State of Georgia

Department of Community Health
Georgia Families Program

AMERIGROUP Community Care

PERFORMANCE IMPROVEMENT PROJECTS REPORT

SFY 2013

November 2012

TABLE OF CONTENTS

1. BACKGROUND

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) for the State of Georgia and overseeing quality improvement activities. The State refers to its Medicaid managed care program as Georgia Families and to its CHIP program as PeachCare for Kids®. For the purposes of this report, "Georgia Families" refers to all Medicaid and CHIP members enrolled in managed care.

The Georgia Families® Managed Care Program serves the majority of Georgia's Medicaid and CHIP populations. The DCH requires its Georgia Families contracted Care Management Organizations (CMOs) to conduct performance improvement projects (PIPs) as set forth in 42 CFR §438.240 to assess and improve the quality of a targeted area of clinical or nonclinical care or service provided to members, and to report the status and results of each PIP annually. AMERIGROUP is one of the Georgia Families® CMOs.

The validation of PIPs is one of three federally-mandated activities for state Medicaid managed care programs. The other two required activities include the evaluation of CMO compliance with State and federal regulations and the validation of CMO performance measures.

These three mandatory activities work together to ensure that the CMOs assure appropriate access to high quality care for their members. While a CMO's compliance with managed care regulations provides the organizational foundation for the delivery of quality health care, the calculation and reporting of performance measure rates provide a barometer of the quality and effectiveness of the care. When performance measures highlight areas of low performance, the DCH requires the CMOs to initiate PIPs to improve the quality of health care in targeted areas. PIPs are key tools in helping the DCH achieve goals and objectives outlined in its quality strategy; they provide the framework for monitoring, measuring and improving the delivery of health care.

The primary objective of PIP validation is 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 system interventions to achieve improvement in quality
- Evaluation of the effectiveness of the interventions
- Planning and initiation of activities to increase or sustain improvement

To meet the federal requirement for the validation of PIPs, the DCH contracted with Health Services Advisory Group, Inc. (HSAG), the State's EQRO, to conduct the validation of AMERIGROUP's PIPs. AMERIGROUP submitted PIPs to HSAG between June 29, 2012, and August 3, 2012, and HSAG validated the PIPs between July 2, 2012, and August 10, 2012. The

validated data represents varying measurement time periods as described in Table 2-3 and Table 2-4.

HSAG reviewed each PIP using the Centers for Medicare & Medicaid Services (CMS) validation protocol[1-1] and evaluated two key components of the quality improvement process, as follows:

1. HSAG evaluated the technical structure of the PIPs to ensure AMERIGROUP designed, conducted and reported PIPs using sound methodology consistent with the CMS protocol for conducting PIPs. HSAG's review determined whether a PIP could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
2. HSAG evaluated the outcomes of the PIPs. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. Outcome evaluation determined whether AMERIGROUP improved its rates through implementation of effective processes (i.e., barrier analyses, intervention design and evaluation of results) and achieved statistically significant improvement over the baseline rate. A primary goal of HSAG's PIP validation is to ensure that the DCH and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

CMO Overview

The DCH contracted with AMERIGROUP beginning in 2006 to provide services to the Georgia Families Program (Medicaid and PeachCare for Kids®) population. Prior to 2012, AMERIGROUP served the eligible population in the Atlanta, North, East and Southeast geographic regions of Georgia. In early 2012, the CMO expanded coverage statewide and added the central and southwest regions. This new membership is not included in the performance improvement project rates in this report.

Study Rationale

The purpose of a PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time in clinical or nonclinical areas. Although HSAG has validated AMERIGROUP's PIPs for five years, the number of PIPs, study topics and study methods has evolved over time.

AMERIGROUP submitted nine (9) PIPs for validation. The PIP topics include:

- Adults' Access to Care
- Annual Dental Visits
- Childhood Immunizations

[1-1] U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. EQR Managed Care Organization Protocol. *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities, Final Protocol, Version 1.0, May 2002*.

- Childhood Obesity
- Emergency Room Utilization
- Lead Screening in Children
- Member Satisfaction
- Provider Satisfaction
- Well-Child Visits

The effectiveness of AMERIGROUP's performance improvement efforts was measured using study indicators that aligned with HEDIS performance measures.

Study Summary

As noted in its Quality Strategic Plan Update (November 2011), the DCH identified the improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance as one of its four performance-driven goals. The goals are designed to demonstrate success or identify challenges in achieving intended outcomes related to providing quality, accessible, and timely services. The June 29, 2012, through August 3, 2012 PIP submission included seven clinical PIPs: *Adults' Access to Care , Annual Dental Visits, Childhood Immunizations, Childhood Obesity, Emergency Room Utilization, Lead Screening in Children* and *Well-Child Visits* and two nonclinical PIPs: *Member Satisfaction* and *Provider Satisfaction*.

Five of the clinical PIP topics directly relate to performance measure outcomes that link to preventive health services delivery and management of disease. They include: *Annual Dental Visits, Childhood Immunizations, Childhood Obesity, Lead Screening in Children* and *Well-Child Visits.* Children's primary health care is a vital part of the effort to prevent, recognize and treat health conditions that can result in significant developmental and health status consequences for children and adolescents. Timely screening and interventions can reduce future complications such as those related to obesity.

The other two clinical PIPs, *Adults' Access to Care* and *Emergency Room Utilization,* represent an essential component in developing a relationship with a health care provider and establishing a medical home, as well as ensuring that members have access to and receive care from the most appropriate care setting. These PIP topics represent a key area of focus for improvement.

Table 1-1 outlines the key study indicators incorporated for the seven HEDIS-based PIPs.

Table 1-1—PIP Study Topics and Indicator Descriptions

PIP Study Topic	PIP Study Indicator Description
Adults' Access to Care	The percentage of members 20–44 years of age who had an ambulatory or preventive care visit.
Annual Dental Visits	The percentage of members 2–3 years of age and 2–21 years of age who had at least one dental visit.
Childhood Immunization	The percentage of children 2 years of age who had the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IVP); one measles, mumps and rubella (MMR); two H influenza type B (Hib); three hepatitis B; and one chicken pox (VZN).
Childhood Obesity	The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, nutrition counseling and physical activity counseling.
Emergency Room Utilization	The number of emergency department visits that did not result in an inpatient stay, per 1,000 member months.
Lead Screening in Children	The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.
Well-Child Visits	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care provider (PCP) during their first 15 months of life.

Table 1-2 outlines the key study indicators incorporated for the two satisfaction-based PIPs.

The effectiveness of the *Member Satisfaction* PIP was measured using the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0H, Child Version measures. This survey provided information on parents' experiences with their child's provider and CMO.

The final AMERIGROUP PIP topic was *Provider Satisfaction*. AMERIGROUP contracted with a vendor to produce and administer a survey to document the effectiveness of this performance improvement project.

Table 1-2—Satisfaction-Based PIP Study Indicators

Survey Type	Question	Survey Question
Member	#10	"In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?"
Member	#11	"In the last 6 months, when there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice you thought was best for your child?"
Provider	#34C*	"Please rate your experience with contacting the AMERIGROUP pharmacy call center to find out about formulary medications and alternatives to non-formulary medications."
* Providers were requested to respond if they agreed with the statement regarding the CMO.		

Validation Overview

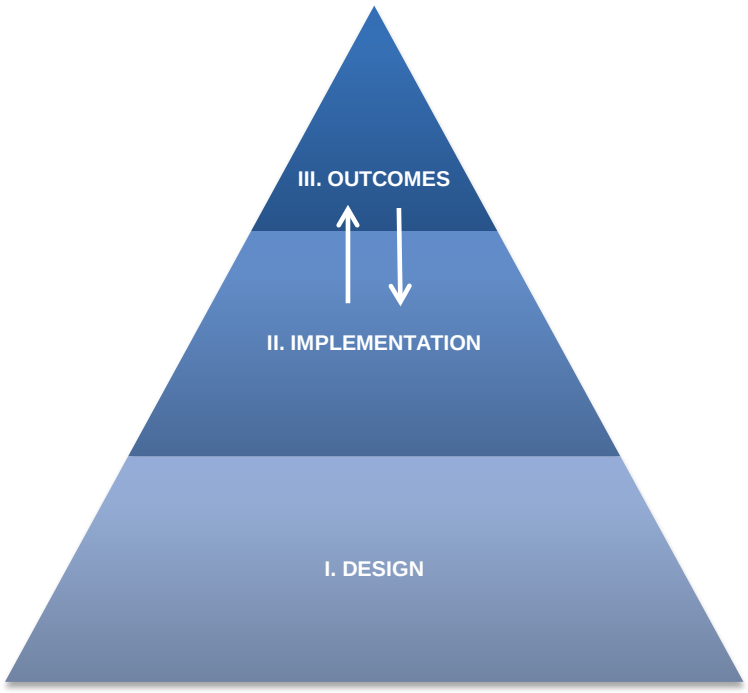
HSAG obtained the data needed to conduct the PIP validation from AMERIGROUP's PIP Summary Forms. These forms provided detailed information about AMERIGROUP's PIPs related to the activities they completed.

Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable* or *Not Assessed*. HSAG designated some of the evaluation elements deemed pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all of the critical elements had to be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A CMO would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provided a *Point of Clarification* when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

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

Figure 1-1 illustrates the three study stages of the PIP process: Design, Implementation and Outcomes. Each sequential stage provides the foundation for the next stage. The Design stage establishes the methodological framework for the PIP. The activities in this section include development of the study topic, question, indicators and population. To implement successful improvement strategies, a strong study design is necessary.

Figure 1-1—PIP Study Stages



Once the study design was established, the PIP process moved into the Implementation stage. This stage included data collection, sampling and interventions. During this stage, AMERIGROUP collected measurement data, evaluated and identified barriers to performance and developed interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. The final stage was Outcomes, which involved data analysis and the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over the baseline rate and sustain the improvement over time and multiple measurements. This stage is the culmination of the previous two stages. If the study outcomes did not improve, AMERIGROUP's responsibility was to investigate the data it collected to ensure it had correctly identified the barriers and implemented targeted interventions to address the identified barriers. If it had not, AMERIGROUP would revise its interventions and collect additional data to re-measure and evaluate outcomes for improvement. This process becomes cyclical until sustained improvement is achieved.

HSAG's Validation Scoring Methodology

During SFY 2012, HSAG worked with DCH to modify the existing PIP validation methodology. The modifications were designed to ensure AMERIGROUP achieves improvement in the study outcomes for all PIPs submitted for validation. Changes were made to the validation activities for Activity VIII (sufficient data analysis and interpretation). AMERIGROUP must now present

study results that are accurate, clear and easily understood. Furthermore, sufficient data analysis and interpretation is now a critical element; therefore, if the study indicator results are not accurate, the PIP cannot receive an overall *Met* validation status. Changes were also made to the validation activities for Activity IX (real improvement achieved) and this activity is now a critical element for all PIPs that progress to this stage. Any PIP that does not achieve statistically significant improvement will not receive an overall *Met* validation status. AMERIGROUP's study indicator outcomes must achieve statistically significant improvement over the baseline rate. Finally, changes were made to the validation activities for Activity X (sustained improvement achieved). HSAG assesses each study indicator for sustained improvement after the PIP indicator achieves statistically significant improvement. For PIPs with multiple indicators, all indicators must achieve statistically significant improvement and report a subsequent measurement period with documented sustained improvement. All study indicators must now achieve statistically significant improvement and sustain this improvement to receive a *Met* score for Activity X.

Aggregate Validation Findings

HSAG organized, aggregated, and analyzed AMERIGROUP's PIP data to draw conclusions about the CMO's quality improvement efforts. The PIP validation process evaluated both the technical methods of the PIP (i.e., the study design) and the outcomes associated with the implementation of interventions. Based on its review, HSAG determined the overall methodological validity of the PIPs, as well as the overall success in achieving improved study indicator outcomes. The results are presented in Table 2-1.

Table 2-1—Performance Improvement Project Validation Scores for AMERIGROUP Community Care

PIP	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Validation Status
Adults' Access to Care	97%	100%	*Met*
Annual Dental Visits	100%	100%	*Met*
Childhood Immunizations	98%	100%	*Met*
Childhood Obesity	96%	93%	*Partially Met*
Emergency Room Utilization	95%	92%	*Partially Met*
Lead Screening in Children	98%	100%	*Met*
Member Satisfaction	87%	86%	*Not Met*
Provider Satisfaction	96%	93%	*Not Met*
Well-Child Visits	94%	93%	*Not Met*

Not all PIPs received an overall *Met* validation status. The *Emergency Room Utilization* PIP received a *Partially Met* validation status due to the reporting of inaccurate data for Remeasurement 2. Although the CMO documented inaccurate data and statistical testing values in the PIP, the CMO correctly reported its study indicator rates in the PIP. This was validated by HSAG through a comparison of AMERIGROUP's PIP reported rates to its audited performance measure rates submitted to NCQA. The *Childhood Obesity* PIP received a *Partially Met* validation score because not all of the study indicators sustained the improvement after statistically significant improvement was achieved. For the *Provider Satisfaction* and *Member Satisfaction* PIPs, none of the study indicators have achieved statistically significant improvement over the baseline rates. The *Well-Child Visits* PIP also received a *Not Met* validation status because the single study indicator has yet to achieve statistically significant improvement.

Table 2-2 displays the combined validation results for all nine AMERIGROUP PIPs validated during FY 2013. This table illustrates the CMO's application of the PIP process and its success in implementing the study. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met* or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 2-2 show

the percentage of applicable evaluation elements that received a *Met* score by activity. Additionally, HSAG calculated an overall score across all activities. Appendix A provides the detailed scores from the validation tool for each of the nine PIPs.

Table 2-2—Performance Improvement Project Validation Results for AMERIGROUP Community Care (N=9 PIPs)

Study Stage	Activity		Percentage of Applicable Elements Scored *Met*
Design	I.	Appropriate Study Topic	100% (50/50)
	II.	Clearly Defined, Answerable Study Question(s)	100% (18/18)
	III.	Clearly Defined Study Indicator(s)	100% (54/54)
	IV.	Correctly Identified Study Population	100% (25/25)
Design Total			**100% (147/147)**
Implementation	V.	Valid Sampling Techniques (if sampling was used)	100% (36/36)
	VI.	Accurate/Complete Data Collection	100% (71/71)
	VII.	Appropriate Improvement Strategies	83% (29/35)
Implementation Total			**96% (136/142)**
Outcomes	VIII.	Sufficient Data Analysis and Interpretation	95% (74/78)
	IX.	Real Improvement Achieved	81% (29/36)
	X.	Sustained Improvement Achieved	80% (4/5)
Outcomes Total			**90% (107/119)**
Percentage Score of Applicable Evaluation Elements *Met*			**96% (390/408)**

Overall, 96 percent of the evaluation elements across all nine PIPs received a score of *Met*. The 96 percent score demonstrates a sound application of the PIP process. While AMERIGROUP's strong performance in the Design stage indicated that each PIP was designed appropriately to measure outcomes and improvement, AMERIGROUP was less successful in the Implementation and Outcomes stages. The following subsections highlight HSAG's validation findings associated with each of the three PIP stages.

Design

AMERIGROUP met 100 percent of the requirements across all nine PIPs for all four activities within the Design stage. Overall, AMERIGROUP designed scientifically sound studies that were supported by the use of key research principles. The technical design of each PIP was sufficient to measure and monitor PIP outcomes associated with AMERIGROUP's improvement strategies. The solid design of the PIPs allowed the successful progression to the next stage of the PIP process.

Implementation

AMERIGROUP met 96 percent of the requirements for the three activities within the Implementation stage; however, only 83 percent for appropriate improvement strategies. The CMO accurately documented and executed the application of the study design and documented conducting causal/barrier analysis; however, not all of the analysis conducted by the CMO was appropriate. Several of the interventions implemented by AMERIGROUP were not relevant to the identified barriers and the CMO lacked a process to evaluate the efficacy of its interventions.

Outcomes

This year, six PIPs (*Adults' Access to Care*, *Childhood Immunizations*, *Annual Dental Visits*, *Childhood Obesity*, *ER Utilization*, *Lead Screening in Children*) were evaluated for sustained improvement, and five of the six achieved sustained improvement. The *Childhood Obesity* PIP achieved sustained improvement for Study Indicator 1 (the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation) and Study Indicator 2 (the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition).Study Indicator 3 (the percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity) needs an additional data point to determine if statistically significant improvement was sustained. Sustained improvement is defined as statistically significant improvement in performance over baseline that is maintained or increased for at least one subsequent measurement period. Additionally, the results of the most current measurement period must reflect improvement when compared to baseline results.

PIP-Specific Outcomes

Analysis of Results

Table 2-3 displays the study indicator rates for each measurement period of the PIP, including the baseline period and each subsequent remeasurement period, through Remeasurement 3. Statistically significant changes between remeasurement periods are noted with an upward or downward arrow. If the PIP achieved statistically significant improvement over the baseline rate, it was then reviewed for sustained improvement. Sustained improvement is defined as

statistically significant improvement in performance over baseline for all study indicators that is maintained or increased for at least one subsequent measurement period. Additionally, the most current measurement period's results must reflect statistically significant improvement when compared to the baseline results for all study indicators. PIPs that did not achieve statistically significant improvement (i.e., did not meet the criteria to be assessed for sustained improvement) were not assessed (NA).

Table 2-3—HEDIS-Based Performance Improvement Project Outcomes for AMERIGROUP Community Care

PIP Study Indicator	Baseline Period (1/1/08–12/31/08)	Remeasurement 1 (1/1/09–12/31/09)	Remeasurement 2 (1/1/10–12/31/10)	Remeasurement 3 (1/1/11–12/31/11)	Sustained Improvement^
Adults' Access to Care					
The percentage of members 20–44 years of age who had an ambulatory or preventive care visit.	81.2%	85.5%↑*	85.3%	84.3%	Yes
Childhood Immunizations					
The percentage of children 2 years of age who had the following vaccines by their second birthday: four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IVP); one measles, mumps and rubella (MMR); two H influenza type B (Hib); three hepatitis B; and one chicken pox (VZN).	29.8%	72.0%↑*¥	78.0%↑*	84.3%↑*	Yes
Lead Screening in Children					
The percentage of children 2 years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.	68.2%	67.8%	65.7%	76.7%↑*	NA
Well-Child Visits					
The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care provider (PCP) during their first 15 months of life.	62.3%	55.0%↓*	60.1%	63.6%	NA

Table 2-4 displays the study indicator rates for AMERIGROUP's three PIPs that progressed to Remeasurement 2.

Table 2-4—HEDIS-Based Performance Improvement Project Outcomes for AMERIGROUP Community Care

PIP Study Indicator	Baseline Period (1/1/09–12/31/09)	Remeasurement 1 (1/1/10–12/31/10)	Remeasurement 2 (1/1/11–12/31/11)	Sustained Improvement^
Annual Dental Visits				
The percentage of members 2–3 years of age who had at least one dental visit.	42.7%	47.3%↑*	47.7%	Yes
The percentage of members 2–21 years of age who had at least one dental visit.	66.7%	69.1%↑*	69.7%↑*	Yes
Childhood Obesity				
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation.	13.7%	28.5%↑*	33.3%	Yes
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition.	40.7%	48.8%↑*	58.3%↑*	Yes
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity.	35.6%	30.9%	44.9%↑*	NA
Emergency Room Utilization				
The number of emergency room visits that did not result in an inpatient stay per 1000 member months	60.9	58.1↑*	55.4%↑*	Yes

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

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

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

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

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

AMERIGROUP was not successful in achieving the desired outcomes for all study indicators. The CMO either did not demonstrate improvement, or it could not be determined whether the improvement was due to the implementation of the CMO's improvement strategy or due to chance.

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address those barriers are necessary steps to improve outcomes. AMERIGROUP's choice of interventions, the combination of intervention types, and the sequence of intervention implementation are all essential to its overall success. Deficiencies were identified during the validation process in each of these areas and will be explained in further detail below.

The following section discusses the improvement strategies the CMO implemented in conjunction with the PIPs' study indicator results. Comparisons to HEDIS benchmarks were made using the Medicaid HEDIS 2010 Audit, Means, Percentiles and Ratios (reflecting the 2009 calendar year [CY]).

Adults' Access to Care

The *Adults' Access to Care* PIP did not demonstrate statistically significant improvement from Remeasurement 2 to Remeasurement 3. Although the percentage of adult members who accessed ambulatory or preventive care decreased by 1 percentage point, there was statistically significant improvement achieved from baseline to Remeasurement 1 that was sustained through Remeasurement 3. However, the Remeasurement 3 study indicator result was 4.2 percentage points below the CY 2011 DCH target (88.5 percent) and between the national HEDIS 2010 Medicaid 50th percentile and 75th percentile (82.9 percent and 86.7 percent, respectively).

For the *Adults' Access to Care* PIP, AMERIGROUP used a cause and effect analysis between Remeasurement 2 and Remeasurement 3 to identify barriers and determine which of its interventions would continue. However, the documentation did not support that AMERIGROUP implemented robust member-focused initiatives in 2010 and 2011. In 2010, member interventions included sending birthday reminder cards and hiring associates to conduct outreach to members. In 2011, the member interventions included community health promotions for diabetes and asthma, breast cancer screening outreach, mailings for well woman exams, and sending text messages to members reminding them to get a flu shot and providing nurse helpline information. There appears to be a disconnect with the interventions implemented for this PIP. Many of the improvement efforts appear to focus on other topics (e.g., asthma, diabetes, hypertension, breast cancer screening, chlamydia screening, and cervical cancer screening). Although these efforts may increase members 20-44 years of age to have a preventive care visit with their PCP, that is not the focus of this measure.

The CMO may consider conducting a small focus group of adult members that did not access care in the last remeasurement year to gain a better understanding of why these members did not seek care. A focus group would also be helpful in understanding what would motivate a member to access care. It is difficult to determine if members truly lack the knowledge to seek care or

whether there are other barriers preventing them from obtaining care. Soliciting member input would help AMERIGROUP in making future decisions.

AMERIGROUP identified lack of knowledge regarding practice performance, lack of provider motivation, and providers needing assistance in identifying members who need an annual visit as provider-based barriers. Based on these findings, AMERIGROUP implemented provider-focused interventions such as implementing pay for performance, posting missed opportunity reports, creating HEDIS score cards, mailing chlamydia screening letters to providers, and creating a HEDIS billing guide. HSAG has concerns regarding these documented barriers and the interventions implemented. It was unclear how AMERIGROUP determined that providers are not motivated and that providers lack an understanding of how they are performing. This lack of motivation and uncertainty regarding performance could be considered quality of care concerns that AMERIGROUP should be addressing.

Since the rates have essentially been stagnant since Remeasurement 1, AMERIGROUP should give thorough consideration as to how it will evaluate the efficacy of each intervention. This evaluation would also enable AMERIGROUP to better target its resources toward interventions that will positively impact the rates.

Annual Dental Visits

Statistically significant improvement over the baseline rates was achieved for both study indicators in the *Annual Dental Visits* PIP. The rates also exceeded the CY 2011 DCH target rate. Additionally, the rate for the dental visits for members 2–21 years of age exceeded the national HEDIS 2010 Medicaid 90th percentile of 64.1 percent.

AMERIGROUP continued several of the interventions already implemented and implemented the following intervention's that may have contributed to the success of the improved rates:

- January–June 2010, AMERIGROUP held 11 dental events in Georgia that were attended by 498 participants.
- In 2010, in conjunction with Kool Smiles, AMERIGROUP held 7 dental presentations at local Head Start locations. Led by a health promotions coordinator, the presentations drew approximately 915 attendees. In 2011, 14 dental presentations were held.
- In 2011, the CMO implemented a pay-for-performance program for high-volume practices that improved quality scores.
- In April through September 2011, AMERIGROUP posted missed opportunity reports through the newly created provider portal for primary care practices.
- In October and December 2011, AMERIGROUP provided annual dental rate report cards to providers.
- AMERIGROUP determined that telephone calls to remind members of their dental benefit and offer assistance in finding a dentist were successful. The calls were placed in May, November, and December 2011. In November 2011, approximately 39 percent of the 72,890 calls placed to members resulted in speaking with a live person. Since the CMO determined

that this intervention was successful (11.4 percent utilization increase following the calls in November), the calls were moved earlier in the year for 2012.

HSAG noted that not all of the barriers identified in AMERIGROUP's analysis have been addressed. AMERIGROUP should reexamine its barriers and consider addressing barriers that were not previously addressed. For example, AMERIGROUP identified lack of extended office hours to accommodate parents/school schedules, office wait times, and lack of available appointment times as barriers. The CMO should determine which of these barriers are priorities and implement new strategies.

Childhood Immunizations

AMERIGROUP achieved statistically significant improvement over the baseline rate and sustained this improvement for the *Childhood Immunizations* PIP. For Remeasurement 3, the rate increased by 6.3 percentage points from 78.0 percent to 84.3 percent. The increase was statistically significant and was slightly below the national HEDIS 2010 Medicaid 90th percentile (85.6 percent).

AMERIGROUP implemented several interventions that were likely to have had an impact on improving the study indicator outcome. In 2010 and 2011, AMERIGROUP hosted member events that included face-to-face, one-on-one education. "Baby showers" were held statewide. In 2010, 2,170 pregnant and new mother members were invited. In 2011, there were 130 baby showers statewide, with 1,550 members in attendance. The events emphasized prenatal care, immunizations, and well child visits.

In 2010, AMERIGROUP held additional events. Members whose children turned two in 2010 and did not complete the entire immunization schedule were invited. For some of the events, an announcement was made on the radio. Events included a Clayton County Head Start parent meeting, Chuck E. Cheese 1-year birthday party, Union Mission Health Day, an immunization shower at an East Region CVC, and the Georgia Southeast Region Immunization Campaign. In June–December 2011, AMERIGROUP held 44 clinic day events, inviting members to visit their primary care practice for well child visits/immunizations/lead screenings.

This year's PIP documentation reported that the member incentive intervention was continued and revised to also include lead screenings. The incentive program provided a chance to win a birthday party for members completing the required services. In 2011, AMERIGROUP reported that these interventions were also made available at provider and member events, in addition to mailing them to members. In July 2011, the CMO created a new outreach database to track members due for services across all measures and placed staff members on a telephone queue to track outbound calls to members. Also in 2011, AMERIGROUP created a new provider portal for providers to access missed care opportunities through the Web. In April 2011, this provider portal was rolled out to 10 practices; and in September 2011, the number of practices increased to 32.

Additionally, AMERIGROUP completed an analysis of interventions. The CMO examined if the outbound calls to members were successful and tracked claims received in each month of 2011.

Following the outbound calls to members, there was a "clear spike" in claims volume. AMERIGROUP also analyzed if members who received a call from a member outreach associate were likely to complete the service. Of those who received a live call reminder for the two months examined, 70 percent and 55 percent, respectively, had a claim for a preventive care service. Based on its analysis, AMERIGROUP added another full-time member outreach associate in April 2012.

Childhood Obesity

The *Childhood Obesity* PIP achieved statistically significant improvement over the baseline rate and sustained the improvement for two of its three study indicators. At Remeasurement 3, all three study indicators rates (BMI documentation [33.3 percent], counseling for nutrition [58.3 percent], and counseling for physical activity [44.9 percent]) demonstrated improvement with two of the three indicators (counseling for nutrition and counseling for physical activity) demonstrating statistically significant improvement. The Remeasurement 3 rates for evidence of BMI percentile documentation (33.3 percent) and counseling for physical activity (44.9 percent) fell between the national HEDIS Medicaid 50th and 75th percentiles. The counseling for nutrition Remeasurement 3 rate fell between the national HEDIS Medicaid 75th and 90th percentiles (57.7 and 67.9 percent, respectively). Only the counseling for nutrition study indicator rate exceeded the CY 2011 DCH goal of 57.7 percent.

AMERIGROUP continued its two-pronged approach and targeted interventions toward both members and providers. In 2010, AMERIGROUP conducted 17 health promotion presentations with Kool Smiles to KinderCare and Head Start programs in 4 regions of Georgia (470 families attended). Twenty-three presentations were made with 448 members impacted in 2011. The CMO also implemented the following interventions in calendar year 2011:

- Text messages were sent to members via a free cellular telephone provided by SafeLink. The text messages provided information related to weight management.
- Sent communications to all primary care physicians about billing for BMI, nutrition, and physical activity counseling. These communications included information on additional reimbursement.
- Distributed a HEDIS billing guide to providers that contained codes for BMI, nutrition, and physical activity counseling.
- Distributed "Power Zone" packets to provider practices for distribution to children and adolescents. The packets included information on nutrition and physical activity, recipes, and a healthy lifestyle chart.
- Distributed BMI wheels with billing codes for BMI percentile to primary care practices.
- Partnered with 5 pediatric practices for a pilot program with the highest volume of obese members. Providers were to distribute Weight Watchers vouchers to children ages 10–17.
- Continued medical record review of high-volume PCPs with corrective action needed because of the deficiencies noted with BMI and nutrition/physical activity counseling documentation.

Several of the interventions listed above were not implemented until the last quarter of 2011 and, therefore, had not been in place long enough to have had an impact on the recently reported results. Additionally, it appeared based on the PIP documentation that AMERIGROUP did not evaluate the effectiveness of any of these interventions. AMERIGROUP should have this evaluation process in place and include the details of this process in each of its PIPs.

Emergency Room Utilization

The focus of this PIP was to decrease the rate of ER visits that did not result in an inpatient stay per 1000 member months. The *Emergency Room Utilization* PIP study indicator outcome demonstrated a statistically significant decrease in emergency room (ER) visits from 58.1 per 1000 member months to 55.4 per 1000 member months, which represented statistically significant improvement. AMERIGROUP's emergency room utilization visit rate was below (lower indicates better performance) both the CY 2011 DCH target and the national HEDIS 2010 Medicaid 25th percentile (58.5 per 1000 member months). For this measure, the HEDIS 2010 Medicaid 25th percentile is the top level of performance.

It appeared that AMERIGROUP implemented strong interventions for this PIP that targeted members, providers, and system improvements. AMERIGROUP's combination and timing of interventions for this PIP has shown improvement in the study indicator rate.

Member interventions included targeted mailings to zip codes with high daytime ER usage. Information in the mailing included nearby urgent care centers and mini-clinics. Case management and marketing outreach was completed for members with ER visits for non-urgent conditions. New member and anniversary letters were updated to include information regarding ER use.

Provider interventions included targeted mailings, telephone calls, and face-to-face meetings with providers of patients with high ER utilization. AMERIGROUP implemented system interventions that included an initiative to locate and contract with additional urgent care centers and primary care providers with extended hours in areas with high ER utilization. AMERIGROUP also implemented a data enhancement of PCP panels. This enabled providers to access more real-time data of their patients' ER usage. AMERIGROUP also completed outreach to PCP and ER leadership where members have high ER utilization. The process was modified to include direct outreach to ER leadership either by telephone or face-to-face discussions.

AMERIGROUP documented that it measures claims data to identify members with high ER utilization for telephonic outreach and educational mailings on an ongoing basis. The goal is to motivate members to access their medical home for non-emergent care. AMERIGROUP documented that although interventions included physician involvement, the CMO believes that it is more important to provide member education and awareness of the medical home and how to establish or enhance the relationship with a primary care provider.

Lead Screening in Children

For the *Lead Screening in Children* PIP, the study indicator achieved statistically significant improvement at Remeasurement 3. For Remeasurement 3, the rate increased by 11 percentage points from 65.7 percent to 76.7 percent. The increase was statistically significant, fell between the national HEDIS 2010 Medicaid 50th and 75th percentiles (71.6 and 81.0 percent, respectively), and was below the CY 2011 DCH target of 81.0 percent.

AMERIGROUP implemented new provider interventions that included: distributing HEDIS report cards for both interim 2011 and final 2010 rates; implementing a pay-for-performance program which included lead screening as a metric for quality measurement; distributing a Medtox letter to network providers notifying them of the Medtox service that was available; creating a Web portal access for monthly missed care; generating monthly data runs to identify children who were missing a lead screening, and providing the resulting lists to providers; and hiring a practice manager to assist providers with PCMH NCQA recognition.

AMERIGROUP held a variety of member outreach events, including 44 well-child events that offered a blood lead screening, and a member incentive to enter a raffle to win a child's birthday party.

AMERIGROUP also implemented a system intervention in 2011. The CMO created a new database for outreach staff to track noncompliant members.

AMERIGROUP reported in this year's PIP submission that preliminary feedback showed that its best-performing practices were drawing blood in their offices. However, AMERIGROUP also identified that none of the providers at that point had indicated that they owned a blood lead analyzer or that their electronic health record system prompted them to perform blood testing. This type of information indicates additional barriers and opportunities for improvement that AMERIGROUP should address.

AMERIGROUP documented that overall improvement in the performance for this measure could be linked to the Medtox service. The CMO partnered with Medtox to provide free lead screen testing kits to providers in September 2011. AMERIGROUP reported a 19.8 percent increase in lead testing claims from Medtox in 2011 when compared to 2010.

Based on its analysis, AMERIGROUP concluded that the same members who were noncompliant for immunizations were also noncompliant for lead screening. This finding was the CMO's rationale for implementing some of the same interventions that crossed over multiple measures (i.e., lead screening, immunizations, and well-child visits).

Interventions that may not have been as influential on the study indicator rates may have been member mailings (e.g., birthday cards, postcards) and provider newsletter articles. In addition, AMERIGROUP documented that attempts to reach members by telephone averaged no more than a 40 percent reach rate for any given month. AMERIGROUP is continuing to explore other ways to reach members, including text messages and e-mail. AMERIGROUP should have a process in place to evaluate the efficacy of its interventions and detail this process in each of its PIPs.

Well-Child Visits

For Remeasurement 3, the *Well-Child Visits* measure's rate demonstrated a non-statistically significant increase from 60.1 to 63.6 percent, remained below the CY 2011 DCH target of 69.7 percent, and fell between the national HEDIS Medicaid 2010 50th and 75th percentiles (60.1 and 69.7 percent, respectively). The study indicator has yet to meet the criteria of statistically significant improvement over baseline.

In 2008 and 2009, there were only a few interventions documented in the PIP, which could explain the decline in performance at Remeasurement 1. Since then, it appeared that AMERIGROUP has made more efforts to increase the WCV 15 rate.

In 2010, AMERIGROUP completed member outreach through "baby showers." This included face-to-face education with pregnant and new mothers. In June through December 2011, the CMO also hosted 44 well-child events where children and their caregivers were invited to their provider's office for a well-child exam, immunizations, and blood lead screenings. In November 2011, AMERIGROUP also implemented a member incentive program.

AMERIGROUP also implemented provider-focused interventions. The CMO completed monthly data runs to identify children with missed opportunities for well visits. AMERIGROUP sent physicians a request to submit the claims or encounters for the well visits. Additional provider interventions included distributing a HEDIS billing guide, distributing notifications of the member incentive program to providers, and sending interim reports to provider practices notifying them of their well child rates.

AMERIGROUP did implement system interventions that included creating a new outreach database to track members due for services and implementing a standardized script used by the outreach staff to ensure consistent messaging. Also, AMERIGROUP increased its primary care network by 88 physicians in 2011.

The CMO also employed a provider practice manager in June–December 2011 to assist practices in becoming patient-centered medical homes.

It appeared through the PIP documentation that AMERIGROUP has evaluated some of its interventions and completed subgroup analysis of its populations. Based on this analysis, AMERIGROUP documented that only 50 percent of its members choose a PCP at the time of enrollment; and the CMO believes that a member who actually selects a PCP will be more likely to visit that practitioner. AMERIGROUP should determine if it can improve this process and increase the percentage of members who choose their PCP. AMERIGROUP should also reexamine its barriers to determine if there are any other barriers that have not been addressed. For example, member transportation was identified as a barrier, and it appeared that there was not a corresponding intervention.

Member and Provider Satisfaction

Table 2-5—Satisfaction-Based Performance Improvement Project Outcomes for AMERIGROUP Community Care

PIP Study Indicator	Baseline Period (2/13/09–5/10/09)	Remeasurement 1 (2/17/10–5/2/10)	Remeasurement 2 (2/13/11–5/10/11)	Remeasurement 3 (2/13/12–5/10/12)	Sustained Improvement^
Member Satisfaction					
1. The percentage of members responding "Yes" to Q10—"In the last six months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care?"	68.9%	60.3%	73.3%↑*	71.3%	NA
2. The percentage of members responding "Yes" to Q11—"In the last six months, when there was more than one choice for your child's treatment or health care, did your child's doctor or other health provider ask you which choice you thought was best for your child?"	61.1%	55.1%	58.3%	66.9%	NA

PIP Study Indicator	Baseline Period (9/1/09–12/31/09)	Remeasurement 1 (9/1/10–12/31/10)	Remeasurement 2 (9/1/11–12/31/11)	Sustained Improvement^
Provider Satisfaction				
1. Percentage of providers answering "Excellent" or "Very Good" to Q34C—"Contacting the AMERIGROUP pharmacy call center to find out about formulary medications and alternatives to nonformulary medications."	18.3%	19.3%	27.5%	NA

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

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

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

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

Member Satisfaction

Both study indicators have yet to achieve statistically significant improvement over the baseline rates. Study Indicator 2 improved from Remeasurement 2 to Remeasurement 3; however, Study Indicator 1 declined for the same time period. While the first study indicator outcome decreased slightly, the rate at Remeasurement 3 was still above the baseline rate.

The PIP documentation did not support that AMERIGROUP had robust provider-focused initiatives in place in 2010 and 2011 to increase the rates for the study indicators. Provider interventions would be key since the member survey questions asked how providers communicated with members about their treatment or health care. The study indicators for the *Member Satisfaction* PIP were as follows:

- Percent of members who answer "definitely yes" to survey question #10: "In the last 6 months, did your child's doctor or other health provider talk with you about the pros and cons of each choice for your child's treatment or health care"?
- Percent of members who answer "definitely yes" to survey question #11: "In the last 6 months, when there was more than once choice for your child's treatment or health care did your child's doctor or other health provider ask you which choice you thought was best for your child"?

AMERIGROUP documented interventions focusing on partnering with pediatric practices to improve well-child visits and immunizations. The CMO also documented mailing health information to members with chronic diseases, such as asthma and diabetes, through disease management. In 2010 and 2011, the provider interventions included provider newsletters and blast faxes. System interventions implemented included increasing the PCP network, hiring additional Spanish-speaking PCPs, and hiring a practice consultant to work with 12 practices for patient-centered medical care homes. Some of these interventions appear to be designed for other PIP topics and not the measures included in this PIP. AMERIGROUP should focus on interventions specific to this study topic and study indicators.

Since the survey questions in this PIP related directly to how the doctor/health care provider communicated with members, it appeared that AMERIGROUP should focus on ensuring that its providers are educated and trained on these measures and on the requirements for communicating with their patients regarding treatment or health care.

AMERIGROUP should consider hosting focus group discussions. A focus group would enable the CMO to interact with potential satisfaction survey participants and gain valuable input on the specific areas that cause dissatisfaction with services provided. Once areas of dissatisfaction are identified, the CMO and respective providers should implement system changes to combat those areas.

Provider Satisfaction

For the *Provider Satisfaction* PIP, the study indicator outcome improved from baseline to Remeasurement 2, although the improvement was not statistically significant.

The study indicator for this PIP was as follows:

- The percent of "excellent/very good" responses for the Pharmacy and Drug Benefit question, "Please rate your experience with contacting the AMERIGROUP pharmacy call center to find out about formulary medications and alternatives to non-formulary medications on the provider satisfaction survey."

AMERIGROUP took on initiatives to improve the pharmacy call center, including placing the call center on a corrective action plan. This involved revising associate schedules to better match telephone call arrival patterns. In addition, AMERIGROUP enhanced and updated the pharmacy Web site for providers and trained the provider relations representatives to use the Web site during provider orientation. The CMO also created a quick reference pharmacy guide for providers and sent provider blast faxes regarding formulary updates.

In 2011, AMERIGROUP added six customer service technicians to the pharmacy call center. AMERIGROUP also discussed the pharmacy process with the Georgia Medical Care Advisory Committee and solicited feedback from this committee on pharmacy satisfaction. The committee shared that the process for prior authorization is not always clearly communicated. As a result, AMERIGROUP created a guide for what to expect during the prior authorization process for non-formulary drugs which was issued to providers in 2012.

AMERIGROUP documented that it focused on improving provider knowledge about the prior authorization process and reducing calls and hold times for the pharmacy department, and addressed reluctance of providers to prescribe generic or formulary drugs.

AMERIGROUP seems to have taken on a broad range of interventions encompassing the entire provider prescribing and pharmacy process. The CMO has taken some actions relating to the pharmacy call center, which is the focus of the study indicator. AMERIGROUP has made progress with the indicator rates; however, opportunity for improvement still exists. To facilitate continued improvement, AMERIGROUP should further investigate the reasons why providers did not earn an "excellent/very good" score on the survey question related to the pharmacy call center and focus its efforts on addressing these reasons.

Individual PIP Strengths

Although the study indicator demonstrated a decline in performance with the most recent remeasurement period for the *Adults' Access to Care* PIP, the indicator has achieved statistically significant improvement when compared to baseline.

AMERIGROUP was able to improve the rate of annual dental visits for members aged 2 to 21 years, as well as for members 2–3 years of age. The improvement was statistically significant for both age groups when compared to baseline. AMERIGROUP continued several interventions and also implemented new ones. For example, in conjunction with Kool Smiles, the CMO held dental presentations at local Head Start locations. Led by a health promotions coordinator, the presentations drew approximately 915 attendees. Another example of a new intervention was placing reminder calls to members in May, November, and December 2011. In November 2011, approximately 39 percent of the 72,890 calls placed to members resulted in speaking with a live person. Since the CMO determined that this intervention was successful (11.4 percent utilization increase following the calls in November), the calls were moved earlier in the year for 2012.

The *Childhood Immunizations* PIP demonstrated AMERIGROUP's success in improving the childhood immunization rate. The rate increased 6.3 percentage points, which was statistically significant. AMERIGROUP implemented several interventions that were likely to have had an impact on improving the study indicator outcome. In 2010 and 2011, AMERIGROUP hosted member events that included face-to-face, one-on-one education. "Baby showers" were held statewide. In 2010, 2,170 pregnant and new mother members were invited. In 2011, there were 130 baby showers statewide, with 1,550 members in attendance. The events emphasized prenatal care, immunizations, and well-child visits.

For the *Childhood Obesity* PIP, two of the three study indicators achieved statistically significant improvement. AMERIGROUP continued its two-pronged approach with ongoing targeted interventions and new interventions aimed at both members and providers. AMERIGROUP conducted 17 health promotion presentations with Kool Smiles to KinderCare and Head Start programs in 4 regions of Georgia (470 families attended). Twenty-three presentations were made with 448 members impacted in 2011. AMERIGROUP also implemented the following interventions in calendar year 2011:

- Sent text messages to members via a free cellular telephone provided by SafeLink. The text messages provided information related to weight management.
- Sent communications to all primary care physicians about billing for BMI, nutrition, and physical activity counseling. These communications included information on additional reimbursement.
- Distributed a HEDIS billing guide to providers that contained codes for BMI, nutrition, and physical activity counseling.
- Distributed "Power Zone" packets to provider practices for distribution to children and adolescents. The Power Zone packets included information on nutrition and physical activity, recipes, and a healthy lifestyle chart.

- Distributed BMI wheels with billing codes for BMI percentile to primary care practices.
- Partnered with 5 pediatric practices for a pilot program with the highest volume of obese members. Providers were to distribute Weight Watchers vouchers to children ages 10–17.
- Continued medical record review of high-volume PCPs with corrective action needed because of the deficiencies noted with BMI and nutrition/physical activity counseling documentation.

In the *Emergency Room Utilization* PIP, AMERIGROUP was able to reduce the ER utilization rate by 2.7 visits per 1000 member months, which was statistically significant. The Remeasurement 2 rate of 55.4 percent was above the benchmark of 58.5 percent (where lower rates indicate better performance for this indicator). AMERIGROUP continued its strategy to target members seen in the ER for nonemergent care and target PCPs whose members demonstrated high daytime ER usage. In addition, AMERIGROUP created an ER notification letter to notify facility ER leadership of members who have been seen in their ERs and also had sought care in multiple ERs.

For the *Lead Screening in Children* PIP, the study indicator achieved statistically significant improvement from Remeasurement 2 to Remeasurement 3, and over the baseline rate. Although the Remeasurement 3 rate of 76.7 was below the DCH goal of 81 percent, AMERIGROUP is working toward meeting this goal. AMERIGROUP held a variety of member outreach events, including 44 well-child events that offered a blood lead screening, and a member incentive to enter a raffle to win a child's birthday party. AMERIGROUP reported that preliminary feedback showed that their best-performing practices were drawing blood in their offices.

The *Well-Child Visits* PIP has demonstrated improvement since baseline, although none of the improvement has been statistically significant. AMERIGROUP has completed evaluations of some of its interventions and performed subgroup analysis of its populations. This type of analysis assisted AMERIGROUP in developing and implementing system interventions that should contribute to future improvement in the study indicator outcome.

For the *Member Satisfaction* PIP, both study indicators have achieved improvement over the baseline rates. AMERIGROUP has the fundamentals of structuring a sound PIP.

The *Provider Satisfaction* PIP has achieved continual improvement with each measurement period. AMERIGROUP implemented targeted interventions, as well as a broad range of interventions as strategies to address provider satisfaction.

Global PIP Strengths

The performance on these PIPs suggests a thorough application of the PIP Design stage (Activities I through VI). The sound study design creates the foundation for AMERIGROUP to progress to subsequent PIP stages—implementing improvement strategies and achieving real and sustained study indicator outcomes. AMERIGROUP appeared to appropriately select and conduct the sampling and data collection activities of the Implementation stage. These activities ensured that the AMERIGROUP properly defined and collected the necessary data to produce accurate study indicator rates.

Individual PIP Opportunities for Improvement

AMERIGROUP has an opportunity to improve documentation related to the standardization of ongoing interventions for the most recent remeasurement period in its *ER Utilization* PIP. In addition, this PIP received an overall validation status of *Partially Met* because of the reporting of inaccurate data. AMERIGROUP should ensure that the data, including numerators, denominators, rates, and statistical testing values are accurate and align with what has been reported in its Interactive Data Submission System (IDSS).

For the *Childhood Obesity* PIP, not all study indicators could be assessed for sustained improvement. AMERIGROUP should focus on strategies to ensure that all indicators sustain the real improvement achieved.

The CMO reported inaccurate data related to *p* values in its *Member Satisfaction* PIP. This inaccuracy did not account for the PIP's overall *Not Met* validation status; however, the evaluation element related to the accurate reporting of data is critical to producing a valid and reliable PIP. Despite the CMO's improvement strategies, neither study indicator has achieved statistically significant improvement when compared to baseline; and only one of two indicators demonstrated improvement with this last reported remeasurement period. AMERIGROUP should ensure that all data and values reported are accurate and that the follow-up activities that are planned in hopes of achieving improvement are carried out.

For the *Provider Satisfaction* and *Well-Child Visits* PIPs, AMERIGROUP has an opportunity to improve on the study indicator outcomes. While the study indicators demonstrated improvement, the improvement was not statistically significant. The CMO should continue its causal/barrier analysis processes to ensure that the appropriate targeted interventions are being implemented.

Global Opportunities for Improvement

AMERIGROUP should ensure that data reported in all PIPs are accurate and align with what has been reported in its IDSS.

AMERIGROUP should conduct an annual causal/barrier and drill-down analysis in addition to periodic analyses of its most recent data. The CMO should include the updated causal/barrier analysis outcomes in its PIPs.

The CMO should be cognizant of the timing of interventions. Interventions implemented in the last few months of the year will not have been in place long enough to have an impact on the results.

For any intervention implemented, the CMO should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. This evaluation process should be detailed in the PIP documentation. If the interventions are not having the desired

effect, the CMO should discuss how it will address these deficiencies and what changes will be made to its improvement strategies.

AMERIGROUP should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier. For example, member-focused interventions will not impact a study indicator measuring the quality of service provided by a PCP.

For member and provider satisfaction study indicators that have not been assessed for sustained improvement, the CMO should consider hosting focus group discussions (i.e., one focused on provider satisfaction and one focused on member satisfaction). These focus groups would enable the CMO to interact with potential satisfaction survey participants and gain valuable input on the specific areas that cause dissatisfaction with services provided. Once areas of dissatisfaction are identified, the CMO should implement system changes to combat those areas.

APPENDIX A. PIP-SPECIFIC VALIDATION SCORES for AMERIGROUP Community Care

Table A-1—AMERIGROUP Community Care's SFY 2013 PIP Performance

Study Stage	Activity	Percentage of Applicable Evaluation Elements Scored *Met*								
		Adults' Access to Care	*Annual Dental Visits*	*Childhood Immunizations*	*Childhood Obesity*	*ER Utilization*	*Lead Screening in Children*	*Member Satisfaction*	*Provider Satisfaction*	*Well-Child Visits*
Design	I. Appropriate Study Topic	100%	100%	100%	100%	100%	100%	100%	100%	100%
	II. Clearly Defined, Answerable Study Question(s)	100%	100%	100%	100%	100%	100%	100%	100%	100%
	III. Clearly Defined Study Indicator(s)	100%	100%	100%	100%	100%	100%	100%	100%	100%
	IV. Correctly Identified Study Population	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Design Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**
Implementation	V. Valid Sampling Techniques (if sampling was used)	*Not Applicable*	*Not Applicable*	100%	100%	*Not Applicable*	100%	100%	100%	100%
	VI. Accurate/Complete Data Collection	100%	100%	100%	100%	100%	100%	100%	100%	100%
	VII. Appropriate Improvement Strategies	75%	100%	100%	75%	75%	75%	67%	100%	75%
	Implementation Total	**89%**	**100%**	**100%**	**95%**	**89%**	**95%**	**94%**	**100%**	**95%**
Outcomes	VIII. Sufficient Data Analysis and Interpretation	100%	100%	89%	100%	88%	100%	78%	100%	100%
	IX. Real Improvement Achieved	100%	100%	100%	100%	100%	100%	25%	50%	50%
	X. Sustained Improvement Achieved	100%	100%	100%	0%	100%	*Not Assessed*	*Not Assessed*	*Not Assessed*	*Not Assessed*
	Outcomes Total	**100%**	**100%**	**93%**	**93%**	**92%**	**100%**	**62%**	**85%**	**85%**
Validation Status		***Met***	***Met***	***Met***	***Partially Met***	***Partially Met***	***Met***	***Not Met***	***Not Met***	***Not Met***