State of Georgia

Department of Community Health

SFY 2013 External Quality Review Annual Report

Including

CY 2011 Performance Measures

SFY 2012 Reported Performance Improvement Projects

SFY 2013 Compliance Reviews

for

Georgia Families Care Management Organizations

January 2013

HSAG Health Services Advisory Group

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HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose of Report

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid managed care program and the Children's Health Insurance Program (CHIP) in the State of Georgia to approximately 1.7 million beneficiaries.[1-1] The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. The State refers to its Medicaid managed care program as Georgia Families 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 Code of Federal Regulations (CFR) at 42 CFR §438.358[1-2] requires that states use an external quality review organization (EQRO) to prepare an annual, independent technical report that analyzes and evaluates aggregated information on the quality, timeliness of, and access to the health care services that managed care organizations provide.

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

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

This report provides:

- An overview of the Georgia Families program.
- A description of the scope of EQR activities included in this report.
- An aggregate assessment of health care timeliness, access, and quality across CMS-required mandatory activities for compliance with standards, performance measures, and quality improvement projects.
- CMO-specific findings and an assessment of the CMOs' strengths and weaknesses.

[1-1] Georgia Department of Community Health. *Georgia Families Quality Strategic Plan*—Update, November 2011.
[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.

- Recommendations to DCH to improve the CMOs' compliance with State and federal requirements that will subsequently lead to improvements in the quality, timeliness, and access to services provided to Georgia Families members.
- Recommendations for the CMOs to improve member access to care, quality of care, and timeliness of care.

Overview of the External Quality Review

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

- *Review of compliance with federal and State-specified operational standards*. HSAG evaluated the CMOs' compliance with State and federal requirements for organizational and structural performance. The DCH contracts with the EQRO to conduct a review of one-third of the full set of standards each year in order to complete the cycle within a three-year period of time. HSAG conducted on-site compliance reviews in August and September 2012. The CMOs submitted documentation that covered the State Fiscal Year (SFY) 2012 review period of July 1, 2011, through June 30, 2012. HSAG provided detailed, final audit reports to the CMOs and DCH in November 2012.
- *Validation of performance measures*. HSAG validated performance measures required by DCH to evaluate the accuracy of the performance measure results reported by the CMOs. The validation also determined the extent to which DCH-specific performance measures calculated by the CMOs followed specifications established by DCH. HSAG assessed performance measure results and their impact on improving the health outcomes of members. HSAG began performance measure validation of the CMOs in February 2012 and completed validation in June 2012. The CMOs submitted performance measure data that generally reflected the period of January 1, 2011, through December 31, 2011. HSAG provided final performance measure validation reports to the CMOs and DCH in October 2012. In addition to validation of the CMO data, DCH used HSAG to perform performance measure validation of its medical management information systems (MMIS) vendor, Hewlett Packard (HP), to determine compliance with generating rates for the Georgia Families Program, the Fee-for-Service (FFS) Program, and for all members enrolled in Medicaid and CHIP.
- *Validation of performance improvement projects (PIPs)*. HSAG reviewed PIPs for each CMO to ensure the CMOs designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocols for validating PIPs. HSAG assessed the PIPs for real improvements in care and services to give confidence to the reported improvements. In addition, HSAG assessed the CMOs' PIP outcomes and impacts on improving care and services provided to members. HSAG began PIP validations in June 2012 and completed validations in August 2012. The CMOs submitted PIP data that reflected varying time periods, depending on the PIP topic. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in December 2012.

Overall Findings, Conclusions, and Recommendations

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

Quality

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

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

HSAG used the CMOs' performance measure rates (which reflect Calendar Year (CY) 2011 measurement data), PIP validation results and outcomes, and scores from the review of compliance with standards related to measurement and improvement to assess the quality domain of care.

The DCH required the CMOs to report rates in SFY 2012 for 41 measures from the original required list of 51 measures, reflecting the measurement period of January 1, 2011, through December 31, 2011. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information. Many of the 41 measures include multiple components or age stratifications. The DCH deferred CMO reporting on 10 of the original 51 required measures due to technical specification clarifications needed for those measures.

The CMOs demonstrated the greatest opportunity for improvement in the quality domain of care. While the CMOs have appropriate structures in place to support the overall delivery of quality care, demonstrating improved health outcomes remains an area for focused attention. The results from the mandatory activities reveal a similar story—CMOs are generally meeting the contractual, State, and federal requirements for performing the activities yet struggle to measure, implement, monitor, and achieve improved member outcomes. The CMOs scored high in the areas of compliance for policies and procedures, high in the areas of study design for PIPs, and high in the area of reporting valid performance measure rates; but they were less likely to effectively manage health care outcomes.

This year's analysis of each of the mandatory activities shows individual opportunities within each activity as previously noted in reports from prior years, yet the greater opportunity points to the notion that these activities are not being administered in tandem at the CMO level and therefore

lead to missed opportunities. For example, the disease management program reviews showed a lack of goals or goals that follow clinical practice guidelines, where appropriate. In addition, the disease management programs did not align goals or objectives consistent with the performance measures or PIP, such as ensuring HbA1c screening or achieving optimal lab values for members with diabetes.

Opportunities also exist in the areas of barrier analysis and intervention development. The PIP analysis this year showed that the CMOs are not always aligning interventions to barriers and/or the barriers are not well substantiated. In many instances, HSAG found interventions implemented that would not have an impact on the measure. There appeared to be a lack of connection between interventions to address process measures and interventions to address outcome measures. For example, the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure is a process measure that simply looks at whether there is documentation in the medical record of a body mass index, counseling for nutrition, and counseling for physical activity. In some cases, the CMOs implemented interventions to target childhood obesity via member education. While this may be a worthwhile activity, this intervention has no impact on improved documentation by the provider. Conversely, interventions solely targeted to remind members with diabetes to receive HbA1c testing or LDL-C screening will have little impact on the lab values themselves.

Access

The access domain of care relates to a CMO's standards, established by the State, to ensure the availability of and access to all covered services for Georgia Families members.

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

Under the access domain of care, overall, the CMOs demonstrated strength in processes to select qualified providers as evidenced by high compliance scores in the areas of provider selection, credentialing, and recredentialing. In addition, the CMOs did well with ensuring that members had access to materials that were linguistically and culturally appropriate as well as access to interpreter services.

While this year's review did not specifically focus on network accessibility, a re-review of prior years' deficiencies revealed that the CMOs still have opportunities to ensure they meet the GeoAccess standards consistent with State ratios. Many CMOs had difficulty providing access to select specialists, particularly in rural areas. The CMOs should pay close attention to member accessibility as two of the three CMOs expanded statewide in 2012 and will need to ensure that the new network provides appropriate access to care. In addition, opportunities exist to ensure appropriate wait time standards for access to care.

A review of PIP interventions showed that the CMOs could benefit from further exploring member barriers to accessing care. Many of the PIP barrier analyses provided by the CMOs listed "lack of member knowledge" as a barrier to access care. It is difficult to discern which member knowledge

gaps actually exist. HSAG recommends that the CMOs consider conducting member focus groups to help narrow down member barriers to help focus targeted interventions.

Timeliness

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

The DCH CMO contracts require that CMOs ensure timeliness of care. HSAG conducts review activities to assess the CMOs' compliance with these standards in areas such as: enrollee rights and protections, the grievance system, continuity and coordination of care, and utilization management. Performance measures such as childhood immunizations, well-care visits, and prenatal and postpartum care fall under the timeliness domain of care because they relate to the provision of a health care service within a recommended period of time after a need is identified. Members' satisfaction with receiving timely care also falls under the timeliness domain of care.

The CMOs did particularly well with compliance related to members' rights and the grievance system. The greatest area for focus under the timeliness of care domain is improved care coordination. Fragmentation of care noted in the case and disease management reviews, such as the process for discharge planning, resulted in some delays in members receiving care or timely follow-up post discharge. These reviews also showed a lack of meaningful care treatment plans to address identified needs, which can also result in a delay of care after a need is identified.

Conclusions and Recommendations

The CMOs continue to demonstrate strength related to contractual, State, and federal requirements across the three mandatory activities. As the Georgia Families program continues to mature, the focus needs to shift from documentation compliance to improved health outcomes. The CMOs have opportunities to align resources dedicated to the three mandatory activities and to begin to identify complementary areas to streamline efforts, such as disease management programs with goals that are consistent with performance measure targets, and case management programs that create care treatment plans that are measureable in terms of health outcomes.

The case management and disease management programs should reflect member benefit and positive health outcomes as a result of services provided with reportable, trackable outcomes for improvement in quality of life; overall health and mental health status; member satisfaction; adherence to treatment plans; compliance with medication regimen; and follow-up on discharge treatments, instructions, and plans. To that end, the CMOs are encouraged to implement reporting systems to track, trend, and report on health outcomes at the member level, by disease, and even by case/ disease manager to show successes or opportunities for improvement. Studying these trends will help ensure that quality services are accessible to members and that the CMOs are providing high-quality, low-cost, effective service delivery programs beneficial to members and DCH.

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

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

Georgia Medicaid Managed Care Service Delivery System Overview

The DCH was created in 1999 to serve as the lead agency for health care planning and purchasing issues in Georgia. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. As the largest division in the Department of Community Health, the Medicaid Division administers the Medicaid and CHIP programs, which provide health care for children, pregnant women, and people who are aged, blind, and disabled. The Department is designated as the single State agency for Medicaid.

The State of Georgia implemented its Georgia Families program in 2006. Georgia Families delivers health care services to Medicaid and CHIP (PeachCare for Kids®) members within a managed care model. Through its three CMOs that DCH selected in a competitive bid process, DCH provides services to individuals enrolled in its Georgia Families program.

By providing a choice of health plans, Georgia Families allows members to select a CMO that fits their needs. Originally, DCH contracted with each CMO to deliver services within three or more of the six designated geographic regions. To ensure a smooth and successful transition from FFS to the Georgia Families managed care program, DCH implemented the program in two phases, beginning with two of the six regions (Atlanta and Central) on June 1, 2006, followed by the remaining four regions (North, East, Southeast, and Southwest) on September 1, 2006. DCH awarded contracts to at least two CMOs within each of the six geographic regions. Beginning in 2012, all three CMOs expanded to provide services statewide.

The Georgia Families program includes more than half of the State's Medicaid population and a majority of the State's PeachCare for Kids® population. Enrollment is mandatory for all PeachCare for Kids® members and for the following Medicaid eligibility categories:

- Low-Income Medicaid (LIM) program
- Transitional Medicaid
- Pregnant women and children in the Right from the Start Medicaid (RSM) program
- Newborns of Medicaid-covered women
- Refugees
- Women with breast and cervical cancer
- Women participating in the Planning for Healthy Babies® (P4HB®) program

Georgia Families Care Management Organizations

The DCH held contracts with three CMOs during the review period of July 1, 2011, through June 30, 2012. All three CMOs provide services to the State's Georgia Families members. In addition to providing medical and mental health Medicaid and CHIP-covered services to members, the CMOs also provide a range of enhanced services, including dental and vision services, disease management and education, and wellness/prevention programs. Beginning in early 2012, all CMOs began serving members statewide, which required statewide expansion efforts for AMERIGROUP and Peach State.

AMERIGROUP Community Care

AMERIGROUP Community Care (AMERIGROUP) is a wholly-owned subsidiary of AMERIGROUP Corp., a multistate managed health care company serving people who receive health care benefits through publicly sponsored programs, including Medicaid and CHIP.

Peach State Health Plan

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

WellCare of Georgia, Inc.

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

Georgia Families Quality Strategy

Federal regulations require that state Medicaid agencies develop and implement a written quality strategy for assessing and improving the quality of health care services offered to their members. The written strategy must describe the standards the state and its contracted plans must meet. The state must conduct periodic reviews to examine the scope and content of its quality strategy, evaluate its effectiveness, and update it as needed.

To comply with federal regulations, DCH submitted to CMS its initial Georgia Families Quality Strategic Plan in June 2007 for ensuring that the Department provided timely, accessible, and quality services to members of Georgia Families. The Plan was approved by CMS in 2008, and a quality strategic plan update was completed in January 2010 and again in November 2011.[2-1] The DCH publishes the updated plans on its Web site.

[2-1] Georgia Department of Community Health. *Georgia Families Quality Strategic Plan Update, November 2011*.

The 2011 Update:

- Highlighted major accomplishments including:
  - Implementation of the new Georgia Medicaid Management Information System (GAMMIS) that incorporates HEDIS certified software and allows DCH to readily report on a number of the CHIPRA Initial Core Set performance measures.
  - Recognition in Secretary Sebelius' *2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP* for reporting 18 of the 24 CHIPRA Initial Core Set measures in federal fiscal year 2010—more than any other state.
  - Organization and sponsorship of the Strategic Quality Council's "Know Your Numbers" campaign to increase awareness of precursors to cardiovascular disease with the hope of reducing cardiovascular deaths.
  - Approval of an 1115 Demonstration application to CMS to reduce low birth weight rates in Georgia. The program was implemented in January 2011.
  - Revision of the EPSDT medical record review process to align with the Bright Futures components.
  - Alignment of the EPSDT periodicity schedule for both FFS and Georgia Families programs.
  - Alignment of the HEDIS and AHRQ performance measures for the FFS and managed care populations.
  - Establishment of a Patient Centered Medical Home (PCMH) work group.
  - Initiation of a collaborative PIP on avoidable emergency room utilization that was implemented in January 2012.
  - Transition of Childhood Obesity and Pediatric Dental focus studies to PIPs, with results reported in SFY 2011.
  - Collaboration with the EQRO to modify the scoring methodology for PIP validation. The new methodology requires CMOs to go beyond the paper compliance for PIP submissions and demonstrate documented improved outcomes.
  - Initiation of a "Reducing Cesarean-Section Rates" focus study.
  - Participation in the Medicaid redesign initiative to identify the most appropriate approach for providing quality health care services to Georgia's Medicaid and CHIP populations in the most cost effective way possible. The target date for implementation is SFY 2014.
- Outlined opportunities for improvement related to quality improvement efforts, including:
  - Recognition that the federally mandated EQR activities must be viewed collectively rather than stand-alone components, which resulted in DCH working with the CMOs to ensure their quality improvement activities incorporate all required areas to drive performance improvement.
  - Determination that the CMOs' reports did not provide sufficient detail to determine the effectiveness of their case and disease management programs. To address this, DCH requested that the CMOs collaborate on the development of a revised standard reporting format for the case and disease management programs. DCH reviewed the initial product and requested additional revisions which were submitted in late November 2011.
  - Determination, as a result of the encounter data validation activity (one of the optional EQR activities), that not all services documented in the members' medical records were found in

the electronic data. Additionally, most records did not contain documentation of all required EPSDT services. Extensive and ongoing education about the EPSDT documentation requirements is now in place and the requirements were updated in the EPSDT (Health Check) manual. The EPSDT medical record review tool has been updated and instructions for this new tool are being revised to improve clarity.

  - The need for DCH to identify a methodology to impact improvements in FFS performance measure results since FFS providers are not organized under an umbrella to which DCH can direct improvement guidance.

- Described for each of DCH's goals, its performance-driven objectives designed to demonstrate success or to identify challenges in meeting intended outcomes related to providing quality, accessible, and timely services. The four goals were described as:
  - Promotion of an organization-wide commitment to quality of care and services.
  - Improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis and improvement of performance.
  - Promotion of a system of health care delivery that provides coordinated and improved access to comprehensive health care and enhanced provider and client satisfaction.
  - Promotion of acceptable standards of health care within the managed care program by monitoring internal/external processes for improvement opportunities.

The DCH used recommendations in the SFY 2012 EQR Annual Report as part of its process to assess the effectiveness of its strategic goals and objectives and provide a road map for potential changes and new goals and strategies.

Georgia Families Quality Initiatives Driving Improvement

HSAG noted several DCH initiatives during the review period of July 1, 2011, through June 30, 2012, that supported the improvement of quality of care and services for Georgia Families members, as well as activities that supported the CMOs' improvement efforts.

Auto-Assignment Program

During CY 2011, DCH continued its auto-assignment program, which began in 2010. The program awards the CMOs with increased default enrollment based on a cost/quality indicator methodology and encourages the CMOs to achieve better quality outcomes for their members. The DCH selected the six clinical performance measures listed below to serve as the basis for determining the quality scores for the CY 2012 auto-assignment algorithm. DCH will use eight clinical performance measure rates, taken from the CY 2011 performance measure rates included in this report, as the basis for the quality component of the auto-assignment algorithm for CY 2013.

- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*
- *Adolescent Well-Care Visits*
- *Follow-Up After Hospitalization for Mental Illness (7-Day Follow-Up)*
- *Childhood Immunization Status—Combination 2*

- *Lead Screening in Children*
- *Comprehensive Diabetes Care—HbA1c Testing*

Quality Improvement Conference

The DCH worked with HSAG to conduct a quality improvement conference, *Rethinking Quality—Strategies for Improvement*, in February 2012. The focus of the 2012 conference was on developing quality improvement strategies to improve health outcomes for Georgia Families members. The primary audience for the conference was CMO staff members involved in quality improvement activities. A secondary audience was the Georgia Families DCH staff members who support and monitor the CMOs in the areas of contract compliance, performance measurement, and quality improvement. The format for the half-day meeting included: sessions on using outcomes to measure success and an alternative approach to engaging non-compliant patients in the care management process; a group discussion on using data to map performance gaps; and group improvement strategy sessions on HEDIS measures, the best care and disease management models, and effective and ineffective approaches to provider incentive programs.

Performance Improvement Project Methodology Changes

The DCH adopted HSAG's enhanced PIP validation scoring methodology in SFY 2012. The new methodology was piloted during SFY 2011. The new methodology provides a stronger connection between an overall *Met* validation status and improved health outcomes. The change was made to address DCH's concern that while the CMOs continued to receive *Met* validation scores for producing valid and reliable PIPs, few projects resulted in actual improvement. HSAG modified its validation scoring to make achievement of statistically significant improvement and then sustained improvement critical elements to receive an overall *Met* validation status. The CMOs' PIPs that underwent validation between July 1, 2011, and September 30, 2011, were scored using the old and new methodologies. HSAG adopted the new scoring methodology beginning July 1, 2012.

CHIPRA Reporting

The DCH was spotlighted by CMS for its quality of care reporting in the September 2011 Department of Health and Human Services Secretary's Report. The State of Georgia collected and reported the most CHIPRA Initial Core Set measures of any state for its Medicaid and CHIP populations. The DCH continues to modify its required performance measure set and methodology to align with the CHIPRA Core Set measures and specifications. Additionally, DCH used its MMIS vendor to calculate rates, including hybrid rates, for its Georgia Families and FFS populations for the second time during this reporting period, which reflected CY 2011 data. This demonstrates a strong commitment from DCH to improve health care outcomes for the entire Medicaid and CHIP populations, further aligning with its Quality Strategy goals.

Compliance Review Enhancements

During the SFY 2012 compliance review, DCH requested that HSAG conduct a detailed case review of each CMOs' case and disease management programs. The DCH noted that while the CMOs received high compliance scores for documentation in meeting the federal requirements, there appeared to be a disconnect between documentation compliance and actual implementation and measurement of health care outcomes. The reviews presented in this report allowed the CMOs and DCH to receive feedback from a different perspective of actual case review instead of sole reliance on policies and procedures and staff interviews.

Review of Compliance With Standards

The DCH contracted with HSAG to perform a review of the CMOs' compliance with standards, one of the three federally mandated activities. The requirements described at 42 CFR §438.358 specify that a review must be conducted within a three-year period to assess the CMOs' compliance with State and federal requirements related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. HSAG reviews one-third of this full set of standards each year so that over a three-year cycle, all requirements will be reviewed. HSAG conducted on-site compliance reviews in August and September 2012. The CMOs submitted documentation that covered the review period of July 1, 2011, through June 30, 2012. HSAG provided detailed, final audit reports to the CMOs and DCH in November 2012. During this cycle, HSAG reviewed the CMOs' performance in the following areas related to access to services:

- Provider Selection, Credentialing, and Recredentialing
- Subcontractual Relationships and Delegation
- Member Rights and Protection
- Member Information
- Grievance System
- Disenrollment Requirements and Limitations
- Coordination and Continuity of Care
- Re-review of all *Partially Met* and *Not Met* elements from the prior year's review

In addition to the above-mentioned review areas, HSAG performed a focused case-specific file review of a sample of the CMOs' members enrolled in the case and disease management programs to better assess the CMOs' performance relative to the Coordination and Continuity of Care standards. This additional review was in response to concerns with the prior review period's results for this section expressed by DCH. Discrepancies were noted between HSAG-audited results and reports submitted by the CMOs to DCH. The DCH affirms that HSAG scored some areas of the review as compliant based on HSAG's evaluation of the CMOs' structure and operations against federal regulatory provisions and State contract requirements. However, outcome data and monitoring reports provided by the CMOs to DCH suggested additional areas in need of improvement for the CMOs to attain desired outcomes. As DCH continues to emphasize improvement in health care outcomes, the methodology used by HSAG to perform compliance audits is evolving to include a more focused and targeted review of CMO data outcomes associated with the CMOs' structure and operations to provide value-added feedback to DCH and the CMOs.

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

SFY 2013 Findings

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

Table 3-1 displays the standards and compliance scores.

Table 3-1—Standards and Compliance Score

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met****	# *Partially Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score
I	Provider Selection, Credentialing, and Recredentialing	6	6	A: 6 P: 6 W: 6	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 100% P: 100% W: 100%
II	Subcontractual Relationships and Delegation	6	6	A: 6 P: 6 W: 6	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 100% P: 100% W: 100%
III	Member Rights and Protection	6	6	A: 6 P: 6 W: 6	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 100% P: 100% W: 100%
IV	Member Information	20	20	A: 20 P: 19 W: 20	A: 0 P: 1 W: 0	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 100% P: 97.5% W: 100%
V	Grievance System	35	35	A: 34 P: 34 W: 35	A: 1 P: 1 W: 0	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 98.6% P: 98.6% W: 100%
VI	Disenrollment Requirements and Limitations	8	8	A: 7 P: 8 W: 8	A: 1 P: 0 W: 0	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 93.8% P: 100% W: 100%
VII	Coordination and Continuity of Care	5	5	A: 2 P: 1 W: 2	A: 3 P: 4 W: 3	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 70.0% P: 60.0% W: 70.0%
Varied	Follow-Up From The SFY 2012 Review	A: 12 P: 11 W: 10	A: 12 P: 11 W: 10	A: 9 P: 8 W: 9	A: 3 P: 3 W: 1	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 87.5% P: 86.4% W: 95.0%
	****Total Compliance Score	A: 98 P: 97 W: 96	A: 98 P: 97 W: 96	A: 90 P: 88 W: 92	A: 8 P: 9 W: 4	A: 0 P: 0 W: 0	A: 0 P: 0 W: 0	A: 95.9% P: 95.4% W: 97.9%

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

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

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

**** **Total Compliance Score**: The overall percentages were calculated by adding the number of elements that received a score of *Met* to the weighted (multiplied by 0.50) number that received a score of *Partially Met*, then dividing this total by the total number of applicable elements.

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

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

The statewide percentage-of-compliance score for WellCare was 97.9 percent, while AMERIGROUP received a score of 95.9 percent and Peach State received a score of 95.4 percent. All three scores reflect commendable CMO performance.

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

Findings

The following overall strengths were noted by HSAG across the three CMOs for each of the standards:

Standard I: Provider Selection, Credentialing, and Recredentialing

- The CMOs' documentation, including policies, procedures, delegated agreements, and workflows related to the provider selection process, credentialing, and recredentialing were detailed and ensured that the CMOs did not contract with an excluded provider. The CMOs used the Excluded Parties List System (EPLS) and the Office of Inspector General's (OIG's) exclusion list to ensure that providers were current and not sanctioned.
- Provider performance was regularly monitored; grievance data were examined; and, if necessary, situations were presented to the CMOs' credentialing committees for review. The CMOs would then begin the corrective action process with applicable providers.

Standard II: Subcontractual Relationships and Delegation

- All of the CMOs established a Joint Operating Committee (JOC) to provide oversight of delegated entities. They also incorporated a scorecard system and presented those scores to this committee as a mechanism to evaluate performance between regular annual performance evaluations.

Standard III: Member Rights and Protection

- Each CMO demonstrated an excellent training program for providers and staff to ensure that member rights were considered during the care process. Providers were trained during their onboarding process, the rights were included in the provider contract, provider offices were provided posters with member rights information, and providers were sent annual provider newsletters that outlined member rights and responsibilities. Member rights and responsibility information was also contained on each CMO's Web site.

Standard IV: Member Information

- The CMOs ensured that all member information was written at an appropriate reading level and benefits were thoroughly explained in the member handbook. They also ensured that materials were produced in alternate formats to meet members' needs and that interpreter services were used to ensure the member understood the provided care and benefits.
- Materials in alternative formats and languages were also available on each CMO's Web site or provided to members when they called Member Services.
- Printed versions of the provider directory contained the required information including provider office hours, alternate languages spoken, and if the provider was accepting new patients. Each CMO Web site contained a provider directory. Members were able to narrow their provider search using sort and search criteria.

Standard V: Grievance System

- The CMOs had strong mechanisms to log grievances, track them throughout the resolution process, document member interactions, and prompt follow-up activities with members after they filed an appeal.
- The member handbooks summarized the grievance and appeals process and included the right to file a grievance or an appeal in the member rights and responsibilities section.

Standard VI: Disenrollment Requirements and Limitations

- The disenrollment process was documented and policies, procedures, and workflows were thorough and described the requirements. Member Services staff proactively contacted members who requested disenrollment and used the opportunity to attempt to retain the member and to resolve any issues he or she might have.

Standard VII: Coordination and Continuity of Care

- Coordination and continuity of care programs within each CMO were well documented with policies, processes, and assessments. Each used a predictive modeling process to identify potential members for inclusion in the programs.

Follow-Up Review

The CMOs corrected most of the previously identified areas of deficiency.

CMO Comparison—Key Findings

HSAG highlighted the following specific strengths and recommendations for each of the CMOs.

AMERIGROUP

Strengths

- Documentation is a strength for the AMERIGROUP staff. In each standard, the processes, procedures, policies, medical assessments, delegation agreements for credentialing, and committee meeting minutes were thorough and included the required information.
- AMERIGROUP's training program for staff members and for providers ensured that member rights were considered during the treatment process. Staff training also covered privacy and confidentiality subjects ensuring that members' records were kept confidential and that the members' interests were protected.
- Member information was provided in any language requested including large print, audiotape, Braille, Spanish, and other languages as needed. The member handbook was available on AMERIGROUP's Web site in English and in Spanish.
- AMERIGROUP was able to effectively resolve nine of the 12 areas identified as deficiencies from the prior year's review. The deficiencies in the areas of Coverage and Authorization and Emergency and Poststabilization Services were fully resolved. The CMO demonstrated significant improvement in the area of Furnishing of Services by meeting appointment standard benchmarks for sick visits for its pediatric and adult populations, routine and urgent dental visits, mental health visits, urgent care provider access, initial visits for pregnant women, and initial health check visits for children newly enrolled in the CMO's plan.

Recommendations

- During the file review, HSAG noted that one of the 10 files reviewed had an acknowledgement letter that was sent out late. The CMO must ensure that it has a mechanism to handle timely receipt and acknowledgement of grievances between its local Georgia office and corporate office.
- Although AMERIGROUP provided its Disenrollment—GA policy and its Disenrollment Desktop Process, the Disenrollment—GA policy did not include a provision that the CMO cannot disenroll a member due to uncooperative or disruptive behavior resulting from his or her special needs or for diminished mental capacity. The CMO should modify its policy and process to include these reasons as unacceptable for discrimination.
- Results for the focused case review related to care coordination functions identified that AMERIGROUP has opportunities to strengthen its programs to ensure that its policies and procedures for case management, disease management, transitions of care, and discharge planning are being operationalized consistently and at the member level.
- The components for care treatment planning, monitoring, and follow-up are operational components in greatest need of improvement. Discharge planning showed mixed results with case managers not consistently obtaining and documenting members' discharge plans and

proactively ensuring that members are linked with needed post-hospital services. Providers were not solicited for input into the member's care treatment plan.

- In addition, while the CMO addresses both physical health and behavioral health issues, the case management component is compartmentalized. Efforts to case manage the individual as a whole would improve the program delivery.
- While the CMO met the State's basic contract requirements for implementing the specified disease management programs as outlined in the contract, the file review revealed opportunities to improve these programs. The goals of the disease management programs were unclear, and the CMO currently does not have a process established to track and report member health outcomes. The disease management monitoring activities observed were not tied to the clinical practice guidelines, and it was difficult to discern from the disease manager's notes the goals for members participating in disease management. AMERIGROUP does not have a mechanism established to evaluate the effectiveness of its disease management programs; therefore, the CMO is not able to determine if either the passive or active disease management approaches are effective. Because goals are not established for the program, its ability to impact related performance measure rates is a missed opportunity. Generally, the CMO is not able to demonstrate that members are getting better as a result of being enrolled in its disease management programs. Instead, the emphasis and targets of the CMO are geared toward numbers and percentages of members enrolled in the program rather than improved health outcomes.
- While the CMO implemented a process to monitor waiting times for non-emergency hospital stays, its procedures did not provide enough detail to demonstrate the frequency at which the CMO conducts monitoring as well as how the data are collected to determine "non-compliance." The current process outlines the CMO's process for identifying hospitals/facilities that do not meet the standard for 30-day elective admissions but is not sufficient to demonstrate a measureable indicator of performance over time. The CMO will need to revise its existing process to include additional details about the methodology for conducting this activity, including how data are collected, the frequency at which the CMO will monitor wait times, and how it will formalize the reporting of results. In addition, the CMO needs to implement a mechanism to report its rate of compliance with monitoring non-emergency elective hospital stays.
- Based on the prior review period, the CMO was not meeting standards for ensuring that provider response times for returning calls after hours do not exceed 20 minutes for urgent calls and one hour for other calls. The CMO indicated challenges with its vendor contracted to conduct the after-hours response time survey; therefore, the CMO was not able to demonstrate compliance during the review period. The CMO needs to address barriers preventing it from reporting results, ensure that all applicable contracted providers have CMO-approved coverage mechanisms, and ensure that after-hours coverage and response times meet requirements.
- A review of the quarterly GeoAccess reports showed that the CMO was not fully meeting all geographic access standards at the 90 percent DCH-established benchmark. The CMO needs to continue to implement strategies to address gaps in the geographic accessibility of services for its members.

Peach State

Strengths

- Peach State has a robust system to ensure that it does not contract with excluded providers. It uses the EPLS and OIG's exclusion list monthly to ensure that providers are current and not sanctioned. Additionally, the CMO conducts regular audits of credentialing files to ensure that it credentials providers consistently and without discrimination for any reason.
- The CMO's committee meeting minutes were detailed regarding deficiencies and oversight. Peach State uses a vendor performance evaluation as an oversight mechanism of its delegates between annual assessments and presents the scorecards to the JOC. Peach State uses JOC meetings to discuss all delegated functions, report statistics, discuss questions and concerns, and follow up on corrective action plans (CAPs). Peach State successfully monitors its delegates consistently throughout the year, ensuring that deficiencies are noted and corrected immediately, rather than waiting until after the annual assessment is conducted to begin corrective action.
- Peach State has a thorough training process for internal staff and providers. It ensures that member rights are considered during all aspects of member interaction. Member rights were emphasized to providers during annual provider newsletters and during provider services on-site visits.
- Peach State clearly ensures that member communications are in a language and format that fit the members' needs. The CMO produces and distributes member materials in the language appropriate for the member and considers the readability of the materials to ensure members understand the information. Peach State also provides translation services when either a member or a provider requests them. Both the printed and online provider directories are thorough and easy to navigate. Staff members are thoroughly versed on the member handbook and could recite sections as needed in great detail.
- Peach State's system for logging and tracking grievances and appeals is very thorough and detailed. The system maintains a record of all appeals and grievances received; describes whether the appeal or grievance was received verbally or in writing; includes a short, dated summary of the issues; and contains the name of the member, the date of the appeal or grievance, the date of the resolution or decision, and multiple other fields which provide grievance/appeal-related details to staff. The CMO chooses to follow more stringent standards for resolving grievances and appeals than are required. During the file review process, it was noted that Peach State consistently met the more stringent time frames. Plan policies were detailed and descriptive and sufficiently outlined State and federal requirements.
- Peach State's documentation related to the disenrollment process was robust. The CMO provided policies and workflows that describe all of the requirements, and staff members followed the process as outlined. Member Services staff approached disenrollment as an opportunity to communicate possible solutions to members and attempt to retain them rather than allowing them to disenroll.
- Peach State was able to effectively resolve eight of the 11 areas identified as deficiencies from the prior year's review. The deficiencies in the areas of Grievance System and Emergency and Poststabilization Services were fully resolved. The CMO demonstrated a significant amount of work in the area of Furnishing of Services to meet the benchmarks for obtaining appointments for pediatric and adult sick visits, and routine and urgent appointment times for dental providers.

Recommendations

- Peach State does have physician incentive plans for improving HEDIS performance and for notifying the CMO when a patient is pregnant; however, it is unclear how the member would obtain information about these physician incentive plans. CMS requires that the CMOs provide information to members about how physicians are incentivized by the CMO. Peach State needs to identify how it would provide physician incentive plan information to members.
- Despite the overall structure to support the case and disease management programs, results from the focused case review related to care coordination functions identified that Peach State has opportunities to strengthen its programs to ensure that its policies and procedures for case management, disease management, transitions of care, and discharge planning are being operationalized consistently and at the individual member level.
- The CMO identified members for case management through its disease management vendor, member services, and providers; however, the case review showed opportunities for the CMO to identify members sooner as many of the cases reviewed could have benefitted by an earlier case management intervention. Additionally, the CMO needs to engage providers and members' support systems as part of the care treatment planning process.
- The components for care treatment planning, monitoring, and follow-up are operational components in greatest need of improvement. The review showed that case managers are not consistently obtaining and documenting members' discharge plans and proactively ensuring that members are linked with needed post-hospital services.
- While the CMO met the State's basic contract requirements for implementing the specified case and disease management programs as outlined in the contract, the file review revealed opportunities to improve these programs. The case management program lacked evidence of "active" case management. Generally, case managers are following up with members as part of their monitoring activities; however, the follow-up activities seem to be set at standardized time intervals and appear to be peripheral without evidence of impact on the member. For example, the case managers are not documenting efforts to help members obtain provider appointments, arrange transportation, or establish meaningful contact with the member's primary care provider (PCP) and specialists. Instead, the activities appear to be geared more toward touching base with the member and obtaining self-reported health updates. Additionally, there was some social worker involvement noted in the cases reviewed, but it was primarily to ensure that the member's Supplemental Security Income (SSI) application or referrals were being handled by the CMO's vendor. The cases lacked evidence of referrals to community resources.
- The goals of the disease management programs were unclear. HSAG noted that many of the cases did not extend beyond two or three telephone calls for members in active disease management, and the monitoring activities did not appear to be tied to clinical practice guidelines.
- Overall, the CMO could benefit from establishing a mechanism to evaluate the effectiveness of its case and disease management programs. Currently, the CMO is not able to determine if the current approaches are effective. Because goals are not established for the programs, Peach State's ability to impact related performance measure rates is a missed opportunity. Generally, the CMO is not able to demonstrate that members are getting better as a result of being enrolled in its case and/or disease management programs. Instead, the emphasis and targets of the CMO

are geared toward numbers and percentages of members enrolled in the program rather than improved health outcomes.

- The review showed a solid organizational structure, leadership support, and talented staff, all of which should be used to refine Peach State's case and disease management programs to more effectively meet the growing needs of the Georgia Families population.
- Despite the CMO's efforts to meet all appointment wait time standards, Peach State did not achieve the standard of 90 percent for providing routine PCP visits within 14 days for pediatric members during the second quarter of 2012. The CMO must continue to work in this area to ensure that it consistently meets the DCH-established threshold of 90 percent for providing routine PCP visits within 14 days.
- The CMO did not achieve the 90 percent benchmark for the following standards:
  - PCP urban access to two providers within eight miles for the Southwest region
  - Family practitioner/General practitioner urban access to two providers within eight miles for the Southwest region
  - Internal medicine rural access to two providers within 15 miles for the Atlanta and Southwest regions
  - Internal medicine urban access to two providers within eight miles for the Southwest region
  - Pediatric urban access to two providers within eight miles for the Southwest region
  - Allergy and immunology urban access to one provider within 30 miles for the Central and Southwest regions
  - Allergy and immunology rural access to one provider within 45 miles for the Central region
- The CMO needs to continue to implement strategies designed to improve performance in meeting the requirements for providing geographically accessible services to its members across all provider types and in both urban and rural areas.
- The CMO did not resolve the requirement to send a Notice of Action letter to the member for the denial of payment at the time of any action affecting claims payment. The CMO must either revise its claims explanation of benefits for denials to include all proposed notice of action required language, or the CMO must send a proposed notice of action letter with the claims denial to be compliant with this requirement.

WellCare of Georgia, Inc.

Strengths

- The CMO runs a query against grievance data focused on quality improvement concerns and initiates corrective action measures. Findings as a result of the query are presented to the credentialing committee for discussion and proposed corrective action.
- Committee meeting minutes were detailed regarding deficiencies and oversight activities. The CMO uses a vendor scorecard as a mechanism of oversight of its delegates between annual assessments and presents the scorecards to the JOC.
- WellCare has a thorough training process for both staff and providers, ensuring that each is trained to consider member rights when conversing with members. Health Insurance Portability and Accountability Act of 1996 (HIPAA) information as well as processes for handling

protected health information were present in many of the CMO's policies and processes, and in the member handbook. Each of these sources emphasized the seriousness of these subjects.

- WellCare clearly ensures that member communications are in a language and format that fit the members' needs. The CMO produces and distributes member materials in the language appropriate for the member and considers the readability of the materials to ensure that the members understand them. WellCare also provides translation services when requested by either a member or a provider. Both the printed and online provider directories are thorough and easy to navigate.
- WellCare's staff members are very knowledgeable about the grievance and appeals process. They have an impressive understanding of the rules and what is contained in the CMO's policies. The policies are very detailed and describe the federal requirements. The CMO has an effective process for obtaining grievances from delegated entities and a strong internal process for monitoring turnaround times.
- WellCare's documentation related to the disenrollment process is robust. The CMO provided policies and workflows that describe all of the requirements, and staff members followed the process as outlined. When Member Services received a concern, they proactively contacted the member to resolve any issues.
- WellCare had well-established processes and programs in place to identify and assess members with special health care needs and/or members who could benefit from case management or disease management programs. The CMO has implemented numerous process improvements over the last several years; it has added more assessment tools and modified existing ones to better meet members' needs. WellCare has plans to implement a new case management system that is targeted to go live on January 1, 2013, which will enhance the case managers' ability to access multiple data sources.
- The CMO did an outstanding job with reducing barriers for members accessing durable medical equipment (DME) and needed services, and in making referrals to community resources. This is important to ensure that members receive the needed DME without unnecessary delays.
- The CMO will be transitioning behavioral health management functions from its vendor to in-house management beginning January 1, 2013. HSAG supports this transition as it should allow for greater integration and case management of the member as a whole.
- WellCare was able to effectively resolve nine of the 10 areas identified as deficiencies from the prior year's review. The deficiencies in the areas of Coverage and Authorization of Services and Emergency and Poststabilization Services were fully resolved. The CMO demonstrated good effort to achieve compliance with access and wait time standards. Staff interviews revealed that the CMO has a process that includes outreach by the medical director to non-compliant providers to better understand their challenges with meeting the contract requirements. This process is excellent and appears to have resulted in substantial improvement. The CMO also described efforts to incorporate the use of telehealth to address some known service gaps.

Recommendations

- Results for the focused case review related to care coordination functions identified that, while WellCare has the appropriate structure, policies, and procedures to support care coordination, the CMO also has opportunities to strengthen its programs to ensure that case management, disease management, transitions of care, and discharge planning policies and procedures are being operationalized consistently and at the member level.

- The CMO must improve transitions of care by ensuring that discharge plans and discharge planning needs are communicated to or obtained by the case manager and are included in the members' care plans. HSAG recommends that the CMO consider the value of having case managers follow the member across the care continuum whether the member is in a hospital or skilled nursing facility (SNF) or is receiving outpatient care services.
- While the CMO met the State's basic requirements for having the specified disease management programs as outlined in the contract, the file review revealed opportunities to improve these programs. Specifically, the reviews showed a lack of individualized care plans that are tailored to a member's needs and associated with clinical practice guidelines.
- WellCare currently does not have a process established to track and report member health outcomes. The CMO needs to consider ways to track individual member health outcomes and report on whether member health is improving as a result of being enrolled in the disease management programs. Because WellCare lacks a mechanism to evaluate the effectiveness of its disease management programs, the CMO is not able to determine if either the passive or active disease management approaches is effective. Because goals are not established for the program, its ability to impact related performance measure rates is a missed opportunity. The CMO needs to identify opportunities to better align its disease management programs with HEDIS indicators and clinical practice guidelines. Overall, the CMO is not able to demonstrate that members are getting better as a result of being enrolled in its disease management programs. Instead, the emphasis and targets of the CMO are geared toward numbers and percentages of members enrolled in the program rather than improved health outcomes.
- Despite the CMO's progress toward correcting routine visit wait times to a PCP, the CMO was not compliant with meeting the 90 percent threshold for providing a routine visit to a PCP within 14 calendar days for the 2nd quarter of 2012, with a score of 89 percent. WellCare should continue to work with providers to ensure that its performance consistently meets or exceeds the DCH-established threshold.

Focused Review—Case and Disease Management

The DCH has required its CMOs to implement case management and disease management programs to address the clinical and non-clinical needs of members. Based on DCH's concerns that CMOs have implemented programs that differ vastly from the programs described within CMO program-specific documents, DCH requested that HSAG conduct an on-site review of each CMO's case management and disease management programs. Appendix D includes a copy of the tool used to conduct the review.

An HSAG review team experienced in case management reviewed selected members enrolled in both case management and disease management programs. The case management review consisted of an on-site review of five case management records targeting key program areas including:

- Identification
- Assessment
- Development of a care plan
- Monitoring to ensure that members are receiving high-quality, individualized care

The disease management review consisted of an on-site review of five disease management records targeting key program areas including:

- Program type and identification
- Assessment and guidelines
- Education
- Monitoring and measureable outcomes

The review tool used by the HSAG clinical review team was based on the Case Management Society of America's principles and DCH's contractual requirements for case management and disease management programs. At the conclusion of the focused review, HSAG provided the CMOs with verbal feedback consisting of a high-level summary of observations and recommendations for each area of the review. The results from both the case management and disease management reviews supplement the Coordination and Continuity of Care standard by highlighting each CMO's strengths and identifying recommendations to strengthen the delivery of these programs. Appendices F and G of each CMO-specific SFY 2013 External Quality Review of Compliance with Standards Report include the individual tools for each case review.

The purpose of this section of the report is to provide the CMOs and DCH with an aggregate overview of the common themes from key findings that emerged from the focused review. This section also contains recommendations for both the CMOs and DCH to consider as they expand their case management and disease management programs to accommodate members with complex medical, behavioral health, and social needs.

Common Themes From Key Findings

The HSAG clinical review team observed and identified a number of common strengths and opportunities for improvement among the CMOs that fell into key program areas. For the case management program, these areas were noted: identification; assessment; care plan development; and monitoring and follow-up, which include a review of transitions of care, and discharge planning. For the disease management programs, these areas were noted: program type and identification; assessment and clinical guidelines; education; monitoring; and measureable outcomes.

Case Management

HSAG reviewed each CMO's process for identifying members and referring them for case management program services, including whether the member was identified as having any special health care needs. The review also included each CMO's process for completing a comprehensive assessment and if the member's needs were identified. The review then determined whether identified needs were included in a care plan containing targeted interventions individualized to meet the member's needs. HSAG assessed whether members, providers, and the member's family and caregivers were engaged in the assessment and care plan development processes. Finally, HSAG reviewed the CMO's ongoing monitoring of the care plan to ensure that the member's individual needs were being met, the frequency of the contact was consistent with those needs,

barriers to achieving care plan goals were reduced, and discharge planning activities were conducted to ensure members had the after-care services and items they needed to achieve positive health outcomes.

CMO Strengths

- Overall, common strengths among the CMOs were observed in the areas of identification and assessment. All CMOs used a variety of predictive modeling software and computerized algorithms to identify members who could benefit from the case management program. The CMOs had several other mechanisms for identifying and referring members to case and disease management including inpatient census lists, staff referrals, provider referrals, and provider incentive programs.
- All of the CMOs were found to have electronic case management software systems in place to support and store clinical information including the assessment, care plan, and case management activity notes. Several CMOs indicated having recently updated their case management programs, or had updates scheduled, to strengthen their processes and reduce the compartmentalization of member information hindering case management and reporting capabilities.
- All of the CMOs used a comprehensive health assessment as well as disease-specific assessments to capture and record the member's medical, behavioral health, social, and psychosocial needs. Additionally, many CMOs included an assessment of whether the member had any cultural or linguistic needs.

CMO Opportunities for Improvement

- Despite the variety and effectiveness of the mechanisms the CMOs have in place to identify and assess members for the case management program, the HSAG clinical review team observed common weaknesses among the CMOs in the areas of care plan development, case management monitoring, and follow-up activities. It was observed that care plans were developed for members that did not include all of the information obtained during the assessment process. Furthermore, the care plans were generated by the CMOs' case management information systems and lacked individualization to the member. Additionally, the care plan goals were found to lack evidence to suggest that a member's health was improving, which is attributable to care plan goals that were not measurable.
- Providers responsible for treating members were found to be ancillary to and disengaged from the assessment, care plan development process, and most of the monitoring and follow-up activities. Many of the CMOs have a process in place to send some type of notification to a member's provider to inform the provider that the member is in case management and how to contact the member's case manager. However, HSAG noted that there was an absence of regular contact and engagement with providers that proved to be a detriment to the care coordination process. Additionally, the same observation was made regarding family and caregivers who were found to be disengaged from the member's assessment, care plan development, and monitoring activities (unless the member was a minor).
- HSAG found evidence of fragmentation of care in all of the CMOs. As a result, opportunities were identified to improve member care transitions from one external care setting to another and/or across the CMOs' internal departments, each specializing in a single piece of the care coordination process. Further fragmentation of care was found in the majority of cases reviewed

involving a member who had been hospitalized. HSAG found that case managers were unaware that a member was in the hospital or emergency room until after the event. Case managers were not responsible for the member's case management while he or she was hospitalized as inpatient utilization management was often referred to another department to handle, such as the concurrent review department. In addition, case managers were not included in any aspect of the discharge planning process. The CMOs appeared to have difficulty obtaining the discharge plan and incorporating any discharge needs into the member's care plan and the case manager's monitoring and follow-up activities.

- In the majority of cases reviewed, monitoring and follow-up activity intervals were observed to be set according to program policy and not based on members' individual needs. The member contact and follow-up activities lacked evidence of member engagement and were not focused on engaging the member in interventions reflective of the member's reported needs or care plan goals.

Disease Management

HSAG reviewed each CMO's process for identifying members and referring them for disease management program services, including the type of disease management program in which the member was enrolled. The review included the CMO's process for completing a comprehensive assessment and whether member needs were identified. In addition, the review determined whether these identified needs were included in care plan interventions individualized to meet the member's needs and reflective of the disease management guidelines for the member's condition. HSAG evaluated the type of educational materials the CMOs were providing to their members and whether the members verbalized a better understanding of their condition as a result of the education provided. HSAG reviewed the CMOs' ongoing monitoring activities to ensure activities were centered on the member's care plan and disease-specific clinical guidelines. Finally, HSAG evaluated the extent to which the CMOs measured member health outcomes to gauge whether members were experiencing positive health outcomes.

CMO Strengths

- Overall, common strengths among the CMOs were observed in the areas of identification and assessment. All CMOs were using a mixture of predictive modeling, computer algorithms, staff referrals, and provider referrals to identify and refer members to disease management.
- Each CMO was found to have an electronic disease management software system in place to support and store clinical information including the assessment, care plan, and disease management activity notes.
- All of the CMOs were observed to have assessments in place that adequately captured disease-specific information and basic member health history.

CMO Opportunities for Improvement

- The common weaknesses observed among the CMOs' disease management programs were primarily in the areas of application of clinical guidelines, education available to the member, monitoring activities, and measurable outcomes. The CMOs also had challenges with disease management stratification levels. All CMOs use multi-level stratification systems consisting of prescribed disease management activities targeted at each stratification level. These systems

were found to be unnecessary since all of the disease management activities boiled down to either "active" or "passive" disease management. To provide context and clarification, in active disease management, a disease manager makes telephonic contact directly with enrolled members typically on a monthly basis, whereas in passive disease management, members are sent newsletters or other educational materials, and no direct contact with a disease manager is provided.

- HSAG found that while members were adequately assessed and care plans were developed for members in active disease management, care plan goals were not tied to the CMOs' clinical practice guidelines, and members' care plan goals were not linked with outcome measures to determine whether the disease management program was affecting the members' overall health.
- The education materials available to members were observed to be mostly a variety of passive educational tools such as pamphlets, fliers, bulletins, and newsletters. While the materials were found to contain appropriate and relevant disease-specific information, they were unremarkable and uninteresting, leading members to easily disregard or discard materials instead of reading them.
- Most CMOs were observed as lacking methods or tools to record and track members' lab value results and to report whether members were healthier as a result of the disease management interventions. HSAG found that members' lab results were documented within disease management case notes, but the information could not be extracted from case notes or be used to track and trend individual member health outcomes.
- HSAG found that CMOs lacked documentation evidencing provider engagement in the care plan development process and monitoring activities. Most CMOs outreached to the members' PCPs using a standard notification form or form requesting the return of clinical information. It was observed that providers rarely made outreach to the disease managers or completed and returned the clinical information forms.
- The disease management case notes lacked evidence of member engagement in the disease management process. Additionally the disease manager's monitoring activities were peripheral to member needs and not tied to care plan goals or clinical guidelines.

Conclusion

As a result of the review, HSAG observed that generally, the CMOs' policies and procedures provide detailed outlines of both case management and disease management program structures, meeting DCH's contractual requirements. However, inconsistencies were observed between the CMOs' program descriptions and the implementation and delivery of the care management and disease management programs.

Recommendations

Based on the focused review results across the CMOs, HSAG recommends that CMOs:

- Develop more individualized, specific goals for members. Goals should be measurable, attainable, timely, and realistic, and should reflect the information obtained during the assessment process.
- Increase accountability for member care plans by implementing outcome measures through the quantifying and assigning of values to care plan goals and interventions, and requiring reporting on the percentage of care plan goals met, not met, partially met, etc.
- Implement mechanisms to demonstrate improved member health outcomes related to the specific case management and disease management problems, interventions, and goals set for the member within the care plan. The care plan goals set for a member, such as a reduction in the HbA1c level for a diabetic member, should be the criteria against which results can later be measured to determine specific outcomes.
- Increase efforts to engage providers in care plan development and monitoring activities to ensure all needed treatments and services are being provided to the member and treatment goals are coordinated between the providers and case manager. Additionally, members' support systems should be engaged in the case management process.
- Improve care coordination and workflow activities to ensure that case managers are notified when their members are admitted to an inpatient facility, are included in the discharge planning process, and obtain the discharge plans to allow the hospital's instructions to be incorporated into the care plan and monitoring activities.
- Reevaluate the frequency of member contact, allow the needs of the member to drive the monitoring activities, and develop ways to increase member engagement and strengthen member-case manager relationships to increase member retention.
- Improve and streamline the delivery of disease management program services by implementing a single stratification disease management program focusing on active disease management interventions only and incorporating those activities into the case management program as Level 1 case management.
- Improve care plan and clinical guideline processes by ensuring that clinical guidelines are reflected in care plan goals and care plan goals are linked with outcome measures to monitor member improvements.
- Explore and expand the variety of educational materials available to members in disease management to include interactive, dynamic educational tools that engage members.
- Explore using online, mobile apps and other interactive tools for members to log lab value results. Consider sending testing reminders to members, providing online chats with a disease manager, or implementing member Health Report Cards so members can track lab value results and gauge their progress over time. Additionally, the Health Report Cards can be used to track and report on specific outcome measures.
- Increase efforts to engage providers in the disease management process by outreaching to providers and improving collaboration to obtain clinical information.

- Increase efforts to engage members and ensure that disease management monitoring and follow-up activities are tied to care plan goals and disease-specific clinical guidelines.

Based on the common themes identified as a result of conducting the focused review, HSAG provides the following recommendations to DCH:

- While member coverage includes a transportation benefit, DCH should consider reducing barriers to this benefit by reducing restrictions on the distance members can be transported, the call-ahead reservation time required, and the number of co-riders that are permitted to accompany members.
- Currently, DCH provides a broad outline of case management and disease management program requirements in the contract between the Georgia Department of Community Health and CMOs. However, DCH may consider revising the program requirements to include more specific and prescriptive requirements (e.g., process standards to require assessments, care plans, and initiation of services to be completed within a set time frame, CMOs to offer a common menu of service items to standardize processes across the State).
- The DCH may consider allowing member eligibility for longer periods of time instead of every six months to help ensure consistency and quality delivery of case management and disease management services and prevent members from experiencing frequent disruptions in services due to eligibility issues.
- The DCH should consider exploration of standardizing case manager caseload size. HSAG observed variation in caseload size across CMOs ranging from 100 to 300 members. High caseloads prevent case managers from devoting time to individual members and require them to spend their time crisis case managing instead. Because there is no single accepted industry standard for caseload size, DCH may consider convening a workgroup to explore the results of several published white papers and solicit input from its CMOs and case management organizations before establishing a threshold.
- Consider implementing incentives and disincentives for case management and disease management for CMO outcome measures.
- Implement case reviews and require reporting of all members who expire while enrolled in a case management or disease management program. Additionally, explore implementation of an incident reporting process and ensure quality assurance using required CAPs.

The case management and disease management programs should reflect member benefit and positive health outcomes as a result of services provided with reportable, trackable outcomes for improvement in quality of life; overall health and mental health status; member satisfaction; adherence to treatment plans; compliance with medication regimen; and follow-up on discharge treatments, instructions, and plans. To that end, HSAG encourages the CMOs to implement reporting systems to track, trend, and report on health outcomes at the member level, by disease, and even by case/disease manager to show successes or opportunities for improvement. Studying these trends will help ensure that quality services are accessible to members and that the CMOs are providing high-quality, low-cost, effective service delivery programs beneficial to members and DCH.

4. Performance Measures

The DCH annually selects performance measures to evaluate the quality of care delivered to Georgia Families members by the CMOs. The selected performance measures reflect the State's priorities and areas of concern for Georgia Families members and include HEDIS, the Agency for Healthcare Research and Quality (AHRQ), and Children's Health Insurance Program Reauthorization Act (CHIPRA) core set measures. The CMOs calculate and report data consistent with the most current reporting-year specifications.

CMS requires that states, through their contracts with managed care plans, measure and report on performance to assess the quality and appropriateness of care and services provided to members. Validation of these performance measures is one of the three mandatory external quality review activities described at 42 CFR 438.358(b)(2). The requirement allows states, agents that are not a managed care organization, or an external quality review organization (EQRO) to conduct the performance measure validation.

The purpose of performance measure validation is to ensure that managed care plans calculate performance measure rates according to state specifications. CMS also requires that states assess the extent to which the managed care plans' information systems provide accurate and complete information.

During SFY 2012, DCH required its CMOs to report performance measure rates in June 2012 using CY 2011 as the measurement period. Additionally, DCH contracted with Hewlett-Packard Enterprise Services (HP), its Medicaid management information system (MMIS) vendor, to calculate performance measures for:

- The Medicaid and PeachCare for Kids® FFS population. Both administrative and hybrid rates were to be calculated.
- The Georgia Families Medicaid and PeachCare for Kids® managed care populations (Georgia Families). Only administrative rates were to be calculated.
- The entire Medicaid and PeachCare for Kids® (ALL) populations. These ALL population's rates were generated for the purposes of rate comparisons with other states and voluntary reporting of CHIPRA Initial Core Set metrics to CMS. Both administrative and hybrid rates were to be calculated.

All Georgia Families CMOs underwent an independent National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™[4-1] by a licensed organization to ensure that the CMOs followed specifications to produce valid and reliable HEDIS measure results. HSAG received the final, audited CMO rates and ensured that the HEDIS compliance protocol met CMS' requirements for validating performance measures. Additionally, HSAG validated performance measures that were not covered under the scope of the HEDIS Compliance Audit, which consisted of measures developed by AHRQ or as part of the CHIPRA core set measures. Finally, HSAG used the CMOs'

[4-1] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance.

audited hybrid rates to calculate a Georgia Families weighted average for hybrid measures. Appendix B contains a more detailed description of the method for conducting the review.

Performance Measure Requirements and Targets

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

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

The DCH required the CMOs to report rates in SFY 2012 for 41 measures from the original required list of 51 measures, reflecting the measurement period of January 1, 2011, through December 31, 2011. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information. Many of the 41 measures include multiple components or age stratifications. The DCH deferred CMO reporting on 10 of the original 51 required measures due to technical specification clarifications needed for those measures.

For the CY 2011 data, DCH established minimum performance targets for many of the required measures and their associated components. A total of 40 targets were established: 37 for the HEDIS measures and their components' rates, and three for the AHRQ and other non-HEDIS measure rates. These minimum performance targets for CY 2011 data were based on NCQA national Medicaid percentiles and the 2008 Nationwide Inpatient Sample (NIS) for the AHRQ measures. The DCH re-evaluates performance targets each year to continue to drive increased performance. For the CY 2011 rates, DCH selected one target using NCQA's national Medicaid 25th percentile, 12 targets using the national Medicaid 50th percentiles, 14 targets using the national Medicaid 75th percentiles, and 10 using the national Medicaid 90th percentiles. The DCH has the ability to impose financial penalties for the CMOs that fail to achieve the established performance targets.

The CMOs submitted their performance measure data that generally reflected the period of January 1, 2011, through December 31, 2011, in June 2012. HSAG provided final performance measure validation reports to the CMOs and DCH in August 2012. HSAG finalized the performance measure validation report for HP's CY 2011 calculated measures in October 2012.

Findings

Performance Measure Validation Key Findings

All three DCH-contracted CMOs underwent performance measure validation for rates calculated using CY 2011 measurement period data. For HEDIS measures, the CMOs underwent an NCQA HEDIS Compliance Audit performed by a certified HEDIS compliance auditor. For non-HEDIS measures, HSAG conducted the audit following the CMS protocols for performance measure validation.

Strengths

The DCH required HP to calculate administrative and hybrid rates for the FFS and ALL populations and administrative rates only for the Georgia Families population. The hybrid methodology uses medical record information to supplement administrative claims/encounters data in order to provide a more accurate reflection of performance. Having comparable methodologies across the three populations allows for greater performance comparison. HP was able to overcome some significant issues identified last year that prevented the vendor from being able to report many hybrid rates due to material bias. HSAG noted strong improvement in the medical record abstraction process for the CY 2011 data.

The CMOs worked with existing software vendors to program their own source code in order to report rates for the new DCH-required CHIPRA core set measures for CY 2011.

Challenges

HSAG identified the following challenges during its review.

- Despite the ability for HP to report a greater percentage of valid rates in CY 2011, the vendor had some issues with its procurement rate reports as they did not clearly convey the completion rate of procurement, making it appear that the vendor failed to procure a sufficient number of records to report valid rates. HSAG's analysis determined that HP's medical record vendor retrieved and reviewed a sufficient number of records for each hybrid measure to ensure the hybrid measure rates were valid.
- While HP and the CMOs followed the technical specifications for the *Otitis Media with Effusion—Avoidance of Inappropriate Use of Systemic Antimicrobials* measure, the rates were not valid because Georgia providers do not typically submit CPT Category II codes, which are necessary to calculate this measure.
- AMERIGROUP rotated performance measure rates for *Prenatal and Postpartum Care* and *Controlling High Blood Pressure* measures, and Peach State rotated its *Controlling High Blood Pressure* measure, which is allowable by NCQA but not allowable by DCH. In subsequent years, the CMOs must ensure that they are not rotating measures.
- The DCH did not require HP to report the Controlling High Blood Pressure measure using the hybrid methodology, and this measure is not valid for administrative reporting; therefore, HP was not able to report this rate for CY 2011 for the FFS and the ALL populations.
- Additionally, HP received a "Not Reportable" audit result for the *Persistence of Beta Blocker Treatment After a Heart Attack* measure because HP did not require fifth-digit specificity, which impacted the measure's denominator and materially biased the rate.
- Finally, while HP produced rates for the *Plan All-Cause Readmission* measure, NCQA does not designate this measure for the Medicaid population; therefore, the results are not comparable and could not be verified as valid.
- The CMOs and HP had systems that were capable of capturing provider specialties at the individual level; however, federally qualified health centers (FQHCs) only used a facility number which does not include a rendering provider; therefore, the rendering provider and associated provider type are not captured on these claims. This can result in under/overreporting for measures that require a provider type. While not impacting rates significantly, the CMOs

and HP should work toward requiring FQHCs to submit the rendering provider for all claims to capture the provider type.

Detailed validation results for the CMOs are documented in the final Validation of Performance Measures audit reports that were provided to DCH and the CMOs in August 2012. HP's detailed results are documented in the final Validation of Performance Measures audit report that was provided to DCH and HP in October 2012. For the purposes of this report, HSAG summarized the relevant information and key findings.

Performance Measure Result Findings

Using the validated performance measure rates, HSAG organized, aggregated, and analyzed the data to draw conclusions about the CMOs' performance in providing accessible, timely, and quality care and services to Georgia Families members.

Table 4-1 through Table 4-6 present the following data:

- CY 2010 and CY 2011 statewide CMO weighted averages for clinical measures from the CMOs' reported and audited data
- CY 2011 Georgia Families rates calculated using DCH MMIS administrative data for administrative measures (validated by HSAG) and CMO-reported hybrid data for hybrid measures
- CY 2011 State of Georgia FFS Medicaid data using DCH MMIS administrative data for administrative measures and HP-reported hybrid rates for hybrid measures (validated by HSAG)
- CY 2011 statewide CMO and FFS data to produce the ALL population using DCH MMIS administrative data for administrative measures and HP-reported hybrid rates for hybrid measures (validated by HSAG)
- CY 2011 performance targets for DCH-selected performance measures

Similar to groupings used in the Georgia Families Quality Strategy, HSAG grouped clinical performance measures into the areas of access to care, children's health, women's health, chronic conditions, behavioral health, and medication management to assess the overall care provided by the CMOs. HSAG compared the CY 2011 CMO weighted average rates with the prior year's rates. Additionally, for CY 2011, the CMO weighted average rates were compared to the FFS rates, the ALL population rates, and the CMOs' performance targets.

The DCH required its MMIS vendor to use the hybrid methodology when calculating rates for both the FFS and ALL populations for CY 2011 data, which allowed the State greater opportunity to compare rates across the CMOs, FFS, and ALL populations. While hybrid methodology was used across the three populations, the CMOs' rates may reflect higher performance for some measures as the CMOs had the opportunity to incorporate supplemental data sources, such as lab value data and immunization registry data, to augment administrative and medical record data. Appendix C contains the utilization measure results along with measures related to health plan membership information.

Table 4-1—2010/2011 Performance Measure Results—Access						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 ALL Population Rate[5]	CY 2011 Performance Target[6]
Children's and Adolescents' Access to Primary Care Providers						
Ages 12–24 Months	96.2%	96.7%↑	93.6%	91.6%	93.4%	
Ages 25 Months–6 Years	91.1%	91.1%	86.5%	84.0%	85.9%	
Ages 7–11 Years	91.7%	91.4%↓	88.1%	84.2%	87.5%	
Ages 12–19 Years	88.9%	88.6%↓	84.4%	77.0%	83.3%	91.8%
Total	--	--	86.9%	80.9%	86.1%	
Adults' Access to Preventive/Ambulatory Health Services						
Ages 20–44 Years	85.1%	85.3%	85.0%	75.2%	80.5%	88.5%
Ages 45–64 Years	88.9%	89.5%	89.5%	85.5%	85.8%	
Ages 65 Years and Above	85.7%	84.0%	87.5%	78.4%	78.4%	
Total	--	--	85.5%	80.3%	81.5%	
Oral Health (Annual Dental Visit Rate)						
Ages 2–3 Years	43.9%	47.8%↑	47.2%	39.5%	44.8%	
Ages 4–6 Years	74.4%	76.8%↑	76.3%	64.1%	73.9%	
Ages 7–10 Years	77.4%	79.6%↑	79.0%	65.5%	76.6%	
Ages 11–14 Years	69.8%	72.2%↑	71.4%	59.6%	68.9%	
Ages 15–18 Years	58.8%	60.9%↑	60.1%	49.9%	57.6%	
Ages 19–21 Years	39.5%	40.1%	39.4%	30.2%	33.1%	
All Members (Ages 2–21 Years)	66.8%	69.5%↑	68.8%	54.0%	65.7%	64.1%

[1] CY 2010 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2010, through December 31, 2010.
[2] CY 2011 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011. Statistically significant changes between 2010 and 2011 rates are displayed where applicable.
[3] CY 2011 Georgia Families rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These rates included members who transitioned between CMOs during the measurement year.
[4] CY 2011 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2011, through December 31, 2011.
[5] CY 2011 ALL population rates reflect data for members in the GF populations, FFS populations, and members that transferred between GF and FFS during the measurement year, which is January 1, 2011, through December 31, 2011.
[6] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.
-- Rates are not available.
↑Indicates a statistically significant increase between the 2010 and 2011 weighted average rates.
↓Indicates a statistically significant decrease between the 2010 and 2011 weighted average rates.

Table 4-2—2010/2011 Performance Measure Results—Children's Health						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 ALL Population Rate[5]	CY 2011 Performance Target[6]
Well-Child/Well-Care Visits						
First 15 Months of Life: Six or More Visits	57.8%	58.7%	58.7%	27.5%	48.9%	69.7%
Third, Fourth, Fifth, and Sixth Years of Life	66.9%	68.1%	68.1%	54.6%	60.8%	71.8%
Adolescent Well Care	39.8%	41.2%	41.2%	23.1%	35.8%	46.8%
Immunization and Screening						
Childhood Immunization Status—Combination 3	74.2%	79.5%↑	79.5%	47.0%	42.3%	82.0%
Childhood Immunization Status—Combination 10	17.3%	17.4%	17.4%	6.8%	7.3%	
Lead Screening in Children	70.3%	75.5%	75.5%	56.7%	69.1%	81.0%
Appropriate Testing for Children with Pharyngitis	67.8%	71.9%↑	72.2%	68.7%	71.8%	73.5%
Immunizations for Adolescents—Combination 1 Total	66.4%	69.7%	69.7%	56.0%	61.1%	65.9%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
Body Mass Index (BMI) Percentile	29.6%	42.5%↑	42.5%	22.9%	21.9%	45.2%
Counseling for Nutrition	48.0%	49.7%	49.7%	49.6%	53.3%	57.7%
Counseling for Physical Activity	31.2%	36.8%↑	36.8%	31.9%	36.7%	45.5%
Upper Respiratory Infection						
Appropriate Treatment for Children With Upper Respiratory Infection	78.5%	77.7%↓	78.1%	76.3%	77.9%	
Otitis Media with Effusion						
Otitis Media with Effusion	--	NR	NR	NR	NR	
Annual Pediatric Hemoglobin						
Annual Pediatric Hemoglobin	--	78.6%	77.3%	59.3%	72.9%	

[1] CY 2010 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2010, through December 31, 2010.

[2] CY 2011 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011. Statistically significant changes between 2010 and 2011 rates are displayed where applicable.

[3] CY 2011 Georgia Families rates for the, *Appropriate Testing for Children with Pharyngitis,* and *Appropriate Treatment for Children With Upper Respiratory Infection* measures were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. All other Georgia Families rates were hybrid measures and were calculated by HSAG using the CMO-submitted IDSS files. These rates included members who transitioned between CMOs during the measurement period.

[4] CY 2011 FFS rates for the *Appropriate Testing for Children with Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection* measures reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2011, through December 31, 2011. All other rates are derived from the hybrid methodology in which both administrative data and medical record review data are used.

Table 4-2—2010/2011 Performance Measure Results—Children's Health

[5] CY 2011 ALL Population rates for the *Appropriate Testing for Children with Pharyngitis* and *Appropriate Treatment for Children With Upper Respiratory Infection* measures were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. All other rates are derived from the hybrid methodology in which both administrative data and medical record review data are used.

[6] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

-- Measures are new for CY 2011; therefore, rates are not available for CY 2010.

↑Indicates a statistically significant increase between the 2010 and 2011 weighted average rates.

↓Indicates a statistically significant decrease between the 2010 and 2011 weighted average rates.

NR—Not Reportable

Table 4-3—2010/2011 Performance Measure Results—Women's Health						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 ALL Population Rate[5]	CY 2011 Performance Target[6]
Prevention and Screening						
Cervical Cancer Screening	71.4%	69.4%	69.4%	34.8%	51.1%	78.9%
Breast Cancer Screening	52.7%	55.4%	54.5%	37.0%	38.3%	59.6%
Chlamydia Screening—Ages 16–20 Years	45.1%	48.6%↑	42.7%	42.4%	45.4%	
Chlamydia Screening—Ages 21–24 Years	62.8%	66.3%↑	60.2%	39.3%	58.4%	
Chlamydia Screening—Total	49.4%	52.9%↑	47.1%	41.2%	49.5%	55.7%
Prenatal Care and Birth Outcomes						
Timeliness of Prenatal Care	85.7%	84.5%[7]	84.5%[7]	63.7%	52.3%	90.0%
Postpartum Care	63.2%	63.3%[7]	63.3%[7]	45.5%	55.0%	70.3%
Cesarean Delivery Rates (AHRQ measure)*	31.6%	32.1%	30.4%	26.0%	29.4%	31.0%
Rate of Infants With Low Birth Weight (AHRQ measure)*	7.6%	7.3%	8.4%	8.8%	8.5%	6.9%
Frequency of Ongoing Prenatal Care						
< 21 Percent*	12.4%	14.4%	14.4%	18.5%	20.2%	
21–40 Percent	4.6%	4.4%	4.4%	17.3%	10.7%	
41–60 Percent	5.2%	6.5%	6.5%	14.6%	7.8%	
61–80 Percent	11.9%	12.1%	12.1%	17.3%	10.5%	
81+ Percent	65.8%	62.6%	62.6%	32.4%	50.9%	73.7%

[1] CY 2010 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2010, through December 31, 2010.

[2] CY 2011 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011. Statistically significant changes between 2010 and 2011 rates are displayed where applicable.

[3] CY 2011 Georgia Families rates for the *Breast Cancer Screening, Chlamydia Screening, Cesarean Delivery Rates,* and *Rate of Infants With Low Birth Weight* measures were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. All other rates were hybrid measures and were calculated by HSAG using CMO-submitted IDSS files. These rates included members who transitioned between CMOs during the measurement period.

[4] CY 2011 FFS rates for the *Breast Cancer Screening, Chlamydia Screening, Cesarean Delivery Rates,* and *Rate of Infants With Low Birth Weight* measures reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2011, through December 31, 2011. All other rates are derived from the hybrid methodology in which both administrative data and medical record review data are used.

[5] CY 2011 ALL Population rates for the *Breast Cancer Screening, Chlamydia Screening, Cesarean Delivery Rates*, and *Rate of Infants With Low Birth Weight* measures were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. All other rates are derived from the hybrid methodology in which both administrative data and medical record review data are used.

[6] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

[7] Rates were calculated based on one or more plans reporting the rates as a rotated measure.

↑Indicates a statistically significant increase between the 2010 and 2011 weighted average rates.

↓Indicates a statistically significant decrease between the 2010 and 2011 weighted average rates.

* A lower rate indicates better performance.

Table 4-4—2010/2011 Performance Measure Results—Chronic Conditions						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 ALL Population Rate[5]	CY 2011 Performance Target[6]
Diabetes						
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	79.7%	79.4%	79.4%	61.9%	60.9%	86.4%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	54.2%	52.3%	52.3%	62.8%	67.9%	43.2%
HbA1c Control (<8.0)	37.6%	41.0%	41.0%	31.0%	27.0%	46.6%
HbA1c Control (<7.0)	28.3%	31.4%	31.4%	20.3%	18.0%	35.5%
Eye Exam (retinal) Performed	47.1%	46.6%	46.6%	42.7%	41.2%	54.0%
LDL-C Screening	71.3%	70.3%	70.3%	59.1%	53.5%	75.4%
LCL-C Control (<100 mg/dL)	24.3%	26.1%	26.1%	25.9%	19.9%	33.6%
Medical Attention for Nephropathy	71.0%	71.8%	71.8%	69.2%	66.2%	77.7%
Blood Pressure Control (<140/80 mm/Hg)	31.1%	31.9%	31.9%	31.9%	18.6%	32.5%
Blood Pressure Control (<140/90 mm/Hg)	53.4%	54.8%	54.8%	42.5%	27.2%	61.6%
Diabetes Admission Rate						
Diabetes Short-Term Complications Admission Rate (per 100,000)	19.5	--	99.6	212.0	213.5	61.7
Respiratory Conditions						
Use of Appropriate Medications for People With Asthma						
Ages 5–11 Years	92.0%	92.1%	91.5%	93.0%	91.4%	
Ages 12–18 Years	--	89.9%	89.3%	90.4%	89.2%	
Ages 19–50 Years	--	71.9%	72.2%	72.5%	72.3%	
Ages 51–64 Years	--	80.0%	77.6%	66.9%	67.6%	
Total[6]	90.7%	90.5%	90.0%	82.9%	88.0%	92.8%
Members With ER/Urgent Care Office Visits for Asthma in the Past Six Months						
Members With ER/Urgent Care Office Visits for Asthma in the Past Six Months	1.5%	--	Not reported by HP	Not reported by HP	Not reported by HP	
Asthma Admission Rate						
Asthma Admission Rate (per 100,000)	100.3	--	90.3	85.4	120.0	59.8
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit						
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit	--	10.6%	11.3%	13.9%	11.9%	
Pharmacotherapy Management of COPD Exacerbation						
Systemic Corticosteroid	--	67.0%	68.3%	33.6%	34.7%	
Bronchodilator	--	84.0%	83.6%	48.4%	49.4%	

Table 4-4—2010/2011 Performance Measure Results—Chronic Conditions						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 ALL Population Rate[5]	CY 2011 Performance Target[6]
Cardiovascular Conditions						
Controlling High Blood Pressure						
Controlling High Blood Pressure	--	47.0%[7]	47.0%[7]	NR	NR	
Persistence of Beta-Blocker Treatment After a Heart Attack						
Persistence of Beta-Blocker Treatment After a Heart Attack	--	68.8%[8]	86.5%	NR	NR	

[1] CY 2010 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2010, through December 31, 2010.

[2] CY 2011 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011. Statistically significant changes between 2010 and 2011 rates are displayed where applicable.

[3] CY 2011 Georgia Families rates for the *Diabetes Short-Term Complications Admission Rate* and *Persistence of Beta-Blocker Treatment After a Heart Attack* measures, and all measures under Respiratory Conditions (except for the *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit* measure) were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. All other rates were hybrid measures and were calculated by HSAG using CMO-submitted IDSS files. These rates included members who transitioned between CMOs during the measurement period.

[4] CY 2011 FFS rate for the *Diabetes Short-Term Complications Admission Rate* measure, all measures under Respiratory Conditions, and all measures under Cardiovascular Conditions reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2011, through December 31, 2011. All other rates are derived from the hybrid methodology in which both administrative data and medical record review data are used.

[5] CY 2011 ALL Population rate for the *Diabetes Short-Term Complications Admission Rate* measure were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. All other rates are derived from the hybrid methodology in which both administrative data and medical record review data are used.

[6] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

[7] Rates were calculated based on one or more plans reporting the rates as a rotated measure.

[8] All three CMOs reported NA; however, when the statewide average was calculated, the sum of each CMO's denominators was greater than 30. Therefore, the rate is reportable and not designated as NA.

-- Rates are not available.

↑ Indicates a statistically significant increase between the 2010 and 2011 weighted average rates.

↓ Indicates a statistically significant decrease between the 2010 and 2011 weighted average rates.

NR—Not Reportable

Table 4-5—2010/2011 Performance Measure Results—Behavioral Health						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 All Population Rate[5]	CY 2011 Performance Target[6]
Follow-Up Care for Children Prescribed ADHD Medication						
Initiation Phase	42.2%	41.7%	36.3%	33.4%	35.8%	48.1%
Continuation and Maintenance Phase	54.0%	56.2%	49.9%	41.7%	47.7%	57.6%
Follow-Up After Hospitalization for Mental Illness						
Follow-Up Within 7 Days	51.5%	53.3%	45.9%	37.1%	40.5%	64.3%
Follow-Up Within 30 Days	72.7%	73.9%	67.6%	59.1%	62.3%	83.6%
Antidepressant Medication Management						
Effective Acute Phase Treatment	--	46.2%	48.7%	56.4%	54.5%	
Effective Continuation Phase Treatment	--	30.9%	30.0%	42.1%	37.5%	
Initiation and Engagement of AOD Dependence Treatment						
Initiation	--	37.1%	43.8%	50.9%	48.8%	
Engagement	--	9.6%	8.5%	6.2%	7.1%	

[1] CY 2010 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2010, through December 31, 2010.
[2] CY 2011 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011. Statistically significant changes between 2010 and 2011 rates are displayed where applicable.
[3] CY 2011 Georgia Families rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These rates included members who transitioned between CMOs during the measurement period.
[4] CY 2011 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2011, through December 31, 2011.
[5] CY 2011 ALL population rates reflect data for members in the GF populations, FFS populations, and members that transferred between GF and FFS during the measurement year, which is January 1, 2011, through December 31, 2011.
[6] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

Table 4-6—2010/2011 Performance Measure Results—Medication Management						
	CY 2010 CMO Rate[1]	CY 2011 CMO Rate[2]	CY 2011 Georgia Families Rate[3]	CY 2011 FFS Rate[4]	CY 2011 All Population Rate[5]	CY 2011 Performance Target[6]
Annual Monitoring for Patients on Persistent Medication						
Total	--	85.9%	85.0%	84.6%	84.7%	

[1] CY 2010 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2010, through December 31, 2010.
[2] CY 2011 CMO rates reflect the weighted averages from the three CMOs' reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011. Statistically significant changes between 2010 and 2011 rates are displayed where applicable.
[3] CY 2011 Georgia Families rates were calculated by HP using CMO-submitted administrative data pulled from the GA MMIS. These rates included members who transitioned between CMOs during the measurement period.
[4] CY 2011 FFS rates reflect FFS claims data submitted to DCH for the measurement year, which is January 1, 2011, through December 31, 2011.
[5] CY 2011 ALL population rates reflect data for members in the GF populations, FFS populations, and members that transferred between GF and FFS during the measurement year, which is January 1, 2011, through December 31, 2011.
[6] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

-- Measures are new for CY 2011; therefore, rates are not available for CY 2010.

CMO Weighted Average Performance Measure Result Findings

Three of the CMOs' CY 2011 performance targets were met, including the targets for *Oral Health (Annual Dental Visit Rate)—All Members (Ages 2–21 Years)*, and *Immunization and Screening—Immunizations for Adolescents—Combination 1 Total*. Although the performance targets were not met for the remaining measures, there was a statistically significant increase in performance from CY 2010 to CY 2011 in the following areas:

- *Children's and Adolescents' Access to Primary Care Providers*
  - *Ages 12–24 Months*
- *Oral Health (Annual Dental Visit Rate)*
  - *Ages 2–3 Years*
  - *Ages 4–6 Years*
  - *Ages 7–10 Years*
  - *Ages 11–14 Years*
  - *Ages 15–18 Years*
  - *All Members (Ages 2–21 Years)*
- *Immunization and Screening*
  - *Childhood Immunization Status—Combination 3*
  - *Appropriate Testing for Children with Pharyngitis*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *Body Mass Index (BMI) Percentile*
  - *Counseling for Physical Activity*
- *Prevention and Screening*
  - *Chlamydia Screening—Ages 16–20 Years*
  - *Chlamydia Screening—Ages 21–24 Years*
  - *Chlamydia Screening—Total*

CMO Comparison Key Findings

HSAG assessed CMO-specific rates for all CY 2011 required performance measures in the areas of access, children's health, women's health, chronic conditions, behavioral health, and medication management.

Access to Care

Table 4-7 displays CMO plan-specific results for access measures. Access to care measures focus on access to primary care providers for children and adolescents, access to preventive/ambulatory health services for adults, and annual dental care visits for people aged 2–21 years.

Table 4-7—Access Domain Measures, CMO Comparison				
	AMERIGROUP	Peach State Health Plan	WellCare	CY 2011 Performance Target[2]
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Children's and Adolescents' Access to Primary Care Providers				
Ages 12–24 Months	97.4%	95.7%	97.0%	
Ages 25 Months–6 Years	91.2%	90.5%	91.3%	
Ages 7–11 Years	92.5%	90.3%	91.5%	
Ages 12–19 Years	89.8%	87.2%	88.7%	91.8%
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	84.3%	84.8%	86.0%	88.5%
Ages 45–64 Years	88.9%	88.6%	90.3%	
Oral Health (Annual Dental Visit Rate)				
Ages 2–3 Years	47.7%	43.9%	50.0%	
Ages 4–6 Years	76.8%	75.6%	77.5%	
Ages 7–10 Years	79.6%	78.6%	80.2%	
Ages 11–14 Years	72.1%	70.5%	73.0%	
Ages 15–18 Years	61.1%	58.9%	62.0%	
Ages 19–21 Years	37.6%	39.2%	41.7%	
Total	69.7%	67.5%	70.5%	64.1%

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

AMERIGROUP outperformed the other two CMOs in the *Children's and Adolescents' Access to Primary Care Providers* measure category, and Peach State ranked last in all four of the categories. None of the CMOs were able to meet the performance target of 91.8 percent for *Ages 12–19 Years.*

WellCare outperformed the other CMOs in the *Adults' Access to Preventive/Ambulatory Health Services* measure, although it was not able to achieve the CY 2011 performance target. There was virtually no difference between the performance of AMERIGROUP and Peach State regarding this measure.

WellCare outperformed the other CMOs in the *Oral Health (Annual Dental Visit Rate)* measure. However, all three CMOs exceeded the CY 2011 performance target of 64.1 percent for the total rate. AMERIGROUP's total rate was 69.7 percent, 5.6 percentage points greater than the target. Peach State's total rate was 67.5 percent, 3.4 percentage points above the target; and WellCare's total rate was 70.5 percent, 6.4 percentage points above the target rate.

Findings in the area of access suggest that the CMOs have an adequate number of providers for Georgia Families members to access preventive care and dental visits; however, as noted in the compliance section, the geographical access requirements are not being met. The CMOs should

ensure that members have the necessary access to providers based on the physical locations of both the members and providers. Findings also suggest that opportunities exist for the development of effective strategies to increase performance for *Children's and Adolescents' Access to Primary Care Providers—Ages 12–19 Years* and *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* since none of the CMOs met the CY 2011 target for these measures. Considering that the *Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years* measure is also the topic of an ongoing PIP, the CMOs should be evaluating their interventions and making the necessary adjustments to ensure that this measure meets DCH's performance target. HSAG's review of the PIP interventions for this measure showed that many of the CMOs' interventions implemented, such as improved provider coding, were not relevant for this measure since this measure simply determines whether an adult has accessed care in an outpatient setting. This suggests a greater need for improved barrier analysis, understanding of the measure, and implementation of interventions that are likely to produce improved rates.

Children's Health

Table 4-8 displays CMO plan-specific results for the children's health measures. The children's health measures focus on well-child/well-care visits, immunization and screening, weight assessment and counseling for nutrition and physical activity for children/adolescents, appropriate treatment for children with upper respiratory and ear infections, and HbA1c testing for children/adolescents with diabetes.

Table 4-8—Children's Health Domain Measures, CMO Comparison				2011 Performance Target[2]
	AMERIGROUP	Peach State Health Plan	WellCare	
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Well-Child/Well-Care Visits				
First 15 Months of Life: Six or More Visits	63.6%	50.5%	61.3%	69.7%
Third, Fourth, Fifth, and Sixth Years of Life	73.6%	67.4%	66.2%	71.8%
Adolescent Well Care	43.9%	38.5%	41.4%	46.8%
Immunization and Screening				
Childhood Immunization Status—Combination 3	80.0%	76.6%	81.0%	82.0%
Childhood Immunization Status—Combination 10	10.4%	17.6%	20.2%	
Lead Screening in Children	76.7%	70.8%	77.6%	81.0%
Appropriate Testing for Children with Pharyngitis	76.5%	68.8%	71.4%	73.5%
Immunizations for Adolescents—Combination 1 Total	67.6%	70.8%	70.1%	65.9%

Table 4-8—Children's Health Domain Measures, CMO Comparison				
	AMERIGROUP	Peach State Health Plan	WellCare	2011 Performance Target[2]
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile (Total)	33.3%	22.7%	56.9%	45.2%
Counseling for Nutrition (Total)	58.3%	40.7%	50.4%	57.7%
Counseling for Physical Activity (Total)	44.9%	29.4%	37.0%	45.5%
Upper Respiratory Infection (URI)				
Appropriate Treatment for Children With URI	79.2%	77.8%	77.0%	
Otitis Media with Effusion				
Otitis Media with Effusion	NR	NR	NR	
Annual Pediatric Hemoglobin				
Annual Pediatric Hemoglobin	75.6%	82.0%	74.7%	

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.
NR—Not Reportable

In the children's health domain, DCH selected ten CY 2011 performance targets compared to eight in CY 2010. Only one target was achieved in CY 2010, but in CY 2011 seven rates reported by the CMOs reached their respective targets. Of the sixteen rates under the *Children's Health* domain, AMERIGROUP performed best on seven of the rates, WellCare performed best on five rates, and Peach State performed best on four.

In the Well-Child/Well-Care Visits category, AMERIGROUP exceeded the performance target for the *Third, Fourth, Fifth, and Sixth Years of Life* measure, while in the *Immunization and Screening* category, both Peach State and WellCare had strong performance. AMERIGROUP was able to surpass the performance target for *Appropriate Testing for Children with Pharyngitis* by three percentage points with a rate of 76.5 percent. All three CMOs exceeded the performance target for *Immunizations for Adolescents—Combination 1 Total.* While *Well-Child Visits in the First 15 Months of Life*, *Childhood Immunization Status—Combination 3*, and *Lead Screening in Children* were also ongoing PIPs, the CMOs have not implemented effective interventions to improve performance enough to meet DCH's targets for these measures.

AMERIGROUP outperformed the other CMOs in the *Counseling for Nutrition* and *Counseling for Physical Activity* measures; however, only 33.3 percent of the eligible children had a BMI percentile documented in their medical chart. WellCare did surpass the performance target for *BMI Percentile (Total)* by an impressive 11.7 percentage points; however, it did not meet the targets for nutrition and physical activity counseling for its members. AMERIGROUP exceeded the performance target for *Counseling for Nutrition (Total)* by 0.6 percentage points.

The other measure categories, *Upper Respiratory Infection (URI)*, *Otitis Media with Effusion*, and *Annual Pediatric Hemoglobin* did not have established performance targets in CY 2011 because these were newly reported measures and a baseline needed to be established. The CMOs performed similarly on *Appropriate Treatment for Children With URI*. For *Otitis Media with Effusion*, the rates were not valid for reporting, and Peach State outperformed the other CMOs on the *Annual Pediatric Hemoglobin* measure.

In the Immunization and Screening category, AMERGROUP exceeded the target rate for the *Appropriate Testing for Children with Pharyngitis* measure; and all three CMO rates were above the performance target for *Immunizations for Adolescents—Combination 1 Total*. This suggests that the CMOs should continue to encourage parents in the accomplishment of and the need for both the Combo 3 and the Combo 10 series immunizations and the need for the screening for lead in children.

Findings in the area of children's health demonstrate that with the exception of AMERIGROUP's performance rate for the *Third, Fourth, Fifth, and Sixth Years of Life* measure, the CMOs' performance rates were well below the DCH target rates. The CMOs should increase educational opportunities that concentrate on children obtaining these necessary services. Additionally, the CMOs need to better partner with their providers, a deficiency discovered during the rapid cycle improvement project process. Providers should be supplied with the clinical guidelines and educated on the performance measure requirements. The CMOs should also supply providers with timely lists of members who have not received the necessary services.

Women's Health

Table 4-9 displays CMO plan-specific results for the women's health measures. Women's health measures focus on prevention and screening, prenatal care and birth outcomes, and frequency of ongoing prenatal care.

Table 4-9—Women's Health Domain Measures, CMO Comparison

Measure	AMERIGROUP CY 2011 Rate[1]	Peach State Health Plan CY 2011 Rate[1]	WellCare CY 2011 Rate[1]	2011 Performance Target[2]
Prevention and Screening				
Cervical Cancer Screening	74.1%	70.0%	66.9%	78.9%
Breast Cancer Screening	55.9%	52.9%	56.4%	59.6%
Chlamydia Screening—Ages 16–20 Years	49.5%	55.6%	44.4%	
Chlamydia Screening—Ages 21–24 Years	64.8%	72.3%	63.0%	
Chlamydia Screening—Total	52.8%	60.2%	48.9%	55.7%

Table 4-9—Women's Health Domain Measures, CMO Comparison				
Measure	AMERIGROUP CY 2011 Rate[1]	Peach State Health Plan CY 2011 Rate[1]	WellCare CY 2011 Rate[1]	2011 Performance Target[2]
Prenatal Care and Birth Outcomes				
Timeliness of Prenatal Care	90.5%[3]	85.8%	80.5%	90.0%
Postpartum Care	65.7%[3]	61.7%	63.0%	70.3%
Cesarean Delivery Rate (Rate per 100) *A lower rate indicates better performance*	33.6	31.9	31.2	31.0
Rate of Infants With Low Birth Weight (Rate per 100) *A lower rate indicates better performance*	7.0	7.0	7.7	6.9
Frequency of Ongoing Prenatal Care				
< 21 Percent	7.9%[3]	7.9%	21.4%	
21–40 Percent	3.0%[3]	3.9%	5.4%	
41–60 Percent	6.1%[3]	5.1%	7.5%	
61–80 Percent	10.7%[3]	12.5%	12.7%	
81+ Percent	72.3%[3]	70.5%	53.0%	73.7%

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.
[3] Plan chose to rotate the measure.

None of the CMOs were able to reach the performance targets for *Cervical Cancer Screening* and *Breast Cancer Screening*. Peach State was the only CMO to meet and exceed the 2011 performance target of 55.7 percent for the *Chlamydia Screening—Total* measure, although the aggregate rate for the CMOs demonstrated statistically significant improvement over the prior year. The CMOs should ensure that the clinical guidelines and measure requirements are shared with the providers. Additionally, the CMOs should supply providers with lists of members who are not receiving the necessary screenings.

Although the data included in this report suggest that AMERIGROUP performed the best of the three CMOs in the *Prenatal Care* measure category, AMERIGROUP rotated its prenatal, postpartum care, and frequency of ongoing prenatal care rate measures from CY 2010. Therefore, AMERIGROUP's true CY 2011 performance for these measures is not known. Because DCH does not allow for measure rotation, in subsequent years, the CMOs will receive a "Not Reportable" audit designation for any rotated measures. AMERIGROUP had the worst performance for Cesarean delivery rates. All three plans failed to meet the target for the Cesarean delivery rate and the *Rate of Infants with Low Birth Weight* measures. To facilitate timely postpartum visits, the CMOs should have a process in place to ensure that they are receiving timely notification of births.

In the *Frequency of Ongoing Prenatal Care* measure category, none of the CMOs performed above the target rate. Peach State had greater than 70 percent of total deliveries with mothers receiving at least 81 percent of the recommended prenatal care visits. AMERIGROUP's true CY 2011 performance is not known. WellCare only had 53 percent of its eligible population achieve the target of 81 percent or greater of expected prenatal visits.

Chronic Conditions

Table 4-10 displays CMO plan-specific results for the chronic conditions domain measures.

Table 4-10—Physical Health Conditions: Chronic Conditions Domain Measures, CMO Comparison				
	AMERIGROUP	Peach State Health Plan	WellCare	CY 2011 Performance Target[2]
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Diabetes				
Comprehensive Diabetes Care				
HbA1c Testing	79.8%	77.4%	80.3%	86.4%
HbA1c Poor Control (>9.0) *A lower rate indicates better performance*	51.2%	54.5%	51.6%	43.2%
HbA1c Good Control <8.0	41.8%	37.4%	42.5%	46.6%
HbA1c Good Control <7.0	32.1%	28.8%	32.3%	35.5%
Eye Exam	43.2%	53.7%	44.5%	54.0%
LDL-C Screening	72.6%	65.5%	71.7%	75.4%
LDL-C Level	26.4%	27.5%	25.2%	33.6%
Medical Attention for Nephropathy	72.4%	71.1%	71.9%	77.7%
Blood Pressure Control < 140/80	32.2%	36.1%	29.6%	32.5%
Blood Pressure Control < 140/90	58.2%	58.0%	51.6%	61.6%
Respiratory Conditions				
Use of Appropriate Medications for People With Asthma				
5–11 Years	92.4%	91.3%	92.4%	
12–18 Years	90.5%	90.6%	89.1%	
19–50 Years	63.8%	73.6%	74.9%	
51–64 Years	NA	NA	80.6%	
Total	90.7%	90.4%	90.6%	92.8%

Table 4-10—Physical Health Conditions: Chronic Conditions Domain Measures, CMO Comparison				
	AMERIGROUP	Peach State Health Plan	WellCare	CY 2011 Performance Target[2]
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Percent of Members Who Have Had a Visit to an Emergency Department/Urgent Care Office for Asthma in the Past Six Months				
Percent of Members Who Have Had a Visit to an Emergency Department/Urgent Care Office for Asthma in the Past Six Months *A lower rate indicates better performance*	NR	NR	NR	
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit				
Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit *A lower rate indicates better performance*	11.9%	11.8%	9.3%	
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	73.8%	69.6%	63.2%	
Bronchodilator	88.1%	87.0%	81.1%	
Cardiovascular Conditions				
Controlling High Blood Pressure				
Controlling High Blood Pressure	48.2%[3]	47.6%[3]	46.2%	

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.
[3] Plan chose to rotate the measure.
NA—The CMO was unable to report a rate for this measure since the denominator was too small to report a valid rate (a denominator of less than 30).
NR—Not Reportable

All the CMO CY 2011 rates were below the CY 2011 performance targets for the chronic conditions domain. Areas within this domain included Diabetes, Respiratory Conditions, and Cardiovascular Conditions. With all three areas not meeting the CY 2011 performance targets, the CMOs should evaluate the effectiveness of their case management and disease management programs. For these programs, the CMOs should have set goals and measureable outcomes. Significant improvement to these programs could translate to improvement across the chronic disease performance measures.

In the *Comprehensive Diabetes Care* measure category, the three CMOs performed similarly and none of them stood out for excellent performance. The CMOs performed best in the areas of HbA1c Testing and LDL-C Screening; however, the rates for diabetes control, which are better indicators of health status, were much poorer and suggest a greater need for the CMOs and their network providers to focus on improving actual health outcomes through active case and disease management.

Again, for the *Use of Appropriate Medications for People With Asthma* measure category, the CMOs performed similarly. Their total rates were all within 0.3 percentage points of each other and were all within 3 percentage points of the performance target of 92.8 percent. Members aged 19–50 presented the greatest opportunity for improvement across the CMOs. For the *Annual Percentage of Asthma Patients with One or More Asthma-Related Emergency Room Visit* measure, a lower number indicates better performance. WellCare had the best performance with a 9.3 percent rate, and the other two CMOs demonstrated higher ER visit rates with performance at just under 12 percent. For both *Pharmacotherapy Management of COPD Exacerbation* measures, *Systemic Corticosteroid* and *Bronchodilator,* AMERIGROUP outperformed the other two CMOs, followed by Peach State, then WellCare.

In the *Cardiovascular Conditions* measure category, the CMOs reported rates for the *Controlling High Blood Pressure* measure. AMERIGROUP earned the highest rate among its members with a rate of 48.2 percent followed by Peach State, then WellCare. The rates for this measure indicate that more than 50 percent of members with diagnosed hypertension had uncontrolled blood pressure, putting them at greater risk for heart attack and stroke. The CMOs have an important opportunity to align intervention strategies with national initiatives to increase the rates of blood pressure control. One national initiative, sponsored by the U.S. Department of Health and Human Services, is the Million Hearts initiative, which seeks to prevent one million heart attacks and strokes over a five-year period.[4-2]

Behavioral Health

Table 4-11 displays CMO plan-specific results for behavioral health measures.

Table 4-11—Behavioral Health Domain Measures, CMO Comparison

Measure	AMERIGROUP CY 2011 Rate[1]	Peach State Health Plan CY 2011 Rate[1]	WellCare CY 2011 Rate[1]	CY 2011 Performance Target[2]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	44.3%	43.7%	40.0%	48.1%
Continuation and Maintenance Phase	61.2%	57.4%	54.5%	57.6%
Follow-Up After Hospitalization for Mental Illness				
Follow-Up Within 7 Days	48.4%	51.3%	57.1%	64.3%
Follow-Up Within 30 Days	71.4%	74.6%	75.1%	83.6%

[4-2] Million Hearts: The Initiative. Overview. Available at: http://millionhearts.hhs.gov/index.html. Accessed on October 31, 2012.

Table 4-11—Behavioral Health Domain Measures, CMO Comparison				
	AMERIGROUP	Peach State Health Plan	WellCare	CY 2011 Performance Target[2]
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Antidepressant Medication Management				
Effective Acute Phase Treatment	47.1%	38.4%	49.1%	
Effective Continuation Phase Treatment	32.0%	23.4%	33.6%	
Initiation and Engagement of AOD Dependence Treatment				
Initiation	42.5%	34.6%	35.7%	
Engagement	11.7%	8.7%	9.0%	

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

Table 4-12—Medication Management Domain Measures, CMO Comparison				
	AMERIGROUP	Peach State Health Plan	WellCare	CY 2011 Performance Target[2]
Measure	CY 2011 Rate[1]	CY 2011 Rate[1]	CY 2011 Rate[1]	
Annual Monitoring for Patients on Persistent Medication				
Total	88.0%	83.8%	86.0%	

[1] CY 2011 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2011, through December 31, 2011.
[2] CY 2011 performance targets reflect the DCH-established CMO performance targets for 2011. Shaded boxes are displayed when no DCH CY 2011 performance target was established.

Overall, AMERIGROUP and WellCare performed similarly, and both outperformed Peach State in the behavioral health domain of care and the medication management domain of care as AMERIGROUP had the highest rate on five measures and WellCare had the highest rate for four measures. For the *Follow-Up Care for Children Prescribed ADHD Medication* measures, AMERIGROUP had the highest rates and finished above the target rate for the *Continuation and Maintenance Phase* measure, with a score of 61.2 percent, surpassing the performance target by 3.6 percentage points. For the *Follow-Up After Hospitalization for Mental Illness* category, WellCare outperformed the other two CMOs for both measures, *Follow-Up Within 7 Days* and *Follow-Up Within 30 Days*. WellCare also outperformed AMERIGROUP and Peach State for the subsequent category *Antidepressant Medication Management* and its two measures, *Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment.* AMERIGROUP performed better than the other CMOs on the *Annual Monitoring for Patients on Persistent Medication* measure. The CMOs should improve their continuity of care with better identification and monitoring of members. Additionally, the CMOs could apply the rapid cycle process to measures other than the *Follow-Up Care for Children Prescribed ADHD Medication* measure, applying effective improvement strategies from high-performing, high-volume providers to low-performing, high-volume providers.

Fee-For-Service and ALL Population Comparisons

In addition to comparing CMO weighted average performance to national benchmarks and targets, HSAG compared the CMOs' performance to the Medicaid FFS population and ALL population. While HSAG assessed the rates of the CMOs' weighted averages, comparisons with the FFS and ALL populations should be made with caution. CMO-reported data may reflect a more accurate assessment of care provided since the CMOs had the ability to incorporate supplemental data sources such as lab value data and immunization registries to increase data capture for some measures. While both the FFS and ALL populations used medical record review, incorporating supplemental data could have an increased advantage for identifying results not located in the medical record.

Performance measure results showed that the CMOs had better performance than the Medicaid FFS and ALL populations when comparing the overall CMO weighted averages to FFS and ALL data on nearly all measures; this was similar to CY 2010's results. The findings suggest that CMO members received higher quality care, had better access to services, and received more timely care than FFS members.

Utilization Measures

In addition to clinical performance measures, DCH required the CMOs to report utilization rates for inpatient, mental health, antibiotic, and outpatient drug utilization. This information can be helpful to the CMOs in reviewing patterns of suspected under- and overutilization of services. High or low rates of utilization do not necessarily indicate better or worse performance. Appendix B contains a table of utilization measures by CMO and an overall CMO weighted average rate for each measure. The CMOs should use these comparisons to further analyze utilization patterns for potential problem areas related to provider practice patterns, geographic accessibility, etc. Some utilization rates, such as maternity and inpatient discharges, do not indicate a need to evaluate performance; rather, they simply provide the CMOs and DCH with information on the CMOs' rates and allow them to be compared to national rates.

Health Plan Demographics

The CMOs reported health plan demographic information for *Race/Ethnicity of Membership*, *Language Diversity of Membership*, and *Weeks of Pregnancy at Time of Enrollment*. Appendix B contains the CMOs' rates for these measures.

The data showed that 39.5 percent of Georgia Medicaid managed care members were Black, 39.0 percent were White, 1.7 percent were Asian, 3.2 percent were Hispanic or Latino, and 18.5 percent were categorized as unknown. Ethnicity data were not captured completely, as 80.8 percent showed an unknown ethnicity. For Georgia Families members, 73.4 percent spoke English, approximately 7 percent were non-English speaking, and 20 percent were unknown.

The data also showed that 59.4 percent of Georgia Medicaid managed care members who were pregnant were enrolled in the program between 13 and 27 weeks of pregnancy. A contributing factor to this rate is the fact that Georgia Medicaid-eligible managed care members are first enrolled into FFS Medicaid and then must select a CMO. This selection process may take up to 60 days, thus

giving the appearance that some pregnant members are without health care coverage until their second trimester when in fact they are able to access prenatal care services as soon as they become eligible for Medicaid.

Health plan demographic information may be useful to DCH and the CMOs when considering targeted interventions to ensure that strategies are appropriate for the targeted populations and culturally and linguistically appropriate services are available to members.

Conclusions

Overall, HSAG found that all the CMOs were compliant with the required information system standards to report valid performance measure rates. The CMOs demonstrated the ability to process, receive, and enter medical and service data efficiently, accurately, timely, and completely. Overall, of the 40 CY 2011 performance targets, the CMOs performed best in these areas: *Oral Health (Annual Dental Visit Rate)—All Members (Ages 2–21 Years)*, and *Immunization and Screening—Immunizations for Adolescents—Combination 1 Total*.

When comparing measures with both CY 2010 and CY 2011 rates, the CMO weighted average rates showed statistically significant improvement in the following areas:

- *Children's and Adolescents' Access to Primary Care Providers*
  - *Ages 12–24 Months*
- *Oral Health (Annual Dental Visits)*
  - *Ages 2–3 Years*
  - *Ages 4–6 Years*
  - *Ages 7–10 Years*
  - *Ages 11–14 Years*
  - *Ages 15–18 Years*
  - *All Members (Ages 2–21 Years)*
- *Immunization and Screening*
  - *Childhood Immunization Status—Combination 3*
  - *Appropriate Testing for Children with Pharyngitis*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *Body Mass Index (BMI) Percentile*
  - *Counseling for Physical Activity*
- *Prevention and Screening*
  - *Chlamydia Screening—Ages 16–20 Years*
  - *Chlamydia Screening—Ages 21–24 Years*
  - *Chlamydia Screening—Total*

Many opportunities for improvement exist for the CMOs as a whole. The domains that have the greatest opportunity for improvement include the following: *Children's and Adolescents' Access to Primary Care Providers, Adults' Access to Preventive/Ambulatory Services, Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents, Prenatal Care and Birth Outcomes, Comprehensive Diabetes Care*, and *Follow-Up After Hospitalization for Mental Illness.* All of these domains had measures that did not reach the CY 2011 performance targets.

For the *Children's and Adolescents' Access to Primary Care Provider* measure category, the sub-measures *Ages 7–11 Years* and *Ages 12–19 Years* both experienced statistically significant declines in CY 2011, as did the *Appropriate Treatment for Children With Upper Respiratory Infection* measure. The CMOs will have an opportunity to reverse these statistically significant decreases in CY 2012.

The CMOs have an opportunity to improve on all of the measures that did not attain the CY 2011 performance target. Most notably, all of the components in the *Comprehensive Diabetes Care* measure fell below the performance targets; and the lowest-performing component was *HbA1c Poor Control (>9.0)* which was approximately 9 percentage points away from the target rate. The CMOs should also focus on lowering rates of Cesarean sections performed as the CMOs had rates that exceeded both FFS and the performance target.

Based on CY 2011 CMO performance, AMERIGROUP was the highest overall performing CMO, followed closely by WellCare, then Peach State. Table 4-13 shows the number of performance targets each CMO met for each domain.

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

Domains	AMERIGROUP	Peach State	WellCare
Access to Care	1	1	1
Children's Health	4	1	2
Women's Health	0	1	0
Chronic Conditions	0	0	0
Behavioral Health	1	0	0
Total	6	3	3

AMERIGROUP met six of the CY 2011 performance targets, while Peach State and WellCare each met three of the targets. AMERIGROUP showed the strongest performance in the children's health domain, and Peach State was the only CMO to meet any of the performance targets in the women's health domain.

Although WellCare made some improvements in performance between CY 2010 and CY 2011, it remains the CMO with the greatest opportunity for improvement since it did not meet any targets for three of the domains of care. All three CMOs have an opportunity for improvement in the domain of chronic conditions. All CMOs have the opportunity to make improvements related to meeting performance targets in all domains.

Recommendations

Based on the CY 2011 performance measure rates and validation of those rates, HSAG provides the following recommendations for improving the quality, timeliness of, and access to care and services for members:

- The DCH should continue to use medical record review methodology to capture FFS and ALL population rates for hybrid measures. This activity would allow for comparisons across the three populations as well as to compare year-over-year performance.
- The DCH may want to consider measures with low performance for the auto-assignment program as a mechanism to drive improvement.
- The DCH may consider retiring performance measures with improved CMO performance to allow the CMOs to focus on areas of low performance.
- The CMOs should evaluate their case management and disease management programs to assess these programs' effectiveness in improving care and make modifications to increase their impact on performance measure rates.
- The CMOs should ensure that clinical guidelines and performance measurement requirements are shared with providers.
- The CMOs should supply providers with lists of members who have not received the required services.
- AMERIGROUP needs to focus quality improvement efforts in the areas of diabetes care and prenatal and postpartum care. Peach State and WellCare need to focus quality improvement efforts in the areas of diabetes care and well-care visits. These efforts should include conducting a causal/barrier analysis; evaluating existing interventions; and developing new, targeted strategies that directly address the identified barriers.

5. Performance Improvement Projects

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

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

The CMOs each had nine DCH-selected PIP topic areas in progress during the review period. Seven topic areas were clinical areas of focus and included the following HEDIS measures:

- *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years of Age*
- *Annual Dental Visit*
- *Childhood Immunization*
- *Childhood Obesity*
- *Emergency Room Utilization*
- *Lead Screening in Children*
- *Well-Child Visits in the First 15 Months of Life—Six or More Visits*

In addition, two nonclinical PIP topics were selected by DCH for the CMOs in the areas of member satisfaction and provider satisfaction.

Validating PIPs is one of three federally mandated external quality review activities. The requirement allows states, agents that are not a managed care organization, or an EQRO to conduct the PIP validations. The DCH contracted with HSAG to conduct the functions associated with validation of PIPs.

Validation of Performance Improvement Projects

As noted in its Quality Strategic Plan Update (November 2011), DCH identified the improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance as one of its four performance-driven goals. The goals are designed to demonstrate success or identify challenges in achieving intended outcomes related to providing quality, accessible, and timely services. The June 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).*

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

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

To ensure that the CMOs achieve improvement in the study outcomes for all PIPs submitted for validation, HSAG worked with DCH in SFY 2012 to modify the existing PIP validation scoring methodology. This scoring methodology was implemented during the SFY 2012 validation. In Activity VIII (sufficient data analysis and interpretation), the CMOs must present study results that are accurate, clear and easily understood. Sufficient data analysis and interpretation is a critical element; therefore, if the study indicator results are not accurate, the PIP cannot receive an overall *Met* validation status. In Activity IX (real improvement achieved), the CMOs must achieve statistically significant improvement across all study indicator outcomes over the baseline rate. Real improvement achieved is a critical element for all PIPs that progress to this stage; therefore, any PIP that does not achieve statistically significant improvement will not receive an overall *Met* validation status. Statistically significant improvement is defined as improvement unlikely to have occurred due to chance. Based on industry standards, statistical significance is assessed at the 95 percent confidence level with a *p* value less than or equal to 0.05. For Activity X (sustained improvement achieved), HSAG assesses each study indicator for sustained improvement once 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 before the indicators can be assessed for sustained improvement. All study indicators must achieve statistically significant improvement and sustain this improvement to receive a *Met* score for Activity X.

Table 5-1 displays aggregate CMO validation results for all PIPs evaluated between June 2012 and August 2012. The CMOs submitted PIP data that reflected varying time periods, depending on the PIP topic. HSAG provided final, CMO-specific PIP validation reports to the CMOs and DCH in November 2012. This table illustrates the CMOs' overall understanding of the PIP process for the studies' Design, Implementation and Outcomes stages. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The percentage of applicable evaluation elements that received *Met* scores is included in the table. Appendix C, Tables C–2, C–5, and C–9 provide the CMO-specific validation scores.

Table 5-1—SFY 2012 Performance Improvement Projects' Validation Results for Georgia Families (N=27 PIPs)		
Study Stage	**Activity**	**Percentage of Applicable Elements Scored *Met***
Design	I. Appropriate Study Topic(s)	99% 149/150
	II. Clearly Defined, Answerable Study Question(s)	100% 54/54
	III. Clearly Defined Study Indicator(s)	100% 162/162
	IV. Correctly Identified Study Population	97% 75/77
Design Total		**99% 440/443**
Implementation	V. Valid Sampling Techniques (if sampling was used)	100% 108/108
	VI. Accurate/Complete Data Collection	100% 214/214
	VII. Appropriate Improvement Strategies	70% 73/104
Implementation Total		**93% 395/426**
Outcomes	VIII. Sufficient Data Analysis and Interpretation	93% 217/234
	IX. Real Improvement Achieved	76% 82/108
	X. Sustained Improvement Achieved	93% 14/15
Outcomes Total		**88% 313/357**
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**94% 1148/1226**

Findings

Performance Improvement Project Validation Key Findings

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

The Implementation stage results demonstrated that the CMOs accurately documented and executed the application of the study design and accurately performed sampling techniques and data collection. The CMOs encountered some challenges in developing improvement strategies to produce statistically significant improvement across all study indicators for all PIPs. Additionally, not all CMOs had processes in place to evaluate the efficacy of each intervention, nor did they have processes in place to address each barrier identified through causal/barrier analysis.

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

CMO Comparison Key Findings

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

Table 5-2—SFY 2012 Performance Improvement Project Validation Results Comparison by CMO (N=27 PIPs)

Study Stage	Activities	Percentage of Applicable Elements Scored *Met*		
		AMERIGROUP	Peach State	WellCare
Design	Activities I–IV	100% 147/147	100% 147/147	98% 146/149
Implementation	Activities V–VII	96% 136/142	86% 123/143	96% 136/141
Outcomes	Activities VIII–X	90% 107/119	88% 106/120	85% 100/118
Overall Percentage of Applicable Evaluation Elements Scored *Met*		**96% 390/408**	**92% 376/410**	**94% 382/408**

All three CMOs met 98 to 100 percent of the requirements across all nine PIPs for all four activities within the Design stage. WellCare did not include plan-specific data in its *Childhood Obesity* PIP, which reduced its score in this stage. Overall, the CMOs 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 the CMOs' improvement strategies. The solid design of the PIPs allowed the successful progression to the next stage of the PIP process.

Two CMOs met 96 percent of the requirements in the Implementation stage, while one achieved a lower score of 86 percent. An opportunity exists across all three CMOs to improve the linkage between barriers and interventions. In addition, each plan needs to revisit its causal/barrier analysis at least annually or more frequently and update interventions based on the results. With the appropriate causal/barrier analysis performed and the successful implementation of corresponding improvement strategies, the CMOs should be able to achieve and sustain improved outcomes across all study indicators.

Peach State and WellCare scored the lowest in the Outcomes stage. This can be attributed to several factors. Not all of the study indicators demonstrated statistically significant improvement over baseline, and the CMOs reported inaccurate data information in their PIPs. All three CMOs reported either inaccurate data, inaccurate interpretations of results, or inaccurate statistical testing outcomes. These inaccuracies affect the scores in this study stage. Although the CMOs documented inaccurate numerators and denominators in their PIP Summary Forms, the CMOs correctly reported study indicator rates in their PIPs. This was validated by HSAG through a comparison of the reported PIP rates to the CMOs' audited performance measure rates submitted to NCQA.

Outcome Results

Adults' Access to Care

AMERIGROUP's *Adults' Access to Care* PIP did not achieve statistically significant improvement between Remeasurement 2 and Remeasurement 3 (one percentage point decrease). However, the CMO achieved statistically significant improvement for the percentage of adult members who accessed ambulatory or preventive care between baseline and Remeasurement 1. Despite the rate decreases in Remeasurement 2 and Remeasurement 3, the Remeasurement 3 rate was statistically significant above the baseline rate. For Peach State, the *Adults' Access to Care* PIP did not demonstrate any significant change from Remeasurement 2 to Remeasurement 3 for the percentage of adult members who accessed ambulatory or preventive care, with its rate increasing slightly to 84.8 percent from 84.3 percent.

WellCare's percentage of adult members who accessed ambulatory or preventive care during the measurement year increased to 86 percent, which was a non-statistically significant increase of 0.6 percentage points. Despite the non-statistically significant improvement at Remeasurement 3, the CMO achieved statistically significant improvement over the baseline rate at Remeasurement 1 and has sustained this improvement in Remeasurement 2 and Remeasurement 3.

Annual Dental Visits

Statistically significant improvement over the baseline rates was achieved for both study indicators in the AMERIGROUP *Annual Dental Visit* PIP. The rates also exceeded the CY 2011 DCH target rates. The DCH targets were based on national NCQA percentiles.

Peach State's rates increased in the most recent remeasurement period, and the increase was statistically significant. Both study indicators achieved real and sustained improvement over the baseline rate. In addition, the rate for Study Indicator 2 (members 2–21) exceeded the CY 2011 DCH target rate of 64.1 percent.

For WellCare, both study indicator rates demonstrated statistically significant improvement in the most recent measurement period. For members 2–3 years old (Study Indicator 1), the annual dental visit rate increased from 45.5 percent to 50.0 percent while the rate for the 2–21 year olds (Study Indicator 2) increased from 67.5 to 70.5 percent. The rate for the 2–21 year olds exceeded the CY 2011 DCH goal.

Childhood Immunizations

AMERIGROUP achieved statistically significant improvement over the baseline rate and sustained this improvement for its *Childhood Immunizations* PIP. The rate increased by 6.3 percentage points from 78.0 percent to 84.3 percent. This increase was statistically significant and was slightly below the DCH CY 2011 target.

Peach State demonstrated improvement that was statistically significant over the baseline rate, despite the non-significant decline at Remeasurement 3. However, the CY 2011 rate did not achieve the DCH target rate.

For WellCare, the rate increased by 9.3 percentage points from 75.9 percent to 85.2 percent in Remeasurement 3. This increase was statistically significant and was slightly below the CY 2011 DCH target.

Childhood Obesity

AMERIGROUP's *Childhood Obesity* PIP achieved statistically significant improvement over the baseline rate and sustained the improvement for two of its three study indicators. 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.

Peach State's outcomes for the *Childhood Obesity* PIP were below CY 2010 results for all three study indicators. In addition, none of the CY 2011 rates for these three PIPs achieved the CY 2011 DCH target rates.

For WellCare, this PIP achieved statistically significant improvement for one of the three study indicators. At Remeasurement 3, all three study indicator rates (BMI documentation [56.9 percent],

counseling for nutrition [50.4 percent], and counseling for physical activity [37.0 percent]) demonstrated improvement, with one of the three indicators (BMI documentation [56.9 percent]) demonstrating statistically significant improvement.

Emergency Room Utilization

All three CMOs demonstrated statistically significant improvement in this measure. AMERIGROUP's rate decreased from 58.1 per 1000 member months to 55.4 per 1000 member months.

For Peach State, the rate went from 54.7 per 1000 member months to 52.5 per 1000 member months; and for WellCare, the rate decreased from 61.7 visits per 1000 member months to 59.3 visits per 1000 member months.

Both AMERIGROUP's and Peach State's emergency room utilization visit rates were below (lower indicates better performance) the CY 2011 DCH target rate.

Lead Screening in Children

For AMERIGROUP's *Lead Screening in Children* PIP, the study indicator achieved statistically significant improvement at Remeasurement 3. However, the rate of 76.7 percent was below the CY 2011 DCH target of 81.0 percent.

Peach State's rate achieved statistically significant improvement over the baseline rate; however, the most recent measurement period rate of 70.8 percent was below the CY 2011 DCH target rate (81.0 percent).

WellCare's rate increased to 77.6 percent. This increase was not statistically significant and was below the CY 2011 DCH target of 81.0 percent. However, the study indicator has achieved statistically significant improvement over baseline and sustained the improvement.

Well-Child Visits

AMERIGROUP's *Well-Child Visits* rate demonstrated a non-statistically significant increase from 60.1 to 63.6 percent from Remeasurement 2 to Remeasurement 3. The study indicator has yet to meet the criteria of statistically significant improvement over baseline.

For Peach State, the *Well-Child Visits* rate achieved improvement for the first and second remeasurement periods; however, the study indicator demonstrated a decline at Remeasurement 3 with the rate falling below the baseline.

WellCare's *Well-Child Visits* rate of 61.3 is a non-statistically significant improvement over the baseline rate and remains below the DCH target of 69.7 percent.

Member Satisfaction

For AMERIGROUP, its *Member Satisfaction* PIP study indicators have yet to achieve statistically significant improvement over the baseline rates.

Peach State achieved non-statistically significant improvement for two of the four study indicator outcomes, while both study indicator outcomes for WellCare's *Member Satisfaction* PIP increased during the most recent measurement period. However, only one of the indicator's improvements was statistically significant.

Provider Satisfaction

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

Peach State demonstrated improvement in all of its study indicators; however, with provider satisfaction rates at 29–38 percent, an opportunity for improvement still exists.

The rates for two of the three WellCare study indicators decreased from the third to the fourth remeasurement. The decline in performance for one of these indicators was statistically significant. Only two of the three *Provider Satisfaction* study indicators have achieved statistically significant improvement over the baseline rate.

Table 5-3 and Table 5-4 display the study indicator outcomes for the CMOs' PIPs. For these HEDIS-based PIPs, each CMO used the same study indicator(s) which allowed HSAG to compare results across CMOs. Statistically significant changes between remeasurement periods are noted with an ↑* or ↓*. If the PIP achieved statistically significant improvement over the baseline rate, it was then assessed 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) for sustained improvement.

Table 5-3—HEDIS-Based Performance Improvement Project Outcomes (validated during SFY 2012) Comparison by CMO						
PIP Topic	AMERIGROUP		Peach State		WellCare	
	Remeasurement 3 Period 1/1/11–12/31/11	Sustained Improvement	Remeasurement 3 Period 1/1/11–12/31/11	Sustained Improvement	Remeasurement 3 Period 1/1/11–12/31/11	Sustained Improvement^
Adults' Access to Preventive/ Ambulatory Health Services—20–44 Years of Age	84.3%	Yes	84.8%	Yes	86.0%	Yes
Childhood Immunization Status—Combination 2	84.3%↑*	Yes	80.6%	Yes	85.2%↑*	NA
Lead Screening in Children	76.7%↑*	NA	70.8%	Yes	77.6%	Yes
Well-Child Visits in the First 15 Months of Life—Six or More Visits	63.6%	NA	50.5%	NA	61.3%	NA
PIP Topic	AMERIGROUP		Peach State		WellCare	
	Remeasurement 2 Period 1/1/11–12/31/11	Sustained Improvement	Remeasurement 2 Period 1/1/11–12/31/11	Sustained Improvement	Remeasurement 2 Period 1/1/11–12/31/11	Sustained Improvement^
Annual Dental Visit— 2–3 Years of Age	47.7%	Yes	43.9%↑*	Yes	50.0%↑*	Yes
Annual Dental Visit— 2–21 Years of Age	69.7%↑*	Yes	67.5%↑*	Yes	70.5%↑*	Yes
Childhood Obesity—BMI Documentation	33.3%	Yes	22.7%↓*	NA	56.9%↑*	NA
Childhood Obesity—Counseling for Nutrition	58.3%↑*	Yes	40.7%	NA	50.4%	NA
Childhood Obesity—Counseling for Physical Activity	44.9%↑*	NA	29.4%	NA	37.0%	NA
Emergency Room Utilization per 1,000 Member Months	55.4%↑*	Yes	52.5%↑*	Yes	59.3%↑*	Yes

Table 5-3—HEDIS-Based Performance Improvement Project Outcomes (validated during SFY 2012) Comparison by CMO

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

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

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

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

All three CMOs demonstrated statistically significant improvement and sustained this improvement for the *Adults' Access to Care*, *Annual Dental Visit* (both study indicators), and *Emergency Room Utilization* PIPs. Across all PIPs, AMERIGROUP demonstrated statistically significant improvement and sustained that improvement for 7 of the 10 study indicators, while Peach State and WellCare achieved this for 6 and 5 study indicators, respectively.

For the satisfaction-based PIPs, each CMO selected different study indicators; therefore, comparisons across the CMOs could not be made. The results are presented as the number of study indicators only instead of specific study indicator rates.

Table 5-4—SFY 2012 Satisfaction-Based Performance Improvement Project Outcomes Comparison by CMO

PIP Topic (Number of Study Indicators)	Comparison to Study Indicator Results From Prior Measurement Period			Sustained Improvement
	Statistically Significant Improvement	Non-Statistically Significant Change	Statistically Significant Decline	
AMERIGROUP				
Member Satisfaction (N=2)	0	2	0	NA
Provider Satisfaction (N=1)	0	1	0	NA
Peach State				
Member Satisfaction (N=4)	0	4	0	NA
Provider Satisfaction (N=4)	0	4	0	Yes
WellCare				
Member Satisfaction (N=2)	1	1	0	NA
Provider Satisfaction (N=3)	0	2	1	NA

With the new scoring methodology implemented, only Peach State's *Provider Satisfaction* PIP achieved statistically significant improvement over the baseline rates and sustained the improvement across all indicators.

Conclusions

PIP study indicator outcomes showed mixed results, with some indicators achieving statistically significant improvement and sustaining the improvement, while others demonstrated a decline in performance. A critical analysis of the interventions showed that all three CMOs have opportunities for improvement related to barrier analysis and improvement strategies. While each CMO performed a causal/barrier analysis and implemented interventions, not all interventions implemented were relevant to the identified barriers or appropriate for what the PIP was measuring. WellCare had the greatest challenge with achieving improved outcomes across all study indicators. HSAG noted that with the new scoring methodology, it is imperative for the CMOs to report accurate data. The reporting of inaccurate data (numerators and denominators) and inaccurate statistical testing outcomes affects the overall validation status. In addition, all study indicators must achieve statistically significant improvement over the baseline rate and sustain this improvement without a statistically significant decline for the CMOs to achieve an overall Met validation status.

HSAG's critical analysis of the CMOs' interventions and improvement strategies implemented for all PIPs validated revealed that opportunities for improvement exist for each of the CMOs. While an indicator's rate may have demonstrated improvement over the baseline rate, some rates have remained stagnant, while other rates remain below the State's goal or NCQA's 25th percentile. The CMOs need to improve the way they evaluate the efficacy of each of their interventions. Additionally, the CMOs should determine through data analysis if barriers once identified for a measure are still relevant to that measure and if the corresponding interventions are appropriate and are having the desired effect.

Recommendations

- The CMOs should carefully complete all necessary documentation and ensure that the data and statistical testing information reported in the PIPs are accurate. In addition, the study indicator rates reported in the PIPs should correspond with the performance measure rates submitted to NCQA.
- The CMOs should select interventions for system changes that increase the likelihood of achieving and sustaining improvement instead of one-time interventions.
- For any intervention implemented, the CMOs should have a process in place to evaluate the efficacy of the intervention to determine if it is having the desired effect. This evaluation process should be detailed in the PIP documentation. If the interventions are not having the desired effect, the CMOs should discuss how they will be addressing these deficiencies and what changes will be made to their improvement strategies.
- The CMOs should ensure that the interventions implemented for a specific barrier are truly relevant to that barrier.

- For study indicators that have not achieved statistically significant improvement or been assessed for sustained improvement, the CMOs should build upon strengths and lessons learned from the PIPs that have been successful.
- The CMOs should be cognizant of the timing of interventions. Interventions implemented late in the year will not have been in place long enough to impact the rates.
- For member and provider satisfaction study indicators that have not been assessed for statistically significant or sustained improvement, the CMOs should consider hosting focus group discussions (i.e., one focused on member satisfaction and one focused on provider satisfaction). These focus groups would enable the CMOs to interact with potential satisfaction survey participants and gain valuable input on the specific areas that cause dissatisfaction with services provided. Once areas of dissatisfaction are identified, the CMOs and respective providers should implement system changes to combat the areas of dissatisfaction that were identified.

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 CMOs addresses HSAG's:

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

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

Objective of Conducting the Review of Compliance With Standards

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

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

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

- Standard I—Provider Selection, Credentialing and Recredentialing
- Standard II—Subcontractual Relationships and Delegation
- Standard III—Member Rights and Protection
- Standard IV—Member Information
- Standard V—Grievance System
- Standard VI—Disenrollment Requirements and Limitations
- Standard VII—Coordination and Continuity of Care
- Follow-up on areas of partial compliance or non-compliance from the prior year's review

In addition to the standards listed above, HSAG conducted a case review of five case management files and five disease management files for members enrolled in the CMO's case management and disease management programs.

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

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

The SFY 2013 review was the second year of a new 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 a 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. The case management and disease management review tools used by the HSAG review team were based on the Case Management Society of America's principles and DCH's contract standards for the case management and disease management programs.

HSAG also followed the guidelines set forth in the February 11, 2003, CMS protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, for the following activities.

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the two day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate their preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMO's operations, identify areas needing clarification, and begin compiling information before the on-site review.

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

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents HSAG requested that the CMOs have available on-site.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

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

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written informational materials
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMOs' key staff members.

Table A-1 lists the major data sources HSAG used in determining the CMOs' performance in complying with requirements and the time period to which the data applied.

Table A-1—Description of the CMOs' Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 1, 2011–June 30, 2012
Information obtained through interviews	July 1, 2011—the last day of each CMO's on-site review
Information obtained from a review of a sample of the CMOs' records for file reviews	July 1, 2011–June 30, 2012

Data Aggregation and Analysis

HSAG used scores of *Met*, *Partially Met*, and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *Monitoring Medicaid Managed Care Organizations (MCOs) and Prepaid Inpatient Health Plans (PIHPs): A Protocol for Determining Compliance With Medicaid Managed Care Proposed Regulations* at 42 CFR Parts 400, 430, et al, dated February 11, 2003. 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.

Partially Met indicates partial compliance defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance defined as *either* of the following:

- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of Not Met or Partially Met would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the seven standards and an overall percentage-of-compliance score across the seven standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Partially Met* (value: 0.50 points), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

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

To draw conclusions about the quality and timeliness of, and access to, care and services the CMOs provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the CMOs' performance in complying with each of the requirements.

- Scores assigned to the CMOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the seven standards.
- The overall percentage-of-compliance score calculated across the seven standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Partially Met* or *Not Met*.

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

Appendix B. Methodology for Conducting Validation of Performance Measures

The following is a description of how HSAG conducted the validation of performance measures activity for DCH Georgia Families CMOs. It includes:

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

Objectives

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

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

HSAG began performance measure validation in February 2012 and completed validation in June 2012. The CMOs submitted performance measure data that reflected the period of January 1, 2011, through December 31, 2011. HSAG provided final performance measure validation reports to the CMOs and DCH in August 2012. HSAG began performance measure validation of HP in March 2012 and completed validation in June 2012. HSAG provided the final performance measure validation report to DCH in September 2012.

Technical Methods of Data Collection and Analysis

HSAG conducted the validation activities as outlined in the CMS publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities,* final protocol, Version 1.0, May 1, 2002. Pre-on-site activities and document review were conducted, followed by an on-site visit to each CMO and HP that included interviews with key staff and system demonstrations. Finally, post-review follow-up was conducted with each CMO and HP on any issues identified during the site visit. Information and documentation from these processes were used to assess the validity of the performance measures.

The CMS protocol identified key types of data that should be collected and reviewed as part of the validation process. The list below describes how HSAG collected and analyzed these data:

- A Record of Administration, Data Management and Processes (Roadmap) that was modified to address all components of the CMS protocol, source code for each performance measure (unless the source code was produced by NCQA-certified software), and any additional supporting documentation necessary to complete the audit was requested from each CMO as well as DCH and its subcontractor, HP. HSAG conducted a high-level review of each Roadmap to ensure that all sections were completed and all attachments were present. The validation team reviewed all

Roadmap documents, noting issues or items that needed further follow-up, and began completing the review tools, as applicable.

- *Source code (programming language) for performance indicators* was requested. Each CMO and HP submitted source code for measures that were not calculated using NCQA-certified software. HSAG completed line-by-line code review and observation of program logic flow to ensure compliance with performance measure definitions. Areas of deviation were identified and shared with the lead auditor to evaluate the impact of the deviation on the indicator and assess the degree of bias (if any).
- Supporting documentation included any documentation that provided 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, with issues or clarifications flagged for further follow-up.

The following table displays the data sources used in the validation of performance measures and the time period to which the data applied.

Table B-1—Description of Data Sources

Data Obtained	Time Period to Which the Data Applied
Roadmap (From the CMOs)	CY 2011
Source Code (Programming Language) for Performance Measures (From the CMOs and DCH)	CY 2011
Supporting Documentation (From the CMOs and DCH)	CY 2011
Current Performance Measure Results (From the CMOs and DCH)	CY 2011
On-site Interviews and Demonstrations (From the CMOs and DCH)	CY 2011

Table B-2—Utilization Domain Measures, CMO Comparison												
	AMERIGROUP			Peach State Health Plan			WellCare			Georgia Families		
Measure	Rate	CY 2011 Percentile Rank[1]	Symbol	Rate	CY 2011 Percentile Rank	Symbol	Rate	CY 2011 Percentile Rank	Symbol	Rate	CY 2011 Percentile Rank	Symbol
Inpatient Utilization—General Hospital/Acute Care												
Total Inpatient Discharges Per 1,000 Member Months	6.2	P10-P24	○	6.6	P25-P49	◑	6.4	P25	◑	NR	ND	ND
Total Inpatient Days Per 1,000 Member Months	20.3	P10-P24	○	21.5	P10-P24	○	20.2	P10-P24	○	17.5	<P10	○
Total Inpatient Average Length of Stay	3.3	P25-P49	◑	3.2	P25	◑	3.1	P10-P24	○	3.0	P10-P24	○
Medicine Discharges Per 1,000 Member Months	1.0	<P10	○	1.2	<P10	○	1.3	<P10	○	NR	ND	ND
Medicine Days Per 1,000 Member Months	3.9	<P10	○	4.4	P10	○	4.2	<P10	○	3.4	<P10	○
Medicine Average Length of Stay	3.9	P75-P89	●	3.6	P50-P74	◑	3.3	P25-P49	◑	3.2	P25	◑
Surgery Discharges Per 1,000 Member Months	0.5	<P10	○	0.5	<P10	○	0.6	<P10	○	NR	ND	ND
Surgery Days Per 1,000 Member Months	4.0	P10-P24	○	4.2	P10-P24	○	3.8	P10-P24	○	2.9	<P10	○
Surgery Average Length of Stay	8.2	>P90	●	7.8	>P90	●	6.0	P50-P74	◑	5.8	P50-P74	◑
Maternity Discharges Per 1,000 Member Months	10.0	P75-P89	●	10.8	>P90	●	10.0	P75-P89	●	NR	ND	ND
Maternity Days Per 1,000 Member Months	26.2	P75-P89	●	28.7	>P90	●	27.0	P75-P89	●	24.4	P75-P89	●
Maternity Average Length of Stay	2.6	P50	◑	2.7	P50-P74	◑	2.7	P50-P74	◑	2.6	P50	◑

[1] CY 2011 percentile rank was based on NCQA's 2010 Audit Means, Percentiles, and Ratios.

○ Below 25th Percentile ◑ 25th–74th Percentile ● 75th Percentile or Above

ND: Since the rate was not reported, the percentile rank and symbol could not be determined.

NR: The CMO did not report the rate.

Table B-2—Utilization Domain Measures, CMO Comparison												
	AMERIGROUP			Peach State Health Plan			WellCare			Georgia Families		
Measure	Rate	CY 2011 Percentile Rank[1]	Symbol	Rate	CY 2011 Percentile Rank	Symbol	Rate	CY 2011 Percentile Rank	Symbol	Rate	CY 2011 Percentile Rank	Symbol
Mental Health Utilization												
Any Services	7.7%	P25-P49	◑	7.7%	P25-P49	◑	8.3%	P25-P49	◑			
Inpatient	0.5%	P25-P49	◑	0.3%	P10-P24	○	0.3%	P10-P24	○			
Intensive Outpatient/Partial Hospitalization	0.1%	P50	◑	0.1%	P50	◑	1.6%	P90	●			
Outpatient/ED	7.6%	P25-P49	◑	7.7%	P25-P49	◑	7.9%	P25-P49	◑			
Antibiotic Utilization												
Average Scrips PMPY for Antibiotics	1.2	P50-P74	◑	1.2	P50-P74	◑	1.4	P90	●			
Average Days Supplied per Antibiotic Scrip	9.3	P50-P74	◑	8.9	P10-P24	○	9.2	P50	◑			
Average Scrips PMPY for Antibiotics of Concern	0.5	P50-P89	--	0.5	P50-P89	--	0.6	P90	●			
Percentage of Antibiotics of Concern of all Antibiotic Scrips	40.2%	P25-P49	◑	41.1%	P25-P49	◑	41.4%	P25-P49	◑			
Ambulatory Care Utilization												
Outpatient Visits Per 1,000 Member Months	343.6	P25-P49	◑	328.2	P25-P49	◑	350.8	P50-P74	◑			
ED Visits Per 1,000 Member Months	55.4	P10-P24	○	52.4	P10-P24	○	59.3	P25-P49	◑			

[1] CY 2011 percentile rank was based on NCQA's 2010 Audit Means, Percentiles, and Ratios.

○ Below 25th Percentile ◑ 25th–74th Percentile ● 75th Percentile or Above

-- Symbols were not assigned since percentile ranks were stretched to multiple ranges.

Table B-3—Health Plan Membership Information			
Health Plan and Membership Measure	**2011 CMO Rate[1]**	**CY 2011 Percentile Rank**	**Symbol**
Race Diversity of Membership			
White	39.0%	P25-P49	◑
Black/African American	39.5%	P75-P89	●
American-Indian and Alaska Native	0.1%	P25-P49	◑
Asian	1.7%	P50-P74	◑
Native Hawaiian and Other Pacific Islanders	0.0%	<P75††	--
Some Other Race	1.3%	P50-P74	◑
Two or More Races	0.0%	<P90†	--
Unknown Race	18.5%	P50-P74	◑
Hispanic/Latino (Total)	3.2%	**	**
Not Hispanic/Latino (Total)	15.9%	**	**
Unknown Ethnicity	80.8%	**	**
Language Diversity of Membership			
Spoken Language Preferred			
English	73.4%	P50-P74	◑
Non-English	6.6%	P50-P74	◑
Unknown	20.1%	P50-P74	◑
Language Preferred for Written Materials			
English	16.2%	P50-P74	◑
Non-English	2.0%	P50-P74	◑
Unknown	81.8%	P25-P50	◑
Weeks of Pregnancy at Time of Enrollment			
<0 Weeks	10.1%		
<1–12 Weeks	8.7%		
<13–27 Weeks	59.4%		
<28 or More Weeks	17.0%		
Unknown	4.6%		
Total	100.0%		

[1] CY 2011 percentile rank was based on NCQA's 2010 Audit Means, Percentiles, and Ratios.

○ Below 25th Percentile ◑ 25th–74th Percentile ● 75th Percentile or Above

-- Symbols were not assigned since percentile ranks were stretched to multiple ranges.

† 0.0% was reported for 10th, 25th, 50th, and 75th percentiles

†† 0.0% was reported for 10th, 25th, and 50th percentiles.

** Starting with HEDIS 2011, the rates associated with members' ethnicity was not based on the total number of members in the health plan. Therefore, the rates presented here were calculated by HSAG using the total number of members reported from each ethnicity column divided by the total number of members in the health plan reported in the CMO's IDS files. Please note that, due to reporting changes, HEDIS 2010 Medicaid benchmark associated with each ethnicity group was not available.

Appendix C. Methodology for Conducting Validation of Performance Improvement Projects

The following is a description of how HSAG conducted the validation of performance improvement projects (PIPs) for the Georgia Families CMOs. It includes:

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

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

Objective

The primary objective of PIP validation was to determine each CMO's compliance with requirements set forth in 42 CFR 438.240(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement 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 fifth year of validating CMO PIPs, HSAG conducted PIP validation on nine DCH-selected PIPs for each CMO. The topics were:

- *Adults' Access to Care*
- *Annual Dental Visit*
- *Childhood Immunization*
- *Childhood Obesity*
- *Emergency Room Utilization*
- *Lead Screening in Children*
- *Member Satisfaction*
- *Provider Satisfaction*
- *Well-Child Visits*

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on CMS guidelines as outlined in the CMS publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002. Using this

protocol, HSAG, in collaboration with DCH, developed a PIP Summary Form to ensure uniform validation of PIPs. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

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

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

Each required protocol activity consisted of evaluation elements necessary to complete a valid PIP. The HSAG PIP Review Team scored evaluation elements within each activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. To ensure a valid and reliable review, HSAG designated some of the elements as critical elements. All of the critical elements had to be *Met* for the PIP to produce valid and reliable results. Given the importance of critical elements to this scoring methodology, any critical element that received a *Not Met* score resulted in an overall validation rating for the PIP of *Not Met*. A CMO would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*.

HSAG included a *Point of Clarification* in its reports when documentation for an evaluation element included the basic components to meet requirements for the evaluation element, but enhanced documentation would demonstrate a stronger understanding of the CMS protocol.

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

HSAG assessed the implications of the study's findings on the validity and reliability of the results with one of the following three determinations of validation status:

- *Met*: High confidence/confidence in the reported PIP results.
- *Partially Met*: Low confidence in the reported PIP results.
- *Not Met*: Reported PIP results that were not credible.

Description of Data Obtained

To validate the PIPs, HSAG obtained and reviewed information from each CMO's PIP Summary Form. The CMOs were required to submit a PIP Summary Form for each DCH-selected topic for validation. The PIP Summary Forms contained detailed information about each PIP and the activities completed for the validation cycle. HSAG began PIP validation in June 2012 and completed validation in August 2012. The CMOs submitted PIP data that reflected varying time periods, depending on the PIP topic. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in November 2012.

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

Table C-1—Description of Data Sources

CMO	Data Obtained	Time Period to Which the Data Applied
AMERIGROUP Peach State WellCare	*Adults' Access to Care* PIP	January 1, 2011–December 31, 2011
	Annual Dentist Visit PIP	
	Childhood Immunizations PIP	
	Childhood Obesity PIP	
	Emergency Room Utilization PIP	
	Lead Screening in Children PIP	
	Well-Child Visits PIP	
AMERIGROUP	*Member Satisfaction* PIP	February 13, 2012–May 10, 2012
	Provider Satisfaction PIP	September 1, 2011–December 31, 2011
Peach State	*Member Satisfaction* PIP	February 20, 2012–May 31, 2012
	Provider Satisfaction PIP	October 31, 2011–December 14, 2011
WellCare	*Member Satisfaction* PIP	January 1, 2012–May 31, 2012
	Provider Satisfaction PIP	October 1, 2010–September 30, 2011

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

AMERIGROUP

Table C-2—SFY 2012 Performance Improvement Projects' Validation Results for AMERIGROUP Community Care (N=9 PIPs)			
Study Stage	**Activity**		**Percentage of Applicable Elements Scored *Met***
Design	I.	Appropriate Study Topic(s)	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)**

Table C-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 who received the recommended vaccinations based on the *Childhood Immunization Status—Combo 2* (4:3:1:2:3:1) guidelines.	29.8%	72.0%↑*¥	78.0%↑*	84.3%↑*	Yes
Lead Screening in Children					
The percentage of children 2 years of age who received one blood lead test (capillary or venous) on or before their second birthday.	68.2%	67.8%	65.7%	76.7%↑*	NA
Well-Child Visits					
The percentage of children who had six or more well-child visits with a PCP during their first 15 months of life.	62.3%	55.0%↓*	60.1%	63.6%	NA

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

PIP Study Indicator	Baseline Period (1/1/09–12/31/09)	Remeasurement 1 (1/1/10–12/31/10)	Remeasurement 2 (1/1/11–12/31/11)	Sustained Improvement^
Annual Dental Visit				
Percentage of members 2–3 years of age who had at least one dental visit.	42.7%	47.3%↑*	47.7%	Yes
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.

Table C-4 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.

Peach State

Table C-5—SFY 2012 Performance Improvement Projects' Validation Results for Peach State Health Plan (N=9 PIPs)			
Study Stage	**Activity**		**Percentage of Applicable Elements Scored *Met***
Design	I.	Appropriate Study Topic(s)	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	44% (16/36)
Implementation Total			**86% (123/143)**
Outcomes	VIII.	Sufficient Data Analysis and Interpretation	94% (73/78)
	IX.	Real Improvement Achieved	75% (27/36)
	X.	Sustained Improvement Achieved	100% (6/6)
Outcomes Total			**88% (106/120)**
Percentage Score of Applicable Evaluation Elements *Met*			**92% (376/410)**

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

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.	78.8%	84.3%↑*	84.3%	84.8%	Yes
Childhood Immunizations					
The percentage of children who received the recommended vaccinations based on the *Childhood Immunization Status—Combo 2* (4:3:1:2:3:1) guidelines.	62.8%¥	67.6%	81.4%↑*	80.6%	Yes
Lead Screening in Children					
The percentage of children 2 years of age who received one blood lead test (capillary or venous) on or before their second birthday.	57.2%¥	62.3%	68.5%	70.8%	Yes
Well-Child Visits					
The percentage of children who had six or more well-child visits with a PCP during their first 15 months of life.	51.6%¥	52.3%	53.9%	50.5%	NA

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

PIP Study Indicator	Baseline Period (1/1/09–12/31/09)	Remeasurement 1 (1/1/10–12/31/10)	Remeasurement 2 (1/1/11–12/31/11)	Sustained Improvement^
Annual Dental Visit				
Percentage of members 2–3 years of age who had at least one dental visit.	33.8%	38.8%↑*	43.9%↑*	Yes
Percentage of members 2–21 years of age who had at least one dental visit.	60.2%	63.6%↑*	67.5%↑*	Yes
Childhood Obesity				
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation.	32.1%	29.0%	22.7%↓*	NA
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition.	36.7%	45.5%↑*	40.7%	NA
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity.	28.2%	32.0%	29.4%	NA
Emergency Room Utilization				
The number of emergency room visits that did not result in an inpatient stay per 1,000 member months.	57.4	54.7↑*	52.5↑*	Yes

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

¥ Rates did not include the PeachCare for Kids® population.

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

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

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

Table C-8—Satisfaction-Based Performance Improvement Project Outcomes for Peach State Health Plan

PIP Study Indicator	Baseline Period (3/13/2009–5/31/2009)	Remeasurement 1 (3/12/2010–5/31/2010)	Remeasurement 2 (3/1/2011–5/31/2011)	Remeasurement 3 (2/20/2012–5/31/2012)	Sustained Improvement^
Member Satisfaction					
1. "Ease of getting appointment with a specialist" (Q26)	71.7%	71.8%	83.7%↑*	75.7%	NA
2. "Getting care, tests, or treatments necessary" (Q30)	79.9%	81.1%	81.3%	82.2%	NA
3. "Getting information/help from customer service" (Q32)	68.5%	80.8%↑*	79.4%	73.4%	NA
4. "Treated with courtesy and respect by customer service staff" (Q33)	86.4%	90.4%	90.3%	91.3%	NA

PIP Study Indicator	Baseline Period (8/1/07–10/30/07)	Remeasurement 1 (11/1/08–2/28/09)	Remeasurement 2 (9/29/09–10/27/09)	Remeasurement 3 (9/28/10–11/15/10)	Remeasurement 4 (10/31/11–12/14/11)	Sustained Improvement^
Provider Satisfaction						
1. The percentage of providers answering "Excellent" or "Very Good" to Q5—"Timeliness to answer questions and/or resolve problems."	15.8%	28.0%↑*	32.3%	36.3%	38.0%	Yes
2. Percentage of providers answering "Excellent" or "Very Good" to Q6—"Quality of the provider orientation process."	14.2%	24.1%↑*	31.0%↑*	32.6%	35.6%	Yes
3. Percentage of providers answering "Excellent" or "Very Good" to Q18—"Health plan takes physician input and recommendations seriously."	10.7%	15.2%	24.5%↑*	25.8%	29.1%	Yes
4. Percentage of providers answering "Excellent" or "Very Good" to Q34—"Accuracy of claims processing."	12.1%	16.0%	28.8%↑*	26.0%	29.7%	Yes

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.

WellCare

Table C-9—SFY 2012 Performance Improvement Projects' Validation Results for WellCare of Georgia, Inc. (N=9 PIPs)			
Study Stage	**Activity**		**Percentage of Applicable Elements Scored *Met***
Design	I.	Appropriate Study Topic(s)	98% (49/50)
	II.	Clearly Defined, Answerable Study Question(s)	100% (18/18)
	III.	Clearly Defined Study Indicator(s)	100% (54/54)
	IV.	Correctly Identified Study Population	93% (25/27)
Design Total			**98% (146/149)**
Implementation	V.	Valid Sampling Techniques (if sampling was used)	100% (36/36)
	VI.	Accurate/Complete Data Collection	100% (72/72)
	VII.	Appropriate Improvement Strategies	85% (28/33)
Implementation Total			**96% (136/141)**
Outcomes	VIII.	Sufficient Data Analysis and Interpretation	90% (70/78)
	IX.	Real Improvement Achieved	72% (26/36)
	X.	Sustained Improvement Achieved	100% (4/4)
Outcomes Total			**85% (100/118)**
Percentage Score of Applicable Evaluation Elements *Met*			**94% (382/408)**

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

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.	78.6%	84.7%↑*	85.4%↑*	86.0%	Yes
Childhood Immunizations					
The percentage of children who received the recommended vaccinations based on the *Childhood Immunization Status—Combo 2* (4:3:1:2:3:1) guidelines.	75.9%	81.0%	75.9%	85.2%↑*	NA
Lead Screening in Children					
The percentage of children 2 years of age who received one blood lead test (capillary or venous) on or before their second birthday.	65.9%	67.4%	73.0%	77.6%	Yes
Well-Child Visits					
The percentage of children who had six or more well-child visits with a PCP during their first 15 months of life.	57.4%	57.4%	59.1%	61.3%	NA

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 Visit				
Percentage of members 2–3 years of age who had at least one dental visit.	40.4%	45.5%↑*	50.0%↑*	Yes
Percentage of members 2–21 years of age who had at least one dental visit.	65.2%	67.5%↑*	70.5%↑*	Yes

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

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^
Childhood Obesity				
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation.	36.5%	30.4%	56.9%↑*	NA
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for nutrition.	42.3%	48.9%	50.4%	NA
The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of counseling for physical activity.	38.7%	30.9%↓*	37.0%	NA
Emergency Room Utilization				
The number of emergency room visits that did not result in an inpatient stay per 1,000 member months.	65.9	61.7↑*	59.3↑*	Yes

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

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

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

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

Table C-11—Satisfaction-Based Performance Improvement Project Outcomes for WellCare of Georgia, Inc.

PIP Study Indicator	Baseline Period (2/1/09–5/31/09)	Remeasurement 1 (2/1/10–5/31/10)	Remeasurement 2 (2/1/11–5/31/11)	Remeasurement 3 (1/1/12–5/31/12)	Sustained Improvement^
Member Satisfaction					
1. The percentage of members responding with either a "9" or "10" to Q24—"Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child's personal doctor?"	72.2%	71.2%	72.6%	87.8%↑*	NA
2. The percentage of eligible members responding with either "Always" or "Usually" to Q23—"In the last 6 months, how often did your child's personal doctor seem informed and up to date about the care your child got from other doctors/providers?"	77.1%	78.4%	74.6%	79.4%	NA

Table C-12—Satisfaction-Based Performance Improvement Project Outcomes for WellCare of Georgia, Inc.

PIP Study Indicator	Baseline Period (10/1/06–9/30/07)	Remeasurement 1 (10/1/07–9/30/08)	Remeasurement 2 (10/1/08–9/30/09)	Remeasurement 3 (10/1/09–9/30/10)	Remeasurement 4 (10/1/10–9/30/11)	Sustained Improvement^
Provider Satisfaction						
1. The percentage of providers answering "Excellent" or "Very Good" to Q11—"Specialist network has an adequate number of high quality specialists to whom I can refer my patients."	22.2%	19.7%	24.7%	24.1%	17.4%↓*	NA
2. The percentage of providers answering "Excellent" or "Very Good" to Q5—"Timeliness to answer and/or resolve problems."	22.2%	29.6%↑*	31.3%	33.6%↑*	36.3%	NA
3. The percentage of providers answering "Excellent" or "Very Good" to Q15—"Timeliness of UM's pre-certification process."	22.5%	25.5%	29.3%	30.3%	27.9%	NA

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

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

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

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

Appendix D. Case and Disease Management Review Tools

Following this page is the Case and Disease Management Evaluation Tool that HSAG used to document HSAG's observations and recommendations for the CMO's Case and Disease management program.

Case Management Evaluation Tool

Case Identifier:
Diagnosis:
Synopsis:

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

-

Recommendations:

-

2. What level of case management or program type is the member enrolled in?

Observations:

-

Recommendations:

-

3. When was the member enrolled in the CMO's case management program?

Observations:

-

Recommendations:

-

4. Was the member identified as having any of the following special needs?

- Chronic condition(s)
- High-cost condition(s)
- High-risk condition(s)
- Pregnant woman under 21 years of age

Case Management Evaluation Guide
◆ High-risk pregnancy ◆ Infant/toddler with risk for developmental delays
Observations: ◆
Recommendations: ◆
II. Assessment
5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history? (Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)
Observations: ◆
Recommendations: ◆
6. Does the assessment include documentation of the member's cultural and/or linguistic needs?
Observations: ◆
Recommendations: ◆
7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?
Observations: ◆
Recommendations: ◆
8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?
Observations: ◆
Recommendations: ◆
9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Case Management Evaluation Guide
Observations: ◆
Recommendations: ◆
III. Care Plan Development
10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions? (Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)
Observations: ◆
Recommendations: ◆
11. Does the care plan reflect participation of any of the following? ◆ The member ◆ The member's caregiver/family ◆ Providers and specialists
Observations: ◆
Recommendations: ◆
12. Does the care plan reflect care gap analysis, identification, and interventions? (Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)
Observations: ◆
Recommendations: ◆
IV. Monitoring and Follow-up
13. Does the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to

Case Management Evaluation Guide
reflect those needs? (Insert case manager monitoring activities and changes to the care plan as observed in the record.)
Observations: ◆
Recommendations: ◆
14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists? (Insert case manager contact with providers.)
Observations: ◆
Recommendations: ◆
15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family? (Insert case manager contact with caregiver/family.)
Observations: ◆
Recommendations: ◆
16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?
Observations: ◆
Recommendations: ◆
17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following? ◆ Grand rounds ◆ Care team meetings ◆ Case conferencing ◆ Member rounds

Case Management Evaluation Guide
◆ Multidisciplinary work pods/groups
Observations:
◆
Recommendations:
◆
V. Transition of Care and Discharge Planning
18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.
Observations:
◆
Recommendations:
◆
19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?
Observations:
◆
Recommendations:
◆
20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?
Observations:
◆
Recommendations:
◆
21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?
Observations:
◆
Recommendations:
◆

Disease Management Evaluation Guide

Case Identifier:
Diagnosis:
Synopsis:

Disease Management Evaluation Guide
I. Program Type and Identification
1. What disease management program(s) is the member enrolled in?
Observations: ◆
Recommendations: ◆
2. How was the member identified or referred for disease management services?
Observations: ◆
Recommendations: ◆
II. Assessment and Guidelines
3. Did the member have a comprehensive assessment? (Insert assessment findings.)
Observations: ◆
Recommendations: ◆
4. Was a care plan created for the member? (Insert care plan goals, interventions, outcomes, barriers, etc.)
Observations:

Disease Management Evaluation Guide
◆
Recommendations: ◆
5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)
Observations: ◆
Recommendations: ◆
III. Education
6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations, etc.)
Observations: ◆
Recommendations: ◆
7. Does the CMO provide members with disease "toolkits" and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans, etc.)
Observations: ◆
Recommendations: ◆
8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and things that the member can do to improve health?
Observations: ◆
Recommendations: ◆
IV. Monitoring
9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Disease Management Evaluation Guide
Observations: ◆
Recommendations: ◆
10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms? (Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)
Observations: ◆
Recommendations: ◆
11. Does the disease manager collaborate and coordinate care with providers, community agencies, or the member's caregivers/family?
Observations: ◆
Recommendations: ◆
12. Was the member transitioned from disease management to case management due to member deterioration?
Observations: ◆
Recommendations: ◆
V. Measureable Outcomes
13. Does the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics, etc.) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care, etc.)**?**
Observations: ◆
Recommendations: ◆