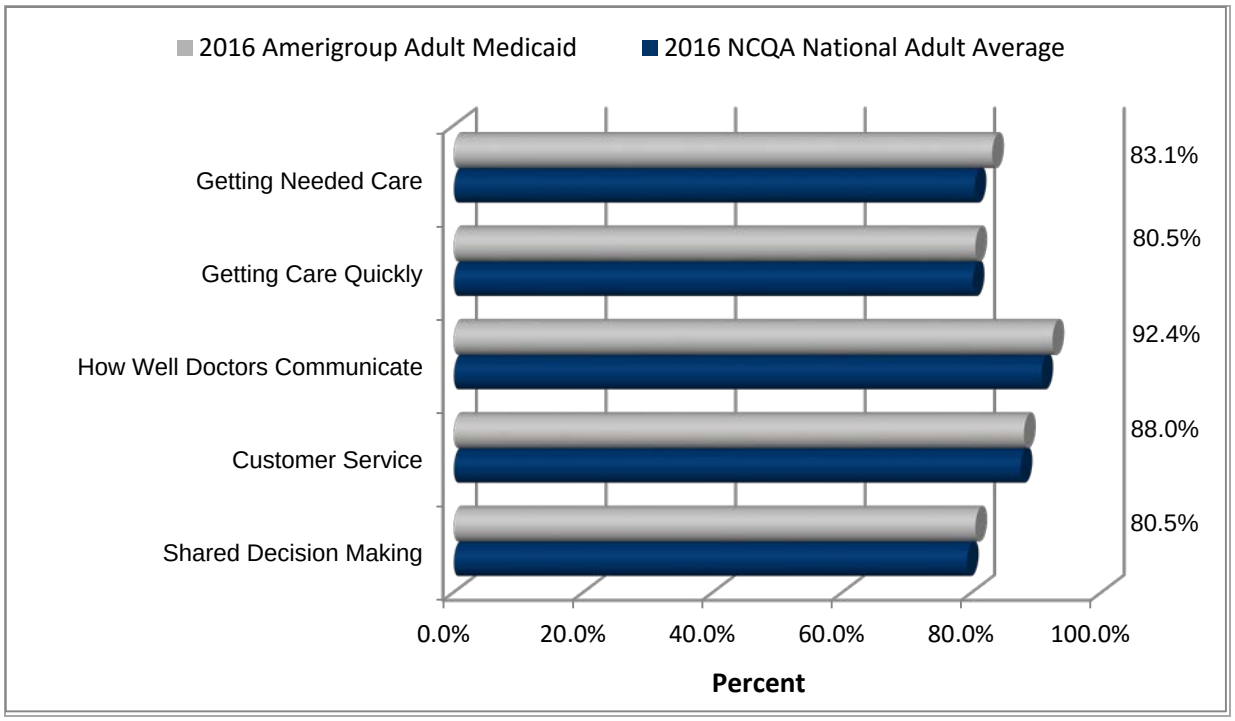


The top-box scores for the adult Medicaid global ratings indicate the following:

- Amerigroup scored between 72 and 81 percent on the four global rating measures.
- Amerigroup scored at or above the 2016 NCQA adult Medicaid national average for one measure, *Rating of All Health Care*.
- Amerigroup scored below the 2016 NCQA adult Medicaid national average for the remaining three measures: *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*.

Figure 4-2 below depicts Amerigroup's adult Medicaid 2016 CAHPS top-box scores and the 2016 NCQA adult Medicaid national average for each of the composite measures. The grey bars represent Amerigroup's top-box scores, and the blue bars represent the 2016 NCQA adult Medicaid national averages.

Figure 4-2—Amerigroup Adult Medicaid CAHPS Survey Results for Composite Measures

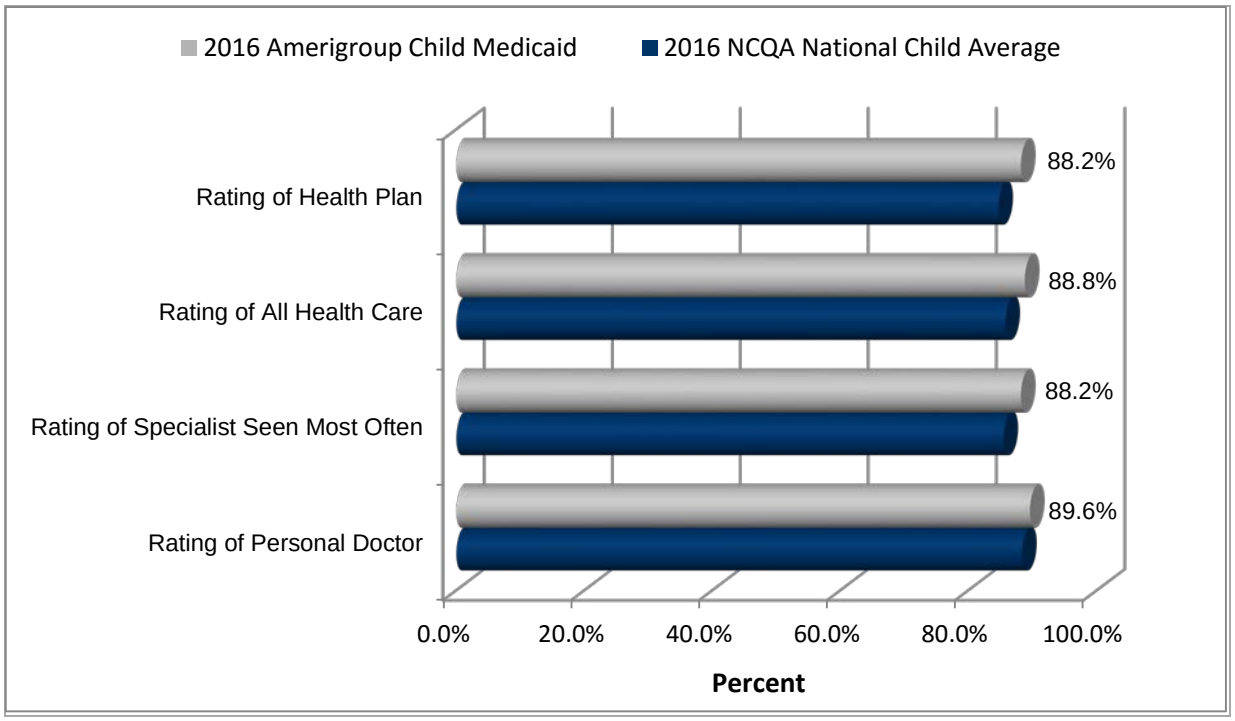


The top-box scores for the adult Medicaid composite measures indicate the following:

- Amerigroup scored between 80 and 93 percent on the five composite measures.
- Amerigroup scored at or above the 2016 NCQA adult Medicaid national average for all five composite measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.

Figure 4-3 below depicts Amerigroup's child Medicaid 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the global ratings. The grey bars represent Amerigroup's top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 4-3—Amerigroup Child Medicaid CAHPS Survey Results for Global Ratings

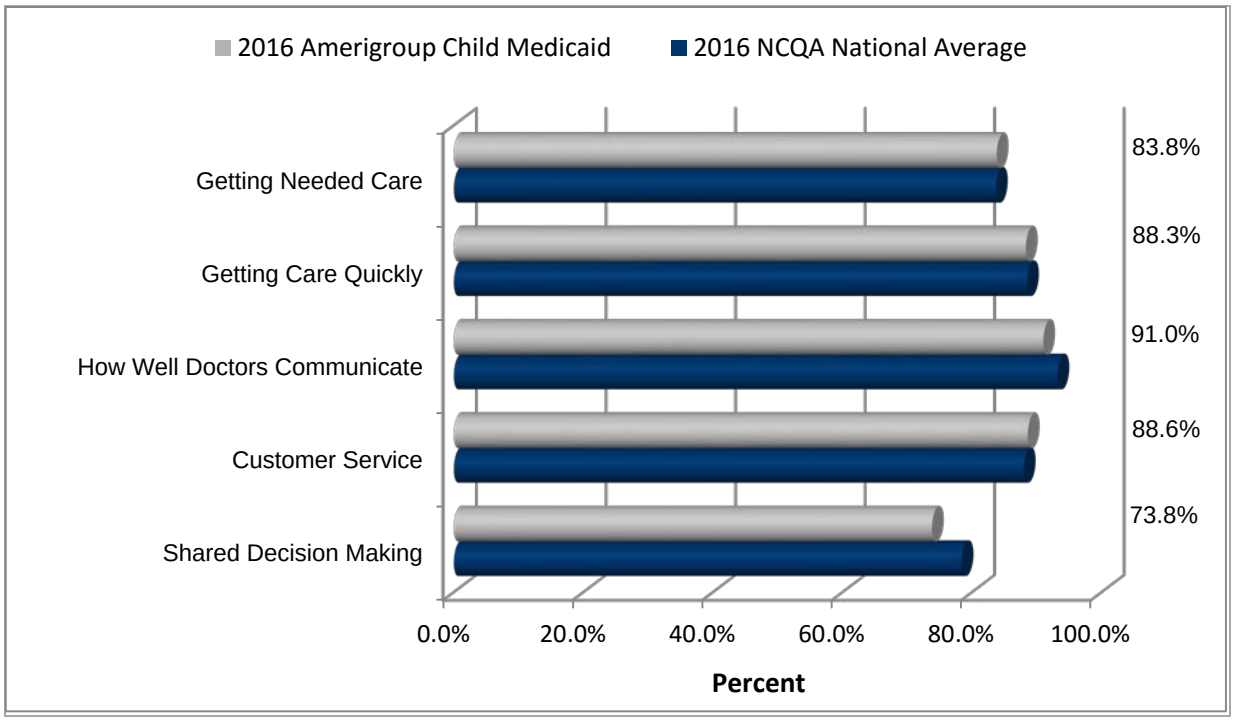


The top-box scores for the child Medicaid global ratings indicate the following:

- Amerigroup scored between 88 and 90 percent on the four global rating measures.
- Amerigroup scored at or above the 2016 NCQA child Medicaid national 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*.

Figure 4-4 below depicts Amerigroup's child Medicaid 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the composite measures. The grey bars represent Amerigroup's top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

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



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

- Amerigroup scored at or between 73 and 91 percent on the five composite measures.
- Amerigroup scored at or above the 2016 NCQA child Medicaid national average for two measures: *Getting Needed Care* and *Customer Service*.
- Amerigroup scored below the 2016 NCQA child Medicaid national average for three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

Strengths and Weaknesses

For Amerigroup's adult Medicaid population, the 2016 top-box rates for three of the CAHPS Survey measures, *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*, were lower than the 2016 NCQA adult Medicaid national average. For the remaining six measures, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*, Amerigroup's 2016 top-box rates were higher than the 2016 NCQA adult Medicaid national averages.

For Amerigroup's child Medicaid population, the 2016 top-box rates for three of the CAHPS Survey measures, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, were lower than the 2016 NCQA child Medicaid national average. For the remaining six 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*, the 2016 top-box rates for the child population were higher than the 2016 NCQA child Medicaid national average.

Recommendations for Improvement

Based on an evaluation of Amerigroup's 2016 adult Medicaid CAHPS Survey results, HSAG recommends that the CMO focus QI initiatives on enhancing members' experiences with *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*, since the rates for these measures were lower than NCQA's 2016 CAHPS adult Medicaid national average. For Amerigroup's child Medicaid population, HSAG recommends that the CMO focus QI initiatives on *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, given that the rates for these measures were below the 2016 NCQA child Medicaid national 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 Medicaid national 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 moderate compliance review results (67.2 percent

of federal and State contract requirements for structure and operations were *Met*) and also demonstrated its commitment to quality process improvement by closing seven of the 12 corrective action plans from the previous year's compliance review.

Conclusions

Overall, Amerigroup's performance results are mixed. Amerigroup implemented processes to demonstrate a foundation for quality, access, and timeliness of care and service delivery. Amerigroup adopted CPGs that were evidence-based, involved provider input, and considered demographic and epidemiological profiles of its population through an analysis of utilization data. Amerigroup continued to build organizational strength in quality improvement (QI) knowledge and training by expanding staff training in the Institute for Healthcare Improvement's (IHI's) Science of Quality Improvement and Lean Six Sigma programs. The CMO also demonstrated active involvement of the chief executive officer, chief medical officer, and executive and senior-level staff in QAPI program activities, including the support of ongoing QI training for staff.

The CMO's QAPI program description and process did not provide a comprehensive roadmap for the organization's priorities for improvement. The QAPI program description should include the timelines and steps the CMO will implement, and provide for sufficient monitoring and tracking of results. Amerigroup's QAPI program description did not fully detail the QI processes the CMO had developed and implemented. For example, the CMO did not provide a comprehensive summary of how the QI goals, objectives, and related initiatives were identified and prioritized; which data were used in the selection process; which interventions were considered (and implemented); how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured in order to provide a comprehensive story of the effectiveness of Amerigroup's QAPI work.

The CMO must continue to implement mechanisms to improve quality, access, and timeliness of care for its members. The CMO should ensure that its methodologies for determining and tracking measureable improvements are sound and can be relied upon to link the success of its interventions to the improved outcome. Amerigroup should also ensure that it integrates a review of related organizational and operational processes as part of its continuous QI efforts.

The results of Amerigroup's performance improvement projects (PIPs) indicate a need for ongoing staff QI training. Performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing the rapid cycle PIP process. For each of the five PIPs, the SMART Aim goal was achieved; however, the QI processes could not be clearly linked to the demonstrated improvement. HSAG recommends ongoing QI training specific to the rapid cycle PIP process to improve results.

HSAG provided recent, formal QI technical assistance to the CMOs in addition to DCH's written guidance and reporting requirements for the CMOs' annual QAPI program evaluation process. Amerigroup should use these tools and request additional process improvement assistance as needed to move its quality program toward success.

Based on Amerigroup's performance in CY 2015, 40 percent of the performance targets were met. Amerigroup should analyze the improvement strategies that can be linked to the overall success within the performance measure sets. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measure sets for which performance was not as strong.

Amerigroup's health information system (HIS) was integrated and supported business intelligence needs. The Amerigroup Management Information System (MIS) included five integrated components, which allowed for the collection, integration, tracking, analysis, and reporting of data. The strength of the CMO's use of the HIS for QI purposes may have contributed to some of its performance measure results. Amerigroup has additional opportunities to use information from its HIS to analyze the improvement strategies that can be linked to the overall success within the Medication Management and Children's Health performance measure sets. In addition, the results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

Although there was evidence of active engagement of CMO staff with members and their families and caregivers, opportunities were missed to collect feedback and input regarding the CMO's QAPI program. The CMO should consider opportunities to seek member and family input in areas where CAHPS survey member experience rates were lower than the Medicaid national average.

5. Peach State Health Plan

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 408,000 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. Peach State provides medical, mental health, vision, dental, and case and disease management services to its enrolled Medicaid and CHIP members, plus a range of enhanced services, including dental and vision services for adults, wellness/prevention programs, and incentives.

Review of Compliance With Standards

Table 5-1 presents the standards and compliance scores for Peach State. For Standards I–III and follow-up on previously noncompliant review findings, HSAG evaluated a total of 59 elements for the SFY 2016 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*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Clinical Practice Guidelines	**11**	**11**	**10**	**1**	**0**	**90.9%**
II	Quality Assessment and Performance Improvement (QAPI)	**32**	**30**	**20**	**10**	**2**	**66.7%**
III	Health Information Systems	**8**	**8**	**8**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**8**	**8**	**5**	**3**	**0**	**62.5%**
	Total Compliance Score	**59**	**57**	**43**	**14**	**2**	**75.4%**

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

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

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

[5-1] Georgia Department of Community Health. Medicaid Management Information System. Georgia Families Monthly Adjustment Summary Report. June 2016.

Findings

Peach State had a total compliance score of 75.4 percent, with one standard scoring 100 percent: Health Information Systems. The Clinical Practice Guidelines standard was noncompliant with one element, and the Quality Assessment and Performance Improvement (QAPI) standard was noncompliant with 10 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. Eight elements were re-reviewed within the following standards: Member Information, Grievance System, and Furnishing of Services. All elements related to Grievance System were *Met* upon reevaluation. Two elements in the Member Information standards and one element in the Furnishing of Services standard 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.

Clinical Practice Guidelines: Peach State adopted preventive guidelines and clinical practice guidelines (CPGs) in conjunction with the Peach State Quality Assessment and Performance Improvement goals and objectives. The CPGs were based on members' health needs and opportunities for improvement identified as part of the QAPI Program. Peach State, under the direction of DCH, implemented a chart review program to audit providers' compliance with the CPGs.

Peach State did not have adequate processes in place to ensure the decisions involving utilization management and coverage of services, made by the CMO's staff, were consistent with the CPGs.

Quality Assessment and Performance Improvement: Peach State used multiple approaches to ensure members received quality healthcare and improved outcomes. The QAPI program evaluation identified areas with highest impact and overall cost on a per-member per-month (PMPM) basis and described interventions—such as incentives, mailings, and phone calls—to maintain or prevent a decline in member health. Peach State coordinated utilization and care management activities with community practitioners. Peach State's executive and management staff were involved in QAPI projects. The QAPI Work Plan included executive and management staff as the accountable person(s) for each standard.

Peach State used the Institute for Healthcare Improvement's (IHI's) Triple Aim as a framework to evaluate the success of the QAPI Program and adopted Lean Six Sigma methodology and Plan-Do-Study-Act (PDSA) processes. Peach State used a Quality Improvement (QI) Work Plan to track QI efforts. Peach State improved its QAPI program description when compared to the previous year. The CMO conducted provider profiling using Centelligence Insight, a web-based reporting and management system, which included advanced capabilities for provider practice pattern and utilization reporting.

Peach State did not have processes to obtain the member's family and guardian input into QAPI activities.

Health Information Systems: Peach State maintained a health information system that was sufficient to support the collection, integration, tracking, analysis, and reporting of data. Peach State used an information system composed of relational and indexed databases to store claims, encounter, and utilization information. The CMO used the Amisys Advanced system as the primary claims system to administer medical claims. Peach State uploaded claims data into a data warehouse, Enterprise Data Warehouse (EDW). EDW was Peach State's proprietary business intelligence and data management platform and was the foundation of its internal and external data integration and reporting capabilities. Peach State developed an interface solution that allowed rapid processing of member, claim, and encounter data from any business partner or subcontractor in any format.

Recommendations for Improvement

Peach State received recommendations for improvement in the Clinical Practice Guidelines and Quality Assessment and Performance Improvement (QAPI) standards. HSAG's specific recommendations for Peach State included the following:

- Implement a process to ensure that decisions involving utilization management and coverage of services, made by the CMO's staff, are consistent with the CPGs.
- Implement processes, in addition to surveys, to obtain the member's family and guardian input into quality management and performance improvement activities.
- Meet all DCH-established performance targets.
- Strengthen its processes for the monitoring, analysis, and evaluation of the delivery, quality, and appropriateness and underutilization of healthcare furnished to members.
- Define members with special healthcare needs and include its method of monitoring, analysis, evaluation, and improvement for the delivery, quality, and appropriateness of healthcare furnished to members with special healthcare needs in its program descriptions and evaluations. Peach State must consider use of data, such as outcome data, to evaluate the quality and appropriateness of care furnished to members, including those with special healthcare needs.
- Update its QAPI program description to describe how it shares QI results and provides feedback to members and providers. Peach State must document the results and feedback that are shared with members and providers, as well as the methods used.
- Develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction.
- Review all quality of care concerns, even those that are referred to and are being reviewed by another entity, such as a hospital. Peach State must make its own quality of care determination, refer to its peer review process, and report to boards and regulatory agencies, as appropriate, as a result of its internal investigation process.

- Update its Patient Safety Plan and other documents to clearly state how incidents and the final disposition of grievances, QI cases, and peer review results are included in the provider profile.

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

- Peach State must update its Distribution of Member Handbook Policy to state that it notifies existing members annually that the member handbook is available online and a hard copy is available upon request.
- Peach State must update the Distribution of Member Materials policy and procedure to reflect the CMO's practice regarding how it will inform members of the availability of the provider directory.
- Peach State must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies. Peach State must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.

Performance Improvement Projects

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. Peach State followed the rapid cycle PIP methodology as identified by HSAG in the Companion Guide sent to the CMO in January 2015. 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 the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving improved outcomes.

Findings

For each PIP, Peach State was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. Peach State developed a SMART Aim statement that quantified the improvement sought for each PIP and used a process map and FMEA to identify one or more interventions that had the potential to impact the SMART Aim goal.

HSAG organized and analyzed Peach State's PIP data to draw conclusions about the CMO's QI efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal. Table 5-2 outlines the PIP topics, final CMO-reported SMART Aim statements, and the overall validation findings for the eight PIPs.

HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation 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*. If the CMO did not execute the PIP according to the approved SMART Aim measure methodology, a confidence level was not assigned because HSAG determined that the reported PIP results were not credible.

Table 5-2—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement	Confidence Level
Annual Dental Visits	By September 30, 2015, increase the percentage of adolescents between ages 15–18 years old in Muscogee County who are eligible for and receive a preventive dental visit from 61.64% to 64.64%	*Reported PIP results were not credible*
Appropriate Use of ADHD Medications	By December 31, 2015, Peach State Health Plan aims to increase the 30-day follow-up rate from 42.94% to 45.50% among children 6–12 years old with a fill for newly prescribed ADHD medication in the Atlanta region	*Low Confidence*
Avoidable Emergency Room Visits	Decrease the avoidable emergency department utilization rate among members ages 0–20 at Hughes Spalding Hospital from 39.1% to 34.5% by December 31, 2015	*Low Confidence*
Bright Futures	Increase the percentage of adolescents 14–18 years old assigned to Dr. Dennis-Smith in Fulton County who are eligible for and receive a preventive health visit from 20.83% to 23.83% by December 31, 2015	*Low Confidence*
Comprehensive Diabetes Care	By December 31, 2015, PSHP aims to increase the percent of completed annual dilated eye exams from 42% to 56% for adult noncompliant diabetic members, ages 18 to 75 residing in DeKalb and Fulton counties who are continuously enrolled for 12 months	*Low Confidence*
Member Satisfaction	By December 31, 2015, PSHP aims to increase the percentage of members in the Atlanta Region who complete the survey from 73% to 80%	*Reported PIP results were not credible*
Postpartum Care	By December 31, 2015, increase the PPCV [postpartum care visit] rate occurring between 21–56 days following a birth event for women under the care of Dourron OB/GYN Associates delivering at DeKalb Medical Center, from 60.0% to 65.0%	*Confidence*
Provider Satisfaction	Peach State aims to reduce the prior-authorization turnaround time for ENT of Georgia from 8.4 days to 6.3 days by December 31, 2015	*Confidence*

HSAG determined a level of *Confidence* in the results of two of Peach State's eight PIPs, *Postpartum Care* and *Provider Satisfaction*. A level of *Confidence* was assigned to the two PIPs because the SMART Aim goal was achieved, and some but not all of the CMO's QI processes could be linked to the demonstrated improvement.

HSAG assigned a level of *Low Confidence* for four of the CMO's eight PIPs: *Appropriate Use of ADHD Medications*, *Avoidable Emergency Room Visits*, *Bright Futures*, and *Comprehensive Diabetes Care*. The SMART Aim goal was not achieved for the *Appropriate Use of ADHD Medications* PIP but was achieved for the remaining three PIPs that were assigned a level of *Low Confidence*; however, the QI processes in those three PIPs were not clearly linked to the demonstrated improvement.

HSAG determined that for two of Peach State's PIPs, *Annual Dental Visits* and *Member Satisfaction*, the CMO's reported PIP results were not credible. For the *Annual Dental Visits* PIP, the CMO did not use the approved methodology for the SMART Aim measure and instead reported a cumulative rate that was plotted on the SMART Aim run chart. For the *Member Satisfaction* PIP, the CMO reported that it chose to modify the SMART Aim statement, including the SMART Aim measure, and SMART Aim goal. The focus of the PIP was changed from improving member satisfaction survey results (percentage of overall satisfaction survey question responses with a score of "Always") to improving the member satisfaction survey response rate (percentage of member surveys completed).

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 the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

Annual Dental Visits

Peach State's goal for the *Annual Dental Visits* PIP was to identify and test interventions to improve the preventive dental visit rate among members 15 to 18 years old living in Muscogee County. The CMO did not use the approved methodology for the SMART Aim measure and instead reported that a cumulative rate was plotted on the SMART Aim run chart; therefore, the reported PIP results were not credible.

The details of the PIP's performance leading to the assigned confidence level are described below.

Table 5-3 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 5-3—SMART Aim Measure Results for *Annual Dental Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 15 to 18 years of age in Muscogee County that completed a preventive dental visit	61.6%	64.6%	70.3%	*Reported PIP results were not credible*

The CMO established a goal of improving the preventive dental visit rate for members 15 to 18 years of age living in Muscogee County by 3 percentage points, from 61.6 percent to 64.6 percent. Although the SMART Aim measure exceeded the goal of 64.6 percent, the CMO's use of an unapproved cumulative rate for the SMART Aim measurement methodology invalidated the SMART Aim measurement results; therefore, meaningful evidence of achieving the goal was not provided. The details of the improvement processes used and the interventions tested are presented in Table 5-4 and in the narrative description below.

Table 5-4—Intervention Testing for *Annual Dental Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Teen Smart webpage	Member awareness/education	Member and parent/guardian may not think preventive visits are important	The CMO chose to abandon the Teen Smart webpage intervention due to the low number of visits to the webpage and the lack of response to the member survey about the webpage.
Teen Smart member incentive	Members schedule/keep appointment for preventive dental visits	Inconvenience of appointment	The CMO chose to abandon the Teen Smart member incentive intervention based on the low enrollment rate and the low preventive dental visit rate.

The CMO identified two interventions to test: the Teen Smart webpage and the Teen Smart member incentive. The purpose of the Teen Smart webpage was to educate teen members and increase awareness about the importance of preventive dental visits. The CMO designed the webpage to attract teenage members and included health and dental information and educational links on the importance of preventive dental visits. The purpose of the Teen Smart member incentive was to motivate teen members to schedule and complete a preventive dental visit. The incentive program offered eligible members who joined the Teen Smart program a $20 gift card for completing a preventive dental visit.

Peach State did not use a methodologically sound process for evaluating the effectiveness of the Teen Smart webpage. The CMO used a telephone survey of members to evaluate member response to the Teen Smart webpage. Survey responses were not linked to whether the member scheduled or attended a preventive dental visit. The CMO did not describe a data collection process for monitoring how many members who viewed the webpage subsequently scheduled or attended a preventive dental visit; therefore, the measurement methodology could not be used to demonstrate the impact of the intervention on the rate of preventive dental visits. Although the CMO could track the number of times the webpage was viewed, there was no way to determine who was viewing the webpage or whether viewing the webpage resulted in a completed preventive dental visit. Ultimately, Peach State chose to abandon the intervention because of the low number of webpage visits and the lack of response to the member survey.

Peach State used a methodologically sound process for evaluating the effectiveness of the Teen Smart member incentive. The CMO's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) coordinators collected data via telephone from members who enrolled in the Teen Smart Program and used a manual tracking tool to record which members were sent the $20 gift card incentive for completing a preventive dental visit. By tracking individual members who were eligible for the incentive to determine whether they completed a preventive dental visit, Peach State was able to determine the true impact of the incentive on the PIP results. The member incentive evaluation results showed that only 7 (0.9 percent) of 764 eligible teenage members in Muscogee County joined the Teen Smart program, completed a preventive dental visit, and submitted documentation to receive the gift card incentive. Based on the low enrollment rate and the low preventive dental visit rate among eligible members, Peach State chose to abandon the intervention, concluding that the Teen Smart program did not motivate adolescent members to complete a preventive dental visit.

Appropriate Use of ADHD Medications

Peach State's goal for the *Appropriate Use of ADHD Medications* PIP was to identify and test interventions to improve the 30-day follow-up appointment compliance rate among members 6–12 years of age in the Atlanta region who received an initial ADHD medication prescription. The SMART Aim goal was not achieved during the life of the PIP; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 5-5 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 5-5—SMART Aim Measure Results for *Appropriate Use of ADHD Medications*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children 6 to 12 years of age in the Atlanta region with a newly prescribed ADHD medication during the measurement month that had a follow-up care visit within 30 days of the ADHD medication being dispensed	42.9%	45.5%	44.1%	*Low Confidence*

The CMO established a goal of improving the ADHD medication follow-up visit rate among members 6 to 12 years old in the Atlanta region, from 42.9 percent to 45.5 percent. None of the PIP's monthly SMART Aim measurements met the goal rate of 45.5 percent. The details of the improvement processes used and the interventions tested are presented in Table 5-6 and in the subsequent narrative description.

Table 5-6—Intervention Testing for *Appropriate Use of ADHD Medications*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Reminder outreach calls to members	Member education	Member forgets to attend the scheduled medication follow-up appointment	The CMO provided a data-driven rationale for the decision to abandon the intervention.

The CMO identified one intervention to test for the PIP: reminder outreach calls to members. To carry out the intervention, the CMO identified eligible members through pharmacy claims data. Automated proactive outreach manager (POM) calls were placed to eligible members, offering a recorded message about the importance of attending follow-up appointments and providing an opportunity to speak with a clinical staff member for additional information and assistance with such issues as scheduling an appointment or arranging transportation for the appointment.

Peach State's data collection process for evaluating intervention effectiveness relied on medical claims data to determine the numerator (number of eligible members who completed a follow-up visit within 30 days) for each monthly measurement. The CMO clearly documented intervention-specific evaluation data in table format and provided an accurate interpretation of the data provided; however, the monthly rates relied on claims data, and the CMO did not provide a thorough discussion of how claims lag impacted the monthly measurements during intervention testing. In general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because of the lag-time associated with claims completeness.

In addition to plotting monthly rates on a run chart, the CMO also analyzed the follow-up visit rate among members who received the intervention and those who did not. The CMO chose to abandon the intervention because the members who received the reminder outreach calls did not have a higher follow-up visit rate. Based on the analysis of intervention evaluation results, the CMO concluded that the intervention was not effective at improving the ADHD medication follow-up visit rate.

Avoidable Emergency Room Visits

Peach State's goal for the *Avoidable Emergency Room Visits* PIP was to identify and test interventions to reduce the avoidable ER visit rate at Hughes Spalding Hospital. Although the SMART Aim goal was achieved, the improvement could not be linked to the QI processes; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 5-7 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence assigned to the PIP by HSAG. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure and the PIP's confidence level.

Table 5-7—SMART Aim Measure Results for *Avoidable Emergency Room Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The percentage of avoidable emergency room visits at Hughes Spalding Hospital during the measurement month for members 20 years of age and younger	39.1%	34.5%	26.9%	*Low Confidence*

*The Lowest Rate Achieved is reported for the *Avoidable Emergency Room Visits* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

The CMO established a goal of reducing the avoidable ER rate for Hughes Spalding Hospital from 39.1 percent to 34.5 percent. Three of the PIP's monthly SMART Aim measurements were at or below the goal rate of 34.5 percent, with the lowest avoidable ER rate achieved being 26.9 percent. The details of the improvement processes used and the intervention tested for the *Avoidable Emergency Room Visits* PIP are presented in Table 5-8 and in the narrative description below.

Table 5-8—Intervention Testing for *Avoidable Emergency Room Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Member awareness/ education outreach by live phone	Member awareness/ education	Member does not know alternative sources of care	The CMO reported that it could not determine whether the intervention successfully impacted the SMART Aim measure; therefore, the CMO chose to abandon the intervention.

The CMO identified one intervention for the PIP: live telephone member outreach following an avoidable ER visit at the targeted hospital. The intervention was targeted toward members who had a nonurgent visit at the targeted hospital and lived within close proximity to the hospital and the targeted urgent care facility.

To evaluate the intervention, Peach State tracked the number of members contacted for the intervention, the number of members who participated in the intervention, and the number of members who participated in the intervention and subsequently returned to the ER with an avoidable diagnosis. The CMO used a data collection process and data sources that relied on medical claims data to determine the numerator (number of members who received the intervention and had a subsequent avoidable ER visit) for each monthly measurement. In general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because of the lag-time associated with claims completeness. The CMO also identified the timing of intervention initiation and seasonal variation in avoidable ER use as confounding factors that likely impacted the SMART Aim measure results.

Based on the analysis of intervention results, Peach State reported that it could not determine whether the member outreach intervention successfully impacted the SMART Aim measure. The CMO chose to abandon the intervention because it was resource-intensive and because its impact could not be fully determined.

Bright Futures

Peach State's goal for the *Bright Futures* PIP was to identify and test interventions to improve the rate of members 14–18 years of age, assigned to Dr. Rachelle Dennis-Smith, who received an adolescent well visit. Although the SMART Aim goal was achieved, the improvement could not be clearly linked to the documented QI processes; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 5-9 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 5-9—SMART Aim Measure Results for *Bright Futures*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved		Confidence Level
The percentage of adolescents 14 to 18 years of age assigned to Dr. Rachelle Dennis-Smith that had a preventive health visit during the measurement period	20.8%	23.8%	40.2%		*Low Confidence*

The CMO established a goal of improving the well-child visit rate for members 14–18 years of age, assigned to Dr. Rachelle Dennis-Smith, from 20.8 percent to 23.8 percent. The PIP's SMART Aim measurements met or exceeded the goal rate of 23.8 percent for three consecutive months during intervention testing. The details of the improvement processes used and the interventions tested are presented in Table 5-10 and in the subsequent narrative description.

Table 5-10—Intervention Testing for *Bright Futures*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Teen Smart webpage	Members complete preventive visits	Member and parent/guardian may not consider preventive health visits important	The CMO chose to abandon the Teen Smart webpage intervention due to the low number of visits to the webpage and the lack of response to the member survey about the webpage.

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Teen Smart incentive program	Members complete preventive visits	Member or parent/guardian did not schedule annual preventive visit	The CMO chose to abandon the Teen Smart member incentive intervention based on the low enrollment rate and the decline in the well-visit rate among eligible members.

The CMO identified two interventions for the PIP: the Teen Smart webpage and the Teen Smart member incentive. The purpose of the Teen Smart webpage was to educate teen members and increase awareness about the importance of adolescent well visits. The CMO designed the webpage to attract teenage members and included health information and educational links on the importance of preventive healthcare. The purpose of the Teen Smart member incentive was to motivate teen members to schedule and complete an adolescent well visit. The incentive program offered eligible members who joined the Teen Smart program a $20 gift card for completing an adolescent well visit.

To test the Teen Smart webpage, Peach State collected survey data on adolescent members' perceptions of the webpage to evaluate effectiveness. The CMO used a telephone survey of members to evaluate member response to the Teen Smart webpage. Survey responses were not linked to whether the member scheduled or attended a preventive well-child visit. The CMO did monitor how many members who viewed the webpage subsequently scheduled or attended a well-child visit. Very few members visited the webpage, and there was a low response to the member survey. The CMO chose to abandon the Teen Smart webpage intervention due to the lack of member response.

To test the Teen Smart incentive program, Peach State tracked the number of members who enrolled in the Teen Smart program and the number of enrolled members who completed a well-child visit. The CMO's EPSDT coordinators collected data via telephone from members who enrolled in the Teen Smart Program and used a manual tracking tool to record which members were sent the $20 gift card incentive for completing a well-child visit. Only 31 adolescent members enrolled in the program, and only six of the 157 adolescent members assigned to the targeted provider who were invited to participate completed a well-child visit. Peach State's decision to abandon the Teen Smart member incentive intervention was supported by the CMO's summary of intervention evaluation results. Based on the low enrollment rate and the decline in the well-visit rate among eligible members during intervention testing, the CMO concluded that the Teen Smart program did not motivate adolescent members to complete a well-child visit.

Comprehensive Diabetes Care

Peach State's goal for the *Comprehensive Diabetes Care* PIP was to identify and test interventions to improve the percentage of noncompliant diabetic members residing in DeKalb and Fulton counties who received a diabetic retinal exam (DRE). Although the SMART Aim goal was achieved, the CMO could not clearly link the demonstrated improvement to the interventions tested; therefore, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 5-11 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 5-11—SMART Aim Measure Results for *Comprehensive Diabetes Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of noncompliant diabetic members 18 to 75 years of age residing in DeKalb and Fulton counties that had a diabetic retinal exam during the measurement period	42.0%	56.0%	61.0%	*Low Confidence*

The CMO established a goal of improving the percentage of noncompliant diabetic members in DeKalb and Fulton counties who received a diabetic retinal exam by 14 percentage points, from 42.0 percent to 56.0 percent. Six of the PIP's monthly SMART Aim measurements met or exceeded the SMART Aim measure goal of 56.0 percent. The details of the improvement processes used and the interventions tested are presented in Table 5-12 and in the subsequent narrative description.

Table 5-12—Intervention Testing for *Comprehensive Diabetes Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Telephonic member outreach	Member's lack of knowledge	Member does not receive education on the need for obtaining an eye exam.	The CMO chose to abandon the live telephone outreach because of the low number of member DREs [diabetic retinal exams] that could be directly attributed to the intervention.
Mail-based intervention	Member's lack of knowledge	• Member does not receive education on the need for obtaining an eye exam. • Member cannot be reached for telephone outreach and education because of incorrect contact information, no phone service, or no answer.	The CMO chose to abandon the intervention based on the analysis of findings and the conclusion that very few completed DREs could be attributed to the one-time mailer.
Educational home visits	Member's lack of knowledge	• Member does not receive education on the need for obtaining an eye exam.	The CMO chose to abandon the intervention based on the analysis of

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
		• Member cannot be reached for telephone outreach and education because of incorrect contact information, no phone service, or no answer.	findings and the resource-intensive nature of the educational home visits intervention.

The CMO identified three interventions for the PIP: live telephonic outreach to eligible members due for a diabetic eye exam, a one-time educational mailer to members who were not reached by telephone, and in-person home visits to members who were not reached by telephone or mail.

For the telephonic member outreach intervention, Peach State identified eligible diabetic members in DeKalb and Fulton counties who were due for a diabetic retinal exam (DRE) and provided a monthly list of members to the care support representative (CSR) team. The CSR team made live outbound calls to members to provide education and facilitate scheduling/attendance of the DRE appointment. To evaluate effectiveness of the intervention, the CMO used a manual tracking tool to track how many members were successfully reached for telephonic outreach and how many members completed their DRE. While claims were used to verify completion of the DRE, the CMO supplemented claims data with physician verification of the exam. The data collection process was methodologically sound; however, the CMO chose to abandon the telephonic outreach intervention after 90 days of testing due to the low rate of completed DREs attributed to telephonic outreach.

For the mail-based intervention, Peach State selected a "preapproved DCH eye exam mailer" and specifically targeted the intervention toward members in DeKalb and Fulton counties who were not reached by the prior telephone outreach intervention and those members who were reached by telephone but did not complete a DRE. The CMO reported that intervention effectiveness (occurrence of a DRE as a result of the one-time mailer) would be tracked by identifying completed DREs through medical claims. For this intervention, the CMO did not describe a supplemental data source (e.g., provider verification of DRE) as described for the telephone outreach intervention; therefore, HSAG concluded that the CMO relied on claims data to track the impact of the mailer on the DRE rate. In general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because of the lag-time associated with claims completeness. The CMO reported that insufficient tracking processes prevented confirming that the three members who completed a DRE completed the appointment as a result of the mailer. Peach State chose to abandon the intervention based on the analysis of findings and the conclusion that very few completed DREs could be attributed to the one-time mailer.

For the education home visits intervention, Peach State identified high-risk diabetic members in DeKalb and Fulton counties who had not been successfully reached by the previous telephonic outreach and one-time mailer interventions. The CMO's member outreach field representatives attempted to contact and visit the identified high-risk members at home. The goal of the home visits was to provide education on health plan benefits and gaps in care related to the DRE. To evaluate intervention effectiveness, Peach

State used a methodologically sound manual tracking tool to track how many members were successfully reached for an educational home visit and how many members completed their DRE. The CMO reported that it used member follow-up and provider verification as additional data sources of completed DREs, in addition to claims data. The CMO chose to abandon the intervention based on the analysis of findings and the resource-intensive nature of the educational home visits.

While Peach State concluded that the three interventions tested were not successful individually, the CMO reported that it plans to combine the three interventions and test the combined efforts as a single, multi-tiered intervention in the future.

Member Satisfaction

The focus of the PIP was changed from improving member satisfaction survey results (percentage of overall satisfaction survey question responses with a score of "Always") to improving the member satisfaction survey response rate (percentage of member surveys completed). The CMO's SMART Aim measure reported in the conclusions (member satisfaction survey response rate) was changed from the approved measure (percentage of member surveys completed at the end of an in-bound call with a response to the overall satisfaction question of "4–Always"). The PIP did not demonstrate evidence of achieving the approved SMART Aim goal. The CMO's modified SMART Aim statement changed the focus of the PIP from the approved methodology aimed at improving the overall member satisfaction survey results to improving the member satisfaction survey response rate. Because the PIP methodology was not executed as approved, the reported PIP results were not credible. A description of the PIP's performance leading to the assignment of "Reported PIP results were not credible" is provided below.

Table 5-13 provides a summary of the SMART Aim measure results reported by the CMO in the conclusions and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

The CMO's originally approved key driver diagram, SMART Aim statement, SMART Aim measure definition, and data collection methodology were documented in Modules 1 and 2. The CMO's rationale for focusing on improving the member survey response rate was provided in Module 4. Table 5-13 provides a summary of the SMART Aim measure results reported by the CMO in Module 5, at the conclusion of the PIP, and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 5-13—SMART Aim Measure Results for *Member Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members in the Atlanta region who completed the satisfaction survey	73.0%	80.0%	98.0%	*Reported PIP results were not credible*

Peach State documented in the PIP conclusions a goal of improving the member satisfaction response rate among members in the Atlanta region by 7.0 percentage points, from 73.0 percent to 80.0. The CMO's final SMART Aim run chart included five monthly measurements surpassing the goal rate of 80.0 percent; however, the results were not credible because the CMO changed the approved SMART Aim measure methodology.

Table 5-14—Intervention Testing for *Member Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Incentivize call center representatives to survey Atlanta region members after an inbound call	Member Engagement	Not enough members willing to participate in the survey	The CMO chose to abandon the intervention based on the analysis of findings, feedback from the CSR staff, and conclusions about lack of intervention effectiveness.
Outbound calls for members' surveys	Member Engagement	Not enough members willing to participate in the survey	The CMO chose to abandon the intervention and reported that the intervention required further testing to assess effectiveness and determine if sustained improvement in the survey response rate could be achieved.

The CMO identified two interventions for the PIP: a customer service representative (CSR) incentive for completing member phone surveys during inbound member calls and after-hours outbound calls to members to collect member survey responses.

For the CSR incentive intervention, Peach State informed CSR staff of the incentive program, which offered a tiered reward system (extended lunch period, $10, $20, or $30 gift card) for the number of completed member surveys. Survey responses were tabulated and incentives were distributed monthly. To evaluate intervention effectiveness, the CMO tracked three measures monthly: the number of CSR staff members who received an incentive, the number of completed member surveys, and the member survey response rate for the targeted geographic region. The CMO reported that the number of CSR staff eligible for the incentive was low, ranging from two to five staff members, during four months of testing. Peach State chose to abandon the intervention based on the analysis of findings, feedback from the CSR staff, and conclusions regarding lack of intervention effectiveness.

For the outbound calls intervention, Peach State generated a weekly list of members who had called the customer service center for assistance. The CMO's member advocates called members on the list after normal business hours (3:00 p.m. to 7:00 p.m.) to request that the member complete a four-question telephone survey on satisfaction. To evaluate the intervention, Peach State tracked the number of outbound calls attempted and the number of members who completed the survey during the after-hours

outbound call. The survey response rate was plotted monthly on the run chart. The CMO reported that, over the four months of intervention testing, 493 members were contacted by the member advocates to solicit a member survey and 464 members completed a survey during the outbound call. Peach State chose to abandon the outbound calls intervention and reported that the intervention required further testing to assess effectiveness and to determine if sustained improvement in the survey response rate could be achieved.

Postpartum Care

Peach State's goal for the *Postpartum Care* PIP was to identify and test interventions to improve the postpartum visit rate among members who delivered a live birth with a Dourron Obstetrics/Gynecology (OB/GYN) Associates provider. The PIP's SMART Aim goal was achieved; however, some but not all of the QI processes could be clearly linked to the demonstrated improvement. As a result, HSAG assigned the PIP a level of *Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 5-15 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence assigned to the PIP by HSAG. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure and the PIP's confidence level.

Table 5-15—SMART Aim Measure Results for *Postpartum Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of women under the care of Dourron OB/GYN Associates that had a postpartum visit 21 to 56 days following a live birth delivered at DeKalb Medical Center.	60.0%	65.0%	79.0%	*Confidence*

The CMO established a goal of improving the percentage of women who completed a postpartum visit with a Dourron OB/GYN Associates provider within 21–56 days post-delivery by 5 percentage points, from 60.0 percent to 65.0 percent. Four of the PIP's monthly SMART Aim measurements exceeded the goal of 65.0 percent. The details of the improvement processes used and the intervention tested are presented in Table 5-16 and in the subsequent narrative description.

Table 5-16—Intervention Testing for *Postpartum Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Proactive Automated Outreach Calls	Member awareness/participation	Member does not schedule the PPCV because the member does not understand the	The CMO chose to abandon the intervention in favor of a more interactive

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
		importance of the PPCV	intervention that could be more clearly assessed for impact on the timely postpartum visit rate.

The CMO planned two interventions for the PIP but tested only one: proactive automated outreach (POM) calls to members. For this intervention, each week, Peach State identified members who delivered at the targeted hospital and who were cared for by a provider from the targeted practice. The list of identified members was used to generate weekly automated outbound calls to those members within 7–10 days after delivery. The automated calls provided education on the importance of scheduling the postpartum visit within 21–56 days after delivery.

Peach State used a methodologically sound data collection process and data sources to evaluate the effectiveness of the POM calls intervention. The CMO tracked how many members received the automated outreach calls, and of those, how many members completed a timely postpartum visit. Peach State reported the number of targeted members who were reached with an automated outreach call and completed a timely postpartum visit. The percentage increased from 50 percent (six out of 12) in August, to 76 percent (22 out of 29) in September, to 79 percent in October (15 out of 19), and to 79 percent in November (11 out of 14). Despite the improvement in the SMART Aim measure, Peach State chose to abandon the intervention, stating that the results were inconclusive because the CMO did not have direct, member-reported data confirming that the automated call was the reason that the member completed the timely postpartum visit. While the CMO's interpretation of results held the PIP to a higher standard (establishing causality between the intervention and demonstrated improvement) than required for HSAG's rapid cycle PIP validation process, the documentation suggested that the demonstrated improvement could not be solely attributed to the intervention.

Provider Satisfaction

Peach State's goal for the *Provider Satisfaction* PIP was to identify and test interventions to reduce the time required to complete the prior authorization (PA) process for providers at Ear, Nose, & Throat (ENT) of Georgia. The SMART Aim goal was achieved; however, some but not all of the QI processes could be clearly linked to the demonstrated improvement. As a result, HSAG assigned the PIP a level of *Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 5-17 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved (lower is better) for the SMART Aim measure.

Table 5-17—SMART Aim Measure Results for *Provider Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The average number of days to complete a prior authorization requested by ENT of Georgia	8.4 days	6.3 days	2 days	*Confidence*

* The Lowest Rate Achieved is reported for the *Provider Satisfaction* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

The CMO established a goal of reducing the average number of days required to complete a prior authorization request for ENT of Georgia providers from 8.4 days to 6.3 days. Following initiation of the intervention, the SMART Aim measure performed better than the goal of 6.3 days for 10 consecutive biweekly measurements. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 5-18 and in the narrative description below.

Table 5-18—Intervention Testing for *Provider Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Provider education on the prior authorization process	Provider awareness	Potential delay identified as incomplete clinical documentation submitted by requesting provider	The CMO chose to continue testing the intervention with additional provider groups and plans to adopt and spread the intervention if additional testing with other providers demonstrates similar success in reducing prior authorization turnaround time.

The CMO identified one intervention for the PIP: provider education and follow-up support for the PA process, to reduce errors in PA requests by the targeted provider and ultimately reduce average PA turnaround time for the targeted provider practice. For the provider education intervention, Peach State compiled an educational packet with information about the PA process, including critical elements of documentation to support medical necessity, authorization submission channels, how to accurately complete the PA form, and tips on avoiding a lengthy PA turnaround time. The CMO met with office staff at ENT of Georgia, reviewed the educational packet, and shared contact information for telephonic support during the PA process.

To evaluate the effectiveness of the provider education intervention, Peach State manually tracked the biweekly average PA turnaround time for the targeted provider practice. The CMO also tracked the number of errors in each PA request received from the targeted provider and the targeted provider's satisfaction with the training session. The CMO reported the following summary of findings.

The run chart demonstrated that the SMART Aim was reached and sustained. It was not possible to determine that the intervention caused this effect; a correlation analysis was performed and showed that

there was no correlation between the number of errors and the TAT (turnaround time) in each PA request. The team became aware of other occurrences after the intervention was implemented such as updating the internal PA process and hiring additional staff, each having the potential to have a positive effect on TAT.

Based on the analysis of findings, Peach State concluded, "Attaining the SMART Aim was likely attributed to a combination of several factors—provider education, increase in staff, and an improved internal process." The CMO chose to continue testing the intervention with additional provider groups and plans to adopt and spread the intervention if additional testing with other providers demonstrates similar success in reducing PA turnaround time.

Strengths and Weaknesses

This was the second year that Peach State submitted PIPs for validation using the rapid cycle PIP framework. HSAG assigned a level of *Confidence* to two of Peach State's eight PIPs and a level of *Low Confidence* to four of Peach State's other PIPs. HSAG determined that for Peach State's remaining two PIPs, the reported PIP results were not credible; therefore, HSAG did not assign a level of confidence for these PIPs. HSAG did not assign a level of *High Confidence* for any of the PIPs. Peach State reported that the SMART Aim goal was achieved for five of the six PIPs with credible results; however, the PIP documentation did not clearly link all of the QI processes to the demonstrated improvement in each PIP.

Peach State's performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing the rapid cycle PIP process. The CMO's greatest opportunities for improvement are in determining interventions and conducting PDSA cycles. As evidenced by the PIP-specific validation findings, many of Peach State's PIPs achieved the SMART Aim goal but the demonstrated improvement could not be linked to the interventions tested. For some PIPs, the CMO concluded that its process maps and FMEAs did not adequately identify the root causes that needed to be addressed in the PIP; therefore, the interventions selected for testing were unlikely to address the most critical barriers to improvement. Additionally, Peach State concluded that for many PIPs, the PDSA cycles conducted did not enable the CMO to make firm conclusions about the individual impact of an intervention on the SMART Aim. Peach State had challenges identifying appropriate measures of intervention effectiveness for the PDSA process.

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. Peach State's PIP performance suggested a number of areas of opportunity that applied across the various PIP topics. HSAG recommends the following for Peach State:

- Ensure detailed and accurate documentation of the SMART Aim statement, SMART Aim measure definition, baseline rate, and goal rate across all modules.

- If the CMO determines that the SMART Aim statement and/or SMART Aim measure need to be revised after Modules 1 and 2 have been approved by HSAG, the CMO must contact HSAG to discuss planned revisions and any methodological implications. Revisions to an approved SMART Aim statement and/or SMART Aim measure methodology must be clearly documented, including the rationale for the revisions, and submitted to HSAG. All subsequent module submissions should clearly explain any changes that were made to an approved SMART Aim statement and/or measure methodology, including the rationale for the changes.
- Institute centralized oversight of the data analysis and results reporting for all PIPs so that all rates are reported accurately and consistently. SMART Aim measure baseline and goal rates, and rate results should be reported to the same number of decimal places for all PIPs. HSAG recommends reporting all PIP rates to one decimal place.
- Conduct multiple sessions to develop and update the key driver diagram, process map, and FMEA, ensuring appropriate use of data and input from all relevant team members, for each PIP. The accuracy and completeness of the process and FMEA will serve as the foundation for identifying and developing impactful improvement strategies. Revisit and update the key driver diagram and FMEA throughout the improvement process. Each version of the key driver diagram and FMEA should be dated to document when it was last revised.
- As Peach State moves through the QI process and conducts additional PDSA cycles, the CMO's PIP team should ensure that it is communicating Peach State's theory about changes that will lead to improvement. Without a common understanding of the theory, the CMO's PIP team may be working on changes for various perceived reasons.
- As Peach State tests new interventions, the CMO should ensure that it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep everyone involved in the project focused on the theory for improvement.
- Avoid relying on medical claims as a data source when defining measures to be used in PDSA cycles, unless the CMO has strong evidence that the claims lag will be minimal. Seek technical assistance from HSAG when considering the use of medical claims data for PDSA cycles so that methodological implications and potential alternative measures can be discussed.
- Incorporate detailed, process-level data into the intervention evaluation plan to further the CMO's understanding of intervention effects.
- Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- When planning to test an intervention with multiple steps or components, consider staggering the initiation of the individual steps or components so that the impact of each step or component can be distinguished. A staggered approach to intervention testing may require shorter data collection intervals so that the multiple intervention components can be introduced and tested within the life of the PIP.
- When planning a test of change, Peach State should think proactively (future tests and implementation).
- Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the current year's rates as compared to last year's rates. Some performance measures include multiple indicators; therefore, some measures may have more than one rate reported. For purposes of this report, measure and measure indicator rates have been evaluated separately and are generally referred to as "rates."

Access to Care

Within the Access to Care measure set, seven measures yielded 17 individual rates. Of those 17, DCH established CY 2015 performance targets for seven rates. Peach State's Access to Care performance measure results are shown in Table 5-19.

Table 5-19—Peach State Access to Care Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.26%	96.74%	↓	NC
25 Months–6 Years	89.96%	89.17%	↓	NC
7–11 Years	91.50%	91.17%	↔	NC
12–19 Years	88.63%	88.78%	↔	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.17%	77.87%	↓	88.52%
Annual Dental Visit				
2–3 Years	45.07%	44.05%	↓	54.20%
4–6 Years	74.66%	72.77%	↓	NC
7–10 Years	77.15%	76.03%	↓	NC
11–14 Years	69.94%	69.85%	↔	NC
15–18 Years	59.32%	59.19%	↔	NC
*19–20 Years**	33.62%	37.57%	↑	34.04%[4]
*Total**	67.67%	66.97%	↓	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total	39.65%	35.24%	↓	43.48%
Engagement of AOD Treatment—Total	8.24%	6.82%	↔	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.23%	0.00%	↔	NC

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Colorectal Cancer Screening				
Colorectal Cancer Screening	^	49.29%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	80.56%	82.38%	↔	85.23%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members ages 19–21 years rather than 19–20 years.

** Due to changes in the technical measure specifications, where the CY 2014 measure included members ages 19–21 years rather than 19–20 years in CY 2015, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

^ *indicates that this is a newly reported rate for CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Access to Care measure set, one of the seven rates reported by Peach State with a performance target for CY 2015, *Annual Dental Visit—19–20 Years*, met or exceeded the target and also demonstrated statistically significant improvement when compared to CY 2014. However, in CY 2014 and in prior years, members 2 to 21 years of age were included in the *Annual Dental Visit* measure, and beginning in CY 2015 only members 2 to 20 years of age were included. Therefore, caution should be exercised when comparing rates between years and to performance targets.

Of the remaining six rates that did not meet the performance targets, three rates demonstrated a statistically significant decline from CY 2014, including *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*, *Annual Dental Visit—2–3 Years*, and *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total*. Five additional rates for which performance targets were not established also demonstrated statistically significant decline from CY 2014, indicating overall opportunities for improvement related to members' access to care.

Children's Health

Within the Children's Health measure set, 12 measures yielded 16 individual rates. Of those 16, DCH established CY 2015 performance targets for 15 rates. Peach State's Children's Health performance measure results are shown in Table 5-20.

Table 5-20—Peach State Children's Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	65.05%	67.79%	↔	64.30%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.91%	68.99%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.07%	47.60%	↔	48.90%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	79.63%	79.09%	↔	80.30%
Combination 6	43.52%	36.30%	↓	59.37%
Combination 10	40.28%	34.38%	↔	38.94%
Lead Screening in Children				
Lead Screening in Children	79.40%	80.05%	↔	75.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	80.31%	82.14%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	76.39%	88.90%	↑	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	69.21%	67.79%	↔	55.09%
Counseling for Nutrition—Total	64.81%	66.59%	↔	60.58%
*Counseling for Physical Activity—Total**	60.19%	57.21%	↔	51.38%
Developmental Screening in the First Three Years of Life				
Total	46.28%	50.60%	↔	46.36%
Percentage of Eligibles Who Received Preventive Dental Services				
Percentage of Eligibles Who Received Preventive Dental Services	52.17%	51.46%	↓	58.00%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	^	20.09%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	83.50%	84.00%	↔	86.11%

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.*
[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.*
[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*
** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*
↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*
↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*
↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*
^ *indicates that this is a newly reported rate for CY 2015.*
NC (i.e., Not Compared) indicates that DCH did not establish a performance target.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Children's Health measure set, seven of the 15 rates with performance targets for CY 2015 met or exceeded the performance targets. Additionally, the *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)* rate demonstrated statistically significant improvement from CY 2014.

Of the remaining eight rates reported that did not meet the performance targets, two of these rates, *Childhood Immunization Status—Combination 6* and *Percentage of Eligibles Who Received Preventive Dental Services*, demonstrated a statistically significant decline from CY 2014.

Women's Health

Within the Women's Health measure set, 12 measures yielded 13 individual rates. Of those 13, DCH established CY 2015 performance targets for 11 rates. Peach State's Women's Health performance measure results are shown in Table 5-21. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex; Cesarean Delivery Rate, Uncomplicated; Percentage of Live Births Weighing Less Than 2,500 Grams;* and *Elective Delivery.*

Table 5-21—Peach State Women's Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	68.53%	68.56%	↔	76.64%
Breast Cancer Screening				
Breast Cancer Screening	71.02%	66.90%	↔	71.35%
Chlamydia Screening in Women				
Total	56.71%	59.83%	↑	54.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	24.54%	21.93%	↔	23.62%
Prenatal Care and Birth Outcomes				

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.13%	77.49%	↔	89.62%
Postpartum Care	70.30%	59.72%	↓	69.47%
Cesarean Section for Nulliparous Singleton Vertex[4]				
Cesarean Section for Nulliparous Singleton Vertex	NR	NR	NT	18.08%
Cesarean Delivery Rate, Uncomplicated[4]				
Cesarean Delivery Rate, Uncomplicated	29.84%	29.32%	↔	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[4]				
Percentage of Live Births Weighing Less Than 2,500 Grams	9.04%	8.87%	↔	8.02%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	0.00%	5.46%	↑	NC
Elective Delivery[4]				
Elective Delivery	NR	NR	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	NR	NR	NT	NC
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	57.77%	59.00%	↔	60.10%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that Cesarean Section for Nulliparous Singleton Vertex, Elective Delivery, and Antenatal Steroids received the NR designation for the audit results. The CMO used a software vendor to produce the denominator for these measures; however, the vendor was not able to identify the gestational age using administrative data, which resulted in false positives in the denominator. Since the gestational age was not determined prior to drawing the sample, the rate was considered materially biased and an audit result of Not Reportable was assigned.

Within the Women's Health measure set, two of the 11 rates with performance targets for CY 2015 were not reportable. Of the remaining nine reportable rates, only the *Chlamydia Screening in Women—Total*

rate met or exceeded its target. Additionally, this rate demonstrated statistically significant improvement from CY 2014.

Of the remaining eight rates reported that did not meet the performance targets, the *Prenatal and Postpartum Care—Postpartum Care* rate also demonstrated a statistically significant decline from CY 2014.

Chronic Conditions

Within the Chronic Conditions measure set, eight measures yielded 15 individual rates. Of those 15, DCH established CY 2015 performance targets for 10 rates. Peach State's Chronic Conditions performance measure results are shown in Table 5-22. Note that a lower rate is better for the following performance measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0), Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months), Asthma in Younger Adults Admission Rate (Per 100,000 Member Months), Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months),* and *Heart Failure Admission Rate (Per 100,000 Member Months).*

Table 5-22—Peach State Chronic Conditions Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care*				
Hemoglobin A1c (HbA1c) Testing	83.63%	81.80%	↔	87.59%
HbA1c Poor Control (>9.0%)[4]	53.17%	59.72%	↓	44.69%
HbA1c Control (<8.0%)	37.32%	32.51%	↔	46.43%
HbA1c Control (<7.0%)	27.73%	23.52%	↔	36.27%
Eye Exam (Retinal) Performed	58.63%	59.36%	↔	54.14%
Medical Attention for Nephropathy	77.82%	91.87%	↑	80.05%
Blood Pressure Control (<140/90 mm Hg)	53.17%	52.83%	↔	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)				
Diabetes Short-Term Complications Admission Rate[4]	18.15	15.46	NT	--
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]				
Asthma in Younger Adults Admission Rate	4.55	3.19	NT	--
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]				
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	28.70	23.78	NT	--

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	69.84%	80.70%	↔	74.94%
Bronchodilator	79.37%	82.46%	↔	83.82%
Cardiovascular Conditions				
Heart Failure Admission Rate (Per 100,000 Member Months)[4]				
Heart Failure Admission Rate	5.45	4.54	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	36.64%	43.14%	↑	56.46%
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NT	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Chronic Conditions measure set, three of the 10 rates with performance targets for CY 2015 met or exceeded the targets: *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Medical Attention for Nephropathy*, and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid.* Additionally, nephropathy care for diabetic members also demonstrated statistically significant improvement from CY 2014. However, for CY 2015, updates to the technical specifications were made to the requirements for meeting the testing criteria for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. In addition, the classification of diabetes changed significantly between ICD-9 and ICD-10. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Comprehensive Diabetes Care* measure.

Of the remaining seven rates that did not meet performance targets in CY 2015, the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* rate demonstrated a statistically significant decline in performance from CY 2014. However, as noted above, caution should be exercised when comparing rates for the *Comprehensive Diabetes Care* measure.

Behavioral Health

Within the Behavioral Health measure set, six measures yielded nine individual rates. Of those nine, DCH established CY 2015 performance targets for seven rates. Peach State's Behavioral Health performance measure results are shown in Table 5-23.

Table 5-23—Peach State Behavioral Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	43.58%	43.84%	↔	53.03%
Continuation and Maintenance Phase	58.19%	58.82%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	56.78%	55.77%	↔	63.21%
30-Day Follow-Up	72.79%	72.53%	↔	80.34%
Antidepressant Medication Management				
Effective Acute Phase Treatment	39.57%	38.66%	↔	54.31%
Effective Continuation Phase Treatment	24.86%	23.89%	↔	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.86%	7.48%	↑	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33.33%	19.63%	↓	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	NR	0.25%	NT	NC

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*
↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target.
NR (i.e., Not Reported) indicates that the CMO produced a rate that was materially biased or chose not to report results for this measure.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Behavioral Health measure set, none of the seven rates with performance targets were met. However, one of the rates without an established performance target, the *Screening for Clinical Depression and Follow-Up Plan* rate, demonstrated statistically significant improvement from CY 2014.

Of the seven measures that did not meet the CY 2015 performance targets, the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* rate also demonstrated a statistically significant decline from CY 2014. However, for CY 2015, updates to the technical specifications extended the index prescription start date by three months. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure.

Medication Management

Within the Medication Management measure set, two measures yielded 13 individual rates. Of those 13, DCH established CY 2015 performance targets for four rates. Peach State's Medication Management performance measure results are shown in Table 5-24.

Table 5-24—Peach State Medication Management Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	87.24%	87.45%	↔	88.00%
Annual Monitoring for Members on Diuretics	86.63%	87.41%	↔	87.90%
Total	86.74%	87.41%	↔	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	44.06%	45.40%	↔	NC
Medication Compliance 50%—Ages 12–18 Years	39.67%	41.64%	↔	NC
Medication Compliance 50%—Ages 19–50 Years	44.19%	50.96%	↔	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 50%—Total	42.56%	44.34%	↔	NC
Medication Compliance 75%—Ages 5–11 Years	18.82%	20.95%	↔	32.32%
Medication Compliance 75%—Ages 12–18 Years	16.03%	16.58%	↔	NC
Medication Compliance 75%—Ages 19–50 Years	23.26%	19.75%	↔	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 75%—Total	18.03%	19.41%	↔	NC

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.*
[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.*
[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*
↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Medication Management measure set, none of the four rates with performance targets were met. However, all of the rates for the *Annual Monitoring for Patients on Persistent Medications* measure were within 1 percentage point of the targets.

Conversely, the remaining rate with a performance target, *Medication Management for People With Asthma—Medication Compliance 75%—Ages 5–11 Years,* fell below its target by more than 11 percentage points.

Utilization

Within the Utilization measure set, four measures yielded 21 individual rates. Of those 21, DCH established a CY 2015 performance target for one rate. Peach State's Utilization measure results are shown in Table 5-25. Note that lower rates are better for the *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total* and *Plan All-Cause Readmission Rate* measures. Significance testing was not performed on the Utilization measure set since variances are not reported to NCQA.

Table 5-25—Peach State Utilization Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	54.10	52.44	NT	52.31
Outpatient Visits—Total	309.79	303.03	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	3.39	3.47	NT	NC
Total Inpatient—Average Length of Stay—<1 Year	9.01	8.92	NT	NC
Medicine—Average Length of Stay—Total	3.43	3.41	NT	NC
Medicine—Average Length of Stay—<1 Year	4.47	4.61	NT	NC
Surgery—Average Length of Stay—Total	8.43	8.37	NT	NC
Surgery—Average Length of Stay—<1 Year	19.95	20.83	NT	NC
Maternity—Average Length of Stay—Total	2.75	2.82	NT	NC
Mental Health Utilization—Total				
Any Service—Total—Total	8.01%	7.68%	NT	NC
Inpatient—Total—Total	0.38%	0.41%	NT	NC

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Intensive Outpatient or Partial Hospitalization—Total—Total	0.13%	0.12%	NT	NC
Outpatient or ED—Total—Total	7.93%	7.59%	NT	NC
Plan All-Cause Readmission Rate[4]				
Age 18–44	^	12.32%	NT	NC
Age 45–54	^	11.21%	NT	NC
Age 55–64	^	5.26%	NT	NC
Age 18–64—Total	^	11.87%	NT	NC
Age 65–74	^	NA	NT	NC
Age 75–84	^	NA	NT	NC
Age 85 and Older	^	NA	NT	NC
Age 65 and Older—Total	^	NA	NT	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

^ indicates that this is a newly reported rate for CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Utilization measure set, the only rate with a performance target for CY 2015, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total*, did not meet the performance target.

Of note, the remaining rates are displayed for information purposes only and may not indicate the quality and timeliness of, or access to, care and services. Therefore, exercise caution in connecting these data to the efficacy of the program, as many factors influence these data. HSAG recommends that Peach State review these results and identify whether a rate is higher or lower than expected. Additional focused analyses related to the measures in this measure set may help to identify key drivers associated with the utilization patterns.

Health Plan Descriptive Information

Peach State's Health Plan Descriptive Information measure results are shown in Table 5-26.

Table 5-26—Peach State Health Plan Descriptive Information Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.88%	13.16%	↔	NC
1–12 Weeks	13.19%	11.87%	↔	NC
13–27 Weeks	58.56%	52.61%	↓	NC
28+ Weeks	16.20%	14.53%	↔	NC
Unknown	1.16%	7.83%	↑	NC
Race/Ethnicity Diversity of Membership				
Total—White	19.73%	34.32%	↑	NC
Total—Black or African American	49.09%	53.57%	↑	NC

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

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

↑ *indicates a statistically significant rate increase between CY 2014 and CY 2015.*

↓ *indicates a statistically significant rate decrease between CY 2014 and CY 2015.*

↔ *indicates no statistically significant change between CY 2014 and CY 2015.*

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Health Plan Descriptive Information rates are presented for information purposes only. HSAG recommends that Peach State review these results and identify whether a rate is higher or lower than expected.

Strengths and Weaknesses

The number of performance targets met by Peach State is shown in Table 5-27.

Table 5-27—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	7	1	14.29%
Children's Health	15	7	46.67%
Women's Health	9	1	11.11%
Chronic Conditions	10	3	30.00%
Behavioral Health	7	0	0.00%
Medication Management	4	0	0.00%
Utilization	1	0	0.00%
Total	**53**	**12**	**22.64%**

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

Based on Peach State's performance in CY 2015, more than 22 percent of the rates met or exceeded the performance targets overall. Peach State's rates met or exceeded nearly half of the performance targets in the Children's Health measure set. Select rates in the Access to Care, Women's Health, and Chronic Conditions measure sets also met or exceeded performance targets. HSAG has highlighted specific strengths and areas for improvement below.

Peach State's greatest strength was in children's health. As illustrated in the table above, Peach State met or exceeded more than 46 percent of the performance targets within the Children's Health measure set. All three rates for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure met or exceeded performance targets. Additionally, Peach State's rates demonstrated statistically significant improvement for two of the 15 rates within this measure set that were reportable for CY 2015 and comparable to CY 2014 rates.

Measures within the Access to Care, Women's Health, and Chronic Conditions measure sets presented several opportunities for improvement as only one of seven, one of nine, and three of 10 rates, respectively, met or exceeded the performance targets for CY 2015, and the remaining rates did not meet the targets. Most notably, three of Peach State's *Comprehensive Diabetes Care* rates were 12–15 percentage points away from meeting the CY 2015 performance targets. Additionally, eight rates within the Access to Care measure set and one rate within both the Women's Health and Chronic Conditions measure sets demonstrated a statistically significant decline from CY 2014. Furthermore, Peach State did not meet any CY 2015 performance targets in the Behavioral Health, Medication Management, and Utilization measure sets. The *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure also demonstrated a statistically significant decline from CY 2014. However, as previously mentioned, changes in technical specifications for the *Comprehensive Diabetes Care* and *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measures should be taken into consideration when interpreting results.

For the Utilization measure set, only one rate, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total,* was compared to performance targets because most of the rates in this measure set are displayed for information purposes only. Peach State's rate for this measure was within half a percentage point of meeting the performance target, indicating opportunities for improvement related to potentially reducing the number of preventable/avoidable or nonemergent ED visits that could be treated in a primary care setting.

Recommendations for Improvement

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

- Analyze the improvement strategies that can be linked to the overall success within 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.

- Analyze all performance measure rates that fell below the DCH-required performance target and either implement new PIPs or adjust the focus of existing PIPs as needed.
- Prioritize focusing on performance measures that demonstrated a statistically significant decline, such as access to care for children and adolescents, dental visits for children, and treatment of drug dependence measures.

In addition to the specific recommendations above, Peach State should focus efforts on the following measure topics in its QI efforts. The measure topics below were derived based on comparisons to the CY 2015 performance targets.

Access to Care

- Primary care for members 12 to 19 years of age and preventive/ambulatory services for adults
- Annual dental visits for members 2 to 3 years of age
- Treatment for members for alcohol and other drug dependence
- BMI assessments for adults

Children's Health

- Well-child/care visits for children 3 to 6 years of age and for adolescents
- Immunizations for children
- Testing for children with pharyngitis
- Preventive dental services for children
- Treatment for children with upper respiratory infections

Women's Health

- Cervical cancer and breast cancer screenings
- Vaccination for human papillomavirus for girls turning 13 years of age during the measurement year
- Prenatal care and postpartum care
- Live births with low birth weight
- Cesarean deliveries

Chronic Conditions

- HbA1c testing and control, and blood pressure control for members with diabetes
- Timely dispensing of bronchodilators for members with COPD
- Blood pressure control for members with hypertension

Behavioral Health

- Follow-up care for children with ADHD
- Follow-up care for members after hospitalization for mental illness

- Management of medications for members who take antidepressants
- Members with schizophrenia who remained on antipsychotic medications

Medication Management

- Monitoring of members on persistent medications
- Appropriate medication management for members with asthma

Utilization

- Emergency department usage

CAHPS Surveys

Findings

To assess Peach State's overall performance, HSAG compared the calculated question summary rates for each global rating and global proportion for each composite measure (i.e., the percentage of respondents offering a positive response) to 2016 NCQA Medicaid national averages.[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 2016 top-box scores to 2016 NCQA Medicaid national data were performed for Peach State's adult and child Medicaid populations.[5-3] For purposes of this report, CAHPS measures are reported even when the NCQA minimum reporting threshold of 100 respondents was not met, which are denoted with a cross (+). 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*

[5-2] Quality Compass® 2016 data served 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 2016 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).

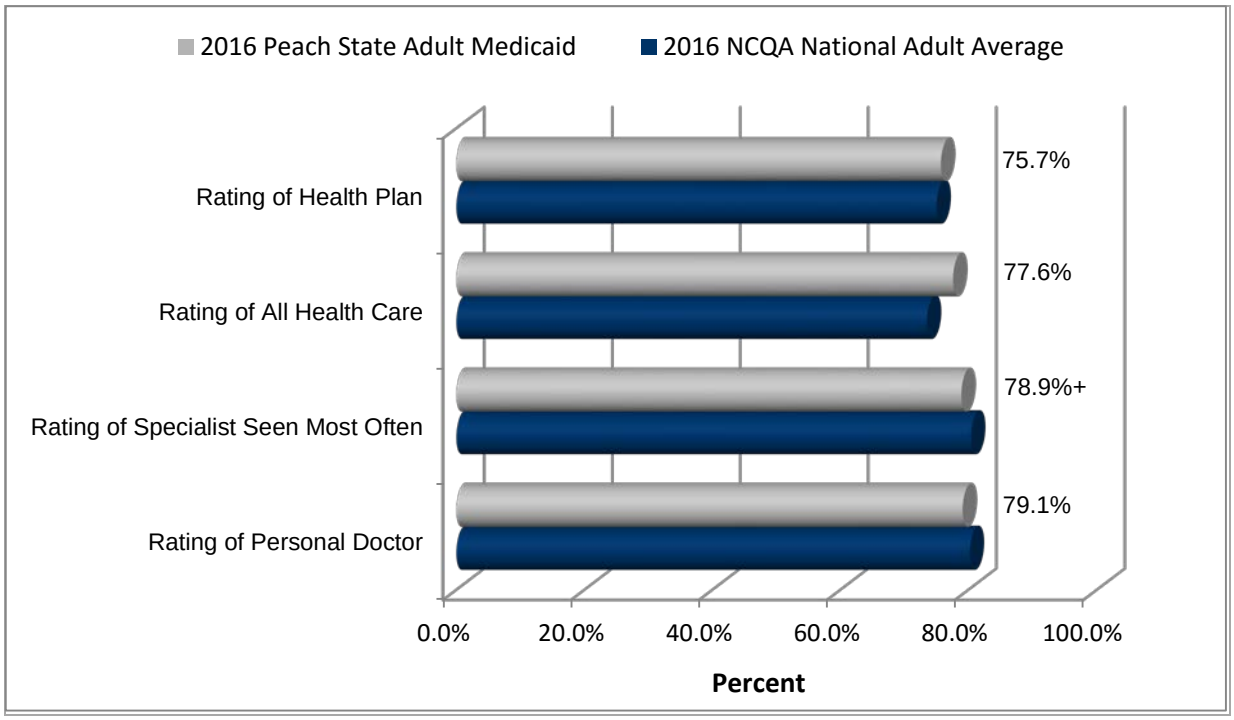
[5-3] The CAHPS Survey results presented throughout this section for Peach State are the CAHPS Survey measure results calculated by the CMO's survey vendor and provided to HSAG for reporting purposes.

CAHPS Composite Measures

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

Figure 5-1 below depicts Peach State's adult Medicaid 2016 CAHPS top-box scores and the 2016 NCQA adult Medicaid national average for each of the global ratings. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2016 NCQA adult Medicaid national averages.

Figure 5-1—Peach State Adult Medicaid CAHPS Survey Results for Global Ratings



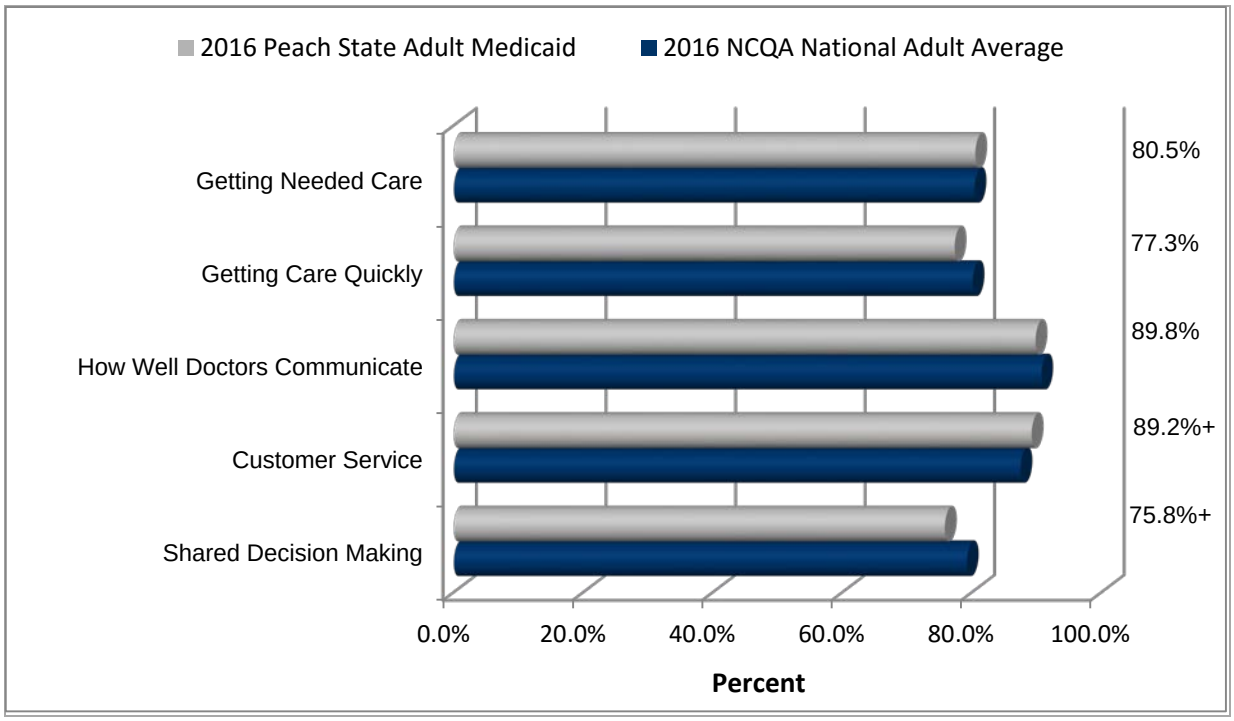
+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response, caution should be exercised when interpreting results for those measures.

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

- Peach State scored between 75 and 80 percent on the four global rating measures.
- Peach State scored at or above the 2016 NCQA adult Medicaid national average for two measures: *Rating of Health Plan* and *Rating of All Health Care.*
- Peach State scored below the 2016 NCQA adult Medicaid national average for the remaining two measures: *Rating of Specialist Seen Most Often* and *Rating of Personal Doctor.*

Figure 5-2 below depicts Peach State's adult Medicaid 2016 CAHPS top-box scores and the 2016 NCQA adult Medicaid national average for each of the composite measures. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2016 NCQA adult Medicaid national averages.

Figure 5-2—Peach State Adult Medicaid CAHPS Survey Results for Composite Measures



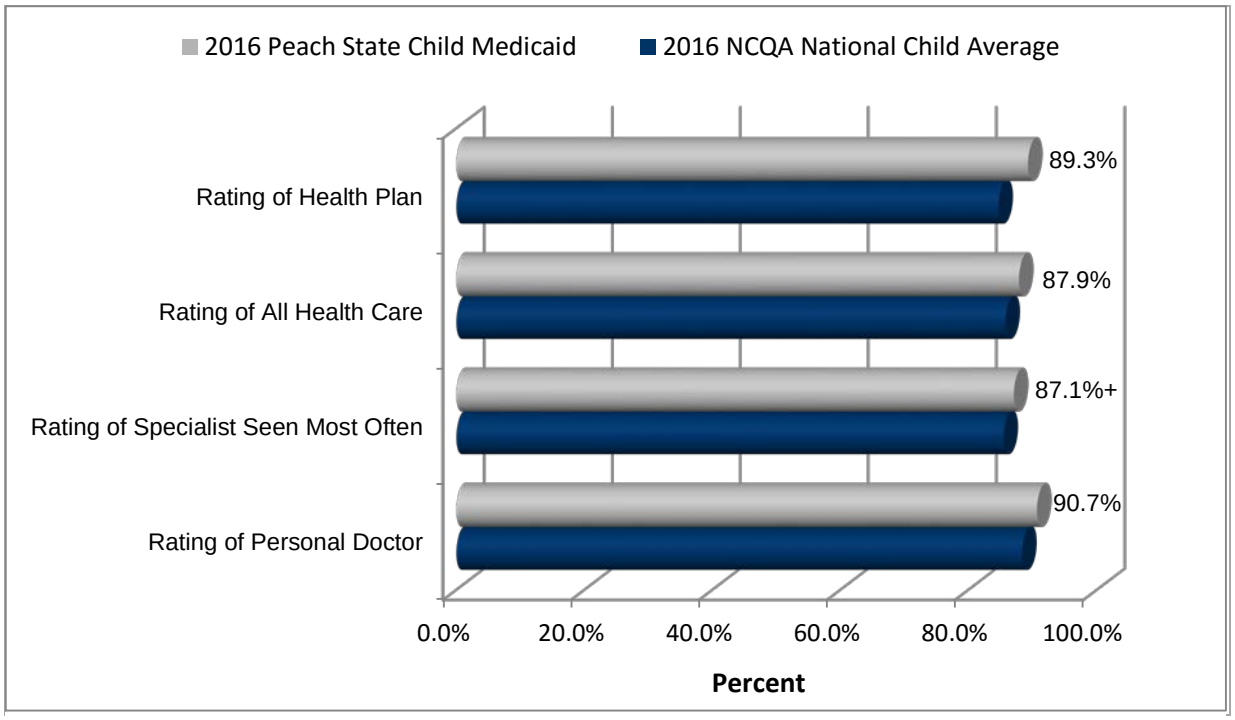
+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response, caution should be exercised when interpreting results for those measures.

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

- Peach State scored between 75 and 90 percent on the five composite measures.
- Peach State scored at or above the 2016 NCQA adult Medicaid national average for two measures: *Getting Needed Care* and *Customer Service.*
- Peach State scored below the 2016 NCQA adult Medicaid national average for the remaining three measures: *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making.*

Figure 5-3 below depicts Peach State's child Medicaid 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the global ratings. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 5-3—Peach State Child Medicaid CAHPS Survey Results for Global Ratings



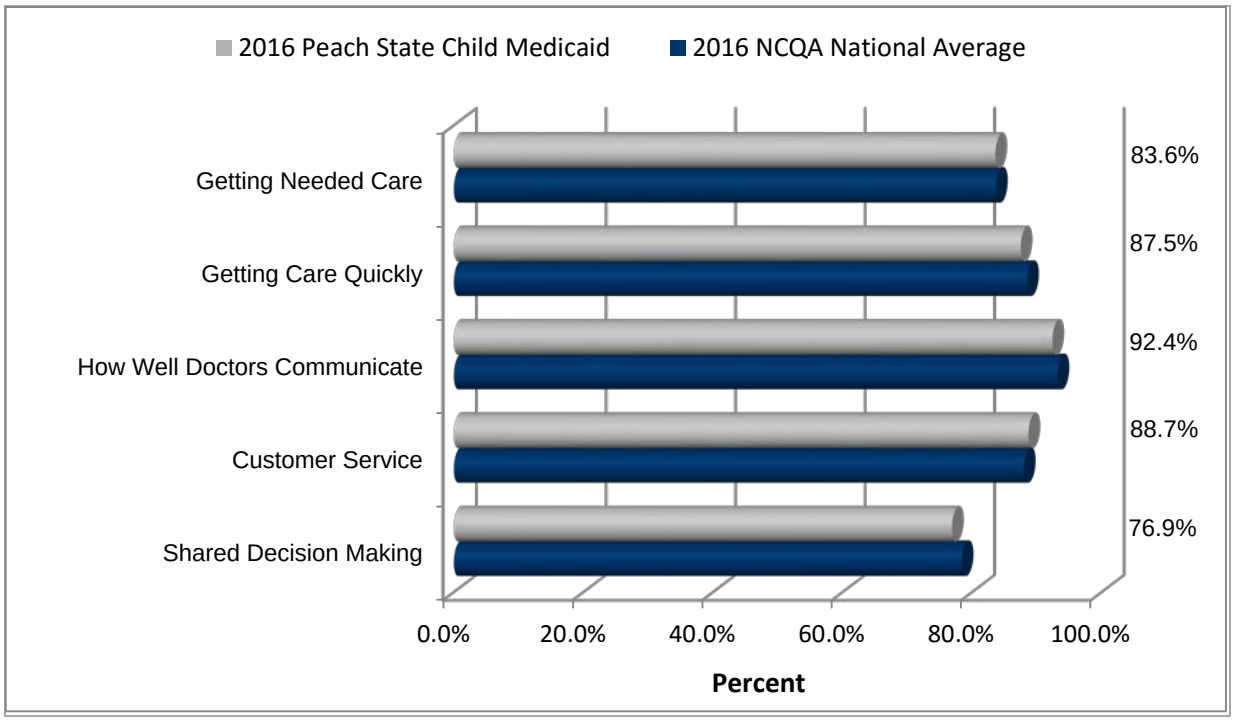
+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response, caution should be exercised when interpreting results for those measures.

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

- Peach State scored between 87 and 91 percent on the four global rating measures.
- Peach State scored at or above the 2016 NCQA child Medicaid national 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*.

Figure 5-4 below depicts Peach State's child Medicaid 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the composite measures. The grey bars represent Peach State's top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 5-4—Peach State Child Medicaid CAHPS Survey Results for Composite Measures



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

- Peach State scored between 76 and 93 percent on the five composite measures.
- Peach State scored at or above the 2016 NCQA child Medicaid national average for one measure, *Customer Service.*
- Peach State scored below the 2016 NCQA child Medicaid national average for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

Strengths and Weaknesses

For Peach State's adult Medicaid population, the 2016 top-box rates for five of the CAHPS Survey measures, *Rating of Specialist Seen Most Often, Rating of Personal Doctor, Getting Care Quickly, How Well Doctors Communicate,* and *Shared Decision Making*, were lower than the 2016 NCQA adult Medicaid national averages. The four remaining comparable measures' 2016 top-box rates, *Rating of Health Plan, Rating of All Health Care, Getting Needed Care,* and *Customer Service,* met or exceeded the 2016 NCQA adult Medicaid national averages.

For Peach State's child Medicaid population, the 2016 top-box rates for four of the measures were lower than the 2016 NCQA child Medicaid national averages: *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate,* and *Shared Decision Making*. The 2016 top-box rates for the five remaining measures met or exceeded the 2016 NCQA child Medicaid national average: *Rating of Health Plan, Rating of All Health Care, Rating of Specialist Seen Most Often, Rating of Personal Doctor,* and *Customer Service.*

Recommendations for Improvement

Based on an evaluation of Peach State's 2016 adult Medicaid CAHPS Survey results, HSAG recommends that the CMO focus efforts on enhancing members' experiences with *Rating of Specialist Seen Most Often, Rating of Personal Doctor, Getting Care Quickly, How Well Doctors Communicate,* and *Shared Decision Making* since the rates for these measures were lower than NCQA's 2016 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 *Shared Decision Making* since the rates for these measures were below the 2016 NCQA child Medicaid national 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 Medicaid national 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.

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 that its structure and operations support core processes for providing care and services and promoting quality outcomes. The CMO demonstrated moderately strong compliance review results (73.7 percent of federal and contract requirements for structure and operations were *Met*) and also

demonstrated its commitment to quality process improvement by closing five of the eight corrective action plans from the previous year's compliance review.

Conclusions

Peach State's performance results are mixed. The CMO should continue to implement mechanisms to improve quality, access, and timeliness of care for its members. Peach State used the Institute for Healthcare Improvement's (IHI's) Triple Aim as a framework to evaluate the success of the QAPI Program and adopted the Lean Six Sigma methodology and PDSA processes. Peach State's executive and management staff were involved in its QAPI projects. As a demonstration of the commitment of management, the QAPI Work Plan included executive and management staff as the accountable person(s) for each project.

The CMO's QAPI program description and process should 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. Peach State should strengthen its processes for the monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members. The PIP and performance measure results indicate a need for Peach State to strengthen and document its QI processes in its QAPI program description. Peach State should strengthen its QAPI program description to include how QI initiatives reflect an understanding of the population served; the use of data to understand where opportunities for improvement exist; and include research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members.

Peach State should continue to provide education opportunities for staff involved in QI work. Peach State's performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing the rapid cycle PIP process and for ongoing QI training for staff. The CMO may benefit from technical assistance to address the critical areas of the rapid cycle process for ongoing and future PIPs to support more efficient and fruitful intervention testing.

HSAG provided recent, formal QI technical assistance to the CMOs in addition to DCH's written guidance and reporting requirements for the CMOs' annual QAPI program evaluation process. Peach State should use these tools and request additional process improvement assistance as needed to move its quality program toward success.

For CY 2015, more than 22 percent of Peach State's performance measure targets were met. Peach State should analyze the improvement strategies that can be linked to the overall success within the measure set. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other measure sets where performance was not as strong. 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.

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 nearly 580,000 GF members in the State of Georgia.[6-1] WellCare provides medical, mental health, vision, dental, and case and disease management services to its enrolled Medicaid and CHIP members, plus a range of enhanced services, including dental and vision services for adults, wellness/prevention programs, and incentives.

Review of Compliance With Standards

Table 6-1 presents the standards and compliance scores for WellCare. For Standards I–III and follow-up on previously noncompliant review findings, HSAG evaluated a total of 57 elements for the SFY 2016 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*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Clinical Practice Guidelines	**11**	**11**	**9**	**2**	**0**	**81.8%**
II	Quality Assessment and Performance Improvement (QAPI)	**32**	**30**	**16**	**14**	**2**	**53.3%**
III	Health Information Systems	**8**	**8**	**7**	**1**	**0**	**87.5%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**6**	**6**	**5**	**1**	**0**	**83.3%**
	Total Compliance Score	**57**	**55**	**37**	**18**	**2**	**67.3%**

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

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

***** Total Compliance Score:** 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. June 2016.

Findings

WellCare had an overall compliance score of 67.3 percent.

WellCare scored highest in the Health Information Systems standard, with a score of 87.5 percent. The Clinical Practice Guidelines standard was noncompliant with three elements, and the Quality Assessment and Performance Improvement standard was noncompliant with 14 elements.

HSAG also reviewed documentation provided by WellCare 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. Six elements were re-reviewed within the following standards: Grievance System and Furnishing of Services. All elements related to Grievance System were *Met* upon reevaluation. One element within the Furnishing of Services standard 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.

Clinical Practice Guidelines: WellCare adopted 41 evidence-based, clinical practice guidelines (CPGs) in the areas of chronic care conditions and preventive and behavioral health. WellCare included community providers and medical societies in the review and adoption of CPGs. The CMO made decisions regarding the CPGs through committee meetings and implemented processes to consider the needs of its members when identifying CPG topics.

WellCare did not document how it ensured that decisions made by staff regarding utilization management or coverage of service were consistent with CPGs. WellCare has not implemented a process to ensure staff decisions involving utilization management and coverage of services are consistent with the guidelines.

Quality Assessment and Performance Improvement: WellCare expanded the role of its staff members who work with provider practices to improve HEDIS scores to include discussions on overutilization, underutilization, member care needs, and healthcare advocacy. WellCare used demographic information, as well as various clinical and behavioral health utilization patterns, to identify members who might benefit from disease management or case management programs. WellCare worked directly with providers and the community on quality improvement (QI) initiatives such as the use of telemedicine and access to school-based care.

Other QI initiatives focused on improving the quality of care coordination and care transitions in efforts to reduce gaps in care. WellCare implemented various QI processes based on patient safety data and trends. The CMO initiated performance improvement projects to address trends identified through monitoring activities, review of complaints and allegations of abuse, provider satisfaction, and utilization management reviews.

WellCare's QAPI program description was not comprehensive and did not meet the DCH guidelines. The QAPI program description should include all QI initiatives and address the CMO's process to measure outcomes. The QAPI program evaluation did not provide a complete summary of how the QI goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered (and implemented); how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured in order to provide a comprehensive story of the effectiveness of WellCare's QAPI work. WellCare's policies, program descriptions, and/or program evaluations did not describe how, as a result of data analysis or evaluation, indicated recommendations are implemented. The QAPI program description did not address the DCH-suggested focus on identifying member demographics and needs and did not document how this work was tied to goals, objectives, interventions, and activities. The CMO did not have a process to measure outcomes related to this work. Neither WellCare's QAPI program description nor its policies provided sufficient detail about the CMO's provider profiling activities. The QM Patient Safety Plan did not clearly distinguish between grievances and the grievance process, and it was not developed or structured according to DCH guidelines. WellCare did not provide evidence that it used the latest available research in the area of quality assurance.

Health Information Systems: WellCare used an integrated application suite to support its Medicaid line of business, which allowed for a seamless integration with other applications and supported all member, provider, benefit, and claims processing applications. WellCare managed reporting functions through the Enterprise Data Warehouse.

WellCare did not provide evidence that it had processes to review data received from providers to ensure that the data were complete, logical, and consistent with those services provided to the member.

Recommendations for Improvement

WellCare received recommendations for improvement in the Clinical Practice Guidelines, Quality Assessment and Performance Improvement (QAPI), and Health Information Systems standards. HSAG's specific recommendations for WellCare were to:

- Develop a comprehensive QAPI program description. The QAPI program description must be developed according to the DCH guidelines.
- Include additional information in its QAPI program description, such as the comprehensive process used, and may want to begin this process with a review of information and data available to the CMO through claims/encounters, grievances and appeals, quality of care cases, disease management, case management, care coordination, and member and provider input, to identify QI opportunities and gaps in care or service delivery. QI initiatives must meet regulatory requirements and also demonstrate an understanding of the population served; use data to understand where QI opportunities exist; and include research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members. The CMO must also consider including in its QAPI program evaluation a more complete summary of how the QI goals, objectives, and related initiatives were identified; which data were used in the selection process;

which interventions were considered; how the interventions were implemented; how the initiatives were resourced, including specific, assigned individuals and their qualifications; and the results or outcomes of the QI work.

- Provide the story of the effectiveness of WellCare's quality assessment and performance improvement work in its QAPI program evaluation.
- Base its QAPI Program on the latest available research in the area of quality assurance.
- Update the QAPI program evaluation to reflect only Georgia WellCare information and data.
- Document results of the DCH-established performance measures in its QAPI report.
- Meet all DCH-established performance targets.
- Develop policies and procedures that support the implementation of the scope, goals, and objectives of the program including quality assessment, utilization management, and continuous QI. The CMO must also assess the policies and procedures periodically for efficacy.
- Implement processes to assess the quality of care furnished to members with special healthcare needs.
- Strengthen its processes for monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members in the areas of underutilization.
- Include information on its method of monitoring, analysis, evaluation, and improvement for the delivery, quality, and appropriateness of healthcare furnished for members with special healthcare needs in its policies, program descriptions, and evaluations.
- Document how it monitors and evaluates internal processes for quality management and performance improvement.
- Update its process descriptions to include how the CMO ensures that data received from providers are complete, logical, and consistent.
- Update its policies, program descriptions, and/or program evaluations to describe how, as a result of data analysis or evaluation, indicated recommendations are implemented.
- Include in its quality of care and peer review process a description of how the results of its internal review processes are tracked and trended, substantiated issues are reviewed for appropriate corrective actions, and a decision made whether the issue should be referred to regulatory boards for review.
- Document the methodology and process used for conducting and maintaining provider profiling in its policies. WellCare must develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction.
- Describe how it ensures that the decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.
- Include in its written process how it will include in the provider's profile a summary of the quality of care and peer review incident(s), including the final disposition.
- Structure the QM Patient Safety Plan as required by DCH. The QM Patient Safety Plan must clearly distinguish between grievances and the grievance process.

Follow-Up Review: HSAG also conducted a follow-up review of the previous compliance review findings. One reevaluated element within the Furnishing of Services standard will require continued corrective action.

- Continue to work to meet the geographic access standards for both urban and rural areas for PCPs, specialists, dental subspecialty providers, and pharmacies. WellCare must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.

Performance Improvement Projects

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. WellCare followed the rapid cycle PIP methodology as identified by HSAG in the Companion Guide sent to the CMO in January 2015. 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 the reported baseline rate and goal. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving improved outcomes.

Findings

For each PIP, WellCare was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. WellCare developed a SMART Aim statement that quantified the improvement sought for each PIP and used a process map and FMEA to identify one or more interventions that had the potential to impact the SMART Aim goal.

HSAG organized and analyzed WellCare's PIP data to draw conclusions about the CMO's QI efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal. Table 6-2 outlines the PIP topics, final CMO-reported SMART Aim statements, and the overall validation findings for the eight PIPs.

HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation 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*. If the CMO did not execute the PIP according to the approved SMART Aim measure methodology, a confidence level was not assigned because HSAG determined that the reported PIP results were not credible.

Table 6-2—PIP Titles, SMART Aim Statements, and Confidence Levels

PIP Title	SMART Aim Statement	Confidence Level
Annual Dental Visits	By December 31, 2015, increase the Annual Dental Visit rate from 49.5% to 54.5% among members 11–18 years of age and residing in Bibb County	*Low Confidence*
Appropriate Use of ADHD Medications	To increase the 30-day follow-up visit rate combined average for select pediatric practices located in rural southwest Georgia for members 6–12 years of age who have newly prescribed ADHD medication (who have four months negative ADHD medication history) from an average of 39% to an overall average of 49% by December 31, 2015	*Reported PIP results were not credible*
Avoidable Emergency Room Visits	Decrease Non-Emergent and Emergent-Primary Care Treatable emergency room visits at Floyd Medical Center ER by 10 percentage points from baseline of 117 visits per 1,000 member months to 105 visits per 1,000 member months for WellCare Medicaid and PeachCare for Kids members assigned to Harbin Clinic by December 31, 2015	*High Confidence*
Bright Futures	Increase the rate of Adolescent well-child visits for members 12 up to 21 years of age at AGC Pediatric LLC from 55.96 percent to 60.96 percent by December 31, 2015	*Low Confidence*
Comprehensive Diabetes Care	By December 31, 2015, increase the HbA1c control (<8.0%) rate for diabetic members 18–75 years of age residing in the North and Central regions of Georgia who are assigned to one of the four selected providers from 16.07 percent to 21.07 percent	*Confidence*
Member Satisfaction	By December 31, 2015, increase the percentage of members responding to phone or field survey questions with a rating of very satisfied or satisfied from 89% to 91%	*Reported PIP results were not credible*
Postpartum Care	Increase the Postpartum Visit rate by 10 percentage points from 26.3 to 36.3 for all Medicaid and PeachCare for Kids women who deliver at Grady Memorial Hospital (between the ages of 15–44), who have a postpartum visit within 21 to 56 days of delivery by Dec 30, 2015	*Confidence*
Provider Satisfaction	By December 31, 2015, aim to increase the percentage of Health One Alliance providers who answer "Excellent" or "Very Good" to WellCare's survey question from 64 percent to 74 percent (10 percentage point increase)	*High Confidence*

HSAG determined *High Confidence* for two of WellCare's eight PIPs: *Avoidable Emergency Room Visits*, and *Provider Satisfaction*. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the QI processes could be clearly linked to the demonstrated improvement.

HSAG assigned a level of *Confidence* to two PIPs, *Comprehensive Diabetes Care* and *Postpartum Care*. A level of *Confidence* was assigned because the SMART Aim goal was achieved; however, some but not all of the CMO's QI processes could be linked to the demonstrated improvement.

HSAG assigned a level of *Low Confidence* to two of the CMO's PIPs, *Annual Dental Visits* and *Bright Futures*. The SMART Aim goal was not achieved for the *Annual Dental Visits* PIP, but the SMART Aim goal was achieved for the *Bright Futures* PIP; however, the QI processes could not be clearly linked to the demonstrated improvement.

HSAG determined that for the remaining two WellCare PIPs, *Appropriate Use of ADHD Medications* and *Member Satisfaction*, the CMO's reported PIP results were not credible. In the *Appropriate Use of ADHD Medications* PIP, the CMO calculated the SMART Aim measure rates incorrectly. In the *Member Satisfaction* PIP, the CMO did not use the approved data collection process for the SMART Aim measurements. For both PIPs, incorrect SMART Aim measurement methodology resulted in PIP results that were deemed not credible.

Annual Dental Visits

WellCare's goal for the *Annual Dental Visits* PIP was to identify and test interventions to improve the annual dental visit rate among members 11 to 18 years old living in Bibb County. Because the SMART Aim goal was not achieved during the life of the PIP, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 6-3 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-3—SMART Aim Measure Results for *Annual Dental Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of adolescents 11 to 18 years of age who reside in Bibb County that received an annual dental visit	49.5%	54.5%	49.4%	*Low Confidence*

In the SMART Aim statement, the CMO established a goal of improving the annual dental visit rate among members 11 to 18 years old living in Bibb County by 5 percentage points, from 49.5 percent to 54.5 percent. None of the PIP's SMART Aim measurements met the goal rate of 54.5 percent. The details of the improvement processes used and the interventions tested are presented in Table 6-4 and in the narrative description below.

Table 6-4—Intervention Testing for *Annual Dental Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Community dental events	• Caretaker priorities • Fear of the dentist	Members not knowing the benefits/costs of their dental care	The CMO chose to adapt the community outreach intervention, reporting that it believed the intervention would be successful in

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
	• Unknown benefits/costs of seeing the dentist		conjunction with the mobile dental van, which will be launched in 2016.

The CMO identified two interventions to test: community dental events and a mobile dental van. The CMO reported that unforeseen complexities related to the mobile dental van intervention extended the planning phase required for this intervention and prevented testing in 2015; therefore, the CMO only tested the community dental events intervention.

WellCare's evaluation plan for testing the community dental events intervention relied on medical encounters data to determine the numerator (number of eligible members who received a dental service) for each monthly measurement. The use of claims and encounter data was not a methodologically sound data source for the monthly PDSA measurements because of the lag-time associated with data completeness. While the CMO accurately described the intervention testing results, the interpretation of the results was not accurate. In summarizing the results, WellCare reported that the intervention reached a total of 15 adolescent members in the targeted county, and none of those members received a dental service after receiving the intervention. Rather than concluding that the intervention was unsuccessful, the CMO reported that the evaluation results were inconclusive due to the claims lag issue. The CMO was continuing to follow three adolescent members who received the intervention but had not yet had a dental service, to determine if claims for dental service encounters were submitted within the 90-day claims lag period following the end of the 2015 PIP. Based on the small number of members who could possibly receive a dental visit and the large eligible population for the PIP, HSAG would have expected the CMO to conclude the intervention was unsuccessful, rather than stating that the evaluation was inconclusive, pending claims run-out in 2016.

The CMO chose to adapt the community outreach intervention, reporting that it believed the intervention would be successful in conjunction with the mobile dental van, which was planned for launch in 2016. The CMO stated that the community outreach events could serve to raise awareness of the mobile dental van and lead to greater dental visit compliance. Given the intervention evaluation results for the community outreach events, in which only seven eligible targeted members were reached and none received a dental visit as a result of the intervention, the rationale for continuing the outreach events was unclear.

Appropriate Use of ADHD Medications

WellCare's goal for the *Appropriate Use of ADHD Medications* PIP was to identify and test interventions to improve the 30-day follow-up appointment compliance rate among members 6–12 years of age who received an initial ADHD medication prescription from one of the targeted pediatric provider practices in rural southwest Georgia. Because the SMART Aim measure rates were calculated incorrectly, the reported PIP results were not credible. The details of the PIP's performance leading to Table 6-5 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-5—SMART Aim Measure Results for *Appropriate Use of ADHD Medications*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children 6 to 12 years of age who complete a follow-up visit within 30 days of the initial fill after receiving an initial prescription for ADHD medication from select pediatric practices in Southwest Georgia	39.0%	49.0%	56.0%	*Reported PIP results were not credible*

In the SMART Aim statement, the CMO established a goal of improving the follow-up visit rate among members 6 to 12 years old who received an initial prescription for ADHD medication from a selected provider in rural southwestern Georgia by 10 percentage points, from 39.0 percent to 49.0 percent. The CMO plotted rates that were incorrectly averaged across the providers in the region, rather than calculating valid aggregate monthly rates across providers. Although the SMART Aim run chart included monthly rates exceeding the goal of 49.0 percent, the rates were incorrectly calculated; therefore, the PIP did not demonstrate evidence of achieving the SMART Aim goal. The details of the improvement processes used and the interventions tested are presented in Table 6-6 and in the narrative description below.

Table 6-6—Intervention Testing for *Appropriate Use of ADHD Medications*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
15-day supply initial ADHD medication prescription	• Member perception of the importance to make follow-up appointments • Provider knowledge or interpretations of best-practice guidelines	Members having medication remaining from the initial fill past the 30-day follow-up period	Because the CMO incorrectly calculated the monthly rates across multiple provider offices, the CMO did not have accurate data to guide decisions about expanding, adapting, or abandoning the intervention.

The CMO identified one intervention to test: partnering with providers and pharmacies to prescribe and fill a 15-day supply of medication for the ADHD medication initiation phase.

WellCare reported that, due to the excessive burden of real-time data collection from multiple providers, the CMO had to shift from the originally planned manual data collection process to a process using claims data to identify the number of members who completed a 30-day follow-up visit. In general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because the lag-time associated with claims completeness yields incomplete rates that do not accurately reflect the impact of an intervention in a timely manner.

In addition to relying on claims data for the intervention evaluation, the CMO incorrectly calculated and reported the monthly rates during intervention testing. To calculate an aggregate follow-up visit rate across providers, the CMO should have summed the numerators and denominators across the providers, divided the aggregate numerator by the aggregate denominator, and then multiplied by 100 to calculate the monthly percentage rates. Instead, the CMO calculated the monthly follow-up visit rates for individual providers, summed the provider-specific rates, and divided by the number of providers to calculate an average.

HSAG also identified the following inaccurate statements documented by the CMO:

> *Due to our experience with the seasonality of ADHD medication utilization in the summer, we chose to plot the data points for June, July, and August but exclude them from our intervention results. In these months, children are not going to school, not filling their medication and not going to the physician for a new diagnosis of ADHD.*

Based on the information submitted by the CMO, HSAG determined that the rates for June, July, and August were 35 percent, 35 percent, and 34 percent, respectively. If the CMO's statements were true, and no children were initiating and filling medication during these months, it would not be possible to calculate monthly rates because the denominators would be zero.

WellCare chose to expand intervention testing to the eastern region based on its interpretation of the intervention's success in the southwestern region. The CMO's decision to adopt the intervention was not based on a sound rationale because the PIP results were calculated incorrectly.

Avoidable Emergency Room Visits

WellCare's goal for the *Avoidable Emergency Room Visits* PIP was to identify and test interventions to reduce the avoidable ER visit rate at Floyd Medical Center among members assigned to Harbin Clinic. The PIP's SMART Aim goal was achieved, the CMO used a sound methodology for evaluating and refining the interventions tested, and the QI processes could be clearly linked to improvement in the SMART Aim measure; therefore, the PIP was assigned a level of *High Confidence.* The details of the PIP's performance leading to the assigned confidence level are described below.

Table 6-7 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the lowest rate achieved for the SMART Aim measure.

Table 6-7—SMART Aim Measure Results for *Avoidable Emergency Room Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
Avoidable ER visits per 1,000 member months at Floyd Medical Center ER among members assigned to Harbin Clinic	117 visits per 1,000 member months	105 visits per 1,000 member months	68 visits per 1,000 member months	*High Confidence*

* The Lowest Rate Achieved is reported for the *Avoidable Emergency Room Visits* SMART Aim measure because the measure is an inverse indicator, where a lower rate is better.

In the SMART Aim statement, the CMO established a goal of reducing the avoidable ER visit rate at Floyd Medical Center for members assigned to Harbin Clinic from 117 visits per 1,000 member months to 105 visits per 1,000 member months. Five of the PIP's monthly SMART Aim measurements indicated better performance (i.e., had lower rates) than the goal rate of 105 visits per 1,000 members. The details of the improvement processes used and the intervention tested for the *Avoidable Emergency Room Visits* PIP are presented in Table 6-8 and in the narrative description below.

Table 6-8—Intervention Testing for *Avoidable Emergency Room Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Telephonic outreach by provider and CMO	• Member Education • Access to Medical Home (Primary Care Providers)	• Lack of relationships between new members and their PCPs • Lack of member knowledge about appropriate ER use and alternative care setting locations, such as urgent care centers and PCP immediate care clinics	The CMO chose to abandon the intervention at the end of testing because of the low number of members reached and the inconsistent impact on the SMART Aim measure.
Provider-based member outreach	• Member Education • Access to Medical Home (Primary Care Providers)	• Lack of relationships between new members and their PCPs • Lack of member knowledge about appropriate ER use and alternative care setting locations, such as urgent care centers and PCP immediate care clinics	Based on the analysis of findings, the CMO plans to continue testing Intervention 2 (provider-based member outreach calls) with the targeted provider and is exploring options for adapting the intervention to further address the barriers identified during the PDSA cycles.

The CMO identified two interventions for the PIP: (1) a joint CMO-provider telephone outreach initiative which involved the targeted PCP calling newly enrolled members to provide education on appropriate emergent and urgent care use and the CMO calling members assigned to the targeted PCP who had an ER visit, to provide further education on appropriate use of care options and facilitate a follow-up appointment with the targeted PCP; and (2) a provider-based outreach initiative which involved the targeted PCP calling members within 48 hours of an ER visit to discuss appropriate use of care and scheduling a recommended follow-up appointment.

WellCare used a two-pronged member outreach approach for the telephone outreach intervention: (1) the targeted clinic called new members assigned to their practice to encourage the scheduling of an initial evaluation appointment and to educate members on appropriate use of different levels of care (e.g., urgent care and emergency care); and (2) the CMO member outreach coordinator made follow-up calls to members assigned to the targeted PCP who had an avoidable ER visit at the targeted hospital, within 48 hours of the visit, to educate on appropriate ER use and alternatives to ER care, and to

facilitate a follow-up visit with the member's PCP. WellCare used a methodologically sound process to evaluate the two-pronged intervention. To test the first part of the intervention, the CMO used enrollment data to identify new members assigned to the targeted PCP. The targeted PCP manually tracked the new members who were called and reached for the first component of the outreach intervention and the number that scheduled an initial appointment with the PCP. To test the second part of the intervention, the CMO collected real-time ER hospital census data daily to identify members assigned to the targeted PCP who had visited the ER. The CMO manually tracked the members called and reached for the follow-up calls to eligible members who had an avoidable ER visit. Additionally, the CMO tracked whether those members who were reached scheduled a follow-up PCP visit. Based on the evaluation results, the CMO determined that the impact of the intervention was inconclusive because the avoidable ER visit rate among members assigned to the targeted provider fluctuated above and below the goal rate of 105 avoidable ER visits per 1,000 member months during intervention testing.

Because the evaluation results did not show a consistent impact of the telephone outreach intervention, the CMO adapted the intervention during testing. For example, the outreach intervention was revised to target all members assigned to the targeted PCP clinic who had an ER visit, rather than just members who had an ER visit for a confirmed avoidable diagnosis, based on a discovery about the daily ER census data used to identify members for outreach; it was determined that the census did not provide a primary diagnosis for each member's ER visit. By broadening the focus to all eligible members who had any ER visit, the intervention could avoid missing members because of incomplete diagnosis data on the ER daily census. Ultimately, the CMO chose to abandon the intervention at the end of testing because of the low number of members reached and the inconsistent impact on the SMART Aim measure. Using the lessons learned in the evaluation of the initial member outreach intervention, the CMO designed the second intervention, provider-based member outreach, for testing.

The provider-based member outreach intervention included outreach calls from the targeted PCP office to members within 48 hours of an ER visit at the targeted hospital. The outreach call provided education on appropriate ER use, alternatives to ER care, PCP verification, and scheduling of a PCP follow-up appointment for the member. To evaluate the intervention, the CMO obtained daily ER census data from the targeted hospital to identify members for the provider-based outreach calls. A manual tracking log was used to monitor the members who received an outreach call and those who scheduled and attended a follow-up visit with the targeted PCP practice. The avoidable ER visit rate was calculated for members assigned to the targeted provider practice. Based on the intervention evaluation results, WellCare plans to continue testing the provider-based member outreach with the targeted provider and is exploring options for adapting the intervention to further address the barriers identified during the PDSA cycles. The CMO provided a sound rationale for adapting the intervention through analysis of process data and drill-down analyses of the reasons members identified for visiting the ER, which were plotted on a Pareto chart.

Bright Futures

WellCare's goal for the *Bright Futures* PIP was to identify and test interventions to improve the rate of members 12 to 21 years of age, assigned to AGC Pediatric LLC, who received an annual well-child visit. Although the SMART Aim goal was achieved, one intervention was poorly executed and the QI processes could not be clearly linked to improvement in the SMART Aim measure; therefore, the PIP

was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 6-9 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-9—SMART Aim Measure Results for *Bright Futures*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of adolescents 12 to 21 years of age assigned to AGC Pediatric LLC who received an annual well-child visit	56.0%	61.0%	70.0%	*Low Confidence*

In the SMART Aim statement, the CMO established a goal of improving the annual adolescent well-child visit rate among members assigned to AGC Pediatric, LLC, by 5 percentage points, from 56.0 percent to 61.0 percent. One of the PIP's monthly SMART Aim measurements exceeded the SMART Aim goal of 61.0 percent. The details of the improvement processes used and the intervention tested for the *Bright Futures* PIP are presented in Table 6-10 and in the narrative description below.

Table 6-10—Intervention Testing for *Bright Futures*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Member outreach	• Members not certain how to use benefits, new to Medicaid • Value of the visits not understood by parents and adolescents	Member apathy	The CMO provided a sound rationale for adapting the intervention and moving onto testing the planned intervention revision of adding a member incentive component.
Member outreach and incentive	• Members not certain how to use benefits, new to Medicaid • Value of the visits not understood by parents and adolescents	Member apathy	The CMO chose to adopt the intervention based on two results: 1. The SMART Aim measure exceeded the goal for one monthly measurement on 10/1/15. 2. An analysis of monthly claims data for the targeted provider for 2014 and 2015 showed that the adolescent well-child visit rate for the targeted provider increased at a more rapid rate during the months when the intervention was tested.

The CMO identified two interventions for the PIP. Both were member outreach initiatives, with one initiative including a gift card incentive for completing an adolescent well-child visit.

For the first member outreach initiative, the CMO partnered with the targeted provider to identify adolescent members who were due for a well-child visit. The intervention entailed telephone calls to adolescent members and their parents. The phone calls offered education on the importance of well visits and scheduling assistance via three-way conference call with the provider office. WellCare used a combination of claims data and manual data collection from the targeted provider to identify adolescent members assigned to the provider who were due for a well-child visit. The CMO collaborated with the targeted provider to collect real-time data on the number of adolescent members who received the intervention and completed a well-child visit. Only one monthly measurement was plotted on the intervention run chart because of unexpected events that occurred during the deployment of the intervention. Because the outreach coordinator did not follow the intervention deployment plan and communicated the member incentive during outreach calls beginning in mid-June, WellCare had no choice but to progress to the second planned intervention earlier than planned and to abandon testing of the member outreach initiative alone.

For the member outreach initiative with incentive intervention, WellCare partnered with the targeted provider to identify and contact adolescent members who were due for a well-child visit. Telephone outreach offered the same education and scheduling assistance as offered in the first intervention, with the addition of offering eligible members a $30 gift card for completing the well-child visit. Although the CMO clearly documented how eligible members were identified for the intervention and how the outreach phone calls and completed well-child appointments were tracked, the CMO did not report a process for tracking whether members requested or received the incentive after completing a well-child visit. It was unclear how the impact of adding the incentive could be assessed if information on the number of incentives requested and received was not tracked. The CMO chose to adopt the intervention based on two evaluation results:

- The SMART Aim measure exceeded the goal for one monthly measurement on 10/1/15.
- An analysis of monthly claims data for the targeted provider for 2014 and 2015 showed that the adolescent well-child visit rate for the targeted provider increased at a more rapid rate during the months when the intervention was tested.

While these two results supported the decision to adopt the intervention, several factors were not addressed by the CMO:

- WellCare was unable to document data on intervention effectiveness beyond October 2015, so data were incomplete for the calendar year of the PIP.
- WellCare reported that the quality department's QI coordinator was unable to continue the member outreach component of the intervention through the end of CY 2015 "because of a lack of external resources and competing priorities" and the module submissions did not describe how these barriers would be overcome so that the intervention could be continued and adopted.

Comprehensive Diabetes Care

WellCare's goal for the *Comprehensive Diabetes Care* PIP was to identify and test interventions to improve the percentage of diabetic members residing in the North and Central regions of Georgia assigned to one of four selected providers who had an HbA1c test result less than 8.0 percent. Because the SMART Aim goal was exceeded, and because some but not all of the improvement could be linked directly to the improvement activities, the PIP was assigned a level of *Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 6-11 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-11—SMART Aim Measure Results for *Comprehensive Diabetes Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 18 to 75 years of age residing in the North and Central regions of Georgia assigned to one of the four selected providers who had HbA1c control <8.0%.	16.1%	21.1%	54.6%	*Confidence*

In the SMART Aim statement, the CMO established a goal of improving the percentage of diabetic members in the North and Central regions of Georgia, assigned to one of the selected providers, with an HbA1c result less than 8.0 percent by 5 percentage points, from 16.1 percent to 21.1 percent. Six consecutive monthly SMART Aim measurements met or exceeded the goal of 21.1 percent. The details of the improvement processes used and the interventions tested are presented in Table 6-12 and in the subsequent narrative description.

Table 6-12—Intervention Testing for *Comprehensive Diabetes Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Monthly provider summits	• Provider engagement • Adherence to WellCare's Diabetes clinical practice guidelines • Monthly surveillance of clinical data for diabetic members	Providers were unable to improve glycemic control of their diabetic members as measured by HbA1c.	The CMO chose to adopt the intervention based on the analysis of findings and reported next steps for pursuing expansion of the intervention beyond the initial scope of the PIP.

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Disease management (DM) engagement	• Diabetes awareness • Member education and diabetes-specific management programs	Members were unaware of how to control their HbA1c.	The CMO chose to adopt the intervention based on the analysis of findings and reported next steps for pursuing expansion of the intervention beyond the initial scope of the PIP.

The CMO identified two interventions for the PIP: monthly provider education summits for the three targeted providers and active enrollment in DM for diabetic members assigned to the three targeted providers.

The monthly provider summits included training from various WellCare departments and from select in-network specialty providers. The targeted participating providers "were equipped with proprietary tools which helped enhance glycemic control for diabetic patients." Additionally, the summits provided an opportunity to discuss "barriers, best practices and lessons learned to improve diabetic patient care." To test the effectiveness of the provider summits, WellCare worked collaboratively with the targeted provider practices to identify diabetic members enrolled and assigned to the targeted providers for the denominator. The numerator (number of diabetic members assigned to the targeted providers who had an HbA1c test result < 8.0%) was tracked monthly using a manual data collection tool. The intervention was at the provider level; therefore, the SMART Aim measure was an appropriate measure for evaluating intervention effectiveness because it was reasonable to assume that all members assigned to the targeted providers received the intervention and could be impacted by it. The CMO chose to adopt the intervention based on the analysis of findings and reported next steps for pursuing expansion of the intervention beyond the initial scope of the PIP.

For the DM engagement intervention, WellCare sought to enroll and actively engage diabetic members assigned to the targeted providers in the CMO's DM program, which provided education, guidance, support, and health coaching. The DM program taught self-management skills to address glycemic control and support healthier life choices. The CMO used two measures to evaluate the effectiveness of the intervention: (1) the percentage of diabetic members assigned to the targeted providers who were successfully enrolled in the DM program, and (2) the SMART Aim measure (percentage of diabetic members assigned to the targeted provider who had HbA1c result < 8.0%). While both of these measures were relevant, the evaluation plan was missing a measure of the specific effectiveness of DM program enrollment on HbA1c control. The evaluation plan should have included a measure of the percentage of diabetic members who were successfully enrolled in the DM program that had an HbA1c result < 8.0%. Without an intervention-specific measure of the outcome, limited to those members who received the intervention (DM program enrollment), it was not possible to clearly assess the impact of the intervention on the SMART Aim measure. The percentage of members enrolled in the DM program increased more than 20 percentage points, and the SMART Aim measure increased substantially during intervention testing. Based on these results, WellCare chose to adopt the DM engagement intervention.

Member Satisfaction

WellCare's goal for the *Member Satisfaction* PIP was to increase the percentage of members who answered "Satisfied" or "Very Satisfied" to the survey question related to satisfaction with customer service received from the CMO. Although the SMART Aim goal was achieved, the CMO used an invalid SMART Aim measurement methodology, which prevented the CMO from reporting valid results; therefore, the reported PIP results were not credible.

Table 6-13 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-13—SMART Aim Measure Results for *Member Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members responding to phone or field customer service satisfaction survey questions with a rating of "very satisfied" or "satisfied."	89.0%	91.0%	100%	*Reported PIP results were not credible*

In the SMART Aim statement, WellCare established a goal of increasing the percentage of members responding to the customer service satisfaction survey questions with an answer of "satisfied" or "very satisfied by 2 percentage points, from 89.0 percent to 91.0 percent. The CMO reported that the SMART Aim measure met or exceeded the goal of 91.0 percent for five monthly measurements. Because the SMART Aim measure data collection process was changed from the process HSAG approved the results were not based on the approved measurement methodology and were not credible. The PIP did not demonstrate evidence of achieving the SMART Aim goal because the SMART Aim measurement methodology was flawed.

Table 6-14—Intervention Testing for *Member Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Customer service agent training on handling member eligibility lag between State and CMO	Customer service training and tools	The high volume of member eligibility calls due to system eligibility discrepancies.	The CMO chose to abandon the intervention based on the analysis of findings, due to the lack of evidence of effectiveness.
Customer service representative adherence to member call protocols, resources, and tools	• Customer service training and tools • Member education and engagement	• Customer Service does not educate members on roles and responsibilities of WellCare versus the State to minimize confusion	The CMO chose to adapt and continue to monitor the intervention based on

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
		before referring them to Compass.org. • Customer Service is not provided updated information and resources relative to market trends to enable first call resolutions.	the analysis of findings.

The CMO identified two interventions for the PIP: (1) customer service agent (CSA) training and tools to handle member calls related to lagging eligibility (i.e., members are not eligible in the CMO system until the first day of the month following eligibility with the State), and (2) CSA training to improve adherence to established protocols and scripts for the top-five member call issues.

The purpose of the first CSA training intervention was to provide CSAs with the knowledge, skills, and tools needed to deal with the high volume of member calls related to the eligibility lag between the State system and the CMO's system (members are not eligible for coverage with the CMO until the first day of the month following eligibility in the State system). The intervention involved training CSAs on how to explain the eligibility discrepancy to members so that member frustration and repeat eligibility-related calls would be reduced. The evaluation plan documented for the intervention lacked sufficient detail for HSAG to validate whether the data collection process was methodologically sound. The CMO stated that it would be using quality audits (QAs) and first call resolution (FCR) to evaluate the effectiveness of the CSA training. The CMO did not, however, document how specific measures related to QA and FCR would be calculated and analyzed to evaluate intervention effectiveness. The CMO's summary of findings also lacked sufficient detail and did not align with the CMO's documented evaluation plan. The CMO did not provide a narrative summary of results for the *Study* step of the PDSA cycle and instead stated that the intervention was abandoned shortly after initiation because it was determined that the CSA training initiative could not address member satisfaction related to the State-CMO eligibility lag issue.

The purpose of the second CSA training initiative was to increase CSA adherence to established protocols and scripts for the top-five member call issues. By following established protocols, the CSAs were expected to improve interactions with members and, ultimately, improve member satisfaction survey responses. The intervention included CSA education on correct caller practices, customer service workflows, and sensitivity training. The intervention targeted improvement in five high-volume member call issues:

- Properly open/close calls.
- Identify members calling multiple times for the same issue.
- Follow the correct process or step action.
- Complete accurate documentation at the end of calls.
- Complete call drivers within the system.

The data collection process for evaluating the second CSA training initiative was not methodologically sound. The CMO reported that it shifted from relying primarily on a telephone survey methodology to primarily relying on another survey that could be completed by phone or in person at community events. Because telephone and field survey methodologies differ, potentially impacting member responses and biasing results, switching from one methodology to another mid-way through intervention testing is not a methodologically sound data collection process. WellCare compiled the results of both surveys and concluded that the intervention was effective. The CMO chose to adapt and continue to monitor the intervention based on the analysis of findings. Planned adaptations to the intervention include the following:

- Add an incentive program for CSAs who consistently meet standards of call handling behavior.
- Update the current quality audit process to ensure effective, results-driven monitoring of call handling behavior.
- Regularly update applicable call tools and training content for CSAs to align with current customer service protocols and requirements.

Postpartum Care

WellCare's goal for the *Postpartum Care* PIP was to identify and test interventions to improve the postpartum visit rate among members 15 to 44 years of age who delivered a live birth at Grady Memorial Hospital. The PIP's SMART Aim goal was achieved; however, some but not all of the QI processes could be clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 6-15 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-15—SMART Aim Measure Results for *Postpartum Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of women 15 to 44 years of age that had a postpartum visit 21 to 56 days after delivering a live birth at Grady Memorial Hospital.	26.3%	36.3%	62.5%	*Confidence*

In the SMART Aim statement, the CMO established a goal of improving the percentage of women who completed a postpartum visit within 21–56 days after delivering a live birth at Grady Memorial Hospital by 10 percentage points, from 26.3 percent to 36.3 percent. Four of the PIP's monthly SMART Aim measurements met or exceeded the goal rate of 36.3 percent. The details of the improvement processes used and the interventions tested are presented in Table 6-16 and in the subsequent narrative description.

Table 6-16—Intervention Testing for *Postpartum Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Provider education	Provider practice	Members did not understand the value of the postpartum visit nor did they distinguish a difference between the incision check and the postpartum visit.	The CMO chose to adopt the intervention based on the analysis of findings.
Member education prior to delivery	Member education (understanding the importance of visit)	• Member does not understand the importance of the postpartum visit (PPV) being within 21–56 days. • Member does not understand the difference between incision check and PPV.	The CMO chose to adopt and pursue expansion of the intervention based on the analysis of findings.

The CMO planned two interventions for the PIP: (1) education for the targeted hospital and clinic staff on the importance and requirements of the timely postpartum visit, and (2) education on the postpartum visit provided at 35 weeks' gestation to members delivering at the targeted hospital and receiving prenatal care at the hospital's on-site clinic.

For the provider education intervention, the CMO's QI nurse offered "train the trainer" educational sessions to administrative and nurse management staff at the targeted hospital. The education was disseminated to staff at the hospital's on-site clinic and affiliated outlying clinics, where members were expected to obtain the postpartum visit. The education sessions covered HEDIS standards and components of the postpartum visit, and the importance of adhering to the 21–56-day post-delivery timeline. The CMO used a manual tracking tool that tracked the date members delivered, the date of the scheduled postpartum appointment, and whether the appointment was completed. The CMO worked collaboratively with the targeted hospital to identify members who were due for delivery, actual date of delivery, and status of the postpartum visit. The CMO chose to adopt the intervention based on the analysis of evaluation results. HSAG determined, however, that the evaluation results were not valid because the measurement intervals were not consistently spaced. The measurement intervals should have been weekly, biweekly, or monthly so that there was an equal amount of time between each measurement.

For the member education intervention, the CMO partnered with the targeted hospital's on-site family planning clinic to offer member education at 35 weeks' gestation regarding the importance of completing the postpartum visit within 21–56 days post-delivery, and the difference between a C-section incision check appointment and the postpartum visit. To test the intervention, the CMO used a manual

tracking tool that tracked members who delivered, whether the member received postpartum visit education at 35 weeks' gestation, whether a postpartum appointment was scheduled, and whether the appointment was completed. The CMO worked collaboratively with the targeted hospital to identify members who were due for delivery, actual date of delivery, and status of the postpartum visit. The targeted clinic tracked whether education occurred at 35 weeks' gestation. The CMO plotted the monthly percentage of members delivering at the targeted hospital that received education at 35 weeks and completed a postpartum visit. The timely postpartum visit rates increased from 30 percent to 55 percent to 58 percent, respectively, during the three months of testing; as a result, the CMO chose to adopt the intervention and pursue expansion.

Provider Satisfaction

WellCare's goal for the *Provider Satisfaction* PIP was to identify and test interventions to increase overall satisfaction with the CMO among Health One Alliance providers. The SMART Aim goal was achieved, the CMO used a sound methodology for evaluating and refining the interventions tested, and the QI processes could be clearly linked to improvement in the SMART Aim measure; therefore, the PIP was assigned a level of *High Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 6-17 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 6-17—SMART Aim Measure Results for *Provider Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of Health One Alliance providers who answer "Excellent" or "Very Good" to WellCare's overall satisfaction survey question.	64.0%	74.0%	76.7%	*High Confidence*

In the SMART Aim statement, the CMO established a goal of increasing the percentage of Health One Alliance providers who answer "Excellent" or "Very Good" to WellCare's overall satisfaction survey question. One of the PIP's SMART Aim measurements exceeded the goal of 74.0 percent. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 6-18 and in the narrative description below.

Table 6-18—Intervention Testing for *Provider Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Targeted provider outreach, education, and issue resolution	• Account management and response	• The provider contacted the incorrect person	The CMO chose to adopt the intervention based on the analysis of

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
	• Access to claims support team • Provider education via Provider Relations • Access to the operations account representative	and/or department within WellCare. • Issue routed to the incorrect department/person within WellCare.	findings and is planning a staged expansion guided by a regional analysis of provider satisfaction to identify areas of highest need for improvement.

The CMO identified one intervention for the PIP: provider education on the provider relations representative's role and the issue escalation process, with follow-up by the provider relations representatives to ensure timely response and claims issues resolution. The intervention was initiated by providing education to the targeted provider about the provider relations representative and the issue escalation process. The provider relations representative acts as a liaison between the provider and other CMO departments to facilitate timely issue resolution and communicate results back to the provider.

To test the provider outreach intervention, WellCare surveyed the targeted provider biweekly about the provider's satisfaction with the issue resolution process and overall satisfaction. The CMO plotted the biweekly percentages of targeted provider responses to the three survey questions on three separate run charts. Two of the survey questions assessed satisfaction with areas of the provider issue resolution process directly targeted by the intervention: (1) the rate of satisfaction with timeliness increased in a linear trend from 33.3 percent at the initiation of the intervention to 70.0 percent at the last testing measurement, and (2) the rate of satisfaction with claims resolution increased from 36.7 percent at initiation to 66.7 percent at the last testing measurement. The third question assessed overall satisfaction, with results following a similar trend, increasing from 23.3 percent to 76.7 percent. The CMO chose to adopt the intervention based on the analysis of evaluation results and is planning a staged expansion guided by a regional analysis of provider satisfaction to identify areas in highest need for improvement.

Strengths and Weaknesses

This was the second year that WellCare submitted PIPs for validation using the rapid cycle PIP framework. WellCare's performance varied across the eight PIPs. HSAG assigned a level of *High Confidence* to two PIPs, a level of *Confidence* to other two PIPs, and a level of *Low Confidence* to another two PIPs. For the remaining two PIPs, HSAG determined that the CMO's reported PIP results were not credible; therefore, HSAG did not assign a level of confidence for these PIPs. WellCare demonstrated strength in applying the rapid cycle PIP process in two PIPs, *Avoidable Emergency Room Visits* and *Provider Satisfaction*, both of which were assigned a level of *High Confidence*. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the QI processes could be clearly linked to the demonstrated improvement.

WellCare's performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing HSAG's rapid cycle PIP process, though the CMO's performance varied widely by topic. In addition to incorporating HSAG's feedback from the PIP validations and seeking technical assistance when planning PDSA cycles, the CMO should also examine the performance of various PIP teams in its organization to determine if best practices for executing rapid cycle PIPs can be identified within the organization and shared across teams and departments.

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. WellCare's PIP performance suggested a number of areas of opportunity that applied across the various PIP topics. HSAG recommends the following for WellCare:

- Ensure detailed, accurate, and consistent documentation of the SMART Aim statement, SMART Aim measure definition, and baseline and goal rates to ensure consistency across all modules.
- If the CMO determines that the SMART Aim statement and/or SMART Aim measure need to be revised after Modules 1 and 2 have been approved by HSAG, the CMO must contact HSAG to discuss planned revisions and any methodological implications. Revisions to an approved SMART Aim statement and/or SMART Aim measure methodology must be clearly documented, including the rationale for the revisions, and submitted to HSAG. All subsequent module submissions should clearly explain any changes that were made to an approved SMART Aim statement and/or measure methodology, including the rationale for the changes.
- Institute centralized oversight of the data analysis and results reporting for all PIPs so that all rates are reported accurately and consistently. SMART Aim measure baseline and goal rates, and results should be reported to the same number of decimal places for all PIPs. HSAG recommends reporting all PIP rates to one decimal place.
- Revisit and update the key driver diagram and FMEA throughout the improvement process. Each version of the key driver diagram and FMEA should be dated to document when it was last revised.
- Conduct multiple sessions to develop and update the process map and FMEA, ensuring appropriate use of data and input from all relevant team members, for each PIP. The accuracy and completeness of the process map and FMEA will serve as the foundation for identifying and developing impactful improvement strategies.
- As WellCare moves through the QI process and conducts additional PDSA cycles, the CMO's PIP team should ensure that it is communicating WellCare's theory about changes that will lead to improvement. Without a common understanding of the theory, the CMO's PIP team may be working on changes for various perceived reasons.
- As WellCare tests new interventions, the CMO should ensure that it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep the theory for improvement in the project in the forefront for everyone involved.

- Avoid relying on medical claims as a data source when defining measures to be used in PDSA cycles, unless the CMO has strong evidence that the claims lag will be minimal. Seek technical assistance from HSAG when considering the use of medical claims data for PDSA cycles so that methodological implications and potential alternative measures can be discussed.
- Incorporate detailed, process-level data into the intervention evaluation plan to further the CMO's understanding of intervention effects.
- Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.
- When planning to test an intervention with multiple steps or components, consider staggering the initiation of the individual steps or components so that the impact of each step or component can be distinguished. A staggered approach to intervention testing may require shorter data collection intervals so that the multiple intervention components can be introduced and tested within the life of the PIP.
- When planning a test of change, WellCare should think proactively (future tests and implementation).
- Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the current year's rates as compared to last year's rates. Some performance measures include multiple indicators; therefore, some measures may have more than one rate reported. For purposes of this report, measure and measure indicator rates have been evaluated separately and are generally referred to as "rates."

Access to Care

Within the Access to Care measure set, seven measures yielded 17 individual rates. Of those 17, DCH established CY 2015 performance targets for seven rates. WellCare's Access to Care performance measure results are shown in Table 6-19.

Table 6-19—WellCare Access to Care Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.51%	96.90%	↓	NC
25 Months–6 Years	91.23%	89.63%	↓	NC
7–11 Years	92.61%	91.36%	↓	NC
12–19 Years	90.35%	89.09%	↓	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.76%	81.52%	↔	88.52%
Annual Dental Visit				
2–3 Years	46.94%	49.80%	↑	54.20%
4–6 Years	72.25%	76.42%	↑	NC
7–10 Years	75.14%	78.49%	↑	NC
11–14 Years	69.30%	72.49%	↑	NC
15–18 Years	58.65%	61.57%	↑	NC
*19–20 Years**	31.96%	40.17%	↑	34.04%[4]
*Total**	66.64%	70.12%	↑	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total	32.34%	34.15%	↔	43.48%
Engagement of AOD Treatment—Total	7.02%	7.09%	↔	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.00%	↔	NC
Colorectal Cancer Screening				
Colorectal Cancer Screening	^	46.72%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	79.94%	82.08%	↔	85.23%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members ages 19–21 years rather than 19–20 years.

** Due to changes in the technical measure specifications, where the CY 2014 measure included members ages 2–21 years and CY 2015 included members ages 2–20 years, use caution when comparing rates for this measure between CY 2014 and 2015 and to performance targets.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

^ indicates that this is a newly reported rate for CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Access to Care measure set, one of the seven rates with a performance target reported by WellCare for CY 2015, *Annual Dental Visit—19–20 Years*, met or exceeded the target and also demonstrated statistically significant improvement when compared to CY 2014. However, in CY 2014 and in prior years, members 2 to 21 years of age were included in the *Annual Dental Visit* measure, and beginning in CY 2015 only members 2 to 20 years of age were included. Therefore, caution should be exercised when comparing rates between years and to performance targets.

Of the remaining six rates that did not meet the performance targets, the *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* rate also demonstrated a statistically significant decline from CY 2014. Additionally, three rates without established performance targets also demonstrated a statistically significant decline from CY 2014.

Children's Health

Within the Children's Health measure set, 12 measures yielded 16 individual rates. Of those 16, DCH established CY 2015 performance targets for 15 rates. WellCare's Children's Health performance measure results are shown in Table 6-20.

Table 6-20—WellCare Children's Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	66.93%	64.69%	↔	69.98%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.93%	68.73%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.54%	53.28%	↔	53.47%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	84.03%	82.10%	↔	82.30%
Combination 6	43.06%	44.54%	↔	59.37%
Combination 10	38.66%	41.48%	↔	40.94%
Lead Screening in Children				
Lead Screening in Children	81.35%	83.85%	↔	77.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	79.09%	80.67%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	76.33%	89.51%	↑	73.43%

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	63.43%	66.26%	↔	45.86%
Counseling for Nutrition—Total	59.49%	60.39%	↔	46.30%
*Counseling for Physical Activity—Total**	54.63%	54.03%	↔	46.30%
Developmental Screening in the First Three Years of Life				
Total	44.91%	51.82%	↑	46.36%
Percentage of Eligibles Who Received Preventive Dental Services				
Percentage of Eligibles Who Received Preventive Dental Services	49.93%	52.91%	↑	58.00%
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	^	12.90%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	82.81%	84.42%	↑	86.11%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

^ indicates that this is a newly reported rate for CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Children's Health measure set, seven of the 15 rates with performance targets for CY 2015 met or exceeded the targets. Furthermore, two of these rates, *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)* and *Developmental Screening in the First Three Years of Life—Total*, demonstrated statistically significant improvement from CY 2014.

Of the remaining eight rates that did not meet the performance targets, the *Childhood Immunization Status—Combination 6* fell below its performance target by more than 14 percentage points. However, three of the rates that did not meet the performance targets demonstrated statistically significant improvement from CY 2014.

Women's Health

Within the Women's Health measure set, 12 measures yielded 13 individual rates. Of those 13, DCH established CY 2015 performance targets for 11 rates. WellCare's Women's Health performance measure results are shown in Table 6-21. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex; Cesarean Delivery Rate, Uncomplicated; Percentage of Live Births Weighing Less Than 2,500 Grams;* and *Elective Delivery.*

Table 6-21—WellCare Women's Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening	74.56%	66.36%	↓	76.64%
Breast Cancer Screening				
Breast Cancer Screening	72.17%	71.61%	↔	71.35%
Chlamydia Screening in Women				
Total	50.26%	53.04%	↑	54.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	20.37%	23.36%	↔	23.62%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.27%	72.32%	↓	89.62%
Postpartum Care	64.56%	52.87%	↓	69.47%
Cesarean Section for Nulliparous Singleton Vertex[4]				
Cesarean Section for Nulliparous Singleton Vertex	NR	NR	NT	18.08%
Cesarean Delivery Rate, Uncomplicated[4]				
Cesarean Delivery Rate, Uncomplicated	29.73%	28.70%	↑	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[4]				
Percentage of Live Births Weighing Less Than 2,500 Grams	9.21%	9.05%	↔	8.02%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	9.95%	15.33%	↑	NC
Elective Delivery[4]				
Elective Delivery	NR	NR	NT	2.00%
Antenatal Steroids				
Antenatal Steroids	NR	NR	NT	NC

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	58.48%	38.90%	↓	60.10%

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that Cesarean Section for Nulliparous Singleton Vertex, Elective Delivery, and Antenatal Steroids received the NR designation for the audit results. The CMO used a software vendor to produce the denominator for these measures; however, the vendor was not able to identify the gestational age using administrative data, which resulted in false positives in the denominator. Since the gestational age was not determined prior to drawing the sample, the rate was considered materially biased and an audit result of Not Reportable was assigned.

Within the Women's Health measure set, two of the 11 rates with performance targets for CY 2015 were not reportable. Of the remaining nine reportable rates, two rates met or exceeded the performance targets, the *Breast Cancer Screening* and *Cesarean Delivery Rate, Uncomplicated* rates. Furthermore, the *Cesarean Delivery Rate, Uncomplicated* measure demonstrated statistically significant improvement since CY 2014. Additionally, two measures that either did not meet their established performance target for CY 2015 or did not have an established performance target, *Chlamydia Screening in Women* and *Behavioral Health Risk Assessment for Pregnant Women*, also demonstrated statistically significant improvement since CY 2014.

Of the remaining seven rates reported that did not meet the targets, four of these rates, *Cervical Cancer Screening*, *Prenatal and Postpartum Care* (both rates), and *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*, demonstrated a statistically significant decline since CY 2014. Furthermore, the *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* rate fell below its performance target by more than 21 percentage points.

Chronic Conditions

Within the Chronic Conditions measure set, eight measures yielded 15 individual rates. Of those 15, DCH established CY 2015 performance targets for 10 rates. WellCare's Chronic Conditions performance measure results are shown in Table 6-22. Note that a lower rate is better for the following performance measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0), Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months), Asthma in Younger Adults Admission Rate (Per 100,000 Member Months), Chronic Obstructive Pulmonary Disease (COPD) or Asthma in*

Older Adults Admission Rate (Per 100,000 Member Months), and *Heart Failure Admission Rate (Per 100,000 Member Months).*

Table 6-22—WellCare Chronic Conditions Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care*				
Hemoglobin A1c (HbA1c) Testing	83.19%	80.43%	↔	87.59%
HbA1c Poor Control (>9.0%)[4]	48.75%	52.74%	↔	44.69%
HbA1c Control (<8.0%)	43.26%	39.80%	↔	46.43%
HbA1c Control (<7.0%)	32.43%	32.39%	↔	36.27%
Eye Exam (Retinal) Performed	35.44%	39.64%	↔	54.14%
Medical Attention for Nephropathy	76.71%	90.88%	↑	80.05%
Blood Pressure Control (<140/90 mm Hg)	55.74%	49.09%	↓	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[4]				
Diabetes Short-Term Complications Admission Rate	18.36	13.69	NT	--
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]				
Asthma in Younger Adults Admission Rate	5.52	3.38	NT	--
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]				
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	41.00	17.30	NT	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	73.61%	69.28%	↔	74.94%
Bronchodilator	84.72%	82.35%	↔	83.82%
Cardiovascular Conditions				
Heart Failure Admission Rate (Per 100,000 Member Months)[4]				
Heart Failure Admission Rate	4.28	5.02	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	43.24%	40.15%	↔	56.46%
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NT	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] *A lower rate indicates better performance for this measure.*

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and C Y2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Chronic Conditions measure set, one of the 10 rates with a performance target for CY 2015, the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* rate, met or exceeded the performance target. Furthermore, this rate also demonstrated statistically significant improvement since CY 2014. However, for CY 2015, updates to the technical specifications were made to the requirements for meeting the testing criteria for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*. In addition, the classification of diabetes changed significantly between ICD-9 and ICD-10. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Comprehensive Diabetes Care* measure.

Of the remaining nine rates reported that did not meet the performance targets, the *Comprehensive Diabetes Care—Blood Pressure Control (<140/90 mm Hg)* rate demonstrated a statistically significant decline and fell below the performance target by more than 12 percentage points.

Behavioral Health

Within the Behavioral Health measure set, six measures yielded nine individual rates. Of those nine, DCH established CY 2015 performance targets for seven rates. WellCare's Behavioral Health performance measure results are shown in Table 6-23.

Table 6-23—WellCare Behavioral Health Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	48.92%	47.02%	↓	53.03%
Continuation and Maintenance Phase	63.78%	64.29%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	50.77%	50.39%	↔	63.21%
30-Day Follow-Up	69.72%	68.75%	↔	80.34%
Antidepressant Medication Management				

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Effective Acute Phase Treatment	46.92%	44.77%	↔	54.31%
Effective Continuation Phase Treatment	30.37%	28.35%	↔	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	0.49%	7.18%	↑	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33.85%	39.23%	↔	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	2.19%	1.59%	↔	NC

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014, through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*
↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Behavioral Health measure set, one of the seven rates with a performance target for CY 2015, the *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase* rate, met or exceeded its target. Additionally, one of the rates without an established performance target, the *Screening for Clinical Depression and Follow-Up Plan* rate, demonstrated statistically significant improvement from CY 2014.

Of the remaining six rates reported that did not meet the performance targets, the *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase* rate demonstrated a statistically significant decline since CY 2014. Additionally, the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure rate fell below the performance target by more than 22 percentage points. However, for CY 2015, updates to the technical specifications extended the index prescription start date by three months. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Adherence to Antipsychotic Medications for Individuals with Schizophrenia* measure.

Medication Management

Within the Medication Management measure set, two measures yielded 13 individual rates. Of those 13, DCH established CY 2015 performance targets for four rates. WellCare's Medication Management performance measure results are shown in Table 6-24.

Table 6-24—WellCare Medication Management Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	86.72%	89.47%	↑	88.00%
Annual Monitoring for Members on Diuretics	87.27%	88.82%	↔	87.90%
Total	86.86%	89.03%	↑	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	45.62%	47.49%	↔	NC
Medication Compliance 50%—Ages 12–18 Years	42.00%	42.44%	↔	NC
Medication Compliance 50%—Ages 19–50 Years	57.79%	56.15%	↔	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 50%—Total	44.91%	46.08%	↔	NC
Medication Compliance 75%—Ages 5–11 Years	21.93%	22.99%	↔	32.32%
Medication Compliance 75%—Ages 12–18 Years	18.25%	19.95%	↔	NC
Medication Compliance 75%—Ages 19–50 Years	33.61%	34.23%	↔	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 75%—Total	21.17%	22.37%	↔	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Medication Management measure set, three of the four rates with performance targets for CY 2015 met or exceeded the target: *Annual Monitoring for Patients on Persistent Medications—Annual Monitoring for Members on ACE Inhibitors or ARBs*, *Annual Monitoring for Members on Diuretics*, and *Total*. Additionally, two of these three rates, *Annual Monitoring for Members on ACE Inhibitors or ARBs* and *Total*, demonstrated statistically significant improvement since CY 2014.

The remaining rate reported that did not meet the performance target, *Medication Management for People With Asthma—Medication Compliance 75%—Ages 5–11 Years*, fell below its target by more than 9 percentage points.

Utilization

Within the Utilization measure set, four measures yielded 21 individual rates. Of those 21, DCH established CY 2015 performance targets for one rate. WellCare's Utilization measure results are shown in Table 6-25. Note that lower rates are better for the *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total* and *Plan All-Cause Readmission Rate* measures. Significance testing was not performed on the Utilization measure set since variances are not reported to NCQA.

Table 6-25—WellCare Utilization Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	61.04	60.95	NT	52.31
Outpatient Visits—Total	334.03	327.56	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	2.99	3.20	NT	NC
Total Inpatient—Average Length of Stay—<1 Year	6.53	6.50	NT	NC
Medicine—Average Length of Stay—Total	3.02	3.18	NT	NC
Medicine—Average Length of Stay—<1 Year	4.06	4.16	NT	NC
Surgery—Average Length of Stay—Total	5.84	5.75	NT	NC
Surgery—Average Length of Stay—<1 Year	13.84	13.95	NT	NC
Maternity—Average Length of Stay—Total	2.53	2.74	NT	NC
Mental Health Utilization—Total				
Any Service—Total—Total	8.88%	9.25%	NT	NC
Inpatient—Total—Total	0.50%	0.55%	NT	NC
Intensive Outpatient or Partial Hospitalization—Total—Total	0.14%	0.13%	NT	NC
Outpatient or ED—Total—Total	8.77%	9.14%	NT	NC
Plan All-Cause Readmission Rate[4]				
Age 18–44	^	11.79%	NT	NC
Age 45–54	^	10.46%	NT	NC
Age 55–64	^	20.95%	NT	NC
Age 18–64—Total	^	11.93%	NT	NC
Age 65–74	^	NA	NT	NC

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Age 75–84	^	NA	NT	NC
Age 85 and Older	^	NA	NT	NC
Age 65 and Older—Total	^	NA	NT	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

^ indicates that this is a newly reported rate for CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Within the Utilization measure set, the only rate with a performance target for CY 2015, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total*, did not meet the performance target.

Health Plan Descriptive Information

WellCare's Health Plan Descriptive Information results are shown in Table 6-26.

Table 6-26—WellCare Health Plan Descriptive Information Measure Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.83%	13.79%	↑	NC
1–12 Weeks	7.11%	13.70%	↑	NC
13–27 Weeks	56.69%	52.04%	↓	NC
28+ Weeks	16.72%	12.33%	↓	NC
Unknown	8.66%	8.14%	↓	NC
Race/Ethnicity Diversity of Membership				
Total—White	48.33%	49.04%	↑	NC
Total—Black or African American	43.96%	44.16%	↑	NC

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

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↑ indicates a statistically significant rate increase between CY 2014 and CY 2015.

↓ indicates a statistically significant rate decrease between CY 2014 and CY 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Health Plan Descriptive Information measure rates are presented for information purposes only. HSAG recommends that WellCare review these results and identify whether a rate is higher or lower than expected.

Strengths and Weaknesses

The number of performance targets met by WellCare is shown in Table 6-27.

Table 6-27—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	7	1	14.29%
Children's Health	15	7	46.67%
Women's Health	9	2	22.22%
Chronic Conditions	10	1	10.00%
Behavioral Health	7	1	14.29%
Medication Management	4	3	75.00%
Utilization	1	0	0.00%
Total	**53**	**15**	**28.30%**

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

Based on WellCare's performance in CY 2015, more than 28 percent of the rates met or exceeded the performance targets overall. WellCare's rates met or exceeded 75 percent of the rates in the Medication Management measure set and nearly half of the rates in the Children's Health measure set. Select rates in the Access to Care, Women's Health, Chronic Conditions, and Behavioral Health measure sets also met or exceeded performance targets. HSAG has highlighted specific strengths and areas for improvement below.

WellCare's greatest strength was in the management of medication for members. As illustrated in the table above, WellCare met or exceeded 75 percent of the performance targets within the Medication Management measure set. All three rates for the *Annual Monitoring for Patients on Persistent Medications* measure met or exceeded performance targets, and two rates demonstrated statistically significant improvement since CY 2014.

For the Utilization measure set, only one rate, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total*, was compared to performance targets because most of the rates in this measure set are displayed for information purposes only. WellCare's rate for this measure did not meet the performance target, indicating opportunities for improvement related to potentially reducing the number of preventable/avoidable or nonemergent ED visits that could be treated in a primary care or urgent care setting.

Recommendations for Improvement

WellCare performed the best in the Medication Management measure set; however, other measure sets require innovative, targeted interventions to improve performance. Therefore, HSAG recommends the following for WellCare:

- Analyze the improvement strategies that can be linked to the overall success within the Medication Management 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.
- Analyze all performance measure rates that fell below the DCH-required performance target and either implement new PIPs or adjust the focus of existing PIPs as needed.
- Prioritize focusing on performance measures that demonstrated a statistically significant decline, such as access to care for children and adolescent measures.

In addition to the specific recommendations above, WellCare should focus efforts on the following measure topics in its QI efforts. The measure topics below were derived based on comparisons to the CY 2015 performance targets.

Access to Care

- Primary care for members 12 to 19 years of age and preventive/ambulatory services for adults
- Annual dental visits for members 2 to 3 years of age
- Treatment for members for alcohol and other drug dependence
- BMI assessments for adults

Children's Health

- Well-child visits for children 15 months of age and younger and for children 3 to 6 years of age
- Well-care visits for adolescents
- Immunizations for children
- Testing for children with pharyngitis
- Preventive dental services for children
- Treatment for children with upper respiratory infections

Women's Health

- Screening for cervical cancer and for chlamydia
- Vaccination for human papillomavirus for girls turning 13 years of age during the measurement year
- Prenatal care and postpartum care
- Live births with low birth weight

Chronic Conditions

- HbA1c testing and control, eye exams, and blood pressure control for members with diabetes
- Timely dispensing of systemic corticosteroids and bronchodilators for members with COPD
- Blood pressure control for members with hypertension

Behavioral Health

- Follow-up care for children with ADHD
- Follow-up care for members after hospitalization for mental illness
- Management of medications for members who take antidepressants
- Members with schizophrenia who remained on antipsychotic medications

Medication Management

- Appropriate medication management for members with asthma

Utilization

- Emergency department usage

CAHPS Surveys

Findings

To assess WellCare's overall performance, HSAG compared the calculated question summary rate for each global rating and global proportion for each composite measure (i.e., the percentage of respondents offering a positive response) to 2016 NCQA Medicaid national Medicaid averages.[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 2016 top-box scores to 2016 NCQA Medicaid national data were performed for WellCare's adult and child Medicaid populations.[6-3] Furthermore, 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 2016 NCQA Medicaid national average. For purposes of this report, CAHPS measures are reported even

[6-2] Quality Compass® 2016 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 2016 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.

when the NCQA minimum reporting threshold of 100 respondents was not met, which are denoted with a cross (+). 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

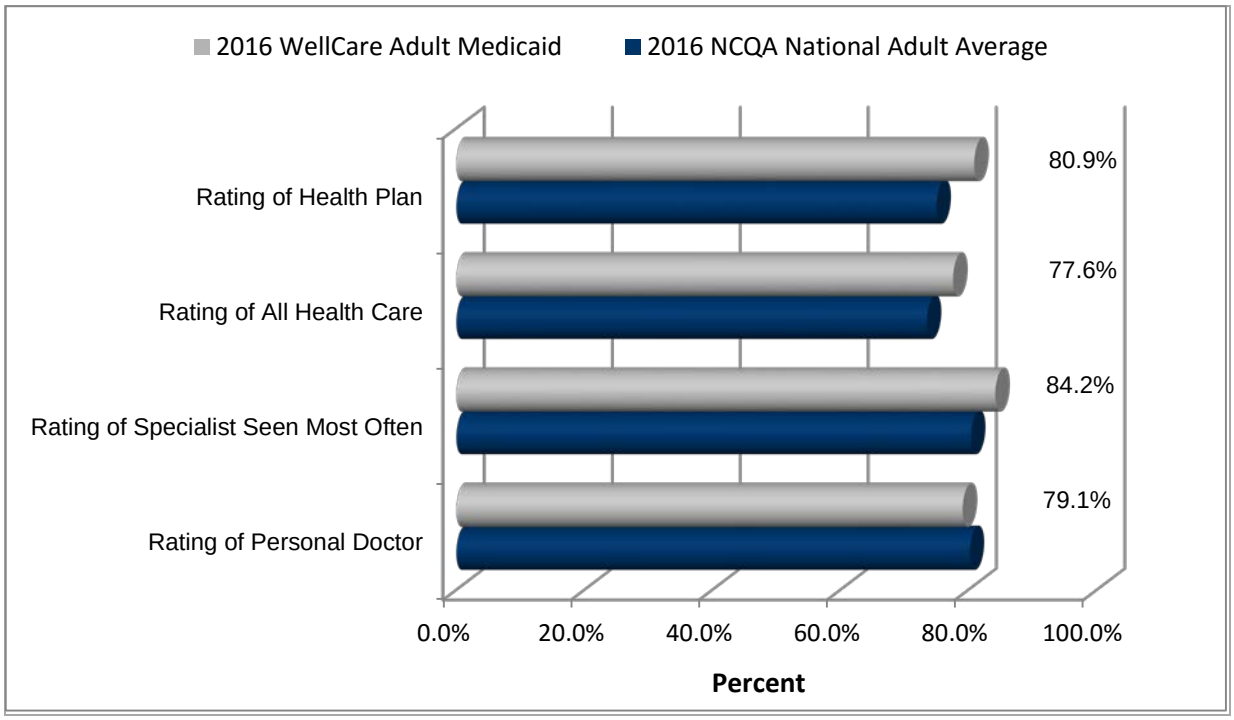
- *Rating of Health Plan*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Personal Doctor*

CAHPS Composite Measures

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

Figure 6-1 below depicts WellCare's adult Medicaid 2016 CAHPS top-box scores and the 2016 NCQA adult Medicaid national average for each of the global ratings. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2016 NCQA adult Medicaid national averages.

Figure 6-1—WellCare Adult Medicaid CAHPS Survey Results for Global Ratings

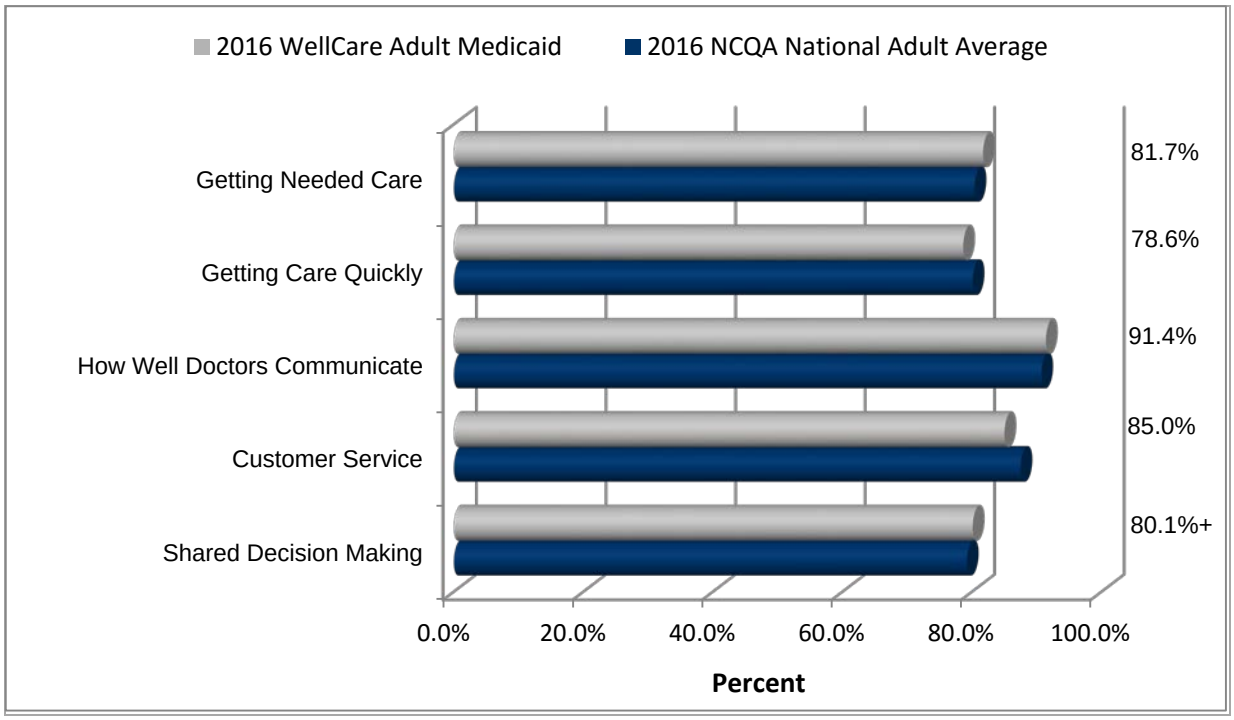


The top-box scores for the adult Medicaid global ratings indicate the following:

- WellCare scored between 77 and 85 percent on the four global rating measures.
- WellCare scored at or above the 2016 NCQA adult Medicaid national average for three of the global rating measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Specialist Seen Most Often*. Furthermore, the rate for *Rating of Health Plan* was more than 5 percentage points higher than the NCQA adult Medicaid national average.
- WellCare scored below the 2016 NCQA adult Medicaid national average on one measure, *Rating of Personal Doctor*.

Figure 6-2 below depicts WellCare's adult Medicaid 2016 CAHPS top-box scores and the 2016 NCQA adult Medicaid national average for each of the composite measures. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2016 NCQA adult Medicaid national averages.

Figure 6-2—WellCare Adult Medicaid CAHPS Survey Results for Composite Measures



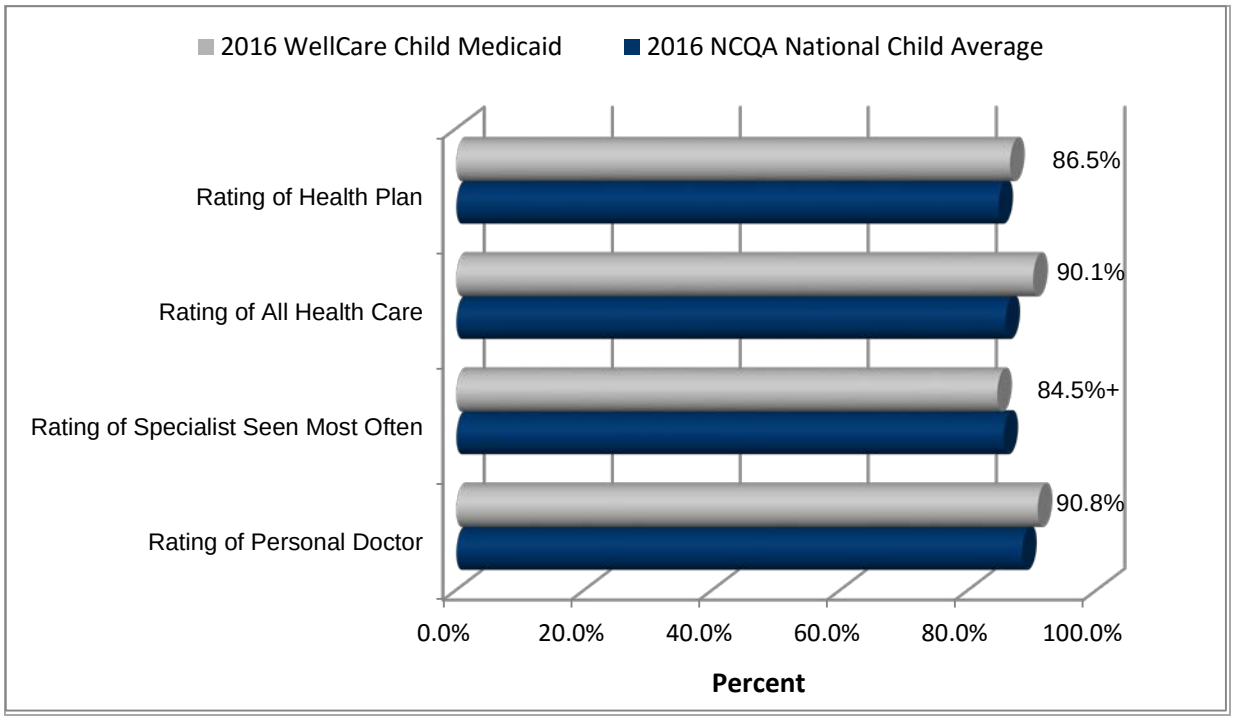
+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response, caution should be exercised when interpreting results for those measures.

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

- WellCare scored between 78 and 92 percent on the five composite measures.
- WellCare scored at or above the 2016 NCQA adult Medicaid national average for three measures: *Getting Needed Care*, *How Well Doctors Communicate*, and *Shared Decision Making*.
- WellCare scored below the 2016 NCQA adult Medicaid national average for two measures: *Getting Care Quickly* and *Customer Service*.

Figure 6-3 below depicts WellCare's child Medicaid 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the global ratings. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 6-3—WellCare Child Medicaid CAHPS Survey Results for Global Ratings



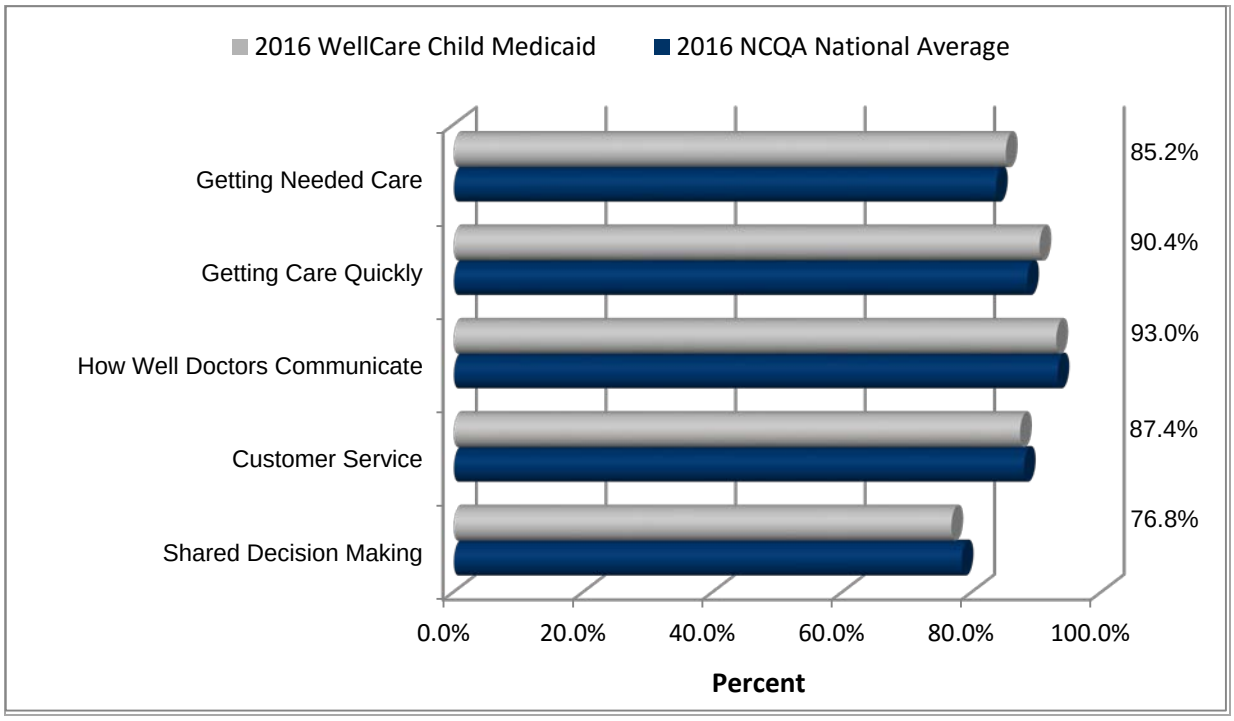
Please note: CAHPS measures with fewer than 100 respondents are denoted with a cross (+). If there are fewer than 100 respondents for a measure, caution should be exercised when interpreting the results.

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

- WellCare scored between 84 and 91 percent on the four global rating measures.
- WellCare scored at or above the 2016 NCQA child Medicaid national average for three measures: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*.
- WellCare scored below the 2016 NCQA child Medicaid national average for one measure, *Rating of Specialist Seen Most Often*.

Figure 6-4 below depicts WellCare's child Medicaid 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the composite measures. The grey bars represent WellCare's top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 6-4—WellCare Child Medicaid CAHPS Survey Results for Composite Measures



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

- WellCare scored at or between 76 and 93 percent on the five composite measures.
- WellCare scored at or above the 2016 NCQA child Medicaid national average for two measures: *Getting Needed Care* and *Getting Care Quickly.*
- WellCare scored below the 2016 NCQA child Medicaid national average for three measures: *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.

Strengths and Weaknesses

For WellCare's adult Medicaid population, the 2016 top-box rates for six measures exceeded the 2016 NCQA adult Medicaid national average; of these, the top-box rate for *Rating of Health Plan* exceeded the 2016 NCQA adult Medicaid national average by at least 5 percentage points. The remaining three 2016 top-box rates for *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service* were lower than the 2016 NCQA adult Medicaid national average.

For WellCare's child Medicaid population, the 2016 top-box rates for five of the measures exceeded the 2016 NCQA child Medicaid national averages: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly*. For the remaining four 2016 top-box rates, the measures were lower than the 2016 NCQA child Medicaid national averages: *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making*.

Based on an evaluation of WellCare's 2016 adult Medicaid CAHPS Survey results, HSAG recommends that the CMO focus efforts on enhancing members' experiences with *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service* since the rates for these measures were lower than NCQA's 2016 CAHPS adult Medicaid national averages. For WellCare's child Medicaid population, HSAG recommends that the CMO focus efforts on *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making* since the rates for these measures were below the 2016 NCQA child Medicaid national averages.

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 Medicaid national 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.

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 moderately strong compliance review results (65.5 percent of federal and contract requirements for structure and operations were *Met*) and also demonstrated its commitment to quality process improvement by closing five of the six corrective action plans from the previous year's compliance review.

Conclusions

Overall, WellCare's performance results are mixed. 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.

The CMO's QAPI program description and process should 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. WellCare's QAPI program description did not detail the QI processes the CMO had developed and implemented. For example, the CMO did not provide a comprehensive summary of how the QI goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered (and implemented); how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured in order to provide a comprehensive story of the effectiveness of WellCare's QAPI work. Strengthening the QAPI program description may result in improved processes leading to improved performance measure rates and PIP results.

WellCare used multiple approaches to ensure members received quality healthcare and improved outcomes. WellCare expanded the role of its staff members who work with provider practices to improve HEDIS scores to include discussions on overutilization, underutilization, member care needs, and healthcare advocacy. WellCare also used demographic information, as well as various clinical and behavioral health utilization patterns, to identify members who might benefit from disease management or case management programs. WellCare worked directly with providers and the community on QI initiatives such as the use of telemedicine and access to school-based care. Although not directly linked, these activities may have had a positive impact on some performance measure rates.

WellCare has an opportunity to strengthen its processes for monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members in order to identify interventions to improve performance measure rates in measure sets where performance was not as strong. Based on WellCare's performance in CY 2015, more than 28 percent of targets were met. WellCare should analyze the improvement strategies that can be linked to the overall success of performance measure sets. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement.

WellCare's performance across the eight PIPs suggests that the CMO continues to have opportunities for improvement in executing HSAG's rapid-cycle PIP process, though the CMO's performance varied widely by topic. In addition to incorporating HSAG's feedback from the PIP validations and seeking technical assistance when planning PDSA cycles, the CMO should also examine the performance of various PIP teams in its organization to determine if best practices for executing rapid-cycle PIPs can be identified within the organization and shared across teams and departments.

The CMO should ensure that its methodologies for determining and tracking 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 QI efforts.

HSAG has provided recent, formal QI 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.

The CMO conducted CAHPS surveys to collect information on members' experiences of care. The CMO should consider additional opportunities to seek member and family input in areas with CAHPS rates lower than the Medicaid national average. The CAHPS results indicate an opportunity for the CMO to develop additional mechanisms to collect member, family, and caregiver input into its QAPI Program.

7. The Georgia Families 360° (GF 360°) Program: Amerigroup Community Care

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. Amerigroup 360° provides medical, mental health, vision, and dental, plus a range of enhanced services, including dental and vision services, wellness/prevention programs, and incentives.

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.

Review of Compliance With Standards

Table 7-1 presents the standards and compliance scores for Amerigroup 360°. For Standards I–III and follow-up on previously noncompliant review findings, HSAG reviewed a total of 63 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	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Clinical Practice Guidelines	**11**	**11**	**11**	**0**	**0**	**100.0%**
II	Quality Assessment and Performance Improvement (QAPI)	**32**	**30**	**16**	**14**	**2**	**53.3%**
III	Health Information Systems	**8**	**8**	**8**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**12**	**12**	**11**	**1**	**0**	**91.7%**
	Total Compliance Score	**63**	**61**	**46**	**15**	**2**	**75.4%**

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

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

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

Findings

Amerigroup 360° had an overall compliance score of 75.4 percent, with two standards scoring 100 percent: Clinical Practice Guidelines and Health Information Systems. The Quality Assessment and Performance Improvement (QAPI) standard was noncompliant with 14 elements.

HSAG also reviewed documentation provided by Amerigroup 360° 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. Twelve elements were re-reviewed within the following standards: Provider Selection, Credentialing, and Recredentialing; Member Information; Grievance System; and Disenrollment Requirements and Limitations. All elements related to these standards were *Met* upon reevaluation*: Provider Selection, Credentialing, and Recredentialing; Member Information; and Disenrollment Requirements and Limitations*. One element within the Grievance System standard 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.

Clinical Practice Guidelines: Amerigroup 360° adopted clinical practice guidelines (CPGs) from evidence-based, professional association recommendations for care and treatment, used demographic and epidemiological profiles of its population, and analyzed utilization data. The Amerigroup 360° network providers participated in committee meetings and actively discussed the CPGs that were under consideration. Amerigroup 360° had processes for informing providers about the CPGs through outreach material, made the guidelines available on its website, and included components of the CPGs in member outreach material, case management programs, and educational materials. Amerigroup 360° provided training for clinical staff involved in disease management and care management regarding guideline recommendations. Amerigroup 360° implemented provider monitoring activities to ensure provider compliance with CPGs.

HSAG did not identify any areas requiring corrective action for Standard I—Clinical Practice Guidelines.

Quality Assessment and Performance Improvement: Amerigroup 360° used diverse processes to solicit provider, member, and community member feedback and input into the quality improvement (QI) processes of the program. Amerigroup 360° developed strong monitoring processes that assessed the performance of providers and delegated entities both in aggregate and by individual member using the member's individualized care plan. In the Pathways to Permanency program, Amerigroup 360° measured outcomes in timely care delivery as well as in measures, such as school attendance. Amerigroup 360° developed action plans focused on increasing access to care and receipt of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The CMO actively involved executive and senior-level staff in QI work. Amerigroup 360° continued to expand current QI knowledge and training throughout its organization. The CMO had a process for ensuring the delivery of quality care

with the primary goal of improving the health status of members who were identified as complex and were in case management. Amerigroup 360° developed strong processes to measure provider network accessibility. Amerigroup 360° also had processes to monitor complaints and grievances in relation to access to care concerns. Amerigroup 360° used monitoring results to identify opportunities for improvement and individual and aggregate results to inform and request corrective actions from providers. Amerigroup 360° developed provider report cards and produced a final measurement year report card that displayed year-over-year performance and variance. Amerigroup 360° used the performance measure results to identify opportunities for improvement.

Amerigroup 360°'s QAPI program description was not comprehensive and did not meet the DCH guidelines. The QAPI program evaluation did not provide a complete summary of how the QI goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered (and implemented); how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured. Amerigroup 360° did not document its use of the latest available research in the area of quality assurance/improvement in its QAPI Program nor fully describe how Amerigroup 360° monitored or evaluated its own processes for quality management and performance improvement. Amerigroup 360° did not identify additional opportunities to engage members' parents, guardians, family members, and community organizations in activities focused on QI. Amerigroup 360° did not include implementation or use of provider profiling information in the QAPI or QM program description. Amerigroup 360° experienced challenges meeting the EPSDT requirements for children in the Kenny A. Consent Decree counties of DeKalb and Fulton.

Health Information Systems: Amerigroup 360°'s health information system (HIS) was integrated and supported business intelligence needs. The Amerigroup Management Information System (MIS) included five integrated components, which collectively allowed for the collection, integration, tracking, analysis, and reporting of data. The MIS included (1) the core operating system that hosted provider, member, claims, and authorizations data; (2) the care management system, CareCompass, which included member utilization data such as claims history, authorizations, immunizations, lab, and case and disease management data; (3) the data warehouse that supported processes and functions, which was populated from source systems such as the core operating system; (4) supplemental applications to support overall functionality and produce business intelligence reports such as dashboards and analytical reporting; and (5) member and provider websites that were used to communicate, share, and deliver vital information.

HSAG did not identify any areas requiring corrective action for Standard III—Health Information Systems.

Recommendations for Improvement

HSAG's specific recommendations for Amerigroup 360° included the following:

- Develop a comprehensive QAPI program description. The QAPI program description must be developed according to DCH guidelines and must be approved by DCH as meeting its guidelines.

- Describe in its QAPI program description the mechanisms that will be used to detect underutilization.
- Include information in its QM or QAPI program description on how, as a result of data analysis or evaluation, indicated recommendations are implemented.
- Develop policies and procedures that support the implementation of the scope, goals, and objectives of the QAPI Program including quality assessment, utilization management, and continuous QI.
- Write the QAPI program evaluation based on DCH specifications. The QAPI program evaluation must be approved by DCH and must also include the comprehensive process used for QI activities, beginning with a review of information and data available to the CMO (e.g., claims/encounters, grievance and appeals, quality of care cases, care management, and member and provider input). In addition, the CMO must include the identification of QI opportunities and gaps in care or service delivery. QI initiatives must go beyond regulatory requirements and reflect an understanding of the population served; use data to understand where opportunities exist; and include research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members. The QAPI program evaluation must provide a complete summary of how the QI goals, objectives, and related initiatives were identified, which data were used in the selection process, which interventions were considered (and implemented), how the initiatives were resourced, and the results or outcomes of the QI work. The QAPI program evaluation must document the story of the effectiveness of Amerigroup 360°'s QAPI work.
- Meet all DCH-established performance targets.
- Document its use of the latest available research in the area of quality assurance/improvement in its QAPI Program.
- Define mechanisms to assess the quality and appropriateness of care furnished to its members with special healthcare needs.
- Continue to monitor and evaluate its service delivery system and provider network to ensure that DCH requirements for access to care are met.
- Develop provider profiling activities that include information such as tracked and trended data regarding utilization management, complaints and grievances, prescribing patterns, and member satisfaction.
- Seek opportunities to include the voice of both the member and the member's caregiver in efforts to actively improve the quality of care provided to members.
- Seek opportunities to include the member's parents, family members, and the member's guardian in efforts to actively improve the quality of care provided to members.
- Develop opportunities for community resources and agencies to provide input and feedback into the QI process.
- Clearly distinguish between grievances and the grievance system in its QM Patient Safety Plan.

Follow-Up Review: HSAG also conducted a follow-up review of the previous compliance review findings. One reevaluated element within the Grievance System standard will require continued corrective action. Below is a summary of the area that requires continued corrective actions.

- Amerigroup 360° must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters.

Performance Improvement Projects

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. Amerigroup 360° followed the rapid cycle PIP methodology as identified by HSAG in the Companion Guide sent to the CMO in January 2015. 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 the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving improved outcomes.

Findings

For each PIP, Amerigroup 360° was to specify the outcome being measured, the baseline value for the outcome measure, a quantifiable goal for the outcome measure, and the target date for attaining the goal. Amerigroup developed a SMART Aim statement that quantified the improvement sought for each PIP and used a process map and FMEA to identify one or more interventions that had the potential to impact the SMART Aim goal.

HSAG organized and analyzed Amerigroup 360°'s PIP data to draw conclusions about the CMO's QI efforts. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving the SMART Aim goal. Table 7-2 outlines the PIP topics, final CMO-reported SMART Aim statements, and the overall validation findings for the three PIPs.

HSAG assigned a confidence level to represent the overall validation findings for each PIP. The validation 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*. If the CMO did not execute the PIP according to the approved SMART Aim measure methodology, a confidence level was not assigned because HSAG determined that the reported PIP results were not credible.

Table 7-2—PIP Titles, SMART Aim Statements, and Confidence Levels

PIP Title	SMART Aim Statement	Confidence Level
7-Day Inpatient Discharge Follow-up	Increase mental health 7-day follow-up compliance rates, for members aged 6 to 18 years, at Peachford Hospital from 40% to 45% by December 31, 2015	*High Confidence*
Adolescent Well-Child Visits	Increase adolescent well-child visit rates by 6 percentage points for adolescents 11–21 assigned to Georgia Family Care, LLC, by December 31, 2015	*Low Confidence*

PIP Title	SMART Aim Statement	Confidence Level
Appropriate Use of ADHD Medications	A 5 percentage point (39.47%–44.47%) increase by December 31, 2015, in the number of members (ages 6–12 years), assigned to Harbin Clinic, who received an initial visit within 30 days after initially being prescribed an ADHD medication	*High Confidence*

HSAG assigned the level of *High Confidence* for Amerigroup 360°'s *7-Day Inpatient Discharge Follow-up* and *Appropriate Use of ADHD Medications* PIPs. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the QI processes could be clearly linked to the demonstrated improvement. HSAG assigned a level of *Low Confidence* for the *Adolescent Well-Child Visits* PIP because the SMART Aim goal was not achieved.

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 the reported baseline rate and goal. The data displayed in the SMART Aim run charts were used to determine whether the SMART Aim goal was achieved. The SMART Aim measure rates, improvement strategies, and validation findings for each PIP are discussed below.

7-Day Inpatient Discharge Follow-up

Amerigroup 360°'s goal for the *7-Day Inpatient Discharge Follow-up* PIP was to identify and test interventions to improve the compliance rates for follow-up visits with a mental health practitioner among Amerigroup 360° members discharged from Peachford Hospital with a principal diagnosis of mental illness. Because the SMART Aim goal was exceeded and the QI processes were clearly linked to the demonstrated improvement, the PIP was assigned a level of *High Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 7-3 below provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 7-3—SMART Aim Measure Results for *7-Day Inpatient Discharge Follow-up*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of inpatient discharges from Peachford Hospital for members with a primary diagnosis of mental illness that were followed by a visit with a mental health practitioner within 7 days of discharge.	40.0%	45.0%	52.4%	*High Confidence*

The CMO established a goal of improving the compliance rate for seven-day follow-up visits at Peachford Hospital by 5 percentage points, from 40.0 percent to 45.0 percent. Three of the PIP's monthly SMART Aim measurements exceeded the goal of 45.0 percent for the seven-day follow-up visit rate among members discharged from Peachford Hospital. The highest monthly follow-up visit compliance rate of 52.4 percent was an improvement of 12.4 percentage points over the baseline rate and exceeded the goal rate by 7.4 percentage points. The details of the improvement processes used and the intervention tested for the *7-Day Inpatient Discharge Follow-up* PIP are presented in Table 7-4 and in the narrative description below.

Table 7-4—Intervention Testing for *7-Day Inpatient Discharge Follow-up*

Intervention	Key Driver Addressed	Failure Modes Addressed	Conclusions
Stabilization team at discharging facility	Guardian's understanding of and participation in the transition appointment	• Appointments are not made • Appointments are not kept	Based on initial success and lessons learned during the PIP, the intervention will be adapted and testing will continue.

The CMO identified one intervention for the PIP: using a stabilization team to educate and coach members and facilitate the scheduling and attendance of the seven-day follow-up visit after discharge from the targeted hospital with a principal diagnosis of mental illness. The purpose of the stabilization team intervention was to assist the member with "transitional care coordination." The stabilization team member educated and coached the member prior to discharge to stress the importance of the seven-day follow-up visit and to identify and address barriers to scheduling and attending the visit. The stabilization team took these steps to facilitate completion of the seven-day follow-up visit:

- Identified a new provider for the member's follow-up visit, if needed.
- Scheduled the follow-up visit or ensured the member scheduled the visit.
- Provided appointment reminder calls and emails to the member.
- Contacted the member to confirm that the follow-up visit was completed.
- Repeated the steps to assist the member to schedule and attend a follow-up visit within 30 days of discharge, if the member fails to complete the seven-day follow-up visit.

Amerigroup 360° used a methodologically sound process for evaluating the effectiveness of the stabilization team intervention. To test the intervention, the CMO plotted the monthly SMART Aim measure (seven-day follow-up visit rate for members discharged from the targeted hospital with a principal diagnosis of mental illness). Because the intervention was tested at the facility level and the SMART Aim measure included all eligible members discharged from the targeted facility, the SMART Aim measure was appropriate for illustrating the impact of the intervention, and the monthly results provided meaningful data on progress toward achieving the goal.

It should be noted that, while the CMO used a methodologically sound evaluation process to test the series of steps carried out by the stabilization team described above, the evaluation results are only valid

for determining the impact of the entire series of steps included in the intervention tested. The evaluation results cannot be extrapolated to any of the individual steps or any other combination of steps. The CMO would need to design a distinct evaluation process specific to each step if the goal was to evaluate each step in the stabilization team process individually.

Based on the analysis of findings, the CMO concluded that the intervention should be adapted and tested further before pursuing expansion. The CMO provided a sound rationale for choosing to adapt the intervention and continue testing it beyond the life of the PIP.

Adolescent Well-Child Visits

Amerigroup 360°'s goal for the *Adolescent Well-Child Visits* PIP was to identify and test interventions to improve the rate Amerigroup 360° members 11–21 years of age assigned to Georgia Family Care, LLC, who received an annual adolescent well-child visit. Because the PIP's SMART Aim goal was not achieved, the PIP was assigned a level of *Low Confidence*. The details of the PIP's performance leading to the assigned confidence level are described below.

Table 7-5 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure.

Table 7-5—SMART Aim Measure Results for *Adolescent Well-Child Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of Amerigroup 360° members 11–21 years of age assigned to Georgia Family Care, LLC, who received an annual adolescent well-child visit	42.9%	48.9%	44.9%	*Low Confidence*

The CMO established a goal of improving the adolescent well-child visit rate at Georgia Family Care, LLC, by 6 percentage points, from 42.9 percent to 48.9 percent. None of the PIP's monthly SMART Aim measurements met the rate of 48.9 percent. The highest monthly adolescent well-child visit rate achieved during the life of the PIP for eligible Amerigroup 360° members was 44.9 percent, which was a 2 percentage point increase over the baseline rate but was 4 percentage points below the goal. The details of the improvement processes used and the intervention tested are presented in Table 7-6 and in the subsequent narrative description.

Table 7-6—Intervention Testing for *Adolescent Well-Child Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Focused member outreach by the targeted provider	Interagency Coordination/ Resources	• Member no-shows for scheduled appointments. • Lack of investment in the long-term healthcare needs of members. • Member is not aware of the importance or frequency of visits needed for adolescent members.	Based on the lack of meaningful improvement during the life of the PIP, the CMO chose to abandon the intervention.

The CMO identified one intervention for the PIP: focused member outreach conducted by the targeted provider. To facilitate the provider's outreach efforts, Amerigroup 360° generated a monthly roster of members due for an adolescent well-child visit and shared the monthly roster with the targeted provider. The targeted provider reached out to members on the roster and offered to schedule a well-child visit. The provider sent appointment confirmation by phone, email, and written communication. The CMO provided monthly improvement progress updates to the provider regarding the adolescent well-child visit rate.

The CMO used a methodologically sound data collection process and data sources to evaluate intervention effectiveness. The CMO tracked the SMART Aim measure (adolescent well-child visit rate among members assigned to the targeted provider) monthly. Because the intervention was tested at the provider level, the SMART Aim measure could be used to illustrate the effect of the intervention. The SMART Aim measure was tracked collaboratively by the CMO and the targeted provider using a manual tracking tool.

The CMO chose to abandon the intervention based on the analysis of findings. The SMART Aim goal was not achieved during the life of the PIP, and the CMO concluded that the intervention was not effective.

Appropriate Use of ADHD Medications

Amerigroup 360°'s goal for the *Appropriate Use of ADHD Medications* PIP was to identify and test interventions to improve the 30-day follow-up appointment compliance rate among Amerigroup 360° members 6–12 years of age who received an initial ADHD medication prescription at Harbin Clinic. Because the PIP's SMART Aim goal was exceeded and the QI processes were clearly linked to the demonstrated improvement, the PIP was assigned a level of *High Confidence*. A description of the PIP's performance leading to the assigned confidence level is provided below.

Table 7-7 provides a summary of the SMART Aim measure results reported by the CMO and the level of confidence HSAG assigned to the PIP. The table presents the baseline rate and goal rate for the SMART Aim measure, as well as the highest rate achieved for the SMART Aim measure and the PIP's confidence level.

Table 7-7—SMART Aim Measure Results for *Appropriate Use of ADHD Medications*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The monthly percentage of members 6–12 years of who received an initial ADHD medication prescription at Harbin Clinic and returned for a follow-up visit within 30 days of initial prescription fill.	39.5%	44.5%	100%	*High Confidence*

The CMO established a goal of improving the ADHD medication follow-up visit rate at Harbin Clinic by 5 percentage points, from 39.5 percent to 44.5 percent. Nine of the PIP's monthly SMART Aim measurements exceeded the goal rate of 44.5 percent, and two of the monthly measurements achieved the maximum possible compliance rate of 100 percent. The details of the improvement processes used and the intervention tested are presented in Table 7-8 and in the subsequent narrative description.

Table 7-8—Intervention Testing for *Appropriate Use of ADHD Medications*

Intervention	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Internal process changes at Harbin Clinic	• Provider engagement • Improve provider processes	• Unsuccessful attempts to schedule member's follow-up visit by telephone • Member is not aware of frequency of visits needed	Based on the sustained success achieved during the PIP, the intervention will be adopted and the CMO is pursuing expansion of the intervention to additional providers.

The CMO identified one intervention for the PIP: a series of related internal process changes undertaken at Harbin Clinic. The four primary process changes that comprised the intervention were:

- Reducing the initial ADHD medication prescription from a 60-day supply to a 21-day supply.
- Scheduling the initial follow-up appointment before the member leaves the appointment with an initial ADHD medication prescription.
- Automated reminder calls 48 hours prior to the scheduled follow-up appointment.
- Scheduling the follow-up appointment within three weeks of ADHD medication initiation to allow time for rescheduling within 30 days, if needed.

The CMO used a methodologically sound data collection process and data sources to evaluate effectiveness of the internal process changes. The CMO tracked the SMART Aim measure (30-day follow-up visit completion rate among members who received an initial prescription for ADHD medication from the targeted provider) monthly. Because the intervention was tested at the provider

level, the SMART Aim measure could be used to illustrate the effect of the intervention. The CMO used a combination of claims data and manual data collection from the targeted provider's office for the SMART Aim measure, so claims lag did not influence the SMART Aim measure rates.

As a result of the meaningful and sustained improvement demonstrated during the PIP, Amerigroup 360° chose to adopt the intervention and is pursuing additional provider partners to participate in the spread of this intervention.

Strengths and Weaknesses

This was the second year that Amerigroup 360° submitted PIPs for validation using the rapid cycle PIP framework. Amerigroup 360°'s performance varied across the three PIPs. HSAG assigned a level of *High Confidence* to two PIPs and a level of *Low Confidence* to the remaining PIP. Amerigroup 360° demonstrated strength in applying the rapid cycle PIP process in two PIPs, *7-Day Inpatient Discharge Follow-up* and *Appropriate Use of ADHD Medications*, both of which were assigned a level of *High Confidence*. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the QI processes could be clearly linked to the demonstrated improvement.

Amerigroup 360°'s performance across the three PIPs suggests that some of Amerigroup 360°'s PIP teams have incorporated a high level of understanding of the rapid cycle PIP process into their projects and have identified promising interventions to pursue for potential spread to their broader member population. All three of Amerigroup 360°'s PIPs incorporated sound measurement methodologies for evaluating intervention effectiveness and outcomes.

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. HSAG recommends the following for Amerigroup 360°:

- Revisit and update the key driver diagram and FMEA throughout the improvement process. Each version of the key driver diagram and FMEA should be dated to document when it was last revised.
- As Amerigroup 360° moves through the QI process and conducts additional PDSA cycles, the CMO's PIP team should ensure that it is communicating Amerigroup 360°'s theory about changes that will lead to improvement. Without a common understanding of the theory, the CMO's PIP team may be working on changes for various perceived reasons.
- As Amerigroup 360° tests new interventions, the CMO should ensure that it is making a prediction in each *Plan* step of the PDSA cycle and discussing the basis for the prediction. This will help keep everyone involved in the project focused on the theory for improvement.
- Incorporate detailed, process-level data into the intervention evaluation plan to further the CMO's understanding of intervention effects.
- Conduct a series of thoughtful and incremental PDSA cycles to accelerate the rate of improvement.

- When planning to test an intervention with multiple steps or components, consider staggering the initiation of the individual steps or components so that the impact of each step or component can be distinguished. A staggered approach to intervention testing may require shorter data collection intervals so that the multiple intervention components can be introduced and tested within the life of the PIP.
- When planning a test of change, Amerigroup 360° should think proactively (future tests and implementation).
- Determine the best method to identify the intended effect of an intervention prior to testing. The intended effect of the intervention should be known upfront to help determine which data need to be collected.

Performance Measures

Findings

The following tables of results are organized by measure sets, or domains of care, and show the CY 2015 rates. Some performance measures include multiple indicators; therefore, some measures may have more than one rate reported. For purposes of this report, measure and measure indicator rates have been evaluated separately and are generally referred to as "rates."

Access to Care

Within the Access to Care measure set, six measures yielded 16 individual rates. Of those 16, DCH established CY 2015 performance targets for six rates. Amerigroup 360°'s Access to Care performance measure results are shown in Table 7-9.

Table 7-9—Amerigroup 360° Access to Care Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	98.75%	NC
25 Months–6 Years	91.06%	NC
7–11 Years	97.46%	NC
12–19 Years	96.92%	93.50%
Adults' Access to Preventive/Ambulatory Health Services		
20–44 Years	52.82%	88.52%
Annual Dental Visit		
2–3 Years	46.87%	54.20%
4–6 Years	80.41%	NC

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
7–10 Years	75.91%	NC
11–14 Years	69.54%	NC
15–18 Years	63.67%	NC
19–20 Years	38.91%	NC
Total	67.48%	66.80%[3]
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment		
Initiation of AOD Treatment—Total	51.75%	43.48%
Engagement of AOD Treatment—Total	20.47%	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional		
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	NC
Adult BMI Assessment		
Adult BMI Assessment	NA	NC

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[3] CY 2015 performance target is derived from previous CY 2014 rates, which included members ages 2–21 years rather than 2–20 years.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Access to Care measure set, four of the six rates with performance targets for CY 2015 met or exceeded these targets, including *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*, *Annual Dental Visit—Total*, *Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total*, and *Engagement of AOD Treatment—Total*. However, in CY 2014 and in prior years, members 2 to 21 years of age were included in the *Annual Dental Visit* measure, and beginning in CY 2015 only members 2 to 20 years of age were included. Therefore, caution should be exercised when comparing these rates to performance targets.

Of the remaining two rates with performance targets that did not meet the targets, the *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years* rate fell below its target by more than 35 percentage points.

Children's Health

Within the Children's Health measure set, 12 measures yielded 16 individual rates. Of those 16, DCH established CY 2015 performance targets for 15 rates. Amerigroup 360°'s Children's Health performance measure results are shown in Table 7-10.

Table 7-10—Amerigroup 360° Children's Health Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Well-Child/Well-Care Visits		
Well-Child Visits in the First 15 Months of Life		
Six or More Well-Child Visits	56.70%	67.98%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.84%	72.80%
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	53.47%	53.47%
Prevention and Screening		
Childhood Immunization Status		
Combination 3	71.06%	80.30%
Combination 6	37.73%	59.37%
Combination 10	26.39%	38.94%
Lead Screening in Children		
Lead Screening in Children	78.94%	75.34%
Appropriate Testing for Children with Pharyngitis		
Appropriate Testing for Children with Pharyngitis	81.98%	77.96%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap/Td)	84.03%	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	68.29%	45.86%
Counseling for Nutrition—Total	68.52%	60.58%
Counseling for Physical Activity—Total	64.12%	46.30%
Developmental Screening in the First Three Years of Life		
Total	50.00%	46.36%
Percentage of Eligibles Who Received Preventive Dental Services		
Percentage of Eligibles Who Received Preventive Dental Services	59.08%	58.00%
Dental Sealants for 6–9-Year Old Children at Elevated Caries Risk		
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	26.93%	NC
Upper Respiratory Infection		
Appropriate Treatment for Children with Upper Respiratory Infection		
Appropriate Treatment for Children with Upper Respiratory Infection	84.11%	86.11%

[1] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.*

[2] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Children's Health measure set, 10 of the 15 rates with performance targets for CY 2015 met or exceeded the targets. These measures included *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Adolescent Well-Care Visits*; *Lead Screening in Children*; *Appropriate Testing for Children with Pharyngitis*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap/Td)*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* (all three rates); *Developmental Screening in the First Three Years of Life—Total*; and *Percentage of Eligibles Who Received Preventive Dental Services*. Furthermore, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* rate exceeded its target by more than 22 percentage points.

The *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*, *Childhood Immunization Status* (all three rates), and *Appropriate Testing for Children with Upper Respiratory Infection* were the remaining five rates that did not meet their targets. Of these measures, the *Childhood Immunization Status—Combination 6* rate fell below its target by more than 21 percentage points.

Women's Health

Within the Women's Health measure set, 10 measures yielded 11 individual rates. Of those 11, DCH established CY 2015 performance targets for eight rates. Amerigroup 360°'s Women's Health performance measure results are shown in Table 7-11. Note that a lower rate is better for the following performance measures: *Cesarean Section for Nulliparous Singleton Vertex; Cesarean Delivery Rate, Uncomplicated; Percentage of Live Births Weighing Less Than 2,500 Grams;* and *Elective Delivery.*

Table 7-11—Amerigroup 360° Women's Health Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Prevention and Screening		
Chlamydia Screening in Women		
Total	54.47%	54.93%
Human Papillomavirus Vaccine for Female Adolescents		
Human Papillomavirus Vaccine for Female Adolescents	22.92%	23.62%
Prenatal Care and Birth Outcomes		
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	81.08%	89.62%
Postpartum Care	59.46%	NC

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Cesarean Section for Nulliparous Singleton Vertex[3]		
Cesarean Section for Nulliparous Singleton Vertex	NR	18.08%
Cesarean Delivery Rate, Uncomplicated[3]		
Cesarean Delivery Rate, Uncomplicated	12.35%	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[3]		
Percentage of Live Births Weighing Less Than 2,500 Grams	NA	8.02%
Behavioral Health Risk Assessment for Pregnant Women		
Behavioral Health Risk Assessment for Pregnant Women	16.25%	NC
Elective Delivery[3]		
Elective Delivery	NR	2.00%
Antenatal Steroids		
Antenatal Steroids	NR	NC
Frequency of Ongoing Prenatal Care		
Frequency of Ongoing Prenatal Care		
≥81 Percent of Expected Visits	37.84%	71.34%

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[3] A lower rate indicates better performance for this measure.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

NR (i.e., Not Reported) indicates that Cesarean Section for Nulliparous Singleton Vertex, Elective Delivery, and Antenatal Steroids received the NR designation for the audit results. The CMO used a software vendor to produce the denominator for these measures; however, the vendor was not able to identify the gestational age using administrative data, which resulted in false positives in the denominator. Since the gestational age was not determined prior to drawing the sample, the rate was considered materially biased and an audit result of Not Reportable was assigned.

Within the Women's Health measure set, three of the eight rates with performance targets were not reportable or had a denominator less than 30. One of the remaining five reportable rates, *Cesarean Delivery Rate, Uncomplicated*, met or exceeded the performance target—by more than 16 percentage points.

Conversely, the remaining four rates in this measure set with performance targets did not meet their targets. Furthermore, the *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* measure fell below its target by more than 33 percentage points.

Chronic Conditions

Within the Chronic Conditions measure set, five measures yielded 11 individual rates. Of those 11, DCH established CY 2015 performance targets for eight rates. Amerigroup 360°'s Chronic Conditions performance measure results are shown in Table 7-12. Note that a lower rate is better for the following performance measures: *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0), Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months), Asthma in Younger Adults Admission Rate (Per 100,000 Member Months),* and *Heart Failure Admission Rate (Per 100,000 Member Months).*

Table 7-12—Amerigroup 360° Chronic Conditions Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Diabetes		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	NA	87.59%
HbA1c Poor Control (>9.0%)[3]	NA	44.69%
HbA1c Control (<8.0%)	NA	46.43%
HbA1c Control (<7.0%)	NA	36.27%
Eye Exam (Retinal) Performed	NA	54.14%
Medical Attention for Nephropathy	NA	80.05%
Blood Pressure Control (<140/90 mm Hg)	NA	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)[3]		
Diabetes Short-Term Complications Admission Rate	16.81	--
Respiratory Conditions		
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[3]		
Asthma in Younger Adults Admission Rate	0.00	--
Cardiovascular Conditions		
Heart Failure Admission Rate (Per 100,000 Member Months)[3]		
Heart Failure Admission Rate	0.00	--
Controlling High Blood Pressure		
Controlling High Blood Pressure	NA	56.46%

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[3] A lower rate indicates better performance for this measure.

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Within the Chronic Conditions measure set, none of the measures with performance targets were reportable by Amerigroup 360° because the rates were not valid or not reported since the denominators were less than 30. As such, comparisons to the CY 2015 performance targets could not be made.

Behavioral Health

Within the Behavioral Health measure set, six measures yielded nine individual rates. Of those nine, DCH established CY 2015 performance targets for seven rates. Amerigroup 360°'s Behavioral Health performance measure results are shown in Table 7-13.

Table 7-13—Amerigroup 360° Behavioral Health Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	51.71%	53.03%
Continuation and Maintenance Phase	54.72%	63.10%
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up	52.15%	63.21%
30-Day Follow-Up	75.68%	80.34%
Antidepressant Medication Management		
Effective Acute Phase Treatment	73.02%	54.31%
Effective Continuation Phase Treatment	61.90%	38.23%
Screening for Clinical Depression and Follow-Up Plan		
Screening for Clinical Depression and Follow-Up Plan	2.56%	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia		
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NA	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
Total	4.93%	NC

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Behavioral Health measure set, one of the seven rates with performance targets was not reported with a valid rate due to a denominator less than 30. Of the remaining six rates reported by Amerigroup 360° with performance targets in CY 2015, both *Antidepressant Medication Management* measure rates met or exceeded their targets. Furthermore, the rates for *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* met or exceeded their targets by more than 18 and 23 percentage points, respectively.

Of the remaining four reported measures in this measure set that did not meet performance targets, the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* rate fell below its target by more than 11 percentage points.

Medication Management

Within the Medication Management measure set, one measure yielded 10 individual rates. Of those 10, DCH established CY 2015 performance targets for one rate. Amerigroup 360°'s Medication Management performance measure results are shown in Table 7-14.

Table 7-14—Amerigroup 360° Medication Management Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Medication Management for People With Asthma		
Medication Compliance 50%—Ages 5–11 Years	NA	NC
Medication Compliance 50%—Ages 12–18 Years	NA	NC
Medication Compliance 50%—Ages 19–50 Years	NA	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NC
Medication Compliance 50%—Total	NA	NC
Medication Compliance 75%—Ages 5–11 Years	NA	32.32%
Medication Compliance 75%—Ages 12–18 Years	NA	NC
Medication Compliance 75%—Ages 19–50 Years	NA	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NC
Medication Compliance 75%—Total	NA	NC

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Medication Management measure set, none of the rates were valid or reported due to denominators being less than 30. Therefore, performance for the only measure with a performance target, the *Medication Management for People With Asthma—Medication Compliance 75%—Ages 5–11 Years* rate, could not be compared to the CY 2015 performance target.

Utilization

Within the Utilization measure set, four measures yielded 21 individual rates. Of those 21, DCH established CY 2015 performance targets for one rate. Amerigroup 360°'s Utilization measure results are shown in Table 7-15. Note that lower rates are better for the *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total* and *Plan All-Cause Readmission Rate* measures.

Table 7-15—Amerigroup 360° Utilization Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Ambulatory Care (Per 1,000 Member Months)—Total		
ED Visits—Total[3]	35.58	52.31
Outpatient Visits—Total	289.86	NC
Inpatient Utilization—General Hospital/Acute Care—Total		
Total Inpatient—Average Length of Stay—Total	4.90	NC
Total Inpatient—Average Length of Stay—<1 Year	5.74	NC
Medicine—Average Length of Stay—Total	3.76	NC
Medicine—Average Length of Stay—<1 Year	4.01	NC
Surgery—Average Length of Stay—Total	8.14	NC
Surgery—Average Length of Stay—<1 Year	10.00†	NC
Maternity—Average Length of Stay—Total	2.89	NC
Mental Health Utilization—Total		
Any Service—Total—Total	56.61%	NC
Inpatient—Total—Total	4.52%	NC
Intensive Outpatient or Partial Hospitalization—Total—Total	0.98%	NC
Outpatient or ED—Total—Total	56.24%	NC
Plan All-Cause Readmission Rate[3]		
Age 18–44	24.00%	NC
Age 45–54	NA	NC
Age 55–64	NA	NC
Age 18–64—Total	24.00%	NC

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[3] A lower rate indicates better performance for this measure.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† The rate for Inpatient Utilization—General Hospital/Acute Care—Total—Surgery—Average Length of Stay—<1 Year for Amerigroup 360° was based on at least one discharge, but fewer than 30 discharges; however, this rate is presented in the results table. Therefore, exercise caution when evaluating this rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Within the Utilization measure set, the only rate with a performance target for CY 2015, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total*, met or exceeded the target by more than 16 visits per 1,000 member months.

Health Plan Descriptive Information

Amerigroup 360°'s Health Plan Descriptive Information measure results are shown in Table 7-16.

Table 7-16—Amerigroup 360° Health Plan Descriptive Information Measure Results

Measure	CY 2015 Rate[1]	2015 Performance Target[2]
Weeks of Pregnancy at Time of Enrollment		
<0 Weeks	64.04%	NC
1–12 Weeks	10.11%	NC
13–27 Weeks	10.11%	NC
28+ Weeks	14.61%	NC
Unknown	1.12%	NC
Race/Ethnicity Diversity of Membership		
Total—White	47.67%	NC
Total—Black or African American	47.82%	NC

[1] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015, through December 31, 2015.

[2] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target.

Health Plan Descriptive Information rates are presented for information purposes only. HSAG recommends that Amerigroup 360° review these results and identify whether a rate is higher or lower than expected.

Strengths and Weaknesses

The number of performance targets met by Amerigroup 360° is shown in Table 7-17.

Table 7-17—Number of Performance Targets Met by Amerigroup 360°

Measure Set	Number of Measures With Performance Target*	Number of Measures That Met Performance Target	Percentage of Targets Met
Access to Care	6	4	66.67%
Children's Health	15	10	66.67%
Women's Health	5	1	20.00%
Chronic Conditions	0	—	—
Behavioral Health	6	2	33.33%
Medication Management	0	—	—
Utilization	1	1	100.00%

Measure Set	Number of Measures With Performance Target*	Number of Measures That Met Performance Target	Percentage of Targets Met
Total	**33**	**18**	**54.55%**

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

— Indicates there were DCH-established performance targets within this measure set, but the CMO did not have any reportable rates for comparison.

Based on Amerigroup 360°'s performance in CY 2015, more than 54 percent of the rates met or exceeded the performance targets overall. Amerigroup 360°'s rates met or exceeded the majority of the performance targets in the Access to Care and Children's Health measure sets, and the one performance target in the Utilization measure set. Select rates in the Women's Health and Behavioral Health measure sets also met or exceeded performance targets. HSAG has highlighted specific strengths and areas for improvement below.

Amerigroup 360°'s greatest strengths were in the Access to Care, Children's Health, and Utilization measure sets. As illustrated in the table above, Amerigroup 360° met or exceeded over 66 percent of the performance targets within the Access to Care and Children's Health measure sets, and the one performance target within the Utilization measure set.

For the Utilization measure set, only one rate, *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total,* was comparable to performance targets since most of the rates in this measure set were displayed for information purposes only. Amerigroup 360°'s rate for this measure exceeded the performance target by more than 16 visits per 1,000 member months, indicating that Amerigroup 360° should continue reducing the number of preventable/avoidable or nonemergent ED visits that could be treated in primary or urgent care settings.

Measures within the Women's Health and Behavioral Health measure sets presented several opportunities for improvement as only one of five and two of six performance rates, respectively, met or exceeded the performance targets for CY 2015, and the remaining rates did not meet the targets. Most notably, the *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits* measure fell below its target by more than 33 percentage points.

Recommendations for Improvement

Amerigroup 360° performed well in the Access to Care, Children's Health, and Utilization measure sets when compared to the other measure sets; however, all measure sets require innovative, targeted interventions to improve performance. Therefore, HSAG recommends the following for Amerigroup 360°:

- Analyze the improvement strategies that can be linked to the overall success within the Access to Care, Children's Health, and Utilization measure sets. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measures.

- Analyze all performance measure rates that fell below the DCH-required performance target and either implement new PIPs or adjust the focus of existing PIPs as needed.

In addition to the specific recommendations above, Amerigroup 360° should focus efforts on the following measure topics in its QI efforts. The measure topics below were derived based on comparisons to the CY 2015 performance targets.

Access to Care

- Preventive/ambulatory services for adults
- Annual dental visits for members 2 to 3 years of age

Children's Health

- Well-child visits for children 15 months of age and younger
- Immunizations for children
- Treatment for children with upper respiratory infections

Women's Health

- Screening for chlamydia
- Vaccination for human papillomavirus for girls turning 13 years of age during the measurement year
- Prenatal care

Behavioral Health

- Follow-up care for children with ADHD
- Follow-up care for members after hospitalization for mental illness

CAHPS Surveys

Findings

To assess Amerigroup 360°'s overall performance, HSAG compared the calculated question summary rate for each global rating and global proportion for each composite measure (i.e., the percentage of respondents offering a positive response) to 2016 NCQA Medicaid national averages, where

applicable.[7-1,7-2] 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. Furthermore, for Amerigroup 360°'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 2016 NCQA Medicaid 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

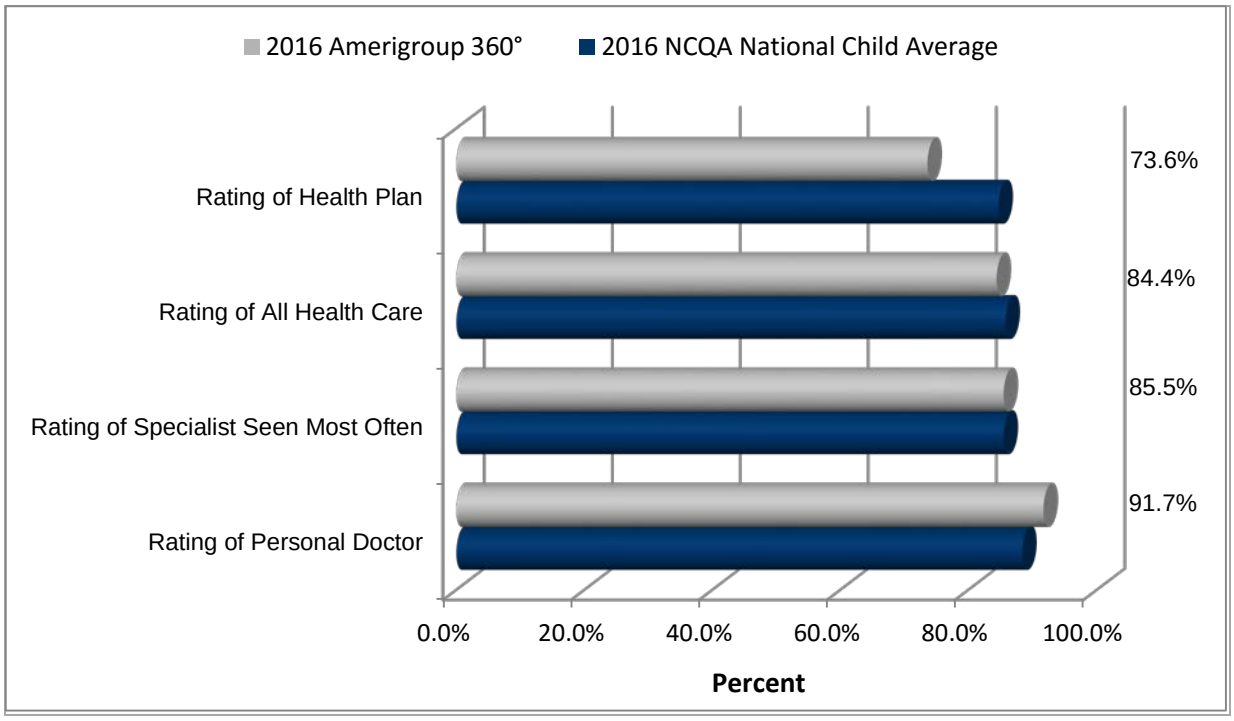
- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*

[7-1] Quality Compass® 2016 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 2016 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).

[7-2] The CAHPS Survey results presented throughout this section for Amerigroup 360° are the CAHPS Survey measure results calculated by the CMO's survey vendor and provided to HSAG for purposes of reporting.

Figure 7-1 below depicts Amerigroup 360°'s 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the global ratings. The grey bars represent Amerigroup 360°'s top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 7-1—Amerigroup 360° CAHPS Survey Results for Global Ratings

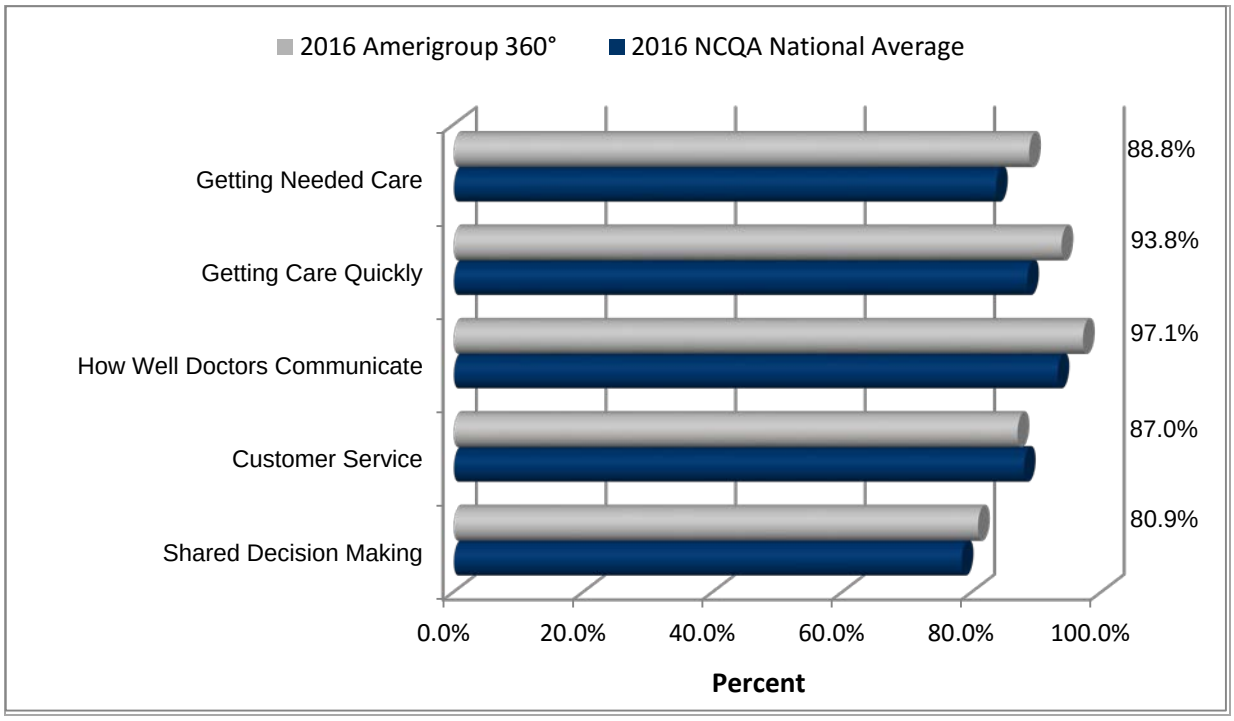


The top-box scores for the global ratings indicate the following:

- Amerigroup 360° scored between 73 and 92 percent on the four global rating measures.
- Amerigroup 360° scored at or above the 2016 NCQA child Medicaid national average for two measures: *Rating of Specialist Seen Most Often* and *Rating of Personal Doctor*.
- Amerigroup 360° scored below the 2016 NCQA child Medicaid national average for the remaining two measures: *Rating of Health Plan* and *Rating of All Health Care*. Furthermore, Amerigroup 360° scored 5 or more percentage points below the NCQA child Medicaid national average for one measure, *Rating of Health Plan*.

Figure 7-2 below depicts Amerigroup 360°'s 2016 CAHPS top-box scores and the 2016 NCQA child Medicaid national average for each of the composite measures. The grey bars represent Amerigroup 360°'s top-box scores, and the blue bars represent the 2016 NCQA child Medicaid national averages.

Figure 7-2—Amerigroup 360° CAHPS Survey Results for Composite Measures



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

- Amerigroup 360° scored at or between 80 and 98 percent on the five composite measures.
- Amerigroup 360° scored at or above the 2016 NCQA child Medicaid national average for four measures: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*. Furthermore, Amerigroup 360° scored 5 or more percentage points higher than the NCQA child Medicaid national average for two measures: *Getting Needed Care* and *Getting Care Quickly*.
- Amerigroup 360° scored below the 2016 NCQA child Medicaid national average for one measure, *Customer Service*.

Strengths and Weaknesses

For Amerigroup 360°, the 2016 top-box rates for three of the CAHPS Survey measures, *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*, were lower than the 2016 NCQA child Medicaid national averages. For the remaining six measures, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, the 2016 top-box rates for Amerigroup 360° were at or above the 2016 NCQA child Medicaid national averages.

Recommendations for Improvement

Based on an evaluation of Amerigroup 360°'s CAHPS survey results, HSAG recommends that the CMO focus efforts on *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*, given that the rates for these measures were below the 2016 NCQA child Medicaid national 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 Medicaid national average.

Amerigroup 360° 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.

Overall Assessment of Quality, Access, and Timeliness of Care

HSAG organized, aggregated, and analyzed results from each EQR activity to draw conclusions about Amerigroup 360°'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 (73.8 percent of federal and contract requirements for structure and operations were *Met*) and also demonstrated its commitment to quality process improvement, by closing 10 of the 12 corrective action plans from the previous year's compliance review.

Conclusions

Overall, although Amerigroup 360°'s performance results are mixed. Amerigroup 360° implemented processes to build a foundation for quality, access and timeliness of care and service delivery. Amerigroup 360° continued to build organizational strength in quality improvement knowledge and training by expanding staff training in the Institute for Healthcare Improvement's (IHI's) Science of Quality Improvement and in Lean Six Sigma programs. Another strength demonstrated by the CMO was

the active involvement of the chief executive officer, chief medical officer, and executive and senior-level staff in QAPI program activities.

The CMO's QAPI program description and process should 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. Amerigroup 360°'s QAPI program description did not fully detail the QI processes the CMO had developed and implemented or provide a comprehensive story of the effectiveness of Amerigroup 360°'s QAPI work.

Amerigroup 360° used diverse processes to solicit provider, member, and community member feedback and input into the QI processes of the program. Amerigroup 360° also developed monitoring processes that assessed the performance of providers and delegated entities both in aggregate and by individual member. In the Pathways to Permanency program, Amerigroup 360° measured outcomes in timely care delivery, as well as in measures, such as school attendance. Amerigroup 360° developed action plans focused on increasing access to care and receipt of EPSDT services. Results of the action plans' implementation indicate the CMO experienced challenges meeting the EPSDT requirements for children in two counties.

Amerigroup 360°'s performance improvement project results suggest that some of the CMO's PIP teams have incorporated a high level of understanding of the rapid cycle PIP process into their projects and have identified promising interventions to pursue for potential spread to their broader member population. Amerigroup 360°'s PIPs incorporated sound measurement methodologies for evaluating intervention effectiveness and outcomes. The CMO should ensure that its methodologies for determining and tracking measureable improvements are sound and can be relied upon to link the success of its interventions to the improved outcome.

Amerigroup 360° should analyze the performance measure quality improvement strategies that can be linked to the overall success within the measure sets. The results of this analysis should be used to identify strategies that can be translated and applied to drive improvement in other performance measure sets where performance was not as strong.

HSAG has provided recent, formal QI 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 continue to move its quality program toward success.

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

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 three compliance standard areas selected for review this year, and for those standards from the previous review period that required a re-review due to noncompliant findings.

Table 8-1—Standards and Compliance Scores

Standard #	Standard Name	Amerigroup	Peach State	WellCare	Amerigroup 360°
I	Clinical Practice Guidelines	**100%**	**90.9%**	**81.8%**	**100%**
II	Quality Assessment and Performance Improvement (QAPI)	**53.3%**	**66.7%**	**53.3%**	**53.3%**
III	Health Information Systems	**100%**	**100%**	**87.5%**	**100%**
	Follow-up Reviews From Previous Noncompliant Review Findings	**75.0%**	**62.5%**	**83.3%**	**91.7%**
	Total Compliance Score	**72.1%**	**75.4%**	**67.3%**	**75.4%**

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 67.3 and 75.4 percent, indicating that the CMOs had the policies, procedures, and operational structure in place to meet many of the federal and State requirements. For the GF 360° program, Amerigroup 360º received an overall compliance score of 75.4 percent. All standards fell within the quality domain. The Health Information Systems standard crossed over into the timeliness of care domain, and the Clinical Practice Guidelines and QAPI standards also crossed over into the access to care domains. The greatest variance across the GF CMOs was evidenced in the follow-up results from the previous review's noncompliant findings. Amerigroup met 75.0 percent of the re-reviewed elements, whereas WellCare and Peach State met 83.3 percent and 62.5 percent, respectively. Amerigroup 360º met 91.7 percent of the re-reviewed elements.

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

- Three of the four CMOs, received their highest compliance score (100 percent) for the Health Information Systems standard, demonstrating that the CMOs maintained health information systems that supported business intelligence needs and allowed for the collection, integration, tracking, analysis, and reporting of data.
- Overall, the CMOs performed well on the Clinical Practice Guidelines standard, demonstrating that their clinical practice guidelines (CPGs) were developed, implemented, and disseminated appropriately and supported the quality of services provided to members. Two of the three GF CMOs were noncompliant with one of the elements that was related to ensuring that staff decisions associated with utilization management were made consistent with the guidelines. Noncompliance with this element indicated an opportunity to strengthen processes to ensure that decisions involving utilization management and coverage of services, made by the CMOs' staff, are consistent with the CPGs.
- The Quality Assessment and Performance Improvement (QAPI) standard received the lowest scores for all CMOs. Areas in which all CMOs failed to demonstrate compliance included the DCH-established performance targets, mechanisms to detect underutilization and to assess quality of care, processes for evaluating the impact and effectiveness of the QAPI Program, processes for provider profiling, and patient safety plans. All CMOs demonstrated a need to continue to develop a comprehensive QAPI program description and QAPI program evaluation that described the CMO's QAPI story based on DCH specifications.

Performance Improvement Projects

Table 8-2 summarizes HSAG's key validation findings for the eight PIPs conducted by Amerigroup, Peach State, and WellCare. The key validation findings include whether each PIP achieved its SMART Aim goal and the overall confidence level HSAG assigned to each PIP.

- The first finding, achieving the SMART Aim goal, represents the PIP outcomes and whether the PIP demonstrated meaningful improvement.
- The second 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 include *High Confidence, Confidence, Low Confidence*, depending on the performance of the PIP. HSAG assigned a level of *High Confidence* to a PIP only if the SMART Aim goal was achieved and the improvement strategies were clearly linked to the demonstrated improvement. HSAG did not assign a confidence level to a PIP when the reported PIP results were not credible.
- The details of the rapid cycle PIP process and HSAG's scoring methodology are described in Appendix B, Methodology for Conducting Validation of Performance Improvement Projects.

Table 8-2—PIP Validation Findings for Amerigroup, Peach State, and WellCare

	Amerigroup		Peach State		WellCare	
PIP Title	**SMART Aim Goal**	**Confidence Level**	**SMART Aim Goal**	**Confidence Level**	**SMART Aim Goal**	**Confidence Level**
Annual Dental Visits	*Achieved*	*Low Confidence*	*Achieved*	*Reported PIP results were not credible*	*Failed*	*Low Confidence*
Appropriate Use of ADHD Medications	*Achieved*	*Low Confidence*	*Failed*	*Low Confidence*	*Achieved*	*Reported PIP results were not credible*
Avoidable ER Visits	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*	*Achieved*	*High Confidence*
Bright Futures	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*	*Achieved*	*Low Confidence*
Comprehensive Diabetes Care	*Achieved*	*Confidence*	*Achieved*	*Low Confidence*	*Achieved*	*Confidence*
Member Satisfaction	*Achieved*	*Confidence*	*Achieved*	*Reported PIP results were not credible*	*Achieved*	*Reported PIP results were not credible*
Postpartum Visits	*Achieved*	*Confidence*	*Achieved*	*Confidence*	*Achieved*	*Confidence*
Provider Satisfaction	*Achieved*	*Low Confidence*	*Achieved*	*Confidence*	*Achieved*	*High Confidence*
Percentage Achieved Across Eight PIPs*	**100.0%**	**0%**	**87.5%**	**0%**	**87.5%**	**25.0%**

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

Amerigroup's, Peach State's, and WellCare's performance on the eight PIPs demonstrates the continued need for further skill development around the application and documentation of the rapid cycle PIP process, especially in the area of intervention testing through Plan-Do-Study-Act (PDSA) cycles. Well-planned, appropriately executed, and clearly documented PDSA cycles are necessary to achieve a *High Confidence* level in a PIP and drive sustainable improvement.

Overall, the three CMOs achieved the SMART Aim goal for 22 of the 24 PIPs. Amerigroup achieved the SMART Aim goal for all eight (100.0 percent) PIPs, while Peach State and WellCare each achieved the SMART Aim goal for seven (87.5 percent) of the eight PIPs. These findings demonstrate that, in general, the CMOs defined attainable goals as part of the rapid cycle PIP process and the goals were achieved during the life of the PIP.

While Amerigroup, Peach State, and WellCare were successful in achieving the outcomes defined by the SMART Aim goals, the CMOs had considerable difficulty achieving a *High Confidence* level for most PIPs. WellCare was the only CMO that received a level of *High Confidence* for any PIPs; none of Amerigroup's or Peach State's PIPs were assigned a level of *High Confidence*. These findings show that, in general, the outcomes achieved in each PIP were not clearly linked to the interventions tested for the PIP. HSAG assigned two (25.0 percent) of WellCare's PIPs a level of *High Confidence*. When the outcomes were not clearly linked to the improvement strategies, HSAG did not assign a level of *High Confidence* to the PIP results.

In addition to having low percentages of PIPs that achieved a level of *High Confidence*, two of the CMOs, Peach State and WellCare, submitted PIPs for validation that could not be assigned a confidence level because the reported PIP results were not credible. Specifically, two (25.0 percent) of Peach State's PIPs and two (25.0 percent) of WellCare's PIPs fell into this category. Because the CMOs did not follow the approved rapid cycle PIP methodology, the PIP results were not credible and a level of confidence could not be assigned.

To improve the percentage of PIPs that have valid results and achieve a level of *High Confidence*, all three CMOs should seek technical assistance on planning and executing the PDSA cycles for testing improvement strategies. The CMOs should ensure the *Plan* step of the PDSA cycle includes making a prediction about the specific impact of each intervention, to ensure the strategy aligns with the theory of improvement for the PIP. Additionally, the CMOs should use data sources for the PDSA cycles that support rapid analysis and learning. The CMOs should incorporate process-level data into the intervention evaluation plan to further understanding and refinement of strategies. Finally, the CMOs should anticipate that the strength of PDSA cycles as a tool for improvement lies in the iterative learning that results from conducting multiple cycles. The CMOs should plan the PIP to allow time and resources for multiple learning cycles to achieve meaningful and sustained improvement.

Table 8-3 summarizes HSAG's key validation findings for the three PIPs conducted by Amerigroup 360°. This CMO conducted three PIPs, compared to eight PIPs conducted by the other three CMOs, and the PIP topics did not align with the PIPs conducted by the other three CMOs; therefore, the key validation findings are presented in a separate table. The key validation findings include whether each PIP achieved its SMART Aim goal and the overall confidence level HSAG assigned to each PIP.

- The first finding, achieving the SMART Aim goal, represents the PIP outcomes and whether the PIP demonstrated meaningful improvement.
- The second finding, the confidence level, represents HSAG's overall validation findings based on the PIP's design, measurement methodology, improvement processes and strategies, and outcomes. HSAG assigned a level of *High Confidence* to a PIP only if the SMART Aim goal was achieved and the improvement strategies were clearly linked to the demonstrated improvement.

Table 8-3—PIP Validation Findings for Amerigroup 360°

PIP Title	SMART Aim Goal	Confidence Level
7-Day Inpatient Discharge Follow-up	*Achieved*	*High Confidence*
Adolescent Well-Child Visits	*Failed*	*Low Confidence*
Appropriate Use of ADHD Medications	*Achieved*	*High Confidence*
Percentage Achieved Across Three PIPs*	**66.7%**	**66.7%**

* The Percentage Achieved Across Three PIPs row displays the percentage of the CMO's PIPs that achieved the SMART Aim goal and achieved a *High Confidence* level.

Two (66.7 percent) of Amerigroup 360°'s three PIPs achieved the SMART Aim goal. HSAG assigned these two PIPs a level of *High Confidence*, suggesting that Amerigroup 360° clearly linked the improvement strategies in each PIP to the demonstrated improvement. A direct comparison between the percentages achieved by Amerigroup 360° and the other three CMOs is difficult because Amerigroup 360° conducted fewer PIPs (three) and, therefore, the performance of each PIP influences the overall percentages achieved more heavily than for the other three CMOs, who each conducted eight PIPs. It can be noted, however, that Amerigroup 360° and WellCare were the only two CMOs that received a level of *High Confidence* for any PIPs, and both CMOs received a *High Confidence* level for the same number of PIPs. HSAG recommends that both Amerigroup 360° and WellCare analyze the variation in performance among their respective PIP teams and identify promising practices among those PIPs that achieved a level of *High Confidence*. By identifying promising practices in designing, implementing, and evaluating PDSA cycles for the PIPs, the CMOs should enhance organizational capacity to conduct successful PIPs.

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 2016. 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 and Amerigroup 360°.

Table 8-4—Percentage of Performance Targets Met by GF CMOs and Amerigroup 360°*

Measure Set	Amerigroup	Peach State	WellCare	Amerigroup 360°
Access to Care	14.29%	14.29%	14.29%	66.67%
Children's Health	66.67%	46.67%	46.67%	66.67%
Women's Health	22.22%	11.11%	22.22%	20.00%
Chronic Conditions	30.00%	30.00%	10.00%	—
Behavioral Health	28.57%	0.00%	14.29%	33.33%
Medication Management	75.00%	0.00%	75.00%	—
Utilization	0.00%	0.00%	0.00%	100.00%
Total	**39.62%**	**22.64%**	**28.30%**	**54.55%**

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

— Indicates there were DCH-established performance targets within this measure set, but the CMO did not have any reportable rates for comparison.

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

- Amerigroup and Amerigroup 360° were the highest-performing CMOs overall, meeting 39.6 and 54.6 percent of the performance measure targets, respectively. Of the five measure sets for which Amerigroup 360°'s rates were compared to performance targets, Amerigroup 360° performed the highest among the four CMOs in three of these measure sets, including Access to Care, Children's Health, and Behavioral Health. Additionally, Amerigroup 360° was the only CMO that met the performance target in the Utilization measure set.
- WellCare was the next-highest-performing CMO, meeting 28.3 percent of its performance targets.
- Of the four CMOs, Peach State demonstrated the lowest performance, meeting 22.6 percent of its performance measure targets. Peach State did not meet any performance targets in the Behavioral Health, Medication Management, and Utilization measure sets. However, Peach State, along with Amerigroup, met the greatest percentage of performance targets in the Chronic Conditions measure set.

Based on the 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 CMOs. For Amerigroup 360°, statistical testing was not performed because CY 2014 data were not comparable to CY 2015 data due to only having nine months of data for CY 2014. Therefore, any references to statistical testing only apply to Amerigroup, Peach State, and WellCare. This measure set also demonstrated significant improvement, indicating positive progress. All three of the GF CMOs exhibited significant improvement in the percentage of children with pharyngitis who received appropriate testing and in the percentage of adolescents who received immunizations.

Additionally, all CMOs met or exceeded the 2015 performance target for *Lead Screening in Children* 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*. All CMOs met or exceeded the 2015 performance targets for *Immunization for Adolescents—*

Combination 1 (Meningococcal, Tdap/Td) and *Developmental Screening in the First Three Years of Life—Total*. However, preventive dental care for children and adolescents was a general weakness across all of the GF CMOs; in fact, two had rates that demonstrated a statistically significant decline since CY 2014.

Within the Access to Care measure set, all CMOs exhibited weakness in the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* measure as none of them met the 2015 performance target. All three GF CMOs demonstrated weakness in the *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years* rate as none of them met the 2015 performance target; moreover, two of the three GF CMOs' rates for this measure had a statistically significant decline since CY 2014. Although none of the CMOs met the performance target for *Annual Dental Visit—2–3 Years*, Amerigroup 360° met or exceeded the performance target for *Annual Dental Visit—Total*, and the remaining CMOs met or exceeded the performance target for *Annual Dental Visit—19–20 Years* and demonstrated significant improvement since CY 2014. However, in CY 2014 and in prior years, members 2 to 21 years of age were included in the *Annual Dental Visit* measure, and beginning in CY 2015 only members 2 to 20 years of age were included. Therefore, caution should be exercised when comparing rates between years and to performance targets.

The Women's Health, Chronic Conditions, and Behavioral Health measure sets were areas of weakness for all CMOs. Specifically, the GF CMOs collectively only met approximately 19 percent of the performance targets for Women's Health, approximately 23 percent of the performance targets for Chronic Conditions, and approximately 19 percent of the performance targets for Behavioral Health. There were, however, several strengths within each of these measure sets. In the Women's Health measure set, three of the CMOs met or exceeded the performance targets for the *Cesarean Delivery Rate, Uncomplicated* measure. Within the Chronic Conditions measure set, all GF CMOs had rates that met or exceeded the performance target for *Comprehensive Diabetes Care—Medical Attention for Nephropathy*; however, for CY 2015, updates to the technical specifications were made to the requirements for meeting the testing criteria for this measure. In addition, the classification of diabetes changed significantly between ICD-9 and ICD-10. Therefore, caution should be exercised when comparing rates between years and to performance targets for the *Comprehensive Diabetes Care* measure.

Within the Behavioral Health measure set, two of the CMOs met or exceeded the performance targets for the *Antidepressant Medication Management* measure.

The Medication Management measure set presented opportunities for improvement for Peach State, as this CMO did not meet any of the performance targets within this measure set. Both Amerigroup and WellCare, however, met 75 percent of the performance targets, including all of the targets for the *Annual Monitoring for Patients on Persistent Medications* measure.

While the Utilization measure set only included one performance target for the *Ambulatory Care (Per 1,000 Member Months)—Total—ED Visits—Total* measure, Amerigroup 360° was the only CMO to meet or exceed the performance target. While the remaining CMOs decreased their rates since CY 2014, none of them met the performance target.

CAHPS Surveys

CAHPS Survey results for both adult and child Medicaid populations were compared across CMOs. HSAG compared the CMOs' top-box scores (i.e., percentage of top-level responses) for the four CAHPS global rating measures and five composite measures. Additionally, HSAG compared the CMOs' CAHPS Survey results to the 2016 NCQA Medicaid national averages.

Adult Medicaid CAHPS Survey Results

Table 8-5 displays the statewide average and the CMOs' 2016 adult Medicaid CAHPS top-box scores for each global rating measure and composite measure. Cells highlighted in yellow represent top-box scores that were equal to or greater than the 2016 NCQA adult Medicaid national average.

Table 8-5—Adult Medicaid CAHPS Survey Results

Measure	Statewide Average	Amerigroup	Peach State	WellCare
Global Ratings				
Rating of Health Plan	76.4%	72.7%	75.7%	80.9%
Rating of All Health Care	77.7%	78.0%	77.6%	77.6%
Rating of Specialist Seen Most Often	81.1%	80.3%	78.9%+	84.2%
Rating of Personal Doctor	79.0%	78.9%	79.1%	79.1%
Composite Measures				
Getting Needed Care	81.8%	83.1%	80.5%	81.7%
Getting Care Quickly	78.8%	80.5%	77.3%	78.6%
How Well Doctors Communicate	91.2%	92.4%	89.8%	91.4%
Customer Service	87.4%	88.0%	89.2%+	85.0%
Shared Decision Making	78.8%	80.5%	75.8%+	80.1%+

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.

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

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

Making. Peach State and WellCare had the highest score for *Rating of Personal Doctor* and the lowest score for *Rating of All Health Care*.

- WellCare scored highest among the CMOs on two measures: *Rating of Health Plan* and *Rating of Specialist Seen Most Often*, while tying with Peach State for the highest score on *Rating of Personal Doctor*. However, WellCare scored lowest among the CMOs on *Customer Service*. As noted above, WellCare and Peach State had the highest score for *Rating of Personal Doctor* and the lowest score for *Rating of All Health Care*.

Comparisons of Amerigroup's, Peach State's, and WellCare's adult Medicaid CAHPS top-box scores to the 2016 NCQA adult Medicaid national averages revealed the following:

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

Child Medicaid CAHPS Survey Results

Table 8-6[8-1] displays the statewide average and CMOs' 2016 child Medicaid CAHPS top-box scores for each global rating measure and composite measure. Cells highlighted in yellow represent top-box scores that were equal to or greater than the 2016 NCQA national child Medicaid average.

Table 8-6—Child Medicaid CAHPS Survey Results

Measure	Statewide Average	Amerigroup	Peach State	WellCare	Amerigroup 360°
Global Ratings					
Rating of Health Plan	88.0%	88.2%	89.3%	86.5%	73.6%
Rating of All Health Care	88.9%	88.8%	87.9%	90.1%	84.4%
Rating of Specialist Seen Most Often	86.6%	88.2%	87.1%+	84.5%+	85.5%
Rating of Personal Doctor	90.4%	89.6%	90.7%	90.8%	91.7%
Composite Measures					
Getting Needed Care	84.2%	83.8%	83.6%	85.2%	88.8%

[8-1] Amerigroup 360°'s rates are not calculated into the Statewide Average for consistency since they are not included in statewide rates for the HEDIS Performance Measures.

Measure	Statewide Average	Amerigroup	Peach State	WellCare	Amerigroup 360°
Getting Care Quickly	88.7%	88.3%	87.5%	90.4%	93.8%
How Well Doctors Communicate	92.1%	91.0%	92.4%	93.0%	97.1%
Customer Service	88.2%	88.6%	88.7%	87.4%	87.0%
Shared Decision Making	75.8%	73.8%	76.9%	76.8%	80.9%

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.

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

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

Amerigroup 360° could not be compared to the other CMOs due to the differences in populations.

Comparisons of Amerigroup's, Peach State's, WellCare's, and Amerigroup 360° CAHPS top-box scores to the 2016 NCQA child Medicaid national averages revealed the following:

- Amerigroup scored at or above the NCQA child Medicaid national average on six 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*.
- Peach State scored at or above the NCQA child Medicaid national average on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, and *Customer Service*.
- WellCare scored at or above the NCQA child Medicaid national average on five measures: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, and *Getting Care Quickly*.
- Amerigroup 360° scored at or above the NCQA child Medicaid national average on six measures: *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*.

Conclusions

Overall, the CMOs' performance results are mixed. The CMOs demonstrated compliance with many of the structure and operations standards reviewed. The results of the compliance review suggest that the CMOs' improvement efforts should be focused on quality assessment and performance improvement (QAPI). Additionally, two of the 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.

The CMOs generally implemented processes to build a foundation for quality, access, and timeliness of care and service delivery. The CMOs adopted CPGs that were evidence-based, involved provider input, and considered demographic and epidemiological profiles of their populations through an analysis of utilization data. The CMOs collaborated with DCH to develop and implement a methodology to measure the consistent use of the CPGs within the provider networks.

The CMOs continued to build organizational strength in quality improvement (QI) knowledge and training with some expanding staff training in the Institute for Healthcare Improvement's (IHI's) Science of Quality Improvement and Lean Six Sigma. The CMOs, to varying degrees, also demonstrated the active involvement of executive and senior-level staff in the QAPI Program work. HSAG recommends that the CMOs train and include staff with working knowledge of the processes in QAPI work teams.

Overall, the CMOs demonstrated strong health information systems with the capability to achieve the requirements for quality, access, and timeliness of care. The CMOs demonstrated various levels of strength in the use of information from the health information systems to analyze the improvement strategies and to link the strategies to the overall QI success. The CMOs have an opportunity to use the results of data analysis to identify strategies that may be translated and applied to drive improvement.

A significant opportunity across the CMOs is the strengthening of their QAPI program's description and evaluation process in order to provide a comprehensive roadmap for the organizations' priorities for improvement, including the timelines, sufficient monitoring and tracking of results. In general, the CMOs' QAPI program descriptions did not detail the QI processes the CMOs had developed and implemented. For example, not all CMOs provided a comprehensive summary of how the QI goals, objectives, and related initiatives were identified; which data were used in the selection process; which interventions were considered and implemented; how the initiatives were resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes were measured in order to provide a comprehensive story of the effectiveness of the CMO's QAPI work.

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 CMOs' performance across the PIPs suggests that the CMOs continue to have opportunities for improvement in executing the rapid cycle PIP process, though the CMOs' performance varied widely by topic. In addition to incorporating HSAG's feedback from the PIP validations and seeking technical assistance when planning PDSA cycles, the CMOs should also examine the

performance of various PIP teams in their organizations to determine if best practices for executing rapid cycle PIPs can be identified within the organization and shared across teams and departments.

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 QI 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 allow 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 the 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.

Performance measure sets may require innovative, targeted interventions to improve performance. The CMOs should ensure that the methodologies for determining and tracking any measureable improvements are sound and can be relied upon to link the success of the interventions to the improved outcome. The CMOs should further ensure that they integrate a review of the related organizational and operational processes as part of continuous QI efforts.

The performance measure results indicate that each CMO must implement mechanisms to improve quality, access, and timeliness of care for its members. Overall, the GF CMOs should target the following performance areas as QI initiatives:

Access to Care

- Preventive and ambulatory health services for adults
- Annual dental visits for members 2 to 3 years of age

Children's Health

- Immunizations for children

Women's Health

- Prenatal and postpartum care
- Live births with low birth weight

Chronic Conditions

- Comprehensive diabetes care
- Blood pressure control for members with hypertension

Behavioral Health

- Follow-up care for children with ADHD
- Follow-up care for members after hospitalization for mental illness
- Members with schizophrenia who remained on antipsychotic medications

Medication Management

- Appropriate medication management for members with asthma

One CMO expanded the role of its staff members who work with provider practices to improve HEDIS scores to include discussions on overutilization, underutilization, member care needs, and healthcare advocacy. The CMO used demographic information, as well as various clinical and behavioral health utilization patterns, to identify members who might benefit from disease management or case management programs. The CMO worked directly with providers and the community on QI initiatives, such as the use of telemedicine and access to school-based care. These activities may have had a positive impact on some of the CMO's rates. The CMOs should also continue to assess areas for targeted interventions in care for members with behavioral health diagnoses and on improving access to care through maintaining an adequate provider network.

With regard to CAHPS survey results, the GF CMOs met or exceeded the 2016 Medicaid national average for the following measures:

- *Rating of All Health Care*—both adult and child Medicaid populations
- *Getting Needed Care*—adult Medicaid population only
- *Rating of Health Plan*—child Medical population only
- *Rating of Personal Doctor*—child Medicaid population only

For all other CAHPS measures, at least one of the CMOs met or exceeded the Medicaid national average with the exception of the *Rating of Personal Doctor* measure for the adult Medicaid population.

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.

Although there was evidence of active engagement of some of the CMOs' staff with members and their families and caregivers, opportunities were missed to collect feedback and input regarding the CMOs' QAPI Program. Although the CMOs conducted CAHPS to collect information on members' experiences of care, the CMOs should also consider other opportunities to seek member and family input in areas with rates lower than the Medicaid national averages.

Recommendations for the Georgia Families and Georgia Families 360° Programs

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

- Continue to provide guidance to the CMOs regarding DCH's requirements for the QAPI program descriptions.
- Monitor each CMO's implementation of staff qualifications, experience, education, and training requirements for staff responsible for quality assessment and performance improvement work.
- Monitor implementation of each CMO's solicitation and incorporation of input from members, their families, guardians, and caregivers in the QI process.
- Identify opportunities for CMOs to share best practices resulting from QAPI Program work, such as successful interventions in PIPs.

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 Georgia Families (GF) program and the GF 360° 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 the CMOs' 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 regarding compliance with State and federal requirements. 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 report related to the findings.

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—Clinical Practice Guidelines
- Standard II—Quality Assessment and Performance Improvement (QAPI)
- Standard III—Health Information Systems
- 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 third 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 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 eight sample cases plus an oversample of three cases for grievance and appeals and case management for the on-site CMO audit from the list of such members submitted to HSAG from the CMOs.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Feb 19, 2016.

On-site review activities: HSAG reviewers conducted an on-site review for the CMOs, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents HSAG requested that the CMOs have available on-site.
- A review of the case files HSAG requested from the CMOs.
- Interviews conducted with the CMOs' key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

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

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, 2015–June 30, 2016
Information obtained through interviews	August 2, 2016—the last day of the CMOs' on-site review
Information obtained from a review of a sample of the CMOs' records for file reviews	July 1, 2015–June 30, 2016

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 *one or more* 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 a final report.

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 and the GF 360° program. It includes:

- Objective for conducting the step according to the rapid cycle 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 methodology used for validating the PIPs is described below.

Objective

The primary objective of PIP validation was to determine each CMO's compliance with requirements set forth in 42 CFR §438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvements in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection and Analysis

In this ninth year of validating CMO PIPs, HSAG conducted PIP validation on eight DCH-required PIPs for Amerigroup, Peach State, and WellCare and three DCH-required PIPs for Amerigroup 360°. The eight PIPs submitted for validation by Amerigroup, Peach State, and WellCare were conducted on the following topics:

- *Annual Dental Visits*
- *Appropriate Use of ADHD Medications*
- *Avoidable Emergency Room Visits*
- *Bright Futures*
- *Comprehensive Diabetes Care*
- *Member Satisfaction*
- *Postpartum Care*
- *Provider Satisfaction*

The three PIPs submitted for validation by Amerigroup 360° were conducted on the following topics:

- *7-Day Inpatient Discharge Follow-up*
- *Adolescent Well-Child Visits*
- *Appropriate Use of ADHD Medications*

In 2014, DCH and HSAG agreed that a comprehensive overhaul of the PIP implementation and validation process was needed in order to embrace a rapid cycle improvement process and facilitate more effective improvement efforts by the CMOs in Georgia. Consequently, HSAG developed a new 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 rapid cycle PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous improvement focused on small tests of change. The methodology focuses on evaluating and refining small process changes to determine the most effective strategies for achieving real improvement. The DCH instructed the CMOs to conduct their rapid cycle improvement projects over a 12-month period.

HSAG provided CMS with a crosswalk of the rapid cycle PIP framework to the CMS PIP protocols in order to illustrate how the rapid cycle PIP framework met the CMS requirements.[B-2] Following HSAG's presentation of the crosswalk and new PIP framework components to CMS, CMS agreed that with the pace of quality improvement science development and the prolific use of Plan-Do-Study-Act (PDSA) cycles in modern PIPs within healthcare settings, a new approach was reasonable. CMS approved HSAG's rapid cycle PIP framework for validation of the CMOs' PIPs for the State of Georgia.

The methodology used to validate the PIPs was based on CMS guidelines as outlined in the CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[B-3] Using this protocol, HSAG, in collaboration with DCH, developed the module submission forms and Companion Guide for rapid cycle 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.

HSAG's validation of rapid cycle PIPs includes the following key components of the quality improvement process:

1. Evaluation of the technical structure to determine whether a PIP's initiation (e.g., topic rationale, PIP team, aim, key driver diagram, and SMART Aim data collection methodology) was based on sound

[B-1] Institute for Healthcare Improvement. How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/default.aspx. Accessed on: Sept 24, 2016.
[B-2] Ibid.
[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: Feb 19, 2016.

methods and could demonstrate reliably positive outcomes. Successful execution of this component ensures accurately reported PIP results that are capable of measuring sustained improvement.

2. Evaluation of the quality improvement activities conducted. Once designed, a PIP's effectiveness in improving outcomes depends on thoughtful and relevant intervention determination, intervention testing and evaluation using iterative PDSA cycles, and sustainability and spreading of successful change. This component evaluates how well the CMO executed its quality improvement activities and whether the desired aim was achieved.

The key concepts of the rapid cycle PIP framework include forming a PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of the rapid cycle 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. The following outlines the rapid cycle PIP framework.

- Module 1—PIP Initiation - outlines the framework for the project. The framework follows the Associates in Process Improvement's (API's) Model, which was popularized by the Institute for Healthcare Improvement, by:
  - Precisely stating a project-specific SMART Aim (specific, measureable, attainable, relevant and time-bound) including the topic rationale and supporting data so that alignment with larger initiatives and feasibility are clear.
  - Building a PIP team consisting of internal and external stakeholders.
  - Completing a key driver diagram which summarizes the changes that are agreed upon by the team as having sufficient evidence to lead to improvement.
- Module 2—SMART Aim Data Collection - operationalizes the SMART Aim measure and the data collection methodology is described. SMART Aim data are displayed in run charts.
- Module 3—Intervention Determination - delves into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions, in addition to those in the original key driver diagram, are identified for PDSA cycles (Module 4) using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking.
- Module 4—Plan-Do-Study-Act - tests the interventions selected in Module 3 and evaluates their effectiveness through a thoughtful and incremental series of PDSA cycles.
- Module 5—PIP Conclusions - summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, plans for evaluating sustained improvement and expansion of successful interventions, and lessons learned.

The scoring methodology evaluates whether the CMO executed a methodologically sound improvement project, whether the PIP's SMART Aim goal was achieved, and whether improvement was clearly linked to the quality improvement processes applied in the project. HSAG assigned a score of *Achieved* or *Failed* for each of the criteria in Modules 1 through 5. Any validation criteria that were not applicable were not scored. HSAG used the findings from the reviews of the Modules 1 through 5 criteria for each PIP to determine a confidence level representing the validity and reliability of the PIP. Using a

standardized scoring methodology, HSAG assigned a level of confidence and reported the overall validity and reliability of the findings as one of the following:

- *High confidence* = the PIP was methodologically sound, achieved the SMART Aim goal, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- *Confidence* = the PIP was methodologically sound, achieved the SMART Aim goal, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however, there was not a clear link between all quality improvement processes and the demonstrated improvement.
- *Low confidence* = (A) the PIP was methodologically sound; however, the SMART Aim goal was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- *Reported PIP results were not credible* = The PIP methodology was not executed as approved.

Description of Data Obtained

HSAG obtained the data needed to conduct the annual PIP validation from the CMOs' PIP Module Submission Forms. The CMOs were required to submit five PIP modules for each PIP topic. The submission forms contained detailed information required for each module.

The CMOs submitted Modules 1 through 3 for each PIP throughout CY 2015. The CMOs initially submitted Modules 1 and 2, received feedback and technical assistance from HSAG, and resubmitted these modules until all validation criteria were met. The CMOs followed the same process for Module 3. Once Module 3 was approved, the CMOs initiated intervention testing for each PIP in Module 4, which continued through the end of 2015. The CMOs submitted Modules 4 and 5 to HSAG on February 29, 2016, for annual validation.

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	*Annual Dental Visits*	January 1, 2015–December 31, 2015
Peach State	*Appropriate Use of ADHD Medications*	January 1, 2015–December 31, 2015
WellCare	*Avoidable Emergency Room Visits*	January 1, 2015–December 31, 2015
	Bright Futures	January 1, 2015–December 31, 2015
	Comprehensive Diabetes Care	January 1, 2015–December 31, 2015
	Member Satisfaction	January 1, 2015–December 31, 2015
	Postpartum Care	January 1, 2015–December 31, 2015
	Provider Satisfaction	January 1, 2015–December 31, 2015

CMO	Data Obtained	Time Period to Which the Data Applied
Amerigroup GF 360°	*7-Day Inpatient Discharge Follow-up*	January 1, 2015–December 31, 2015
	Adolescent Well-Child Visits	January 1, 2015–December 31, 2015
	Appropriate Use of ADHD Medications	January 1, 2015–December 31, 2015

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, including:

- 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 rates in SFY 2016 for 53 HEDIS and non-HEDIS measures. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information measures. Many of the measures included multiple indicators or age stratifications. The measurement period was identified by DCH as CY 2015 for all measures except the two Child Core Set dental measures. The dental measures were reported for federal fiscal year (FFY) 2015, which covered the time frame of October 1, 2014, through September 30, 2015, according to CMS requirements. All performance measure rates were reported by the CMOs in June 2016.

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 GF 360° population, DCH required Amerigroup to report 46 HEDIS and non-HEDIS measures for CY 2016. 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. The non-HEDIS measure rates for this population were validated by HSAG.

To assess the CY 2015 reported rates, DCH established performance targets for the GF population and for the GF 360° population. Performance targets for CY 2015 data were based on the NCQA national Medicaid HEDIS percentiles and the Nationwide Inpatient Sample (NIS) for the Agency for Healthcare Research and Quality (AHRQ) measures. The performance targets were the same for all four GF CMOs for 37 rates, and DCH established CMO-specific target values for the remaining measures with performance targets.

Objectives

HSAG validated 17 non-HEDIS measures calculated and reported by the CMOs for the GF program and 15 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 2016. HSAG provided final performance measure validation reports to the CMOs and DCH in September 2016. 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-1] 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 2016 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 the performance measures under review by HSAG. The source code review was conducted via a web-assisted session where Inovalon

C-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: Oct 26, 2015.

displayed the source code for each measure and explained its rate generation and data integration processes 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.

Rate Review: Upon receiving the calculated rates from each CMO, HSAG conducted a review on the reasonableness and integrity of the rates. The review included trending with prior rates and comparison of rates across all CMOs.

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.

Medical Record Documentation

The CMOs completed the MRR section within the Roadmap. In addition, they submitted the following documentation for review: medical record hybrid tools and instructions, training materials for MRR staff members, and policies and procedures outlining the processes for monitoring the accuracy of the reviews performed by the review staff members. To ensure the accuracy of the hybrid data being abstracted by the CMOs, HSAG followed NCQA's guidelines to validate the integrity of the MRR processes used by each CMO and then used the MRRV results to determine if the findings impacted the audit results for each performance measure rate.

Description of Data Obtained

For the non-HEDIS rates displayed in this technical report, HSAG conducted the performance measure validation for all the GF CMOs and for Amerigroup 360°, and the audited rate files were obtained from the individual performance measure validation reports previously prepared by HSAG.

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 Applicable*, *Biased Rate*, *No Benefit*, *Not Required*, and *Not Reported* 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 *Biased Rate* 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 measure 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 in September 2016.

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.

Appendix D. Methodology for Reviewing 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, WellCare, and Amerigroup 360° 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 and CHIIP members enrolled in Amerigroup, Peach State, WellCare, and Amerigroup 360°. 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 and Amerigroup 360° 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, 2015; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2015.

The surveys administered by each CMO's vendor included 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 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with

[D-1] National Committee for Quality Assurance. *HEDIS® 2016, Volume 3: Specifications for Survey Measures.* Washington, DC: NCQA Publication, 2015.

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 2016 adult and child CAHPS scores were compared to 2016 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 2016 NCQA national Medicaid averages.[D-2] These comparisons were performed on the four global ratings and five composite measures.

[D-2] Quality Compass® 2016 data serve as the source for the 2016 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. For the adult population, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 24, 28, and 42. For the child population, a survey was assigned a disposition code of "completed" if at least three of the following five questions were answered: 3, 15, 27, 31, and 36. Eligible members included the entire 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, they were mentally or physically incapacitated (adult population only), or they were removed from the sample during deduplication. 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 8, 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 Rating	EQR Discussion and Recommendation
Amerigroup			
At the outset of the PIP, Amerigroup established a goal of improving the preventive dental visit rate for members 21 years of age and younger assigned to Family Health Care Centers of Georgia by 4.2 percentage points (10 percent) from 41.7 percent to 45.9 percent. On the final SMART Aim measure run chart, Amerigroup plotted the baseline and goal rates as 47.0 percent and 57.0 percent, respectively. Because the highest SMART Aim rate achieved (64.7 percent) exceeded both initial (45.9 percent) and final goal rates (57.0 percent), HSAG determined the SMART Aim goal was achieved.	• Dental clinic events with scheduling assistance	Low Confidence	Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes; therefore, the PIP was assigned a level of *Low Confidence*. There were discrepancies in Amerigroup's documentation of the SMART Aim measure baseline and goal rates in several areas of the PIP documentation; however, because the SMART Aim measure exceeded the highest documented goal rate, HSAG determined that the SMART Aim goal was achieved. To evaluate intervention effectiveness, Amerigroup plotted and analyzed the SMART Aim measure results and did not report how many eligible members assigned to the targeted provider actually received the intervention; therefore, the specific impact of the intervention could not be determined.

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			HSAG recommends that Amerigroup more carefully plan and design the PDSA cycles used to evaluate intervention effectiveness for future improvement projects. The PDSA process should include the collection of both process and outcome measures that will allow Amerigroup to determine the specific impact of the intervention on the observed outcomes. In addition to careful planning of PDSA cycles, Amerigroup must ensure the accurate and consistent documentation of the SMART Aim measure statement, baseline rate, and goal rates throughout the PIP modules. The baseline and goal rates plotted on the SMART Aim run chart must align with the baseline and goal rates established in the PIP's SMART Aim statement.
Peach State			
Peach State's goal for the *Annual Dental Visits* PIP was to identify and test interventions to improve the preventive dental visit rate among members 15 to 18 years old living in Muscogee County by 3 percentage points, from	• Teen Smart webpage • Teen Smart member incentive	Reported PIP results were not credible	The CMO did not use the approved methodology for the SMART Aim measure and instead plotted a cumulative preventive dental visit rate on the SMART Aim run chart; therefore, the reported PIP results were not credible.

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
61.6 percent to 64.6 percent. The CMO did not use the approved Module 2 methodology for the SMART Aim measure and instead plotted the cumulative preventive dental visit rate on the SMART Aim run chart. The cumulative rate did not allow meaningful measurement of improvement during the life of the PIP.			Given the lack of meaningful improvement demonstrated for the *Annual Dental Visits* PIP, the CMO should review the techniques used to identify and prioritize failure modes in the process for members to complete a preventive dental visit. The CMO's approach to prioritizing process failures and developing interventions to address high-priority failures should include the use of data and organizational experience to validate the assumed relationship between key drivers, failure modes, and interventions. By using data to validate these relationships, the CMO will be more likely to address the root causes impeding improvement and develop more impactful interventions to test.
WellCare			
WellCare established a goal of improving the annual dental visit rate among members 11 to 18 years old living in Bibb County by 5 percentage points, from 49.5 percent to 54.5 percent. None of the PIP's SMART Aim measurements met the goal rate of 54.5 percent.	• Community dental events	Low Confidence	Because the SMART Aim goal was not achieved, the PIP was assigned a level of *Low Confidence*. Based on the validation findings, HSAG recommends that WellCare review and refine its approach to the *Plan* step of the PDSA process used in Module 4 to test interventions. The measures, data collection

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			process, and data sources for the intervention evaluation plan should be well-defined prior to intervention initiation. In general, medical claims data are not a methodologically sound data source for monthly PDSA measurements because of the lag-time associated with claims completeness. Unless the CMO can verify that claims lag will not be an issue, measures of intervention effectiveness should rely on alternative data sources that provide more real-time feedback for rapid improvement.

Table E-2—*Appropriate Use of ADHD Medications*

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
Amerigroup established a goal of improving the rate of members who received an initial ADHD medication prescription and returned within 30 days for a follow-up visit at Medical Specialists by 5 percentage points, from 23.7 percent to 28.7 percent. Six of the PIP's monthly SMART Aim measurements met	• Clinical practice consultant • Member outreach and incentive	Low Confidence	Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes; therefore, the PIP was assigned a level of *Low Confidence*. For future improvement efforts, HSAG recommends that Amerigroup seek technical

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
or exceeded the goal rate of 28.7 percent.			assistance when planning the PDSA cycles to test interventions. The measure used for PDSA cycles must include data specific to the intervention to determine effectiveness. Frequently, the SMART Aim measure cannot be used to capture the individual impact of an intervention. Amerigroup should design the intervention evaluation plan to collect both intervention-specific process data and outcome data for those members who received the intervention.
Peach State			
Peach State established a goal of improving the rate of members who received an initial ADHD medication prescription and returned within 30 days for a follow-up visit in the Atlanta region, from 42.9 percent to 45.5 percent. None of the PIP's monthly SMART Aim measurements met the goal rate of 45.5 percent.	• Reminder outreach calls to members	Low Confidence	The SMART Aim goal was not achieved during the life of the PIP; therefore, the PIP was assigned a level of *Low Confidence*. Based on the validation findings for the *Appropriate Use of ADHD Medications* PIP, HSAG recommends that Peach State revisit the intervention determination processes used in Module 3 and the *Plan* step of the PDSA process used in Module 4 for this PIP. In Module 3, the CMO should ensure that the process mapping and FMEA activities undertaken by the PIP team are including the appropriate team

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			members and utilizing the appropriate data sources. In Module 4, the CMO should consider seeking technical assistance from HSAG to ensure that the evaluation plan for chosen interventions is methodologically sound and that data sources and measures of effectiveness are clearly defined.
WellCare			
In the SMART Aim statement, WellCare established a goal of improving the 30-day follow-up visit rate among members 6 to 12 years old who received an initial prescription for ADHD medication from a selected provider in rural southwestern Georgia by 10 percentage points, from 39.0 percent to 49.0 percent. WellCare plotted rates that were incorrectly averaged across the providers in the region, rather than calculating valid aggregate monthly rates across providers. Although the SMART Aim run chart included monthly rates exceeding the goal of 49.0 percent, the rates were incorrectly calculated; therefore, the PIP did not demonstrate	• 15-day supply initial ADHD medication prescription	Reported PIP results were not credible	Because the SMART Aim measure rates were calculated incorrectly, the reported PIP results were not credible. WellCare's decision to adopt the intervention was not based on a sound rationale because the PIP results were calculated incorrectly. WellCare documented one lesson learned at the conclusion of the PIP: the necessity of working with a single targeted provider office, rather than multiple provider offices, to reduce the burden of real-time data collection and prevent the reliance on medical claims data as part of the intervention testing plan. Selecting a single provider office for future rapid cycle PIPs can help to simplify the data collection process and the calculation of rates, since it would

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
evidence of achieving the SMART Aim goal.			not be necessary to aggregate rates from multiple providers. HSAG supports the CMO's pursuit of single providers for future rapid cycle PIPs; however, the CMO should consider the population size for the selected single provider to ensure a sufficient denominator size for the monthly or weekly measurements. HSAG encourages WellCare to request technical assistance with considering the PIP's population size and SMART Aim measure to ensure a methodologically sound design for future PIPs.

Table E-3—Avoidable Emergency Room Visits

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
Amerigroup established a goal of reducing the avoidable ER rate for members less than 21 years of age assigned to the Nuestros Niños practice by 5 percentage points, from 21.0 percent to 16.0 percent. The SMART Aim measure run chart included five monthly data points from July, September, October, November,	• Primary care-based member education about appropriate emergency care utilization and alternative care options	Low Confidence	Although the SMART Aim goal was achieved, the improvement could not be clearly linked to the documented quality improvement processes; therefore, the PIP was assigned a level of *Low Confidence*. Amerigroup used the SMART Aim measure (the percentage of avoidable ER visits for members

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
and December, when the avoidable ER visit rate for members assigned to the targeted primary care provider (PCP) was lower (better) than the goal of 16.0 percent.			assigned to the targeted primary care provider) to evaluate the intervention's effectiveness; however, the SMART Aim measure was not specific to those members who received the intervention. To evaluate the impact of the intervention, Amerigroup should have tracked those members who received the intervention to determine how many sought care at the urgent care facility and how many visited the ER for an avoidable diagnosis. Amerigroup did not use a metric that allowed the CMO to determine the specific impact of the intervention on the SMART Aim measure. In addition to using an inappropriate measure to evaluate intervention effectiveness, Amerigroup reported several potential, confounding factors that may have contributed to some of the low avoidable ER visit rates plotted on the SMART Aim run chart. Specifically, Amerigroup reported that the summer school break may have resulted in the low rate in July, and unseasonably warm weather from October through December may have contributed to the avoidable ER visit rate being zero during these three months. Given the

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			lack of intervention-specific evaluation results and Amerigroup's reported confounding factors, it is not possible to draw an accurate conclusion of the impact of the intervention on the SMART Aim measure. The lack of an appropriate measure to evaluate intervention effectiveness inhibited Amerigroup's ability to determine the true impact of the intervention on improving the avoidable ER rate. HSAG recommends that future improvement efforts incorporate identification of the data sources and measures necessary to evaluate each intervention's impact.
Peach State			
Peach State established a goal of reducing the avoidable ER rate for Hughes Spalding Hospital from 39.1 percent to 34.5 percent. Three of the PIP's monthly SMART Aim measurements were at or below the goal rate of 34.5 percent, with the lowest avoidable ER rate achieved being 26.9 percent.	• Member awareness/ education outreach by live phone	Low Confidence	Although the SMART Aim goal was achieved, the improvement could not be linked to the quality improvement processes; therefore, the PIP was assigned a level of *Low Confidence*. Given the validation findings for the *Avoidable Emergency Room Visits* PIP, HSAG recommends that Peach State apply lessons learned about engaging external partners and timing of intervention testing to

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			future improvement efforts. Additionally, when planning the evaluation design for intervention testing, the CMO should avoid the use of claims data in most circumstances. Unless the CMO can verify that claims lag will not be an issue, measures of intervention effectiveness should rely on alternative data sources that provide more real-time feedback for rapid improvement.
WellCare			
WellCare established a goal of reducing the avoidable ER visit rate at Floyd Medical Center ER for members assigned to Harbin Clinic from 117 visits per 1,000 member months to 105 visits per 1,000 member months. Five of the PIP's monthly SMART Aim measurements indicated better performance (i.e., had lower rates) than the goal rate of 105 visits per 1,000 members.	• Telephonic outreach by provider and CMO • Provider-based member outreach	High Confidence	The SMART Aim goal was achieved, the CMO used a sound methodology for evaluating and refining the interventions tested, and the quality improvement processes were clearly linked to improvement in the SMART Aim measure; therefore, the PIP was assigned a level of *High Confidence*. Due to WellCare's success at applying the rapid cycle PIP methodology in the *Avoidable Emergency Room Visits* PIP, HSAG recommends that the CMO consider how the PIP's team may be able to share best practices with the CMO's other PIP teams to facilitate success in future improvement projects.

Table E-4—Bright Futures

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
Amerigroup established a goal of improving the well-child visit rate for members 0–15 months of age at Southeastern Permanente (Kaiser) by 10 percentage points, from 59.6 percent to 69.6 percent. The PIP's SMART Aim measurements met or exceeded the goal rate of 69.6 percent for eight consecutive months during intervention testing.	• Member Outreach Coordinator	Low Confidence	Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes; therefore, the PIP was assigned a level of *Low Confidence*. Amerigroup's intervention evaluation plan was not sufficient to determine the impact of the individual components of the complex member outreach coordinator intervention. The data sources and data collection processes documented for the evaluation plan did not demonstrate how all of the intervention components would be evaluated for impact on the SMART Aim measure. HSAG recommends that Amerigroup closely examine both the *Plan* and *Study* steps of the PDSA process as they are applied in the rapid cycle PIP methodology. During the *Plan* step, Amerigroup must ensure that the evaluation plan is designed to measure the individual impact of each component of a complex intervention, such as the

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			member outreach coordinator position. The data sources and measures needed to evaluate the impact of each component of the intervention should be identified and defined prior to initiating the intervention. For the *Study* step of the PDSA process, Amerigroup should consider factors such as timing of intervention initiation and any external changes beyond the CMO's control that may have impacted the process related to the desired improvement. Intervention timing and external changes should be considered when interpreting the SMART Aim measure results and any demonstrated improvement.
Peach State			
Peach State established a goal of improving the well-child visit rate for members 14–18 years of age, assigned to Dr. Rachelle Dennis-Smith, from 20.8 percent to 23.8 percent. The PIP's SMART Aim measurements met or exceeded the goal rate of 23.8 percent for three consecutive months during intervention testing.	• Teen Smart webpage • Teen Smart incentive program	Low Confidence	Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes; therefore, the PIP was assigned a level of *Low Confidence*. Peach State's performance on the *Bright Futures* PIP illustrates the importance of the intervention determination and PDSA cycle planning steps in the rapid cycle process. HSAG recommends that

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			Peach State revisit its approach to both Module 3 (Intervention Determination) and Module 4 (Plan-Do-Study-Act) and seek technical assistance as the CMO refines its approaches to these steps for current and future improvement projects.
WellCare			
WellCare established a goal of improving the annual adolescent well-child visit rate among members 12–21 years of age assigned to AGC Pediatric, LLC, by 5 percentage points, from 56.0 percent to 61.0 percent. One of the PIP's monthly SMART Aim measurements exceeded the SMART Aim goal of 61.0 percent.	• Member outreach • Member outreach and incentive	Low Confidence	Although the SMART Aim goal was achieved, one intervention was poorly executed and the quality improvement processes were not clearly linked to improvement in the SMART Aim measure; therefore, the PIP was assigned a level of *Low Confidence*. HSAG's validation findings for the *Bright Futures* PIP illustrate the importance of planning and communication prior to the initiation of intervention testing in the PDSA cycle. The CMO should ensure that future improvement efforts are preceded by clear communication with partnering providers about the intervention to be tested and the plan for rolling out staggered improvement strategies, such as member outreach and member incentives. Additionally, the CMO should ensure that appropriate

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			measures of effectiveness are clearly defined prior to intervention initiation. The data sources of those measures should be readily accessible, and the measures should clearly demonstrate the impact of intervention components on observed outcomes.

Table E-5—Comprehensive Diabetes Care

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
Amerigroup established a goal of improving the timely diabetic medication refill rate for members assigned to Absolute Care by 12 percentage points, from 28.0 percent to 40.0 percent. Three of the monthly SMART Aim measurements exceeded the goal of a timely diabetic medication refill rate of 40 percent.	• Clinical practice consultant partnership with Absolute Care	Confidence	The SMART Aim goal was achieved, and some but not all of the quality improvement processes were linked to the improvement; therefore, the PIP was assigned a level of *Confidence*. Amerigroup clearly described a methodologically sound data collection process and data sources to track the monthly SMART Aim measure (the monthly percentage of diabetic medication refills for members assigned to the targeted PCP that were refilled with "no gap in fill"). Amerigroup partnered with the targeted PCP to complete a manual tracking tool and use real-

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			time pharmacy data to determine the rate of timely medication refills. Amerigroup also tracked the percentage of medications that were filled with only a one- or two-day gap in fill. Additionally, Amerigroup tracked and analyzed HbA1c levels of diabetic members assigned to the targeted PCP. During the testing of the CPC intervention, the rate of timely diabetic medication refills for the targeted group exceeded the goal rate of 40 percent for three monthly measurements, but the rate fluctuated throughout the PIP, with three subsequent monthly measurements falling below the baseline rate.
Peach State			
Peach State established a goal of improving the percentage of noncompliant diabetic members in DeKalb and Fulton counties who received a diabetic retinal exam by 14 percentage points, from 42.0 percent to 56.0 percent. Six of the PIP's monthly SMART Aim measurements met or exceeded the SMART Aim measure goal of 56.0 percent.	• Telephonic member outreach • Mail-based intervention • Educational home visits	Low Confidence	Although the SMART Aim goal was achieved, the CMO could not clearly link the demonstrated improvement to the interventions tested; therefore, the PIP was assigned a level of *Low Confidence*. If Peach State pursues testing the three combined interventions in a single, multi-tiered intervention strategy, HSAG recommends that the CMO seek technical assistance to

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			ensure that the *Plan* step of the PDSA process to test the multi-tiered intervention includes the necessary components and incorporates a methodologically sound evaluation design. The evaluation plan should be designed to account for the multiple components and ensure that the CMO can gain meaningful information about the intervention and its individual components to drive further improvement of health outcomes for its diabetic members.
WellCare			
WellCare established a goal of improving the percentage of diabetic members in the North and Central regions of Georgia, assigned to one of the selected providers, with an HbA1c result <8.0 percent by 5 percentage points, from 16.1 percent to 21.1 percent. Six consecutive monthly SMART Aim measurements met or exceeded the goal of 21.1 percent.	• Monthly provider summits • Disease management (DM) engagement	Confidence	Because the SMART Aim goal was exceeded, improvement exceeding the goal was sustained for six consecutive measurements, and because some but not all of the improvement could be linked directly to the improvement activities, the PIP was assigned a level of *Confidence*. Although the *Comprehensive Diabetes Care* SMART Aim measure exceeded the goal rate for six consecutive monthly measurements during the life of the PIP, the lack of an intervention-specific measure of intervention effectiveness for the DM

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			engagement intervention prevented the intervention from being clearly linked to the demonstrated improvement. HSAG encourages WellCare to ensure appropriate measures of effectiveness are used for the PDSA cycles in ongoing and future PIPs. The CMO can apply HSAG's feedback and seek additional technical assistance, as needed, to ensure the appropriate measures are selected prior to initiating future interventions.

Table E-6—Member Satisfaction

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
Amerigroup established a goal of reducing the PCP change request call rate from 191/1,000 member months to 181/1,000 member months. The SMART Aim goal was achieved for six consecutive monthly SMART Aim measurements. A total of eight monthly measurements during the PIP indicated better performance (had rates lower) than the goal of 181 PCP change	• Timely updates and corrections to the provider network database	Confidence	The CMO accurately summarized the overall key findings, linking the quality improvement processes to improvement in the SMART Aim measure, but inconsistently documented the number of SMART Aim measurements in the PIP; therefore, the PIP was assigned a level of *Confidence*. While Amerigroup's summary of key findings and interpretation of overall results were accurate, the

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
request calls per 1,000 member months.			CMO did not accurately document the number of SMART Aim measurements that were collected for the PIP. The SMART Aim run chart submitted in Modules 4 and 5 includes 11 monthly measurements (February–December); however, the Module 4 narrative describes "8 of the 12 months" and the Module 5 narrative documents "9 of the 12 months." HSAG recommends that the CMO ensure a thorough review of all PIP documentation to ensure that all results accurately and consistently reflect the number of measurements for the PIP. The CMO should ensure that all modules of the PIP process undergo a quality assurance check so that PIP details, such as the total number of SMART Aim measurements, are accurately and consistently documented throughout all five modules.
Peach State			
Peach State's documentation in the Module 5 Submission Form established a goal of improving the member satisfaction response rate among members in the Atlanta region by 7.0 percentage points, from 73.0 percent to 80.0 percent. The CMO's final	• Incentivize call center representatives to survey Atlanta region members after an inbound call • Outbound calls for members' surveys	Reported PIP results were not credible	The CMO's modified SMART Aim statement changed the focus of the PIP from the approved methodology aimed at improving the overall member satisfaction survey results to improving member satisfaction survey response rate. Because the PIP methodology was not executed

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
SMART Aim run chart included five monthly measurements surpassing the goal rate of 80.0 percent; however, the results were not credible because the CMO changed the SMART Aim measure definition from the methodology approved in Module 2.			as approved in Modules 1 and 2, the reported PIP results were not credible. While HSAG's rapid cycle PIP methodology allows the CMOs a certain amount of flexibility to revise the SMART Aim statement as they progress through each module and learn additional information about the problem being addressed, the CMO must notify HSAG when the SMART Aim statement and/or SMART Aim measure need revisions and provide a written rationale for the desired changes. For substantial SMART Aim statement revisions, as seen in the *Member Satisfaction* PIP, the CMO should also arrange a technical assistance session with HSAG to ensure that the desired changes will not threaten the methodological integrity of the PIP.
WellCare			
WellCare established a goal of increasing the percentage of members responding to the customer service satisfaction survey questions with an answer of "satisfied" or "very satisfied by 2 percentage points, from	• Customer service agent training on handling member eligibility lag between State and CMO • Customer service representative adherence to	Reported PIP results were not credible	Although the SMART Aim goal was achieved, the invalid SMART Aim measurement methodology prevented the CMO from reporting valid results; therefore, the reported PIP results were not credible.

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
89.0 percent to 91.0 percent. The CMO reported that the SMART Aim measure met or exceeded the goal of 91.0 percent for five monthly measurements. Because the SMART Aim measure data collection process was changed from the process HSAG approved in Module 2, the results were not based on the approved measurement methodology and were not credible.	member call protocols, resources, and tools		Based on the validation findings for the *Member Satisfaction* PIP, HSAG recommends that WellCare review the intervention determination processes used in Module 3 and the four steps of the PDSA process used in Module 4. In Module 3, the CMO should ensure that the process mapping and FMEA activities undertaken by the PIP team are including the appropriate team members and utilizing the appropriate data sources, to ensure that interventions selected for testing address the root causes and barriers to improvement. In Module 4, the CMO should consider seeking technical assistance from HSAG to ensure that the evaluation plan for chosen interventions is methodologically sound and that data sources and measures of effectiveness are clearly defined. If the CMO determines a need to change the evaluation plan for an intervention after it is initiated, WellCare is encouraged to discuss the planned changes with HSAG so that methodological implications can be fully examined and biased results can be avoided.

Table E-7—Postpartum Care

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
The CMO established a goal of improving the percentage of women who completed a postpartum visit with an Eagle's Landing provider within 21–56 days post-delivery by 5 percentage points, from 67.0 percent to 72.0 percent. Three of the monthly SMART Aim measurements exceeded the goal of 72 percent.	• Scheduler incentive program for Eagle's Landing OB/GYN Associates	Confidence	The SMART Aim goal was achieved, and some but not all of the quality improvement processes were linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Confidence*. Although the SMART Aim goal was exceeded for three monthly measurements, Amerigroup determined that the intervention process was too resource-intensive for both the CMO and the targeted provider. The process, which required manual tracking by the targeted provider and a hybrid data collection process—reviewing both claims and medical records—was not sustainable. HSAG recommends that Amerigroup ensure that the resources needed to carry out an intervention are thoroughly researched and identified prior to selecting the intervention for testing. The CMO should thoughtfully consider the reliability and sustainability of the intervention prior to selecting it for a PIP. No

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			matter how successful an intervention is in a small-scale test, the testing results cannot be translated into long-term and widespread improvement if the intervention is too resource-intensive to support long-term sustainability.
Peach State			
The CMO established a goal of improving the percentage of women who completed a postpartum visit with a Dourron OB/GYN Associates provider within 21–56 days post-delivery by 5 percentage points, from 60.0 percent to 65.0 percent. Four of the PIP's monthly SMART Aim measurements exceeded the goal of 65.0 percent.	• Proactive Automated Outreach Calls	Confidence	The SMART Aim goal was achieved, and some but not all of the quality improvement processes were clearly linked to the improvement; therefore, the PIP was assigned a level of *Confidence*. Based on the validation findings for the *Postpartum Care* PIP, HSAG recommends that Peach State select appropriate and methodologically sound measures to evaluate intervention effectiveness for the PDSA process in Module 4. The CMO should identify the data sources and data collection processes for the PDSA measures prior to the initiation of intervention testing and confirm that the selected measures will provide meaningful data that will give the CMO and other stakeholders confidence that the results can be used to support conclusions about the impact of the

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			intervention on the desired improvement. If the PDSA measures are not thoughtfully identified and defined in a way that will provide needed results, substantial improvement efforts will be expended without obtaining the necessary information to achieve the CMO's improvement goals.
WellCare			
WellCare established a goal of improving the percentage of women 15–44 years of age who completed a postpartum visit within 21–56 days after delivering a live birth at Grady Memorial Hospital by 10 percentage points, from 26.3 percent to 36.3 percent. Four of the PIP's monthly SMART Aim measurements met or exceeded the goal rate of 36.3 percent.	• Provider practice education • Member education prior to delivery	Confidence	The SMART Aim goal was achieved and some of the CMO's quality improvement processes were clearly linked to the improvement; therefore, the PIP was assigned a level of *Confidence*. HSAG recommends that WellCare apply the lessons learned in the *Postpartum Care* PIP when selecting partner providers for future improvement efforts. HSAG also recommends that the CMO pay particular attention to the evaluation plan during the *Plan* step of the PDSA cycle. When planning measurement intervals for PDSA cycles, the intervals should be consistent throughout the testing cycles. Additionally, the more frequently the CMO can measure results, the more rapidly patterns can

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			be identified to refine the intervention and drive improvement in the outcomes.

Table E-8—Provider Satisfaction

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Amerigroup			
The CMO established a goal of reducing the percentage of providers terminated from the network because of recredentialing issues by 3.2 percentage points (10 percent), from 32.0 percent to 28.8 percent. The SMART Aim measure (an inverse measure, where a lower rate is better) indicated better performance than the goal rate of 28.8 percent for 10 of the PIP's monthly measurements.	• Provider outreach	Low Confidence	Although the SMART Aim goal was achieved, the CMO's quality improvement processes were not clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *Low Confidence*. Based on Amerigroup's PIP documentation, the CMO did not select an appropriate data collection process and data sources to evaluate the effectiveness of the intervention. Amerigroup did not track the number of providers who received the intervention in relation to the SMART Aim measure. Without this information, the evaluation data collection process did not link receiving the outreach intervention to the recredentialing outcome; therefore, the CMO could not directly measure the impact of the

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			intervention on the SMART Aim measure. HSAG also identified gaps in Amerigroup's interpretation of overall SMART Aim measure results. While the CMO accurately summarized the improvement in the annual rate of provider terminations due to recredentialing from 2014 to 2015, the CMO did not discuss the trends in the monthly SMART Aim measurements. Because the SMART Aim measure had better rates than the goal prior to initiation of the intervention, the CMO's interpretation of results should have included consideration of factors other than the intervention that may have impacted the SMART Aim measure. Amerigroup did not use an appropriate intervention evaluation design and did not accurately interpret the overall key PIP findings; therefore, the rationale provided for adopting the intervention was not sound. HSAG recommends that Amerigroup seek technical assistance when designing the

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			intervention evaluation plan to ensure that a methodologically sound approach is used. Additionally, Amerigroup should ensure that its interpretation of key findings and overall PIP results account for the timing of the intervention initiation and consider other factors that may have contributed to any demonstrated improvement, beyond the interventions tested.
Peach State			
The CMO established a goal of reducing the average number of days required to complete a prior authorization request by ENT of Georgia providers from 8.4 days to 6.3 days. Following initiation of the intervention, the SMART Aim measure performed better than the goal of 6.3 days for 10 consecutive biweekly measurements.	• Provider education on the prior authorization process	Confidence	Based on the PIP results, Peach State concluded, "Attaining the SMART Aim was likely attributed to a combination of several factors—provider education, increase in staff, and an improved internal process." The CMO chose to continue testing the intervention with additional provider groups and plans to adopt and spread the intervention if additional testing with other providers demonstrates similar success in reducing prior authorization turnaround time. HSAG recommends that Peach State closely examine its approach to selecting interventions for testing and identifying measures to evaluate

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			intervention effectiveness. These key steps that occur in Modules 3 and 4 of the rapid cycle PIP process are pivotal in achieving the desired outcomes for each PIP.
WellCare			
WellCare established a goal of increasing the percentage of Health One Alliance providers who answer "Excellent" or "Very Good" to WellCare's overall satisfaction survey question. One of the PIP's SMART Aim measurements exceeded the goal of 74.0 percent.	• Targeted provider outreach, education, and issue resolution	High Confidence	The SMART Aim goal was achieved, the CMO used a sound methodology for evaluating and refining the interventions tested, and the quality improvement processes were clearly linked to improvement in the SMART Aim measure; therefore, the PIP was assigned a level of *High Confidence*. Given the success of the *Provider Satisfaction* PIP, HSAG recommends that WellCare consider asking the *Provider Satisfaction* PIP team to identify and share best practices with the CMO's other PIP teams. While individual PIPs cannot be directly compared because of the varying topics, eligible populations, and improvement strategies, the CMO may identify approaches or strategies used in the *Provider Satisfaction* PIP that can be translated and applied to other improvement projects.

Table E-9—Performance Summary for Amerigroup 360°

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
7-Day Inpatient Discharge Follow-up			
Amerigroup 360° established a goal of improving the compliance rate for seven-day follow-up visits at Peachford Hospital by 5 percentage points, from 40.0 percent to 45.0 percent. Three of the PIP's monthly SMART Aim measurements exceeded the goal of 45.0 percent for the seven-day follow-up visit rate among members discharged from Peachford Hospital. The highest monthly follow-up visit compliance rate of 52.4 percent was an improvement of 12.4 percentage points over the baseline rate and exceeded the goal rate by 7.4 percentage points.	• Stabilization team at discharging facility	High Confidence	The PIP's SMART Aim goal was achieved and the quality improvement processes were clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *High Confidence*. It should be noted that, while the CMO used a methodologically sound evaluation process to test the series of steps carried out by the stabilization team described above, the evaluation results are only valid for determining the impact of the entire series of steps included in the intervention tested. The evaluation results cannot be extrapolated to any of the individual steps or any other combination of steps. The CMO would need to design a distinct evaluation process specific to each step if the goal was to evaluate each step in the stabilization team process individually.
Adolescent Well-Child Visits			
Amerigroup 360° established a goal of improving the 11–21 years of age adolescent well-child visit rate at Georgia Family	• Focused member outreach by the targeted provider	Low Confidence	Because the SMART Aim goal was not achieved, the PIP was assigned a level of *Low Confidence*.

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Care, LLC, by 6 percentage points, from 42.9 percent to 48.9 percent. None of the PIP's monthly SMART Aim measurements met the rate of 48.9 percent. The highest monthly adolescent well-child visit rate achieved during the life of the PIP for eligible Amerigroup 360° members was 44.9 percent, which was a 2 percentage point increase over the baseline rate but was 4 percentage points below the goal.			The CMO used a methodologically sound data collection process and data sources to evaluate intervention effectiveness. The CMO tracked the SMART Aim measure (adolescent well-child visit rate among members assigned to the targeted provider) monthly. Because the intervention was tested at the provider level, the SMART Aim measure could be used to illustrate the effect of the intervention. The CMO reported that the greatest barrier to improving the adolescent well-child visit rate was a lack of accurate member contact information. Those members who were reached already had a well-child visit scheduled 75 percent of the time. Additionally, most members (81 percent) with a scheduled well-child visit completed the visit as scheduled. Based on the lack of meaningful improvement, the CMO chose to abandon the intervention.

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
Appropriate Use of ADHD Medications			
Amerigroup 360° established a goal of improving the rate of members 6–12 years of age who received an initial ADHD medication prescription at Harbin Clinic and returned for a follow-up visit within 30 days by 5 percentage points, from 39.5 percent to 44.5 percent. Nine of the PIP's monthly SMART Aim measurements exceeded the goal rate of 44.5 percent, and two of the monthly measurements achieved the maximum possible compliance rate of 100 percent.	• Internal process changes at Harbin Clinic	High Confidence	The PIP's SMART Aim goal was achieved and the quality improvement processes were clearly linked to the demonstrated improvement; therefore, the PIP was assigned a level of *High Confidence.* The CMO tested the intervention by tracking the SMART Aim measure (30-day follow-up visit completion rate among members who received an initial ADHD medication prescription from the targeted provider) monthly. The SMART Aim measure was an appropriate measure of intervention effectiveness because the CMO's intent was to test the combination of all four related process changes as a single intervention. The SMART Aim measure results are a valid measure of the impact of the intervention as tested, but the results cannot be used as a valid measure of the impact of the individual process changes alone; the CMO would need to develop measures specific to each individual process change if it wanted to assess the individual impact of the four related process changes.

Summary of Performance	PIP Intervention and Activities	EQR Validation Rating	EQR Discussion and Recommendation
			As a result of the meaningful and sustained improvement demonstrated during the PIP, Amerigroup 360° chose to adopt the intervention and is pursuing additional provider partners to participate in the spread of this intervention.

Appendix F. Performance Measure Results—Care Management Organization Comparison

Care Management Organization (CMO) Summary Results Comparison

The following tables display the performance measure rates for Amerigroup, Peach State, WellCare, and Amerigroup 360° for calendar year (CY) 2015. The rates were calculated by each CMO and audited by either HSAG or the CMO's NCQA HEDIS compliance auditor. Where applicable, rates with a green upward arrow (↑) indicate a statistically significant improvement in performance between CY 2014 and CY 2015. Rates with a red downward arrow (↓) indicate a statistically significant decline in performance between CY 2014 and CY 2015. Performance comparisons are based on the Chi-square test of statistical significance with a *p* value <0.05. Of note, rates presented in the Health Plan Descriptive Information measure set are not linked to performance; therefore, rates with a black upward arrow (↑) indicate a statistically significant rate increase between CY 2014 and CY 2015, and rates with a black downward arrow (↓) indicate a statistically significant rate decrease between CY 2014 and CY 2015.
Additionally, measure names shaded green with one cross ($^{+}$) indicate that DCH established a single performance target across all CMOs, and rates shaded green with a superscripted letter "G" (^{G}) indicate that the rate met or exceeded the CMO-specific performance target. Measure names shaded orange with two crosses ($^{++}$) indicate that DCH established CMO-specific performance targets for the measure, and rates shaded orange with superscripted letters "OR" (^{OR}) indicate that the rate met or exceeded these CMO-specific performance targets.
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.

Access to Care

A comparison of CY 2015 Access to Care measure results across CMOs is shown in Table F-1.

Table F-1—CMO Comparison of CY 2015 Access to Care Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.61%	96.74% ↓	96.90% ↓	98.75%
25 Months–6 Years	89.42% ↓	89.17% ↓	89.63% ↓	91.06%
7–11 Years	92.23% ↓	91.17%	91.36% ↓	97.46%
12–19 Years^{+}	89.92% ↓	88.78%	89.09% ↓	96.92%^{G}
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years^{+}	79.48%	77.87% ↓	81.52%	52.82%
Annual Dental Visit				
2–3 Years^{+}	46.51% ↓	44.05% ↓	49.80% ↑	46.87%

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
4–6 Years	75.11% ↓	72.77% ↓	76.42% ↑	80.41%
7–10 Years	78.48%	76.03% ↓	78.49% ↑	75.91%
11–14 Years	71.85%	69.85%	72.49% ↑	69.54%
15–18 Years	60.80%	59.19%	61.57% ↑	63.67%
19–20 Years++	39.47%OR↑	37.57%OR↑	40.17%OR↑	38.91%
Total++	68.81%	66.97% ↓	70.12% ↑	67.48%OR
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total+	36.94% ↓	35.24% ↓	34.15%	51.75%G
Engagement of AOD Treatment—Total+	8.23% ↓	6.82%	7.09%	20.47%G
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.00%	0.00%	0.00%	0.00%
Colorectal Cancer Screening				
Colorectal Cancer Screening	45.24%	49.29%	46.72%	—
Adult BMI Assessment				
Adult BMI Assessment++	71.46%	82.38%	82.08%	NA

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

Measure names shaded green with one cross (+) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (G) indicate that the rate met or exceeded the single performance targets.

Measure names shaded orange with two crosses (++) indicate that DCH established CMO-specific performance targets for the measure. Rates shaded orange with superscripted letters "OR" (OR) indicate that the rate met or exceeded the CMO-specific performance targets.

— indicates that the CMO was not required to report the measure for CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Children's Health

A comparison of CY 2015 Children's Health measure results across CMOs is shown in Table F-2.

Table F-2—CMO Comparison of CY 2015 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 Well-Child Visits++	68.52%OR	67.79%OR	64.69%	56.70%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life+	73.04%G	68.99%	68.73%	73.84%G

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Adolescent Well-Care Visits				
Adolescent Well-Care Visits^{++}	56.02%^{OR}	47.60%	53.28%	53.47%^{OR}
Prevention and Screening				
Childhood Immunization Status				
Combination 3^{++}	76.16%	79.09%	82.10%	71.06%
Combination 6^{+}	39.35%	36.30% ↓	44.54%	37.73%
Combination 10^{++}	35.42%	34.38%	41.48%^{OR}	26.39%
Lead Screening in Children				
Lead Screening in Children^{++}	80.09%^{OR}	80.05%^{OR}	83.85%^{OR}	78.94%^{OR}
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis^{++}	82.38% ↑	82.14% ↑	80.67% ↑	81.98%^{OR}
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)$^{++}$	90.49%^{OR} ↑	88.90%^{OR} ↑	89.51%^{OR} ↑	84.03%^{OR}
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total^{++}	67.75%^{OR} ↑	67.79%^{OR}	66.26%^{OR}	68.29%^{OR}
Counseling for Nutrition—Total^{++}	63.57%^{OR}	66.59%^{OR}	60.39%^{OR}	68.52%^{OR}
Counseling for Physical Activity—Total$^{++,1}$	56.84%^{OR}	57.21%^{OR}	54.03%^{OR}	64.12%^{OR}
Developmental Screening in the First Three Years of Life				
Total^{+}	48.38%^{G} ↑	50.60%^{G}	51.82%^{G} ↑	50.00%^{G}
Percentage of Eligibles Who Received Preventive Dental Services				
Percentage of Eligibles Who Received Preventive Dental Services^{+}	52.34% ↓	51.46% ↓	52.91% ↑	59.08%^{G}
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	24.81%	20.09%	12.90%	26.93%
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection^{+}	86.82%^{G} ↑	84.00%	84.42% ↑	84.11%

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

Measure names shaded green with one cross ($^{+}$) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (^{G}) indicate that the rate met or exceeded the single performance targets.

Measure names shaded orange with two crosses ($^{++}$) indicate that DCH established CMO-specific performance targets for the measure. Rates shaded orange with superscripted letters "OR" (^{OR}) indicate that the rate met or exceeded the CMO-specific performance targets.

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between CY 2014 and CY 2015.*

Women's Health

A comparison of CY 2015 Women's Health measure results across CMOs is shown in Table F-3.

Table F-3—CMO Comparison of CY 2015 Women's Health Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Prevention and Screening				
Cervical Cancer Screening				
Cervical Cancer Screening+	64.49%	68.56%	66.36% ↓	—
Breast Cancer Screening				
Breast Cancer Screening+	67.84%	66.90%	71.61%G	—
Chlamydia Screening in Women				
Total+	53.71% ↓	59.83%G ↑	53.04% ↑	54.47%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents+	29.17%G ↑	21.93%	23.36%	22.92%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care+	78.09%	77.49%	72.32% ↓	81.08%
Postpartum Care++	64.10%	59.72% ↓	52.87% ↓	59.46%
Cesarean Section for Nulliparous Singleton Vertex				
Cesarean Section for Nulliparous Singleton Vertex+,*	NR	NR	NR	NR
Cesarean Delivery Rate, Uncomplicated				
Cesarean Delivery Rate, Uncomplicated+,*	21.59%G ↑	29.32%	28.70%G ↑	12.35%G
Percentage of Live Births Weighing Less Than 2,500 Grams				
Percentage of Live Births Weighing Less Than 2,500 Grams+,*	9.34%	8.87%	9.05%	NA
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	11.00% ↑	5.46% ↑	15.33% ↑	16.25%
Elective Delivery				
Elective Delivery+,*	NR	NR	NR	NR
Antenatal Steroids				
Antenatal Steroids	NR	NR	NR	NR

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits[++,*]	49.65%	59.00%	38.90% ↓	37.84%

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

Measure names shaded green with one cross (+) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (G) indicate that the rate met or exceeded the single performance targets. Of note, the Cervical Cancer Screening and Breast Cancer Screening measures are shaded green with one cross (+) to indicate that rates for Amerigroup, Peach State, and WellCare are all compared to a single performance target for these measures for 2016. These measures were not reported for Amerigroup 360°.

Measure names shaded orange with two crosses (++) indicate that DCH established CMO-specific performance targets for the measure.

— indicates that the CMO was not required to report the measure for CY 2015.

** A lower rate indicates better performance for this measure.*

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NR (i.e., Not Reported) indicates that Cesarean Section for Nulliparous Singleton Vertex, Elective Delivery, and Antenatal Steroids received the NR designation for the audit results. The CMO used a software vendor to produce the denominator for these measures; however, the vendor was not able to identify the gestational age using administrative data, which resulted in false positives in the denominator. Since the gestational age was not determined prior to drawing the sample, the rate was considered materially biased and an audit result of Not Reportable was assigned.

Chronic Conditions

A comparison of CY 2015 Chronic Conditions measure results across CMOs is shown in Table F-4.

Table F-4—CMO Comparison of CY 2015 Chronic Conditions Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Diabetes				
Comprehensive Diabetes Care[1]				
Hemoglobin A1c (HbA1c) Testing[+]	88.35%G	81.80%	80.43%	NA
HbA1c Poor Control (>9.0%)[+,*]	53.22%	59.72% ↓	52.74%	NA
HbA1c Control (<8.0%)[+]	38.96%	32.51%	39.80%	NA
HbA1c Control (<7.0%)[+]	28.93%	23.52%	32.39%	NA
Eye Exam (Retinal) Performed[+]	49.74%	59.36%G	39.64%	NA
Medical Attention for Nephropathy[+]	92.87%G ↑	91.87%G ↑	90.88%G ↑	NA
Blood Pressure Control (<140/90 mm Hg)[+]	50.78% ↑	52.83%	49.09% ↓	NA
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)^				
Diabetes Short-Term Complications Admission Rate[+,*]	13.46	15.46	13.69	16.81

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,00 Member Months)^				
Asthma in Younger Adults Admission Rate[+,]*	4.42	3.19	3.38	0.00
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)^				
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate[+,]*	30.22	23.78	17.30	—
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid[+]	79.07%[G]	80.70%[G]	69.28%	—
Bronchodilator[+]	83.72% ↑	82.46%	82.35%	—
Cardiovascular Conditions				
Heart Failure Admission Rate (Per 100,000 Member Months)^				
Heart Failure Admission Rate[+,]*	4.11	4.54	5.02	0.00
Controlling High Blood Pressure				
Controlling High Blood Pressure[+]	42.72% ↑	43.14% ↑	40.15%	NA
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	93.75%	NA	NA	—

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

Measure names shaded green with one cross (+) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (G) indicate that the rate met or exceeded the single performance targets. Of note, the Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate measure and Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator measures are shaded green with one cross (+) to indicate that rates for Amerigroup, Peach State, and WellCare are all compared to a single performance target for 2016. These measures were not reported for Amerigroup 360°.

^ *indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, these rates were not compared to the 2015 performance target.*

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between CY 2014 and CY 2015.*

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

* *A lower rate indicates better performance for this measure.*

— *indicates that the CMO was not required to report the measure for CY 2015.*

Behavioral Health

A comparison of CY 2015 Behavioral Health measure results across CMOs is shown in Table F-5.

Table F-5—CMO Comparison of CY 2015 Behavioral Health Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase+	46.42%	43.84%	47.02% ↓	51.71%
Continuation and Maintenance Phase+	61.59%	58.82%	64.29%G	54.72%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up+	50.40%	55.77%	50.39%	52.15%
30-Day Follow-Up+	67.73%	72.53%	68.75%	75.68%
Antidepressant Medication Management				
Effective Acute Phase Treatment+	57.03%G ↑	38.66%	44.77%	73.02%G
Effective Continuation Phase Treatment+	39.89%G ↑	23.89%	28.35%	61.90%G
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.34%	7.48% ↑	7.18% ↑	2.56%
Adherence to Antipsychotic Medications for Individuals with Schizophrenia[1]				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia+	40.57%	19.63% ↓	39.23%	NA
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	2.82%	0.25%	1.59%	4.93%

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

Measure names shaded green with one cross (+) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (G) indicate that the rate met or exceeded the single performance targets.

[1] *Due to changes in the technical specifications for this measure, exercise caution when trending rates between CY 2014 and CY 2015.*

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Medication Management

A comparison of CY 2015 Medication Management measure results across CMOs is shown in Table F-6.

Table F-6—CMO Comparison of CY 2015 Medication Management Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs[+]	88.67%[G]	87.45%	89.47%[G] ↑	—
Annual Monitoring for Members on Diuretics[+]	88.14%[G]	87.41%	88.82%[G]	—
Total[+]	88.32%[G]	87.41%	89.03%[G] ↑	—
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	53.31% ↑	45.40%	47.49%	NA
Medication Compliance 50%—Ages 12–18 Years	50.69% ↑	41.64%	42.44%	NA
Medication Compliance 50%—Ages 19–50 Years	53.25%	50.96%	56.15%	NA
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	NA
Medication Compliance 50%—Total	52.54% ↑	44.34%	46.08%	NA
Medication Compliance 75%—Ages 5–11 Years[+]	27.16% ↑	20.95%	22.99%	NA
Medication Compliance 75%—Ages 12–18 Years	24.22% ↑	16.58%	19.95%	NA
Medication Compliance 75%—Ages 19–50 Years	33.73% ↑	19.75%	34.23%	NA
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	NA
Medication Compliance 75%—Total	26.58% ↑	19.41%	22.37%	NA

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

Measure names shaded green with one cross ([+]*) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (*[G]*) indicate that the rate met or exceeded the single performance targets. Of note, the Annual Monitoring for Patients on Persistent Medications measures are shaded green with one cross (*[+]*) to indicate that each measure rate for Amerigroup, Peach State, and WellCare are all compared to a single performance target for 2016. This measure is not reported for Amerigroup 360°.*

— indicates that the CMO was not required to report the measure for CY 2015.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

Utilization

A comparison of CY 2015 Utilization measure results across CMOs is shown in Table F-7.

Table F-7—CMO Comparison of CY 2015 Utilization Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[+,*]	56.35	52.44	60.95	35.58[G]
Outpatient Visits—Total	306.89	303.03	327.56	289.86
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	3.36	3.47	3.20	4.90
Total Inpatient—Average Length of Stay—<1 Year	8.05	8.92	6.50	5.74
Medicine—Average Length of Stay—Total	3.54	3.41	3.18	3.76
Medicine—Average Length of Stay—<1 Year	4.59	4.61	4.16	4.01
Surgery—Average Length of Stay—Total	7.44	8.37	5.75	8.14
Surgery—Average Length of Stay—<1 Year	16.53	20.83	13.95	10.00[†]
Maternity—Average Length of Stay—Total	2.77	2.82	2.74	2.89
Mental Health Utilization—Total				
Any Service—Total—Total	9.69%	7.68%	9.25%	56.61%
Inpatient—Total—Total	0.54%	0.41%	0.55%	4.52%
Intensive Outpatient or Partial Hospitalization—Total—Total	0.14%	0.12%	0.13%	0.98%
Outpatient or ED—Total—Total	9.59%	7.59%	9.14%	56.24%
Plan All-Cause Readmission Rate*				
Age 18–44	11.26%	12.32%	11.79%	24.00%
Age 45–54	17.07%	11.21%	10.46%	NA
Age 55–64	6.58%	5.26%	20.95%	NA
Age 18–64—Total	12.11%	11.87%	11.93%	24.00%
Age 65–74	NA	NA	NA	—
Age 75–84	NA	NA	NA	—
Age 85 and Older	NA	NA	NA	—
Age 65 and Older—Total	NA	NA	NA	—

Measure names shaded green with one cross (+) indicate that DCH established a single performance target across all CMOs. Rates shaded green with a superscripted letter "G" (G) indicate that the rate met or exceeded the single performance targets.

** A lower rate indicates better performance for this measure.*

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

† *The rate for Inpatient Utilization—General Hospital/Acute Care—Total—Surgery—Average Length of Stay—<1 Year for Amerigroup 360° was based on at least one discharge, but fewer than 30 discharges; however, this rate is presented in the results table. Therefore, exercise caution when evaluating this rate.*

— indicates that the CMO was not required to report the measure for CY 2015.

Health Plan Descriptive Information

A comparison of CY 2015 Health Plan Descriptive Information measure results across CMOs is shown in Table F-8.

Table F-8—CMO Comparison of CY 2015 Health Plan Descriptive Information Measure Rates

Measure	Amerigroup	Peach State	WellCare	Amerigroup 360°
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.70%	13.16%	13.79% ↑	64.04%
1–12 Weeks	13.68% ↑	11.87%	13.70% ↑	10.11%
13–27 Weeks	52.53% ↓	52.61% ↓	52.04% ↓	10.11%
28+ Weeks	15.03% ↓	14.53%	12.33% ↓	14.61%
Unknown	8.06%	7.83% ↑	8.14% ↓	1.12%
Race/Ethnicity Diversity of Membership				
Total—White	47.41% ↑	34.32% ↑	49.04% ↑	47.67%
Total—Black or African American	44.87%	53.57% ↑	44.16% ↑	47.82%

↑ *indicates a statistically significant rate increase between CY 2014 and CY 2015.*

↓ *indicates a statistically significant rate decrease between CY 2014 and CY 2015.*

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 Medicaid national 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. Furthermore, progress of QI initiatives should be monitored and reported internally to assess the effectiveness of these efforts.

Rating of All Health Care

- **Access to Care**—The CMO should identify potential barriers for patients receiving appropriate access to care. Access to care issues include obtaining the care that the patient and/or physician deemed necessary, obtaining timely urgent care, locating a personal doctor, or receiving adequate assistance when calling a physician office. The CMO should attempt to reduce any hindrances a patient might encounter while seeking care. Standard practices and established protocols for access to care issues can assist in this process by ensuring issues are handled consistently across all practices. As an example, the CMO could develop standardized protocols and scripts for common occurrences within the provider office setting, such as patients who are late for scheduled appointments. Additionally, having a well-written script prepared in the event of an uncommon but

expected situation allows staff to work quickly in providing timely access to care while following protocol.

- **Patient and Family Engagement Advisory Councils**—Since both patients and families have the direct experience of an illness or healthcare system, their perspectives can provide significant insight when performing an evaluation of healthcare processes. As such, the CMO should consider creating opportunities and functional roles that include the patients and families who represent the populations they serve. Patient and family members could serve as advisory council members providing new perspectives and serving as a resource for feedback on healthcare processes. Involvement in advisory councils can provide a structure and process for ongoing dialogue and creative problem-solving between the CMO and its members. The councils' roles within a health plan organization can vary and responsibilities may include input into or involvement in program development, implementation, and evaluation; design of materials or tools that support the provider-patient relationship; and marketing of healthcare services.

Rating of Specialist Seen Most Often

- **Planned Visit Management**—The CMO should 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 should 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. Furthermore, the local provider is more involved in the consultation process and more informed about care the patient is receiving.

Rating of Personal Doctor

- **Maintain Truth in Scheduling**—The CMO should 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. Furthermore, 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. Furthermore, 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 should 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 should 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.

Shared Decision Making

- **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. Therefore, 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.