State of Georgia
Department of Community Health

2018 External Quality Review Annual Report

Including

Contract Year Compliance Review Summary (Review Period: July 1, 2014–June 30, 2016)
Reporting Year 2017 Performance Measure Rates
Calendar Year Performance Improvement Project Results (Performance Period: January 2016 through June 2017)
Contract Year 2017 Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Results

April 2018

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Overview of the 2016–2017 External Quality Review

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the Georgia Families® 360° (GF 360°) managed care program. The Georgia Families® (GF) program serves all other Medicaid and CHIP managed care members not enrolled in the GF 360° program. Approximately 1.6 million members are enrolled in the GF program. Approximately 47,000 members are enrolled in the GF 360° program.

The GF and the GF 360° programs cover approximately 1.64 million members

The DCH provides Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH is dedicated to a healthy Georgia. The goal of the care management program is to maintain a successful partnership with quality health plans to provide care to members while focusing on continual quality improvement. The Georgia-enrolled member population encompasses Low-Income Medicaid (LIM), Transitional Medicaid, pregnant women and children in the Right from the Start (RSM) Medicaid program, newborns of Medicaid-covered women, refugees, women with breast or cervical cancer, women participating in the Planning for Healthy Babies® (P4HB®) program, as well as the CHIP population. Infants ages birth to 1 year qualify if they are up to 185 percent of the federal poverty level, children 1 through 5 years of age qualify if they are up to 200 percent of the federal poverty level, children 6 to 18 years of age qualify if they are up to 138 percent of the federal poverty level, and pregnant women qualify if they are up to 200 percent of the federal poverty level.

The DCH contracted with the following CMOs to provide services to the GF population for the 2016–2017 contract year, which covers the time span of July 1, 2016, through June 30, 2017: Amerigroup Community Care (Amerigroup), Peach State Health Plan (Peach State), and WellCare of Georgia, Inc. (WellCare). An additional contracted CMO was added July 1, 2017; however, it was not included in the EQRO activities during 2017. Amerigroup also has a contract with DCH to provide services to the GF 360° population, and in these instances, Amerigroup is referred to as Amerigroup 360°. For ease of reporting information relevant to both GF and GF 360° populations, HSAG uses the term "CMOs" in the remainder of this report to refer to Amerigroup, Peach State, WellCare, and Amerigroup 360° results collectively.

The Code of Federal Regulations (CFR) at 42 CFR §438.364[1-1] requires that states use an external quality review organization (EQRO) to prepare an annual technical report that describes how data from activities were collected, and in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality and timeliness of, and access to healthcare services that managed care organizations provide.

To comply with these requirements, DCH contracted with Health Services Advisory Group, Inc. (HSAG), an EQRO, to aggregate and analyze the CMOs' performance data across mandatory and optional activities and prepare an annual technical report. HSAG has served as the EQRO for DCH since 2008. HSAG used the Centers for Medicare & Medicaid Services' (CMS') November 9, 2012, update of its External Quality Review Toolkit for States when preparing this report.[1-2]The report also includes an assessment of the CMOs' strengths and weaknesses, as well as recommendations for improvement and a comparison of the performance of the CMOs that operate in the GF Medicaid program.

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

- *Review of compliance with federal and state-specified operational standards.* HSAG evaluated the GF and GF 360° CMOs' compliance with State and federal requirements for organizational and structural performance. The DCH contracts with the EQRO to conduct a review of one-third of the full set of standards each year to complete the cycle within a three-year period of time. On-site compliance with standards reviews were completed for contract year (CY) 2014, CY 2015, and CY 2016.
- *Validation of performance improvement projects (PIPs).* PIPs are conducted on a calendar year basis. HSAG validated PIPs for each GF and GF 360° CMO to ensure the CMOs designed, conducted, and reported projects in a methodologically sound manner consistent with the CMS protocol for validating PIPs. For calendar year 2017, the CMOs in Georgia used HSAG's rapid cycle PIP process for all PIPs HSAG validated. Amerigroup 360° submitted three PIPs and the other three GF CMOs submitted four PIPs for validation. HSAG assessed all PIPs for real improvements in care and services to validate the reported improvements. In addition, HSAG assessed the CMOs' PIP outcomes and impacts on improving care and services provided to members. HSAG validated PIPs from February 1, 2016, through April 17, 2017. The CMOs submitted PIP data that reflected varying time periods in calendar year 2016, depending on the PIP topic. HSAG provided final, CMO-specific PIP reports to the CMOs and DCH in June 2017.
- *Validation of performance measures (PMs).* HSAG validated the PM rates required by DCH to evaluate the accuracy of the PM results reported by the GF and GF 360° CMOs. The validation also determined the extent to which the DCH-specific PM rates followed specifications established by DCH. HSAG assessed the PM results and their impact on improving members' health outcomes.

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 68, No. 16/Friday, January 23, 2003/Rules and Regulations, p. 3597. 42 CFR Parts 433 and 438 Medicaid Program; External Quality Review of Medicaid Managed Care Organizations, Final Rule.

[1-2] The Centers for Medicare & Medicaid Services. External Quality Review Toolkit, November 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-toolkit.pdf. Accessed on: March 8, 2018.

HSAG conducted validation of the PM rates following the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] Compliance Audit™ timeline, from January 2017 through July 2017. The final PM validation results reflected the measurement period of January 1, 2016, through December 31, 2016, unless otherwise stated in the measure specifications. HSAG provided final PM validation reports to the CMOs and DCH in August 2017.

- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Surveys*.[1-4] The DCH required that the three GF CMOs conduct CAHPS surveys of their adult and child populations to learn more about member satisfaction and experiences with care. The DCH required the GF 360° CMO to also conduct a CAHPS survey of its child population to learn more about member satisfaction and experiences with care in this special-needs population. HSAG did not conduct these surveys but included the results from the Adult and Child CAHPS surveys for all four CMOs in this report.
- *Validation of performance improvement projects (PIPs).* From January to June 2017, HSAG provided technical assistance to the GF CMOs to support improvement projects the CMOs conducted in collaboration with the Centers for Disease Control and Prevention's (CDC's) 6|18 Initiative and DCH. The purpose of the improvement projects was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence. The CMOs' improvement projects were part of the CDC 6|18 Initiative's broader efforts to improve health outcomes and control healthcare costs through the application of evidence-based prevention strategies for common and costly health conditions, like asthma.

In accordance with 42 CFR §438.364, this report includes the following information for each activity conducted:

- Activity objectives
- Technical methods of data collection and analysis (Appendix A)
- Descriptions of data obtained
- Conclusions drawn from the data

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

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[1-4] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Quality—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

> Quality, as it pertains to external quality review, means the degree to which an MCO [managed care organization] or PIHP [prepaid inpatient health plan] increases the likelihood of desired health outcomes of its recipients through its structural and operational characteristics, through provision of health services that are consistent with current professional knowledge, and interventions for performance improvement. [1-5]

Access—CMS defines "access" in the final rule at 42 CFR §438.230 as follows:

> Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[1-6]

Timeliness—Federal managed care regulations at 42 CFR §438.206 require the state to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the MCO/PIHP—e.g., processing expedited member grievances and appeals and providing timely follow-up care. In addition, NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[1-7] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

Lastly, consistent with 42 CFR §438.364(a)(6), HSAG has included in Section 8 of this report an assessment of the degree to which each CMO has effectively addressed previous recommendations for quality improvement that HSAG made related to each activity.

Review of Compliance With Standards

Over the three-year compliance review cycle (July 1, 2015, through June 30, 2017), HSAG organized, aggregated, and analyzed results from the compliance with standards monitoring reviews to draw conclusions about each CMO's performance in providing quality, accessible, and timely healthcare and services to its members. During each year's review, HSAG also reviewed elements that were found to be noncompliant from the previous years' compliance reviews. Overall, the CMOs had documentation describing their processes, practices, action plans, performance results, and outcomes related to each requirement reviewed. The following provides a high-level summary of each of the CMO's performance over the three-year compliance review cycle in the domains of quality, access, and timeliness of care.

[1-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocols Introduction*, September 2012.
[1-6] Ibid.
[1-7] National Committee for Quality Assurance. 2013 Standards and Guidelines for the Accreditation of Health Plans.

Table 1-1—CMO Compliance With Standards Score Comparison

Standard #	Standard Name	Amerigroup	Peach State	WellCare	Amerigroup 360°
CY 2015					
I	Availability of Services	100.0%	100.0%	100.0%	NA
II	Furnishing of Services	90.9%	63.6%	86.4%	NA
III	Cultural Competence	100.0%	100.0%	92.9%	NA
IV	Coordination and Continuity of Care	85.7%	61.9%	81.0%	NA
V	Coverage and Authorization of Services	88.0%	88.0%	88.0%	NA
VI	Emergency and Poststabilization Services	100.0%	80.0%	100.0%	NA
NA	Follow-up Reviews From Previous Noncompliant Review Findings	20.0%	50.0%	0.0%	NA
	Total CY 2015 Compliance Score	**90.3%**	**79.7%**	**87.2%**	**NA**
CY 2016					
I	Provider Selection, Credentialing and Recredentialing	90.0%%	100.0%	90.0%	88.9%
II	Subcontractual Relationships and Delegation	100.0%	100.0%	100.0%	100.0%
III	Member Rights and Protections	100.0%	100.0%	100.0%	100.0%
IV	Member Information	95.0%	90.0%	100.0%	92.6%
V	Grievance System	91.5%	91.5%	91.5%	91.5%
VI	Disenrollment Requirements and Limitations	90.0%	100.0%	100.0%	64.3%
NA	Follow-up Reviews From Previous Noncompliant Review Findings	25.0%	84.0%	70.6%	N/A
	Total CY 2016 Compliance Score	**85.7%**	**92.0%**	**91.5%**	**89.1%**
CY 2017					
I	Clinical Practice Guidelines	100.0%	90.9%	81.8%	100.0%
II	Quality Assessment and Performance Improvement (QAPI)	53.3%	66.7%	53.3%	53.3%
III	Health Information Systems	100.0%	100.0%	87.5%	100.0%
NA	Follow-up Reviews From Previous Noncompliant Review Findings	75.0%	75.4%	83.3%	91.7%
	Total CY 2017 Compliance Score	**72.1%**	**75.4%**	**67.3%**	**75.4%**
	Total CY 2015–CY 2017 Compliance Score	**84.8%**	**83.9%**	**85.3%**	**84.4%**

Summary of Amerigroup's Compliance With Standards Performance

Amerigroup had processes that demonstrated a foundation for the delivery of healthcare services based on the principles of quality, access, and timeliness. Amerigroup has implemented processes to address members' physical, behavioral, and psychosocial needs. Amerigroup also had processes to link members

to services based on the results of the comprehensive assessment to ensure timely, comprehensive care. Amerigroup routinely monitored access to care to ensure access to timely care and services. Amerigroup also monitored provider network accessibility using provider surveys to determine availability of appointments and after-hours care. Amerigroup continued to monitor and evaluate its service delivery system and provider network according to DCH-established time and distance standards and response times for returning calls after-hours to ensure that DCH requirements for access to care are met.

Amerigroup was compliant with most requirements related to member information as well as member rights and protections. Amerigroup informed members of their rights and responsibilities and ensured member communications were culturally appropriate. Information was available to Amerigroup members in multiple languages and formats based on member needs. However, Amerigroup has an opportunity to improve member grievance and appeal letters to ensure they are written in easily understood language.

Amerigroup also had processes to monitor complaints and grievances in relation to quality and timeliness of, and access to care and services to identify opportunities for improvement. Amerigroup used provider report cards, as well as a performance measurement report cards that display provider year-over-year performance and variance. The report cards were also used to facilitate discussions with providers about performance and opportunities for improvement.

Amerigroup continued to build organizational strength in quality improvement knowledge and training by expanding staff training in the Institute for Healthcare Improvement's (IHI's) Science of Quality Improvement and the Lean Six Sigma programs.[1-8] The CMO strengthened its quality improvement program by having the chief executive officer, chief medical officer, and executive and senior-level staff actively involved in quality improvement activities. In addition, Amerigroup's health information system (HIS) supported its business intelligence needs.

Amerigroup's Quality Assessment and Performance Improvement (QAPI) program description should be strengthened to provide a comprehensive roadmap of Amerigroup's priorities for its quality improvement program and document the story of the effectiveness of Amerigroup's QAPI work.

Summary of Peach State's Compliance With Standards Performance

Peach State used multiple approaches to ensure members receive quality healthcare that results in improved outcomes and prevents declines in a member's health status. Peach State had a strong community presence and coordinated utilization and care management activities with community practitioners. Peach State continued to monitor and evaluate its service delivery system and provider

[1-8] Institute for Healthcare Improvement. Science of Improvement: How to Improve. Available at: http://www.ihi.org/resources/Pages/HowtoImprove/ScienceofImprovementHowtoImprove.aspx. Accessed on: Mar 27, 2018.

network according to DCH-established time and distance standards to ensure that DCH requirements for access to care are met.

Peach State met most requirements related to member information as well as member rights and protections. Peach State's member information was easily accessible and offered in English and Spanish, and offered no-cost linguistic services to both members and providers to improve the experience of care. Peach State continued to improve its denial and appeal resolution letters to ensure that they are easily understood and address the member's issues.

Peach State had processes to monitor complaints and grievances in relation to the quality and timeliness of, and access to care and services to identify opportunities for improvement. Peach State has an opportunity to review quality of care concerns, including those referred to another entity for review. Peach State should make its own quality of care determinations, refer appropriate cases to its peer review process, and report to boards and regulatory agencies, as appropriate, as a result of its internal investigation process.

Peach State identified members who would benefit from case management (CM) services and ensured timely, comprehensive assessments that address the members physical, behavioral, and psychosocial needs. Peach State had a robust process for contacting members and providers in the outpatient setting. Peach State also had a pharmacy lock-in program that provides an added layer of services to ensure that members are appropriately accessing and using medications.

Peach State's business intelligence and data management platform provided the foundation of its internal and external data integration and reporting capabilities. Peach State used an interface solution that allows rapid processing of member, claim, and encounter data from any business partner or subcontractor in any format. The CMO also conducted provider profiling using a web-based reporting and management system, which includes advanced capabilities for provider practice pattern and utilization reporting.

Peach State used IHI's Triple Aim as a framework to evaluate the success of the QAPI program and adopted Lean Six Sigma methodology and Plan-Do-Study-Act (PDSA) processes.[1-9] Peach State's QAPI program description and evaluation should be enhanced to provide a comprehensive roadmap of Peach State's quality improvement priorities and document the story of the effectiveness of Peach State's QAPI program.

Summary of WellCare's Compliance With Standards Performance

WellCare continued to monitor and evaluate its service delivery system and provider network according to DCH-established time and distance standards to ensure that the DCH requirements for access to care are met. WellCare monitored provider offices to ensure that they are accepting new patients and ensured continuity of care is maintained when a member needs to obtain services from non-contracted providers.

[1-9] Ibid.

When out-of-network providers are needed, the CMO would coordinate payment such that the member would not be balance-billed and would attempt to contract with those providers to make the provider network more robust.

WellCare provided guidance to staff and providers on the varying needs of a diverse member population. WellCare's member website included information that is easily accessible and offered in English and Spanish, and offered no-cost linguistic services to both members and providers to improve the experience of care. WellCare continued to work to improve its denial and appeal resolution letters to ensure that they are easily understood and address all member issues.

WellCare included community providers and medical societies in the review and adoption of clinical practice guidelines (CPGs). The CMO made decisions regarding the CPGs through committee meetings that consider the needs of members.

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

WellCare's health information allowed for a seamless integration with other applications and supported all member, provider, benefit, and claims processing applications. WellCare continued to develop provider profiling tools that include information such as utilization data, complaints and grievances, prescribing, and member satisfaction.

WellCare continued to improve its QAPI program description to ensure it provides a comprehensive roadmap of WellCare's priorities for its quality improvement program and tells the story of the effectiveness of WellCare's QAPI work.

Summary of Amerigroup 360°'s Compliance With Standards Performance

Amerigroup 360° had processes that demonstrate a foundation for the delivery of healthcare services based on the principles of quality, access, and timeliness. Amerigroup 360° had implemented processes to address members' physical, behavioral, and psychosocial needs. Amerigroup 360° also had processes to link members to services based on the results of the comprehensive assessment to ensure timely, comprehensive care. Amerigroup 360° continued to improve processes to ensure that children in the Kenny A. Consent Decree counties of DeKalb and Fulton meet Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements. Amerigroup 360° monitored provider network accessibility using provider surveys to determine availability of appointments and after-hours care.

Amerigroup 360° informed members of their rights and responsibilities and ensured member communications are culturally appropriate. Information is available to Amerigroup 360° members in

multiple languages and formats based on member needs. Amerigroup 360° continued to improve member grievance and appeal letters to ensure that they are easily understood.

Amerigroup 360° also had processes to monitor complaints and grievances in relation to quality and timeliness of, and access to care and services. Amerigroup 360° used provider report cards that display provider year-over-year performance and variance to facilitate discussions with providers about performance and opportunities for improvement.

Amerigroup 360° continued to monitor and evaluate its service delivery system and provider network according to DCH-established time and distance standards and response times for returning calls after-hours to ensure that DCH requirements for access to care are met. Amerigroup 360° also had a training plan for law enforcement officials, judges, and other key stakeholders.

Amerigroup 360° used diverse processes to solicit provider, member, and community member feedback and input into the quality improvement processes of the program. In the Pathways to Permanency program, Amerigroup 360° measured outcomes in timely care delivery as well as in measures, such as school attendance. Amerigroup 360° developed action plans focused on increasing access to care and receipt of EPSDT services. Amerigroup 360° has an opportunity to include the voice of both the member and the member's caregiver to actively improve the quality of care provided to members.

Amerigroup 360° continued to build organizational strength in quality improvement knowledge and training by expanding staff training in IHI's Science of Quality Improvement and the Lean Six Sigma programs.[1-10] The CMO strengthened its quality improvement program by having the chief executive officer, chief medical officer, and executive and senior-level staff involved in quality improvement activities. In addition, Amerigroup 360°'s HIS supported its business intelligence needs.

Amerigroup 360° continued to improve its QAPI program description and QAPI evaluation to provide a comprehensive roadmap of Amerigroup 360°'s priorities for the QAPI program and to document the effectiveness of Amerigroup 360°'s QAPI work.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG validated rates of performance measures that DCH selected for validation which originated from CMS' Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set),[1-11] Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid (Adult Core Set),[1-12] HEDIS, and the Agency for Healthcare Research and Quality's (AHRQ's) Quality Indicator measures. The measurement period was CY 2016 for all measures except the Child Core Set dental measure. The dental measure was reported according to CMS requirements for federal fiscal year (FFY) 2016, which

[1-10] Ibid.
[1-11] The Centers for Medicare & Medicaid Services. Core Set of Children's Health Care Quality Measures for Medicaid and CHIP, June 2016.
[1-12] The Centers for Medicare & Medicaid Services. Core Set of Health Care Quality Measures for Adults Enrolled in Medicaid, June 2016.

covered the time frame of October 1, 2015, through September 30, 2016. Table 1-2 lists the performance measures that HSAG validated, the method required by DCH for data collection, and the specifications the CMO was required to use for each of the measures.

Table 1-2—List of CY 2017 GF Performance Measures

	Performance Measure	Method	Specifications
1.	*Antenatal Steroids*	Hybrid	Adult Core Set
2.	*Asthma in Younger Adults Admission Rate*	Admin	Adult Core Set
3.	*Behavioral Health Risk Assessment for Pregnant Women*	Hybrid	Child Core Set
4.	*Cesarean Delivery Rate*	Admin	AHRQ
5.	*Cesarean Section for Nulliparous Singleton Vertex*	Hybrid	Child Core Set
6.	*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate*	Admin	Adult Core Set
7.	*Colorectal Cancer Screening**	Hybrid	HEDIS*
8.	*Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*	Admin	Child Core Set
9.	*Developmental Screening in the First Three Years of Life*	Hybrid	Child Core Set
10.	*Diabetes Short-Term Complications Admission Rate*	Admin	Adult Core Set
11.	*Elective Delivery*	Hybrid	Adult Core Set
12.	*Heart Failure Admission Rate*	Admin	Adult Core Set
13.	*Live Births Weighing Less Than 2,500 Grams*	Admin	Child Core Set
14.	*Plan All-Cause Readmissions Rate***	Admin	Adult Core Set
15.	*Screening for Clinical Depression and Follow-up Plan*	Hybrid	Adult Core Set
16.	*Use of Opioids at High Dosage*	Admin	Adult Core Set

*The CMO reported this measure using the *HEDIS 2017, Volume 2: Technical Specifications for Health Plans* for the Commercial and Medicare populations but applied the specifications to the Medicaid population.
**Risk adjustment was not required.

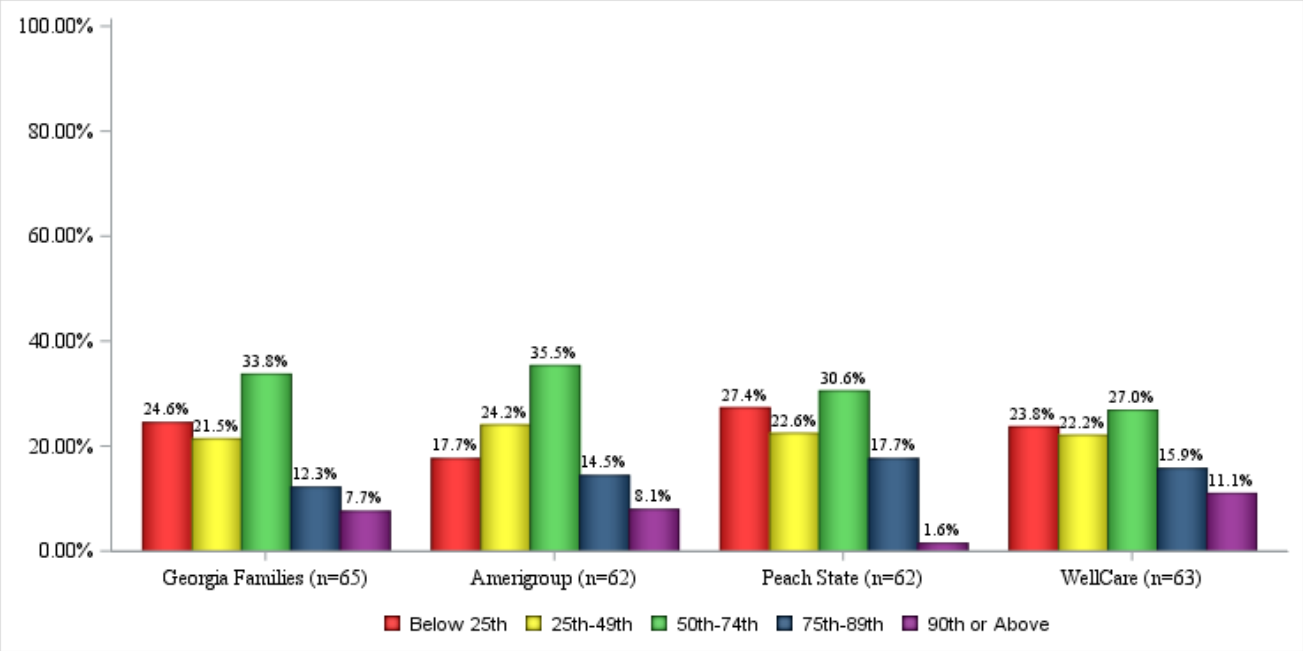
In addition to the AHRQ and CMS adult and child core set measures audited by HSAG, DCH required all four CMOs to report a selected set of HEDIS measures to DCH. CMOs were required to contract with an NCQA-licensed audit organization and undergo an NCQA HEDIS Compliance Audit™.[1-13] Final audited HEDIS measure results from NCQA's Interactive Data Submission System (IDSS) were submitted to HSAG and provided to DCH.

[1-13] NCQA HEDIS Compliance Audit™ is a trademark of the National Committee for Quality Assurance (NCQA).

Georgia Families Findings

Figure 1-1 displays the percentage of reporting year (RY) 2017 performance measure rates compared to NCQA's 2016 Quality Compass®,[1-14] national Medicaid health maintenance organization (HMO) percentiles for the Georgia Families weighted average, Amerigroup, Peach State, and WellCare.

Figure 1-1—Percentage of RY 2017 Performance Measure Rates for Georgia Families Compared to National Medicaid Percentiles



Note: Percentages may not total 100 percent due to rounding.

Table 1–4 presents the RY 2017 rates along with star ratings based on rate comparisons to the NCQA 2016 Quality Compass national Medicaid HMO percentiles, where applicable, for Amerigroup, Peach State, WellCare, and the Georgia Families weighted average. Measure results were compared to benchmarks and rated using the following star ratings:

Table 1–3—Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

[1-14] Quality Compass® is a registered trademark for the National Committee for Quality Assurance (NCQA).

Table 1–4—RY 2017 Results for Georgia Families CMOs

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	78.59% ★★	77.22% ★★	82.55% ★★★	79.78% ★★★
Adult BMI Assessment				
Adult BMI Assessment	81.02% ★★	85.88% ★★★	82.06% ★★	82.90% ★★
Annual Dental Visit				
2–3 Years	45.54% ★★★★	39.98% ★★★	50.00% ★★★★	45.86% ★★★★
4–6 Years	74.81% ★★★★★	70.18% ★★★★	77.21% ★★★★★	74.49% ★★★★★
7–10 Years	78.00% ★★★★★	73.04% ★★★★	79.18% ★★★★★	77.05% ★★★★★
11–14 Years	71.73% ★★★★★	66.51% ★★★★	73.37% ★★★★★	70.96% ★★★★★
15–18 Years	60.43% ★★★★	56.94% ★★★★	63.20% ★★★★★	60.62% ★★★★
19–20 Years	36.44% ★★★	35.07% ★★★	43.14% ★★★★	38.81% ★★★
Total	68.44% ★★★★★	63.90% ★★★★	70.93% ★★★★★	68.21% ★★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.12% ★★★	96.84% ★★★	97.13% ★★★	97.04% ★★★
25 Months–6 Years	89.71% ★★★	89.69% ★★★	90.80% ★★★	90.18% ★★★
7–11 Years	92.06% ★★★	90.64% ★★	91.55% ★★★	91.41% ★★★
12–19 Years	89.51% ★★★	88.73% ★★	89.48% ★★★	89.28% ★★
Colorectal Cancer Screening				
Colorectal Cancer Screening	47.80% NC	48.84% NC	50.93% NC	49.36% NC
Children's Health				
Prevention and Screening				
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	80.76% ★★★	83.95% ★★★★	81.16% ★★★★	81.84% ★★★★
Childhood Immunization Status				
Combination 3	74.31% ★★★	71.88% ★★★	78.24% ★★★★	75.28% ★★★
Combination 6	32.87% ★★	30.53% ★	30.79% ★★	31.26% ★★

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Combination 10	28.47% ★★	26.68% ★★	28.24% ★★	27.83% ★★
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	26.47% NC	11.18% NC	22.83% NC	22.90% NC
Developmental Screening in the First Three Years of Life				
Total	58.10% NC	55.88% NC	47.92% NC	53.11% NC
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	89.12% ★★★★★	87.02% ★★★★★	89.35% ★★★★★	88.63% ★★★★★
HPV	19.68% NC	22.84% NC	16.90% NC	19.31% NC
Lead Screening in Children				
Lead Screening in Children	78.70% ★★★	83.17% ★★★★	81.02% ★★★★	81.05% ★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	75.00% ★★★	73.32% ★★★	77.78% ★★★★	75.77% ★★★
Counseling for Nutrition—Total	70.60% ★★★	68.27% ★★★	69.68% ★★★	69.51% ★★★
Counseling for Physical Activity—Total	65.28% ★★★★	57.93% ★★★	56.25% ★★★	59.07% ★★★
Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	88.32% ★★	87.16% ★★	86.91% ★★	87.34% ★★
Well-Child/Well-Care Visits				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	56.71% ★★★	50.00% ★★★	51.62% ★★★	52.51% ★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	71.69% ★★★★	63.73% ★★★	63.41% ★★★	65.81% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.20% ★★★	72.80% ★★★	71.16% ★★	72.46% ★★★
Women's Health				
Prenatal Care and Birth Outcomes				
Antenatal Steroids				
Antenatal Steroids	21.28% NC	54.55% NC	NA	51.31% NC
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	18.98% NC	5.58% NC	21.99% NC	17.17% NC

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Cesarean Delivery Rate, Uncomplicated				
*Cesarean Delivery Rate, Uncomplicated**	28.89% NC	30.22% NC	29.89% NC	29.69% NC
Cesarean Rate for Nulliparous Singleton Vertex				
*Cesarean Rate for Nulliparous Singleton Vertex**	1.67% NC	NR	NR	1.67% NC
Elective Delivery				
*Elective Delivery**	6.82% NC	NR	NA	6.62% NC
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	58.56% ★★	48.18% ★★	56.50% ★★	54.27% ★★
Percentage of Live Births Weighing Less Than 2,500 Grams				
*Percentage of Live Births Weighing Less Than 2,500 Grams**	8.65% NC	8.86% NC	8.69% NC	8.74% NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.25% ★★	73.72% ★	80.38% ★★	78.36% ★★
Postpartum Care	68.98% ★★★★	61.07% ★★★	60.28% ★★	63.19% ★★★
Prevention and Screening				
Breast Cancer Screening				
Breast Cancer Screening	70.66% ★★★★	66.12% ★★★★	67.85% ★★★★	68.29% ★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	66.75% ★★★★	66.19% ★★★★	69.77% ★★★★	67.80% ★★★★
Chlamydia Screening in Women				
Total	58.98% ★★★	62.60% ★★★★	56.69% ★★★	59.02% ★★★
Chronic Conditions				
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	86.07% ★★★	83.48% ★★	81.79% ★	83.53% ★★
*HbA1c Poor Control (>9.0%)**	51.58% ★★	61.04% ★	56.30% ★	56.23% ★
HbA1c Control (<8.0%)	38.64% ★	29.91% ★	37.63% ★	35.76% ★
HbA1c Control (<7.0%)	29.14% ★	22.46% ★	28.97% ★	27.17% ★
Eye Exam (Retinal) Performed	45.27% ★★	59.83% ★★★	42.94% ★	48.37% ★★
Medical Attention for Nephropathy	90.88% ★★★	88.70% ★★	92.41% ★★★★	90.92% ★★★

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Blood Pressure Control (<140/90 mm Hg)	55.72% ★★	46.78% ★	47.04% ★	49.53% ★
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)				
*Diabetes Short-Term Complications Admission Rate**	14.32 NC	12.82 NC	17.21 NC	14.94 NC
Cardiovascular Conditions				
Controlling High Blood Pressure				
Controlling High Blood Pressure	47.43% ★★	37.82% ★	34.30% ★	38.98% ★
Heart Failure Admission Rate (per 100,000 Member Months)				
*Heart Failure Admission Rate**	5.42 NC	7.49 NC	7.49 NC	6.89 NC
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	78.57% ★★	74.68% ★
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)				
*Asthma in Younger Adults Admission Rate**	2.54 NC	5.24 NC	5.98 NC	4.76 NC
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)				
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	22.01 NC	20.51 NC	45.76 NC	30.65 NC
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	38.46% ★	31.53% ★	33.99% ★	34.57% ★
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.53% ★★	40.76% ★	44.88% ★	45.35% ★
Effective Continuation Phase Treatment	30.95% ★	24.84% ★	29.07% ★	28.47% ★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.66% ★★★	85.39% ★★★★	83.97% ★★★	84.22% ★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	49.09% ★★★	50.75% ★★★	52.45% ★★★	51.00% ★★★
30-Day Follow-Up	67.43% ★★★	66.67% ★★★	70.61% ★★★	68.62% ★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	46.10% ★★★	45.69% ★★★	49.76% ★★★★	47.74% ★★★

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Continuation and Maintenance Phase	62.79% ★★★★	59.84% ★★★	68.00% ★★★★★	64.65% ★★★★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment				
Initiation of AOD Treatment—Total	39.02% ★★★	35.32% ★★	32.98% ★	35.27% ★★
Engagement of AOD Treatment—Total	9.40% ★★	6.71% ★	6.79% ★	7.50% ★★
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	14.73% NC	10.90% NC	7.25% NC	10.46% NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
*Total**	2.91% ★★	1.37% ★★★	1.70% ★★★	1.96% ★★★
Medication Management				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.59% ★★★★	87.22% ★★	89.23% ★★★	89.13% ★★★
Diuretics	88.49% ★★★	86.68% ★★	89.56% ★★★	88.50% ★★★
Total	89.45% ★★★	86.91% ★★	89.22% ★★★	88.69% ★★★
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	42.62% ★	46.01% ★	47.46% ★★	45.78% ★
Medication Compliance 50%—Ages 12–18 Years	44.62% ★★	44.02% ★★	45.63% ★★	44.89% ★★
Medication Compliance 50%—Ages 19–50 Years	46.98% ★	52.74% ★	53.77% ★	51.87% ★
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	63.77% ★
Medication Compliance 50%—Total	43.77% ★	45.69% ★	47.12% ★	45.82% ★
Medication Compliance 75%—Ages 5–11 Years	19.72% ★	20.28% ★	21.84% ★★	20.82% ★
Medication Compliance 75%—Ages 12–18 Years	18.41% ★	19.77% ★★	19.52% ★★	19.30% ★★
Medication Compliance 75%—Ages 19–50 Years	24.83% ★	21.89% ★	33.22% ★★	27.73% ★
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	43.48% ★★
Medication Compliance 75%—Total	19.77% ★	20.25% ★	21.56% ★	20.70% ★
Use of Opioids at High Dosage (per 1,000 Member Months)				
Use of Opioids at High Dosage—All Ages	19.40 NC	10.65 NC	16.45 NC	15.77 NC

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Utilization				
Ambulatory Care (per 1,000 Member Months)—Total				
*ED Visits—Total**	54.90 NC	52.27 NC	62.39 NC	57.20 NC
Outpatient Visits—Total	303.58 NC	307.29 NC	406.77 NC	347.83 NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	5.04 NC	6.05 NC	7.02 NC	6.18 NC
Total Inpatient—Days per 1,000 Member Months—Total	17.83 NC	20.48 NC	20.79 NC	19.90 NC
Total Inpatient—Average Length of Stay—Total	3.54 NC	3.39 NC	2.96 NC	3.22 NC
Maternity—Discharges per 1,000 Member Months—Total	6.84 NC	8.63 NC	8.02 NC	7.89 NC
Maternity—Days per 1,000 Member Months—Total	19.31 NC	24.48 NC	19.52 NC	21.00 NC
Maternity—Average Length of Stay—Total	2.82 NC	2.83 NC	2.43 NC	2.66 NC
Surgery—Discharges per 1,000 Member Months—Total	0.56 NC	0.52 NC	0.86 NC	0.67 NC
Surgery—Days per 1,000 Member Months—Total	4.27 NC	4.10 NC	5.30 NC	4.65 NC
Surgery—Average Length of Stay—Total	7.66 NC	7.89 NC	6.16 NC	6.91 NC
Medicine—Discharges per 1,000 Member Months—Total	1.01 NC	1.24 NC	2.19 NC	1.58 NC
Medicine—Days per 1,000 Member Months—Total	3.78 NC	4.23 NC	5.82 NC	4.77 NC
Medicine—Average Length of Stay—Total	3.73 NC	3.40 NC	2.66 NC	3.03 NC
Mental Health Utilization—Total				
Inpatient—Total	0.55% NC	0.40% NC	0.55% NC	0.50% NC
Intensive Outpatient or Partial Hospitalization—Total	0.12% NC	0.10% NC	0.12% NC	0.12% NC
Outpatient, ED, or Telehealth—Total	9.73% NC	7.76% NC	9.47% NC	9.00% NC
Any Service—Total	9.86% NC	7.86% NC	9.57% NC	9.11% NC
Plan All-Cause Readmissions Rate*				
18–44 Years	12.66% NC	11.87% NC	11.17% NC	11.76% NC

Measure	Amerigroup	Peach State	WellCare	Georgia Families
45–54 Years	10.31% NC	9.78% NC	11.03% NC	10.52% NC
55–64 Years	10.26% NC	11.94% NC	14.29% NC	12.55% NC
18–64—Total	12.18% NC	11.58% NC	11.29% NC	11.61% NC
65–74 Years	NA	NA	NA	NA
75–84 Years	NA	NA	NA	NA
85 and Older	NA	NA	NA	NA
65 and Older—Total	NA	NA	NA	NA
Health Plan Descriptive Information				
Race/Ethnicity Diversity of Membership				
Total—White	47.71% NC	33.30% NC	49.40% NC	43.69% NC
Total—Black or African American	44.91% NC	50.42% NC	44.01% NC	46.35% NC

** A lower rate indicates better performance for this measure.*
NC indicates the RY 2017 rate was not compared to benchmarks either because data are not available or because a measure is informational only and comparisons to benchmarks are not appropriate.
NA indicates the denominator for the measure is too small to report (less than 30).
NR indicates the rate was not reported or the calculated rate was determined to be materially biased.

For RY 2017, performance varied among the three CMOs and the Georgia Families weighted average. Among the three CMOs, Amerigroup displayed high performance as 36 of 62 measure rates (58.1 percent), where comparisons to percentiles could be made, ranked at or above the national Medicaid 50th percentile. Additionally, WellCare displayed strength with 34 of 63 measure rates (54.0 percent) performing at or above the national Medicaid 50th percentile and seven measure rates (11.1 percent) meeting or exceeding the 90th percentile. Of note, five of the seven rates above the 90th percentile are indicators for the *Annual Dental Visit* measure, suggesting the CMO's high performance is mostly concentrated to this one area and not spread over several different measures. Further, Peach State had the fewest measure rates, 31 of 62 (50.0 percent), that ranked at or above the national Medicaid 50th percentile for the CMOs.

All CMOs exhibited strength by performing at or above the national Medicaid 50th percentile for *Annual Dental Visit*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years*; *Appropriate Testing for Children With Pharyngitis*; *Childhood Immunization Status—Combination 3*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Lead Screening in Children*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*; *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life*; *Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women*; *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; *Follow-Up After Hospitalization for Mental Illness*; and *Follow-Up Care for Children Prescribed ADHD Medication*.

Peach State demonstrated the most opportunity for improvement for the CMOs, as 31 of 62 measure rates (50.0 percent) fell below the national Medicaid 50th percentile, with 17 measure rates (27.4 percent) falling below the 25th percentile. For WellCare, 29 of 63 measure rates (46.0 percent) fell below the national Medicaid 50th percentile, with 15 measure rates (23.8 percent) falling below the 25th percentile. Additionally, 26 of 62 measure rates (41.9 percent) for Amerigroup fell below the national Medicaid 50th percentile, with 11 measure rates (17.7 percent) falling below the 25th percentile. All three CMOs would benefit from focused improvement efforts in the Chronic Conditions, Behavioral Health, and Medication Management domains, as most of the CMOs' rates that fell below the national Medicaid 25th or 50th percentiles were indicators for the following measures: *Comprehensive Diabetes Care*, *Controlling High Blood Pressure*, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Antidepressant Medication Management*, *Initiation and Engagement of AOD Dependence Treatment*, and *Medication Management for People With Asthma*.

For the GF 360° population, HSAG validated rates for the following set of performance measures selected by DCH for validation. All performance measures were selected from CMS' Child Core Set, Adult Core Set, and AHRQ's Quality Indicator measures. The measurement period was CY 2016 for all measures except the Child Core Set dental measure. The dental measure was reported for FFY 2016 according to CMS requirements, which covered the time frame of October 1, 2015, through September 30, 2016. Table 1-5 lists the performance measures that HSAG validated, the method required by DCH for data collection, and the specifications the CMO was required to use for each of the measures.

Table 1-5—List of CY 2017 GF 360° Performance Measures for Amerigroup 360°

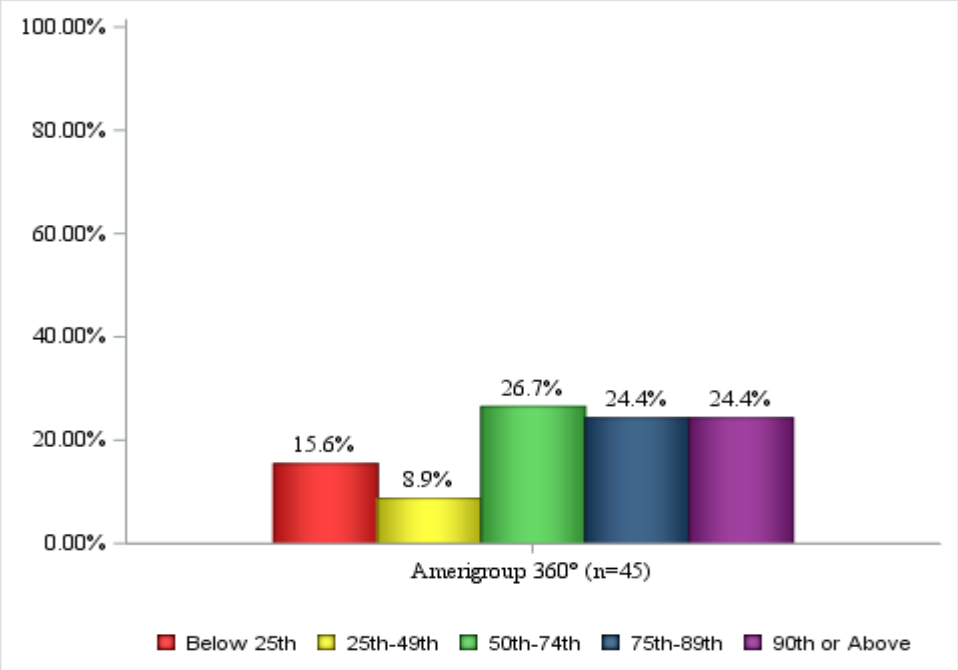
	Performance Measure	Method	Specifications
1.	*Asthma in Younger Adults Admission Rate*	Admin	Adult Core Set
2.	*Behavioral Health Risk Assessment for Pregnant Women*	Hybrid	Child Core Set
3.	*Cesarean Delivery Rate*	Admin	AHRQ
4.	*Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*	Admin	Child Core Set
5.	*Developmental Screening in the First Three Years of Life*	Hybrid	Child Core Set
6.	*Diabetes Short-Term Complications Admission Rate*	Admin	Adult Core Set
7.	*Live Births Weighing Less Than 2,500 Grams*	Admin	Child Core Set
8.	*Plan All-Cause Readmissions Rate**	Admin	Adult Core Set
9.	*Screening for Clinical Depression and Follow-up Plan*	Hybrid	Adult Core Set

*Risk adjustment was not required.

Georgia Families 360° Findings

Figure 1-2 displays the percentage of RY 2017 performance measure rates compared to NCQA's 2016 Quality Compass national Medicaid HMO percentiles for Amerigroup 360°.

Figure 1-2—Percentage of RY 2017 Performance Measure Rates for Amerigroup 360° Compared to National Medicaid Percentiles



Note: Percentages may not total 100 percent due to rounding.

Table 1–6 presents the RY 2017 rates along with star ratings based on rate comparisons to the NCQA 2016 Quality Compass national Medicaid HMO percentiles, where applicable, for Amerigroup 360°. Star ratings were assigned as shown in Table 1–3.

Table 1–6—RY 2017 Results for Amerigroup 360°

Measure	Amerigroup 360°
Access to Care	
Adults' Access to Preventive/Ambulatory Health Services[1]	
20–44 Years	55.68% ★
Adult BMI Assessment[1]	
Adult BMI Assessment	62.82% ★
Annual Dental Visit	
2–3 Years	56.93% ★★★★★
4–6 Years	79.94% ★★★★★
7–10 Years	78.41% ★★★★★
11–14 Years	70.91% ★★★★★

Measure	Amerigroup 360°
15–18 Years	65.96% ★★★★★
19–20 Years	40.70% ★★★
Total	69.78% ★★★★★
Children and Adolescents' Access to Primary Care Practitioners	
12–24 Months	98.95% ★★★★★
25 Months–6 Years	91.88% ★★★★
7–11 Years	88.23% ★★
12–19 Years	82.69% ★
Children's Health	
Prevention and Screening	
Appropriate Testing for Children With Pharyngitis	
Appropriate Testing for Children With Pharyngitis	83.10% ★★★★
Childhood Immunization Status	
Combination 3	72.22% ★★★
Combination 6	37.27% ★★
Combination 10	27.55% ★★
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	26.42% NC
Developmental Screening in the First Three Years of Life	
Total	62.96% NC
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	84.49% ★★★★
HPV	19.44% NC
Lead Screening in Children	
Lead Screening in Children	84.49% ★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	78.24% ★★★★
Counseling for Nutrition—Total	79.63% ★★★★★

Measure	Amerigroup 360°
Counseling for Physical Activity—Total	73.15% ★★★★★
Upper Respiratory Infection	
Appropriate Treatment for Children With Upper Respiratory Infection	
Appropriate Treatment for Children With Upper Respiratory Infection	87.63% ★★
Well-Child/Well-Care Visits	
Adolescent Well-Care Visits	
Adolescent Well-Care Visits	56.61% ★★★
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	62.73% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.10% ★★★
Women's Health	
Prenatal Care and Birth Outcomes	
Behavioral Health Risk Assessment for Pregnant Women	
Behavioral Health Risk Assessment for Pregnant Women	17.20% NC
Cesarean Delivery Rate, Uncomplicated	
*Cesarean Delivery Rate, Uncomplicated**	22.89% NC
Frequency of Ongoing Prenatal Care	
≥81 Percent of Expected Visits	66.27% ★★★
Percentage of Live Births Weighing Less Than 2,500 Grams	
*Percentage of Live Births Weighing Less Than 2,500 Grams**	NA
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	65.06% ★
Postpartum Care	67.47% ★★★
Prevention and Screening	
Chlamydia Screening in Women	
Total	60.88% ★★★
Chronic Conditions	
Diabetes	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	NA
*HbA1c Poor Control (>9.0%)**	NA

Measure	Amerigroup 360°
HbA1c Control (<8.0%)	NA
Eye Exam (Retinal) Performed	NA
Medical Attention for Nephropathy	NA
Blood Pressure Control (<140/90 mm Hg)	NA
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)	
*Diabetes Short-Term Complications Admission Rate**	12.21 NC
Cardiovascular Conditions	
Controlling High Blood Pressure	
Controlling High Blood Pressure	NA
Respiratory Conditions	
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)	
*Asthma in Younger Adults Admission Rate**	0.00 NC
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA
Antidepressant Medication Management	
Effective Acute Phase Treatment	46.88% ★
Effective Continuation Phase Treatment	31.25% ★
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up	51.83% ★★★
30-Day Follow-Up	72.80% ★★★★
Follow-Up Care for Children Prescribed ADHD Medication	
Initiation Phase	53.95% ★★★★
Continuation and Maintenance Phase	66.27% ★★★★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	
Initiation of AOD Treatment—Total	55.65% ★★★★★
Engagement of AOD Treatment—Total	22.61% ★★★★★
Screening for Clinical Depression and Follow-Up Plan	
Screening for Clinical Depression and Follow-Up Plan	10.99% NC

Measure	Amerigroup 360°
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	
*Total**	5.96% ★
Medication Management	
Medication Management for People With Asthma	
Medication Compliance 50%—Ages 5–11 Years	62.57% ★★★★
Medication Compliance 50%—Ages 12–18 Years	56.25% ★★★★
Medication Compliance 50%—Ages 19–50 Years	NA
Medication Compliance 50%—Total	59.72% ★★★
Medication Compliance 75%—Ages 5–11 Years	37.43% ★★★★
Medication Compliance 75%—Ages 12–18 Years	28.41% ★★★
Medication Compliance 75%—Ages 19–50 Years	NA
Medication Compliance 75%—Total	32.50% ★★★
Utilization	
Ambulatory Care (per 1,000 Member Months)—Total	
*ED Visits—Total**	35.44 NC
Outpatient Visits—Total	302.00 NC
Inpatient Utilization—General Hospital/Acute Care—Total	
Total Inpatient—Discharges per 1,000 Member Months—Total	1.84 NC
Total Inpatient—Days per 1,000 Member Months—Total	9.26 NC
Total Inpatient—Average Length of Stay—Total	5.04 NC
Maternity—Discharges per 1,000 Member Months—Total	0.62 NC
Maternity—Days per 1,000 Member Months—Total	1.97 NC
Maternity—Average Length of Stay—Total	3.19 NC
Surgery—Discharges per 1,000 Member Months—Total	0.43 NC
Surgery—Days per 1,000 Member Months—Total	3.97 NC
Surgery—Average Length of Stay—Total	9.29 NC

Measure	Amerigroup 360°
Medicine—Discharges per 1,000 Member Months—Total	1.06 NC
Medicine—Days per 1,000 Member Months—Total	4.19 NC
Medicine—Average Length of Stay—Total	3.94 NC
Mental Health Utilization—Total	
Inpatient—Total	3.87% NC
Intensive Outpatient or Partial Hospitalization—Total	0.72% NC
Outpatient, ED, or Telehealth—Total	54.51% NC
Any Service—Total	54.88% NC
Plan All-Cause Readmissions Rate*	
18–44 Years[1]	18.63% NC
Health Plan Descriptive Information	
Race/Ethnicity Diversity of Membership	
Total—White	49.04% NC
Total—Black or African American	45.52% NC

** A lower rate indicates better performance for this measure.*
[1] Indicates that the data for this measure only include members 21 years of age and younger.
NC indicates the RY 2017 rate was not compared to benchmarks either because data are not available or because a measure is informational only and comparisons to benchmarks are not appropriate.
NA indicates the denominator for the measure is too small to report (less than 30).

For RY 2017, 34 of 45 measure rates (75.6 percent), where comparisons to percentiles could be made, ranked at or above the national Medicaid 50th percentile for Amerigroup 360°. Eleven of the rates (24.4 percent) met or exceeded the 90th percentile, demonstrating strength for the CMO within the Access to Care, Children's Health, and Behavioral Health domains for the following measure rates: *Annual Dental Visit—2–3 Years*, *4–6 Years*, *7–10 Years*, *11–14 Years*, *15–18 Years*, and *Total*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*; and *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*.

Conversely, 7 of 45 measure rates (15.6 percent) for Amerigroup 360° fell below the national Medicaid 25th percentile, indicating opportunities for improvement for the CMO within the Access to Care, Women's Health, and Behavioral Health domains for the following measure rates: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*; *Adult BMI Assessment*; *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*; *Prenatal and Postpartum Care—*

Timeliness of Prenatal Care; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*. Three of the seven rates affect members within the Behavioral Health domain, suggesting focused improvement in medication management within this area for the CMO may be beneficial. Additionally, as Amerigroup 360° serves members 21 years of age and younger, caution should be exercised when evaluating rates for measures that typically include only adult members (e.g., *Adults' Access to Preventive/Ambulatory Health Services*, *Adult BMI Assessment*, and *Plan All-Cause Readmission Rate*).

Validation of Performance Improvement Projects (PIPs)

In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement[1-15] and modified by IHI. The redesigned methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects CMOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement.

HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings, a new approach was needed. After meeting with DCH and HSAG staff members to discuss the topics and approach, CMS gave approval for DCH to implement this new PIP approach in Georgia.

PIPs are conducted on a calendar year cycle; therefore, CY in the PIP section refers to calendar year. In CY 2016–2017, the CMOs continued using the rapid-cycle PIP approach. Table 1-7 summarizes the PIP topics addressed by the CMOs.

Table 1-7—CY 2016–2017 PIP Topics

CMO	PIP Topics
Amerigroup	*Bright Futures*
	Member Satisfaction
	Postpartum Care
	Provider Satisfaction
Peach State	*Annual Dental Visits*
	Avoidable Emergency Room Visits
	Member Satisfaction
	Provider Satisfaction

[1-15] Associates in Process Improvement. Model for Improvement. Available at: http://www.apiweb.org/. Accessed on: Mar 30, 2018.

CMO	PIP Topics
WellCare	*Appropriate Use of ADHD [Attention Deficit Hyperactivity Disorder] Medications*
	Comprehensive Diabetes Care
	Member Satisfaction
	Provider Satisfaction
Amerigroup GF 360°	*7-Day Inpatient Discharge Follow-up*
	Adolescent Well-Child Visits
	Appropriate Use of ADHD Medications

The topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to care and services. Upon final validation, each PIP was given a validation score of either *High Confidence*, *Confidence*, *Low Confidence*, or *PIP Results Were Not Credible*. See Appendix A for a detailed description of PIP validation scoring.

Summary of Amerigroup's PIP Performance

Amerigroup submitted four PIPs for the calendar year 2016–2017 validation cycle. The CMO's performance across the four PIPs suggests that Amerigroup has made progress in successfully executing the rapid cycle PIP process compared to the previous year's (CY 2015–2016) validation findings. Table 1-8 summarizes Amerigroup's CY 2016–2017 PIP performance.

Table 1-8—Amerigroup CY 2016–2017 PIP Performance

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Bright Futures	The percentage of members in Chatham County that received a 9-month developmental screening	63.3%	73.3%	87.5%	*High Confidence*
Member Satisfaction	The percentage of members serviced at Toccoa Clinic who answered question 18, "In the last six months, how often did your child's personal doctor listen carefully to you?" with the response, "Always"	76.0%	90.0%	100.0%	*High Confidence*

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Postpartum Care	The percentage of members who received care from The Longstreet Clinic, delivered a live birth, and completed a postpartum follow-up visit within 21–56 days of the birth	76.5%	86.5%	79.0%	*Low Confidence*
Provider Satisfaction	The percentage of providers invited to provider orientation who reported being satisfied with the orientation	24.0%	60.0%	67.0%	*Confidence*

HSAG assigned a level of *High Confidence* for two of Amerigroup's PIPs, *Bright Futures* and *Member Satisfaction*. In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the quality improvement processes were clearly linked to the demonstrated improvement. HSAG assigned a level of *Confidence* for the *Provider Satisfaction* PIP because the SMART Aim goal was achieved; however, some but not all of the CMO's quality improvement processes could be linked to the demonstrated improvement. Finally, HSAG assigned a level of *Low Confidence* for the *Postpartum Care* PIP because the SMART Aim goal was not achieved during the life of the PIP.

CDC 6/18 Initiative: The purpose of Amerigroup's improvement project was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members 0–18 years of age who were seen at the participating emergency room (ER) for an asthma-related diagnosis, and who were enrolled in the CMO's DM program. The CMO used PDSA cycles to test the effectiveness of the two interventions for the project.

Overall, HSAG determined that Amerigroup appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO clearly documented the targeted population, intervention plans, and intervention testing measures. HSAG found that while the CMO reported some improvement in the monthly asthma controller medication rate during the testing of Intervention 1 (intensive self-management education) and Intervention 2 (follow-up reminder outreach), the CMO concluded that results were mixed, and additional data points were needed to fully evaluate the effectiveness of the interventions. Amerigroup reported plans to adapt both interventions and continue PDSA testing cycles to further refine the improvement strategies for its member population.

Summary of Peach State's PIP Performance

Peach State submitted four PIPs for the CY 2016–2017 validation cycle. The CMO's performance across the four PIPs suggests that Peach State has made progress in successfully executing the rapid cycle PIP process compared to the previous year's validation findings. Table 1-9 summarizes Peach State's CY 2016–2017 PIP performance.

Table 1-9—Peach State CY 2016–2017 PIP Performance

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Annual Dental Visits	The percentage of members 6 to 9 years of age in Muscogee County that received a sealant on a molar from Candler Dental	14.9%	34.9%	53.9%	*High Confidence*
Avoidable Emergency Room Visits	The rate of utilization of avoidable emergency room visits at Coffee Regional Medical Center	1,553.9	1,522.8	1,447.5	*Confidence*
Member Satisfaction	The average level of satisfaction for caregivers who were seen at Dr. Charlene Johnson's office who answered the question, "When you talked about your child's health, did a doctor or other health provider ask you what you thought was best for your child"	2.2	2.5	3.0	*High Confidence*
Provider Satisfaction	The average number of calendar days to complete a prior authorization requested by Spine and Orthopedic Clinic	8.4 days	5.0 days	4. 6 days	*Low Confidence*

HSAG determined *High Confidence* in the results of two PIPs, *Annual Dental Visits* and *Member Satisfaction.* In each of these PIPs, the design was methodologically sound, the SMART Aim goal was achieved, and the quality improvement processes were clearly linked to the demonstrated improvement. HSAG assigned a level of *Confidence* for the *Avoidable Emergency Room Visits* PIP because the SMART Aim goal was achieved; however, some but not all of the CMO's quality improvement processes could be linked to the demonstrated improvement. Finally, HSAG assigned a level of *Low Confidence* for the *Provider Satisfaction* PIP; the SMART Aim goal was achieved, but the improvement was not clearly linked to the CMO's quality improvement processes.

CDC 6/18 Initiative: The purpose of Peach State's CDC 6|18 initiative improvement project was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members in active DM whose asthma is not well controlled. For the project, "not well controlled" was defined as not adherent with controller medication

refills for three months. The CMO used PDSA cycles to test the effectiveness of one intervention for the project.

Overall, HSAG found that Peach State appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO demonstrated strength in developing a robust intervention evaluation plan. Notably, Peach State collected extensive process data to guide intervention assessment and refinement during the PDSA cycle. HSAG's validation process determined that the CMO tracked data related to scheduling and completion of the home visits and adjusted the intervention plan by adding unannounced home visits to address identified barriers and improve the home visit completion rate. Based on the intervention testing results, the CMO concluded that the intervention was effective but resource-intensive. The CMO reported plans to adapt the intervention to focus on a narrower, high-need population, incorporating the strategies into the DM program for members with asthma who have poor medication adherence and have had an inpatient hospitalization with a primary diagnosis of asthma in the last 30 days.

Summary of WellCare's PIP Performance

WellCare submitted four PIPs for the CY 2016–2017 validation cycle. The CMO's performance varied widely by PIP topic, similar to the previous year's validation findings for WellCare. Table 1-10 summarizes WellCare's CY 2016–2017 PIP performance.

Table 1-10—WellCare CY 2016–2017 PIP Performance

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Appropriate Use of ADHD Medications	By December 31, 2016, increase the rate of 30-day follow-up visits among members who are in the care of seven selected practices and are newly prescribed an ADHD medication therapy, from an average of 29.0% to 39.0%.	29.0%	39.0%	56.6%	*Confidence*
Comprehensive Diabetes Care	By December 31, 2016, increase the rate of diabetic retinal eye (DRE) exams among diabetic members 18–75 years of age who are assigned to one of the three selected providers, from 20.0% to 30.0%.	20.0%	30.0%	46.8%	*High Confidence*
Member Satisfaction	By December 31, 2016, we will increase the percentage of members participating in New Member Orientation Sessions in Gwinnett County, from 1.4% to 3.4%.	1.4%	3.4%	NR*	*Reported PIP results were not credible*

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
Provider Satisfaction	By December 31, 2016, increase the rate of Provider Satisfaction among providers in the Southwest Region who answer "excellent" or "very good," from 54.8% to 59.8%.	54.8%	59.8%	100.0%	*Confidence*

* In the PIP conclusions described in Module 5, the CMO reported rates for a different measure that did not align with the SMART Aim statement or measure; therefore, HSAG could not determine the Highest Rate Achieved for the SMART Aim measure.

HSAG assigned a level of *High Confidence* for WellCare's *Comprehensive Diabetes Care* PIP. The PIP design was methodologically sound, the SMART Aim goal was achieved, and the quality improvement processes could be clearly linked to the demonstrated improvement.

HSAG assigned a level of *Confidence* for WellCare's *Appropriate Use of ADHD Medications* and *Provider Satisfaction* PIPs. In the *Appropriate Use of ADHD Medications* PIP, the SMART Aim goal was achieved, and the intervention was linked to the demonstrated improvement; however, the CMO failed to update the SMART Aim statement to reflect changes in the number of participating providers and failed to recalculate the baseline and goal rates for the SMART Aim measure. In the *Provider Satisfaction* PIP, the SMART Aim goal was achieved, and one of the two interventions was clearly linked to the demonstrated improvement.

HSAG determined that for WellCare's *Member Satisfaction* PIP, the reported PIP results were not credible. The CMO did not report results of the approved SMART Aim measure at the conclusion of the PIP. Because the CMO did not follow the approved SMART Aim measure methodology, the final run chart in Module 5 could not be used to evaluate the success of the PIP by comparing the SMART Aim measurements to the established baseline and goal rates. The PIP did not demonstrate evidence of achieving the SMART Aim goal because the SMART Aim measurement methodology was flawed.

CDC 6/18 Initiative: The purpose of WellCare's CDC 6|18 initiative improvement project was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members in active DM whose asthma is not well controlled. For the project, "not well controlled" was defined as not adherent with controller medication refills for three months. The CMO used PDSA cycles to test the effectiveness of one intervention for the project.

Overall, HSAG determined that WellCare appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO demonstrated strength in developing a robust intervention evaluation plan. Notably, WellCare collected extensive process data to guide intervention assessment and refinement during the PDSA cycle. HSAG found that the CMO tracked data related to scheduling and completion of the home visits and adjusted the intervention plan by adding unannounced home visits to address identified barriers and improve the home visit completion rate. Based on the intervention testing results, the CMO concluded that the intervention was effective but resource-intensive. The CMO reported plans to adapt the intervention to

focus on a narrower, high-need population, incorporating the strategies into the DM program for members with asthma who have poor medication adherence and have had an inpatient hospitalization with a primary diagnosis of asthma in the last 30 days.

Summary of Amerigroup 360°'s PIP Performance

Amerigroup 360° submitted three PIPs for the CY 2016–2017 validation cycle. HSAG's validation findings for the three CY 2016 PIPs suggest that there was a lack of continuity in the CMO's improvement efforts as PIP performance declined from CY 2015 to CY 2016. Table 1-11 summarizes Amerigroup 360°'s CY 2016–2017 PIP performance.

Table 1-11—Amerigroup 360° CY 2016–2017 PIP Performance

PIP Title	SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
7-Day Inpatient Discharge Follow-up	The percentage of discharges from Crescent Pines Hospital and Peachford Hospital with a principal diagnosis of mental illness that were followed by a mental health follow-up visit within seven days of discharge.	51.0%*	56.0%*	49.4%	*Low Confidence*
Adolescent Well-Child Visits	The percentage of members 12–21 years old living in Gwinnett County who completed an adolescent well-child visit	37.8%	42.8%	NR**	*Reported PIP results were not credible*
Appropriate Use of ADHD Medications	The percentage of members 6–12 years of age in Fulton County who completed a follow-up visit within 30 days of filling a new ADHD medication prescription	50.2%	55.2%	57.6%	*Low Confidence*

* It should be noted that the CMO inconsistently documented the baseline rate and SMART Aim goal rate for the PIP. The rates included in Table 1-11 were taken from the SMART Aim statement in the CMO's final key driver diagram in the Module 5 submission form.
** The CMO reported rates for a different measure that did not align with the SMART Aim statement or measure; therefore, HSAG could not determine the Highest Rate Achieved for the SMART Aim measure.

HSAG assigned a level of *Low Confidence* for Amerigroup 360°'s *7-Day Inpatient Discharge Follow-up* and *Appropriate Use of ADHD Medications* PIPs. HSAG assigned a level of *Low Confidence* for the *7-Day Inpatient Discharge Follow-up* PIP because the SMART Aim goal was not achieved. Although

the SMART Aim goal was achieved for the *Appropriate Use of ADHD Medications* PIP, the improvement was not clearly linked to the intervention tested.

HSAG determined that Amerigroup 360°'s reported results for the *Adolescent Well-Child Visits* PIP were not credible. The CMO did not report the results of the approved SMART Aim measure as part of the PIP conclusions in Module 5 and instead reported results only for the intervention-specific measure that was used to evaluate the effectiveness of the intervention tested in Module 4. Because the CMO did not report results of the approved SMART Aim measure, the success of the PIP in achieving the SMART Aim goal could not be evaluated.

Summary of CAHPS Results

CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that patients have with their healthcare experiences. The CAHPS summary information below discusses ***Top Box Scores***, which are used to display the percentage of survey respondents who chose the most positive score for a given item response scale.

Table 1-12—2017 Adult Medicaid Plan Comparisons

	Amerigroup	Peach State	WellCare
Composite Measures			
Getting Needed Care	80.8% ⇔	79.2% ⇔	81.8% ⇔
Getting Care Quickly	82.1% ⇔	82.7% ⇔	87.3% ⇔
How Well Doctors Communicate	91.2% ⇔	92.6% ⇔	93.3% ⇔
Customer Service	86.7% ⇔	86.9% ⇔	89.0% + ⇔
Shared Decision Making	82.1% + ⇔	78.0% ⇔	81.8% + ⇔
Global Ratings			
Rating of All Health Care	77.7% ⇔	75.6% ⇔	72.5% ⇔
Rating of Personal Doctor	83.7% ⇔	84.1% ⇔	84.4% ⇔
Rating of Specialist Seen Most Often	91.0% ↑	78.3% ⇔	80.0% + ⇔
Rating of Health Plan	77.8% ⇔	78.0% ⇔	78.7% ⇔

\+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.
↑ Indicates the CMO's score is statistically better than the Georgia CMO program average.
⇔ Indicates the CMO's score is not statistically significantly different than the Georgia CMO program average.
↓ Indicates the CMO's score is statistically worse than the Georgia CMO program average.

The results of the adult Medicaid CMO comparison indicated that Amerigroup scored statistically higher than the Georgia program average on one CAHPS measure—*Rating of Specialist Seen Most Often*.

Table 1-13—2017 Child Medicaid Plan Comparisons

	Amerigroup	Peach State	WellCare
Composite Measures			
Getting Needed Care	84.5% ⇔	83.9% ⇔	88.0% ⇔
Getting Care Quickly	91.0% ⇔	90.9% ⇔	94.4% ⇔
How Well Doctors Communicate	93.1% ⇔	92.6% ⇔	96.2% ↑
Customer Service	88.4% ↓	90.6% ⇔	94.9% ↑
Shared Decision Making	79.6% ⇔	74.3% ⇔	71.8% + ⇔
Global Ratings			
Rating of All Health Care	89.8% ⇔	88.6% ⇔	88.9% ⇔
Rating of Personal Doctor	89.6% ⇔	90.0% ⇔	89.4% ⇔
Rating of Specialist Seen Most Often	87.8% ⇔	84.7% ⇔	81.2% + ⇔
Rating of Health Plan	88.7% ⇔	90.3% ⇔	87.3% ⇔

\+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.
↑ Indicates the CMO's score is statistically better than the Georgia CMO program average.
⇔ Indicates the CMO's score is not statistically significantly different than the Georgia CMO program average.
↓ Indicates the CMO's score is statistically worse than the Georgia CMO program average.

The results of the child Medicaid CMO comparisons indicated that Amerigroup scored statistically significantly lower than the Georgia CMO program average on one CAHPS measure, *Customer Service*. The results also showed that WellCare scored statistically significantly higher than the Georgia CMO program on two CAHPS measures, *How Well Doctors Communicate* and *Customer Service*.

Summary of Amerigroup's CAHPS Performance

Amerigroup's 2017 top-box rates for the adult Medicaid population were at least 5 percentage points less than the 2017 NCQA adult Medicaid national averages for *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Amerigroup's rates decreased between 2016 and 2017 for six measures; however, none of these six measures had a substantial decrease of 5 percentage points or more from the 2016 rate.

Amerigroup's 2017 top-box rates for the adult Medicaid population were at least 5 percentage points greater than the 2017 NCQA adult Medicaid national averages for *Rating of Specialist Seen Most Often* and *Rating of Health Plan*. Amerigroup's rates increased between 2016 and 2017 for six measures; however, these six measures did not have a substantial increase of 5 percentage points or more from the 2016 rate.

Amerigroup's 2017 top-box rate for the child Medicaid population was less than the 2017 NCQA child Medicaid national average for one measure. Amerigroup's 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for seven measures. None of the measure rates were at least 5 percentage points greater or less than the 2017 national averages.

Amerigroup's rates decreased between 2016 and 2017 for two measures. Neither rate had a substantial decrease of 5 percentage points or more from the 2016 rate. Amerigroup's rates increased between 2016 and 2017 for six measures. Of the six measures, *Shared Decision Making* showed a substantial increase of 5 percentage points or more.

Summary of Peach State's CAHPS Performance

Peach State's 2017 top-box rates for the adult Medicaid population were at least 5 percentage points less than the 2017 NCQA adult Medicaid national averages for *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. Peach State's rates decreased between 2016 and 2017 for seven measures; however, none of these seven measures had a substantial decrease of 5 percentage points or more from the 2016 rate.

None of Peach State's 2017 top-box rates for the adult Medicaid population exceeded the 2017 NCQA adult Medicaid national averages by 5 percentage points or more. Peach State's rates increased between 2016 and 2017 for five measures; however, these five measures did not have a substantial increase of 5 percentage points or more from the 2016 rate.

Peach State's 2017 top-box rates for the child Medicaid population were less than the 2017 NCQA child Medicaid national averages for four measures. Peach State's 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for five measures. None of the measure rates were at least 5 percentage points greater or less than the 2017 national average.

Peach State's rates decreased between 2016 and 2017 for three child Medicaid population measures. Peach State's rates increased between 2016 and 2017 for six measures. None of the measure rates had a substantial increase or decrease of 5 percentage points or more from the 2016 rate.

Summary of WellCare's CAHPS Performance

WellCare's 2017 top-box rates for the adult Medicaid population were less than the 2017 NCQA adult Medicaid national averages for six measures. Of these, *Discussing Cessation Medications* and *Discussing Cessation Strategies* were at least 5 percentage points less than the 2017 national averages.

WellCare's 2017 top-box rates for the adult Medicaid population exceeded the 2017 NCQA adult Medicaid national averages for six measures. Of these, the *Getting Care Quickly* rate was at least 5 percentage points greater than the 2017 national average.

WellCare's adult Medicaid population rates decreased between 2016 and 2017 for six measures. Of these, *Rating of All Health Care* showed a substantial decrease of 5 percentage points or more. WellCare's adult Medicaid population rates increased between 2016 and 2017 for six measures. Of these, *Getting Care Quickly* and *Rating of Personal Doctor* showed a substantial increase of 5 percentage points or more.

WellCare's 2017 top-box rates for the child Medicaid population were less than the 2017 NCQA child Medicaid national averages for two measures. Of these, *Shared Decision Making* and *Rating of Specialist Seen Most Often* were at least 5 percentage points less than the 2017 national averages.

WellCare's 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for seven measures. Of these, *Getting Care Quickly* and *Customer Service* were at least 5 percentage points greater than the 2017 national averages.

WellCare's child Medicaid population rates decreased between 2016 and 2017 for four measures. Of these, *Shared Decision Making* showed a substantial decrease of 5 percentage points or more. WellCare's child Medicaid population rates increased between 2016 and 2017 for five measures. Of these, *Customer Service* showed a substantial increase of 5 percentage points or more.

Summary of Amerigroup 360°'s CAHPS Performance

Amerigroup 360°'s 2017 top-box rates for the child Medicaid population were less than the 2017 NCQA child Medicaid national averages for three measures. Of these, the *Rating of Health Plan* rate was at least 5 percentage points less than the 2017 national average.

Amerigroup 360°'s 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for six measures. Of these, the rate for *Getting Care Quickly* was at least 5 percentage points greater than the 2017 national average.

Amerigroup 360°'s child Medicaid population rates decreased between 2016 and 2017 for two measures. Neither of these rates showed a substantial decrease of more than 5 percentage points. Amerigroup 360°'s rates increased between 2016 and 2017 for six measures. Of these, *Rating of Health Plan* showed a substantial increase of more than 5 percentage points.

Summary of the Quality and Timeliness of, and Access to Care Furnished by CMOs

The following paragraphs provide a high-level overview of examples of the CMOs' performance related to the quality and timeliness of, and access to care furnished to members. The information is intended to be representative and should not be considered an all-inclusive list.

Quality

The CMOs in Georgia submitted a total of 15 PIPs for the calendar year 2016–2017 validation cycle. The project topics addressed CMS requirements related to quality outcomes, specifically the quality and timeliness of, and access to care and services. Upon final validation, each PIP was given a validation score of either *High Confidence*, *Confidence*, *Low Confidence*, or *PIP Results Were Not Credible.* SMART Aim goals were reached for most of the PIPs, except for cases in which the quality improvement processes could not be linked to the demonstrated improvement. All CMOs except

Amerigroup 360° selected member satisfaction as a PIP topic, and these interventions were established in different ways. Overall, the CMOs' performance across the PIPs varied greatly in executing the rapid cycle PIP process compared to the previous year's (calendar year 2015–2016) validation findings.

There were varying degrees of compliance with requirements focused on coordination and continuity of care. GF CMO compliance scores for this standard ranged from 61.9 percent to 85.7 percent. The CMOs had appropriate policies, procedures, program descriptions, process workflows, and monitoring process. However, the day-to-day activities were not congruent with the CMOs' written documentation. Care plans were not consistently member-centered or measurable and did not consistently align with the member's current problem, diagnosis, or goals. The case managers did not consistently include the provider, caregiver, or the member in the development of the care plan or in discharge planning and follow-up in relation to the implementation of the care plan. The CMOs did, however, provide copies of the care plans to the member's primary care provider.

The CMOs all used similar methods to identify members appropriate for CM services, including predictive modeling software, staff referrals, self-referrals, data mining, and "trigger lists" that were based on inpatient admissions. Care management assessments were completed in a timely manner and addressed the member's physical, mental, and psychosocial needs. Cultural requests and concerns plus linguistic needs were considered. Care plans were not always individualized to the member, and the member's caregiver (when appropriate) was not always involved in the care plan creation. Overall, the CMOs did not consistently use a multidisciplinary team approach when monitoring members who were in CM. Discharge planning documentation and follow-up were limited to information provided to the member or guardian upon discharge.

The GF CMOs received compliance scores of 100 percent for standards related to member rights and protections, indicating that the CMOs provide appropriate education and information to members regarding their rights. However, results of the review of member information and disenrollment requirements indicated that the CMOs generally had an opportunity to improve communications with members to ensure that they had adequate and timely information (e.g., when the member handbook was updated).

Care management assessments addressed the member's physical, mental, and psychosocial needs and considered cultural issues/concerns and linguistic needs.

The GF and GF 360° CMOs all scored 91.5 percent for the Grievance System compliance standard. The GF CMOs experienced some challenges in ensuring that grievance and appeal communications with members were written in easily understood language, with some communications including advanced medical terminology. The CMOs generally communicated grievance and appeal resolutions to members in a timely manner.

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

The CMOs received their highest compliance scores for the Availability of Services, Subcontractual Relationships and Delegation, and Member Rights and Protections standards.

Overall, the CMOs performed well on the Clinical Practice Guidelines standard, demonstrating that their CPGs were developed, implemented, and disseminated appropriately and supported the quality of services provided to members. Scores for the GF and GF 360° programs ranged from 81.8 percent to 100 percent. The compliance review results identified an opportunity to strengthen processes to ensure that decisions involving utilization management and coverage of services made by CMO staff were consistent with the CPGs.

The QAPI standard received the lowest scores for all CMOs. Compliance review scores for the GF and GF 360° CMOs ranged from 53.3 percent to 66.7 percent. Areas in which all CMOs failed to demonstrate compliance included the DCH-established performance measure targets, mechanisms to detect underutilization and to assess quality of care, processes for evaluating the impact and effectiveness of the QAPI program, processes for provider profiling, and ensuring patient safety plans were developed. All CMOs demonstrated a need to continue to develop comprehensive QAPI program descriptions and QAPI program evaluations that describe each CMO's QAPI story.

Access

Amerigroup, Peach State, WellCare, and Amerigroup 360° were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. Data were collected via mailed surveys with an Internet link included in the cover letter and telephone follow-up for non-respondents. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare.

The adult Medicaid plan comparisons revealed the following statistically significant results:

- Amerigroup scored statistically significantly higher than the Georgia CMO program average on one CAHPS measure, *Rating of Specialist Seen Most Often*.

The child Medicaid plan comparisons revealed the following statistically significant results:

- WellCare scored statistically significantly higher than the Georgia CMO program average on two CAHPS measures: *How Well Doctors Communicate* and *Customer Service*.

The GF CMOs received a compliance score of 100 percent for subcontractual relationships and delegation, indicating that the CMOs provide adequate oversight of their delegated entities.

The CMO's CDC 6|18 initiative improvement projects to improve asthma controller medication adherence among members in active DM whose asthma is not well controlled aimed to address gaps in access to appropriate asthma care. Overall, HSAG determined that the CMOs appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence within the test population (those members with asthma who have poor medication adherence and have had an inpatient hospitalization with a primary diagnosis of asthma within the last 30 days).

For performance measure RY 2017 among the three CMOs, five of the seven rates above the 90th percentile are indicators for the *Annual Dental Visit* measure, suggesting the CMO's high performance is mostly concentrated to this one area and not spread over several different measures. For the GF 360° program, 11 of the performance measure rates met or exceeded the 90th percentile, demonstrating strength for the CMO within the Access to Care, Children's Health, and Behavioral Health domains.

Timeliness

The GF CMOs generally met the requirements specified in 42 CFR §438 and established standards for timely access to care and services, taking into account the urgency of the member's need for services. Compliance scores for the Furnishing of Services standard ranged from 63.6 percent to 90.9 percent. The GF CMOs had processes in place to ensure that providers responded to urgent needs of members within 20 minutes of receiving a calls and routine calls within one hour at least 90 percent of the time.

The CMOs experienced some challenges in meeting the DCH requirement to have 90 percent of members with access to providers within the DCH time and distance requirements established for both urban and rural categories. Compliance scores for Provider Selection, Credentialing and Recredentialing ranged from 88.9 percent for the GF 360° CMO and 90 percent to 100 percent for the GF CMOs. The CMOs generally had challenges ensuring an adequate network of primary care providers, specialists, and dental, mental health, and pharmacy providers in both urban and rural areas of the State. It should be noted that in some instances, a limited number of primary care and specialty providers within certain geographic areas required the CMOs to explore opportunities such as transporting members outside of their communities for care.

Overall, the CMOs had policies, procedures, provider agreements, assessment forms, example letters, and monitoring documents that described their coverage and authorization of service activities. The GF CMOs all scored 88 percent for the coverage and authorization of services compliance review standards. However, the CMOs did not consistently follow their own policies or procedures, particularly in relation to timeliness of authorization decisions. One CMO also experienced some challenges with ensuring that appropriate medical staff members were available to review and triage emergency and poststabilization services.

HSAG assigned *Confidence* and *Low Confidence* levels for the *Provider Satisfaction* PIPs undertaken by three of the CMOs because the SMART Aim goal was achieved; however, some but not all of the CMOs' quality improvement processes could be linked to the demonstrated improvement. By improving internal processes that positively impact provider satisfaction, CMOs can attract and retain high-quality providers to accommodate patient demand and improve the efficiency by which existing members are served.

Follow-Up on Corrective Actions From Compliance With Standards Reviews

The CMOs implemented corrective action plans (CAPs) with targeted interventions focused on:

- Increasing and improving member and provider education and communications.
- Provider training.
- Surveys.
- Provider recruitment to address network gaps and access to care concerns.
- Monitoring appointment availability time frames.
- Improving care plan components and the process for completing and communicating care plan information.
- Improving processes for discharge planning.
- Improving time frames for authorization of services and grievance and appeal decisions.
- Writing grievance and appeal communications in plain language.
- Improving performance measure rates.

HSAG followed up on implementation of the CAPs during the following year's compliance with standards review. Although some progress was made, the CMOs did not consistently implement the CAPs successfully.

2. Overview of Georgia Managed Care Program

Georgia State Managed Care Program

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the Georgia Families 360° (GF 360°) managed care program. The Georgia Families (GF) program serves all other Medicaid and CHIP managed care members not enrolled in the GF 360° program. Approximately 1.6 million beneficiaries are enrolled in the GF program. Approximately 47,000 members are enrolled in the GF 360° program.[2-1]

As mentioned in its 2016 Quality Strategic Plan for Georgia Families, DCH was created in 1999 to serve as the lead agency for healthcare planning, purchasing, and oversight, and is designated as the single State agency for Medicaid in Georgia.[2-2] The DCH mission is to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH's vision is that the agency will be a lean and responsive state agency that promotes the health and prosperity of its citizens through innovative and effective delivery of quality healthcare programs. The DCH is dedicated to a healthy Georgia.

The DCH's Key Goals are to:

- *Improve the health status of Georgians by promoting healthy lifestyles, preventive care, disease management and disparity elimination.*
- *Improve access to quality health care at an affordable price.*
- *Ensure value in health care contracts.*
- *Move health plans administered by DCH toward being financially solvent to meet the needs of the members.*
- *Increase effectiveness and efficiency in the delivery of health care programs.*
- *Ensure DCH has enough workers with the necessary skills and competencies to meet the current and future demand.*

[2-1] Georgia Department of Community Health. Medicaid Management Information System.

[2-2] Georgia Department of Community Health. 2016 Quality Strategic Plan for Georgia Families and Georgia Families 360°. Available at: https://dch.georgia.gov/sites/dch.georgia.gov/files/2016-Quality-Strategic-Plan-Final-6.17.16.pdf. Accessed on: Mar 19, 2018.

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

The DCH has administered a fee-for-service (FFS) model since the inception of Medicaid. The FFS model delivers services to Medicaid and some PeachCare for Kids® members through a statewide provider network. In addition to the FFS model, the State of Georgia introduced the GF managed care program in 2006 and currently partners with three private CMOs to deliver services to enrolled members.

Demographics of Georgia State Managed Care Program

The GF program includes more than half of the State's Medicaid and PeachCare for Kids® populations. Enrollment in managed care is mandatory for certain Medicaid and PeachCare for Kids® members. In some cases, PeachCare for Kids® members can receive an exemption from enrollment into the GF program. The following Medicaid eligibility categories have mandatory GF program enrollment:

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

Table 2-1—2016 CMO Demographics*

2016 Statistic Category		Amerigroup	Peach State	WellCare
Georgia Families CMO Reported Total for All Ages		308,267	381,355	684,233
PeachCare for Kids® CMO Reported Population Total		33,955	37,934	70,974
Ethnicity: Black		45%	55%	49%
Ethnicity: Caucasian		48%	36%	46%
Ethnicity: Hispanic		2%	12%**	1%
Ethnicity: Other		5%	9%	4%

**Data taken from CMO 2016 QAPI Evaluations. Raw numbers are considered accurate for point-in-time analysis, but the numbers are contingent on the method that each CMO used to retrieve and categorize the data. Members were not required to disclose their race/ethnicity, and not all possible categories are listed in the table above.*

***Members could select both a race and an ethnicity category, so the total is greater than 100 percent.*

In addition to the GF program, DCH implemented GF 360° managed care coverage in March 2014 for the following populations:

- Children in state custody
- Children receiving adoption assistance
- Certain youth in the custody of the Department of Juvenile Justice (DJJ)

The GF 360° program served approximately 47,000 members during CY 2017. A detailed demographic breakdown is not available for this population.

Network Capacity Analysis

With the May 2016 release of revised federal regulations for managed care, The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) began requiring states to set standards to ensure ongoing state assessment and certification of CMO, prepaid inpatient health plan (PIHP), and prepaid ambulatory health plan (PAHP) networks; set threshold standards to establish network adequacy measures for a specified set of providers; establish criteria to develop network adequacy standards for managed long-term services and supports (MLTSS) programs; and ensure the transparency of network adequacy standards. The requirement stipulates that states must establish time and distance standards for the following network provider types: primary care (adult and pediatric), obstetricians/gynecologists, behavioral health, specialists (adult and pediatric), hospitals, pharmacies, pediatric dental, and additional provider types when they promote the objectives of the Medicaid program for the provider type to be subject to such time and distance standards.

Table 2-2—DCH-Established Distance Standards by Provider Type

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

Provider Type	Urban	Rural
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles
Therapy (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

*PCPs [primary care providers] row does not include the practitioner categories listed in the rows below.

The DCH held contracts with three CMOs (Amerigroup, Peach State, and WellCare) during the review period for this annual report. All three CMOs provide services to the State's GF members. In addition to providing medical and mental health services to their enrolled Medicaid and CHIP members, the CMOs also provide a range of enhanced services, including dental and vision services, case and disease management and education, and wellness/prevention programs. The DCH's goals for care provided by the CMOs include that the care:

- Be of acceptable quality.
- Assure accessibility.
- Provide for continuity.
- Promote efficiency.

The DCH also held a contract with Amerigroup for the GF 360° program during the review period. The goals for this program are to:

- Enhance the coordination of care and access to services.
- Improve health outcomes.
- Develop and utilize meaningful and complete electronic medical records.
- Comply fully with regulatory reporting requirements.

Table 2-3 provides a profile for each of the DCH-contracted care management organizations.

Table 2-3—Care Management Organization Profiles as of July 2017

CMO	Year Operations Began in Georgia as a Medicaid CMO	Profile Description
Amerigroup	2006	Amerigroup Community Care is a subsidiary of Amerigroup Corporation. Amerigroup is a wholly owned subsidiary of Anthem, Inc., founded in 2004 with the merger of Anthem and WellPoint Health Networks. Product lines include Medicaid, Medicare commercial, federal employees, and specialty services.
Amerigroup 360°	2014	Amerigroup 360° is a subsidiary of Amerigroup Corporation. Amerigroup is a wholly owned subsidiary of Anthem, Inc., founded in 2004 with the merger of Anthem and WellPoint Health Networks. Product lines include Medicaid, Medicare commercial, federal employees, and specialty services.
Peach Care	2006	Peach State Health Plan is a subsidiary of the Centene Corporation. Centene was founded in 1984. Product lines include Medicaid, Medicare, and the Exchange plans in some states.
WellCare	2006	WellCare of Georgia is a subsidiary of WellCare Health Plans, Inc. WellCare was founded in 1985. Product lines include Medicaid, Medicare Advantage, Medicare Prescription Drug Plans, State Children's Health Insurance Programs, and others.

Georgia State Quality Strategy

CMS' Medicaid managed care regulations at 42 CFR §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of healthcare services offered to Medicaid members. The written strategy must describe the standards the state and its contracted plans must meet for ensuring timely, accessible, and quality services to its members. This section outlines the goals and objectives of DCH's 2016 Quality Strategy as well as the annual evaluation of the strategy for CY 2017. In addition, the state must conduct periodic reviews to examine the scope and content of its quality strategy, evaluate the strategy's effectiveness, and update it as needed.

To comply with federal regulations, DCH developed and submitted its GF Quality Strategic Plan for CMS' review and approval, receiving CMS approval on the initial plan in 2008. Updates to the plan were completed in January 2010 and again in November 2011.[2-3] During 2015, in collaboration with numerous stakeholders, DCH prepared a new quality strategic plan to coincide with the reprocurement of the GF and GF 360° managed care contractors. The plan was posted for public comment in December

[2-3] Georgia Department of Community Health. Medicaid Quality Reporting. Quality Strategic Plans. Available at: http://dch.georgia.gov/medicaid-quality-reporting. Accessed on: Mar 19, 2018.

2015 and was implemented as of February 2016 upon receiving CMS approval. The 2016 Quality Strategic Plan is consistent with CMS' guidance in the 2013 Quality Strategy Toolkit for States[2-4] and aligns with the Department of Health and Human Services National Quality Strategy Aims for better care, affordable care, and healthy people/healthy communities.[2-5]

The State's revised plan describes:

- *Quality performance measures with targets for the CMOs related to access, utilization, service quality, and appropriateness.*
- *Value-based purchasing performance metrics for the GF and GF 360° programs that align with some of the State's key focus areas for improved care and member outcomes (e.g., low birth weight, diabetes, and ADHD [attention deficit hyperactivity disorder]).*
- *DCH's processes for assessing, monitoring, and reporting on the CMOs' performance, progress, and outcomes related to the State's strategic goals and areas of focus.*
- *Adoption of innovative quality improvement strategies, such as rapid cycle performance improvement projects, and ensuring DCH and the CMOs are in tune with the latest advances in quality improvement science through participation in quality improvement trainings and technical assistance sessions sponsored by CMS and/or hosted by the EQRO.*
- *Numerous collaborative efforts by DCH that include inter-agency coordination and participation of other key stakeholders, along with the CMOs and provider community, to leverage the talent and resources needed to address shared challenges that impede improved performance.*

Quality Strategy Goals and Objectives

The Quality Strategy Recommendations section of this report, Section 9, identifies areas in which DCH could leverage or modify the Georgia Quality Strategic Plan to promote improvement based on CMO performance.[2-6]

[2-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. Quality Strategy Toolkit for States. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/quality-strategy-toolkit-for-states.pdf. Accessed on: Jan 5, 2018.

[2-5] Department of Health and Human Services, Agency for Healthcare Research and Quality. About the National Quality Strategy (NQS). Available at: https://www.ahrq.gov/workingforquality/about.htm. Accessed on: Jan 5, 2018.

[2-6] Georgia Department of Community Health. 2016 Quality Strategic Plan for Georgia Families and Georgia Families 360°. Available at: https://dch.georgia.gov/sites/dch.georgia.gov/files/2016-Quality-Strategic-Plan-Final-6.17.16.pdf. Accessed on: Mar 19, 2018.

Goal 1: Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members.

Objective 1: Improve access to high quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

- Strategy: Increase and monitor access to health services for members

Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10 percent increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

- Strategy: Increase preventive health and follow up care service utilization

Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10 percent increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

- Strategy 1: Improve care coordination programs
- Strategy 2: Improve evidence-based practices
- Strategy 3: Implement improvement activities focused on chronic conditions

Objective 4: Decrease the statewide LBW rate to 8.6 percent by December 2019 as reported in June 2020.

- Strategy 1: Improve early access to prenatal care and perinatal case management
- Strategy 2: Improve access to family planning and interpregnancy care services
- Strategy 3: Decrease non-medically necessary early elective inductions and deliveries and increase

Objective 5: Require CMOs' use of rapid cycle process improvement/Plan-Do-Study-Act principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10 percent increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

- Strategy 1: Review quarterly utilization; prior authorization; case management; disease management; EPSDT; and P4HB reports to ensure rapid cycle process improvement principles are in use across all program areas and improving care management strategies.
- Strategy 2: Continue annual tracking of performance measure rates and comparisons with HEDIS percentiles to monitor improvements in preventive care, birth outcomes, and chronic disease management.

- Strategy 3: Participate with CMS in the implementation of a new performance metric to monitor contraceptive utilization.
- Strategy 4: Conduct annual CMO and DCH CAHPS adult and child surveys and the annual DCH CAHPS survey of the PeachCare for Kids® (CHIP) members.

Goal 2: Smarter Utilization of each Medicaid dollar.

Objective 1: Improve the member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management (UM) rates for the adult and child populations compared with the CY 2014 rates as reported in June 2020 based on CY 2019 data.

- Strategy 1: Reduce ER visits for ambulatory sensitive conditions
- Strategy 2: Increase access to urgent care services
- Strategy 3: Medical necessity determinations are made using evidence-based criteria

Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all-cause readmission rate for all Medicaid populations to 9 percent by the end of CY 2019 as reported in June 2020.

- Strategy 1: Improve the transition of care process
- Strategy 2: Ensure effective concurrent review and discharge-planning processes are in place for CMO and FFS members

Objective 3: Continue payment denials for identified medically induced negative outcomes and measure effectiveness through claims auditing.

- Strategy 1: Ensure hospitals do not receive payments for hospital-acquired conditions
- Strategy 2: Ensure providers are not reimbursed for nonmedically necessary early elective deliveries

Objective 4: Improve access to healthcare information through collaboration with the Georgia Health Information Technology Extension Center and the Georgia Health Information Network (GaHIN) until 90 percent of all Georgia's providers are connected to an HIE and to the GaHIN.

- Strategy 1: Increase the provider's use of technology
- Strategy 2: Encourage members' access to personal health information available through their providers' electronic health records (EHRs)

Annual Quality Strategy Evaluation[2-7]

There have been three strategic plan assessments or revisions completed for the Georgia Families program—the original in June 2007, approved by CMS in February 2008; the second, a revision in February 2010; and the third, a revision in November 2011. Both revisions were submitted to CMS for review and approval, and all assessments and revisions followed the CMS 2006 Quality Strategy Toolkit for States. The 2016 Quality Strategic Plan follows the outline contained in the 2012 Quality Strategy Toolkit for States.

In July 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to concerns that the Patient Protection and Affordable Care Act, the national recession, and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high-quality care in a cost-effective manner. After the delivery of the comprehensive assessment and recommendations in 2012, DCH engaged several stakeholder groups to obtain feedback while considering Medicaid redesign options. DCH compiled a table of stakeholder group comments and recommendations which covered such areas as DCH program administration, provider credentialing, co-payments, claims, reimbursement, prior authorizations, benefits and services, care coordination, data collection, electronic medical records, data sharing, monitoring and oversight, provider networks, access to care, and quality improvement.

DCH Quality Initiatives Driving Improvement

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

- **Awarded new CMO contracts in response to the CY 2015 CMO reprocurement.** The DCH first implemented Georgia Families, the Medicaid managed care program for Medicaid for Parent/Caretaker with Children (formerly Low-Income Medicaid), and PeachCare for Kids® members in CY 2005. The DCH released a Request for Proposal (RFP) for new services in CY 2015 and awarded the new contracts in CY 2016. The previous contracts expired at the end of CY 2017.
- **Conducted extensive implementation readiness review activities.** The DCH, during CY 2017, with assistance from partner agencies, including the Department of Behavioral Health and Developmental Disabilities (DBHDD) and the Department of Human Services (DHS), completed readiness reviews to successfully launch the new managed care contracts.
- **Launched CareSource Georgia Co.** The DCH successfully launched CareSource as a new Georgia Families CMO and a fourth option for members in July 2017.
- **Conducted open enrollment for the new plan year during the month of March for all Georgia Families members.** In the past, Georgia Families Open Enrollment took place on the members'

[2-7] Ibid.

anniversaries. Members now had the opportunity to choose from four CMOs: Amerigroup, CareSource, Peach State Health Plan, and WellCare. Members had the option to make CMO selections via phone, fax, or online. The DCH, the CMOs, DXC Technology (DCH's fiscal agent and administrator of the GA Medicaid Management Information System [GAMMIS]) and GaHIN worked collaboratively to develop a secure, electronic process of exchanging information to facilitate member transition and coordination of care.

- **Piloted and implemented the Integrated Eligibility System (IES), Georgia Gateway.** In CY 2017, DCH, in conjunction with other State agencies, piloted and implemented the new system, which was procured in CY 2015. The DCH is working closely on this project with DHS, the Georgia Department of Public Health (DPH), and Department of Early Care and Learning (DECAL). Gateway provides a single point of entry to serve those applying for Medicaid; PeachCare for Kids®; Planning for Healthy Babies® (P4HB®); Food Stamps (Supplemental Nutrition Assistance Program [SNAP]); Temporary Assistance for Needy Families (TANF); Women, Infants, and Children (WIC) benefits; and Childcare and Parent Services (CAPS). The pilot for Georgia Gateway began February 2017 and ran through April 2017. The pilot involved converting the entire PeachCare for Kids® and P4HB® population into Gateway, along with one Division of Family and Children Services (DFCS) county office (Henry). The pilot was extremely successful, and the issues identified were quickly addressed. This led to the first full implementation wave in May, which ran through June, and involved approximately half the counties in the State. The second wave, which involved the remaining counties, was broken out into two parts, the first being implemented in July. The second part, incorporating DeKalb, Fulton, and Gwinnett counties, occurred in September 2017 (FY 2018). Both waves 1 and 2 were even more successful than the pilot and have seen a quick adoption rate by both staff and the public. With the full implementation of Gateway, incorporating all the various medical assistance programs into one eligibility system, a seamless determination of eligibility now exists across these programs, including Medicaid to PeachCare for Kids® and back, which often had either a gap or overlapping coverage.
- **Continued operations of the centralized credentialing verification organization.** In CY 2017, DCH continued operations of its new streamlined provider credentialing process, which was first implemented during CY 2016. The Credentialing Verification Organization (CVO) is responsible for credentialing and recredentialing Medicaid, PeachCare for Kids®, Georgia Families, and Georgia Families 360° providers in accordance with guidelines established by the National Committee for Quality Assurance (NCQA). The CVO conducts primary source verification as well as monthly monitoring of provider fraud and abuse sanctions. The CVO has a Credentialing Committee chaired by a medical director and is responsible for reviewing all credentialing and recredentialing applications. In CY 2016, the CVO also began credentialing FFS only providers. Georgia Medicaid is one of the first state agencies in the country to use a centralized credentialing process, and to use that process to credential FFS providers. During CY 2017, more than 25,000 providers were credentialed, and more than 4,000 providers were recredentialed.
- **Implementation of the new HCBS [Home and Community-Based Services] Settings Rule.** CMS issued a regulation in CY 2014 defining the characteristics and qualities of HCBS, and the characteristics and qualities of the settings in which services can be delivered. The regulation required states to develop a Statewide Transition Plan describing how they would assure compliance with the new rules that call for services to be provided in an integrated setting and in the most

community-inclusive manner. Georgia's work toward compliance has included engagement of a statewide task force, public meetings to solicit stakeholder input on the development of the transition plan, and preparation of four waiver-specific transition plans as well as a statewide transition plan (STP). Georgia's STP was formally submitted to CMS in May 2017. CMS responded with a few clarifying questions and suggested policy revisions in July 2017. The final revised draft was not approved by CMS during CY 2017. The work associated with implementation of the HCBS Rule continues. All providers are being surveyed to ensure compliance with the rule. Technical assistance is scheduled to begin with those providers needing to gain compliance following CMS approval of the STP.

- **Non-emergency medical transportation (NEMT).** Through the NEMT program, DCH provided more than 3.8 million trips to Medicaid Members across Georgia who had no other means of transportation in CY 2017. The DCH's modes of transit included ambulatory transport, wheelchair, stretcher, and public transport. NEMT services in Georgia are managed by two brokers under contract with DCH. The brokers subcontract with more than 200 transportation providers and independent drivers. In addition, both brokers have begun to utilize ride share services such as Lyft in certain areas of the State. NEMT also provided services for nursing home relocations over the course of the fiscal year, partnering with DCH Healthcare Facility Regulation Division (HFRD), Adult Protective Services, the Georgia Bureau of Investigations (GBI), and local law enforcement agencies. NEMT also participated and partnered with Georgia Emergency Management Agency (GEMA) and DPH in evacuating members from the Georgia coast due to Hurricane Matthew.
- **Paperless initiatives.** The DCH continues to move new categories of service into the centralized prior authorization portal. The DCH implemented an online process for providers to submit and track appeals, which has improved process efficiency.
- **Secured a consulting firm.** The DCH secured a consulting firm to assist with project planning and the development of a strategic approach to reprocure GAMMIS, and to align with new federal requirements for modularity and drive the advancement of Medicaid Information Technology Architecture (MITA) maturity and improvements in the efficiency and effectiveness of program operations and the member and provider experience, as well as leverage and interact efficiently with other systems. The DCH conducts ongoing procurement and contract implementation activities to secure services and support continued Medicaid operations. The project has a completed analysis of the current state and capability of IT systems and processes that make up the MMIS. CMS requires states to implement solutions which are modular and MITA-aligned. A market scan has also been conducted to determine the state of modularity in the MMIS and Medicaid systems marketplace.
- **Medicaid EHR incentive program.** The Division of Health Information Technology continued its administrative oversight of the EHR Incentive Program and increased the number of program participants transitioning from AIU [Adopt, Implement, Upgrade] Payment Year one to Modified Stage 2 by 15.6 percent. As of June 30, 2017, the program paid more than $287 million to Georgia healthcare providers since its inception in September 2011.
- **Member appeals and provider appeals.** The Office of General Counsel's Legal Section received and processed 727 member and provider appeals.
- **Background checks and recoveries.** The Office of Inspector General's Background Investigation Unit processed 1,627 criminal history records of DCH-licensed facilities. The Special Investigations

teams opened 465 Medicaid recipient cases, and 319 cases were closed which resulted in a cost savings of $291,330.77 for the State of Georgia. The Third-Party Liability (TPL) Unit contractor recovered $39.7 million, and $1.8 million was recovered with the assistance of the Office of the Attorney General for total TPL recoveries of $41.5 million.

- **Demonstrating e-health in Medicaid services and supports.** The DCH successfully completed the third year of the National Testing Experience and Functional Tools (TEFT) grant. The DCH was awarded the four-year grant by CMS to field-test a cross-disability experience of care survey and a set of functional assessment items, demonstrate personal health records, and create an electronic Long-Term Services and Supports (eLTSS) service plan standard. In CY 2017, Georgia was awarded a supplemental grant to augment the eLTSS scope of work with CMS and the Office of the National Coordinator for Health Information Technology. This allowed for the development of a data standard to share information across the LTSS ecosystem. The DCH completed the second phase of the CAHPS Experience of Care (EoC) Survey for Georgia, which elicits feedback on beneficiaries' experience with the services they receive in Medicaid Community-Based Long-Term Services & Supports (CB-LTSS) programs. Additionally, DCH completed the requirements for the personal health record tool which can encourage a more active role for beneficiaries/caregivers in managing care and result in better outcomes through more efficient management of services.
- **Advancing the use of EHR technology through quality improvement.** The Georgia Clinical Quality Measures System (CQMS) was created to improve health outcomes for Medicaid members. Health IT, in partnership with DXC Technology and HealthTech Solutions, is taking a phased approach in deploying the CQMS to better track the quality outcomes of Medicaid providers for many of the chronic diseases affecting Georgia's population. The popHealth component of the CQMS solution evaluates and presents provider-supplied measurements against industry-standard measures.

Quality Initiatives and Emerging Practices

Emerging practices can be achieved by incorporating evidence-based guidelines into operational structures, policies, and procedures. Emerging practices are born out of continuous quality improvement efforts to improve a service, health outcome, systems process, or operational procedure. The goal of these efforts is to improve the quality of and access to services and to improve health outcomes. Only through continual measurement and analyses to determine the efficacy of an intervention can an emerging practice be identified. Therefore, DCH encourages the CMOs to continually track and monitor the effectiveness of quality improvement initiatives and interventions, using a PDSA cycle, to determine if the benefit of the intervention outweighs the effort and cost. CMOs report quality improvement progress in their annual QAPI evaluation.

Another method used by DCH to promote best and emerging practices among the CMOs is to ensure that the State's contractual requirements for the CMOs are at least as stringent as those described in the federal rules and regulations for managed care (42 CFR Part 438—Managed Care). The DCH actively promotes the use of nationally recognized protocols, standards of care, and benchmarks by which CMO performance is measured.

CMO-Specific Quality Initiatives

The DCH requires each CMO to have a QAPI program that meets contractual standards at least as stringent as those requirements specified in 42 CFR §438.236–438.242. The CMOs' ongoing program objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and improved health outcomes for their members.

Each QAPI program should be based on the latest available research around quality assurance and include a method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and overutilization of services). The DCH requires the CMOs to submit annual evaluations of and updates to their QAPI programs. In early 2014, DCH issued a new policy with specifications for the CMOs regarding their QAPI reports. This new guidance established a template for the QAPI reports and specified the components to be included in the QAPI report.

The CMO QAPI Evaluation must include:

- *A brief overview of the QAPI program, the program's goals and objectives for the preceding calendar year, and a summary of the goals and objectives met and not met during the year.*
- *An analysis of the demographics of the population served.*
- *The network resources available to the population served and an alignment of those resources with the population.*
- *The effectiveness of the QAPI program.*
- *Conclusions.*

The DCH reviews all of the CMOs' QAPI report submissions, and staff have noted that the QAPI reports continue to improve. One GF CMO, in its 2015 QAPI report resubmission, was able to demonstrate understanding of the populations it served and the associated needs of those populations. The CMO correlated its goals, objectives, and interventions to drive the necessary improvements in health outcomes for members going forward.

Listed below is a sampling of the strategic quality initiatives the CMOs employ to improve health outcomes. This list is not intended to be a comprehensive survey of all quality initiatives occurring among the CMOs in the State of Georgia.

Amerigroup

Amerigroup highlighted the following strategic quality initiatives aimed at the stated goals in the Georgia Quality Strategic Report as priorities for CY 2017:

- **Behavioral health home and dental health home:** The CMO is using dental assignment and report cards similar to methods used for PCPs to strengthen dental provider interventions with members. The CMO has developed behavioral health homes for members diagnosed with a behavioral health condition.
- **Teach-back method training:** Amerigroup implemented a teach-back method of training in pediatric offices through a partnership with a pharmaceutical organization that focused on improving member satisfaction with care and services in the primary care setting.
- **Enable local innovations:** Amerigroup has continued to develop its Value-Added Benefits to better align with health outcomes such as offering gym memberships and Weight Watchers vouchers for members identified as overweight or obese.
- **Preventive Health Education:** The CMO has taken action in educating and encouraging members and the parents of members to ensure members receive preventive screenings including EPSDT services.
- **Member outreach:** Amerigroup uses multiple methods to reach out to and inform members of the benefits of preventive health services to promote healthy outcomes and the importance of establishing strong PCP relationships. Amerigroup continues to facilitate members' procurement of free SafeLink phones, which also provides an opportunity for text messaging. Amerigroup contracted with LexisNexis, a vendor which provides alternate demographic data on Amerigroup members including but not limited to cellular phones, email addresses, and alternate addresses.
- **Health promotion events:** Amerigroup participated in provider clinic days, a health fair, community presentations focused on health promotion such as well-check exams, immunizations, and lead screening.
- **Health Promotions staff:** The Health Promotions consultants work directly with high-volume providers to increase the rate of preventive health services. Providers are encouraged to extend office hours to accommodate schools and working parents' schedules.
- **Telemedicine:** Amerigroup continues to promote the use of telemedicine to expand access and decrease appointment wait times.
- **EHRs and the GaHIN:** Amerigroup continued to promote the use of EHRs in primary care and specialty practices through the support of its Medical Practice consultants working with practices on NCQA Patient-Centered Medical Home (PCMH) designation. The CMO also used incentives to practices who obtain PCMH designation to further promote use of PCMHs and EHRs.

- **Health information system data sharing:** Amerigroup is also actively working with the Georgia Health Information Network (GaHIN) and their partner, Truven Health analytics, to implement data sharing between Amerigroup's MIS and the GaHIN.
- **Provider engagement:** A key strategy that continues through all facets of the CMO is collaboration with providers on quality improvement initiatives. These include practices working with Amerigroup practice consultants on PCMH designation, providers participating in pay-for-performance (P4P) programs, practices acting as pilot sites for performance improvement projects (PIPs), and on initiatives to improve performance such as Clinic Day events.
- **Provider report cards:** Performance measure provider report cards indicate the practice's rate, the State target, overall Amerigroup rate, and the number of members for which a gap in care would need to be closed to reach the targets set by DCH. Practices with more than 900 members are emailed the report quarterly to a point of contact at the practice, which allows for distribution to key staff throughout the practice.
- **Navigate members to high-performing providers:** Amerigroup Georgia has been in the process of executing a program to navigate members toward high-quality PCPs. Practices with higher quality performance based on these key indicators are assigned more members.
- **Staff development:** Amerigroup supports ongoing learning though sponsoring local health plan staff to obtain Six Sigma certification and requiring those with plan-sponsored certification to participate in process or performance improvement initiatives through the year.

Peach State

Peach State highlighted the following strategic quality initiatives aimed at the stated goals in the Georgia Quality Strategic Report as priorities for CY 2017:

- **Effective, integrated approach to quality:** To encourage a more effective, integrated approach to quality improvement, the Peach State senior leadership team (SLT) established a culture of quality—a collaborative model of cross-departmental, multidisciplinary clinical and operational workgroups with specific areas of quality focus: quality improvement, EPSDT, women's health, medical management, medical affairs, chronic disease management, provider issues, vendor management, and pharmacy issues.
- **Core quality improvement business strategy:** Peach State Health Plan adopted quality improvement (QI) as a core corporate business strategy to support DCH objectives.
- **Disparity data:** Staff combine results of operational data, including GeoAccess reports, call center volumes, and call categories (including translation requests) to obtain a nuanced understanding of Peach State's membership and the factors leading to disparities.
- **Partner with high-volume behavioral health facility:** Peach State partnered with an innovative clinical initiative using the PDSA Rapid Cycle Improvement methodology. The CMO's behavioral health care coordination team (CCT) engaged members while still hospitalized and provided needed mental health assessments and support immediately following discharge, including attending all follow-up appointments.

- **Doula program:** Peach State uses an innovative clinical initiative in partnership with a high-volume obstetrician provider group using the PDSA Rapid Cycle Improvement methodology. The program involves providing a doula to African-American members in certain regions. A doula, or resource mother, is a nonmedical person who assists the pregnant member before, during, and after childbirth. The doula also supports the member's partner and/or family by providing assistance and emotional support.
- **Reducing neonatal intensive care unit (NICU) births:** Peach State uses masters-level social workers working on-site or embedded at federally qualified health centers (FQHCs) to provide face-to-face services to pregnant and postpartum members receiving care from the FQHC to reduce NICU births.
- **Collaboration with Public Health:** Peach State Health Plan collaborates with the DPH to identify members in need of services such as chlamydia screening. Peach State quality improvement representatives met with DPH personnel to streamline data exchange processes for members in Peach State's system.
- **Making Outcomes Memorable (M.O.M.):** Peach State partnered with the five facilities with the highest number of Peach State member deliveries to offer encouragement and support, and to promote breastfeeding and encourage follow-up for new mothers. The program engaged the mother in breastfeeding by supplying an electric breast pump to the mother's bedside immediately following delivery; included face-to-face home visits within two days of discharge to complete an assessment of the mother's continuation of breastfeeding; provided lactation support and resources; and ensured follow-up with the postpartum appointment within 21–56 days of delivery.
- **Mobile applications:** Peach State uses mobile applications (apps) to support members, including MyPSHP, which assists members in finding a provider, accessing care gaps, and scheduling an appointment. Also, the Start Smart mobile app provides reminders expressly for expectant moms and care gap notification. These innovative tools promote engagement and investment in new information technology to engage members or their caregivers in their health, including new tools delivered on mobile devices and tablets.
- **Direct appointment scheduling:** MyHealthDirect improves member engagement through using MyHealthDirect (MHD). MHD employs secure, web-based appointment scheduling technology to allow any Peach State personnel who have telephonic or face-to-face contact with members to instantly schedule appointments for members with their MHD-enrolled provider, for the most convenient available time for members.
- **Dental home:** Together with DentaQuest, Peach State used a dental home program. Members chose or were auto-assigned to a dentist to promote access to, and appropriate use of, dental services as well as overall healthcare integration, continuity of care, and a stronger provider-member relationship.
- **Dental Days:** In collaboration with community dental hygienists, Peach State conducts dental education in preschool and kindergarten classes. Peach State's community field staff engages the children in fun activities that educate them on the importance of daily dental hygiene, followed by a hygienist demonstrating the proper technique for brushing and flossing.

- **Missed appointment program:** Missed appointments are a costly, unnecessary expense for providers. To address this common issue among GF participants, Peach State uses a broken appointment program in partnership with DentaQuest. Dentists can log members who missed their appointment in the DentaQuest provider portal, and DentaQuest forwards the information to Peach State for member outreach and education.
- **Integrated care model:** Peach State uses an integrated care model to manage the needs of members with complex conditions. The model includes interdisciplinary teams (Adult, Pediatric, High Risk Obstetrics and Behavioral Health) that are led by medical directors. Teams include case managers, care coordinators, pharmacists, social workers, connections representatives, UM nurses, disease management staff, and behavioral health/mental health specialists.
- **Telehealth:** Peach State partners with Georgia Partnership for Telehealth (GPT) to provide members with access to specialists (representing more than 46 specialty and subspecialty provider types), including Community Service Boards (CSBs) and psychiatrists, that provide services via telemedicine. This network provides members quick access to specialty care, avoiding expensive travel and improving compliance with needed services/care that otherwise might be deferred or ignored.
- **Provider profiling and report cards:** Peach State provides report cards to its obstetricians and PCPs to keep them informed regarding how well they meet performance measures compared to their peers in the Peach State network. Peach State generates quarterly report cards based on profiling metrics, including measures that reflect preventive care guidelines for adults and children.

WellCare

WellCare highlighted the following strategic quality initiatives aimed at the stated goals in the Georgia Quality Strategic Report as priorities for CY 2017:

- **Care coordinators:** WellCare employs a targeted strategy using care coordinators who are nonclinical staff to complete tasks such as sending durable medical equipment to members, sending health education and life planning information, researching specialists to find providers accepting new members with the soonest available appointments, and assisting members in making PCP appointments.
- **PCMH coaching:** WellCare began offering coaching assistance to practices that had received PCMH recognition and were in the process of renewing their recognition.
- **MyWellCare mobile app:** WellCare offers members a free mobile app called MyWellCare. Using this app, members can access information about their health benefits, retrieve their identification card, and find a provider. The app is also able to assist members in finding wellness or quick care services in their area.
- **Lean Six Sigma:** WellCare has assigned to each PIP team an analyst who has a background in Lean Six Sigma to assist the team in conducting the cause and effect analysis and failure modes and effects analysis (FMEA) at the beginning of each project. The analyst will also be responsible for the accuracy of the SMART Aim and the key driver diagrams.

- **Hospital on-site case management:** WellCare placed case managers in two hospital settings with the highest two-day admission rates. The case managers worked with the facilities and the members to place members in observation status rather than admit for a two-day stay.
- **Member engagement:** WellCare uses an integrated model to engage members in managing, maintaining, and improving their current health status. The integrated team includes case management, disease management, member outreach, and community relations.
- **Member committee:** WellCare uses a Member Advisory Committee to hear directly from members regarding their experience of care.
- **Community investment program:** The community investment program includes mini farmer's markets, mobile dental vans, localized transportation pilots, school-based health initiatives, homeless initiatives, and the Prenatal Peer Support Program with Healthy Start.
- **WellCare Days:** WellCare uses an event called WellCare Days which is designed to educate the member on benefits, the PCP Home program, health screenings such as EPSDT and prenatal care, and appropriate use of ER/urgent care facilities.
- **Telemedicine:** WellCare uses telemedicine for responding to long-term provider shortages, particularly in rural areas. WellCare works with the Georgia Partnership for Telehealth and makes community investments in telemedicine equipment to support the expansion of telemedicine in rural areas of the State.
- **EHRs:** WellCare continues to implement strategies to increase the number of providers using EHRs.
- **Provider quality improvement participation:** Through WellCare's Provider Advisory Committee (PAC), WellCare opens the lines of communication between its provider network and quality improvement departments. This allows providers to play an active role in idea generation and decision making, so WellCare of Georgia's policies are provider-friendly and allow for quality medical care of members.
- **Member and Provider Advisory Committees:** WellCare uses the member and provider advisory committees to provide a regular forum for associates to interact with members and providers to learn about their needs, collaborate on improvements to programs and processes, and create responsive changes that help WellCare to better serve members and providers.
- **Member information:** WellCare updated its member website to include Spanish translations; give users the ability to increase and decrease font size depending on need; and enhanced the provider search tool to allow search by gender, accessibility, and language spoken.
- **PCMH program development:** WellCare's PCMH incentive program is shared with its PAC and strongly supported by a multi-clinic FQHC group that has approximately 19 PCMH-certified sites. WellCare has also used the PAC as a forum to educate providers on the PCMH model and WellCare of Georgia's Enhanced PCMH Initiative.
- **WellCare emergency department diversion program:** WellCare uses an emergency department (ED) diversion process to educate members on appropriate ED use and why utilizing PCPs is a better choice for members identified as having three or more ED admissions within a rolling 12-month period.

- **Comprehensive data review**: The WellCare QAPI staff work closely with Case Management (CM), Disease Management (DM), Provider Relations, and others to ensure that comprehensive views of data and results are continuously performed to collectively address any barriers.
- **Chronic care improvement program:** WellCare's Chronic Care Improvement Program is used to reduce costs and admissions related to coronary artery disease, hypertension, and congestive heart failure.

Amerigroup 360°

Amerigroup 360° highlighted the following strategic quality initiatives aimed at the stated goals in the Georgia Quality Strategic Report as priorities for CY 2017:

- **Behavioral health home and dental health home:** The CMO is using dental assignment and report cards similar to methods used for PCPs to strengthen dental provider interventions with members. The CMO has created behavioral health homes for members diagnosed with a behavioral health condition.
- **Teach-back method training:** Amerigroup 360° implemented a teach-back method of training in pediatric offices through a partnership with a pharmaceutical organization that focused on improving member satisfaction with care and services in the primary care setting.
- **Enable local innovations:** Amerigroup 360° has continued to develop its Value-Added Benefits to better align with health outcomes such as offering gym memberships and Weight Watchers vouchers for members identified as overweight or obese.
- **Member outreach:** Amerigroup 360° utilized outreach activities focused on member education including email and text message campaigns, and provider collaboration to ensure members have access to healthcare. The CMO has taken action in educating and encouraging members and the parents of members to ensure members receive preventive screenings including EPSDT services.
- **Member outreach:** Amerigroup 360° uses multiple methods to reach out to and inform members of the benefits of preventive health services to promote healthy outcomes and the importance of establishing strong PCP relationships. Amerigroup 360° continues to facilitate members' procurement of free SafeLink phones, which also provides an opportunity for text messaging. Amerigroup 360° contracted with LexisNexis, a vendor which provides alternate demographic data on Amerigroup 360° members including but not limited to cellular phones, email addresses, and alternate addresses.
- **Health Promotions staff:** The Health Promotions consultants work directly with high-volume providers to increase the rate of preventive health services. Providers are encouraged to extend office hours to accommodate schools and working parents' schedules.
- **Telemedicine:** Amerigroup 360° continues to promote the use of telemedicine to expand access and decrease appointment wait times.
- **EHRs and GaHIN:** Amerigroup 360° continued to promote the use of EHRs in primary care and specialty practices through the support of its Medical Practice consultants working with practices on NCQA PCMH designation. The CMO also used incentives to practices who obtain PCMH designation to further promote use of PCMHs and EHRs.

- **Health information system data sharing:** Amerigroup 360° is also actively working with the GaHIN and GaHIN's partner, Truven Health analytics, to implement data sharing between Amerigroup 360°'s MIS and the GaHIN.
- **Provider engagement:** A key strategy that continues through all facets of the CMO is collaboration with providers on quality improvement initiatives. These include practices working with Amerigroup 360° practice consultants on PCMH designation, providers participating in P4P programs, practices acting as pilot sites for PIPs, and on initiatives to improve performance such as Clinic Day events.
- **Provider report cards:** Performance measure provider report cards indicate the practice's rate, the State target, overall Amerigroup 360° rate, and the number of members for which a gap in care would need to be closed to reach the targets set by DCH. Practices with more than 900 members are emailed the report quarterly to a point of contact at the practice, which allows for distribution to key staff throughout the practice.
- **Navigate members to high-performing providers:** Amerigroup 360° has been in the process of executing a program to navigate members to high-quality PCPs. Practices with higher quality performance based on these key indicators are assigned more members.
- **Staff development:** Amerigroup 360° supports ongoing learning though sponsoring local health plan staff to obtain Six Sigma certification and requiring those with plan-sponsored certification to participate in process or performance improvement initiatives through the year.

3. Description of EQR Activities

Mandatory Activities

As mandated by CFR §438.364 and in compliance with CMS' EQR Protocols and the External Quality Review Toolkit for States, this technical report:

- Describes how data from mandatory and optional EQR activities were aggregated and analyzed by HSAG.
- Describes the scope of the EQR activities.
- Assesses each CMO's strengths and weaknesses and presents conclusions drawn about the quality of, timeliness of, and access to care furnished by the CMOs.
- Includes recommendations for improving the quality of, timeliness of, and access to care and services furnished by the CMOs, including recommendations for each individual CMO and recommendations for DCH to target the Georgia Quality Strategic Plan to improve the quality of care provided by the DCH managed care program as a whole.
- Contains methodological and comparative information for all CMOs.
- Assesses the degree to which each CMO has addressed the recommendations for quality improvement made by the EQRO during the 2016 EQR.

Mandatory EQRO activities include:

- *Compliance With Standards*
- *Validation of Performance Measures*
- *Validation of Performance Improvement Projects*
- *Annual Technical Report*

In accordance with 42 CFR §438.356, DCH contracted with HSAG as the EQRO for the State of Georgia to conduct the mandatory EQR activities as set forth in 42 CFR §438.358. In State fiscal year (SFY) 2017, HSAG conducted the following mandatory EQR activities for the Georgia Families (GF) and Georgia Families 360° programs:

Compliance Monitoring Evaluation: According to federal requirements, the state or its EQRO must conduct a review to determine a Medicaid managed care plan's compliance with standards established by the state related to enrollee rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. The DCH contracted with HSAG to conduct a review of one-third of the full set of standards each year in order to complete the cycle within a three-year period. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality*

Review (EQR), Version 2.0, September 2012.[3-1] HSAG completed the three-year cycle in SFY 2016. Compliance monitoring was designed to determine the level of compliance for the GF CMOs and the GF 360° CMO with the federal Medicaid managed care regulations and the associated DCH contract requirements.

Validation of Performance Measures: HSAG validated the performance measures (PM) identified by the State to evaluate their accuracy as reported by, or on behalf of, the CMOs. The DCH annually selects a set of performance measures to evaluate the quality of care and services delivered by its contracted CMOs to GF and GF 360° members. The DCH requires that the CMOs submit externally validated performance measure rates. Performance measure validation determines the extent to which the CMOs followed specifications established by DCH for its performance measures when calculating the performance measure rates.

HSAG conducted validation of the PM rates following the NCQA HEDIS Compliance Audit timeline, typically from January 2017 through July 2017. The final PM validation results generally reflected the measurement period of January 1, 2016, through December 31, 2016. HSAG provided final PM validation reports to the CMOs and DCH in August 2017.[3-2]

Validation of Performance Improvement Projects (PIPs): HSAG validated the CMOs' PIPs to determine if they were designed to achieve, through ongoing measurement and intervention, significant and sustained improvement in clinical and nonclinical care. HSAG also evaluated if the PIPs would have a favorable effect on health outcomes and member satisfaction.

HSAG reviews each PIP using CMS' validation protocol to ensure that the CMOs design, conduct, and report PIPs in a methodologically sound manner and meet all State and federal requirements. HSAG uses a rapid cycle PIP process, which places an emphasis on applying improvement science to the PIP process and using rapid cycle evaluation through Plan-Do-Study-Act (PDSA) cycles to more efficiently achieve desired health outcomes.

Because PIPs must meet CMS requirements, HSAG completed a crosswalk of the rapid cycle framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[3-3] HSAG presented the crosswalk and new PIP framework

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2018.

[3-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2018

[3-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 22, 2018.

components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that, with the pace of quality improvement science development and the prolific use of PDSA cycles in modern PIPs within healthcare settings, the new approach was reasonable.

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

Optional Activities

In addition to conducting the mandatory EQR activities, HSAG reviewed the results of the CMOs' CAHPS Survey activities. The DCH periodically assesses the perceptions and experiences of members as part of its process for evaluating the quality of healthcare services provided by the CMOs to their members. Administration of the CAHPS surveys is an optional Medicaid EQR activity to assess managed care members' satisfaction with their healthcare services. The DCH requires that the CMOs administer CAHPS surveys to both adult members and parents or caretakers of child members. In 2017, the CMOs contracted with survey vendors to administer standardized survey instruments, CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys, to adult and child Medicaid members enrolled in their respective CMO.

The DCH's EQR contract with HSAG did not require HSAG to conduct or analyze and report results, conclusions, or recommendations from any other CMS-defined optional activities.

4. Review of Compliance with Standards

Overview

According to 42 CFR §438.358, which describes the activities related to external quality reviews, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid MCO's compliance with federal standards, as well as standards established by the state for access to care, structure and operations, and quality measurement and improvement. To meet this requirement, DCH contracted with HSAG to perform a comprehensive review of compliance with State and federal standards for Amerigroup Community Care, Peach State Health Plan, WellCare of Georgia, Inc., and Amerigroup 360º.

CY 2017 was the third year of the three-year cycle of reviews for Georgia. CY 2018 initiates a new three-year cycle of reviews. The following tables and narrative summarize the plan-specific findings for the compliance with standards reviews over the three-year cycle.

Plan-Specific Findings

Amerigroup

Table 4-1—Amerigroup Compliance With Standards Scores

Standard #	Standard Name	Total Compliance Score*
CY 2015		
I	Availability of Services	**100.0%**
II	Furnishing of Services	**90.9%**
III	Cultural Competence	**100.0%**
IV	Coordination and Continuity of Care	**85.7%**
V	Coverage and Authorization of Services	**88.0%**
VI	Emergency and Poststabilization Services	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**20.0%**
	Total CY 2015 Compliance Score	**90.3%**
CY 2016		
I	Provider Selection, Credentialing and Recredentialing	**90.0%**
II	Subcontractual Relationships and Delegation	**100.0%**
III	Member Rights and Protections	**100.0%**
IV	Member Information	**95.0%**

Standard #	Standard Name	Total Compliance Score*
V	Grievance System	**91.5%**
VI	Disenrollment Requirements and Limitations	**90.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**25.0%**
	Total CY 2016 Compliance Score	**85.7%**
CY 2017		
I	Clinical Practice Guidelines	**100.0%**
II	Quality Assessment and Performance Improvement (QAPI)	**53.3%**
II	Health Information Systems	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**75.0%**
	Total CY 2017 Compliance Score	**72.1%**
	Total CY 2015–CY 2017 Compliance Score	**84.8%**

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

Summary of Amerigroup Strengths

Amerigroup served its members in a culturally competent manner, considering the unique circumstances and approaches of each. Amerigroup ensured that its members have access to contracted providers and services in a manner that is consistent with individuals receiving services in a fee-for-service (FFS) payment environment. Amerigroup's member website included information that is easily accessible and available in English and Spanish, and offered no-cost linguistic services to both members and providers to improve the experience of care. Amerigroup had several mechanisms to inform members of their rights and responsibilities, such as the member handbook and CMO website. Member rights were also included in the provider manual as a method to keep providers informed and aware of issues regarding member rights. Member handbooks were provided to Amerigroup's members upon enrollment and were available online (a hard copy would be mailed upon member request) and in alternate formats, meeting the needs of the visually impaired, those with limited reading proficiency, and those for whom English is a second language.

As part of ongoing efforts to address members' physical, behavioral, and psychosocial needs, Amerigroup identified members who could benefit from case management services post-assessment. Member care plans would be linked to the results of the comprehensive assessment to ensure timely, comprehensive care.

Amerigroup demonstrated a strong knowledge and overall compliance with prior authorization requirements, and requirements focused on ensuring that members have access to emergency services 24 hours a day, seven days a week for treatment of emergency conditions.

Amerigroup maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities are performed to industry and State requirements. As of August 1, 2015, DCH

assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized credentialing verification organization (CVO). Amerigroup routinely monitored providers to ensure the provision of quality care. When quality issues were identified, the CMO would implement disciplinary action that may include suspension, restriction, or termination of a practitioner's CMO participation status. The CMO monitored delegate performance through ongoing assessment of individual delegate functions and would take corrective action when deficiencies are identified.

Amerigroup had processes to measure provider network accessibility, using provider surveys to determine availability of appointments and after-hours care. Amerigroup also had processes to monitor complaints and grievances in relation to access to care concerns and used monitoring results to identify opportunities for improvement. Amerigroup used provider report cards, as well as performance measurement report cards that display provider year-over-year performance and variance. The report cards were used to facilitate discussions with providers about performance and opportunities for improvement.

Amerigroup had processes that demonstrate a foundation for the delivery of healthcare services based on the principles of quality, access, and timeliness. Amerigroup adopted clinical practice guidelines (CPGs) that are evidence-based, involve provider input, and consider demographic and epidemiological profiles of its population through an analysis of utilization data. Amerigroup disseminated the CPGs through outreach materials for providers, included components of the guidelines in member materials, and made the CPGs available on demand to members and providers on the CMO's website.

Amerigroup continued to build organizational strength in quality improvement (QI) knowledge and training by expanding staff training in the Institute for Healthcare Improvement's (IHI's) Science of Quality Improvement and Lean Six Sigma programs. The CMO also demonstrated active involvement of the chief executive officer, chief medical officer, and executive and senior-level staff in QAPI program activities, including the support of ongoing QI training for staff.

> *Amerigroup continued to build organizational strength in QI knowledge and training by expanding staff training in IHI's Science of Quality Improvement and Lean Six Sigma programs.*

The Amerigroup Management Information System (MIS) included five integrated components, which collectively allowed for the collection, integration, tracking, analysis, and reporting of data. The MIS included (1) the core operating system that hosts provider, member, claims, and authorizations data; (2) the care management system, CareCompass, which includes member utilization data such as claims history, authorizations, immunizations, lab, and case and disease management data; (3) the data warehouse that supports processes and functions, which is populated from source systems such as the core operating system; (4) supplemental applications to support overall functionality and produce business intelligence reports such as dashboards and analytical reporting; and (5) member and provider websites that are used to communicate, share, and deliver vital information. Amerigroup's health information system (HIS) supported business intelligence needs. The strength of the CMO's use of the HIS for QI purposes contributed to some of its improved performance measure results.

Summary of Amerigroup Opportunities for Improvement

Amerigroup staff demonstrated a comprehensive understanding of the grievance system process. However, the CMO has an opportunity to improve its policies to reflect that administrative review (appeal) written acknowledgement letters are mailed within 10 working days of receipt in the member's primary language and that the CMO provides information that advises the member of the limited time available for presenting evidence in the case of an expedited administrative review (appeal). In addition, the CMO has an opportunity to focus on ensuring that the grievance and appeal letters to members are written in a manner that is easily understood.

Amerigroup has an opportunity to improve its QAPI program description to more closely align with DCH requirements. Amerigroup should add a comprehensive roadmap of its priorities for QI including processes for monitoring and oversight of the QAPI program and how the CMO provides a comprehensive story of the effectiveness of its QAPI work.

The CMO should include the identification of QI opportunities and any gaps in care or service delivery in its QAPI plan. Quality initiatives should reflect an understanding of the population served; use claims and encounter data to understand where opportunities exist; and include the results of research of potential interventions and activities that may have a positive impact on the care, services, and outcomes for members.

Amerigroup has a continued need to monitor and evaluate its service delivery system and provider network to ensure that DCH requirements for access to care are met. Amerigroup has an opportunity to define mechanisms to assess the quality and appropriateness of care furnished to its members with special healthcare needs. Amerigroup also should consider developing activities focused on provider profiling that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction. There are also opportunities for Amerigroup to work more closely with community organizations beyond the area of care coordination.

Amerigroup has an opportunity to continue to evaluate providers that are not compliant with response times for returning calls after-hours. Amerigroup should also continue its recruitment efforts in geographic areas with network gaps to ensure that access to care standards are met.

Amerigroup has an opportunity to strengthen its discharge planning program. The program should include a discharge plan that is a comprehensive evaluation of the member's health needs following discharge, including the identification of services and supplies that are required for appropriate care. Amerigroup should also ensure that members consent to the care plan and actively participate in the care planning process.

The CMO has an opportunity to ensure that its notice of adverse benefit determinations processes are congruent with its policies. Amerigroup should ensure that its members receive administrative review appeal and upholding denial letters written in easily understood terminology and in the member's primary language.

Peach State

Table 4-2—Peach State Compliance With Standards Scores

Standard #	Standard Name	Total Compliance Score*
CY 2015		
I	Availability of Services	**100.0%**
II	Furnishing of Services	**63.6%**
III	Cultural Competence	**100.0%**
IV	Coordination and Continuity of Care	**61.9%**
V	Coverage and Authorization of Services	**88.0%**
VI	Emergency and Poststabilization Services	**80.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**50.0%**
	Total CY 2015 Compliance Score	**79.7%**
CY 2016		
I	Provider Selection, Credentialing and Recredentialing	**100.0%**
II	Subcontractual Relationships and Delegation	**100.0%**
III	Member Rights and Protections	**100.0%**
IV	Member Information	**90.0%**
V	Grievance System	**91.5%**
VI	Disenrollment Requirements and Limitations	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**84.0%**
	Total CY 2016 Compliance Score	**92.0%**
CY 2017		
I	Clinical Practice Guidelines	**90.9%**
II	Quality Assessment and Performance Improvement (QAPI)	**66.7%**
III	Health Information Systems	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**75.4%**
	Total CY 2017 Compliance Score	**62.5%**
	Total CY 2015–CY 2017 Compliance Score	**83.9%**

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

Summary of Peach State Strengths

Peach State served its members in a culturally competent manner. Peach State ensured that its members have access to contracted providers and services in a way that is consistent with individuals receiving services in an FFS payment environment. Peach State ensured that members are able to request disenrollment for cause at any time and provided assistance to members to coordinate disenrollment

with DCH. Peach State's member website included information that is easily accessible and available in English and Spanish, and offered no-cost linguistic services to both members and providers to improve the experience of care. Peach State had several mechanisms to inform members of their rights and responsibilities, such as the member handbook and the CMO's website. Member rights were also included in the provider manual as a method to keep providers informed regarding member rights. Member handbooks were provided to Peach State's members upon enrollment and were available online (a hard copy would be mailed upon member request) and in alternate formats, meeting the needs of the visually impaired, those with limited reading proficiency, and those for whom English is a secondary language.

Peach State adopted preventive guidelines and CPGs in conjunction with the Peach State QAPI goals and objectives. The guidelines were based on members' health needs and opportunities for improvement identified as part of the CMO's QAPI program.

Peach State used multiple approaches to ensure members receive quality healthcare and actualize improved outcomes. Peach State identified areas with highest impact and overall cost on a per-member per-month (PMPM) basis and implemented interventions—such as incentives, mailings, and phone calls—to maintain or prevent a decline in member health. Peach State also coordinated utilization and care management activities with community practitioners.

Peach State identified areas with highest impact and overall cost on a PMPM basis and implemented interventions—such as incentives, mailings, and phone calls—to maintain or prevent a decline in member health.

Peach State used IHI's Triple Aim as a framework to evaluate the success of the QAPI program and adopted Lean Six Sigma methodology and Plan-Do-Study-Act (PDSA) processes.[4-1] Peach State used a Quality Improvement (QI) Work Plan to track QI efforts.

The CMO also conducted provider profiling using Centelligence Insight, a web-based reporting and management system, which includes advanced capabilities for provider practice pattern and utilization reporting.

Peach State demonstrated a strong knowledge and overall compliance with prior authorization requirements, and requirements focused on ensuring that members have access to emergency services 24 hours a day, seven days a week for treatment of emergency conditions.

Peach State was able to identify members who would benefit from case management services and ensured timely, comprehensive assessments that address the member's physical, behavioral, and psychosocial needs. Peach State's monitoring and follow-up of members in case management was focused and specific to the member's needs. The frequency of contact with members and providers was

[4-1] Ibid.

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

Peach State maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities are performed according to industry and State requirements. Peach State monitored its providers to ensure the provision of quality care. Peach State also monitored its delegated entities' performance on an ongoing basis.

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

Summary of Peach State Opportunities for Improvement

Peach State has an opportunity to improve its QAPI program description to conform to DCH requirements. A comprehensive description or roadmap of Peach State's priorities for QI could include:

- Processes for monitoring and oversight of the QAPI program.
- A summary of how the QI goals, objectives, and related initiatives are identified.
- Which data are used in the selection process.
- Which interventions are considered (and implemented).
- How the initiatives are resourced, including specific, assigned individuals and their qualifications.
- How the results or outcomes are measured to provide a comprehensive story of the effectiveness of Peach State's QAPI work.

The CMO has an opportunity to continue to evaluate providers that are noncompliant with timeliness standards for appointment availability and that are not responding to members' calls in a timely manner. Peach State should consider establishing a monitoring mechanism to oversee provider office wait times and when a provider returns calls to GF members. Peach State should also continue its recruitment efforts in geographic areas with identified network gaps to ensure that access to care standards are met.

Peach State has an opportunity to strengthen its discharge planning program. The program should include a discharge plan that is a comprehensive evaluation of the member's health needs following discharge, including the identification of services and supplies that are required for appropriate care. Peach State should also ensure that members consent to the care plan and actively participate in the care planning process.

Peach State has an opportunity to review its grievance system policies, procedures, and other documents to ensure consistency in the grievance system information available to members and providers. All

documents should accurately provide members access to the appeal process when Peach State fails to meet required time frames for resolution of grievances and appeals. Denial and appeal resolution letters should be written in easily understood language and address all issues identified by the member in his or her complaint.

Peach State did not define members with special healthcare needs or monitor, analyze, evaluate, and improve the delivery, quality, and appropriateness of healthcare furnished to these members in its program descriptions and evaluations. Peach State should consider the use of data, such as outcome data, to evaluate the quality and appropriateness of care furnished to members, including those with special healthcare needs.

Peach State has an opportunity to review all quality of care concerns, even those referred to another entity for review, such as a hospital. Peach State should make its own quality of care determinations, refer to its peer review process, and report to boards and regulatory agencies, as appropriate, as a result of its internal investigation process. Peach State should develop provider profiling activities that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction.

WellCare

Table 4-3—WellCare Compliance With Standards Scores

Standard #	Standard Name	Total Compliance Score*
CY 2015		
I	Availability of Services	**100.0%**
II	Furnishing of Services	**86.4%**
III	Cultural Competence	**92.9%**
IV	Coordination and Continuity of Care	**81.0%**
V	Coverage and Authorization of Services	**88.0%**
VI	Emergency and Poststabilization Services	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**0.0%**
	Total CY 2015 Compliance Score	**87.2%**
CY 2016		
I	Provider Selection, Credentialing and Recredentialing	**90.0%**
II	Subcontractual Relationships and Delegation	**100.0%**
III	Member Rights and Protections	**100.0%**
IV	Member Information	**100.0%**
V	Grievance System	**91.5%**
VI	Disenrollment Requirements and Limitations	**100.0%**

Standard #	Standard Name	Total Compliance Score*
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**70.6%**
	Total CY 2016 Compliance Score	**91.5%**
CY 2017		
I	Clinical Practice Guidelines	**81.8%**
II	Quality Assessment and Performance Improvement (QAPI)	**53.3%**
III	Health Information Systems	**87.5%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**83.3%**
	Total CY 2017 Compliance Score	**67.3%**
	Total CY 2015–CY 2017 Compliance Score	**85.2%**

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

Summary of WellCare Strengths

WellCare had outlined standards for delivering services to its member population in a culturally competent manner and provided guidance by educating staff and providers on the varying needs of a diverse member population. WellCare monitored provider offices to ensure that they are accepting new patients and ensured continuity of care is maintained if or when a member needs to obtain services from noncontracted providers. When out-of-network providers were needed, the CMO would coordinate payment such that the member will not be balance-billed, and WellCare would attempt to contract with those providers to make the provider network more robust.

WellCare ensured that members are able to request disenrollment for cause at any time and provided assistance to members to coordinate disenrollment with DCH. WellCare's member website included information that is easily accessible and offered in English and Spanish. WellCare has several mechanisms to inform members of their rights and responsibilities, such as the member handbook and the CMO's website. Member rights were also included in the provider manual to keep providers informed regarding member rights. Member handbooks were provided to WellCare's members upon enrollment and were available online and in alternate formats, meeting the needs of the visually impaired, those with limited reading proficiency, and those for whom English is a second language.

WellCare ensured that members are able to access emergency services 24 hours a day, seven days a week to treat emergency medical conditions. WellCare's obstetrics (OB) case management program monitoring/follow-up is focused and specific to the member's identified needs. Overall, WellCare's staff demonstrated strong knowledge of medical management policies and processes, with consideration of members' behavioral and physical health needs.

WellCare monitored its providers to ensure the provision of quality care. As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized CVO. The CMO maintained credentialing and recredentialing policies and procedures to ensure compliance with industry and State standards. WellCare monitored delegate performance through

ongoing assessment of individual delegate functions and applied corrective action when deficiencies are identified.

WellCare adopted evidence-based CPGs in the areas of chronic care conditions, prevention, and behavioral health. WellCare included community providers and medical societies in the review and adoption of CPGs. The CMO made decisions regarding the CPGs through committee meetings and implemented processes to consider the needs of its members when identifying CPG topics.

For staff members who work with provider practices to improve HEDIS scores, WellCare expanded their roles to include discussions on overutilization, underutilization, member care needs, and healthcare advocacy.

WellCare worked directly with providers and the community on QI initiatives such as the use of telemedicine and access to school-based care. WellCare used demographic information, as well as various clinical and behavioral health utilization patterns, to identify members who might benefit from disease management or case management programs.

WellCare worked directly with providers and the community on QI initiatives such as the use of telemedicine and access to school-based care.

WellCare used an integrated application suite to support its Medicaid line of business, which allows for a seamless integration with other applications and supports all member, provider, benefit, and claims processing applications. WellCare managed reporting functions through the EDW.

Summary of WellCare Opportunities for Improvement

WellCare has an opportunity to improve its QAPI program description to conform to DCH requirements. A comprehensive description or roadmap of WellCare's priorities for QI could include:

- Processes for monitoring and oversight of the QAPI program.
- A summary of how the QI goals, objectives, and related initiatives are identified.
- Which data are used in the selection process.
- Which interventions are considered (and implemented).
- How the initiatives are resourced, including specific, assigned individuals and their qualifications.
- How the results or outcomes are measured to provide a comprehensive story of the effectiveness of WellCare's QAPI work and an understanding of the population served.

The CMO has an opportunity to continue to evaluate providers that are noncompliant with timeliness standards for appointment availability and that are not responding to members' calls in a timely manner. WellCare should consider establishing a monitoring mechanism to oversee provider office wait times and when a provider returns calls to GF members. WellCare has an opportunity to continue its

recruitment efforts in geographic areas where there are identified network gaps to ensure that access to care standards are met.

WellCare has an opportunity to review its grievance system policies, procedures, and other documents to ensure consistency in the grievance system information available to members and providers. All documents should accurately provide members access to the appeal process when WellCare fails to meet required time frames for resolution of grievances and appeals. Denial and appeal resolution letters should be written in easily understood language and address all issues identified by the member in his or her complaint.

WellCare has an opportunity to strengthen its discharge planning program. The program should include a discharge plan that is a comprehensive evaluation of the member's health needs following discharge, including the identification of services and supplies that are required for appropriate care. WellCare should also ensure that members consent to the care plan and actively participate in the care planning process. WellCare case managers should ensure that care plans are member-centered and that interventions are linked to the member's goals and are measurable.

WellCare has an opportunity to include in its quality of care and peer review process a description of how the results of its internal review processes are tracked and trended, how substantiated issues are reviewed for appropriate corrective actions, and how the CMO decides whether the issue should be referred to regulatory boards for review.

Amerigroup 360°

Table 4-4—Amerigroup 360° Compliance With Standards Scores

Standard #	Standard Name	Total Compliance Score*
CY 2016		
I	Provider Selection, Credentialing and Recredentialing	**88.9%**
II	Subcontractual Relationships and Delegation	**100.0%**
III	Member Rights and Protections	**100.0%**
IV	Member Information	**92.6%**
V	Grievance System	**91.5%**
VI	Disenrollment Requirements and Limitations	**64.3%**
	Total CY 2016 Compliance Score	**89.1%**
CY 2017		
I	Clinical Practice Guidelines	**100.0%**
II	Quality Assessment and Performance Improvement (QAPI)	**53.3%**
III	Health Information Systems	**100.0%**

Standard #	Standard Name	Total Compliance Score*
NA	Follow-up Reviews From Previous Noncompliant Review Findings	91.7%
	Total CY 2017 Compliance Score	**75.4%**
	Total CY 2015–CY 2017 Compliance Score	**84.4%**

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

Below is a discussion of the conclusions and recommendations for improvement that were identified during the compliance with standards review process.

Summary of Amerigroup 360° Strengths

Amerigroup 360° served its members in a culturally competent manner. Amerigroup 360° ensured that its members have access to contracted providers and services in a manner that is consistent with individuals receiving services in an FFS payment environment. Amerigroup 360°'s member website included information that is easily accessible and available in English and Spanish, and offered no-cost linguistic services to both members and providers to improve the experience of care. Amerigroup 360° had several mechanisms to inform members of their rights and responsibilities, such as the member handbook and CMO website. Member rights were also included in the provider manual as a method to keep providers informed regarding member rights. Member handbooks were provided to Amerigroup 360°'s members upon enrollment and were available online (a hard copy would be mailed upon member request) and in alternate formats, meeting the needs of the visually impaired, those with limited reading proficiency, and for those for whom English is a secondary language.

Amerigroup 360° maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities are performed to industry and State requirements. As of August 1, 2015, DCH assumed most credentialing and recredentialing activities previously performed by the CMOs via its centralized CVO. Amerigroup 360° also had a training plan for law enforcement officials, judges, and other key stakeholders. Amerigroup 360° monitored providers to ensure they provide quality care. When quality issues are identified, the CMO would implement disciplinary action that may include suspension, restriction, or termination of a practitioner's CMO participation status. The CMO monitored delegate performance through ongoing assessment of individual delegate functions and would take corrective action when deficiencies are identified.

Amerigroup 360° also had a training plan for law enforcement officials, judges, and other key stakeholders.

Amerigroup 360° had processes to measure provider network accessibility, using provider surveys to determine availability of appointments and after-hours care. Amerigroup 360° also had processes to

monitor complaints and grievances in relation to access to care concerns and used monitoring results to identify opportunities for improvement. Amerigroup 360° used provider report cards, as well as a performance measurement report cards, that display provider year-over-year performance and variance. The report cards were used to facilitate discussions with providers about performance and opportunities for improvement.

Amerigroup 360° had processes that demonstrate a foundation for quality, access, and timeliness of care and service delivery. Amerigroup 360° adopted CPGs that are evidence-based, involve provider input, and consider demographic and epidemiological profiles of its population through an analysis of utilization data. Amerigroup 360° disseminated the CPGs through outreach materials for providers, included components of the guidelines in member materials, and made the CPGs available to members and providers on the CMO's website.

Amerigroup 360° staff demonstrated a comprehensive understanding of the grievance system process. The CMO had detailed policies and procedures for grievances, administrative review, and administrative law hearings.

Amerigroup 360° continued to build organizational strength in QI knowledge and training by expanding staff training in the IHI's Science of Quality Improvement and Lean Six Sigma programs.[4-2] The CMO also demonstrated active involvement of the chief executive officer, chief medical officer, and executive and senior-level staff in QAPI program activities, including the support of ongoing QI training for staff.

Amerigroup 360° used diverse processes to solicit provider, member, and community member feedback and input into the QI processes of the program. Amerigroup 360° had strong monitoring processes that assess the performance of providers and delegated entities both in aggregate and by individual member using the member's individualized care plan. In the Pathways to Permanency program, Amerigroup 360° measured outcomes in timely care delivery as well as in measures, such as school attendance.

Amerigroup 360° developed action plans focused on increasing access to care and receipt of EPSDT services.

Amerigroup 360° developed action plans focused on increasing access to care and receipt of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services. The CMO actively involved executive and senior-level staff in QI work. Amerigroup 360° continued to expand current QI knowledge and training throughout its organization. The CMO had a process for ensuring the delivery of quality care with the primary goal of improving the health status of members who were identified as complex and who are enrolled in case management.

Amerigroup 360° also had strong processes to measure provider network accessibility. Amerigroup 360° had processes to monitor complaints and grievances in relation to access to care concerns. Amerigroup

[4-2] Ibid.

360° used monitoring results to identify opportunities for improvement, and it used individual and aggregate results to inform and request corrective actions from providers. Amerigroup 360° developed provider report cards and produced a final measurement year report card that displayed year-over-year performance and variances. Amerigroup 360° used the performance measure results to identify opportunities for improvement.

The Amerigroup 360° MIS included five integrated components, which collectively allowed for the collection, integration, tracking, analysis, and reporting of data. The MIS included (1) the core operating system that hosts provider, member, claims, and authorizations data; (2) the care management system, CareCompass, which includes member utilization data such as claims history, authorizations, immunizations, lab, and case and disease management data; (3) the data warehouse that supports processes and functions, which is populated from source systems such as the core operating system; (4) supplemental applications to support overall functionality and produce business intelligence reports such as dashboards and analytical reporting; and (5) member and provider websites that are used to communicate, share, and deliver vital information. Amerigroup 360°'s HIS supported business intelligence needs. The strength of the CMO's use of the HIS for quality improvement purposes contributed to some of its improved performance measure results.

Summary of Amerigroup 360° Opportunities for Improvement

Amerigroup 360° has an opportunity to improve its QAPI program description to more closely align with DCH requirements. Amerigroup 360° should add a comprehensive roadmap of its priorities for QI including processes for monitoring and oversight of the QAPI program and how the CMO provides a comprehensive story of the effectiveness of its QAPI work. Amerigroup 360° has an opportunity to ensure that children in the Kenny A. Consent Decree counties of DeKalb and Fulton meet the EPSDT requirements.

Amerigroup 360° has an opportunity to include the voice of both the member and the member's caregiver in efforts to actively improve the quality of care provided. The CMO should seek opportunities to include the member's parents, family members, and guardian to actively improve the quality of care provided to the member. Amerigroup 360° should develop opportunities for community resources and agencies to provide input and feedback into the quality improvement process.

Amerigroup 360° staff demonstrated a comprehensive understanding of the grievance system process. However, the CMO has an opportunity to improve its policies to reflect that administrative review (appeal) acknowledgement letters are provided in writing within 10 working days of receipt in the member's primary language and that the CMO provides information that advises the member of the limited time available for presenting evidence in the case of an expedited administrative review (appeal). In addition, the CMO has an opportunity to focus on ensuring that the grievance and appeal letters to members are written in a manner that is easily understood.

The CMO should include the identification of quality improvement opportunities and gaps in care or service delivery in its QAPI plan. Quality initiatives should reflect an understanding of the population served; use data to understand where opportunities exist; and include the research results of potential

interventions and activities that may have a positive impact on the care, services, and outcomes for members. The QAPI program evaluation should document the story of the effectiveness of Amerigroup 360°.

Amerigroup 360° has a continued need to monitor and evaluate its service delivery system and provider network to ensure that DCH requirements for access to care are met. Amerigroup 360° has an opportunity to define mechanisms to assess the quality and appropriateness of care furnished to its members with special healthcare needs. Amerigroup 360° also should consider developing activities focused on provider profiling that include information such as tracked and trended data regarding utilization, complaints and grievances, prescribing, and member satisfaction. There are also opportunities for Amerigroup 360° to work more closely with community organizations beyond the area of care coordination. Amerigroup 360° also has an opportunity to develop GF 360° training plan tracking tools to capture which training modules are being completed by key stakeholders.

Amerigroup 360° has an opportunity to continue to evaluate providers that are noncompliant with response times for returning calls after-hours. Amerigroup 360° should also continue its recruitment efforts in geographic areas with identified network deficiencies to ensure that access to care standards are met.

Amerigroup 360° has an opportunity to strengthen its discharge planning program. The program should include a discharge plan that is a comprehensive evaluation of the member's health needs following discharge, including the identification of services and supplies that are required for appropriate care. Amerigroup 360° should also ensure that members consent to the care plan and actively participate in the care planning process.

The CMO has an opportunity to ensure that its notice of adverse benefit determinations processes are congruent with its policies. Amerigroup 360° should ensure that its members receive administrative review appeal and upholding denial letters written in easily understood language and in the member's primary language.

Care Management Organization (CMO) Summary Results Comparison

Table 4-5 displays the compliance with standards review results for Amerigroup, Peach State, WellCare, and Amerigroup 360° for the three-year (CY 15–CY 17) compliance with standards review cycle.

Table 4-5—CMO Compliance With Standards Score Comparison

Standard #	Standard Name	Amerigroup	Peach State	WellCare	Amerigroup 360°
CY 2015					
I	Availability of Services	100.0%	100.0%	100.0%	NA
II	Furnishing of Services	90.9%	63.6%	86.4%	NA
III	Cultural Competence	100.0%	100.0%	92.9%	NA
IV	Coordination and Continuity of Care	85.7%	61.9%	81.0%	NA
V	Coverage and Authorization of Services	88.0%	88.0%	88.0%	NA
VI	Emergency and Poststabilization Services	100.0%	80.0%	100.0%	NA
NA	Follow-up Reviews From Previous Noncompliant Review Findings	20.0%	50.0%	0.0%	NA
	Total CY 2015 Compliance Score	**90.3%**	**79.7%**	**87.2%**	**NA**
CY 2016					
I	Provider Selection, Credentialing and Recredentialing	90.0%	100.0%	90.0%	88.9%
II	Subcontractual Relationships and Delegation	100.0%	100.0%	100.0%	100.0%
III	Member Rights and Protections	100.0%	100.0%	100.0%	100.0%
IV	Member Information	95.0%	90.0%	100.0%	92.6%
V	Grievance System	91.5%	91.5%	91.5%	91.5%
VI	Disenrollment Requirements and Limitations	90.0%	100.0%	100.0%	64.3%
NA	Follow-up Reviews From Previous Noncompliant Review Findings	25.0%	84.0%	70.6%	N/A
	Total CY 2016 Compliance Score	**85.7%**	**92.0%**	**91.5%**	**89.1%**
CY 2017					
I	Clinical Practice Guidelines	100.0%	90.9%	81.8%	100.0%
II	Quality Assessment and Performance Improvement (QAPI)	53.3%	66.7%	53.3%	53.3%
III	Health Information Systems	100.0%	100.0%	87.5%	100.0%
NA	Follow-up Reviews From Previous Noncompliant Review Findings	75.0%	62.5%	83.3%	91.7%
	Total CY 2017 Compliance Score	**72.1%**	**75.4%**	**67.3%**	**75.4%**
	Total CY 2015-CY 2017 Compliance Score	**84.8%**	**83.9%**	**85.3%**	**84.4%**

CMO Overall Conclusions

The CMOs received 100 percent scores in the areas of Availability of Services, Subcontractual Relationships and Delegation, and Member Rights and Protections.

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

Overall, the CMOs' performance results are mixed. The CMOs demonstrated compliance with many of the structure and operations standards reviewed. The results of the compliance review suggest that the CMOs' improvement efforts should be focused on the QAPI program with particular attention paid to the QAPI plan and the QAPI evaluation. Additionally, two of the CMOs closed most of their corrective action plans (CAPs) from the previous year's review. All CMOs should continue to enhance and develop new interventions, as needed, to improve performance and close the remaining CAPs.

The CMOs generally implemented processes to build a foundation for quality, access, and timeliness of care and service delivery. The CMOs adopted CPGs that were evidence-based, involved provider input, and considered demographic and epidemiological profiles of their populations through an analysis of utilization data. The CMOs collaborated with DCH to develop and implement a methodology to measure consistent use of the CPGs within the provider networks.

The CMOs generally implemented processes to build a foundation for quality, access, and timeliness of care and service delivery.

The CMOs continued to build organizational strength in QI knowledge and training, with some CMOs expanding staff training in the IHI's Science of Quality Improvement and Lean Six Sigma.[4-3] The CMOs, to varying degrees, also demonstrated active involvement of executive and senior-level staff in the QAPI program work. The CMOs should continue to train and include staff with working knowledge of the processes in QAPI work teams.

[4-3] Ibid.

Overall, the CMOs demonstrated strong health information systems capable of achieving the requirements for quality, access, and timeliness of care. The CMOs demonstrated various levels of strength in the use of information from these systems to analyze the improvement strategies and to link them to the overall QI success. The CMOs have an opportunity to use the results of data analysis to identify strategies that may be translated and applied to drive improvement.

A significant opportunity across the CMOs is the strengthening of their QAPI program description and evaluation process to provide a comprehensive roadmap for the organizations' priorities for improvement, including the timelines, sufficient monitoring, and tracking of results. In general, the CMOs' QAPI program descriptions did not detail the QI processes the CMOs had developed and implemented. For example, not all CMOs provided a comprehensive summary of how the QI goals, objectives, and related initiatives are identified; which data are used in the selection process; which interventions are considered and implemented; how the initiatives are resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes are measured to provide a comprehensive story of the effectiveness of the CMO's QAPI work.

CMO Overall Recommendations

HSAG recommends that the CMOs work on improvement opportunities for their QAPI program descriptions to conform to DCH requirements. A comprehensive description or roadmap of their priorities for quality improvement could include processes for monitoring and oversight of the QAPI program and a summary of how the quality improvement goals, objectives, and related initiatives are identified; which data are used in the selection process; which interventions are considered (and implemented); how the initiatives are resourced, including specific, assigned individuals and their qualifications; and how the results or outcomes are measured to provide a comprehensive story of the effectiveness of the CMO's QAPI work and an understanding of the population served.

HSAG recommends that the CMOs continue to review policies, procedures, and other documents to ensure consistent grievance systems information is available to members and providers. All documents should accurately provide members access to the appeal process. The CMOs should work to ensure that denial and appeal resolution letters are written in easily understood language and address all issues identified by the member in his or her complaint.

HSAG recommends that the CMOs review their internal policies to ensure that they align with the day-to-day practices at all levels of the organization. This consistency should be evident through a review of policies and procedures in comparison with the job aids used by CMO staff members and how they describe the work that they perform. All work activities should also align with DCH guidance and contractual requirements.

HSAG recommends that the CMOs continue collaboration with and monitoring of provider networks to ensure that CMOs deliver appropriate care, members have timely access to care, and the CMO is responsive to member and provider concerns as well as network and policy changes. The CMOs should continue to fill network gaps to meet the time and distance standards established by DCH.

HSAG recommends that the CMOs focus quality improvement efforts to strengthen their discharge planning programs. The programs should include a discharge plan that is a comprehensive evaluation of the member's health needs following discharge, including the identification of services and supplies that are required for appropriate care to minimize readmissions. CMOs should also ensure that members consent to the care plan that is developed and actively participate in the care planning process. CMOs' case managers should ensure that care plans are member-centered and that interventions are linked to the member's goals and are measurable.

5. Validation of Performance Measures—NCQA HEDIS Compliance Audit

The DCH requires the CMOs to submit performance measurement data as part of their QAPI programs for the Georgia Families and Georgia Families 360° populations. Validating the CMOs' performance measures is one of the federally required EQR activities described in 42 CFR §438.330(c) and §438.358(b)(2). To comply with this requirement, DCH contracted with HSAG to validate the performance measures through NCQA HEDIS Compliance Audits. These audits focused on the ability of the CMOs to process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data accurately. As part of the audits, HSAG also explored the issue of completeness of claims and encounter data to improve rates for the performance measures.

The following section provides summary information from the NCQA HEDIS Compliance Audits conducted for Amerigroup, Peach State, WellCare, and Amerigroup 360°.

Objectives

The objectives of the NCQA HEDIS Compliance Audit were to assess the performance of the CMOs with respect to the HEDIS 2017 Technical Specifications, the CMS Core Measure Set, and State-specific performance measures. The audits incorporated two main components:

- A detailed assessment of the CMOs' information system (IS) capabilities for collecting, analyzing, and reporting performance measure information.
- A review of the specific reporting methods used for performance measures, including databases and files used to store measure information, medical record abstraction tools and abstraction procedures used, certified measure status when applicable, and any manual processes employed in performance measure data production and reporting. The audit included any data collection and reporting processes supplied by vendors, contractors, or third parties, as well as the CMOs' oversight of these outsourced functions.

The performance measure validation evaluated the strengths and weaknesses of the CMOs in achieving compliance with performance measures.

HSAG validated rates for the following set of performance measures selected by DCH for validation. All performance measures were selected from the 2017 HEDIS measures developed by the NCQA, CMS' Child Core Set, Adult Core Set, and the Agency for Healthcare Research and Quality's (AHRQ's) Quality Indicator measures. The measurement period was identified by DCH as CY 2016 for all measures except the Child Core Set dental measure. The dental measure was reported for federal fiscal year (FFY) 2016, which covered the time frame of October 1, 2015, through September 30, 2016, according to CMS requirements. Table 5–1 lists the performance measures that were validated for each of the audited populations and identifies the method for data collection and specifications that were used for each of the measures. Performance measures that list Core Set and HEDIS specifications were reported according to the age breakouts required by both sets of specifications.

Audited Populations

Georgia Families 360º program (GF 360º program)—On March 3, 2014, DCH launched the Georgia Families 360° program. This program's population consisted of children, youth, and young adults in foster care; children and youth receiving adoption assistance; and select youth involved in the juvenile justice system. The DCH contracted with Amerigroup to provide services to improve care coordination and continuity of care, and to provide better health outcomes for these members. To be included in the GF 360° program rates, a member had to be enrolled in the GF 360° program at some point during CY 2016.

Georgia Families (GF)—the GF population consisted of Medicaid and PeachCare for Kids® members excluded from the GF 360° program and enrolled in one of the three contracted GF CMOs during the measurement year:[5-1] Amerigroup, Peach State, and WellCare. To be included in the GF rates, a member had to be continuously enrolled in GF but could have switched CMOs during the measurement period. The GF rates excluded members who were simultaneously enrolled in Medicare and Medicaid (referred to as dual-eligible members).

Table 5–1 lists the required reporting year (RY) 2017 measures for the Georgia Families and Georgia Families 360° populations.

Table 5–1—Required RY 2017 Performance Measures

Measure	Georgia Families	Georgia Families 360°	Specifications			Populations & Data Collection Method (A=Admin; H=Hybrid)	
			Core Set	AHRQ	HEDIS	GF	GF 360º
Access to Care							
Adults' Access to Preventive/Ambulatory Health Services							
20–44 Years	✓	✓			✓	**A**	**A**
Adult BMI Assessment							
Adult BMI Assessment	✓	✓	✓		✓	**A**	**H**
Annual Dental Visit							
2–3 Years	✓	✓			✓	**A**	**A**
4–6 Years	✓	✓			✓	**A**	**A**
7–10 Years	✓	✓			✓	**A**	**A**
11–14 Years	✓	✓			✓	**A**	**A**
15–18 Years	✓	✓			✓	**A**	**A**
19–20 Years	✓	✓			✓	**A**	**A**

[5-1] The DCH required its CMOs to contract with an NCQA-licensed audit organization to undergo an NCQA HEDIS Compliance Audit. To validate the rates calculated for the non-HEDIS measures, DCH contracted HSAG to perform an independent performance measure validation for each CMO. Results for these validations are presented in each CMO-specific PMV report.

Measure	Georgia Families	Georgia Families 360°	Specifications			Populations & Data Collection Method (A=Admin; H=Hybrid)	
			Core Set	AHRQ	HEDIS	GF	GF 360°
Total	✓	✓			✓	A	A
Children and Adolescents' Access to Primary Care Practitioners							
12–24 Months	✓	✓	✓		✓	A	A
25 Months–6 Years	✓	✓	✓		✓	A	A
7–11 Years	✓	✓	✓		✓	A	A
12–19 Years	✓	✓	✓		✓	A	A
Colorectal Cancer Screening							
Colorectal Cancer Screening	✓	X	CUSTOM			A	
Children's Health							
Prevention and Screening							
Appropriate Testing for Children With Pharyngitis							
Appropriate Testing for Children With Pharyngitis	✓	✓			✓	A	A
Childhood Immunization Status							
Combination 3	✓	✓	✓		✓	A	H
Combination 6	✓	✓	✓		✓	A	H
Combination 10	✓	✓	✓		✓	A	H
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk							
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	✓	✓	✓			A	A
Developmental Screening in the First Three Years of Life							
Total	✓	✓	✓			A	H
Immunizations for Adolescents							
Combination 1 (Meningococcal, Tdap)	✓	✓	✓		✓	A	H
HPV	✓	✓	✓		✓	A	H
Lead Screening in Children							
Lead Screening in Children	✓	✓			✓	A	H
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents							
BMI Percentile—Total	✓	✓	✓		✓	A	H
Counseling for Nutrition—Total	✓	✓	✓		✓	A	H
Counseling for Physical Activity—Total	✓	✓	✓		✓	A	H
Upper Respiratory Infection							
Appropriate Treatment for Children With Upper Respiratory Infection							
Appropriate Treatment for Children With Upper Respiratory Infection	✓	✓			✓	A	A
Well-Child/Well-Care Visits							
Adolescent Well-Care Visits							
Adolescent Well-Care Visits	✓	✓	✓		✓	A	H
Well-Child Visits in the First 15 Months of Life							
Six or More Well-Child Visits	✓	✓	✓		✓	A	H
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life							

Measure	Georgia Families	Georgia Families 360°	Specifications			Populations & Data Collection Method (A=Admin; H=Hybrid)	
			Core Set	AHRQ	HEDIS	GF	GF 360°
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	✓	✓	✓		✓	A	H
Women's Health							
Prenatal Care and Birth Outcomes							
Antenatal Steroids							
Antenatal Steroids	✓	X	✓			H	
Behavioral Health Risk Assessment for Pregnant Women							
Behavioral Health Risk Assessment for Pregnant Women	✓	✓	✓			A	H
Cesarean Delivery Rate, Uncomplicated							
Cesarean Delivery Rate, Uncomplicated	✓	✓		✓		A	A
Cesarean Rate for Nulliparous Singleton Vertex							
Cesarean Rate for Nulliparous Singleton Vertex	✓	X	✓			H	
Elective Delivery							
Elective Delivery	✓	X	✓			H	
Frequency of Ongoing Prenatal Care							
≥81 Percent of Expected Visits	✓	✓	✓		✓	A	H
Percentage of Live Births Weighing Less Than 2,500 Grams							
Percentage of Live Births Weighing Less Than 2,500 Grams	✓	✓	✓	✓		A	A
Prenatal and Postpartum Care							
Timeliness of Prenatal Care	✓	✓	✓		✓	A	H
Postpartum Care	✓	✓	✓		✓	A	H
Prevention and Screening							
Breast Cancer Screening							
Breast Cancer Screening	✓	X	✓		✓	A	
Cervical Cancer Screening							
Cervical Cancer Screening	✓	X	✓		✓	A	
Chlamydia Screening in Women							
Total	✓	✓	✓		✓	A	A
Chronic Conditions							
Diabetes							
Comprehensive Diabetes Care							
Hemoglobin A1c (HbA1c) Testing	✓	✓	✓		✓	A	H
HbA1c Poor Control (>9.0%)	✓	✓	✓		✓	A	H
HbA1c Control (<8.0%)	✓	✓	✓		✓	A	H
HbA1c Control (<7.0%)	✓	X	✓		✓	A	
Eye Exam (Retinal) Performed	✓	✓	✓		✓	A	H
Medical Attention for Nephropathy	✓	✓	✓		✓	A	H

Measure	Georgia Families	Georgia Families 360°	Specifications			Populations & Data Collection Method (A=Admin; H=Hybrid)	
			Core Set	AHRQ	HEDIS	GF	GF 360°
Blood Pressure Control (<140/90 mm Hg)	✓	✓	✓		✓	A	H
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)							
Diabetes Short-Term Complications Admission Rate	✓	✓	✓	✓		A	A
Cardiovascular Conditions							
Controlling High Blood Pressure							
Controlling High Blood Pressure	✓	✓	✓		✓	H	H
Heart Failure Admission Rate (per 100,000 Member Months)							
Heart Failure Admission Rate	✓	X	✓	✓		A	
Persistence of Beta-Blocker Treatment After a Heart Attack							
Persistence of Beta-Blocker Treatment After a Heart Attack	✓	X			✓	A	
Respiratory Conditions							
Asthma in Younger Adults Admission Rate (per 100,000 Member Months							
Asthma in Younger Adults Admission Rate	✓	✓	✓	✓		A	A
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)							
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	✓	X	✓	✓		A	
Behavioral Health							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia							
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	✓	✓	✓		✓	A	A
Antidepressant Medication Management							
Effective Acute Phase Treatment	✓	✓	✓		✓	A	A
Effective Continuation Phase Treatment	✓	✓	✓		✓	A	A
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications							
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	X	✓		✓	A	
Follow-Up After Hospitalization for Mental Illness							
7-Day Follow-Up	✓	✓	✓		✓	A	A
30-Day Follow-Up	✓	✓	✓		✓	A	A
Follow-Up Care for Children Prescribed ADHD Medication							
Initiation Phase	✓	✓	✓		✓	A	A
Continuation and Maintenance Phase	✓	✓	✓		✓	A	A
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment							
Initiation of AOD Treatment—Total	✓	✓	✓		✓	A	A
Engagement of AOD Treatment—Total	✓	✓	✓		✓	A	A

Measure	Georgia Families	Georgia Families 360°	Specifications			Populations & Data Collection Method (A=Admin; H=Hybrid)	
			Core Set	AHRQ	HEDIS	GF	GF 360°
Screening for Clinical Depression and Follow-Up Plan							
Screening for Clinical Depression and Follow-Up Plan	✓	✓	✓			H	H
Use of Multiple Concurrent Antipsychotics in Children and Adolescents							
Total	✓	✓	✓		✓	A	A
Medication Management							
Annual Monitoring for Patients on Persistent Medications							
ACE Inhibitors or ARBs	✓	X	✓		✓	A	
Diuretics	✓	X	✓		✓	A	
Total	✓	X	✓		✓	A	
Medication Management for People With Asthma							
Medication Compliance 50%—Ages 5–11 Years	✓	✓	✓		✓	A	A
Medication Compliance 50%—Ages 12–18 Years	✓	✓	✓		✓	A	A
Medication Compliance 50%—Ages 19–50 Years	✓	✓	✓		✓	A	A
Medication Compliance 50%—Ages 51–64 Years	✓	X	✓		✓	A	
Medication Compliance 50%—Total	✓	✓	✓		✓	A	A
Medication Compliance 75%—Ages 5–11 Years	✓	✓	✓		✓	A	A
Medication Compliance 75%—Ages 12–18 Years	✓	✓	✓		✓	A	A
Medication Compliance 75%—Ages 19–50 Years	✓	✓	✓		✓	A	A
Medication Compliance 75%—Ages 51–64 Years	✓	X	✓		✓	A	
Medication Compliance 75%—Total	✓	✓	✓		✓	A	A
Use of Opioids at High Dosage (per 1,000 Member Months)							
Use of Opioids at High Dosage—All Ages	✓	X	✓			A	
Utilization							
Ambulatory Care (per 1,000 Member Months)—Total							
ED Visits—Total	✓	✓	✓		✓	A	A
Outpatient Visits—Total	✓	✓	✓		✓	A	A
Inpatient Utilization—General Hospital/Acute Care—Total							
Total Inpatient—Discharges per 1,000 Member Months—Total	✓	✓			✓	A	A
Total Inpatient—Days per 1,000 Member Months—Total	✓	✓			✓	A	A
Total Inpatient—Average Length of Stay—Total	✓	✓			✓	A	A

Measure	Georgia Families	Georgia Families 360°	Specifications			Populations & Data Collection Method (A=Admin; H=Hybrid)	
			Core Set	AHRQ	HEDIS	GF	GF 360°
Maternity—Discharges per 1,000 Member Months—Total	✓	✓			✓	A	A
Maternity—Days per 1,000 Member Months—Total	✓	✓			✓	A	A
Maternity—Average Length of Stay—Total	✓	✓			✓	A	A
Surgery—Discharges per 1,000 Member Months—Total	✓	✓			✓	A	A
Surgery—Days per 1,000 Member Months—Total	✓	✓			✓	A	A
Surgery—Average Length of Stay—Total	✓	✓			✓	A	A
Medicine—Discharges per 1,000 Member Months—Total	✓	✓			✓	A	A
Medicine—Days per 1,000 Member Months—Total	✓	✓			✓	A	A
Medicine—Average Length of Stay—Total	✓	✓			✓	A	A
Mental Health Utilization—Total							
Inpatient—Total	✓	✓			✓	A	A
Intensive Outpatient or Partial Hospitalization—Total	✓	✓			✓	A	A
Outpatient, ED, or Telehealth—Total	✓	✓			✓	A	A
Any Service—Total	✓	✓			✓	A	A
Plan All-Cause Readmissions Rate							
18–44 Years	✓	✓	Custom			A	A
45–54 Years	✓	X				A	
55–64 Years	✓	X				A	
18–64—Total	✓	X				A	
65–74 Years	✓	X				A	
75–84 Years	✓	X				A	
85 and Older	✓	X				A	
65 and Older—Total	✓	X				A	
Health Plan Descriptive Information							
Race/Ethnicity Diversity of Membership							
Total—White	✓	✓			✓	A	A
Total—Black or African American	✓	✓			✓	A	A

X Measure not applicable to the GF 360° population.

Plan-Specific Findings—Amerigroup

A detailed review of the 2017 performance reports submitted by Amerigroup determined that the rates were prepared according to the *HEDIS 2017 Technical Specifications* for the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that Amerigroup was compliant with the standards assessed, as follows:

- Amerigroup was fully compliant with IS standard 1.0. Amerigroup continued to use the Facets claims system to capture most of the medical services required for reporting measures. In addition to Facets, Amerigroup used data provided by its pharmacy and dental vendors to supplement any medical claims. The auditor reviewed the multiple systems and processes used for each data source and found each to be compliant. Each system captured appropriate, standard coding schemes as required for reporting. Amerigroup used only standard claim forms for each service type. Most of Amerigroup's claims were submitted electronically through either clearinghouses or direct submitters. Paper claims, though small in quantity, were submitted to Amerigroup's optical character recognition (OCR) vendor for scanning and conversion into a standard Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 format. Amerigroup appropriately monitored vendor data submissions and controls regularly to ensure data completion for measure production. Amerigroup's oversight of this process ensured that all relevant data were captured prior to measure production. Amerigroup used an additional data source, the Georgia Medical Care Foundation (GMCF) birth file.
- Amerigroup was fully compliant with IS standard 2.0. Amerigroup captured the State enrollment files daily and monthly, and loaded them into Facets. Using the aid codes provided on the enrollment files, Amerigroup was able to identify and separate the GF 360° population from the Community Care population when reporting on each measure. The auditor verified the aid codes and populations during the on-site audit and conducted primary source verification of distinct members to ensure the populations were separated. Amerigroup's Facets system captured all relevant fields from the State's enrollment files and continued to monitor daily file updates, cancelations, and renewals.
- Amerigroup was fully compliant with IS standard 3.0. Amerigroup used the CACTUS (credentialing) and Facets (billing and payment) systems to store its provider data. The CMO had a systematic process to capture, review, and update provider credentialing and specialty data in both systems. The two systems were linked using Facets' common practitioner identifiers, and changes in provider data from Facets were automatically loaded into CACTUS, eliminating any potential manual data entry or merge errors. Amerigroup implemented daily, weekly, and monthly edit checks on provider data submitted via claims. Additionally, the CMO's audit team reviewed 25 percent of all completed records for accuracy and completeness each month. Amerigroup's oversight of its delegates contracted for credentialing and recredentialing activities also met industry standards. Effective August 1, 2015, DCH implemented a centralized credentials verification organization (CVO), and most of the credentialing functions previously performed by Amerigroup were transitioned to the new CVO. Although the State is now responsible for credentialing all providers in Georgia, the auditor still conducted primary source verification of the CACTUS and Facets systems to identify any issues across the two systems. The auditor selected several records from numerator-compliant members in various measures to ensure the provider specialties matched the measure

requirements. The auditor did not identify any issues with providers during this review. The auditor also reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. The auditor found Amerigroup to be compliant with the credentialing and assignment of individual providers at federally qualified health centers (FQHCs). Audit staff reviewed and approved the specialty mapping for Amerigroup and determined it to be compliant for the measure reporting.

- Amerigroup was fully compliant with IS standard 4.0. The auditor reviewed Amerigroup's IS 4 Roadmap pertaining to the policies and procedures for IS standard 4.0. The Roadmap review found these policies and procedures to be consistent with the NCQA *HEDIS 2017, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. Amerigroup completed sampling according to HEDIS and non-HEDIS measure sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. Amerigroup staff used the Quality Spectrum Hybrid Reporter (QSHR) hybrid medical record abstraction tools. The auditor participated in a live vendor demonstration of the QSHR tools and instructions. All fields, edits, and dropdown boxes were reviewed for accuracy against the current year's Child Core Set Technical Specifications; Adult Core Set Technical Specifications; AHRQ Quality Indicator Technical Specifications; and NCQA's *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*. Amerigroup used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's Child Core Set Technical Specifications; Adult Core Set Technical Specifications; AHRQ Quality Indicator Technical Specifications; *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*; and the use of QSHR's abstraction tools to accurately conduct medical record reviews. The auditor reviewed Amerigroup's training abstraction manual and found no concerns. Amerigroup maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusion, and a random sample of numerator negatives.

  Due to challenges encountered with the CMS and HEDIS measures during the 2015 medical record review validation (MRRV), a convenience sample was required for *Colorectal Cancer Screening (COL)*, *Antenatal Steroids*, and the *Elective Delivery* performance measures. Amerigroup passed the convenience sample process.

  Amerigroup passed the MRRV process for the following measures:

  – Non-HEDIS—*Antenatal Steroids (PC03-AD)*
  – Non-HEDIS—*Elective Delivery (PC01-AD)*
  – Non-HEDIS—*Developmental Screening in the First Three Years of Life (DEV-CH)*
  – Non-HEDIS—*Behavioral Health Risk Assessment for Pregnant Women (BHRA-CH)*
  – Non-HEDIS—*Developmental Screening in the First Three Years of Life (DEV-CH)*
  – Non-HEDIS—*Exclusions*

- Amerigroup was fully compliant with IS standard 5.0. A standard supplemental data source was allowed for use for Amerigroup. The supplemental data were obtained from the state historical fee-for-service (FFS) file from the State of Georgia. Since this source was considered standard by the auditor, no proof of service verification was required. The auditor identified significant numerator positive hits for the *Colorectal Cancer Screening*, *Developmental Screening in the First Three Years*

of Life, *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*, and *Screening for Clinical Depression and Follow-up Plan* measures. The auditor reviewed supplemental impact reports and found them to be compliant with the measure expectations.

- Amerigroup was fully compliant with IS standard 7.0. Amerigroup used its internal Facets system along with the GMCF birth file to determine eligible populations for the *Antenatal Steroids*, *Elective Delivery*, and *Cesarean Section for Nulliparous Singleton Vertex* measures. Amerigroup continued to use its internal relational database to store all incoming data. The internal data warehouse contained both internal and external data files used for reporting. Amerigroup also contracted with a vendor, Inovalon, to produce the performance measures under review. Amerigroup was responsible for loading and running the data monthly, as well as running the data for measure production and final rates. The auditor reviewed the source code for the measures under review and conducted primary source verification on all administrative measures. The auditor had no concerns following the review of these measures. Amerigroup maintained its quality review processes during the measurement year to ensure all data were loaded. Amerigroup continued to conduct monthly data runs for measures to monitor progress throughout the year—a best practice for ensuring accurate data management and measure production. Monthly measure production continued to assist Amerigroup with identifying issues, if any, early. If data errors were found, Amerigroup was able to easily retract and reload the data to correct the issues. Amerigroup used Inovalon's software to produce the final rates for the measures. Amerigroup continued to have an excellent disaster recovery process in place and backed up data nightly. The auditor reviewed Amerigroup's performance measure rates and found no anomalies.

Performance Measure Results

The RY 2015, 2016, and 2017 rates for Amerigroup are presented in Table 5–2, along with RY 2015 to RY 2017 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Measures in the Utilization and Health Plan Descriptive Information domains are designed to capture the frequency of services provided by the CMO and characteristics of the population served by the CMO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* and the *Plan All-Cause Readmissions Rate* measure rates, higher or lower rates in these domains do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5–2—Performance Measure Results for Amerigroup

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	79.69%	79.48%	78.59%	-1.10

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Adult BMI Assessment				
Adult BMI Assessment	66.51%	71.46%	81.02%	14.51
Annual Dental Visit				
2–3 Years	47.54%	46.51%	45.54%	-2.00
4–6 Years	75.89%	75.11%	74.81%	-1.08
7–10 Years	78.32%	78.48%	78.00%	-0.32
11–14 Years	71.65%	71.85%	71.73%	0.08
15–18 Years	60.07%	60.80%	60.43%	0.36
19–20 Years[1]	30.58%	39.47%	36.44%	5.86
Total	68.78%	68.81%	68.44%	-0.34
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.00%	96.61%	97.12%	0.12
25 Months–6 Years	90.85%	89.42%	89.71%	-1.14
7–11 Years	92.99%	92.23%	92.06%	-0.93
12–19 Years	90.68%	89.92%	89.51%	-1.17
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	45.24%	47.80%	NC
Children's Health				
Prevention and Screening				
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	80.92%	82.38%	80.76%	-0.16
Childhood Immunization Status				
Combination 3	79.12%	76.16%	74.31%	-4.81
Combination 6	43.39%	39.35%	32.87%	-10.52
Combination 10	38.05%	35.42%	28.47%	-9.58
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	24.81%	26.47%	NC
Developmental Screening in the First Three Years of Life				
Total	38.19%	48.38%	58.10%	19.91
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)[2]	80.20%	90.49%	89.12%	8.92
HPV	—	—	19.68%	NC
Lead Screening in Children				

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Lead Screening in Children	78.70%	80.09%	78.70%	0.00
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	54.40%	67.75%	75.00%	20.60
Counseling for Nutrition—Total	58.80%	63.57%	70.60%	11.80
Counseling for Physical Activity—Total[3]	53.47%	56.84%	65.28%	11.81
Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	85.92%	86.82%	88.32%	2.40
Well-Child/Well-Care Visits				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	53.01%	56.02%	56.71%	3.70
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	65.97%	68.52%	71.69%	5.72
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.84%	73.04%	74.20%	0.36
Women's Health				
Prenatal Care and Birth Outcomes				
Antenatal Steroids				
Antenatal Steroids	NR	NR	21.28%	NC
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	4.57%	11.00%	18.98%	14.41
Cesarean Delivery Rate, Uncomplicated				
*Cesarean Delivery Rate, Uncomplicated**	28.59%	21.59%	28.89%	0.30
Cesarean Rate for Nulliparous Singleton Vertex				
*Cesarean Rate for Nulliparous Singleton Vertex**	NR	NR	1.67%	NC
Elective Delivery				
*Elective Delivery**	NR	NR	6.82%	NC
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	48.02%	49.65%	58.56%	10.54
Percentage of Live Births Weighing Less Than 2,500 Grams				
*Percentage of Live Births Weighing Less Than 2,500 Grams**	8.87%	9.34%	8.65%	-0.22
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.02%	78.09%	81.25%	2.23

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Postpartum Care	62.94%	64.10%	68.98%	6.04
Prevention and Screening				
Breast Cancer Screening				
Breast Cancer Screening	69.04%	67.84%	70.66%	1.62
Cervical Cancer Screening				
Cervical Cancer Screening	66.40%	64.49%	66.75%	0.35
Chlamydia Screening in Women				
Total	56.96%	53.71%	58.98%	2.02
Chronic Conditions				
Diabetes				
Comprehensive Diabetes Care[3]				
Hemoglobin A1c (HbA1c) Testing	85.37%	88.35%	86.07%	0.70
*HbA1c Poor Control (>9.0%)**	58.54%	53.22%	51.58%	-6.96
HbA1c Control (<8.0%)	35.02%	38.96%	38.64%	3.62
HbA1c Control (<7.0%)	25.21%	28.93%	29.14%	3.93
Eye Exam (Retinal) Performed	46.86%	49.74%	45.27%	-1.59
Medical Attention for Nephropathy	76.66%	92.87%	90.88%	14.22
Blood Pressure Control (<140/90 mm Hg)	36.93%	50.78%	55.72%	18.79
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)				
*Diabetes Short-Term Complications Admission Rate**	14.87	13.46	14.32	-0.55
Cardiovascular Conditions				
Controlling High Blood Pressure				
Controlling High Blood Pressure	29.07%	42.72%	47.43%	18.36
Heart Failure Admission Rate (per 100,000 Member Months)				
*Heart Failure Admission Rate**	6.44	4.11	5.42	-1.02
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	93.75%	NA	NC
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)				
*Asthma in Younger Adults Admission Rate**	7.39	4.42	2.54	-4.85
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)				
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	37.71	30.22	22.01	-15.70

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	44.57%	40.57%	38.46%	-6.11
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.99%	57.03%	50.53%	3.54
Effective Continuation Phase Treatment	31.83%	39.89%	30.95%	-0.88
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.92%	80.87%	83.66%	1.74
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	51.01%	50.40%	49.09%	-1.92
30-Day Follow-Up	70.29%	67.73%	67.43%	-2.86
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	45.04%	46.42%	46.10%	1.06
Continuation and Maintenance Phase	59.36%	61.59%	62.79%	3.43
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment				
Initiation of AOD Treatment—Total	52.57%	36.94%	39.02%	-13.55
Engagement of AOD Treatment—Total	12.84%	8.23%	9.40%	-3.44
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.33%	2.34%	14.73%	12.40
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
*Total**	3.26%	2.82%	2.91%	-0.35
Medication Management				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	88.67%	88.67%	90.59%	1.92
Diuretics	89.47%	88.14%	88.49%	-0.98
Total	88.86%	88.32%	89.45%	0.59
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	47.33%	53.31%	42.62%	-4.71
Medication Compliance 50%—Ages 12–18 Years	42.68%	50.69%	44.62%	1.94
Medication Compliance 50%—Ages 19–50 Years	50.00%	53.25%	46.98%	-3.02
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	NC
Medication Compliance 50%—Total	45.73%	52.54%	43.77%	-1.96

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Medication Compliance 75%—Ages 5–11 Years	21.27%	27.16%	19.72%	-1.55
Medication Compliance 75%—Ages 12–18 Years	19.60%	24.22%	18.41%	-1.19
Medication Compliance 75%—Ages 19–50 Years	21.43%	33.73%	24.83%	3.40
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	NC
Medication Compliance 75%—Total	20.80%	26.58%	19.77%	-1.03
Use of Opioids at High Dosage (per 1,000 Member Months)				
Use of Opioids at High Dosage—All Ages	—	—	19.40	NC
Utilization				
Ambulatory Care (per 1,000 Member Months)—Total				
*ED Visits—Total**	56.83	56.35	54.90	-1.93
Outpatient Visits—Total	314.23	306.89	303.58	-10.65
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	5.70	6.11	5.04	-0.66
Total Inpatient—Days per 1,000 Member Months—Total	19.45	20.51	17.83	-1.62
Total Inpatient—Average Length of Stay—Total	3.42	3.36	3.54	0.12
Maternity—Discharges per 1,000 Member Months—Total	8.36	8.76	6.84	-1.52
Maternity—Days per 1,000 Member Months—Total	22.58	24.28	19.31	-3.27
Maternity—Average Length of Stay—Total	2.70	2.77	2.82	0.12
Surgery—Discharges per 1,000 Member Months—Total	0.60	0.60	0.56	-0.04
Surgery—Days per 1,000 Member Months—Total	4.81	4.46	4.27	-0.54
Surgery—Average Length of Stay—Total	7.96	7.44	7.66	-0.30
Medicine—Discharges per 1,000 Member Months—Total	0.96	1.03	1.01	0.05
Medicine—Days per 1,000 Member Months—Total	3.48	3.65	3.78	0.30
Medicine—Average Length of Stay—Total	3.62	3.54	3.73	0.11
Mental Health Utilization—Total				
Inpatient—Total	0.52%	0.54%	0.55%	0.03
Intensive Outpatient or Partial Hospitalization—Total	0.14%	0.14%	0.12%	-0.02
Outpatient, ED, or Telehealth—Total	9.04%	9.59%	9.73%	0.69
Any Service—Total	9.14%	9.69%	9.86%	0.72
Plan All-Cause Readmissions Rate*				
18–44 Years	—	11.26%	12.66%	NC
45–54 Years	—	17.07%	10.31%	NC
55–64 Years	—	6.58%	10.26%	NC
18–64—Total	—	12.11%	12.18%	NC

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
65–74 Years	—	NA	NA	NC
75–84 Years	—	NA	NA	NC
85 and Older	—	NA	NA	NC
65 and Older—Total	—	NA	NA	NC
Health Plan Descriptive Information				
Race/Ethnicity Diversity of Membership				
Total—White	46.67%	47.41%	47.71%	1.04
Total—Black or African American	44.67%	44.87%	44.91%	0.24

[1] Due to changes in the technical specifications for this measure (e.g., revised the indicator from ages 19–21 to 19–20), exercise caution when comparing the rate for 2016 and 2017 to the rate for 2015.
[2] Due to changes in the technical specifications for this measure (e.g., removed tetanus, diphtheria toxoids, and meningococcal polysaccharide vaccines), exercise caution when comparing the 2017 rate to historical rates.
[3] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between 2015, 2016, and 2017.
** A lower rate indicates better performance for this measure.*
— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.
NC indicates the 2015–2017 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.
NA indicates the denominator for the measure is too small to report (less than 30).
NR indicates the CMO rate for the measure was materially biased.

Amerigroup demonstrated a notable increase in performance (i.e., increase of more than 5 points) from RY 2015 to RY 2017 for several measure rates, including: *Adult BMI Assessment*; *Annual Dental Visits—19–20 Years*; *Developmental Screening in the First Three Years of Life—Total*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; *Behavioral Health Risk Assessment for Pregnant Women*; *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*; *Prenatal and Postpartum Care—Postpartum Care*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *Medical Attention for Nephropathy*, and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*; and *Screening for Clinical Depression and Follow-Up Plan*. Due to technical specification changes, exercise caution when evaluating the improvement in the rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator. The most notable increases were for the *Developmental Screening in the First Three Years of Life—Total* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* measure indicators, where rates increased by 19.91 points and 20.60 points, respectively.

Conversely, Amerigroup showed a notable decline in performance (i.e., decline of more than 5 points) from RY 2015 to RY 2017 for several measure rates, including: *Childhood Immunization Status—Combination 6* and *Combination 10*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*; and *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD*

Treatment—Total. The most notable decreases were for the *Childhood Immunization Status—Combination 6* and *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total* measure indicators, where rates decreased by 10.52 points and 13.55 points, respectively. Of note, the performance decline for *Childhood Immunization Status—Combination 6* was mainly driven by declines in influenza vaccine rates. This decline may be indicative of poor administrative documentation of the influenza vaccine rather than poor CMO performance.

Plan-Specific Findings—Peach State

A detailed review of the 2017 performance reports submitted by Peach State determined that the rates were prepared according to the *HEDIS 2017 Technical Specifications* for all of the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that Peach State was compliant with the standards assessed, as follows:

- Peach State was fully compliant with IS standard 1.0. Peach State used AMISYS as its primary claims processing system for the last several years. There were no significant changes to the system other than routine maintenance and minor upgrades. In addition to AMISYS, Peach State used data provided by its pharmacy and dental vendors to supplement medical claims. The auditor reviewed the multiple systems and processes used for each data source and found each to be compliant. The CMO continued to capture most of its claims electronically. Peach State still received some paper claims; however, all paper claims were submitted to the scanning vendor and transmitted back to Peach State via electronic format. Peach State had very little manual intervention, and those processes were limited to claims with high dollar amounts. The auditor reviewed the coding schemes again this year and determined that standard coding was used to pay claims. Peach State's AMISYS system captured primary, secondary, and modifier codes appropriately. Coding updates to the AMISYS system were made annually to ensure the most recent coding schemes are captured. Most of Peach State's providers (99 percent) were reimbursed on a fee-for-service (FFS) basis, which ensured that claims were submitted in a timely manner. The auditor reviewed the outstanding incurred but not reported (IBNR) report and found that most claims for CY 2016 (greater than 95 percent) were received within 30 days during the measurement year, which was the same as the previous year's rate. Peach State had very few capitated arrangements with providers, which ensured a high, timely data capture rate. Additionally, the GMCF file was used to assist Peach State in determining gaps in administrative claims information, particularly in determining the gestational age and parity. The auditor had concerns with how Peach State used the GMCF file since this file was not integrated until after the eligible populations were drawn. Further investigation of the GMCF file determined that Peach State had several thousand more claims for live births than were accounted for in the GMCF file. At the time of the audit, no information was available to identify the reasons for or the accuracy of this discrepancy. The auditor had no concerns with Peach State's claims and encounter data processes from AMISYS.
- Peach State was fully compliant with IS standard 2.0. Peach State's enrollment data were housed in the AMISYS system. Enrollment data were received daily and monthly from the State. New members were processed and entered into AMISYS systematically. Occasionally, enrollment data

were added manually upon request by the State. Peach State's load program contained logic for cross-checking manually entered member information to avoid duplicate records. Peach State performed monthly reconciliation of enrollment data to ensure all member information was complete and accurate. Additionally, Peach State submitted enrollment files to its external vendors for processing. The auditor verified that the CMO properly excluded the product and rate types that distinguish the Planning for Healthy Babies® (P4HB®) population in AMISYS before the final rates were calculated. New members were processed and entered into the AMISYS Advance system. The systematic enrollment process at Peach State included translation and compliance validation of the 834 file and loading the data into AMISYS. The load program contained logic for matching manually entered member enrollment for newborns to avoid duplicate records when received electronically on the 834 file. Peach State also processed enrollment changes. Enrollment changes were made primarily via the systematic loads after a change was received in the State files. Enrollment processors manually updated change requests submitted via telephone. The auditor selected a sample of members from several administrative numerators and verified that the members were compliant with the measure specifications. The auditor verified age, gender, and enrollment history along with diagnosis and procedure codes. There were no issues found during the system review.

- Peach State was fully compliant with IS standard 3.0. Peach State continued to use two systems for provider processing—Portico and AMISYS. Provider files were first loaded into Peach State's Portico system when the provider began the credentialing process. Once the provider was credentialed, the provider information was loaded into AMISYS. Peach State had a process in place for validating provider information daily to ensure both systems contained identical demographic information. Specialties were validated in Portico and then matched with AMISYS. Peach State's two systems, Portico and AMISYS, were linked by the unique provider identification number. No significant changes were made to the systems during the measurement year. Effective August 1, 2015, DCH implemented a centralized credentials verification organization (CVO), and most of the credentialing functions previously performed by Peach State were transitioned to the new CVO. Although the State is now responsible for credentialing all providers in Georgia, the auditor still selected a few random providers, which it used to validate that the two systems maintained accurate information. All data matched in both systems. AMISYS maintained all relevant information as required for measure reporting. Both Portico and AMISYS contained unique identifiers and captured identical information as expected.
- Peach State was fully compliant with IS standard 4.0. The auditor reviewed Peach State's IS 4 Roadmap pertaining to the policies and procedures for IS standard 4.0. The Roadmap review found these policies and procedures to be consistent with the NCQA *HEDIS 2017, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. Peach State completed sampling according to HEDIS and non-HEDIS measure sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. Peach State contracted with Altegra Health to retrieve and abstract hybrid medical record data using Altegra Health data entry tools. The auditor participated in a live vendor demonstration of the Altegra Health data entry tools and instructions. All fields, edits, and dropdown boxes were reviewed for accuracy against the current year's Child Core Set Technical Specifications; Adult Core Set Technical Specifications; AHRQ Quality Indicator Technical Specifications; and NCQA's

HEDIS 2017, Volume 2: Technical Specifications for Health Plans. Peach State used Altegra Health's abstractors to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's Child Core Set Technical Specifications; Adult Core Set Technical Specifications; AHRQ Quality Indicator Technical Specifications; *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*; and the use of Altegra Health's data entry tools to accurately conduct medical record reviews. The auditor reviewed Altegra Health's training abstraction manual and found no concerns. Peach State maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusions, and a random sample of numerator negatives.

According to the auditor's request, a convenience sample was requested for the *Colorectal Cancer Screening (COL)* measure, and Peach State passed the convenience sample process.

The auditor reviewed the following measures for Peach State as part of the MRRV process:

- Non-HEDIS—*Behavioral Health Risk Assessment for Pregnant Women (BHRA-CH)*
- Non-HEDIS—*Cesarean Section for Nulliparous Singleton Vertex (NSV)*
- Non-HEDIS—*Elective Delivery (PC01-AD)*
- Non-HEDIS—*Antenatal Steroids (PC03-AD)*

Peach State passed the MRRV process for all the measures. However, the appropriate eligible population and sample size were not met for reporting the *Cesarean Section for Nulliparous Singleton Vertex (NSV)* and *Elective Delivery (PC01-AD)* measures. Since the appropriate eligible population and sample size were not met, these measures were not approved for reporting.

- Peach State was fully compliant with IS standard 5.0. Peach State did not use supplemental data for any measures.
- Peach State was fully compliant with IS standard 7.0. Peach State continued to use Inovalon software for performance measure production. The auditor reviewed and approved Inovalon's non-certified source code used to generate the performance measures under the scope of the audit. The auditor determined that the source code was compliant with the performance measure specifications, and no concerns were noted upon final review. Peach State's corporate team, Centene, ran monthly reports out of Inovalon's system to review data regularly. Centene frequently produced month-over-month comparison reports to ensure data were complete and accurate. During the on-site audit, the auditor conducted primary source verification of administrative measures and reviewed the process for determining the gestational age for the *Elective Delivery*, *Antenatal Steroids,* and *Cesarean Section for Nulliparous Singleton Vertex* measures. Additionally, the auditor reviewed Peach State's process for determining the parity for the *Cesarean Section for Nulliparous Singleton Vertex* measure. For the *Elective Delivery*, *Antenatal Steroids,* and *Cesarean Section for Nulliparous Singleton Vertex* measures, Peach State used data supplied by the physician through the pregnancy notification process to determine the gestational age of the baby. Peach State determined the approximate gestational age to within 7–10 days. The auditor found that process to be sufficient for two of the measures, *Antenatal Steroids* and *Elective Delivery,* but insufficient for the *Cesarean Section for Nulliparous Singleton Vertex* measure, which further requires the CMO to determine the parity for the eligible population. The auditor advised Peach State to explore using the GMCF file and redraw the sample for the *Cesarean Section for Nulliparous Singleton Vertex* measure. Peach State followed the advice of the audit team and obtained the GMCF file, albeit late in the process,

and drew a new sample for the *Cesarean Section for Nulliparous Singleton Vertex* measure. Since the new sample was drawn late in the medical record abstraction process, Peach State was unable to gather enough records in time to have sufficient counts. The auditor determined that the measure was biased as the medical record process was not completed. Peach State advised that it will incorporate data from the GMCF file regularly throughout the 2017 measurement year in order to be able to report this measure in 2018. Another issue was discovered during the on-site audit regarding the GMCF file; the auditor requested that Peach State match the member counts in the GMCF file against data obtained from its claims system to determine how closely the GMCF file birth counts matched the claims indicating live births. Peach State indicated that it had several hundred more births in the claims file than were provided in the GMCF file. Neither the auditor nor Peach State could determine why there was such a discrepancy between the two files. Due to the number of exclusions in the *Elective Delivery* measure, the auditor determined the measure was also biased and designated it as Not Reportable. The number of exclusions reduced the denominator below the minimum required sample size. In the auditor's opinion, the eligible population determination was materially biased. Peach State had a sufficient backup and disaster recovery program and reported having no issues during the measurement year. The auditor did not have any significant concerns with Peach State's system integrity or measure production, and no further issues were identified with Peach State's data integration processes.

Performance Measure Results

The RY 2015, 2016, and 2017 rates for Peach State are presented in Table 5–3, along with RY 2015 to RY 2017 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Measures in the Utilization and Health Plan Descriptive Information domains are designed to capture the frequency of services provided by the CMO and characteristics of the population served by the CMO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* and the *Plan All-Cause Readmissions Rate* measure rates, higher or lower rates in these domains do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5–3—Performance Measure Results for Peach State

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.17%	77.87%	77.22%	-3.95
Adult BMI Assessment				
Adult BMI Assessment	80.56%	82.38%	85.88%	5.32
Annual Dental Visit				

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
2–3 Years	45.07%	44.05%	39.98%	-5.09
4–6 Years	74.66%	72.77%	70.18%	-4.48
7–10 Years	77.15%	76.03%	73.04%	-4.11
11–14 Years	69.94%	69.85%	66.51%	-3.43
15–18 Years	59.32%	59.19%	56.94%	-2.38
19–20 Years[1]	33.62%	37.57%	35.07%	1.45
Total	67.67%	66.97%	63.90%	-3.77
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.26%	96.74%	96.84%	-0.42
25 Months–6 Years	89.96%	89.17%	89.69%	-0.27
7–11 Years	91.50%	91.17%	90.64%	-0.86
12–19 Years	88.63%	88.78%	88.73%	0.10
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	49.29%	48.84%	NC
Children's Health				
Prevention and Screening				
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	80.31%	82.14%	83.95%	3.64
Childhood Immunization Status				
Combination 3	79.63%	79.09%	71.88%	-7.75
Combination 6	43.52%	36.30%	30.53%	-12.99
Combination 10	40.28%	34.38%	26.68%	-13.60
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	20.09%	11.18%	NC
Developmental Screening in the First Three Years of Life				
Total	46.28%	50.60%	55.88%	9.60
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)[2]	76.39%	88.90%	87.02%	10.63
HPV	—	—	22.84%	NC
Lead Screening in Children				
Lead Screening in Children	79.40%	80.05%	83.17%	3.77
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	69.21%	67.79%	73.32%	4.11

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Counseling for Nutrition—Total	64.81%	66.59%	68.27%	3.46
Counseling for Physical Activity—Total[3]	60.19%	57.21%	57.93%	-2.26
Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	83.50%	84.00%	87.16%	3.66
Well-Child/Well-Care Visits				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.07%	47.60%	50.00%	0.93
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	65.05%	67.79%	63.73%	-1.32
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.91%	68.99%	72.80%	2.89
Women's Health				
Prenatal Care and Birth Outcomes				
Antenatal Steroids				
Antenatal Steroids	NR	NR	54.55%	NC
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	0.00%	5.46%	5.58%	5.58
Cesarean Delivery Rate, Uncomplicated				
*Cesarean Delivery Rate, Uncomplicated**	29.84%	29.32%	30.22%	0.38
Cesarean Rate for Nulliparous Singleton Vertex				
*Cesarean Rate for Nulliparous Singleton Vertex**	NR	NR	NR	NC
Elective Delivery				
*Elective Delivery**	NR	NR	NR	NC
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	57.77%	59.00%	48.18%	-9.59
Percentage of Live Births Weighing Less Than 2,500 Grams				
*Percentage of Live Births Weighing Less Than 2,500 Grams**	9.04%	8.87%	8.86%	-0.18
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.13%	77.49%	73.72%	-8.41
Postpartum Care	70.30%	59.72%	61.07%	-9.23
Prevention and Screening				
Breast Cancer Screening				

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Breast Cancer Screening	71.02%	66.90%	66.12%	-4.90
Cervical Cancer Screening				
Cervical Cancer Screening	68.53%	68.56%	66.19%	-2.34
Chlamydia Screening in Women				
Total	56.71%	59.83%	62.60%	5.89
Chronic Conditions				
Diabetes				
Comprehensive Diabetes Care[3]				
Hemoglobin A1c (HbA1c) Testing	83.63%	81.80%	83.48%	-0.15
*HbA1c Poor Control (>9.0%)**	53.17%	59.72%	61.04%	7.87
HbA1c Control (<8.0%)	37.32%	32.51%	29.91%	-7.41
HbA1c Control (<7.0%)	27.73%	23.52%	22.46%	-5.27
Eye Exam (Retinal) Performed	58.63%	59.36%	59.83%	1.20
Medical Attention for Nephropathy	77.82%	91.87%	88.70%	10.88
Blood Pressure Control (<140/90 mm Hg)	53.17%	52.83%	46.78%	-6.39
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)				
*Diabetes Short-Term Complications Admission Rate**	18.15	15.46	12.82	-5.33
Cardiovascular Conditions				
Controlling High Blood Pressure				
Controlling High Blood Pressure	36.64%	43.14%	37.82%	1.18
Heart Failure Admission Rate (per 100,000 Member Months)				
*Heart Failure Admission Rate**	5.45	4.54	7.49	2.04
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	NA	NC
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)				
*Asthma in Younger Adults Admission Rate**	4.55	3.19	5.24	0.69
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)				
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	28.70	23.78	20.51	-8.19
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	33.33%	19.63%	31.53%	-1.80

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Antidepressant Medication Management				
Effective Acute Phase Treatment	39.57%	38.66%	40.76%	1.19
Effective Continuation Phase Treatment	24.86%	23.89%	24.84%	-0.02
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.69%	82.22%	85.39%	4.70
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	56.78%	55.77%	50.75%	-6.03
30-Day Follow-Up	72.79%	72.53%	66.67%	-6.12
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	43.58%	43.84%	45.69%	2.11
Continuation and Maintenance Phase	58.19%	58.82%	59.84%	1.65
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment				
Initiation of AOD Treatment—Total	39.65%	35.24%	35.32%	-4.33
Engagement of AOD Treatment—Total	8.24%	6.82%	6.71%	-1.53
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.86%	7.48%	10.90%	8.04
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
*Total**	NR	0.25%	1.37%	NC
Medication Management				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	87.24%	87.45%	87.22%	-0.02
Diuretics	86.63%	87.41%	86.68%	0.05
Total	86.74%	87.41%	86.91%	0.17
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	44.06%	45.40%	46.01%	1.95
Medication Compliance 50%—Ages 12–18 Years	39.67%	41.64%	44.02%	4.35
Medication Compliance 50%—Ages 19–50 Years	44.19%	50.96%	52.74%	8.55
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	NC
Medication Compliance 50%—Total	42.56%	44.34%	45.69%	3.13
Medication Compliance 75%—Ages 5–11 Years	18.82%	20.95%	20.28%	1.46
Medication Compliance 75%—Ages 12–18 Years	16.03%	16.58%	19.77%	3.74
Medication Compliance 75%—Ages 19–50 Years	23.26%	19.75%	21.89%	-1.37

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	NC
Medication Compliance 75%—Total	18.03%	19.41%	20.25%	2.22
Use of Opioids at High Dosage (per 1,000 Member Months)				
Use of Opioids at High Dosage—All Ages	—	—	10.65	NC
Utilization				
Ambulatory Care (per 1,000 Member Months)—Total				
*ED Visits—Total**	54.10	52.44	52.27	-1.83
Outpatient Visits—Total	309.79	303.03	307.29	-2.50
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	6.05	5.62	6.05	0.00
Total Inpatient—Days per 1,000 Member Months—Total	20.48	19.52	20.48	0.00
Total Inpatient—Average Length of Stay—Total	3.39	3.47	3.39	0.00
Maternity—Discharges per 1,000 Member Months—Total	9.20	7.99	8.63	-0.57
Maternity—Days per 1,000 Member Months—Total	25.34	22.53	24.48	-0.86
Maternity—Average Length of Stay—Total	2.75	2.82	2.83	0.08
Surgery—Discharges per 1,000 Member Months—Total	0.54	0.54	0.52	-0.02
Surgery—Days per 1,000 Member Months—Total	4.59	4.54	4.10	-0.49
Surgery—Average Length of Stay—Total	8.43	8.37	7.89	-0.54
Medicine—Discharges per 1,000 Member Months—Total	1.09	1.14	1.24	0.15
Medicine—Days per 1,000 Member Months—Total	3.72	3.88	4.23	0.51
Medicine—Average Length of Stay—Total	3.43	3.41	3.40	-0.03
Mental Health Utilization—Total				
Inpatient—Total	0.38%	0.41%	0.40%	0.02
Intensive Outpatient or Partial Hospitalization—Total	0.13%	0.12%	0.10%	-0.03
Outpatient, ED, or Telehealth—Total	7.93%	7.59%	7.76%	-0.17
Any Service—Total	8.01%	7.68%	7.86%	-0.15
Plan All-Cause Readmissions Rate*				
18–44 Years	—	12.32%	11.87%	NC
45–54 Years	—	11.21%	9.78%	NC
55–64 Years	—	5.26%	11.94%	NC
18–64—Total	—	11.87%	11.58%	NC
65–74 Years	—	NA	NA	NC
75–84 Years	—	NA	NA	NC
85 and Older	—	NA	NA	NC

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
65 and Older—Total	—	NA	NA	NC
Health Plan Descriptive Information				
Race/Ethnicity Diversity of Membership				
Total—White	19.73%	34.32%	33.30%	13.57
Total—Black or African American	49.09%	53.57%	50.42%	1.33

[1] Due to changes in the technical specifications for this measure (e.g., revised the indicator from ages 19–21 to 19–20), exercise caution when comparing the rate for 2016 and 2017 to the rate for 2015.
[2] Due to changes in the technical specifications for this measure (e.g., removed tetanus, diphtheria toxoids, and meningococcal polysaccharide vaccines), exercise caution when comparing the 2017 rate to historical rates.
[3] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between 2015, 2016, and 2017.
** A lower rate indicates better performance for this measure.*
— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.
NC indicates the 2015–2017 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.
NA indicates the denominator for the measure is too small to report (less than 30).
NR indicates the CMO rate for the measure was materially biased.

Peach State demonstrated a notable increase in performance (i.e., increase of more than 5 points) from RY 2015 to RY 2017 for several measure rates, including: *Adult BMI Assessment*; *Developmental Screening in the First Three Years of Life—Total*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Behavioral Health Risk Assessment for Pregnant Women*; *Chlamydia Screening in Women—Total*; *Comprehensive Diabetes Care—Medical Attention for Nephropathy*; *Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)*; *COPD or Asthma in Older Adults Admission Rate (per 100,000 Member Months)*; *Screening for Clinical Depression and Follow-Up Plan*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 19–50 Years*. Due to technical specification changes, exercise caution when evaluating the improvement in the rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator. The most notable increases were for the *Developmental Screening in the First Three Years of Life—Total* and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicators, where rates increased by 9.60 points and 10.63 points and, respectively.

Conversely, Peach State showed a notable decline in performance (i.e., decline of more than 5 points) from RY 2015 to RY 2017 for several measure rates, including: *Annual Dental Visit—2–3 Years*; *Childhood Immunization Status—Combination 3*, *Combination 6*, and *Combination 10*; *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *HbA1c Control (<7.0%)*, and *Blood Pressure Control (<140/90 mm Hg)*; and *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*. The most notable decreases were for the *Childhood Immunization Status—Combination 6* and *Combination 10* measure indicators, where rates decreased by 12.99 points and 13.60 points, respectively. Of note, the performance declines for *Combination 6* and *Combination 10* were mainly driven by declines in influenza vaccine rates. This decline may be indicative of poor administrative documentation of the influenza vaccine rather than poor CMO performance.

Plan-Specific Findings—WellCare

A detailed review of the RY 2017 performance reports submitted by WellCare determined that the rates were prepared according to the *HEDIS 2017 Technical Specifications* for the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that WellCare was compliant with the standards assessed, as follows:

- WellCare was fully compliant with IS standard 1.0. WellCare continued to use the Xcelys claims and encounter system. During the on-site review of the claims process, the auditor conducted a system review of Xcelys to verify code specificity and capture. The auditor did not identify any issues during this validation and concluded that WellCare had used appropriate code specificity to capture denominators and numerators. WellCare's claims and encounter data were submitted either electronically or via paper from WellCare's external providers. Electronic data were submitted through clearinghouses and processed overnight in Xcelys. Paper claims and encounters were submitted directly to WellCare's vendor for scanning and conversion into the standard 837 format. Once converted, the data followed the same process as electronic claims and encounters. In addition to Xcelys, WellCare used data provided by its pharmacy and dental vendors to supplement medical claims. The auditor reviewed the multiple systems and processes used for each data source and found each to be compliant. The auditor also reviewed the outstanding IBNR report during the on-site audit and found that most claims for CY 16 (greater than 98 percent) were received by April 2017. Outstanding claims or encounters did not have a significant impact on reporting. WellCare was afforded the opportunity to use a file from the Georgia Medical Care Foundation (GMCF) that provided parity and gestational age for members having a live birth during the measurement year. WellCare did not use this file in a timely manner to capture the gestational age and parity prior to selecting the sample of members for the *Cesarean Section for Nulliparous Singleton Vertex* measure. The GMCF file was also not used for the *Elective Delivery* or *Antenatal Steroids* measures. WellCare staff used an alternative formula from vital statistics data to capture the gestational age. The auditor recommends that WellCare explore using the GMCF file to capture the parity and gestational age for these three measures.
- WellCare was fully compliant with IS standard 2.0. WellCare received daily and monthly files from the State for member enrollment. Daily files were reconciled against the full monthly file and loaded into Xcelys. No enrollment files were manually processed, and all files were handled in standard 834 transactions. Xcelys captured all relevant fields required for measure reporting. The auditor confirmed with WellCare staff that there were no backlogs or outages for the enrollment process during the measurement year. The auditor also confirmed that the assignment of member identification numbers was automatic in Xcelys, but that these identifiers were cross-checked prior to assignment to determine if an Xcelys identifier already existed. In the cases where a match was identified, the Member Services Department reviewed to determine if the member had an existing number or if a new number needed to be assigned. The auditor verified that WellCare appropriately and clearly flagged the P4HB® population in Inovalon's measure calculation software so that this population was excluded from the final performance measure rates. The auditor conducted multiple queries during the on-site audit to ensure that members found to be numerator compliant actually met the age and gender requirements. The queries did not reveal any deviation from expectations,

and numerator compliance was verified. WellCare's enrollment system identified duplicate members and merged the multiple records into one unique enrollment string. Duplicate identifiers, although not a frequent occurrence, were verified using the State enrollment files to ensure the most accurate information was captured.

- WellCare was fully compliant with IS standard 3.0. WellCare used Xcelys to capture its provider data for claims processing. WellCare used both direct contracted and delegated entities to enroll providers. WellCare used an internal software tracking mechanism (Omniflow) to manage its provider information. Omniflow was used to send provider data to WellCare's Credentialing department for provider management prior to loading into Xcelys. Once the provider information passed through Omniflow, the data were then loaded into Xcelys. A unique provider identifier was created along with provider specialties. WellCare's credentialing staff ensured that provider specialties were appropriate by validating the provider's education and specialty assignment authorized by the issuing provider board. The auditor verified that the required HEDIS reporting elements were present in Xcelys and that provider specialties were accurate based on the provider mapping documents submitted with WellCare's Roadmap. Effective August 1, 2015, DCH implemented a centralized CVO, and most of the credentialing functions previously performed by WellCare were transitioned to the new CVO. Although the State is now responsible for credentialing all providers in Georgia, the auditor still reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. The auditor found WellCare to be compliant with the credentialing and assignment of individual providers at FQHCs.
- WellCare was fully compliant with IS standard 4.0. The auditor reviewed WellCare's IS 4 Roadmap pertaining to the policies and procedures for IS standard 4.0. The Roadmap review found these policies and procedures to be consistent with the NCQA *HEDIS 2017, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. WellCare completed sampling according to HEDIS and non-HEDIS measure sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. WellCare contracted with Altegra Health to abstract hybrid medical record data using Altegra Health data entry tools. The auditor participated in a live vendor demonstration of the Altegra Health data entry tools and instructions. The auditor reviewed all fields, edits, and drop-down boxes for accuracy against the current year's Child Core Set Technical Specifications; Adult Core Set Technical Specifications; AHRQ Quality Indicator Technical Specifications; and NCQA's *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*. WellCare used Altegra Health's abstractors to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's Child Core Set Technical Specifications; Adult Core Set Technical Specifications; AHRQ Quality Indicator Technical Specifications; *HEDIS 2017, Volume 2: Technical Specifications for Health Plans*; and the use of Altegra Health's data entry tools to accurately conduct medical record reviews. The auditor reviewed Altegra Health's training abstraction manual and found no concerns. WellCare maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusions, and a random sample of numerator negatives.

  The auditor requested a convenience sample for the *Colorectal Cancer Screening (COL)* measure, and WellCare passed the convenience sample process.

  The auditor reviewed the following measures for WellCare as part of the MRRV process:

  - Non-HEDIS—*Screening for Clinical Depression and Follow-up Plan (SCD)*
  - Non-HEDIS—*Cesarean Section for Nulliparous Singleton Vertex (NSV)*
  - Non-HEDIS—*Elective Delivery (PC01-AD)*
  - Non-HEDIS—*Antenatal Steroids (PC03-AD)*

  WellCare passed the MRRV process for all measures. However, the appropriate eligible population and sample size were not met for reporting the *Cesarean Section for Nulliparous Singleton Vertex (NSV)* measure; therefore, this measure was not approved for reporting.
- WellCare was fully compliant with IS standard 5.0. WellCare did not use supplemental data for any portion of measure production.
- WellCare was fully compliant with IS standard 7.0. WellCare continued to use the Green Plumb data warehouse to house and consolidate files prior to loading into Inovalon's measure production software. The auditor reviewed WellCare's processes related to the Green Thumb data warehouse and determined that no significant changes occurred from the previous year's review. WellCare's information technology staff continued to extract data monthly from the CMO's core systems. Several internal data sources were consolidated to produce files for the software vendor. Internal data sources validated by the auditor included enrollment, claims, provider, encounters, pharmacy, and laboratory files. These internal files were transformed and merged into the software vendor's file layouts in order to produce the measures. The auditor conducted primary source verification for each measure's administrative numerators during the on-site audit. The auditor reviewed a minimum of three cases for each measure with an administrative hit to determine whether numerators met age, gender, diagnosis, and procedural compliance with the specifications. The auditor did not find any issues during the primary source review. WellCare used a new process to identify the gestational age for the *Antenatal Steroids*, *Elective Delivery*, and *Cesarean Section for Nulliparous Singleton Vertex* measures. WellCare followed an internal process to estimate the gestational age using the estimated date of delivery (EDD). WellCare required obstetricians/gynecologists (OB/GYNs) to submit a maternity form to WellCare containing the EDD information at the member's first prenatal visit. The EDD calculation was used to determine the gestational age component for the *Antenatal Steroids*, *Elective Delivery*, and *Cesarean Section for Nulliparous Singleton Vertex* measure denominators. Although WellCare had an alternate method available to identify the eligible populations for the *Antenatal Steroids*, *Elective Delivery*, and *Cesarean Section for Nulliparous Singleton Vertex* measures using the GMCF file, the CMO did not use that methodology. The EDD methodology was acceptable for identifying the gestational age; however, it was not useful for determining the parity. Since no methodology was used to identify parity for the eligible population for the *Cesarean Section for Nulliparous Singleton Vertex* measure, WellCare was not compliant and the measure was Not Reportable (NR). Both the *Antenatal Steroids* and *Elective Delivery* measures were designated as Not Applicable (NA) since their denominators, after exclusions, did not meet the minimum required sample size based on the specification's eligible population. The remaining measures under the scope of the audit were reviewed and approved without issue. The auditor conducted on-site primary source verification for the administrative measures along with year-over-year comparisons and found that WellCare's rates were consistent overall and were approved for reporting.

Performance Measure Results

The RY 2015, 2016, and 2017 rates for WellCare are presented in Table 5–4, along with RY 2015 to RY 2017 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2015 to 2017 represents performance improvement and an increase in the rate from 2015 to 2017 represents performance decline. Measures in the Utilization and Health Plan Descriptive Information domains are designed to capture the frequency of services provided by the CMO and characteristics of the population served by the CMO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* and the *Plan All-Cause Readmissions Rate* measure rates, higher or lower rates in these domains do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5–4—Performance Measure Results for WellCare

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.76%	81.52%	82.55%	0.79
Adult BMI Assessment				
Adult BMI Assessment	79.94%	82.08%	82.06%	2.12
Annual Dental Visit				
2–3 Years	46.94%	49.80%	50.00%	3.06
4–6 Years	72.25%	76.42%	77.21%	4.96
7–10 Years	75.14%	78.49%	79.18%	4.04
11–14 Years	69.30%	72.49%	73.37%	4.07
15–18 Years	58.65%	61.57%	63.20%	4.55
19–20 Years[1]	31.96%	40.17%	43.14%	11.18
Total	66.64%	70.12%	70.93%	4.29
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.51%	96.90%	97.13%	-0.38
25 Months–6 Years	91.23%	89.63%	90.80%	-0.43
7–11 Years	92.61%	91.36%	91.55%	-1.06
12–19 Years	90.35%	89.09%	89.48%	-0.87
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	46.72%	50.93%	NC
Children's Health				
Prevention and Screening				

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	79.09%	80.67%	81.16%	2.07
Childhood Immunization Status				
Combination 3	84.03%	82.10%	78.24%	-5.79
Combination 6	43.06%	44.54%	30.79%	-12.27
Combination 10	38.66%	41.48%	28.24%	-10.42
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	—	12.90%	22.83%	NC
Developmental Screening in the First Three Years of Life				
Total	44.91%	51.82%	47.92%	3.01
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)[2]	76.33%	89.51%	89.35%	13.02
HPV	—	—	16.90%	NC
Lead Screening in Children				
Lead Screening in Children	81.35%	83.85%	81.02%	-0.33
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	63.43%	66.26%	77.78%	14.35
Counseling for Nutrition—Total	59.49%	60.39%	69.68%	10.19
Counseling for Physical Activity—Total[3]	54.63%	54.03%	56.25%	1.62
Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	82.81%	84.42%	86.91%	4.10
Well-Child/Well-Care Visits				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.54%	53.28%	51.62%	2.08
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	66.93%	64.69%	63.41%	-3.52
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	66.93%	68.73%	71.16%	4.23
Women's Health				
Prenatal Care and Birth Outcomes				
Antenatal Steroids				
Antenatal Steroids	NR	NR	NA	NC

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	9.95%	15.33%	21.99%	12.04
Cesarean Delivery Rate, Uncomplicated				
*Cesarean Delivery Rate, Uncomplicated**	29.73%	28.70%	29.89%	0.16
Cesarean Rate for Nulliparous Singleton Vertex				
*Cesarean Rate for Nulliparous Singleton Vertex**	NR	NR	NR	NC
Elective Delivery				
*Elective Delivery**	NR	NR	NA	NC
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	58.48%	38.90%	56.50%	-1.98
Percentage of Live Births Weighing Less Than 2,500 Grams				
*Percentage of Live Births Weighing Less Than 2,500 Grams**	9.21%	9.05%	8.69%	-0.52
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.27%	72.32%	80.38%	-0.89
Postpartum Care	64.56%	52.87%	60.28%	-4.28
Prevention and Screening				
Breast Cancer Screening				
Breast Cancer Screening	72.17%	71.61%	67.85%	-4.32
Cervical Cancer Screening				
Cervical Cancer Screening	74.56%	66.36%	69.77%	-4.79
Chlamydia Screening in Women				
Total	50.26%	53.04%	56.69%	6.43
Chronic Conditions				
Diabetes				
Comprehensive Diabetes Care[3]				
Hemoglobin A1c (HbA1c) Testing	83.19%	80.43%	81.79%	-1.40
*HbA1c Poor Control (>9.0%)**	48.75%	52.74%	56.30%	7.55
HbA1c Control (<8.0%)	43.26%	39.80%	37.63%	-5.63
HbA1c Control (<7.0%)	32.43%	32.39%	28.97%	-3.46
Eye Exam (Retinal) Performed	35.44%	39.64%	42.94%	7.50
Medical Attention for Nephropathy	76.71%	90.88%	92.41%	15.70
Blood Pressure Control (<140/90 mm Hg)	55.74%	49.09%	47.04%	-8.70
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)				

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
*Diabetes Short-Term Complications Admission Rate**	18.36	13.69	17.21	-1.15
Cardiovascular Conditions				
Controlling High Blood Pressure				
Controlling High Blood Pressure	43.24%	40.15%	34.30%	-8.94
Heart Failure Admission Rate (per 100,000 Member Months)				
*Heart Failure Admission Rate**	4.28	5.02	7.49	3.21
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	78.57%	NC
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)				
*Asthma in Younger Adults Admission Rate**	5.52	3.38	5.98	0.46
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)				
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	41.00	17.30	45.76	4.76
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	33.85%	39.23%	33.99%	0.14
Antidepressant Medication Management				
Effective Acute Phase Treatment	46.92%	44.77%	44.88%	-2.04
Effective Continuation Phase Treatment	30.37%	28.35%	29.07%	-1.30
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.15%	80.40%	83.97%	0.82
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	50.77%	50.39%	52.45%	1.68
30-Day Follow-Up	69.72%	68.75%	70.61%	0.89
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	48.92%	47.02%	49.76%	0.84
Continuation and Maintenance Phase	63.78%	64.29%	68.00%	4.22
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment				
Initiation of AOD Treatment—Total	32.34%	34.15%	32.98%	0.64
Engagement of AOD Treatment—Total	7.02%	7.09%	6.79%	-0.23
Screening for Clinical Depression and Follow-Up Plan				

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Screening for Clinical Depression and Follow-Up Plan	0.49%	7.18%	7.25%	6.76
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
*Total**	2.19%	1.59%	1.70%	-0.49
Medication Management				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	86.72%	89.47%	89.23%	2.51
Diuretics	87.27%	88.82%	89.56%	2.29
Total	86.86%	89.03%	89.22%	2.36
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	45.62%	47.49%	47.46%	1.84
Medication Compliance 50%—Ages 12–18 Years	42.00%	42.44%	45.63%	3.63
Medication Compliance 50%—Ages 19–50 Years	57.79%	56.15%	53.77%	-4.02
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	NC
Medication Compliance 50%—Total	44.91%	46.08%	47.12%	2.21
Medication Compliance 75%—Ages 5–11 Years	21.93%	22.99%	21.84%	-0.09
Medication Compliance 75%—Ages 12–18 Years	18.25%	19.95%	19.52%	1.27
Medication Compliance 75%—Ages 19–50 Years	33.61%	34.23%	33.22%	-0.39
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	NC
Medication Compliance 75%—Total	21.17%	22.37%	21.56%	0.39
Use of Opioids at High Dosage (per 1,000 Member Months)				
Use of Opioids at High Dosage—All Ages	—	—	16.45	NC
Utilization				
Ambulatory Care (per 1,000 Member Months)—Total				
*ED Visits—Total**	61.04	60.95	62.39	1.35
Outpatient Visits—Total	334.03	327.56	406.77	72.74
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	6.89	5.95	7.02	0.13
Total Inpatient—Days per 1,000 Member Months—Total	20.63	19.07	20.79	0.16
Total Inpatient—Average Length of Stay—Total	2.99	3.20	2.96	-0.03
Maternity—Discharges per 1,000 Member Months—Total	9.97	8.05	8.02	-1.95
Maternity—Days per 1,000 Member Months—Total	25.18	22.09	19.52	-5.66
Maternity—Average Length of Stay—Total	2.53	2.74	2.43	-0.10
Surgery—Discharges per 1,000 Member Months—Total	0.76	0.73	0.86	0.10

Measure	RY 2015 Rate	RY 2016 Rate	RY 2017 Rate	2015–2017 Rate Comparison
Surgery—Days per 1,000 Member Months—Total	4.46	4.20	5.30	0.84
Surgery—Average Length of Stay—Total	5.84	5.75	6.16	0.32
Medicine—Discharges per 1,000 Member Months—Total	1.40	1.26	2.19	0.79
Medicine—Days per 1,000 Member Months—Total	4.24	4.00	5.82	1.58
Medicine—Average Length of Stay—Total	3.02	3.18	2.66	-0.36
Mental Health Utilization—Total				
Inpatient—Total	0.50%	0.55%	0.55%	0.05
Intensive Outpatient or Partial Hospitalization—Total	0.14%	0.13%	0.12%	-0.02
Outpatient, ED, or Telehealth—Total	8.77%	9.14%	9.47%	0.70
Any Service—Total	8.88%	9.25%	9.57%	0.69
Plan All-Cause Readmissions Rate*				
18–44 Years	—	11.79%	11.17%	NC
45–54 Years	—	10.46%	11.03%	NC
55–64 Years	—	20.95%	14.29%	NC
18–64—Total	—	11.93%	11.29%	NC
65–74 Years	—	NA	NA	NC
75–84 Years	—	NA	NA	NC
85 and Older	—	NA	NA	NC
65 and Older—Total	—	NA	NA	NC
Health Plan Descriptive Information				
Race/Ethnicity Diversity of Membership				
Total—White	48.33%	49.04%	49.40%	1.07
Total—Black or African American	43.96%	44.16%	44.01%	0.05

[1] Due to changes in the technical specifications for this measure (e.g., revised the indicator from ages 19–21 to 19–20), exercise caution when comparing the rate for 2016 and 2017 to the rate for 2015.
[2] Due to changes in the technical specifications for this measure (e.g., removed tetanus, diphtheria toxoids, and meningococcal polysaccharide vaccines), exercise caution when comparing the 2017 rate to historical rates.
[3] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between 2015, 2016 and 2017.
** A lower rate indicates better performance for this measure.*
— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.
NC indicates the 2015–2017 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.
NA indicates the denominator for the measure is too small to report (less than 30).
NR indicates the CMO rate for the measure was materially biased.

WellCare demonstrated a notable increase in performance (i.e., increase of more than 5 points) from RY 2015 to RY 2017 for several measure rates, including: *Annual Dental Visit—19–20 Years*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Weight Assessment and*

Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total and *Counseling for Nutrition—Total*; *Behavioral Health Risk Assessment for Pregnant Women*; *Chlamydia Screening in Women—Total*; *Comprehensive Diabetes Care—Eye Exam (Retinal) Performed* and *Medical Attention for Nephropathy*; and *Screening for Clinical Depression and Follow-Up Plan*. Due to technical specification changes, exercise caution when evaluating the improvement in the rates for the *Comprehensive Diabetes Care—Medical Attention for Nephropathy* measure indicator. The most notable increases were for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total* and *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* measure indicators, where rates increased by 14.35 points and 13.02 points, respectively.

Conversely, WellCare showed a notable decline in performance (i.e., decline of more than 5 percentage points) from RY 2015 to RY 2017 for several measure rates, including: *Childhood Immunization Status—Combination 3, 6, and 10*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%),* and *Blood Pressure Control (<140/90 mm Hg)*; and *Controlling High Blood Pressure*. The most notable decreases were for the *Childhood Immunization Status—Combination 6* and *Combination 10* measure indicators, where rates decreased by 12.27 points and 10.42 points, respectively. Of note, the performance declines for *Combination 6* and *Combination 10* were mainly driven by declines in influenza vaccine rates. This decline may be indicative of poor administrative documentation of the influenza vaccine rather than poor CMO performance.

Plan-Specific Findings—Amerigroup 360°

A detailed review of the 2017 performance reports submitted by Amerigroup 360° determined that the rates were prepared according to the *HEDIS 2017 Technical Specifications* for the audited measures. Audits of IS capabilities for accurate HEDIS reporting found that Amerigroup 360° was compliant with the standards assessed, as follows:

- Amerigroup 360° was fully compliant with IS standard 1.0. Amerigroup 360° continued to use the Facets claims system to capture most of the medical services required for reporting the measures. In addition to Facets, Amerigroup 360° used data provided by its pharmacy and dental vendors to supplement any medical claims. The auditor reviewed the multiple systems and processes for each data source and found each to be compliant. Each system captured appropriate, standard coding schemes as required for reporting. Amerigroup 360° used only standard claim forms for each service type (i.e., dental, professional, institutional, and pharmacy). Most of Amerigroup 360°'s claims were submitted electronically through either clearinghouses or direct submitters. Paper claims, though small in quantity, were submitted to Amerigroup 360°'s OCR vendor for scanning and conversion into a standard Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant 837 format. Amerigroup 360° appropriately monitored vendor data submissions and controls regularly to ensure data completion for measure production. Amerigroup 360°'s oversight of this process ensured that all relevant data were captured prior to measure production. The on-site review by the auditors did not reveal any concerns with how claims/encounters are captured and used for reporting.

- Amerigroup360º was fully compliant with IS standard 2.0. Amerigroup 360° captured the State enrollment files daily and monthly and loaded them to Facets. Using the aid codes provided on the enrollment files, Amerigroup 360° was able to identify and separate the GF 360° population from the Georgia Families population when reporting on each measure. The auditor verified the aid codes and populations during the on-site audit and conducted primary source verification of the distinct members to ensure the populations were separated. Amerigroup 360°'s Facets system captured all relevant fields from the State's enrollment files and continued to monitor daily file updates, cancelations, and renewals.
- Amerigroup 360º was fully compliant with IS standard 3.0. Amerigroup 360° used the CACTUS (credentialing) and Facets (billing and payment) systems to store its provider data. The CMO had a systematic process to capture, review, and update provider credentialing and specialty data in both systems. The two systems were linked using Facet's common practitioner identifiers, and changes in provider data from Facets were automatically loaded into CACTUS, eliminating any potential manual data entry or merge errors. Amerigroup 360° implemented daily, weekly, and monthly edit checks on provider data submitted via claims. Additionally, the CMO's audit team reviewed 25 percent of all completed records for accuracy and completeness each month. Amerigroup 360°'s oversight of its delegates contracted for credentialing and recredentialing activities also met industry standards. Effective August 1, 2015, DCH implemented a centralized CVO, and most of the credentialing functions previously performed by Amerigroup 360° were transitioned to the new CVO. Although the State is now responsible for credentialing all providers in Georgia, the auditor still conducted primary source verification of the CACTUS and Facets systems to identify any issues across the two systems. As in the past reviews, the auditor selected several records from numerator-compliant members in various measures to ensure the provider specialties matched the measure requirements. The auditor did not identify any issues with providers during this review. The auditor also reviewed a sample of provider specialties to ensure the specialties matched the credentialed providers' education and board certification. The auditor found Amerigroup 360° to be compliant with the credentialing and assignment of individual providers at FQHCs. The audit staff reviewed and approved the specialty mapping for Amerigroup 360° and determined it to be compliant for measure reporting.
- Amerigroup 360º was fully compliant with IS standard 4.0. The auditor reviewed Amerigroup 360°'s IS 4 Roadmap pertaining to the policies and procedures for IS standard 4.0. The Roadmap review found these policies and procedures to be consistent with the NCQA *HEDIS 2017, Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*. Amerigroup 360° completed sampling according to the measure sampling guidelines and assigned measure-specific oversamples. Provider chase logic was reviewed and determined appropriate across the hybrid measures. Amerigroup 360° staff used QSHR hybrid medical record abstraction tools. The audit team participated in a live vendor demonstration of the QSHR tools and instructions. The auditor reviewed all fields, edits, and drop-down boxes for accuracy against the current year's Child Core Set Technical Specifications, Adult Core Set Technical Specifications, and AHRQ Quality Indicator Technical Specifications, as applicable. Amerigroup 360° used internal staff members to conduct medical record reviews and quality assurance. Staff members were sufficiently qualified and trained in the current year's Child Core Set Technical Specifications, Adult Core Set Technical Specifications, AHRQ Quality Indicator Technical Specifications, and the use of QSHR's

abstraction tools to accurately conduct medical record reviews. The auditor reviewed Amerigroup 360°'s training abstraction manual and found no concerns. Amerigroup 360° maintained appropriate quality assurance of reviews, including over-reads of all abstractions resulting in a numerator positive or exclusions, and a random sample of numerator negatives.

Due to challenges encountered with the CMS measures during the 2015 medical record review validation, a convenience sample was required for the following measures:

- Non-HEDIS—*Behavioral Health Risk Assessment for Pregnant Women (BHRA-CH)*
- Non-HEDIS—*Screening for Clinical Depression and Follow-up Plan (CDF)*

Amerigroup 360° passed the convenience sample process.

Amerigroup 360° passed the MRRV process for the following measures:

- Non-HEDIS—*Developmental Screening in the First Three Years of Life (DEV-CH)*
- Non-HEDIS—*Screening for Clinical Depression and Follow-up Plan (CDF) (Numerator Positives and Exclusions)*
- Non-HEDIS—*Behavioral Health Risk Assessment for Pregnant Women (BHRA-CH)*
- Non-HEDIS—*Exclusions*

Of note, the auditor identified critical errors in the *Screening for Clinical Depression* and *Behavioral Health Risk Assessment for Pregnant Women* measures. Second samples were drawn and cases were reviewed. No critical errors were identified with the second samples for these measures.

- Amerigroup 360º was fully compliant with IS standard 5.0. A standard supplemental data source was allowed for use for Amerigroup 360°. The supplemental data were obtained from the state historical FFS file from the State of Georgia. Since this source was considered standard by the auditor, no proof of service verification was required. The auditor identified significant numerator positive hits for the *Colorectal Cancer Screening*, *Developmental Screening in the First Three Years of Life*, *Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk*, and *Screening for Clinical Depression and Follow-up Plan* measures. The auditor reviewed supplemental impact reports and found them to be compliant with the measure expectations.
- Amerigroup 360° was fully compliant with IS standard 7.0. Amerigroup 360° continued to use its internal relational database to store all incoming data. The internal data warehouse contained both internal and external data files used for reporting. Amerigroup 360° also contracted with a vendor, Inovalon, to produce the performance measures under review. Amerigroup 360° was responsible for loading and running the data monthly, as well as running the data for measure production and final rates. The auditor reviewed the source code for the measures under review and conducted primary source verification on all administrative measures. The auditor had no concerns following the review of these measures. Amerigroup 360° maintained its quality review processes during the measurement year to ensure all data were accurately loaded. Amerigroup 360° continued to conduct monthly data runs for measures to monitor progress throughout the year—a best practice for ensuring accurate data management and measure production. Monthly measure production continued to assist Amerigroup 360° with identifying issues, if any, early. If data errors were found, Amerigroup 360° was able to easily retract and reload the data to correct the issues. Amerigroup 360° used Inovalon's software to produce the final rates for the measures. Amerigroup 360° continued to have an excellent disaster recovery process in place and backed up data nightly.

Performance Measure Results

The RY 2016 and 2017 rates for Amerigroup 360° are presented in Table 5–5, along with RY 2016 to RY 2017 rate comparisons. Measures for which lower rates suggest better performance are indicated by an asterisk (*). For these measures, a decrease in the rate from 2016 to 2017 represents performance improvement and an increase in the rate from 2016 to 2017 represents performance decline. Measures in the Utilization and Health Plan Descriptive Information domains are designed to capture the frequency of services provided by the CMO and characteristics of the population served by the CMO. With the exception of the *Ambulatory Care (per 1,000 Member Months)—ED Visits—Total* and the *Plan All-Cause Readmissions Rate* measure rates, higher or lower rates in these domains do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5–5—Performance Measure Results for Amerigroup 360°

Measure	RY 2016 Rate	RY 2017 Rate	2016–2017 Rate Comparison
Access to Care			
Adults' Access to Preventive/Ambulatory Health Services^			
20–44 Years	52.82%	55.68%	2.86
Adult BMI Assessment^			
Adult BMI Assessment	NA	62.82%	NC
Annual Dental Visit			
2–3 Years	46.87%	56.93%	10.06
4–6 Years	80.41%	79.94%	-0.47
7–10 Years	75.91%	78.41%	2.50
11–14 Years	69.54%	70.91%	1.37
15–18 Years	63.67%	65.96%	2.29
19–20 Years	38.91%	40.70%	1.79
Total	67.48%	69.78%	2.30
Children and Adolescents' Access to Primary Care Practitioners			
12–24 Months	98.75%	98.95%	0.20
25 Months–6 Years	91.06%	91.88%	0.82
7–11 Years	97.46%	88.23%	-9.23
12–19 Years	96.92%	82.69%	-14.23
Children's Health			
Prevention and Screening			
Appropriate Testing for Children With Pharyngitis			
Appropriate Testing for Children With Pharyngitis	81.98%	83.10%	1.12

Measure	RY 2016 Rate	RY 2017 Rate	2016–2017 Rate Comparison
Childhood Immunization Status			
Combination 3	71.06%	72.22%	1.16
Combination 6	37.73%	37.27%	-0.46
Combination 10	26.39%	27.55%	1.16
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk			
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	26.93%	26.42%	-0.51
Developmental Screening in the First Three Years of Life			
Total	50.00%	62.96%	12.96
Immunizations for Adolescents			
Combination 1 (Meningococcal, Tdap)[1]	84.03%	84.49%	0.46
HPV	—	19.44%	NC
Lead Screening in Children			
Lead Screening in Children	78.94%	84.49%	5.55
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile—Total	68.29%	78.24%	9.95
Counseling for Nutrition—Total	68.52%	79.63%	11.11
Counseling for Physical Activity—Total[2]	64.12%	73.15%	9.03
Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection			
Appropriate Treatment for Children With Upper Respiratory Infection	84.11%	87.63%	3.52
Well-Child/Well-Care Visits			
Adolescent Well-Care Visits			
Adolescent Well-Care Visits	53.47%	56.61%	3.14
Well-Child Visits in the First 15 Months of Life			
Six or More Well-Child Visits	56.70%	62.73%	6.03
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life			
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	73.84%	77.10%	3.26
Women's Health			
Prenatal Care and Birth Outcomes			
Behavioral Health Risk Assessment for Pregnant Women			
Behavioral Health Risk Assessment for Pregnant Women	16.25%	17.20%	0.95
Cesarean Delivery Rate, Uncomplicated			
*Cesarean Delivery Rate, Uncomplicated**	12.35%	22.89%	10.54

Measure	RY 2016 Rate	RY 2017 Rate	2016–2017 Rate Comparison
Frequency of Ongoing Prenatal Care			
≥81 Percent of Expected Visits	37.84%	66.27%	28.43
Percentage of Live Births Weighing Less Than 2,500 Grams			
*Percentage of Live Births Weighing Less Than 2,500 Grams**	NA	NA	NC
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	81.08%	65.06%	-16.02
Postpartum Care	59.46%	67.47%	8.01
Prevention and Screening			
Chlamydia Screening in Women			
Total	54.47%	60.88%	6.41
Chronic Conditions			
Diabetes			
Comprehensive Diabetes Care[2]			
Hemoglobin A1c (HbA1c) Testing	NA	NA	NC
*HbA1c Poor Control (>9.0%)**	NA	NA	NC
HbA1c Control (<8.0%)	NA	NA	NC
Eye Exam (Retinal) Performed	NA	NA	NC
Medical Attention for Nephropathy	NA	NA	NC
Blood Pressure Control (<140/90 mm Hg)	NA	NA	NC
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)			
*Diabetes Short-Term Complications Admission Rate**	16.81	12.21	-4.60
Cardiovascular Conditions			
Controlling High Blood Pressure			
Controlling High Blood Pressure	NA	NA	NC
Respiratory Conditions			
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)			
*Asthma in Younger Adults Admission Rate**	0.00	0.00	0.00
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA	NA	NC
Antidepressant Medication Management			
Effective Acute Phase Treatment	73.02%	46.88%	-26.14
Effective Continuation Phase Treatment	61.90%	31.25%	-30.65

Measure	RY 2016 Rate	RY 2017 Rate	2016–2017 Rate Comparison
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up	52.15%	51.83%	-0.32
30-Day Follow-Up	75.68%	72.80%	-2.88
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	51.71%	53.95%	2.24
Continuation and Maintenance Phase	54.72%	66.27%	11.55
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment			
Initiation of AOD Treatment—Total	51.75%	55.65%	3.90
Engagement of AOD Treatment—Total	20.47%	22.61%	2.14
Screening for Clinical Depression and Follow-Up Plan			
Screening for Clinical Depression and Follow-Up Plan	2.56%	10.99%	8.43
Use of Multiple Concurrent Antipsychotics in Children and Adolescents			
*Total**	4.93%	5.96%	1.03
Medication Management			
Medication Management for People With Asthma			
Medication Compliance 50%—Ages 5–11 Years	NA	62.57%	NC
Medication Compliance 50%—Ages 12–18 Years	NA	56.25%	NC
Medication Compliance 50%—Ages 19–50 Years	NA	NA	NC
Medication Compliance 50%—Total	NA	59.72%	NC
Medication Compliance 75%—Ages 5–11 Years	NA	37.43%	NC
Medication Compliance 75%—Ages 12–18 Years	NA	28.41%	NC
Medication Compliance 75%—Ages 19–50 Years	NA	NA	NC
Medication Compliance 75%—Total	NA	32.50%	NC
Utilization			
Ambulatory Care (per 1,000 Member Months)—Total			
*ED Visits—Total**	35.58	35.44	-0.14
Outpatient Visits—Total	289.86	302.00	12.14
Inpatient Utilization—General Hospital/Acute Care—Total			
Total Inpatient—Discharges per 1,000 Member Months—Total	1.88	1.84	-0.04
Total Inpatient—Days per 1,000 Member Months—Total	9.20	9.26	0.06
Total Inpatient—Average Length of Stay—Total	4.90	5.04	0.14
Maternity—Discharges per 1,000 Member Months—Total	0.50	0.62	0.12
Maternity—Days per 1,000 Member Months—Total	1.45	1.97	0.52

Measure	RY 2016 Rate	RY 2017 Rate	2016–2017 Rate Comparison
Maternity—Average Length of Stay—Total	2.89	3.19	0.30
Surgery—Discharges per 1,000 Member Months—Total	0.55	0.43	-0.12
Surgery—Days per 1,000 Member Months—Total	4.45	3.97	-0.48
Surgery—Average Length of Stay—Total	8.14	9.29	1.15
Medicine—Discharges per 1,000 Member Months—Total	1.04	1.06	0.02
Medicine—Days per 1,000 Member Months—Total	3.90	4.19	0.29
Medicine—Average Length of Stay—Total	3.76	3.94	0.18
Mental Health Utilization—Total			
Inpatient—Total	4.52%	3.87%	-0.65
Intensive Outpatient or Partial Hospitalization—Total	0.98%	0.72%	-0.26
Outpatient, ED, or Telehealth—Total	56.24%	54.51%	-1.73
Any Service—Total	56.61%	54.88%	-1.73
Plan All-Cause Readmissions Rate*			
*18–44 Years^*	24.00%	18.63%	-5.37
Health Plan Descriptive Information			
Race/Ethnicity Diversity of Membership			
Total—White	47.67%	49.04%	1.37
Total—Black or African American	47.82%	45.52%	-2.30

^ Indicates that the data for this measure only includes members 21 years of age and younger.
[1] Due to changes in the technical specifications for this measure (e.g., removed tetanus, diphtheria toxoids, and meningococcal polysaccharide vaccines), exercise caution when comparing the 2017 rate to historical rates.
[2] Due to changes in the technical specifications for this measure, exercise caution when comparing rates between 2016 and 2017.
** A lower rate indicates better performance for this measure.*
— Indicates the rate is not presented in the table above because reporting the measure was not required for the respective reporting year.
NC indicates the 2016–2017 Rate Comparison could not be calculated because data are not available for both years or because an increase or decrease in the rate does not necessarily indicate better or worse performance.
NA indicates the denominator for the measure is too small to report (less than 30).

Amerigroup 360° demonstrated a notable increase in performance (i.e., increase of more than 5 points) from RY 2016 to RY 2017 for several measure rates, including: *Annual Dental Visit—2–3 Years*; *Developmental Screening in the First Three Years of Life—Total*; *Lead Screening in Children*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected Visits*; *Prenatal and Postpartum Care—Postpartum Care*; *Chlamydia Screening in Women—Total*; *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*; and *Screening for Clinical Depression and Follow-Up Plan*. The most notable increases were for the *Frequency of Ongoing Prenatal Care—≥81 Percent of Expected*

Visits and *Developmental Screening in the First Three Years of Life—Total* measure indicators, where rates increased by 28.43 points and 12.96 points, respectively.

Conversely, Amerigroup 360° showed a notable decline in performance (i.e., decline of more than 5 points) from RY 2016 to RY 2017 for several measure rates, including: *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*; *Cesarean Delivery Rate, Uncomplicated*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; and *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*. The most notable decreases were for the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment* measure indicators, where rates decreased by 26.14 points and 30.65 points, respectively.

Plan Comparison

The RY 2017 measure rates for Amerigroup, Peach State, and WellCare, and the statewide weighted average results for the Georgia Families population relative to the NCQA 2016 Quality Compass national Medicaid percentiles are shown in Table 5–7. Measure results were compared to benchmarks and rated using the following star ratings:

Table 5–6—Star Ratings

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the 75th percentile
★★	At or above the national Medicaid 25th percentile but below the 50th percentile
★	Below the national Medicaid 25th percentile

For the measures denoted with an asterisk (*), lower rates indicate better performance. Since measures in the Utilization and Diversity of Membership measure domain are designed to capture the frequency of services provided by the CMOs as well as characteristics of the population served by the CMO, higher or lower rates in this domain do not necessarily indicate better or worse performance. These rates are provided for information purposes only, and comparisons to benchmarks were not performed.

Georgia Families Results

Table 5–7 presents the RY 2017 CMO-specific rates and the Georgia Families weighted average rates along with the corresponding star ratings.

Table 5–7—RY 2017 Results for Georgia Families

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Access to Care				
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	78.59% ★★	77.22% ★★	82.55% ★★★	79.78% ★★★
Adult BMI Assessment				
Adult BMI Assessment	81.02% ★★	85.88% ★★★	82.06% ★★	82.90% ★★
Annual Dental Visit				
2–3 Years	45.54% ★★★★	39.98% ★★★	50.00% ★★★★	45.86% ★★★★
4–6 Years	74.81% ★★★★★	70.18% ★★★★	77.21% ★★★★★	74.49% ★★★★★
7–10 Years	78.00% ★★★★★	73.04% ★★★★	79.18% ★★★★★	77.05% ★★★★★
11–14 Years	71.73% ★★★★★	66.51% ★★★★	73.37% ★★★★★	70.96% ★★★★★
15–18 Years	60.43% ★★★★	56.94% ★★★★	63.20% ★★★★★	60.62% ★★★★
19–20 Years	36.44% ★★★	35.07% ★★★	43.14% ★★★★	38.81% ★★★
Total	68.44% ★★★★★	63.90% ★★★★	70.93% ★★★★★	68.21% ★★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.12% ★★★	96.84% ★★★	97.13% ★★★	97.04% ★★★
25 Months–6 Years	89.71% ★★★	89.69% ★★★	90.80% ★★★	90.18% ★★★
7–11 Years	92.06% ★★★	90.64% ★★	91.55% ★★★	91.41% ★★★
12–19 Years	89.51% ★★★	88.73% ★★	89.48% ★★★	89.28% ★★
Colorectal Cancer Screening				
Colorectal Cancer Screening	47.80% NC	48.84% NC	50.93% NC	49.36% NC
Children's Health				
Prevention and Screening				
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	80.76% ★★★	83.95% ★★★★	81.16% ★★★★	81.84% ★★★★
Childhood Immunization Status				

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Combination 3	74.31% ★★★	71.88% ★★★	78.24% ★★★★	75.28% ★★★
Combination 6	32.87% ★★	30.53% ★	30.79% ★★	31.26% ★★
Combination 10	28.47% ★★	26.68% ★★	28.24% ★★	27.83% ★★
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk				
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	26.47% NC	11.18% NC	22.83% NC	22.90% NC
Developmental Screening in the First Three Years of Life				
Total	58.10% NC	55.88% NC	47.92% NC	53.11% NC
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	89.12% ★★★★★	87.02% ★★★★★	89.35% ★★★★★	88.63% ★★★★★
HPV	19.68% NC	22.84% NC	16.90% NC	19.31% NC
Lead Screening in Children				
Lead Screening in Children	78.70% ★★★	83.17% ★★★★	81.02% ★★★★	81.05% ★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	75.00% ★★★	73.32% ★★★	77.78% ★★★★	75.77% ★★★
Counseling for Nutrition—Total	70.60% ★★★	68.27% ★★★	69.68% ★★★	69.51% ★★★
Counseling for Physical Activity—Total	65.28% ★★★★	57.93% ★★★	56.25% ★★★	59.07% ★★★
Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	88.32% ★★	87.16% ★★	86.91% ★★	87.34% ★★
Well-Child/Well-Care Visits				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	56.71% ★★★	50.00% ★★★	51.62% ★★★	52.51% ★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	71.69% ★★★★	63.73% ★★★	63.41% ★★★	65.81% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.20% ★★★	72.80% ★★★	71.16% ★★	72.46% ★★★

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Women's Health				
Prenatal Care and Birth Outcomes				
Antenatal Steroids				
Antenatal Steroids	21.28% NC	54.55% NC	NA	51.31% NC
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	18.98% NC	5.58% NC	21.99% NC	17.17% NC
Cesarean Delivery Rate, Uncomplicated				
*Cesarean Delivery Rate, Uncomplicated**	28.89% NC	30.22% NC	29.89% NC	29.69% NC
Cesarean Rate for Nulliparous Singleton Vertex				
*Cesarean Rate for Nulliparous Singleton Vertex**	1.67% NC	NR	NR	1.67% NC
Elective Delivery				
*Elective Delivery**	6.82% NC	NR	NA	6.62% NC
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	58.56% ★★	48.18% ★★	56.50% ★★	54.27% ★★
Percentage of Live Births Weighing Less Than 2,500 Grams				
*Percentage of Live Births Weighing Less Than 2,500 Grams**	8.65% NC	8.86% NC	8.69% NC	8.74% NC
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.25% ★★	73.72% ★	80.38% ★★	78.36% ★★
Postpartum Care	68.98% ★★★★	61.07% ★★★	60.28% ★★	63.19% ★★★
Prevention and Screening				
Breast Cancer Screening				
Breast Cancer Screening	70.66% ★★★★	66.12% ★★★★	67.85% ★★★★	68.29% ★★★★
Cervical Cancer Screening				
Cervical Cancer Screening	66.75% ★★★★	66.19% ★★★★	69.77% ★★★★	67.80% ★★★★
Chlamydia Screening in Women				
Total	58.98% ★★★	62.60% ★★★★	56.69% ★★★	59.02% ★★★
Chronic Conditions				

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Diabetes				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	86.07% ★★★	83.48% ★★	81.79% ★	83.53% ★★
*HbA1c Poor Control (>9.0%)**	51.58% ★★	61.04% ★	56.30% ★	56.23% ★
HbA1c Control (<8.0%)	38.64% ★	29.91% ★	37.63% ★	35.76% ★
HbA1c Control (<7.0%)	29.14% ★	22.46% ★	28.97% ★	27.17% ★
Eye Exam (Retinal) Performed	45.27% ★★	59.83% ★★★	42.94% ★	48.37% ★★
Medical Attention for Nephropathy	90.88% ★★★	88.70% ★★	92.41% ★★★★	90.92% ★★★
Blood Pressure Control (<140/90 mm Hg)	55.72% ★★	46.78% ★	47.04% ★	49.53% ★
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)				
*Diabetes Short-Term Complications Admission Rate**	14.32 NC	12.82 NC	17.21 NC	14.94 NC
Cardiovascular Conditions				
Controlling High Blood Pressure				
Controlling High Blood Pressure	47.43% ★★	37.82% ★	34.30% ★	38.98% ★
Heart Failure Admission Rate (per 100,000 Member Months)				
*Heart Failure Admission Rate**	5.42 NC	7.49 NC	7.49 NC	6.89 NC
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	NA	NA	78.57% ★★	74.68% ★
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)				
*Asthma in Younger Adults Admission Rate**	2.54 NC	5.24 NC	5.98 NC	4.76 NC
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (per 100,000 Member Months)				
*Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate**	22.01 NC	20.51 NC	45.76 NC	30.65 NC
Behavioral Health				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	38.46% ★	31.53% ★	33.99% ★	34.57% ★

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.53% ★★	40.76% ★	44.88% ★	45.35% ★
Effective Continuation Phase Treatment	30.95% ★	24.84% ★	29.07% ★	28.47% ★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.66% ★★★	85.39% ★★★★	83.97% ★★★	84.22% ★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	49.09% ★★★	50.75% ★★★	52.45% ★★★	51.00% ★★★
30-Day Follow-Up	67.43% ★★★	66.67% ★★★	70.61% ★★★	68.62% ★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	46.10% ★★★	45.69% ★★★	49.76% ★★★★	47.74% ★★★
Continuation and Maintenance Phase	62.79% ★★★★	59.84% ★★★	68.00% ★★★★★	64.65% ★★★★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment				
Initiation of AOD Treatment—Total	39.02% ★★★	35.32% ★★	32.98% ★	35.27% ★★
Engagement of AOD Treatment—Total	9.40% ★★	6.71% ★	6.79% ★	7.50% ★★
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	14.73% NC	10.90% NC	7.25% NC	10.46% NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
*Total**	2.91% ★★	1.37% ★★★	1.70% ★★★	1.96% ★★★
Medication Management				
Annual Monitoring for Patients on Persistent Medications				
ACE Inhibitors or ARBs	90.59% ★★★★	87.22% ★★	89.23% ★★★	89.13% ★★★
Diuretics	88.49% ★★★	86.68% ★★	89.56% ★★★	88.50% ★★★
Total	89.45% ★★★	86.91% ★★	89.22% ★★★	88.69% ★★★
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	42.62% ★	46.01% ★	47.46% ★★	45.78% ★

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Medication Compliance 50%—Ages 12–18 Years	44.62% ★★	44.02% ★★	45.63% ★★	44.89% ★★
Medication Compliance 50%—Ages 19–50 Years	46.98% ★	52.74% ★	53.77% ★	51.87% ★
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NA	63.77% ★
Medication Compliance 50%—Total	43.77% ★	45.69% ★	47.12% ★	45.82% ★
Medication Compliance 75%—Ages 5–11 Years	19.72% ★	20.28% ★	21.84% ★★	20.82% ★
Medication Compliance 75%—Ages 12–18 Years	18.41% ★	19.77% ★★	19.52% ★★	19.30% ★★
Medication Compliance 75%—Ages 19–50 Years	24.83% ★	21.89% ★	33.22% ★★	27.73% ★
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NA	43.48% ★★
Medication Compliance 75%—Total	19.77% ★	20.25% ★	21.56% ★	20.70% ★
Use of Opioids at High Dosage (per 1,000 Member Months)				
Use of Opioids at High Dosage—All Ages	19.40 NC	10.65 NC	16.45 NC	15.77 NC
Utilization				
Ambulatory Care (per 1,000 Member Months)—Total				
*ED Visits—Total**	54.90 NC	52.27 NC	62.39 NC	57.20 NC
Outpatient Visits—Total	303.58 NC	307.29 NC	406.77 NC	347.83 NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Discharges per 1,000 Member Months—Total	5.04 NC	6.05 NC	7.02 NC	6.18 NC
Total Inpatient—Days per 1,000 Member Months—Total	17.83 NC	20.48 NC	20.79 NC	19.90 NC
Total Inpatient—Average Length of Stay—Total	3.54 NC	3.39 NC	2.96 NC	3.22 NC
Maternity—Discharges per 1,000 Member Months—Total	6.84 NC	8.63 NC	8.02 NC	7.89 NC
Maternity—Days per 1,000 Member Months—Total	19.31 NC	24.48 NC	19.52 NC	21.00 NC
Maternity—Average Length of Stay—Total	2.82 NC	2.83 NC	2.43 NC	2.66 NC
Surgery—Discharges per 1,000 Member Months—Total	0.56 NC	0.52 NC	0.86 NC	0.67 NC

Measure	Amerigroup	Peach State	WellCare	Georgia Families
Surgery—Days per 1,000 Member Months—Total	4.27 NC	4.10 NC	5.30 NC	4.65 NC
Surgery—Average Length of Stay—Total	7.66 NC	7.89 NC	6.16 NC	6.91 NC
Medicine—Discharges per 1,000 Member Months—Total	1.01 NC	1.24 NC	2.19 NC	1.58 NC
Medicine—Days per 1,000 Member Months—Total	3.78 NC	4.23 NC	5.82 NC	4.77 NC
Medicine—Average Length of Stay—Total	3.73 NC	3.40 NC	2.66 NC	3.03 NC
Mental Health Utilization—Total				
Inpatient—Total	0.55% NC	0.40% NC	0.55% NC	0.50% NC
Intensive Outpatient or Partial Hospitalization—Total	0.12% NC	0.10% NC	0.12% NC	0.12% NC
Outpatient, ED, or Telehealth—Total	9.73% NC	7.76% NC	9.47% NC	9.00% NC
Any Service—Total	9.86% NC	7.86% NC	9.57% NC	9.11% NC
Plan All-Cause Readmissions Rate*				
18–44 Years	12.66% NC	11.87% NC	11.17% NC	11.76% NC
45–54 Years	10.31% NC	9.78% NC	11.03% NC	10.52% NC
55–64 Years	10.26% NC	11.94% NC	14.29% NC	12.55% NC
18–64—Total	12.18% NC	11.58% NC	11.29% NC	11.61% NC
65–74 Years	NA	NA	NA	NA
75–84 Years	NA	NA	NA	NA
85 and Older	NA	NA	NA	NA
65 and Older—Total	NA	NA	NA	NA
Health Plan Descriptive Information				
Race/Ethnicity Diversity of Membership				
Total—White	47.71% NC	33.30% NC	49.40% NC	43.69% NC
Total—Black or African American	44.91% NC	50.42% NC	44.01% NC	46.35% NC

** A lower rate indicates better performances for this measure.*
NC indicates the RY 2017 rate was not compared to benchmarks either because data are not available or because a measure is informational only and comparisons to benchmarks are not appropriate.
NA indicates the denominator for the measure is too small to report (less than 30).
NR indicates the CMO rate for the measure was materially biased.

For RY 2017, performance varied among the three CMOs and the Georgia Families weighted average. Among the three CMOs, Amerigroup displayed consistently high performance as 36 of 62 measure rates (58.1 percent) where comparisons to percentiles could be made ranked at or above the national Medicaid 50th percentile. Additionally, WellCare displayed strength with 34 of 63 measure rates (54.0 percent) performing at or above the national Medicaid 50th percentile and seven measure rates (11.1 percent) meeting or exceeding the 90th percentile. Of note, five of the seven rates above the 90th percentile are indicators for the *Annual Dental Visit* measure, suggesting the CMO's high performance is mostly concentrated to this one area and not spread over several different measures. Further, Peach State had the fewest measure rates, 31 of 62 (50.0 percent), that ranked at or above the national Medicaid 50th percentile for the CMOs. All CMOs exhibited strength by scoring above the 50th percentile for *Annual Dental Visit*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months* and *25 Months–6 Years*; *Appropriate Testing for Children With Pharyngitis*; *Childhood Immunization Status—Combination 3*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Lead Screening in Children*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*; *Adolescent Well-Care Visits*; *Well-Child Visits in the First 15 Months of Life*; *Breast Cancer Screening*; *Cervical Cancer Screening*; *Chlamydia Screening in Women*; *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*; *Follow-Up After Hospitalization for Mental Illness*; and *Follow-Up Care for Children Prescribed ADHD Medication*.

Peach State demonstrated the most opportunity for improvement for the CMOs, as 31 of 62 measure rates (50.0 percent) fell below the national Medicaid 50th percentile, with 17 measure rates (27.4 percent) falling below the 25th percentile. For WellCare, 29 of 63 measure rates (46.0 percent) fell below the national Medicaid 50th percentile, with 15 measure rates (23.8 percent) falling below the 25th percentile. Additionally, 26 of 62 measure rates (41.9 percent) for Amerigroup fell below the national Medicaid 50th percentile, with 11 measure rates (17.7 percent) falling below the 25th percentile. All three CMOs would benefit from focused improvement efforts in the Chronic Conditions, Behavioral Health, and Medication Management domains, as most of the CMOs' rates that fell below the national Medicaid 25th or 50th percentile were indicators for the following measures: *Comprehensive Diabetes Care*, *Controlling High Blood Pressure*, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*, *Antidepressant Medication Management*, *Initiation and Engagement of AOD Dependence Treatment*, and *Medication Management for People With Asthma*.

Data Completeness

Table 5–8 provides an estimate of encounter data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included, as well as measures that only used medical record review data (i.e., *Controlling High Blood Pressure*). The table shows the RY 2017 rates and the percentage of each reported rate that was determined solely through administrative data for all CMOs. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data. Higher or lower

rates of encounter data completeness do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5–8—Estimated Encounter Data Completeness for Georgia Families Hybrid Measures

HEDIS Measure	Amerigroup RY 2017 Rate	Amerigroup Percent from Admin Data	Peach State RY 2017 Rate	Peach State Percent from Admin Data	WellCare RY 2017 Rate	WellCare Percent from Admin Data
Access to Care						
Adult BMI Assessment						
Adult BMI Assessment	81.02%	**45.14%^^**	85.88%	52.05%	82.06%	56.28%
Colorectal Cancer Screening						
Colorectal Cancer Screening	47.80%	89.32%	48.84%	91.94%^	50.93%	93.64%^
Children's Health						
Prevention and Screening						
Childhood Immunization Status						
Combination 3	74.31%	98.75%^	71.88%	79.26%	78.24%	98.52%^
Combination 6	32.87%	99.30%^	30.53%	85.04%	30.79%	98.50%^
Combination 10	28.47%	99.19%^	26.68%	84.68%	28.24%	99.18%^
Developmental Screening in the First Three Years of Life						
Total	58.10%	73.31%	55.88%	97.00%^	47.92%	94.69%^
Immunizations for Adolescents						
Combination 1 (Meningococcal, Tdap)	89.12%	98.96%^	87.02%	100.00%^	89.35%	99.22%^
HPV	19.68%	77.65%	22.84%	95.79%^	16.90%	97.26%^
Lead Screening in Children						
Lead Screening in Children	78.70%	95.88%^	83.17%	97.69%^	81.02%	98.57%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents						
BMI Percentile—Total	75.00%	72.84%	73.32%	73.77%	77.78%	77.68%
Counseling for Nutrition—Total	70.60%	64.26%	68.27%	73.59%	69.68%	76.74%
Counseling for Physical Activity—Total	65.28%	**13.83%^^**	57.93%	**32.78%^^**	56.25%	**34.57%^^**
Well-Child/Well-Care Visits						
Adolescent Well-Care Visits						
Adolescent Well-Care Visits	56.71%	91.84%^	50.00%	91.83%^	51.62%	95.07%^
Well-Child Visits in the First 15 Months of Life						

HEDIS Measure	Amerigroup RY 2017 Rate	Amerigroup Percent from Admin Data	Peach State RY 2017 Rate	Peach State Percent from Admin Data	WellCare RY 2017 Rate	WellCare Percent from Admin Data
Six or More Well-Child Visits	71.69%	87.45%	63.73%	84.52%	63.41%	90.12%^
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life						
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	74.20%	97.66%^	72.80%	97.36%^	71.16%	98.51%^
Women's Health						
Prenatal Care and Birth Outcomes						
Antenatal Steroids						
Antenatal Steroids	21.28%	**0.00%^^**	54.55%	**0.00%^^**	NA	NA
Behavioral Health Risk Assessment for Pregnant Women						
Behavioral Health Risk Assessment for Pregnant Women	18.98%	**0.00%^^**	5.58%	**0.00%^^**	21.99%	**0.00%^^**
Cesarean Rate for Nulliparous Singleton Vertex						
Cesarean Rate for Nulliparous Singleton Vertex	1.67%	**0.00%^^**	NR	NR	NR	NR
Elective Delivery						
Elective Delivery	6.82%	97.56%^	NR	NR	NA	NA
Frequency of Ongoing Prenatal Care						
≥81 Percent of Expected Visits	58.56%	**22.13%^^**	48.18%	**21.72%^^**	56.50%	**26.36%^^**
Prenatal and Postpartum Care						
Timeliness of Prenatal Care	81.25%	53.56%	73.72%	57.10%	80.38%	55.88%
Postpartum Care	68.98%	64.77%	61.07%	74.50%	60.28%	65.88%
Prevention and Screening						
Cervical Cancer Screening						
Cervical Cancer Screening	66.75%	90.94%^	66.19%	92.45%^	69.77%	95.19%^
Chronic Conditions						
Diabetes						
Comprehensive Diabetes Care						
Hemoglobin A1c (HbA1c) Testing	86.07%	96.92%^	83.48%	98.75%^	81.79%	97.96%^
HbA1c Poor Control (>9.0%)	51.58%	72.03%	61.04%	76.92%	56.30%	82.48%

HEDIS Measure	Amerigroup RY 2017 Rate	Amerigroup Percent from Admin Data	Peach State RY 2017 Rate	Peach State Percent from Admin Data	WellCare RY 2017 Rate	WellCare Percent from Admin Data
HbA1c Control (<8.0%)	38.64%	50.64%	29.91%	**37.79%^^**	37.63%	**41.53%^^**
HbA1c Control (<7.0%)	29.14%	53.42%	22.46%	**42.31%^^**	28.97%	**42.68%^^**
Eye Exam (Retinal) Performed	45.27%	94.87%^	59.83%	88.08%	42.94%	97.17%^
Medical Attention for Nephropathy	90.88%	98.36%^	88.70%	98.82%^	92.41%	99.34%^
Blood Pressure Control (<140/90 mm Hg)	55.72%	**7.44%^^**	46.78%	**9.29%^^**	47.04%	**10.65%^^**
Behavioral Health						
Screening for Clinical Depression and Follow-Up Plan						
Screening for Clinical Depression and Follow-Up Plan	14.73%	**12.28%^^**	10.90%	**11.11%^^**	7.25%	**27.59%^^**

Green Shading^ *indicates that more than 90 percent of the final rate was derived from administrative data.*
Red Shading^^ *indicates that 50 percent or less of the final rate was derived from administrative data.*
NA indicates the denominator for the measure is too small to report (less than 30).
NR indicates the CMO rate for the measure was materially biased.

Amerigroup 360° Results

Table 5–9 presents the RY 2017 Amerigroup 360°-specific rates along with star ratings based on comparisons of the rates to the NCQA 2016 Quality Compass national Medicaid percentiles. Measure results were compared to benchmarks and rated as shown in Table 5–6.

Table 5–9—RY 2017 Results for Amerigroup 360°

Measure	Amerigroup 360°
Access to Care	
Adults' Access to Preventive/Ambulatory Health Services[1]	
20–44 Years	55.68% ★
Adult BMI Assessment[1]	
Adult BMI Assessment	62.82% ★
Annual Dental Visit	
2–3 Years	56.93% ★★★★★
4–6 Years	79.94% ★★★★★

Measure	Amerigroup 360°
7–10 Years	78.41% ★★★★★
11–14 Years	70.91% ★★★★★
15–18 Years	65.96% ★★★★★
19–20 Years	40.70% ★★★
Total	69.78% ★★★★★
Children and Adolescents' Access to Primary Care Practitioners	
12–24 Months	98.95% ★★★★★
25 Months–6 Years	91.88% ★★★★
7–11 Years	88.23% ★★
12–19 Years	82.69% ★
Children's Health	
Prevention and Screening	
Appropriate Testing for Children With Pharyngitis	
Appropriate Testing for Children With Pharyngitis	83.10% ★★★★
Childhood Immunization Status	
Combination 3	72.22% ★★★
Combination 6	37.27% ★★
Combination 10	27.55% ★★
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	
Dental Sealants for 6–9 Year Old Children at Elevated Caries Risk	26.42% NC
Developmental Screening in the First Three Years of Life	
Total	62.96% NC
Immunizations for Adolescents	
Combination 1 (Meningococcal, Tdap)	84.49% ★★★★
HPV	19.44% NC

Measure	Amerigroup 360°
Lead Screening in Children	
Lead Screening in Children	84.49% ★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	
BMI Percentile—Total	78.24% ★★★★
Counseling for Nutrition—Total	79.63% ★★★★★
Counseling for Physical Activity—Total	73.15% ★★★★★
Upper Respiratory Infection	
Appropriate Treatment for Children With Upper Respiratory Infection	
Appropriate Treatment for Children With Upper Respiratory Infection	87.63% ★★
Well-Child/Well-Care Visits	
Adolescent Well-Care Visits	
Adolescent Well-Care Visits	56.61% ★★★
Well-Child Visits in the First 15 Months of Life	
Six or More Well-Child Visits	62.73% ★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.10% ★★★
Women's Health	
Prenatal Care and Birth Outcomes	
Behavioral Health Risk Assessment for Pregnant Women	
Behavioral Health Risk Assessment for Pregnant Women	17.20% NC
Cesarean Delivery Rate, Uncomplicated	
*Cesarean Delivery Rate, Uncomplicated**	22.89% NC
Frequency of Ongoing Prenatal Care	
≥81 Percent of Expected Visits	66.27% ★★★
Percentage of Live Births Weighing Less Than 2,500 Grams	
*Percentage of Live Births Weighing Less Than 2,500 Grams**	NA
Prenatal and Postpartum Care	
Timeliness of Prenatal Care	65.06% ★

Measure	Amerigroup 360°
Postpartum Care	67.47% ★★★
Prevention and Screening	
Chlamydia Screening in Women	
Total	60.88% ★★★
Chronic Conditions	
Diabetes	
Comprehensive Diabetes Care	
Hemoglobin A1c (HbA1c) Testing	NA
*HbA1c Poor Control (>9.0%)**	NA
HbA1c Control (<8.0%)	NA
Eye Exam (Retinal) Performed	NA
Medical Attention for Nephropathy	NA
Blood Pressure Control (<140/90 mm Hg)	NA
Diabetes Short-Term Complications Admission Rate (per 100,000 Member Months)	
*Diabetes Short-Term Complications Admission Rate**	12.21 NC
Cardiovascular Conditions	
Controlling High Blood Pressure	
Controlling High Blood Pressure	NA
Respiratory Conditions	
Asthma in Younger Adults Admission Rate (per 100,000 Member Months)	
*Asthma in Younger Adults Admission Rate**	0.00 NC
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NA
Antidepressant Medication Management	
Effective Acute Phase Treatment	46.88% ★
Effective Continuation Phase Treatment	31.25% ★
Follow-Up After Hospitalization for Mental Illness	
7-Day Follow-Up	51.83% ★★★
30-Day Follow-Up	72.80% ★★★★
Follow-Up Care for Children Prescribed ADHD Medication	

Measure	Amerigroup 360°
Initiation Phase	53.95% ★★★★
Continuation and Maintenance Phase	66.27% ★★★★
Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment	
Initiation of AOD Treatment—Total	55.65% ★★★★★
Engagement of AOD Treatment—Total	22.61% ★★★★★
Screening for Clinical Depression and Follow-Up Plan	
Screening for Clinical Depression and Follow-Up Plan	10.99% NC
Use of Multiple Concurrent Antipsychotics in Children and Adolescents	
*Total**	5.96% ★
Medication Management	
Medication Management for People With Asthma	
Medication Compliance 50%—Ages 5–11 Years	62.57% ★★★★
Medication Compliance 50%—Ages 12–18 Years	56.25% ★★★★
Medication Compliance 50%—Ages 19–50 Years	NA
Medication Compliance 50%—Total	59.72% ★★★
Medication Compliance 75%—Ages 5–11 Years	37.43% ★★★★
Medication Compliance 75%—Ages 12–18 Years	28.41% ★★★
Medication Compliance 75%—Ages 19–50 Years	NA
Medication Compliance 75%—Total	32.50% ★★★
Utilization	
Ambulatory Care (per 1,000 Member Months)—Total	
*ED Visits—Total**	35.44 NC
Outpatient Visits—Total	302.00 NC
Inpatient Utilization—General Hospital/Acute Care—Total	
Total Inpatient—Discharges per 1,000 Member Months—Total	1.84 NC
Total Inpatient—Days per 1,000 Member Months—Total	9.26 NC

Measure	Amerigroup 360°
Total Inpatient—Average Length of Stay—Total	5.04 NC
Maternity—Discharges per 1,000 Member Months—Total	0.62 NC
Maternity—Days per 1,000 Member Months—Total	1.97 NC
Maternity—Average Length of Stay—Total	3.19 NC
Surgery—Discharges per 1,000 Member Months—Total	0.43 NC
Surgery—Days per 1,000 Member Months—Total	3.97 NC
Surgery—Average Length of Stay—Total	9.29 NC
Medicine—Discharges per 1,000 Member Months—Total	1.06 NC
Medicine—Days per 1,000 Member Months—Total	4.19 NC
Medicine—Average Length of Stay—Total	3.94 NC
Mental Health Utilization—Total	
Inpatient—Total	3.87% NC
Intensive Outpatient or Partial Hospitalization—Total	0.72% NC
Outpatient, ED, or Telehealth—Total	54.51% NC
Any Service—Total	54.88% NC
Plan All-Cause Readmissions Rate*	
18–44 Years[1]	18.63% NC
Health Plan Descriptive Information	
Race/Ethnicity Diversity of Membership	
Total—White	49.04% NC
Total—Black or African American	45.52% NC

[1] *Indicates that the data for this measure only includes members 21 years of age and younger.*
** A lower rate indicates better performances for this measure.*
NC indicates the RY 2017 rate was not compared to benchmarks either because data are not available or because a measure is informational only and comparisons to benchmarks are not appropriate.
NA indicates the denominator for the measure is too small to report (less than 30).

For RY 2017, 34 of 45 measure rates (75.6 percent) ranked at or above the national Medicaid 50th percentile for Amerigroup 360°. Eleven of the rates (24.4 percent) met or exceeded the 90th percentile, demonstrating strength for the CMO within the Access to Care, Children's Health, and Behavioral Health domains for the following measure rates: *Annual Dental Visit—2–3 Years*, *4–6 Years*, *7–10 Years*, *11–14 Years*, *15–18 Years*, and *Total*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total*; and *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*.

Conversely, 7 of 45 measure rates (15.6 percent) for Amerigroup 360° fell below the national Medicaid 25th percentile, indicating opportunities for improvement for the CMO within the Access to Care, Women's Health, and Behavioral Health domains for the following measure rates: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*; *Adult BMI Assessment*; *Children and Adolescents' Access to Primary Care Practitioners—12–19 Years*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*. Three of the seven rates affect members within the Behavioral Health domain, suggesting focused improvement in medication management within this area for the CMO may be beneficial for multiple measure rates. Additionally, as Amerigroup 360° serves members 21 years of age and younger, caution should be exercised when evaluating rates for measures that typically include only adult members (e.g., *Adults' Access to Preventive/Ambulatory Health Services* and *Adult BMI Assessment*).

Data Completeness

Table 5–10 provides an estimate of encounter data completeness for the hybrid performance measures. These measures used administrative data (i.e., claims and encounter data) and supplemented the results with medical record review data. Measures that used only administrative data were not included, as well as measures that only used medical record review data (i.e., *Controlling High Blood Pressure*). The table shows the RY 2017 rates and the percentage of each reported rate that was determined solely through administrative data for the CMO. Rates shaded green with one caret (^) indicate that more than 90 percent of the final rate was derived using administrative data. Rates shaded red with two carets (^^) indicate that less than 50 percent of the final rate was derived using administrative data. Higher or lower rates of encounter data completeness do not necessarily indicate better or worse performance. Therefore, these rates are provided for information purposes only.

Table 5–10—Estimated Encounter Data Completeness for Amerigroup 360° Hybrid Measures

HEDIS Measure	Georgia Families 360° RY 2017 Rate	Georgia Families 360° Percent from Admin Data
Access to Care		
Adult BMI Assessment		
Adult BMI Assessment	62.82%	53.57%
Children's Health		
Prevention and Screening		
Childhood Immunization Status		
Combination 3	72.22%	98.08%^
Combination 6	37.27%	97.52%^
Combination 10	27.55%	98.32%^
Developmental Screening in the First Three Years of Life		
Total	62.96%	75.37%
Immunizations for Adolescents		
Combination 1 (Meningococcal, Tdap)	84.49%	98.08%^
HPV	19.44%	79.76%
Lead Screening in Children		
Lead Screening in Children	84.49%	97.66%^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile—Total	78.24%	71.60%
Counseling for Nutrition—Total	79.63%	64.83%
Counseling for Physical Activity—Total	73.15%	**18.35%**^^
Well-Child/Well-Care Visits		
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	56.61%	88.52%
Well-Child Visits in the First 15 Months of Life		
Six or More Well-Child Visits	62.73%	82.29%
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	77.10%	98.50%^
Women's Health		
Prenatal Care and Birth Outcomes		
Behavioral Health Risk Assessment for Pregnant Women		
Behavioral Health Risk Assessment for Pregnant Women	17.20%	**0.00%**^^
Frequency of Ongoing Prenatal Care		

HEDIS Measure	Georgia Families 360° RY 2017 Rate	Georgia Families 360° Percent from Admin Data
≥81 Percent of Expected Visits	66.27%	63.64%
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	65.06%	85.19%
Postpartum Care	67.47%	91.07%^
Chronic Conditions		
Diabetes		
Comprehensive Diabetes Care		
Hemoglobin A1c (HbA1c) Testing	NA	NA
HbA1c Poor Control (>9.0%)	NA	NA
HbA1c Control (<8.0%)	NA	NA
Eye Exam (Retinal) Performed	NA	NA
Medical Attention for Nephropathy	NA	NA
Blood Pressure Control (<140/90 mm Hg)	NA	NA
Behavioral Health		
Screening for Clinical Depression and Follow-Up Plan		
Screening for Clinical Depression and Follow-Up Plan	10.99%	**33.33%^^**

Green Shading^ *indicates that more than 90 percent of the final rate was derived from administrative data.*
Red Shading^^ *indicates that 50 percent or less of the final rate was derived from administrative data.*
NA indicates the denominator for the measure is too small to report (less than 30).

Conclusions

In order to assess the CMOs' performance measure results, RY 2017 rates were compared to prior years' results to determine notable declines and improvements in rates, as well as to the NCQA 2016 Quality Compass national Medicaid percentiles. For prior year rate comparisons, Georgia Families' RY 2017 rates were compared to RY 2015 rates, and Georgia Families 360° RY 2017 rates were compared to RY 2016 rates. Table 5–11 below displays the measure criteria HSAG used to identify the greatest strengths, the greatest weaknesses, and the best targets for quality improvement (QI) efforts.

Table 5–11—Performance Measure Priority Level Determination Scale

Star Rating	Prior Year Rate Comparison	Priority Level
★★★★★	↑	Greatest Strength
★★★★★	↔	Greatest Strength
★★★★	↑	Greatest Strength
★★★	↓	Best Target for QI Efforts
★★	↑	Best Target for QI Efforts
★★	↔	Best Target for QI Efforts
★★	↓	Greatest Weakness
★	↔	Greatest Weakness
★	↓	Greatest Weakness

↑ indicates a 5 point or more improvement in performance between RY 2017 and the prior year.
↓ indicates a 5 point or more decline in performance between RY 2017 and the prior year.
↔ indicates a difference of less than 5 points in performance between RY 2017 and the prior year.
★★★★★ = 90th percentile and above
★★★★ = 75th to 89th percentile
★★★ = 50th to 74th percentile
★★ = 25th to 49th percentile
★ = Below 25th percentile

Amerigroup

Amerigroup's performance for RY 2017 demonstrated the following measure rates as the greatest strengths: *Annual Dental Visit—4–6 Years*, *7–10 Years*, *11–14 Years*, and *Total*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*; *Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*; and *Prenatal and Postpartum Care—Postpartum Care*.

Amerigroup's performance for RY 2017 demonstrated the following measure rates as the greatest weaknesses: *Childhood Immunization Status—Combination 6* and *Combination 10*; *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* and *HbA1c Control (<7.0%)*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*; *Antidepressant Medication Management—Effective Continuation Phase Treatment*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years*, *Ages 19–50 Years*, and *Total*, and *Medication Compliance 75%—Ages 5–11 Years*, *Ages 12–18 Years*, *Ages 19–50 Years*, and *Total*.

Amerigroup's performance for RY 2017 demonstrated that the following measure rates are the greatest targets for QI efforts: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*; *Adult BMI Assessment*; *Appropriate Treatment for Children With Upper Respiratory Infection; Frequency of Ongoing Prenatal Care—>81 Percent of Expected Visits*; *Prenatal and Postpartum Care—Timeliness of*

Prenatal Care; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *Eye Exam (Retinal) Performed*, and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Antidepressant Medication Management—Effective Acute Phase Treatment*; *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*; *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 12–18 Years*.

Peach State

Peach State's performance for RY 2017 demonstrated the following measure rates as the greatest strengths: *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)* and *Chlamydia Screening in Women—Total*.

Peach State's performance for RY 2017 demonstrated the following measure rates as the greatest weaknesses: *Childhood Immunization Status—Combination 6* and *Combination 10*; *Frequency of Ongoing Prenatal Care—≥ 81 Percent of Expected Visits*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)*, *HbA1c Control (<8.0%)*, *HbA1c Control (<7.0%)*, and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; *Initiation and Engagement of AOD Dependence Treatment—Engagement of AOD Treatment—Total*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years* and *Total*, and *Medication Compliance 75%—Ages 5–11 Years*, *Ages 19–50 Years*, and *Total*.

Peach State's performance for RY 2017 demonstrated that the following measure rates are the greatest targets for QI efforts: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*; *Annual Dental Visit—2–3 Years*; *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*; *Childhood Immunization Status—Combination 3*; *Appropriate Treatment for Children With Upper Respiratory Infection*; *Prenatal and Postpartum Care—Postpartum Care*; *Comprehensive Diabetes Care—HbA1c Testing* and *Medical Attention for Nephropathy*; *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up*; *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total*; *Annual Monitoring for Patients on Persistent Medications—ACE Inhibitors or ARBs*, *Diuretics*, and *Total*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 12–18 Years* and *Medication Compliance 75%—Ages 12–18 Years*.

WellCare

WellCare's performance for RY 2017 demonstrated the following measure rates as the greatest strengths: *Annual Dental Visit—4–6 Years*, *7–10 Years*, *11–14 Years*, *15–18 Years*, *19–20 Years*, and *Total*; *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*;

Comprehensive Diabetes Care—Medical Attention for Nephropathy; and *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*.

WellCare's performance for RY 2017 demonstrated the following measure rates as the greatest weaknesses: *Childhood Immunization Status—Combination 6* and *Combination 10*; *Comprehensive Diabetes Care—HbA1c Testing, HbA1c Poor Control (>9.0%), HbA1c Control (<8.0%), HbA1c Control (<7.0%),* and *Blood Pressure Control (<140/90 mm Hg)*; *Controlling High Blood Pressure*; *Adherence to Antipsychotic Medications for Individuals With Schizophrenia*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 19–50 Years* and *Total*; and *Medication Compliance 75%—Total*.

WellCare's performance for RY 2017 demonstrated that the following measure rates are the greatest targets for QI efforts: *Adult BMI Assessment*; *Appropriate Treatment for Children with Upper Respiratory Infection*; *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*; *Frequency of Ongoing Prenatal Care—≥ 81 Percent of Expected Visits*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*; *Persistence of Beta-Blocker Treatment After a Heart Attack*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years* and *Ages 12–18 Years*, and *Medication Compliance 75%—Ages 5–11 Years, Ages 12–18 Years,* and *Ages 19–50 Years*.

Amerigroup 360°

Amerigroup 360°'s performance for RY 2017 demonstrated the following measure rates as the greatest strengths: *Annual Dental Visit—2–3 Years, 4–6 Years, 7–10 Years, 11–14 Years, 15–18 Years,* and *Total*; *Children and Adolescents' Access to Primary Care Practitioners—12–24 Months*; *Lead Screening in Children*; *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total; Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*; *Initiation and Engagement of AOD Dependence Treatment—Initiation of AOD Treatment—Total* and *Engagement of AOD Treatment—Total*; and *Medication Management for People With Asthma—Medication Compliance 50%—Ages 5–11 Years*, and *Ages 12–18 Years*, and *Medication Compliance 75%—Ages 5–11 Years*.

Amerigroup 360°'s performance for RY 2017 demonstrated the following measure rates as the greatest weaknesses: *Adults' Access to Preventive/Ambulatory Health Services—20–44 Years*; *Children and Adolescents' Access to Primary Care Practitioners—7–11 Years* and *12–19 Years*; *Prenatal and Postpartum Care—Timeliness of Prenatal Care*; *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Effective Continuation Phase Treatment*; and *Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total*.

Amerigroup 360°'s performance for RY 2017 demonstrated that the following measure rates are the greatest targets for QI efforts: *Childhood Immunization Status—Combination 6* and *Combination 10*; and *Appropriate Treatment for Children With Upper Respiratory Infection*.

6. Validation of Performance Improvement Projects

As described in 42 CFR §438.358(b)(1), validating PIPs is one of the mandatory EQR activities. The DCH requires CMOs to conduct PIPs in accordance with 42 CFR §438.330 (d). PIPs must be designed to achieve significant, sustained improvement in clinical and/or nonclinical areas of care through ongoing measurement and intervention, and they must be designed to have a favorable effect on health outcomes and member satisfaction.

Over time, HSAG and some of its contracted states identified that while CMOs have designed methodologically valid projects and received *Met* validation scores by complying with documentation requirements, few of them achieved real and sustained improvement. In July 2014, HSAG developed a new PIP framework based on a modified version of the Model for Improvement developed by Associates in Process Improvement and modified by the Institute for Healthcare Improvement. The redesigned PIP methodology is intended to improve processes and outcomes of healthcare by way of continuous quality improvement. The redesigned framework redirects MCOs to focus on small tests of change to determine which interventions have the greatest impact and can bring about real improvement. PIPs must meet CMS requirements; therefore, HSAG completed a crosswalk of this new framework against the Department of Health and Human Services, CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR), Version 2.0*, September 2012.[6-1] HSAG presented the crosswalk and new PIP framework components to CMS to demonstrate how the new PIP framework aligned with the CMS validation protocols. CMS agreed that—with the pace of quality improvement science development and the prolific use of PDSA cycles in modern improvement projects within healthcare settings—a new approach was needed.

Objectives

PIPs provide a structured method to assess and improve processes, and thereby outcomes, of care for the population that a CMO serves. This structure facilitates the documentation and evaluation of improvements in care or services. CMOs conduct PIPs to assess and improve the quality of clinical and nonclinical healthcare and services received by members.

The primary objective of PIP validation is to determine compliance with the requirements of 42 CFR §438.330 (d) and 42 CFR §438.358(b)(1), including:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve quality improvement.

[6-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2018.

- Evaluating effectiveness of the interventions.
- Planning and initiating activities for increasing and sustaining improvement.

For the rapid cycle PIP approach, HSAG developed five modules with an accompanying companion guide. Throughout CY 2017, HSAG continued to provide guidance, training, and oversight for the CMO's PIPs. HSAG has been involved from the onset of the PIPs to determine methodological soundness and to ensure that CMOs had the knowledge and guidance needed to be successful, not only in documenting their approach but also in applying the rapid cycle quality improvement methods that are central to achieving improved outcomes. HSAG's validation requirements, which were approved by DCH, stipulated that the CMOs must achieve the goal set for each component of the SMART Aim for the PIP to receive a rating of *Confidence* or *High Confidence*. See Appendix A, Technical Methods of Data Collection and Analysis, for more information on PIP validation scoring.

Plan-Specific Results—Amerigroup

For CY 2016, Amerigroup submitted four PIPs for validation. The PIPs were validated using HSAG's rapid cycle PIP validation process. The PIP topics included the following:

- *Bright Futures*
- *Member Satisfaction*
- *Postpartum Care*
- *Provider Satisfaction*

For each PIP conducted in CY 2016, Amerigroup defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation.

Table 6-1—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Bright Futures	By December 31, 2016, increase the rate of developmental screenings for 9-month-old members in Chatham County from 63.3% to 73.3%.
Member Satisfaction	By December 31, 2016, increase the rate of "Always" responses to question 18, "In the last six months, how often did your child's personal doctor listen carefully to you?" for members serviced at Toccoa Clinic from 76.0% to 90.0%.
Postpartum Care	By December 31, 2016, increase the rate of postpartum visits between 21–56 days after a live birth from 76.5% to 86.5% for The Longstreet Clinic.
Provider Satisfaction	By December 31, 2016, increase the rate of provider satisfaction among providers who were invited to orientation from 24.0% to 60.0%.

HSAG organized and analyzed the PIP information and data submitted by Amerigroup to draw conclusions about the MCOs' quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. HSAG also evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

CDC 6/18 Initiative: The purpose of Amerigroup's improvement project was to test interventions, based on evidence-based intervention guidance from the Centers for Disease Control and Prevention's (CDC's) 6|18 initiative, to improve asthma controller medication adherence among members 0–18 years of age who were seen at the participating emergency room (ER) for an asthma-related diagnosis, and who were enrolled in the CMO's disease management (DM) program. The CMO used PDSA cycles to test the effectiveness of two interventions for the project.

Overall, Amerigroup appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO clearly documented the targeted population, intervention plans, and intervention testing measures. While the CMO reported some improvement in the monthly asthma controller medication rate during the testing of Intervention 1 (intensive self-management education) and Intervention 2 (follow-up reminder outreach), the CMO concluded that results were mixed and that additional data points were needed to fully evaluate the effectiveness of the interventions. Amerigroup reported plans to adapt both interventions and continue PDSA testing cycles to further refine the improvement strategies for its member population.

Bright Futures PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup's goal for the *Bright Futures* PIP was to improve the rate of members in Chatham County who received a nine-month developmental screening. The details of the improvement processes used and the intervention tested are presented in Table 6-2 and in the subsequent narrative.

Table 6-2—Intervention Testing for *Bright Futures*

Intervention	Key Drivers Addressed	Failure Mode Addressed	Conclusions
Monthly fax communication with primary care providers in Chatham County to provide education on eligible members assigned to the provider who were due for a nine-month developmental screening	• Primary Driver: Provider compliance • Secondary Driver: Provider education and engagement	Provider realizes too late that the member has not scheduled an appointment by the recommended age and therefore misses the opportunity for a preventive visit	Based on success in achieving the SMART Aim goal and lessons learned during the PIP from participating providers, the intervention will be adapted and testing will continue.

Amerigroup tested one intervention for the PIP: faxing lists of members due for a nine-month developmental screening to primary care providers in Chatham County. To carry out this intervention, the CMO identified eligible members by age, residence, and PCP. The CMO sent monthly fax communications to PCPs in Chatham County that included a list of members who would be due for a nine-month developmental screening in the next month. The purpose of the monthly fax communications was to enable providers to easily identify members due for the service and engage providers in scheduling and completing the developmental screening during the recommended time frame.

The CMO used the SMART Aim measure (percentage of members in Chatham County who were due for a nine-month developmental screening and received a screening) to test the intervention and also collected process data on the provider response rate to the faxed member lists. The SMART Aim measure was appropriate to evaluate intervention effectiveness because the intervention included all members eligible for the measure. The CMO used the provider response rate to examine the administrative burden of the intervention on providers and to determine reasons members did not receive the nine-month screening. The CMO tested the intervention for six months, from June through November, and the SMART Aim goal of 73.3 percent was exceeded for five consecutive months from July through November. The CMO concluded that the intervention was successful; however, it determined that the intervention needed to be adapted to address the administrative burden and increase buy-in from participating providers, as a next step.

CDC 6/18 Initiative: The purpose of Amerigroup's CDC 6|18 initiative improvement project was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members in active disease management whose asthma is not well controlled. For the project, "not well controlled" was defined as not adherent with controller medication refills for three months. The CMO used Plan-Do-Study-Act (PDSA) cycles to test the effectiveness of one intervention for the project.

Overall, Amerigroup appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO clearly documented the targeted population, intervention plans, and intervention testing measures. While the CMO reported some improvement in the monthly asthma controller medication rate during the testing of Intervention 1 (intensive self-management education) and Intervention 2 (follow-up reminder outreach), the CMO concluded that results were mixed and additional data points were needed to fully evaluate the effectiveness of the interventions. Amerigroup reported plans to adapt both interventions and continue PDSA testing cycles to further refine the improvement strategies for its member population.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-3—SMART Aim Measure Results for *Bright Futures*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members in Chatham County that received a 9-month developmental screening	63.3%	73.3%	87.5%	*High Confidence*

The CMO established a goal of improving the nine-month developmental screening rate for members in Chatham County by 10 percentage points, from 63.3 percent to 73.3 percent. The SMART Aim measure rate exceeded the goal rate of 73.3 percent for five consecutive months following initiation of the intervention.

HSAG determined *High Confidence* in Amerigroup's *Bright Futures* PIP results. Amerigroup demonstrated that the selected intervention, monthly fax communication with providers, was effective in improving the nine-month developmental screening rate in the targeted county. Although the intervention facilitated achievement of the SMART Aim goal, the CMO identified aspects of the intervention that could be refined to support sustained and expanded improvement of the nine-month developmental screening rate. Amerigroup provided a sound rationale for adapting the intervention and testing it further.

Member Satisfaction PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup's goal for the *Member Satisfaction* PIP was to improve member satisfaction by improving communication between members and providers. The details of the improvement processes used and the intervention tested are presented in Table 6-4 and in the subsequent narrative.

Table 6-4—Intervention Testing for *Member Satisfaction*

Intervention	Key Driver Addressed	Failure Modes Addressed	Conclusions
Training providers at the targeted clinic on the teach-back method for improving communication between providers and members	Members do not understand the explanation or direction given to them by their providers	• Doctor does not read back the question to validate he or she understands the member's question • Doctor does not consider this member might not understand the treatment plan, so the doctor moves on to the next visit	Based on the summary of findings, the CMO determined the intervention was successful. The CMO chose to adapt the intervention to incorporate lessons learned and address additional components of provider-member communication that can impact member satisfaction.

Amerigroup tested one intervention for the PIP: training providers at the targeted clinic on the teach-back method for improving interactions between providers and members. The teach-back method is a communication strategy that can be taught to providers to ensure they are listening to their patients and are communicating health information in a way that is easy to understand and remember. To initiate the intervention, the CMO partnered with Merck & Co., Inc., to present a teach-back technique training class to providers at the targeted clinic. Thirty-three providers from the targeted clinic attended the training, which included a presentation, role playing, and open discussion. The providers were informed during the training of the expectation that the teach-back method be used during office visits with members.

To test the intervention, the CMO tracked an intervention-specific measure focused on those providers who received the training and those members who experienced the teach-back method during a visit with one of the trained providers. Phone survey data from these members regarding their satisfaction with provider listening were collected and measured monthly. The intervention-specific measure was separate from the SMART Aim measure, but the same goal of 90.0 percent was set for both measures. The intervention-specific measure of effectiveness met or exceeded the goal of 90.0 percent for four of six monthly measurements after the intervention occurred, and all measurements following the intervention exceeded the baseline rate. The SMART Aim measure met or exceeded the goal of 90.0

percent for five of six monthly measurements following the intervention. Based on the monthly performance on the intervention-specific measure of effectiveness and the overall SMART Aim measure performance, the CMO concluded that the intervention was effective.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-5—SMART Aim Measure Results for *Member Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members serviced at Toccoa Clinic who answered question 18, "In the last six months, how often did your child's personal doctor listen carefully to you?" with the response, "Always"	76.0%	90.0%	100.0%	*High Confidence*

The CMO established a goal of increasing the percentage of members who received care at Toccoa Clinic and answered "Always" to the survey question, "In the last six months, how often did your child's personal doctor listen carefully to you?" by 14 percentage points, from 76.0 percent to 90.0 percent. The SMART Aim measure met or exceeded the goal of 90.0 percent for five of six monthly measurements following the intervention.

HSAG determined *High Confidence* in Amerigroup's *Member Satisfaction* PIP results because the SMART Aim goal was exceeded and the quality improvement processes were clearly linked to the demonstrated improvement. Amerigroup demonstrated that the tested intervention, training providers on the teach-back method of communication, was effective in improving member satisfaction with provider communication during appointments at the targeted clinic. The intervention supported achievement of the SMART Aim goal; however, the CMO identified additional areas of member-provider interactions that could be addressed to support sustained and expanded improvement of member satisfaction.

Postpartum Care PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup's goal for the *Postpartum Care* PIP was to improve the postpartum visit rate among members who delivered a live birth and received care from a provider at The Longstreet Clinic. The details of the improvement processes used and the intervention tested are presented in Table 6-6 and in the subsequent narrative.

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

Intervention	Key Driver Addressed	Failure Modes Addressed	Conclusions
Live outreach calls conducted by the targeted provider to members who delivered a live birth and were due for a postpartum visit	Member engagement	• Member has not scheduled appointment for postpartum visit at time of discharge • Member does not receive education on scheduling a postpartum visit prior to visit due date • Member has Cesarean section incision check but does not schedule a separate postpartum visit	Based on the intervention testing results, the CMO chose to adapt the intervention and conduct further testing.

Amerigroup tested one intervention for the PIP, telephone outreach conducted by the participating clinic, to members who delivered a live birth, to promote and schedule the postpartum visit. To initiate outreach activities, the CMO provided lists of members to the participating clinic, based on hospital billing data for deliveries. The clinic staff conducted live outreach phone calls to members within 21 days of the delivery date. During the outreach call, the clinic staff offered the member education on the postpartum visit and assisted in scheduling the visit within 21–56 days following the birth.

To test the intervention, the CMO collected process data on the clinic's outreach call volume and tracked the percentage of eligible members outreached who completed a timely postpartum visit. The monthly data were plotted on a run chart. The test results showed that the clinic's outreach call volume increased after the intervention was initiated and the postpartum visit rate was higher among those who received the telephone outreach intervention; however, the intervention was not sufficient to achieve the SMART Aim goal for all eligible members included in the PIP.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-7—SMART Aim Measure Results for *Postpartum Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members who received care from The Longstreet Clinic, delivered a live birth, and completed a postpartum follow-up visit within 21–56 days of the birth	76.5%	86.5%	79.0%	*Low Confidence*

The CMO established a goal of improving the percentage of women who received care at The Longstreet Clinic and completed a postpartum visit within 21–56 days of delivering a live birth by 10 percentage points, from 76.5 percent to 86.5 percent. None of the monthly SMART Aim measurements met the goal of 86.5 percent.

HSAG determined *Low Confidence* in Amerigroup's *Postpartum Care* PIP results. The PIP did not demonstrate real improvement because the SMART Aim goal was not achieved during the life of the PIP. The CMO tested one intervention, member outreach calls by the targeted provider, and this intervention alone was not sufficient to achieve a postpartum visit rate of 86.5 percent among all eligible members receiving care at the selected clinic. The PIP results suggest that the telephone outreach intervention did not address all of the barriers to completing a timely postpartum visit and the CMO needed to pursue additional interventions, beyond telephone outreach, to meet the goal.

Provider Satisfaction PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup's goal for the *Provider Satisfaction* PIP was to improve provider satisfaction with the CMO's provider orientation process and resources. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 6-8 and in the subsequent narrative.

Table 6-8—Intervention Testing for *Provider Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Live telephone outreach to providers to promote registration for provider orientation and enhanced online provider orientation materials and resources	Provider awareness	The orientation ends but outstanding provider questions remain	Based on the intervention testing results, the CMO determined that the intervention was too resource-intensive and chose to adapt it for further testing.

Amerigroup tested one intervention for the PIP: live telephone outreach to promote registration for provider orientation and increase awareness of enhanced online provider orientation materials. To carry out the intervention, the CMO's Provider Solutions staff placed follow-up outreach calls to new providers who had received an invitation to attend an in-person provider orientation session. During the outreach call, providers were encouraged to register for and attend an orientation session. The phone calls directed the providers to the updated provider training website, where providers can register for an orientation session and access provider resources. The providers were educated on the web-based resources which included tools, webinars, forms, and tutorials for providers.

The CMO tested the intervention by linking process data on successful outreach calls and provider orientation registration to results of a follow-up telephone survey which gauged satisfaction with the CMO's provider orientation process. Following initiation of the intervention, the CMO reported an increase in registration rates for provider orientation. Concurrently, the SMART Aim measure remained above the baseline rate of 24.0 percent for seven consecutive months, and the SMART Aim goal (60.0 percent for the percentage of providers who reported being satisfied with the orientation) was met for two monthly SMART Aim measurements. The CMO determined that the intervention was successful and provided a sound rationale for adapting the intervention, based on lessons learned, and conducting further testing with additional providers.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-9—SMART Aim Measure Results for *Provider Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of providers invited to provider orientation who reported being satisfied with the orientation	24.0%	60.0%	67.0%	*Confidence*

The CMO established a goal of increasing the percentage of providers who reported being satisfied with provider orientation by 36.0 percentage points, from 24.0 percent to 60.0 percent. The SMART Aim measure rate exceeded the goal rate of 60.0 percent for two of the PIP's monthly measurements. Three additional monthly measurements (40.0 percent, 50.0 percent, and 50.0 percent, respectively) were more than 15 percentage points above the baseline rate but did not achieve the goal rate.

HSAG determined *Confidence* in the PIP results, based on a detailed review and evaluation of Amerigroup's *Provider Satisfaction* PIP documentation. The SMART Aim goal was achieved, and some but not all of the quality improvement processes were clearly linked to the demonstrated improvement. The CMO's documented summary of findings for intervention testing in Module 4, and overall PIP results in Module 5, contained minor errors. The primary error in the CMO's summary of findings was the omission of December data for the intervention testing run charts in Module 4 and the SMART Aim run chart in Module 5. While the omission of December data did not prevent the CMO from demonstrating improvement in the SMART Aim measure and linking the demonstrated improvement to the intervention for the months of May through November, the missing data for December prevented the CMO from linking the SMART Aim measure results to the intervention for the last month of the PIP.

Plan-Specific Results—Peach State

For CY 2016, Peach State submitted four PIPs for validation. The PIPs were validated using HSAG's rapid cycle PIP validation process. The PIP topics included the following:

- *Annual Dental Visits*
- *Avoidable Emergency Room Visits*
- *Member Satisfaction*
- *Provider Satisfaction*

For each PIP conducted in CY 2016, Peach State defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator

used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation.

Table 6-10—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Annual Dental Visits	By December 31, 2016, PSHP aims to increase sealants applied for members ages 6–9 years old residing in Muscogee County with a history of receiving treatment from Candler Dental that have no claims history of a sealant or restorative service on a molar, from 14.9% to 34.9%.
Avoidable Emergency Room Visits	By December 31, 2016, Peach State Health Plan will decrease the rate of utilization of avoidable ED visits to Coffee Regional Medical Center for members > 18 years old from 1,553.9 to 1,522.8 member visits per 1,000 (which represents a 2.0% reduction).
Member Satisfaction	By December 31, 2016, increase the average level of satisfaction from 2.2 to 2.5 for caregivers who were seen at Dr. Charlene Johnson's office in the Atlanta region who answered the question, "When you talked about your child's health, did a doctor or other health provider ask you what you thought was best for your child?"
Provider Satisfaction	By December 31, 2016, decrease the average prior authorization approval turnaround time from 8.4 calendar days to 5.0 calendar days, for Spine and Orthopedic Clinic, in the Atlanta Region.

HSAG organized and analyzed the PIP information and data submitted by Peach State to draw conclusions about the MCO's quality improvement efforts. Based on its review, HSAG determined the overall methodological validity of the PIP as well as the overall success in achieving the SMART Aim goal. HSAG also evaluated the appropriateness and validity of the SMART Aim measure as well as trends in the SMART Aim measurements, in comparison with the reported baseline rate and goal. The data displayed in the SMART Aim run chart were used to determine whether the SMART Aim goal was achieved.

CDC 6/18 Initiative: The purpose of Peach State's CDC 6|18 initiative improvement project was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members in active disease management whose asthma is not well controlled. For the project, "not well controlled" was defined as not adherent with controller medication refills for three months. The CMO used PDSA cycles to test the effectiveness of one intervention for the project.

Overall, Peach State appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO demonstrated strength in developing a robust intervention evaluation plan. Notably, Peach State collected extensive process data to guide intervention assessment and refinement during the PDSA cycle. The CMO tracked data related to scheduling and completion of the home visits and adjusted the intervention plan by adding unannounced home visits to address identified barriers and improve the home visit completion rate. Based on the intervention testing results, the CMO concluded that the intervention was effective but

resource-intensive. The CMO reported plans to adapt the intervention to focus on a narrower, high-need population, incorporating the strategies into the disease management program for members with asthma who have poor medication adherence and have had an inpatient hospitalization with a primary diagnosis of asthma in the last 30 days.

Annual Dental Visits PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Peach State's goal for the *Annual Dental Visits* PIP was to identify and test interventions to improve the dental sealant rate among members 6 to 9 years old living in Muscogee County. The details of the improvement processes used and the interventions tested are presented in Table 6-11 and in the subsequent narrative.

Table 6-11—Intervention Testing for *Annual Dental Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Provider incentive for completion of sealant placement during a preventive dental visit	Provider education and addressing missed opportunities	Low prioritization of sealant placements and preventive care	The CMO concluded the intervention was successful and chose to adapt the provider incentive intervention and test the intervention with another provider before spreading the intervention on a larger scale.

Peach State tested one intervention for the PIP: offering the participating provider a financial incentive for each completed sealant placement for members 6 to 9 years of age living in Muscogee County. The CMO initiated the intervention by communicating the incentive program to the participating provider. The participating provider was offered a $25 incentive for each sealant placed for an eligible member. To facilitate scheduling of preventive visits for sealant placement, the CMO's dental vendor generated lists of eligible members 6 to 9 years of age in the targeted county who had no history of receiving a dental sealant and shared the member lists with the participating provider through the dental provider portal and via secure email.

To test the intervention, the CMO tracked a process measure, number of sealants placed on eligible members per month, and compared the number of sealants placed by the participating provider before and after the intervention was initiated. The CMO also tracked the amount of incentive dollars paid to the participating provider through the intervention. In the five months prior to initiation of the

intervention, the provider placed sealants on 32 members 6 to 9 years of age. During five months of intervention testing, the provider placed 70 dental sealants on 52 eligible members and received a total of $1,750 in incentive payments. The SMART Aim goal was exceeded for four months during intervention testing and for two additional months following the end of the intervention. Based on the intervention testing results and the SMART Aim measure results, the CMO concluded that the intervention was effective.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-12—SMART Aim Measure Results for *Annual Dental Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 6 to 9 years of age in Muscogee County that received a sealant on a molar from Candler Dental	14. 9%	34.9%	53.9%	*High Confidence*

The CMO established a goal of improving the dental sealant rate at Candler Dental for members 6 to 9 years of age living in Muscogee County by 20 percentage points, from 14.9 percent to 34.9 percent. The SMART Aim measure rate exceeded the goal rate of 34.9 percent for six consecutive months.

HSAG determined *High Confidence* in Peach State's *Annual Dental Visits* PIP results because the SMART Aim goal was exceeded and the quality improvement processes were clearly linked to the demonstrated improvement. Peach State provided clear evidence that the selected intervention, provider incentive for completion of dental sealant placements, was associated with an increase in the dental sealant rate among eligible members. The CMO provided a sound rationale for adapting and further testing the intervention prior to large-scale dissemination of the improvement strategy.

Avoidable Emergency Room Visits PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Peach State's goal for the *Avoidable Emergency Room Visits* PIP was to reduce the avoidable ER visit rate at Coffee Regional Medical Center. The details of the improvement processes used and the intervention tested for the *Avoidable Emergency Room Visits* PIP are presented in Table 6-13 and in the subsequent narrative.

Table 6-13—Intervention Testing for *Avoidable Emergency Room Visits*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Partner with Coffee Regional Medical Center (CRMC) emergency department to distribute member educational flyer and provide information on appropriate ED use to members	Member awareness/education on alternative locations for nonurgent care (primary care physician, urgent care centers, physicians with extended hours)	Member's lack of understanding regarding avoidable ED use	The CMO will adapt the intervention by testing it during multiple seasons throughout the year and include member input on the design of the educational flyer.

Peach State tested one intervention for the PIP: partnering with the CRMC emergency department to present and explain educational materials on alternative facilities for seeking nonemergent care to members who were seen for an avoidable ED visit. The CMO originally planned to test the intervention with Phoebe Putney Memorial Hospital (PPMH); however, confounding factors beyond the CMO's control arose shortly after initiating the intervention with PPMH. After consultation with HSAG and DCH, the CMO switched to partnering with CRMC to test the intervention. To carry out the intervention, Peach State provided CRMC with the State approved "Is it an Emergency?" flyer, which included the address of a collaborating urgent care center. CRMC ED staff presented the flyer to members who were seen for an avoidable ED visit and provided a verbal explanation of appropriate ED use and alternative facilities for nonemergent care.

To test the intervention at CRMC, the CMO tracked a process measure (weekly number of members seen at CRMC ED facility for an avoidable diagnosis after receiving the intervention). A total of 38 members received the intervention during an initial ED visit. The CMO followed members for 12 weeks after they received the intervention to determine if a subsequent, avoidable ED visit occurred. The CMO set an intervention-specific goal for a 60.0 percent decrease in avoidable ED visits among members who received the intervention. The intervention-specific goal was above and beyond the SMART Aim goal of reducing the avoidable ED utilization rate at CRMC to 1522.8 visits per 1,000-member months. The intervention testing results were as follows: of the 38 members who received the intervention, 10 members (26.3 percent) returned to the ED a second time for an avoidable diagnosis compared to three members (7.9 percent) who sought care at the urgent care clinic.

While the SMART Aim goal was met for two monthly measurements during intervention testing, the CMO's intervention-specific goal for a 60.0 percent decrease in avoidable ED visits was not met. Additionally, the avoidable ED visit rate increased above the baseline rate for several months after the completion of intervention testing. Based on these results, the CMO concluded that the intervention was not successful.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-14—SMART Aim Measure Results for *Avoidable Emergency Room Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The avoidable emergency room utilization rate at Coffee Regional Medical Center	1,553.9	1,522.8	1,447.5	*Confidence*

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

The CMO established a goal of reducing the avoidable ER rate for Coffee Regional Medical Center from 1,553.9 visits per 1,000-member months to 1,522.8 visits per 1,000-member months. Two of the PIP's monthly SMART Aim measurements were at or below the goal rate of 1,522.8, with the lowest avoidable ER rate achieved being 1,447.5 visits per 1,000-member months.

HSAG determined *Confidence* in Peach State's *Avoidable Emergency Room Visits* PIP results. The SMART Aim goal was met, and the intervention testing results showed that 28 of the 38 members who received the intervention did not return to the ED for nonemergent symptoms during the follow-up period. Because 10 of the 38 members who received the intervention returned to the ED for nonemergent symptoms, and only three of the 38 members sought care at the urgent care clinic, some but not all the improvement could be logically linked to the intervention.

Member Satisfaction PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Peach State's goal for the *Member Satisfaction* PIP was to improve member satisfaction by improving communication between members and providers. The details of the improvement processes used and the intervention tested are presented in Table 6-15 and in the subsequent narrative.

Table 6-15—Intervention Testing for *Member Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Develop and distribute to members a checklist of questions to ask during the doctor visit to help with shared decision making	Member empowerment and engagement	Member unable to comprehend provider's recommendations	The CMO chose to test the intervention at a new primary care practice. The CMO plans to adopt the intervention if successful testing results are observed with the new provider.

Peach State tested one intervention for the PIP: developing a checklist of questions to guide shared decision making during the doctor visit. The CMO provided the checklist to members prior to their appointment at the participating provider's office. Each week, the CMO's Community Relations Representative (CRC) was located on-site at the provider's office. The CRC met with members and caregivers prior to their appointment and educated caregivers on using the checklist. The checklist suggested questions the member could ask during the appointment to promote shared decision making and understanding.

To test the intervention, the CMO collected post-appointment survey data from members who received the checklist, to determine if members and caregivers found the checklist helpful in improving their understanding of the doctor's instructions. Across the seven months of intervention testing, 80.9 percent of respondents provided the most favorable response (i.e., "Always") to the post-visit survey question. Additionally, the SMART Aim goal for an average monthly response of 2.5 to the survey question, "When you talked about your child's health, did a doctor or other health provider ask you what you thought was best for your child?" was exceeded during all seven months during intervention testing. Based on the analysis of findings, the CMO chose to adopt the intervention and planned to test it with another targeted provider to replicate the initial testing results. If intervention testing with a second targeted provider yields similarly successful results, the CMO plans to adopt the intervention and incorporate the checklist into standard processes, distributing the checklist to all members.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-16—SMART Aim Measure Results for *Member Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The average rating of satisfaction for caregivers whose child was seen by Dr. Charlene Johnson and who answered the survey question, "When you talked about your child's health, did a doctor or other health provider ask you what you thought was best for your child?"	2.2	2.5	3.0	*High Confidence*

The CMO established a goal of increasing the average rating of satisfaction from 2.2 to 2.5 among caregivers who responded to the survey question, "When you talked about your child's health, did a doctor or other health provider ask you what you thought was best for your child?" where the response choices ranged from 1.0 ("Never") to 3.0 ("Always"). The SMART Aim measure rate exceeded the goal rate of 2.5 for seven consecutive monthly measurements, with the highest monthly average response being 3.0, the most favorable response.

HSAG determined *High Confidence* in Peach State's *Member Satisfaction* PIP results. The SMART Aim goal was achieved, and the demonstrated improvement was clearly linked to the quality improvement processes implemented. The PIP results clearly demonstrated that the checklist for shared decision making was associated with increased caregiver satisfaction with the listening and communication skills of the participating provider.

Provider Satisfaction PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Peach State's goal for the *Provider Satisfaction* PIP was to improve provider satisfaction by reducing the time required to complete the prior authorization (PA) process for providers at the Spine and Orthopedic Clinic. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 6-17 and in the subsequent narrative.

Table 6-17—Intervention Testing for *Provider Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Provider education to Spine and Orthopedic Clinic providers on using InterQual Pain Management Clinical Policy SmartSheets to request prior authorization for pain management services	Provider knowledge	Required documentation to determine medical necessity not received	The CMO deemed the intervention ineffective because the goal of 80 percent complete pain management prior authorization requests was not met. The CMO chose to abandon the intervention because only 56 percent of the pain management prior authorization requests received after the training were complete.

Peach State tested one intervention for the PIP: equipping the participating provider with InterQual SmartSheets, which outline medical necessity requirements for PA requests. The CMO provided training to the participating provider on the use of SmartSheets to ensure submission of complete and accurate documentation for PA requests. During the training, the provider was instructed to use the SmartSheets for all subsequent PA requests related to pain management.

The CMO tested the intervention by evaluating a process measure: the completeness of pain management-related PA requests received from the targeted provider and tracking completeness of those requests. The CMO set an intervention-specific goal of receiving complete PA requests 80.0 percent of the time, following initiation of the intervention. This goal was separate from the SMART Aim goal. The CMO also tracked the SMART Aim measure (average turnaround time in days for all PA requests received from the targeted provider) before and after initiation of the intervention. Although the SMART Aim goal for an average turnaround time of 5.0 days was achieved for four biweekly measurements, the process measure (percentage of PA requests that were complete) fell short of the CMO's intervention-specific goal of 80.0 percent by 24.0 percentage points. The CMO chose to abandon the intervention and pursue other interventions in response to feedback received from the targeted provider.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-18—SMART Aim Measure Results for *Provider Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Lowest Rate Achieved*	Confidence Level
The average number of calendar days to complete a prior authorization requested by Spine and Orthopedic Clinic	8.4 days	5.0 days	4.6 days	*Low Confidence*

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

The CMO established a goal of reducing the average number of days required to complete a prior authorization request for Spine and Orthopedic Clinic providers from 8.4 days to 5.0 days. The SMART Aim measure rate fell below the goal of 5.0 days for four biweekly measurements following initiation of the intervention, indicating better performance.

HSAG determined *Low Confidence* in Peach State's reported *Provider Satisfaction* PIP results. HSAG identified several errors in the CMO's summary of intervention testing results and overall key findings. The raw data on intervention testing submitted with Module 4 did not support the CMO's summary of intervention testing results. Also, there were discrepancies between the data presented in the SMART Aim run chart and the narrative summary of SMART Aim measure results. Overall, the CMO did not provide a clear explanation of how the intervention testing results (completeness of PA requests related to pain management) were linked to the improvement in the SMART Aim measure (average turnaround time for all PA requests). There was not a clear link between the InterQual SmartSheets intervention and the improvement demonstrated in PA request turnaround time. Although the SMART Aim goal was achieved, the quality improvement processes were not clearly linked to the demonstrated improvement.

Plan-Specific Results—WellCare

For CY 2016, WellCare submitted four PIPs for validation. The PIPs were validated using HSAG's rapid-cycle PIP validation process. The PIP topics included:

- *Appropriate Use of ADHD [Attention Deficit Hyperactivity Disorder] Medications*
- *Comprehensive Diabetes Care*
- *Member Satisfaction*
- *Provider Satisfaction*

For each PIP conducted in CY 2016, WellCare defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation.

Table 6-19—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
Appropriate Use of ADHD Medications	By December 31, 2016, increase the rate of 30-day follow-up visits among members who are in the care of seven selected practices and are newly prescribed an ADHD medication therapy, from an average of 29.0% to 39.0%.
Comprehensive Diabetes Care	By December 31, 2016, increase the rate of diabetic retinal eye (DRE) exams among diabetic members 18–75 years of age who are assigned to one of the three selected providers, from 20.0% to 30.0%.
Member Satisfaction	By December 31, 2016, we will increase the percentage of members participating in New Member Orientation Sessions in Gwinnett County, from 1.4% to 3.4%.
Provider Satisfaction	By December 31, 2016, increase the rate of Provider Satisfaction among providers in the Southwest Region who answer "excellent" or "very good," from 54.8% to 59.8%.

CDC 6/18 Initiative: The purpose of WellCare's CDC 6|18 initiative improvement project was to test interventions, based on evidence-based intervention guidance from the CDC 6|18 initiative, to improve asthma controller medication adherence among members in active disease management whose asthma is not well controlled. For the project, "not well controlled" was defined as not adherent with controller medication refills for three months. The CMO used PDSA cycles to test the effectiveness of one intervention for the project.

Overall, WellCare appropriately applied the PDSA process for testing interventions selected from the CDC 6|18 initiative to improve asthma medication adherence. The CMO demonstrated strength in developing a robust intervention evaluation plan. Notably, WellCare collected extensive process data to guide intervention assessment and refinement during the PDSA cycle. The CMO tracked data related to scheduling and completion of the home visits and adjusted the intervention plan by adding unannounced home visits to address identified barriers and improve the home visit completion rate. Based on the intervention testing results, the CMO concluded that the intervention was effective but resource-intensive. The CMO reported plans to adapt the intervention to focus on a narrower, high-need population, incorporating the strategies into the disease management program for members with asthma who have poor medication adherence and have had an inpatient hospitalization with a primary diagnosis of asthma in the last 30 days.

Appropriate Use of ADHD Medications PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

WellCare's goal for the *Appropriate Use of ADHD Medications* PIP was to improve the 30-day follow-up appointment compliance rate among members 6–12 years of age who received an initial ADHD medication prescription from one of seven participating provider practices. The details of the improvement processes used and the intervention tested for the *Appropriate Use of ADHD Medications* PIP are presented in Table 6-20 and in the subsequent narrative.

Table 6-20—Intervention Testing for *Appropriate Use of ADHD Medications*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Assigning a clinical HEDIS practice advisor (CHPA) to the selected provider practices to provide in-person education on the required follow-up visit within 30 days after initial ADHD medication prescription fill	Provider knowledge or interpretation of best-practice guidelines that require new ADHD medication follow-up visits to occur within 30 days of the initial prescription fill for newly diagnosed children	Provider not aware of the NCQA requirements of the initial follow-up visit to occur in < 30 days	The CMO adopted the intervention and decided to use CHPAs across the entire State to educate ADHD medication prescribers.

WellCare tested one intervention for the PIP: assigning a clinical HEDIS practice advisor (CHPA) to selected provider practices and providing in-person education and ongoing support to the provider practices regarding the HEDIS requirement for a follow-up visit within 30 days of an initial ADHD medication prescription fill.

To test the intervention, the CMO tracked monthly SMART Aim measurements (percentage of eligible members seen by the selected providers who filled an initial ADHD medication prescription and completed a follow-up visit within 30 days). The SMART Aim measure was appropriate for evaluating intervention effectiveness because all of the providers included in the measure received the intervention. The CMO concluded that the intervention was effective because the SMART Aim measure rate exceeded the goal rate of 39.0 percent for six consecutive monthly measurements following the intervention.

The CMO's summary of test results was flawed because the CMO compared the monthly SMART Aim measurements to incorrect baseline and goal rates. Because three of the seven originally selected provider practices stopped participating in the PIP, the CMO should have compared the monthly measurements to recalculated baseline and goal rates, based on historical data from only the four participating practices. Using the practice-level historical data from Module 1, HSAG was able to

recalculate the baseline rate for the four provider practices that continued through the life of the PIP. HSAG calculated a corrected baseline rate of 41.0 percent and, using the CMO's goal of a 10 percentage point increase over baseline, a corrected goal rate of 51.0 percent. Using the corrected baseline and goal rates, the SMART Aim measure rate exceeded the goal rate of 51.0 percent for four consecutive monthly measurements, demonstrating that the intervention positively impacted the SMART Aim measure. The CMO's decision to adopt and expand the intervention was supported by the SMART Aim measure results.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-21—SMART Aim Measure Results for *Appropriate Use of ADHD Medications*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of children 6 to 12 years of age who complete a follow-up visit within 30 days of the initial fill of ADHD medication from the 7 selected provider practices	29.0%	39.0%	56.6%	*Confidence*

WellCare established a goal of improving the follow-up visit rate among members 6 to 12 years old who received an initial prescription for ADHD medication from one of seven selected provider practices by 10 percentage points, from 29.0 percent to 39.0 percent. The CMO reported six consecutive monthly measurements of the SMART Aim measure that exceeded the goal rate of 39.0 percent. Because WellCare documented that only four of the seven provider practices actively participated in the PIP and provided data for the SMART Aim measure, HSAG calculated a revised baseline rate of 41.0 percent and goal rate of 51.0 percent using historical, provider-specific data documented by the CMO in Module 1 for the four actively participating provider practices. The SMART Aim measure rate exceeded the revised goal rate of 51.0 percent for four consecutive monthly measurements.

HSAG determined *Confidence* in WellCare's reported *Appropriate Use of ADHD Medications* PIP results. The SMART Aim goal was achieved, and the intervention was linked to the demonstrated improvement; however, the CMO failed to update the SMART Aim statement to reflect changes in the number of participating providers. In future PIPs, WellCare should ensure that the SMART Aim statement and the baseline and goal rates for the SMART Aim measure are updated to reflect any changes that occur in the narrowed focus of the PIP. To accurately assess the success of the PIP at achieving the SMART Aim goal, the SMART Aim measure results must be evaluated against comparable baseline and goal rates focused on the same member or provider population. If a subgroup of members or providers leave the PIP and are not included in the SMART Aim measurements, this occurrence should be documented and the SMART Aim baseline and goal rates should be updated

accordingly. The CMO should request technical assistance as needed to ensure changes in the SMART Aim population are addressed appropriately.

Comprehensive Diabetes Care PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

WellCare's goal for the *Comprehensive Diabetes Care* PIP was to improve the percentage of diabetic members residing in the North and Central regions of Georgia, assigned to one of three selected PCP offices, who had a retinal eye exam during the measurement year. The details of the improvement processes used and the interventions tested are presented in Table 6-22 and in the subsequent narrative.

Table 6-22—Intervention Testing for *Comprehensive Diabetes Care*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Telephone outreach to diabetic members providing education about the need for a retinal eye exam	Diabetes awareness and education	Members did not keep their appointment for eye exams.	The CMO chose to adopt the intervention based on the analysis of findings, showing an upward trend in the monthly data from September 2016 through December 2016.
Test the implementation of portable RetinaVue scanners for performing retinal eye exams at a primary care provider (PCP) office	Provider engagement	Members did not keep their appointment for eye exams.	The CMO chose to adapt the intervention based on conversations with the participating PCP. Future tests will incorporate a stationary scanner instead of a hand-held scanner.

WellCare planned three interventions but tested only two. The CMO abandoned Intervention 1 prior to testing and tested the two remaining interventions for the PIP: Intervention 2—telephone outreach to educate diabetic members on the importance of retinal eye exams, and Intervention 3—partnering with a PCP office to offer retinal eye exams using a portable RetinaVue scanner. For Intervention 2, the CMO called eligible members, provided education on the need for retinal eye exams, and offered a referral to complete the exam with a local ophthalmologist. For Intervention 3, the CMO partnered with one of the three selected PCP offices to offer retinal eye exams in the PCP office during a routine diabetic care appointment. The PCP used a portable, handheld retinal scanner to complete the exams and sent the DRE image to an ophthalmologist for review.

To test Intervention 2, the CMO tracked an intervention-specific measure of members reached for telephone outreach and plotted the monthly percentage of completed DREs among members who

received the outreach and education. The CMO set an intervention-specific goal of 30.0 percent that was specific to members who received Intervention 2 and was separate from the overall SMART Aim goal of 30.0, which included all eligible members, not just members who received Intervention 2. The monthly DRE rates among members who received the outreach intervention exceeded the intervention-specific goal rate of 30.0 percent (not the SMART Aim goal) for the four months of testing; and the rates demonstrated an increasing trend, with the final data point being more than 25.0 percentage points above the goal. The SMART Aim goal was also exceeded for three consecutive monthly measurements during Intervention 2 testing. The CMO concluded that Intervention 2 was successful, based on the testing results, and documented a plan to adopt and expand the intervention.

To test Intervention 3, the CMO partnered with one of the selected PCP offices to offer DREs, using the portable RetinaVue scanner, as part of routine diabetes care appointments at the PCP office. WellCare tracked process-level data on members assigned to the selected PCP office who were due for a DRE and determined which members received a DRE with the portable scanner. The CMO concluded that the portable scanner was not an effective intervention because the monthly percentage of members who received a DRE via the portable scanner at the PCP office during the five months of intervention testing was very low. Additionally, the participating PCP reported technical difficulties in using the portable scanner. Based on the testing results, the CMO planned to adapt the intervention and conduct future testing of the use of a stationary scanner in the PCP office.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-23—SMART Aim Measure Results for *Comprehensive Diabetes Care*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 18 to 75 years of age residing in North and Central regions assigned to one of the three selected PCP offices that had a retinal eye exam during the measurement year	20.0%	30.0%	46.8%	*High Confidence*

The CMO established a goal of improving the percentage of diabetic members in the North and Central regions of Georgia, assigned to one of the three selected PCP offices, who had a retinal eye exam during the measurement year by 10 percentage points, from 20.0 percent to 30.0 percent. The SMART Aim measure rate exceeded the goal rate of 30.0 percent for three consecutive monthly measurements.

HSAG determined *High Confidence* in WellCare's reported *Comprehensive Diabetes Care* PIP results. The SMART Aim goal of 30.0 percent for the DRE rate among all eligible members was exceeded for three consecutive monthly SMART Aim measurements. The SMART Aim goal was achieved, and the quality improvement processes were clearly linked to the demonstrated improvement. Based on the PIP

results, the CMO provided a sound rationale for choosing to adopt Intervention 2 and adapt Intervention 3 for further testing.

Member Satisfaction PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

WellCare's goal for the *Member Satisfaction* PIP was to increase the percentage of members who participate in new member orientation after receiving an invitation to attend an orientation. The details of the improvement processes used and the interventions tested are presented in Table 6-24 and in the subsequent narrative.

Table 6-24—Intervention Testing for *Member Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Updating process flows to include telephone outreach for members in Gwinnett County who did not respond to mailed invitations	Continuous improvement of established protocols related to member outreach and event notification	No plans in place if members do not receive invitations	The CMO reported that data integrity issues due to staff turnover and reporting inconsistencies did not allow for accurate assessment of the intervention's effectiveness. The CMO decided to combine the intervention with another intervention and conduct a new test. The intervention was adapted.
Telephonic outreach combined with mailing postcards that were updated with marketing language designed to increase members' interest in attending the session.	Continuous improvement of established protocols related to member outreach and event notification	Lack of member interest	The CMO reported the intervention was ineffective since the data remained static with no increase in attendance. The intervention was abandoned.
The CMO offered orientation sessions at various times, in the evening, and on weekends to accommodate new members' schedules.	Flexible Member Orientation session times with consideration of work, transportation, and childcare	Time of the orientation	The CMO reported the intervention was deemed ineffective due to no increase in attendance. The intervention was abandoned.

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Telephonic new member orientation	Member/Provider education and engagement	Work and life events conflict with scheduled orientation	The CMO reported that the testing period of one month was not long enough to determine the intervention's effectiveness. As such, the CMO reported that it will adapt the intervention and determined that the intervention could be modified and deployed statewide to all members regardless of geographic location.

WellCare tested four interventions for the PIP: (1) updating process flows related to new member orientation to include telephone outreach for members who did not respond to a mailed new member orientation invitation, (2) new marketing language in the mailed orientation invitation and telephone follow-up for members who did not respond to the mailed invitation, (3) offering orientation sessions at various times in the evening, and on weekends to accommodate new members' schedules, and (4) offering telephonic new member orientation sessions.

The CMO documented similar evaluation plans for the four interventions: comparing the number of members who were invited and/or outreached for member orientation sessions to the number of members who actually attended the sessions. HSAG identified issues in the CMO's execution of the evaluations for Interventions 1 and 3. For Intervention 1, the CMO used a flawed data collection methodology and documented conflicting statements about the effectiveness of the intervention in the summary of findings. For Intervention 3, the CMO's summary of evaluation findings did not align with the evaluation plan. The summary of findings included only the number of members who registered for the afternoon and evening orientation sessions and did not report the number of members who attended the orientation sessions. The CMO used a sound methodology for testing Intervention 2 and accurately reported the testing results; however, the testing results did not indicate any improvement in attendance at the new member orientation sessions. WellCare ultimately abandoned Interventions 1, 2, and 3 and chose to adapt Intervention 4 for further testing.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-25—SMART Aim Measure Results for *Member Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of new members invited to a new member orientation session who attended the orientation session	1.4%	3.4%	NR*	*Reported PIP results were not credible*

* In the PIP conclusions described in Module 5, the CMO reported rates for a different measure that did not align with the SMART Aim statement or measure; therefore, HSAG could not determine the Highest Rate Achieved for the SMART Aim measure.

WellCare established a goal of increasing the percentage of members invited to attend a new member orientation, who attended an orientation session, by 2 percentage points, from 1.4 percent to 3.4 percent. The final results reported by the CMO in Module 5, at the conclusion of the PIP, did not align with the goal or the approved SMART Aim measure. At the conclusion of the PIP, the CMO presented a run chart with raw numbers, rather than percentages, of members who attended a session plotted on the chart. The run chart did not reflect the goal rate of 3.4 percent; instead, the goal line on the run chart represented fluctuating numbers of members for each data point. Because the CMO did not follow the approved SMART Aim measure methodology, the final run chart in Module 5 could not be used to evaluate the success of the PIP by comparing the SMART Aim measurements to the established baseline and goal rates. The PIP did not demonstrate evidence of achieving the SMART Aim goal because the SMART Aim measurement methodology was flawed.

HSAG determined that WellCare's reported *Member Satisfaction* PIP results were not credible. Because the CMO did not follow the approved SMART Aim measure methodology, the final run chart in Module 5 could not be used to evaluate the success of the PIP by comparing the SMART Aim measurements to the established baseline and goal rates. The PIP could not demonstrate whether the SMART Aim goal was achieved.

Provider Satisfaction PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

WellCare's goal for the *Provider Satisfaction* PIP was to increase overall satisfaction with the CMO among providers in the Southwest region. The details of the improvement processes used and the intervention tested for the *Provider Satisfaction* PIP are presented in Table 6-26 and in the subsequent narrative.

Table 6-26—Intervention Testing for *Provider Satisfaction*

Intervention	Key Driver Addressed	Failure Mode Addressed	Conclusions
Developed an internal job aid to educate Southwest Region providers on the appeals process.	Internal education for Provider Relations, hospital service specialists, and operation account representatives on the appeals process	Inconsistent process	The CMO reported that 75 percent of the internal staff members increased their knowledge of the appeals process as a result of the training. The CMO adopted the intervention.
Educating the Southwest Region provider community on appeals via Provider Relations representatives.	Provider education via Provider Relations representatives	Provider not educated on the appeals process	The CMO reported that the provider's understanding of the appeals process increased after training. The CMO adopted the intervention and plans to test the intervention in the Atlanta region.

WellCare tested two interventions for the PIP: (1) an internal job aid for enhanced training of staff who work directly with providers on the appeals process and (2) telephonic education on the appeals process for providers. For Intervention 1, the CMO developed an internal job aid focused on the information staff should know about the provider appeals process and incorporated the job aid into enhanced staff training sessions. For Intervention 2, the CMO's Provider Relations representatives reached out to providers in the Southwest Region by phone and offered education on the provider appeals process.

To test Intervention 1, the CMO assessed internal staff members on their knowledge of the appeals process before and after providing enhanced staff training using the internal job aid. Based on the result that 75.0 percent of staff members who received the intervention demonstrated improved knowledge of the appeals process, the CMO concluded the intervention was effective and chose to adopt the intervention. To test Intervention 2, the CMO surveyed providers before and after they received telephonic education on the appeals process, concluding that the intervention was successful based on the survey results. The CMO did not provide the survey tools used to evaluate Intervention 2 and did not clearly present the survey results; therefore, HSAG was unable to validate the summary of findings for the intervention.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-27—SMART Aim Measure Results for *Provider Satisfaction*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of providers in the Southwest region who answered "Excellent" or "Very Good" to WellCare's overall satisfaction survey question.	54.8%	59.8%	100.0%	*Confidence*

WellCare established a goal of increasing the percentage of providers in the Southwest region who answer "Excellent" or "Very Good" to WellCare's overall satisfaction survey question by 5 percentage points, from 54.8 percent to 59.8 percent. The SMART Aim measure rate exceeded the goal for five consecutive monthly measurements.

HSAG determined *Confidence* in WellCare's reported *Provider Satisfaction* PIP results. The SMART Aim goal was achieved, and one of the two interventions was clearly linked to the demonstrated improvement. The CMO used a methodologically sound approach for evaluating Intervention 1 (internal job aid for educating provider-facing staff) and clearly summarized the evaluation results, linking Intervention 1 to the improvement demonstrated in the SMART Aim measure. For Intervention 2 (telephonic education of providers), the CMO did not provide sufficient documentation of the survey tools used to evaluate intervention effectiveness and did not clearly summarize the intervention evaluation results; therefore, the intervention was not clearly linked to improvement in the SMART Aim measure. In Module 5, the CMO clearly reported the results of the SMART Aim measure (percentage of providers responding to the overall satisfaction question on a monthly provider telephone survey with a response of "Very Good" or "Excellent"), documenting that the SMART Aim measure rate exceeded the goal of 59.8 percent for five consecutive monthly measurements, with monthly percentages ranging from 87.5 percent to 100.0 percent.

Plan-Specific Results—Amerigroup 360°

For CY 2016, Amerigroup 360° submitted three PIPs for the GF 360° population. The PIPs were validated using HSAG's rapid cycle PIP validation process. The PIP topics included:

- *7-Day Inpatient Discharge Follow-up*
- *Adolescent Well-Child Visits*
- *Appropriate Use of ADHD Medications*

For each PIP conducted in CY 2016 for the GF 360° population, Amerigroup 360° defined a SMART Aim statement that identified the narrowed population and process to be evaluated, set a goal for improvement, and defined the indicator used to measure progress toward the goal. The SMART Aim statement sets the framework for the PIP and identifies the goal against which the PIP will be evaluated for the annual validation.

Table 6-28—PIP Titles and SMART Aim Statements

PIP Title	SMART Aim Statement
7-Day Inpatient Discharge Follow-up	To increase the rate of mental health 7-day follow-up appointments among members discharged from Crescent Pines Hospital and Peachford Hospital from 51.0% to 56.0% by December 31, 2016.
Adolescent Well-Child Visits	By December 31, 2016, increase the rate of AWC visits among members ages 12–21 years old living in Gwinnett County from 37.8% to 42.8%.
Appropriate Use of ADHD Medications	Improve the initial 30-day ADHD follow-up rate for GF 360° members ages 6–12 years old in Fulton County by 5 percentage points (from 50.2% to 55.2%) by December 31, 2016.

7-Day Inpatient Discharge Follow-up PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup 360°'s goal for the *7-Day Inpatient Discharge Follow-up* PIP was to improve the compliance rates for follow-up visits with a mental health practitioner among GF 360° members discharged from Crescent Pines Hospital or Peachford Hospital with a principal diagnosis of mental illness. The details of the improvement processes used and the intervention tested for the *7-Day Inpatient Discharge Follow-up* PIP are presented in Table 6-29 and in the subsequent narrative.

Table 6-29—Intervention Testing for *7-Day Inpatient Discharge Follow-up*

Intervention	Key Driver Addressed	Failure Modes Addressed	Conclusions
Use of a motivational interviewing technique to encourage scheduling and attendance of the 7-day follow-up mental health visit	Education of member, caregiver, and DFCS [Division of Family and Children Services]	Follow-up appointments are not kept	Based on the lack of success at achieving the SMART Aim goal, the CMO concluded the intervention was not effective and chose to abandon it.

Amerigroup 360° tested one intervention for the PIP: using the OARS (Open-ended questions, Affirmations, Reflective listening, and Summaries) motivational interviewing (MI) technique to encourage scheduling and attendance of the seven-day follow-up visit for members discharged from

inpatient treatment with a primary diagnosis of mental illness. The OARS MI technique is a person-centered, skills-based communication strategy that can be used by providers and the healthcare team to assist members in recognizing their internal motivations for adopting healthy behaviors, such as attending the seven-day mental health follow-up visit. The CMO deployed the OARS MI intervention through its care coordinator and health educator staff members who were involved with mental health discharge planning and follow-up. The care coordinator and health educator staff members incorporated the OARS MI into communication with the member and/or caregiver either prior to discharge or within 24 hours of discharge.

To test the intervention, the CMO tracked the SMART Aim measure (seven-day follow-up visit compliance rate among all eligible members). The SMART Aim goal for the seven-day follow-up visit compliance rate was not met during the life of the PIP; therefore, the CMO concluded that the intervention was not effective and chose to abandon it.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-30—SMART Aim Measure Results for *7-Day Inpatient Discharge Follow-up*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of discharges from Crescent Pines Hospital and Peachford Hospital with a principal diagnosis of mental illness that were followed by a mental health follow-up visit within seven days of discharge.	51.0%*	56.0%*	49.4%	*Low Confidence*

* It should be noted that the CMO inconsistently documented the baseline rate and SMART Aim goal rate for the PIP. The baseline and goal rates included in Table 6-30 were taken from the SMART Aim statement in the CMO's final key driver diagram in the Module 5 submission form.

The CMO established a goal of improving the seven-day mental health follow-up visit rate for members discharged from Crescent Pines Hospital or Peachford Hospital by 5 percentage points, from 51.0 percent to 56.0 percent. It should be noted that the CMO reported different baseline and goal rates in the final SMART Aim run chart submitted for Module 5. In the final SMART Aim run chart, the CMO plotted a baseline rate of 48.2 percent and a goal rate of 53.2 percent. The highest rate achieved for the SMART Aim measure was 49.4 percent, which was lower than both goal rates reported in Module 5; therefore, HSAG concluded that the SMART Aim goal was not met during the life of the PIP.

HSAG determined *Low Confidence* in Amerigroup 360°'s *7-Day Inpatient Discharge Follow-up* PIP results. The PIP did not demonstrate real improvement because the SMART Aim goal was not achieved during the life of the PIP. The CMO's summary of overall PIP findings submitted in Module 5 included errors, with the baseline and goal rates reported inconsistently in the CMO's summary of PIP results.

HSAG compared the documented SMART Aim measure results against the two different goal rates documented by the CMO, and neither goal was achieved during the life of the PIP.

The CMO used the SMART Aim measure to evaluate the effectiveness of the intervention during testing in Module 4. While the CMO's SMART Aim measure was methodologically sound for evaluating the overall impact of the PIP on achieving the SMART Aim goal, the measure was not specific to the intervention tested and was, therefore, not an appropriate measure of effectiveness for testing the intervention in Module 4. The SMART Aim measure includes the entire eligible member population for the PIP, defined by the SMART Aim statement. Because the OARS MI intervention was received by a subgroup of members in the PIP's eligible population and not the entire eligible population, the SMART Aim measure could not be used to effectively assess the impact of the intervention.

Adolescent Well-Child Visits PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup 360°'s goal for the *Adolescent Well-Child Visits* PIP was to improve the rate GF 360° members 12–21 years of age living in Gwinnett County who completed an annual adolescent well-child visit. The details of the improvement processes used and the intervention tested are presented in Table 6-31 and in the subsequent narrative.

Table 6-31—Intervention Testing for *Adolescent Well-Child Visits*

Intervention	Key Drivers Addressed	Failure Mode Addressed	Conclusions
Offering adolescent well-child visits at a MAU in a central location in Gwinnett County	<u>Providers:</u> • Initial refusal of members • Limited hours, walk-ins • Long waiting times • Poor relationship with the member <u>Gwinnett County DFCS:</u> • Unaware of the member's need for an adolescent well-child visit • Unreachable	Member does not attend appointment	Based on the intervention testing results, the CMO concluded that the intervention was not effective at improving the adolescent well-child visit rate but was successful at increasing well-child visits among younger children.

Intervention	Key Drivers Addressed	Failure Mode Addressed	Conclusions
	• Fails to arrange transportation • Unaware of GF 360°'s purpose • Member's location unknown		

Amerigroup 360° tested one intervention for the PIP: offering adolescent well-child visits at a MAU in a central location in Gwinnett County. The CMO located the MAU at the Gwinnett County Division of Family and Children Services (DFCS) office two Wednesdays per month. Each day the MAU was scheduled, 22 appointment slots were available for members. The CMO generated lists of GF 360° members who were in need of a well-care visit and conducted telephone outreach to these members to schedule a well-care appointment at the MAU.

The CMO measured the effectiveness of the intervention by tracking the monthly rate of eligible members who completed an adolescent well-child visit at the MAU on a run chart from June through December. The CMO compared the monthly adolescent well-visit rate at the MAU during intervention testing against the SMART Aim goal of 42.8 percent. This comparison was invalid; the SMART Aim goal applies to the SMART Aim measure (adolescent well-child visit rate for Gwinnett County), which was different than the adolescent well-child visit rate for the MAU only. The intervention-testing measure rate exceeded the goal for two monthly measurements at the beginning of the intervention testing cycle and then fell below the baseline rate for the remaining five months. Based on the testing results, the CMO concluded that the intervention was not effective at improving the adolescent well-child visit rate.

The CMO also analyzed the effectiveness of the intervention among two member subgroups (members under 12 years of age and newly enrolled members) that were not part of the eligible population defined by the approved SMART Aim statement. The CMO's decision to adopt the intervention for members under 12 years of age and newly enrolled members did not align with the SMART Aim statement or narrow focus of the PIP. In Module 5, the CMO reported the intervention testing results documented in Module 4 but did not report findings based on the approved SMART Aim measure from Module 2. The reported PIP results were based on the rate of adolescent well-child visits that were obtained at the MAU. This measure differed from the Module 2 approved measure, which was the overall adolescent well-child visit rate among GF 360° members living in Gwinnett County, regardless of where the visit occurred.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-32—SMART Aim Measure Results for *Adolescent Well-Child Visits*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 12–21 years old living in Gwinnett County who completed an adolescent well-child visit	37.8%	42.8%	NR*	*Reported PIP results were not credible*

* In the PIP conclusions described in Module 5, the CMO reported rates for a different measure that did not align with the SMART Aim statement or measure; therefore, HSAG could not determine the Highest Rate Achieved for the SMART Aim measure.

Amerigroup 360° established a goal of improving the well-child visit rate among adolescent members living in Gwinnett County by 5 percentage points, from 37.8 percent to 42.8 percent. The final results reported by the CMO in Module 5 at the conclusion of the PIP did not align with the goal or the approved SMART Aim measure. At the conclusion of the PIP, the CMO reported the percentage of adolescent members who completed a well-child visit on the mobile access unit (MAU). This measure was the same measure that was presented in Module 4 for intervention testing and was limited to only those members who completed an adolescent well-child visit at the MAU, rather than including all eligible members living in Gwinnett County. The CMO did not report findings based on the approved SMART Aim measure; therefore, HSAG could not determine the highest rate achieved or evaluate whether the goal was met.

HSAG determined Amerigroup 360°'s reported *Adolescent Well-Child Visits* PIP results were not credible. HSAG was unable to determine whether the PIP's SMART Aim goal was achieved because the SMART Aim measure methodology used in Module 5, at the conclusion of the PIP, was changed from the approved methodology in Module 2. The CMO did not report results for the SMART Aim measure (adolescent well-child visit rates for all eligible members) at the conclusion of the PIP and, instead, reported only intervention-testing results for members who completed a well-child visit at the MAU.

Appropriate Use of ADHD Medications PIP

Module 4: Plan-Do-Study-Act (PDSA) Intervention Testing

Amerigroup 360°'s goal for the *Appropriate Use of ADHD Medications* PIP was to identify and test interventions to improve the 30-day follow-up appointment compliance rate among 6–12-year-old GF 360° members in Fulton County who received an initial ADHD medication. The details of the improvement processes used and the intervention tested are presented in Table 6-33 and in the subsequent narrative.

Table 6-33—Intervention Testing
for *Appropriate Use of ADHD Medications*

Intervention	Key Drivers Addressed	Failure Modes Addressed	Conclusions
Outreach calls to remind the member/caregiver to schedule the 30-day ADHD medication initiation follow-up appointment	ADHD Initiation Phase Follow-up process	Member no-shows	Based on the intervention testing results, the CMO concluded that the intervention was successful for the foster care subgroup of members. The CMO only reported conclusions for this subgroup and did not report conclusions for the eligible population as defined by the SMART Aim statement.

Amerigroup 360° tested one intervention for the PIP: member outreach calls to remind the member/caregiver to schedule the 30-day ADHD medication initiation follow-up appointment. The intervention entailed identifying members who had recently filled an initial ADHD medication prescription and conducting telephone outreach to those members/caregivers to remind them to schedule a 30-day follow-up appointment with the participating provider. The CMO changed several key components of the intervention midway through the testing cycle. When the CMO began testing the intervention, the list of eligible members was generated monthly, and one pharmacy technician conducted outreach calls. In October, the CMO switched to generating the list of eligible members weekly and enlisted a team of care coordinators to conduct the outreach calls. The CMO collected only one subsequent month of data after the changes took place. The CMO should have completed two separate PDSA cycles, with separate Module 4 submission forms, to document the testing of the intervention before and after the substantial changes described above. Because the changes occurred during a single PDSA cycle, it was unclear whether the testing results should be attributed to the initial intervention or the modified intervention.

To test the intervention, Amerigroup 360° tracked the monthly 30-day follow-up visit completion rate among all members who received the intervention, grouping those members into two subgroups: adoption assistance (AA) members and foster care (FC) members. The CMO tracked the ADHD follow-up visit rate among all members who received the intervention and for two subgroups (AA and FC) of members who received the intervention. The CMO concluded that the intervention was effective based on the FC subgroup's results; however, the CMO did not provide an interpretation of effectiveness for the AA subgroup or for the entire population (FC and AA combined) who received the intervention. Based on the CMO's perceived effectiveness of the intervention on the FC subgroup, the CMO chose to adopt the intervention for one subgroup (FC) but did not report whether the intervention would be adopted, adapted, or abandoned for the AA subgroup of members.

Module 5: PIP Conclusions

SMART Aim Measure Outcomes

Table 6-34—SMART Aim Measure Results for *Appropriate Use of ADHD Medications*

SMART Aim Measure	Baseline Rate	SMART Aim Goal Rate	Highest Rate Achieved	Confidence Level
The percentage of members 6–12 years of age in Fulton County who completed a follow-up visit within 30 days of filling a new ADHD medication prescription	50.2%	55.2%	57.6%	*Low Confidence*

The CMO established a goal of improving the ADHD medication follow-up visit rate among members in Fulton County by 5 percentage points, from 50.2 percent to 55.2 percent. One of the PIP's monthly SMART Aim measurements exceeded the goal rate of 55.2 percent.

HSAG assigned Amerigroup 360°'s *Appropriate Use of ADHD Medications* PIP results the level of *Low Confidence*. Although the SMART Aim goal was achieved, the improvement was not clearly linked to the documented quality improvement processes. Several major methodological issues in the PIP prevented the CMO from clearly linking the intervention to the demonstrated improvement in the SMART Aim measure. First, the CMO did not execute a methodologically sound PDSA cycle to test the outreach call intervention. Second, the CMO did not report conclusions about intervention effectiveness for the entire group of members who received the intervention during testing, and instead focused on effectiveness for only one subgroup of members. Finally, the CMO did not report conclusions about the success of the PIP for the entire SMART Aim population and instead focused on reporting success for only one subgroup of the SMART Aim population. The CMO's conclusions for the PIP were flawed because the SMART Aim statement focused on all eligible members in Fulton County; therefore, the CMO should have evaluated the success of the PIP based on the entire eligible population, not based on a subpopulation.

Plan Comparison

For the CY 2016–2017 PIP validation cycle, HSAG validated three PIPs for Amerigroup 360° and four PIPs each for Amerigroup, Peach State, and WellCare. HSAG's validation findings varied by CMO and PIP topic. Among the four CMOs, Amerigroup and Peach State demonstrated the strongest PIP performance by each receiving a level of *High Confidence* for two PIPs and *Confidence* for one other PIP. Only one of Amerigroup's PIPs, *Postpartum Care*, and one of Peach State's PIPs, *Provider Satisfaction*, received a level of *Low Confidence.* The remaining three PIPs conducted by Amerigroup and Peach State achieved the SMART Aim goal, and some or all of the quality improvement processes were clearly linked to the demonstrated improvement. WellCare also demonstrated solid performance on three of four PIPs. Three of WellCare's four PIPs achieved the SMART Aim goal, with one PIP

receiving a level of *High Confidence* and two other PIPs receiving a level of *Confidence*. However, for WellCare's fourth PIP, *Member Satisfaction*, HSAG determined that the reported PIP results were not credible because the CMO did not report final PIP outcomes based on the approved SMART Aim measure methodology. HSAG's validation findings for Amerigroup 360°'s three PIPs demonstrated the greatest opportunities for improvement among the four CMOs. HSAG assigned a level of *Low Confidence* to two of Amerigroup 360°'s PIPs and determined the reported results for the remaining PIP, *Adolescent Well-Child Visits*, were not credible because the CMO did not report final outcomes for the approved SMART Aim measure at the conclusion of the PIP.

Summary of Recommendations

The CDC 6/18 Initiative includes the following recommendations for CMOs:

- CMOs should continue testing the adapted interventions to more clearly determine their impact on the targeted population. The CDC 6/18 initiative had a limited duration of six months.
- The CMOs should ensure detailed, accurate, and consistent documentation of intervention testing results across all project documentation. With the extensive process data reported for the project, HSAG identified minor inconsistencies in some of the numbers reported.
- The CMOs should implement an internal review process of the data analysis and results reporting so that all rates are reported accurately and consistently throughout the project documentation.
- The CMOs should incorporate member and caregiver feedback from initial PDSA cycles into the testing of adapted or new interventions.
- The CMOs should seek technical assistance on how to best represent missing data on a run chart. CMOs should avoid plotting a missing data point on a run chart as zero.
- The CMO should report the numerator and denominator for each data point displayed in the run chart. Including the numerators and denominators for each rate allows for more comprehensive, meaningful analyses.
- When the CMO chooses to adapt an intervention, as part of the Act step in the PDSA process, the CMO should document the specific adaptations planned and describe how the adapted intervention will be tested going forward.

Based on the validation and outcome findings for the DCH PIPs, HSAG offers the following recommendations:

- **CMOs should execute improvement projects according to the approved methodology outlined in the PIP initiation phase.** The methodology established at the outset of the project should serve as a guide for accurately tracking progress toward the SMART Aim goal throughout the life of the PIP. By maintaining the integrity of the approved methodology, the CMOs can ensure the SMART Aim measurements are consistently tracked and documented throughout the project, allowing for an accurate assessment of project results and providing meaningful information for future improvement efforts.

- **CMOs should conduct a series of thoughtful and incremental PDSA cycles during the intervention testing phase of each improvement project.** Prior to testing an intervention, CMOs should conduct upfront analyses to gauge current performance, provide a comparison for assessing the impact of the intervention, and inform necessary testing cycle length. After completing upfront analyses, the CMOs should initiate each PDSA cycle with a methodologically sound evaluation plan using a clearly defined testing measure to ensure actionable testing results. The plan should include a concrete prediction of the anticipated impact of the intervention in the evaluation plan and should incorporate detailed process-level and outcome data to provide a complete understanding of intervention effects. At the end of each PDSA cycle, CMOs should apply lessons learned and begin the cycle again.
- **At the conclusion of the improvement project, CMOs should integrate knowledge gained and apply lessons learned to advance ongoing and future improvement efforts.** For PIPs that did not demonstrate real improvement, the CMOs should convene key PIP team members and stakeholders to review the key driver diagram, process map, and failure modes and effects analysis (FMEA). Considering the PIP results, the team should explore additional barriers, gaps, or failures to address in future improvement efforts. For PIPs that identified effective interventions, the CMOs should pursue avenues for spreading effective interventions beyond the initial scope of the rapid cycle PIP. The CMOs should identify new populations, facilities, or outcomes that could be positively impacted by the interventions. PDSA cycles should be used to test and gradually ramp up intervention dissemination. For PIPs that successfully demonstrated real improvement, CMOs should continue to monitor outcomes beyond the life of the PIP. Ongoing monitoring will enable long-term evaluation of sustained improvement and allow the CMOs to continually refine interventions to achieve and sustain optimal outcomes.

7. CAHPS Surveys

Objectives

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to consumers, such as the communication skills of providers and the accessibility of services. Amerigroup, Peach State, WellCare, and Amerigroup 360° were responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on their behalf. The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on the level of satisfaction that patients have with their healthcare experiences.

Technical Methods of Data Collection and Analysis

Two populations were surveyed for Amerigroup, Peach State, and WellCare: adult Medicaid and child Medicaid. One population was surveyed for Amerigroup 360°: child Medicaid. DSS Research administered the 2017 CAHPS surveys for Amerigroup and Amerigroup 360°. Morpace administered the 2017 CAHPS surveys for Peach State. SPH Analytics administered the 2017 CAHPS surveys for WellCare. All three vendors were NCQA-certified vendors.

The technical method of data collection was through administration of the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (without the Children with Chronic Conditions [CCC] measurement set) to the child Medicaid population. Amerigroup, WellCare, and Amerigroup 360° used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents). Peach State used a mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents) for data collection. Respondents were given the option of completing the survey in Spanish for all CMOs, except for WellCare. Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2017; and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2017.

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all healthcare. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result was denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a

question summary rate (or top-box response). For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior year's results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

Plan-Specific Findings—Amerigroup

Table 7-1 shows Amerigroup's 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 1,755 adult members were administered a survey, of which 263 completed a survey. After ineligible members were excluded, the response rate was 15.4 percent. In 2017, the average NCQA response rate for the adult Medicaid population was 23.3 percent, greater than Amerigroup's response rate.

Table 7-1—Amerigroup Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	83.1%	80.8%
Getting Care Quickly	80.5%	82.1%
How Well Doctors Communicate	92.4%	91.2%
Customer Service	88.0%	86.7%
Shared Decision Making	80.5%	82.1%+
Global Ratings		
Rating of All Health Care	78.0%	77.7%
Rating of Personal Doctor	78.9%	83.7%
Rating of Specialist Seen Most Often	80.3%	91.0%
Rating of Health Plan	72.7%	77.8%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	71.4%	70.7%
Discussing Cessation Medications	42.7%	42.4%
Discussing Cessation Strategies	35.7%	36.4%

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

* These rates follow NCQA's methodology of calculating a rolling two-year average.

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

Amerigroup's adult 2017 global rate for Rating of Specialist Seen Most Often is at least 5 percentage points greater than the 2017 national average.

Amerigroup's 2017 top-box rates for the adult Medicaid population were less than the 2017 NCQA adult Medicaid national averages for six measures:

- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Of these, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* rates were at least 5 percentage points less than the 2017 national averages.

Amerigroup's 2017 top-box rates for the adult Medicaid population exceeded the 2017 NCQA adult Medicaid national averages for six measures:

- *Getting Care Quickly*
- *Shared Decision Making*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Of these, the rate for *Rating of Specialist Seen Most Often* was at least 5 percentage points greater than the 2017 national average.

Amerigroup's rates decreased between 2016 and 2017 for six measures:

- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Customer Service*

- *Rating of All Health Care*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*

None of the measure rates had a substantial decrease of 5 percentage points or more from the 2016 rate.

Amerigroup's rates increased between 2016 and 2017 for six measures:

- *Getting Care Quickly*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*
- *Discussing Cessation Strategies*

Of these, *Rating of Specialist Seen Most Often* and *Rating of Health Plan* showed a substantial increase of 5 percentage points or more.

Table 7-2 shows Amerigroup's 2016 and 2017 child Medicaid CAHPS top-box rates. In 2017, a total of 2,640 child members were administered a survey, of which 613 completed a survey. After ineligible members were excluded, the response rate was 23.7 percent. In 2017, the average NCQA response rate for the child Medicaid population was 22.3 percent, less than Amerigroup's response rate.

Table 7-2—Amerigroup Child Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	83.8%	84.5%
Getting Care Quickly	88.3%	91.0%
How Well Doctors Communicate	91.0%	93.1%
Customer Service	88.6%	88.4%
Shared Decision Making	73.8%	79.6%
Global Ratings		
Rating of All Health Care	88.8%	89.8%
Rating of Personal Doctor	89.6%	89.6%
Rating of Specialist Seen Most Often	88.2%	87.8%
Rating of Health Plan	88.2%	88.7%

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

Amerigroup's 2017 top-box rate for the child Medicaid population was less than the 2017 NCQA child Medicaid national average for one measure:

- *How Well Doctors Communicate*

Amerigroup's 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for seven measures:

- *Getting Care Quickly*
- *Customer Service*
- *Shared Decision Making*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

None of the measure rates were at least 5 percentage points greater or less than the 2017 national averages.

Amerigroup's rates decreased between 2016 and 2017 for two measures:

- *Customer Service*
- *Rating of Specialist Seen Most Often*

Neither rate had a substantial decrease of 5 percentage points or more from the 2016 rate.

Amerigroup's rates increased between 2016 and 2017 for six measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of All Health Care*
- *Rating of Health Plan*

Of these, *Shared Decision Making* showed a substantial increase of 5 percentage points or more.

Plan-Specific Findings—Peach State

Table 7-3 shows Peach State's 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 2,727 adult members were administered a survey, of which 429 completed a survey. After ineligible

members were excluded, the response rate was 16.0 percent. In 2017, the average NCQA response rate for the adult Medicaid population was 23.3 percent, greater than Peach State's response rate.

Table 7-3—Peach State Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	80.5%	79.2%
Getting Care Quickly	77.3%	82.7%
How Well Doctors Communicate	89.8%	92.6%
Customer Service	89.2%+	86.9%
Shared Decision Making	75.8%+	78.0%
Global Ratings		
Rating of All Health Care	77.6%	75.6%
Rating of Personal Doctor	79.1%	84.1%
Rating of Specialist Seen Most Often	78.9%+	78.3%
Rating of Health Plan	75.7%	78.0%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	64.1%	66.7%
Discussing Cessation Medications	31.7%	28.1%
Discussing Cessation Strategies	28.0%	30.6%

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

* These rates follow NCQA's methodology of calculating a rolling two-year average.

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

Peach State's 2017 top-box rates for the adult Medicaid population were less than the 2017 NCQA adult Medicaid national averages for seven measures:

- *Getting Needed Care*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Of these, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies* rates were at least 5 percentage points less than the 2017 national averages.

Peach State's 2017 top-box rates for the adult Medicaid population exceeded the 2017 NCQA adult Medicaid national averages for five measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

None of the measure rates were at least 5 percentage points greater than the 2017 national averages.

Peach State's rates decreased between 2016 and 2017 for five measures:

- *Getting Needed Care*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Discussing Cessation Medications*

None of the measure rates had a substantial decrease of 5 percentage points or more from the 2016 rate.

Peach State's rates increased between 2016 and 2017 for seven measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Health Plan*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Strategies*

Of these, *Getting Care Quickly* and *Rating of Personal Doctor* showed a substantial increase of 5 percentage points or more.

Table 7-4 shows Peach State's 2016 and 2017 child Medicaid CAHPS top-box rates. In 2017, a total of 3,003 child members were administered a survey, of which 770 completed a survey. After ineligible

members were excluded, the response rate was 26.0 percent. In 2017, the average NCQA response rate for the child Medicaid population was 22.3 percent, less than Peach State's response rate.

Table 7-4—Peach State Child Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	83.6%	83.9%
Getting Care Quickly	87.5%	90.9%
How Well Doctors Communicate	92.4%	92.6%
Customer Service	88.7%	90.6%
Shared Decision Making	76.9%	74.3%
Global Ratings		
Rating of All Health Care	87.9%	88.6%
Rating of Personal Doctor	90.7%	90.0%
Rating of Specialist Seen Most Often	87.1%+	84.7%
Rating of Health Plan	89.3%	90.3%

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

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

Peach State's 2017 top-box rates for the child Medicaid population were less than the 2017 NCQA child Medicaid national averages for four measures:

- *Getting Needed Care*
- *How Well Doctors Communicate*
- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*

Peach State's 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for five measures:

- *Getting Care Quickly*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

None of the measure rates were at least 5 percentage points greater or less than the 2017 national average.

Peach State's rates decreased between 2016 and 2017 for three measures:

- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

Peach State's rates increased between 2016 and 2017 for six measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Health Plan*

None of the measure rates had a substantial increase or decrease of 5 percentage points or more from the 2016 rate.

Plan-Specific Findings—WellCare

Table 7-5 shows WellCare's 2016 and 2017 adult Medicaid CAHPS top-box rates. In 2017, a total of 2,107 adult members were administered a survey, of which 228 completed a survey. After ineligible members were excluded, the response rate was 11.0 percent. In 2017, the average NCQA response rate for the adult Medicaid population was 23.3 percent, greater than WellCare's response rate.

Table 7-5—WellCare Adult Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	81.7%	81.8%
Getting Care Quickly	78.6%	87.3%
How Well Doctors Communicate	91.4%	93.3%
Customer Service	85.0%	89.0%+
Shared Decision Making	80.1%+	81.8%+
Global Ratings		
Rating of All Health Care	77.6%	72.5%

	2016 Top-Box Rates	2017 Top-Box Rates
Rating of Personal Doctor	79.1%	84.4%
Rating of Specialist Seen Most Often	84.2%	80.0%+
Rating of Health Plan	80.9%	78.7%
Effectiveness of Care*		
Advising Smokers and Tobacco Users to Quit	73.9%	72.5%
Discussing Cessation Medications	33.1%	29.6%
Discussing Cessation Strategies	30.1%	27.4%

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

* These rates follow NCQA's methodology of calculating a rolling two-year average.

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

WellCare's adult composite measure rate for Getting Care Quickly was at least 5 percentage points greater than the 2017 national average.

WellCare's 2017 top-box rates for the adult Medicaid population were less than the 2017 NCQA adult Medicaid national averages for six measures:

- *Getting Needed Care*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Of these, *Discussing Cessation Medications* and *Discussing Cessation Strategies* were at least 5 percentage points less than the 2017 national averages.

WellCare's 2017 top-box rates for the adult Medicaid population exceeded the 2017 NCQA adult Medicaid national averages for six measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*

- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Of these, the *Getting Care Quickly* rate was at least 5 percentage points greater than the 2017 national average.

WellCare's rates decreased between 2016 and 2017 for six measures:

- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*
- *Advising Smokers and Tobacco Users to Quit*
- *Discussing Cessation Medications*
- *Discussing Cessation Strategies*

Of these, *Rating of All Health Care* showed a substantial decrease of 5 percentage points or more.

WellCare's rates increased between 2016 and 2017 for six measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Of these, *Getting Care Quickly* and *Rating of Personal Doctor* showed a substantial increase of 5 percentage points or more.

Table 7-6 shows WellCare's 2016 and 2017 child Medicaid CAHPS top-box rates. In 2017, a total of 1,898 child members were administered a survey, of which 303 completed a survey. After ineligible members were excluded, the response rate was 16.1 percent. In 2017, the average NCQA response rate for the child Medicaid population was 22.3 percent, greater than WellCare's response rate.

Table 7-6—WellCare Child Medicaid CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	85.2%	88.0%
Getting Care Quickly	90.4%	94.4%
How Well Doctors Communicate	93.0%	96.2%
Customer Service	87.4%	94.9%
Shared Decision Making	76.8%	71.8%+
Global Ratings		
Rating of All Health Care	90.1%	88.9%
Rating of Personal Doctor	90.8%	89.4%
Rating of Specialist Seen Most Often	84.5%+	81.2%+
Rating of Health Plan	86.5%	87.3%

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

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

WellCare's child composite measure rates for both Getting Care Quickly and Customer Service were at least 5 percentage points greater than the 2017 national average.

WellCare's 2017 top-box rates for the child Medicaid population were less than the 2017 NCQA child Medicaid national averages for two measures:

- *Shared Decision Making*
- *Rating of Specialist Seen Most Often*

Moreover, both were at least 5 percentage points less than the 2017 national averages.

WellCare's 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for seven measures:

- *Getting Needed Care*
- *Getting Care Quickly*

- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Health Plan*

Of these, *Getting Care Quickly* and *Customer Service* were at least 5 percentage points greater than the 2017 national averages.

WellCare's rates decreased between 2016 and 2017 for four measures:

- *Shared Decision Making*
- *Rating of All Health Care*
- *Rating of Personal Doctor*
- *Rating of Specialist Seen Most Often*

Of these, *Shared Decision Making* showed a substantial decrease of 5 percentage points or more.

WellCare's rates increased between 2016 and 2017 for five measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of Health Plan*

Of these, *Customer Service* showed a substantial increase of 5 percentage points or more.

Plan-Specific Findings—Amerigroup 360°

Table 7-7 shows Amerigroup 360°'s 2016 and 2017 child Medicaid CAHPS top-box rates. In 2017, a total of 2,640 child members were administered a survey, of which 580 completed a survey. After ineligible members were excluded, the response rate was 22.2 percent. In 2017, the average NCQA response rate for the child Medicaid population was 22.3 percent, slightly higher than Amerigroup 360°'s response rate.

Table 7-7—Amerigroup 360° CAHPS Results

	2016 Top-Box Rates	2017 Top-Box Rates
Composite Measures		
Getting Needed Care	88.8%	88.8%
Getting Care Quickly	93.8%	95.1%
How Well Doctors Communicate	97.1%	97.2%
Customer Service	87.0%	90.6%
Shared Decision Making	80.9%	80.2%
Global Ratings		
Rating of All Health Care	84.4%	86.3%
Rating of Personal Doctor	91.7%	91.6%
Rating of Specialist Seen Most Often	85.5%	86.5%
Rating of Health Plan	73.6%	79.8%

Indicates the 2017 rate is at least 5 percentage points greater than the 2017 national average.

Indicates the 2017 rate is at least 5 percentage points less than the 2017 national average.

Amerigroup 360°'s composite measure rate for Getting Care Quickly was at least 5 percentage points greater than the 2017 national average.

Amerigroup 360°'s 2017 top-box rates for the child Medicaid population were less than the 2017 NCQA child Medicaid national averages for three measures:

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

Of these, the *Rating of Health Plan* rate was at least 5 percentage points less than the 2017 national average.

Amerigroup 360°'s 2017 top-box rates for the child Medicaid population exceeded the 2017 NCQA child Medicaid national averages for six measures:

- *Getting Needed Care*
- *Getting Care Quickly*
- *How Well Doctors Communicate*

- *Customer Service*
- *Shared Decision Making*
- *Rating of Personal Doctor*

Of these, the rate for *Getting Care Quickly* was at least 5 percentage points greater than the 2017 national average.

Amerigroup 360°'s rates decreased between 2016 and 2017 for two measures:

- *Shared Decision Making*
- *Rating of Personal Doctor*

Neither of these rates showed a substantial decrease of more than 5 percentage points.

Amerigroup 360°'s rates increased between 2016 and 2017 for six measures:

- *Getting Care Quickly*
- *How Well Doctors Communicate*
- *Customer Service*
- *Rating of All Health Care*
- *Rating of Specialist Seen Most Often*
- *Rating of Health Plan*

Of these, *Rating of Health Plan* showed a substantial increase of more than 5 percentage points.

Plan Comparisons

To identify performance differences in member satisfaction between the three CMOs, the results for Amerigroup, Peach State, and WellCare were compared to the Georgia CMO program average using standard tests for statistical significance.[7-1] For this comparison, results were case-mix adjusted. Case-mix refers to the characteristics of respondents used in adjusting the results for comparability among CMOs. Results for the CMOs were case-mix adjusted for the member's general health status, respondent educational level, and respondent age.[7-2] Given that differences in case-mix can result in differences in ratings between CMOs that are not due to differences in quality, the data were adjusted to account for

[7-1] Caution should be exercised when evaluating plan comparisons, given that population and plan differences may impact CAHPS results.

[7-2] Agency for Healthcare Research and Quality. *CAHPS Health Plan Survey and Reporting Kit 2008*. Rockville, MD: US Department of Health and Human Services, July 2008.

disparities in these characteristics. The case-mix adjustment was performed using standard regression techniques (i.e., covariance adjustment).

The scoring of the global ratings, composite measures, and individual item measures involved assigning top-level (or top-box response) responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the percentage of top-level responses was calculated to determine the question summary rates and global proportions. For additional detail, please refer to NCQA's *HEDIS 2017 Volume 3: Specifications for Survey Measures*.

Statistically significant differences are noted in the tables by arrows. A measure rate statistically significantly greater than the Georgia CMO program average is denoted with an upward (↑) arrow. Conversely, a measure rate statistically significantly less than the Georgia CMO program average is denoted with a downward (↓) arrow. A measure rate that is not statistically significantly different than the Georgia CMO program average is denoted with a horizontal (↔) arrow.

For this report, CAHPS scores are reported for measures even when NCQA's minimum reporting threshold of 100 respondents was not met; therefore, caution should be exercised when interpreting these results. CAHPS scores with fewer than 100 respondents are denoted with a cross (+).

Table 7-8 shows the results of the plan comparisons analysis of the 2017 adult Medicaid CAHPS top-box rates.

Table 7-8—Adult Medicaid Plan Comparisons

	Amerigroup	Peach State	WellCare
Composite Measures			
Getting Needed Care	80.8% ↔	79.2% ↔	81.8% ↔
Getting Care Quickly	82.1% ↔	82.7% ↔	87.3% ↔
How Well Doctors Communicate	91.2% ↔	92.6% ↔	93.3% ↔
Customer Service	86.7% ↔	86.9% ↔	89.0% + ↔
Shared Decision Making	82.1% + ↔	78.0% ↔	81.8% + ↔
Global Ratings			
Rating of All Health Care	77.7% ↔	75.6% ↔	72.5% ↔
Rating of Personal Doctor	83.7% ↔	84.1% ↔	84.4% ↔
Rating of Specialist Seen Most Often	91.0% ↑	78.3% ↔	80.0% + ↔
Rating of Health Plan	77.8% ↔	78.0% ↔	78.7% ↔

\+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.
↑ Indicates the CMO's score is statistically greater than the Georgia CMO program average.
↔ Indicates the CMO's score is not statistically significantly different than the Georgia CMO program average.
↓ Indicates the CMO's score is statistically less than the Georgia CMO program average.

Summary of Adult Medicaid Plan Comparisons Results

The adult Medicaid plan comparisons revealed the following statistically significant results:

- Amerigroup's score was statistically significantly greater than the Georgia CMO program average on one CAHPS measure, *Rating of Specialist Seen Most Often*.

Table 7-9 shows the results of the plan comparisons analysis of the 2017 child Medicaid CAHPS top-box rates.

Table 7-9—Child Medicaid Plan Comparisons

	Amerigroup	Peach State	WellCare
Composite Measures			
Getting Needed Care	84.5% ⇔	83.9% ⇔	88.0% ⇔
Getting Care Quickly	91.0% ⇔	90.9% ⇔	94.4% ⇔
How Well Doctors Communicate	93.1% ⇔	92.6% ⇔	96.2% ↑
Customer Service	88.4% ↓	90.6% ⇔	94.9% ↑
Shared Decision Making	79.6% ⇔	74.3% ⇔	71.8% + ⇔
Global Ratings			
Rating of All Health Care	89.8% ⇔	88.6% ⇔	88.9% ⇔
Rating of Personal Doctor	89.6% ⇔	90.0% ⇔	89.4% ⇔
Rating of Specialist Seen Most Often	87.8% ⇔	84.7% ⇔	81.2% + ⇔
Rating of Health Plan	88.7% ⇔	90.3% ⇔	87.3% ⇔

\+ CAHPS scores with fewer than 100 respondents are denoted with a cross (+). Due to the low response rate, caution should be exercised when interpreting results for those measures.
↑ Indicates the CMO's score is statistically better than the Georgia CMO program average.
⇔ Indicates the CMO's score is not statistically significantly different than the Georgia CMO program average.
↓ Indicates the CMO's score is statistically worse than the Georgia CMO program average.

Summary of Child Medicaid Plan Comparisons Results

The child Medicaid plan comparisons revealed the following statistically significant results:

- Amerigroup's score was statistically significantly less than the Georgia CMO program average on one CAHPS measure, *Customer Service*.
- WellCare's score was statistically significantly greater than the Georgia CMO program average on two CAHPS measures: *How Well Doctors Communicate* and *Customer Service*.

Conclusions and Recommendations

Amerigroup

For the adult population, HSAG recommends that Amerigroup focus quality improvement initiatives on improving the medical assistance it provides related to smoking and tobacco use cessation (i.e., the Effectiveness of Care measures—*Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*) since these rates fell below NCQA's 2017 CAHPS adult Medicaid national averages by at least 5 percentage points. In addition, Amerigroup could focus efforts on improving the rates for *Getting Needed Care*, *How Well Doctors Communicate*, and *Customer Service* since they were lower than both 2016 adult CAHPS results and NCQA 2017 CAHPS adult Medicaid national averages.

Since the global ratings for *Rating of Personal Doctor* and *Rating of Specialist Seen Most Often* improved (indicating that the CMO's members were satisfied with their providers' care), Amerigroup has an opportunity to work with these providers and specialists to improve rates for the adult Effectiveness of Care measures. For those patients who smoke or use tobacco, providers could discuss strategies on how to quit smoking and tobacco use. Amerigroup may also identify opportunities to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns.

For the child Medicaid population, Amerigroup should focus on improving the rate for the *How Well Doctors Communicate* measure since it fell below the NCQA 2017 CAHPS child Medicaid national average. Additionally, efforts should focus on improving *Customer Service* and *Rating of Specialist Seen Most Often* measure rates since they decreased between 2016 and 2017.

Interventions targeted at the provider level and toward provider communication and interaction with Medicaid members most likely will have the greatest impact on the CAHPS measures.

Peach State

HSAG recommends that Peach State focus quality improvement initiatives on enhancing members' experiences with *Getting Needed Care*, *Customer Service*, *Rating of Specialist Seen Most Often*, and *Discussing Cessation Medications* for the adult Medicaid population, since these rates were less than the 2016 adult CAHPS results and fell below NCQA's 2017 CAHPS adult Medicaid national averages. Peach State should focus quality improvement initiatives on improving providing medical assistance with smoking and tobacco use cessation (*Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*), since these rates fell below NCQA's 2017 CAHPS adult Medicaid national averages by at least 5 percentage points.

Peach State's Adult Effectiveness of Care measures all fell at least 5 percentage points less than the 2017 national average. Peach State adult members improved the Global Rating for *Rating of Personal*

Doctor by 5 percentage points. Because members rate their personal doctor high, Peach State has an opportunity to work with primary care providers for smoking and tobacco-using members to discuss smoking cessation medications and strategies that may help their patients to quit smoking and tobacco use. Peach State may also identify opportunities to collaborate with public health and community organization work related to smoking and tobacco secession campaigns.

For the child Medicaid population, Peach State should focus on improving the *Shared Decision Making* and *Rating of Specialist Seen Most Often* rates since these rates were less than the 2016 child CAHPS result and fell below NCQA's 2017 CAHPS child Medicaid national averages. In addition, Peach State should look to improve *Getting Needed Care* and *How Well Doctors Communicate* measure rates since they also fell below the NCQA 2017 child Medicaid national averages.

CAHPS measures such as *How Well Doctors Communicate*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, *Discussing Cessation Strategies*, and *Shared Decision Making* would be most affected by targeting interventions at the provider level.

WellCare

HSAG recommends that WellCare focus quality improvement initiatives on enhancing members' experiences with *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medication*, and *Discussing Cessation Strategies* for the adult Medicaid population since these rates were lower than the 2016 adult CAHPS results and fell below NCQA's 2017 CAHPS adult Medicaid national averages. WellCare's rates for two of the adult Effectiveness of Care measures (*Discussing Cessation Medications* and *Discussing Cessation Strategies*) fell below the NCQA 2017 CAHPS adult Medicaid national averages by at least 5 percentage points. Also, the *Rating of All Health Care* measure rate showed a substantial decrease of at least 5 percentage points between 2016 and 2017.

Since the global rating for *Rating of Personal Doctor* improved (indicating that the CMO's members were satisfied with their providers' care), WellCare has an opportunity to work with these providers to improve rates for the adult Effectiveness of Care measures. For those patients who smoke or use tobacco, providers could discuss strategies on how to quit smoking and tobacco use. WellCare may also identify opportunities to collaborate with public health and community organizations and their work related to smoking and tobacco cessation campaigns.

For the child Medicaid population, WellCare should focus on improving rates for the *Shared Decision Making* and *Rating of Specialist Seen Most Often* measures since the rates were lower than the 2016 child CAHPS result and fell below NCQA's 2017 CAHPS child Medicaid national averages (both by at least 5 percentage points). Furthermore, the rate for *Shared Decision Making* showed a substantial decrease of at least 5 percentage points between 2016 and 2017.

WellCare's *Getting Care Quickly* and *Customer Service* child composite measure rates exceeded the 2017 national average by at least 5 percentage points. WellCare should identify best practices to share

with DCH and the other CMOs that may improve satisfaction with care and services received through the GF program.

Rates for WellCare's child composite measure, *Shared Decision Making*, and its global rating measure, *Rating of Specialist Seen Most Often*, were at least 5 percentage points below the 2017 national average. WellCare should review its internal data related to complaints, grievances, and quality of care concerns to identify trends or opportunities to improve care and services provided by specialists. In addition, WellCare may wish to use member focus groups or targeted provider education to better understand and provide information to providers about involving members and their caregivers in decision making regarding the member's care and services. Including the member's voice in quality improvement provides an opportunity for WellCare to target specific areas that may improve satisfaction with the specialist seen most often as well as ensuring members perceive that they participate in making healthcare decisions with their providers.

Amerigroup 360°

For the child Medicaid population, Amerigroup 360° should focus on improving the *Rating of Health Plan* measure rate since the rate for this measure was at least 5 percentage points lower than NCQA's 2017 CAHPS child Medicaid national average. Additionally, efforts should focus on improving the *Rating of All Health Care* and *Rating of Specialist Seen Most Often* measure rates since they were lower than NCQA's 2017 CAHPS child Medicaid national averages. Amerigroup 360° should conduct a root cause analysis of indicators identified as areas of low performance and devise potential improvement strategies.

The rate for Amerigroup 360°'s child composite measure, *Getting Care Quickly*, was at least 5 percentage points greater than the 2017 national average. Amerigroup 360° has an opportunity to review and determine what best practices (e.g., network, providers maintaining same-day appointment schedules) have resulted in members perceiving that they receive care quickly. The *Rating of Health Plan* measure rate was at least 5 percentage points less than the 2017 national average. Amerigroup 360° may want to consider implementing best practices used by its sister organization, Amerigroup—which had higher rates for this measure.

8. Follow-Up on Recommendations

Introduction

This section of the EQR annual report presents an assessment of how effectively the CMOs and DCH addressed the recommendations that HSAG made based on the results of the CY 2017 EQR activities.

Compliance With Standards Review

The DCH reviewed each of the corrective action plans (CAPs) that resulted from the compliance with standards review activities and clarified program requirements for the CMOs. The DCH approved the CAPs submitted by the CMOs. HSAG conducted follow-up reviews from previous noncompliant review findings at each annual Compliance with Standards review. In CY 2015, the corrective actions implemented by the CMOs for the prior years' noncompliant findings resulted in compliance scores ranging from 0 percent to 50 percent. In CY 2016, the CMOs' corrective actions from the prior years' noncompliant findings resulted in compliance scores ranging from 25 percent to 84 percent. In CY 2017, the CMOs' corrective actions from the prior years' noncompliant findings resulted in compliance scores ranging from 62.5 percent to 91.7 percent.

The CMOs' corrective actions improved compliance from the prior years' noncompliant findings from 0 to 50 percent in CY 2015 to 62.5 to 91.7 percent in CY 2017.

Amerigroup Follow-Up on Corrective Action-Specific Findings

During the CY 2017 compliance with standards review, HSAG reviewed documentation provided by Amerigroup to determine whether the CMO had met the intent of the CAPs DCH approved for *Not Met* elements from the previous noncompliant review findings. HSAG's review found that the Amerigroup CAPs were implemented for the Member Information and Disenrollment Requirements and Limitations standards and received a *Met* status upon reevaluation. The CMO required continued corrective actions for the Grievance System and Furnishing of Services standards. The summary below describes the areas that require continued corrective actions.

- Amerigroup must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters. The CMO should write separate letters that are specific for provider and the member.
- Amerigroup must continue to apply current and new interventions with providers until the goal of returning urgent calls within 20 minutes and routine calls within one hour is achieved at least 90 percent of the time.

- Amerigroup must continue efforts to close its network adequacy gaps by implementing new network strategies and keep DCH informed of its progress. Amerigroup must meet the geographic standards for both urban and rural areas for primary care providers, specialists, oral health providers, mental health providers, and pharmacies.

Amerigroup's QAPI evaluation indicated that Amerigroup was working to identify network deficiencies and to use telemedicine to address various specialty gaps. Amerigroup conducted an extensive network analysis that identified members who used the emergency department and reviewed the cases to determine if more frequent use may have resulted from gaps in the provider network. Amerigroup was unable to identify network gaps as a cause of frequent emergency department utilization. Amerigroup also reviewed member complaints regarding access to care. Amerigroup's analysis indicated that the counties where the members resided met the network requirement standards for primary care providers.

Peach State Follow-Up on Corrective Action-Specific Findings

HSAG reviewed documentation during the CY 2017 compliance with standards review that were provided by Peach State to determine whether the CMO had met the intent of the CAPs DCH approved for *Not Met* elements from the previous noncompliant review findings. HSAG's review found that Peach State's CAPs were implemented for the Grievance System standard and received a *Met* status upon reevaluation. The CMO required continued corrective actions for the Member Information and Furnishing of Services. Below is a summary of the areas that require continued corrective actions.

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

Peach State's QAPI evaluation indicated that Peach State has expanded its use of mobile applications to support members in finding a provider, accessing care gaps, and in scheduling provider appointments. Peach State used MyHealthDirect, which allowed members to use web-based appointment scheduling with MyHealthDirect-enrolled providers. Peach State also worked to fill network gaps through the use of a telehealth network by partnering with the Georgia Partnership for Telehealth.

WellCare Follow-Up on Corrective Action-Specific Findings

HSAG reviewed documentation provided by WellCare during the CY 2017 compliance with standards review to determine whether the CMO had met the intent of the CAPs DCH approved for *Not Met* elements from the previous noncompliant review findings. HSAG's review found that the WellCare CAPs that were implemented for the Grievance System standard and received a *Met* status upon reevaluation. The CMO required continued corrective actions for the Furnishing of Services standard. Below is a summary of the area that requires continued corrective actions.

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

WellCare's QAPI evaluation indicated that WellCare used several activities to ensure access to care for members in areas that had identified network gaps. WellCare used care coordinators to assist members in receiving supplies and medical equipment and to assist members in scheduling soonest available appointments with providers. WellCare also offered members the MyWellCare mobile application, which allowed them to find a provider. WellCare also used telemedicine for responding to long-term provider shortages, particularly in rural areas. WellCare partnered with the Georgia Partnership for Telehealth to make community investments in telemedicine equipment to support the expansion of telemedicine in rural areas of the State.

Amerigroup 360° Follow-Up on Corrective Action-Specific Findings

During the CY 2017 compliance with standards review, HSAG reviewed documentation provided by Amerigroup 360° to determine whether the CMO had met the intent of the corrective action plans DCH approved for *Not Met* elements from the previous noncompliant review findings. HSAG's review found that the Amerigroup 360°'s corrective action plans that were implemented for the Provider Selection, Credentialing, and Recredentialing; Member Information; and Disenrollment Requirements and Limitations standards received a *Met* status upon reevaluation. The CMO required continued corrective actions for the Grievance System standard. Below is a summary of the area that requires continued corrective actions.

- Amerigroup 360° must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters.

Amerigroup 360°'s QAPI evaluation did not address any activities or initiatives that were implemented or used in order to ensure that administrative review resolution letters for members were written in easily understood language.

Validation of Performance Measures

The RY 2016 validation of performance measures activity identified several areas of improvement related to measure indicator rates. The CMOs were to focus interventions on those areas for which measure indicator rates did not meet performance targets.

A summary of emerging practices and opportunities for improvement for the CMOs is included in this section. Emerging practices and improvement are defined as a performance level that is at or above the national Medicaid 75th percentile. For the performance measures that demonstrated this performance level, HSAG reviewed the CMOs' QAPI evaluations to identify the types of interventions and quality improvement initiatives that the CMOs used to positively impact the performance measure rates and ultimately improve access to care and the quality and timeliness of care.

Performance Measure Emerging Practices and Improvement

The following RY 2017 performance measure rate levels were at or above the national Medicaid 75th percentile:

Amerigroup

- *Annual Dental Visit*
  - *2–3 Years*
  - *4–6 Years*
  - *7–10 Years*
  - *11–14 Years*
  - *15–18 Years*
  - *Total*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *Counseling for Physical Activity—Total*
- *Well-Child Visits in the first 15 Months of Life*
  - *Six or More Well-Child Visits*
- *Prenatal and Postpartum Care*
  - *Postpartum Care*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Follow-Up Care for Children Prescribed ADHD Medication*
  - *Continuation and Maintenance Phase*
- *Annual Monitoring for Patients on Persistent Medications*
  - *ACE Inhibitors or ARBs*

Amerigroup's positive performance measure rate levels may have been a result of the following activities:

- Amerigroup used an auto-dialer to conduct EPSDT outreach calls focused on children's health issues and increasing preventive health visits, including immunizations and preventive dental services. Amerigroup customer service staff were able to successfully connect with over 40 percent of members called using the auto-dialer system.
- Amerigroup used an interactive voice response call campaign to connect with pregnant women to encourage them to receive prenatal and postpartum care. Amerigroup also offered pregnant members incentives if they completed prenatal and postpartum visits. Additionally, Amerigroup offered incentives to providers to reach out to pregnant members in order to receive maternity services and also continued the use of an obstetrical quality improvement pay-for-performance program that was implemented in 2016.
- Amerigroup used strategy meetings with its dental vendor to target members due for preventive dental services as well as members who were at risk for dental caries. Amerigroup conducted member education on the importance of sealants for appropriate age groups. Amerigroup also conducted a dental data analysis to identify low-performing counties and completed a drill-down analysis to target population by age, race, and region.
- The CMO continued outreach efforts to educate members on the importance of preventive screenings and preventive services such as immunization and well visits.
- The CMO collaborated with the pharmacy department to develop a gap-in-care report for antidepressant medication management and attention-deficit/hyperactivity disorder (ADHD) to distribute reminders for providers to schedule follow-up appointments with members.
- The CMO continued interventions focused on access to behavioral and physical health services. The interventions included member incentives for completing follow–up visits, partnering with hospitals that had a high number of discharges to proactively schedule follow-up visits, and reminder letters to providers that prescribed ADHD or antidepressant medications to remind them to schedule follow-up appointments for members who were prescribed these medications.

Peach State

Peach State's RY 2017 performance measure rate levels that were at or above the national Medicaid 75th percentile:

- *Annual Dental Visit*
  - *4–6 Years*
  - *7–10 Years*
  - *11–14 Years*
  - *15–18 Years*
  - *Total*
- *Appropriate Testing for Children With Pharyngitis*

- *Immunizations for Adolescents Combination 1 (Meningococcal, Tdap)*
- *Lead Screening in Children*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Chlamydia Screening in Women—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*

Peach State's positive performance measure rate levels may have been a result of the following activities:

- Peach State's monthly monitoring indicated that the Southeast Georgia Families Region had lower compliance rates for HEDIS children's and adolescents' well visits and adolescent immunizations than any other region in Georgia. The CMO emailed noncompliant members in the Southeast Region with messages encouraging them to receive their preventive visit and offered a nominal incentive if the member completed the preventive service or visit.
- Peach State identified that Southern Crescent Pediatrics serviced a high volume of Hispanic/Latino members and had a low compliance rate for well-child visits for children between 3 and 21 years of age. The CMO contacted members and scheduled member appointments with this practice for adolescent immunizations and well visits.
- Peach State's monthly administrative rates indicated that African American males in the Southwest Region had the lowest rate for adolescent well-care visits of all regions. The CMO performed live outreach to caregivers of Black or African American males in the Southwest Region.
- Peach State activities focused on improving the well child, adolescent, and CMS 416 performance measure rates included providing gift cards to members for completing well visits; email campaigns for members who were not compliant with recommended well visits; and completing live calls to members and using MyHealthDirect, a scheduling system used to assist members with scheduling well-visit appointments with their primary care provider. The CMO also conducted in-person events such as Peach State Days (clinic days) in which members were invited to receive their due/past due preventive health services. Peach State also used a care gap alert program that notified staff of missed services/screening opportunities so that they could contact members and help them, whenever possible, schedule an appointment with their provider.
- The CMO worked with practitioners to improve use and adherence to the clinical practice guidelines (CPGs). The CMO's staff also collaborated to improve diabetic control in the Southwest Region by planning and implementing a Diabetes Wellness Day to empower members to better manage their diabetes. Peach State also collaborated with Phoebe Physician Group in Albany (Southwest Region) to conduct a small pilot that included mailing a diabetes action plan and trackers to Phoebe Physician Group members to encourage diabetes self-management and to reinforce the importance of checking HbA1c levels and discussing the results with their provider.
- The CMO also discussed with providers the opportunity to include diabetes CPGs in the electronic medical record to assist them with following the guidelines.

WellCare

Well Care's RY 2017 performance measure rate levels that were at or above the national Medicaid 75th percentile:

- *Annual Dental Visit*
  - *2–3 Years*
  - *4–6 Years*
  - *7–10 Years*
  - *11–14 Years*
  - *15–18 Years*
  - *19–20 Years*
  - *Total*
- *Appropriate Testing for Children With Pharyngitis*
- *Childhood Immunization Status—Combination 3*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Lead Screening in Children*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Breast Cancer Screening*
- *Cervical Cancer Screening*
- *Comprehensive Diabetes Care—Medical Attention for Nephropathy*
- *Follow-Up Care for Children Prescribed ADHD Medication*
  - *Initiation Phase*
  - *Continuation and Maintenance Phase*

WellCare's positive performance measure rate level may have been a result of the following activities:

- WellCare focused attention on a review of care gap reports and stressing the need to discuss care gaps during each and every call with members. WellCare updated its care gap call scripts to ensure appropriate member messaging.
- WellCare continued the use of social media campaigns on Facebook and Twitter on a variety of health topics including influenza shots, immunizations, well-child visits and screenings, dental checkups, sickle cell disease, and mental health topics including depression, anxiety, stress reduction, and World Mental Health Day. WellCare also participated in Head Start's Fall Festival.
- WellCare conducted an in-depth analysis of members with behavioral health conditions, including those diagnosed with depression or ADHD. The analysis was used to develop a quality improvement project focused on the behavioral health case management program.

- WellCare also focused interventions on decreasing parental refusal of immunizations for children and adolescents. In addition, WellCare implemented social media messaging with information on topics such as weight management, tobacco use and cessation tips, farmers markets, heart disease, diabetes, women's health, dental screenings, and immunizations.

Amerigroup 360°

Amerigroup 360°'s RY 2017 performance measure rate levels that were at or above the national Medicaid 75th percentile:

- *Annual Dental Visit*
  - *2–3 Years*
  - *4–6 Years*
  - *7–10 Years*
  - *11–14 Years*
  - *15–18 Years*
  - *Total*
- *Appropriate Testing for Children with Pharyngitis*
- *Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)*
- *Medication Management for People with Asthma*
  - *Medication Compliance 50%—Ages 5–11 Years*
  - *Medication Compliance 50%—Ages 12–18 Years*
  - *Medication Compliance 75%—Ages 5–11 Years*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents*
  - *BMI Percentile—Total*
  - *Counseling for Nutrition—Total*
  - *Counseling for Physical Activity—Total*
- *Children and Adolescents' Access to Primary Care Practitioners*
  - *12–24 Months*
  - *25 Months–6 Years*
- *Follow-Up After Hospitalization for Mental Illness*
  - *30-Day Follow-Up*
- *Initiation and Engagement of Alcohol and Other Drug (AOD) Dependence Treatment*
  - *Initiation of AOD Treatment—Total*
  - *Engagement of AOD Treatment—Total*
- *Lead Screening in Children*
- *Follow-Up Care for Children Prescribed ADHD Medications*

- *Continuation and Maintenance Phase*
- *Initiation Phase*

Amerigroup 360°'s positive performance measure rate level may have been a result of the following activities:

- Amerigroup 360° used an auto-dialer to conduct EPSDT outreach calls focused on children's health issues and increasing preventive health visits, including immunizations and preventive dental services. Amerigroup 360°'s customer service staff was able to successfully connect with over 40 percent of members called using the auto-dialer system.
- Amerigroup 360° used strategy meetings with its dental vendor to target members due for preventive dental services as well as members who were at risk for dental caries. Amerigroup 360° conducted member education on the importance of sealants for appropriate age groups. Amerigroup 360° also completed a dental data analysis to identify low-performing counties and completed a drill-down analysis to target its population by age, race, and region.
- The CMO collaborated with the pharmacy department to develop a gap-in-care report for antidepressant medication management and ADHD medications to distribute reminders to remind providers to schedule follow-up appointments with members.
- The CMO continued interventions focused on access to behavioral and physical health services. The interventions included member incentives for completing follow-up visits, partnering with hospitals that had a high number of discharges to proactively schedule follow-up visits, and reminder letters to providers that prescribed ADHD or antidepressant medications to remind them to schedule follow-up appointments for members who were prescribed these medications.

Performance Improvement Projects

The 2017 External Quality Review Annual Report offered recommendations for the CMOs based on their performance on the calendar year 2015 PIPs. PIPs are conducted on a calendar year cycle; therefore, CY in the PIP section refers to calendar year. The CMOs had the opportunity to address HSAG's recommendations by applying the recommended quality improvement processes and strategies in their CY 2016 PIPs. The CY 2016 PIPs were entirely new projects that addressed new topics. Also of note, DCH reduced the number of PIPs required of Amerigroup, Peach State, and WellCare from eight PIPs in CY 2015 to four PIPs in CY 2016. Amerigroup 360° was required to implement three PIPs during each year. Overall, the reduction in the number of required PIPs was associated with the CMOs' ability to address many of the recommendations and improve PIP performance.

Amerigroup

The 2017 External Quality Review Annual Report summarized the validation findings for Amerigroup's eight CY 2015 PIPs. HSAG assigned a confidence level to each PIP, representing the overall validity and reliability of the PIP results. Among the eight CY 2015 PIPs, three PIPs received the level of

Confidence and the remaining five PIPs received the level of *Low Confidence*. The SMART Aim goal was achieved for each PIP, but not all quality improvement processes were clearly linked to the demonstrated improvement; therefore, none of the PIPs received the level of *High Confidence*. HSAG's recommendations focused on Module 4 (Plan-Do-Study-Act) and the planning and executing of PDSA cycles to test interventions. To clearly determine the impact of an intervention and link it to improvement in the SMART Aim measure, the CMO must use a methodologically sound approach for the PDSA cycle.

HSAG's validation findings for Amerigroup's four CY 2016 PIPs suggest that the CMO improved its PIP performance overall. Among the four CY 2016 PIPs, two PIPs received the level of *High Confidence*, compared to none of the CY 2015 PIPs receiving *High Confidence*. Amerigroup successfully incorporated HSAG's recommendations into two of the CY 2016 PIPs by conducting methodologically sound PDSA cycles, meeting the SMART Aim goal for each PIP, and clearly linking the quality improvement processes to demonstrated improvement. Among the remaining two PIPs, one PIP received the level of *Confidence*, and the remaining PIP received the level of *Low Confidence*. The validation findings for these two PIPs suggest that Amerigroup continues to have opportunities for improvement in addressing HSAG's recommendations and applying the rapid cycle PIP approach.

Peach State

In the 2017 External Quality Review Annual Report, HSAG summarized the validation findings for Peach State's eight CY 2015 PIPs. The assigned confidence level for each PIP represented the overall validity and reliability of the PIP results. Among the eight CY 2015 PIPs, two PIPs received the level of *Confidence*, four PIPs received the level of *Low Confidence*, and HSAG determined the results of the remaining two PIPs were not credible. The validation findings suggested that Peach State had many opportunities for improvement in PIP performance; none of the PIPs received the level of *High Confidence*, and HSAG determined that the reported results for two PIPs were not credible because the CMO did not follow the approved methodology. For some PIPs, the CMO reported that its process maps and failure modes and effect analyses (FMEAs) in Module 3 (Intervention Determination) did not adequately identify the root causes that needed to be addressed in the PIP; therefore, the interventions selected for testing were unlikely to address the most critical barriers to improvement. Additionally, Peach State reported for many PIPs that the PDSA cycles conducted in Module 4 (Plan-Do-Study-Act) did not enable the CMO to make firm conclusions about the individual impact of an intervention.

Based on the validation findings, HSAG's recommendations focused on effective group processes for developing process maps and conducting FMEAs in Module 3 and planning and executing methodologically sound PDSA cycles in Module 4. To address PIP results that were not credible, HSAG recommended that Peach State contact HSAG for technical assistance if the CMO determined that the SMART Aim statement or SMART Aim measure needed to be revised after initial approval. To ensure the SMART Aim measure methodology produces accurate and comparable results, the CMO should consistently apply the methodology throughout the life of the PIP. The CMO should review any necessary methodology changes with HSAG with the goal of maintaining the integrity of the SMART Aim methodology throughout the project.

HSAG's validation findings for Peach State's four CY 2016 PIPs suggest that the CMO improved its PIP performance overall. Among the four CY 2016 PIPs, none of the CY 2016 PIPs were determined to have results that were not credible. Two PIPs received the level of *High Confidence*, compared to none of the CY 2015 PIPs receiving *High Confidence*. Peach State successfully incorporated HSAG's recommendations into two of the CY 2016 PIPs by developing meaningful process maps, conducting actionable FMEAs, and executing methodologically sound PDSA cycles. Subsequently, these two PIPs met the SMART Aim goal and clearly linked the quality improvement processes to demonstrated improvement. Among the remaining two PIPs, one PIP received the level of *Confidence*, and the remaining PIP received the level of *Low Confidence*. These findings suggest that Peach State continues to have opportunities for improvement in addressing HSAG's recommendations and applying the rapid cycle PIP approach.

WellCare

HSAG summarized the validation findings for WellCare's eight CY 2015 PIPs in the 2017 External Quality Review Annual Report. The assigned confidence level for each PIP represented the overall validity and reliability of the PIP results. The CMO's performance varied widely by PIP topic. Among the eight CY 2015 PIPs, two PIPs received *High Confidence*, two PIPs received *Confidence*, two PIPs received *Low Confidence*, and HSAG determined the results of the remaining two PIPs were not credible. The validation findings suggested that WellCare was successful in some PIPs and had opportunities for improvement in other PIPs. While two of WellCare's PIPs received the level of *High Confidence* by meeting the SMART Aim goal and clearly linking quality improvement processes to demonstrated improvement, HSAG determined, for two other PIPs, the reported results were not credible because the CMO did not follow the approved methodology for the PIPs.

To address PIP results that were not credible, HSAG recommended that WellCare contact HSAG for technical assistance, if the CMO determined that the SMART Aim statement or SMART Aim measure needed to be revised after initial approval, to ensure the PIP produces accurate and comparable results. The CMO should review any necessary methodology changes with HSAG with the goal of maintaining the integrity of the SMART Aim methodology throughout the project. HSAG also offered recommendations focused on Module 4 (Plan-Do-Study-Act) related to planning and executing methodologically sound intervention testing cycles. Finally, HSAG also recommended that CMO examine and compare the varied performance across different PIP topics to identify opportunities for successful strategies in one project that could be applied to other projects.

HSAG's validation findings for WellCare's four CY 2016 PIPs suggest that the CMO's performance continued to vary widely by PIP topic, similar to the CMO's performance on the CY 2015 PIPs. HSAG assigned the level of *High Confidence* to one PIP, the level of *Confidence* to two PIPs, and determined the results of one other PIP were not credible. These findings suggest that, for one PIP, WellCare did not address HSAG's recommendation to maintain the integrity of the SMART Aim methodology throughout the life of the PIP. The CMO also continued to have opportunities for improvement in using methodologically sound PDSA cycles in Module 4 to clearly link improvement strategies to demonstrated improvement.

Amerigroup 360°

HSAG summarized the validation findings for Amerigroup 360°'s three PIPs in the 2017 External Quality Review Annual Report. The assigned confidence level for each PIP represented the overall validity and reliability of the PIP results. The CMO performed well in two of the three PIPs, for which HSAG assigned the level of *High Confidence*. For these two PIPs, the SMART Aim goal was achieved, and the improvement strategies were clearly linked to demonstrated improvement. HSAG assigned the remaining PIP the level of *Low Confidence* because the SMART Aim goal was not achieved. HSAG's recommendations focused on Module 4 (Plan-Do-Study-Act) and the planning and executing of PDSA cycles to test interventions. The CMO must use a methodologically sound approach for the PDSA cycle to obtain actionable data for driving improvement in subsequent PDSA cycles.

HSAG's validation findings for Amerigroup 360°'s three CY 2016 PIPs suggest that there was a lack of continuity in the CMO's improvement efforts as PIP performance declined from CY 2015 to CY 2016. None of the CMO's PIPs received the level of *High Confidence* or *Confidence*. HSAG assigned the level of *Low Confidence* to two of the three PIPs and determined that the results for the third PIP were not credible. Based on Amerigroup 360°'s CY 2016 PIP performance, the CMO did not address HSAG's recommendations related to carrying out effective PDSA cycles in Module 4 to clearly demonstrate the impact of the intervention and drive improvement towards meeting the SMART Aim goal. The CMO also has opportunities for improvement in consistently executing the approved SMART Aim measure methodology throughout the PIP.

CAHPS Surveys

Amerigroup

During 2017, HSAG recommended, based on an evaluation of Amerigroup's 2016 adult Medicaid CAHPS Survey results, that the CMO focus quality improvement initiatives on enhancing members' experiences with *Rating of Health Plan*, *Rating of Specialist Seen Most Often*, and *Rating of Personal Doctor*, since the rates for these measures were lower than NCQA's 2016 CAHPS adult Medicaid national averages. For Amerigroup's child Medicaid population, HSAG recommended that the CMO focus quality improvement initiatives on *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making*, given that the rates for these measures were below the 2016 NCQA child Medicaid national averages.

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

In response to the recommendations, the CMO continued to focus several efforts to improve member satisfaction. Amerigroup continued to support the Teach-Back technique in pediatric practices in

partnership with Merck pharmaceuticals. This work had initially been implemented as a performance improvement project for one pilot site in 2016.

Amerigroup continued to support the PCMH expansion and use of provider self-surveys to evaluate member satisfaction with the practices. Amerigroup also notified practitioners in writing of any complaint received by the CMO regarding their practice.

Amerigroup also continued to evaluate gaps in availability of providers representing high-volume languages spoken by members by county and addressed the gaps as needed in order to improve members' satisfaction with access to care.

Peach State

During 2017, HSAG recommended, based on an evaluation of Peach State's 2016 adult Medicaid CAHPS Survey results, that the CMO focus efforts on enhancing members' experiences with *Rating of Specialist Seen Most Often*, *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making* since the rates for these measures were lower than NCQA's 2016 CAHPS adult Medicaid national averages. For Peach State's child Medicaid population, HSAG recommended that the CMO focus QI initiatives on *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Shared Decision Making* since the rates for these measures were below the 2016 NCQA child Medicaid national averages.

HSAG also recommended that Peach State conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network.

For the Effectiveness of Care section of the CAHPS survey, Peach State conducted several population-specific outreach activities primarily focused on preventive health services (well visits) that addressed potential regional, ethnic, and racial health disparities. For example, Peach State monitored monthly administrative performance measure rates. Monthly monitoring indicated that the Southeast Georgia Families Region had lower compliance rates for HEDIS children's and adolescents' well visits than any other region in Georgia. The CMO emailed noncompliant members in the Southeast Region with messages encouraging them to receive their preventive visit for a nominal incentive.

Peach State identified that Southern Crescent Pediatrics serviced a high volume of Hispanic/Latino members and had a low compliance rate for well-child visits (ages 3–21). The CMO contacted members and scheduled member appointments with this practice.

Peach State's monthly administrative rates indicated that Black or African American males in the Southwest Region had the lowest rate for adolescent well-care visits of all regions. The CMO performed live outreach to caregivers of Black or African American males in the Southwest Region.

WellCare

In 2017, HSAG recommended, based on an evaluation of WellCare's 2016 adult Medicaid CAHPS Survey results, that the CMO focus efforts on enhancing members' experiences with *Rating of Personal Doctor*, *Getting Care Quickly*, and *Customer Service* since the rates for these measures were lower than NCQA's 2016 CAHPS adult Medicaid national averages. For WellCare's child Medicaid population, HSAG recommended that the CMO focus efforts on *Rating of Specialist Seen Most Often*, *How Well Doctors Communicate*, *Customer Service*, and *Shared Decision Making* since the rates for these measures were below the 2016 NCQA child Medicaid national averages.

In addition, HSAG recommended that WellCare conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network.

In WellCare's QAPI evaluation, the CMO stated that to investigate gaps in access to care for both children and adults, WellCare chose to include supplemental questions in the CAHPS survey to discover which specialty areas members have the most difficulty getting needed care/appointments. Once the final results of the CAHPS survey are available, key lessons learned will be used to drive recruiting efforts and fill gaps in access to specialty care.

Amerigroup 360°

In 2017, HSAG recommended, based on an evaluation of Amerigroup 360°'s 2016 CAHPS survey results, that the CMO focus efforts on *Rating of Health Plan*, *Rating of All Health Care*, and *Customer Service*, given that the rates for these measures were below the 2016 NCQA child Medicaid national averages.

HSAG also recommended that Amerigroup 360° conduct a causal/barrier analysis of its performance and apply the appropriate interventions to improve member experience with the CMO and its provider network.

In response to the recommendations, the CMO continued to focus efforts to improve member satisfaction. Amerigroup 360° continued to support the Teach-Back technique in pediatric practices in partnership with Merck pharmaceuticals. This work had initially been implemented as a performance improvement project for one pilot site in 2016.

Amerigroup 360° continued to support the PCMH expansion and use of provider self-surveys to evaluate member satisfaction with the practices. Amerigroup 360° also notified practitioners in writing of any complaint received by the CMO regarding their practice.

Amerigroup 360° also continued to evaluate gaps in availability of providers representing high-volume languages spoken by members by county and addressed the gaps as needed in order to improve members' satisfaction with access to care.

2017 External Quality Review Annual Report

Georgia Department of Community Health Recommendations

Based on a comparative review of CY 2017 findings for all activities, HSAG provided the following recommendations for DCH regarding the EQR findings:

- HSAG recommended that DCH provide additional guidance to the CMOs related to the DCH requirements for the content and level of detail CMOs should include in the QAPI program descriptions. HSAG also recommended that DCH provide technical assistance to the CMOs to ensure their understanding of the requirements. HSAG recommended that DCH provide additional technical assistance to the CMOs regarding the development, implementation, and evaluation of the QAPI Program. It was recommended that DCH consider implementing ongoing monitoring processes related to the CMO implementation of CAPs to ensure timelines are met.
- HSAG recommended that DCH consider the minimum qualifications, experience, education, or training that should be required for key CMO quality improvement staff positions.
- HSAG recommended that DCH consider defining its expectations for the CMOs to more actively engage with members, their families, guardians, and caregivers to solicit and incorporate input in quality improvement processes.
- HSAG recommended that DCH focus efforts on CMO best practices resulting from the CMOs' QAPI work. It was recommended that DCH review PIP results, and for the CMOs with improved outcomes, review the CMO's performance improvement processes to identify best practices that can be shared with other CMOs. The DCH has an opportunity to review outcomes that resulted from reducing the number of PIPs.

Georgia Department of Community Health Actions Taken

The DCH implemented many initiatives focused on quality improvement of the Medicaid program. The DCH included key staff positions in its 2017 CMO contracts. The key staff positions include minimum education, training, experience, and certification requirements.

In its 2017 CMO contracts, DCH included a requirement for each CMO to maintain a Member Advisory Committee. The committee must include current and past members and/or authorized member representatives as well as representatives from community agencies that do not provide CMO-covered services but are important to the health and well-being of members. CMOs are required to convene the Member Advisory Committees at least monthly.

The DCH also included a requirement that each CMO participate in the Georgia Families Monitoring and Oversight Committee and associated subcommittees in its 2017 CMO contracts. The committee serves as a forum for the exchange of best practices and to foster communication and provide an

opportunity for feedback and collaboration between State agencies, the CMOs, and external stakeholders.

The 2017 CMO contracts also identify specific topics that must be included in the QAPI plan and QAPI evaluation. The contract refers the CMOs to the DCH report templates for the documents and indicates that the QAPI plan must tell the story of the effectiveness of each CMO's QAPI plan in meeting defined goals and objectives and achieving improved health outcomes for each CMO's members. The DCH also included in the contract a statement that it may require the CMOs to report on QAPI progress more frequently than annually.

9. Quality Strategy Recommendations

Recommendations for the Georgia Families and Georgia Families 360° Programs

HSAG used its analyses and evaluations of EQR activity findings from the review period of July 1, 2016–June 30, 2017, to comprehensively assess the performance of CMOs in providing quality, timely, and accessible healthcare services to GF members. The overall findings and conclusions for all CMOs were compared and analyzed to develop overarching recommendations for the GF care management program as a whole. For a more detailed discussion of the strengths, weaknesses, conclusions, and recommendations for the Georgia Medicaid care management program and for each CMO, please refer to Sections 4 through 7 of this report.

Compliance With Standards

- HSAG recommends that DCH consider forming a workgroup with representatives from each CMO to develop a guide or manual for denial, grievance, and appeal language to ensure notice of adverse benefit determination letters and appeal resolution letters are written in easily understood language, address all concerns presented by the member, and include all content required by contract and federal regulations. The guideline should include a list of service types, service descriptions, and sample language explaining the reason for the denial that are easy for the member to understand.
- HSAG recommends that DCH consider strengthening its requirements for the CMOs to engage stakeholders, advocates, and members in quality improvement activities.
- HSAG recommends that DCH consider requiring more frequent updates from the CMOs on the status of quality improvement activities. Submission of quarterly reports that provide an update on the activities identified in the CMO's QAPI plan would allow DCH to proactively identify areas that are not on track or are not achieving the activity goals.
- HSAG recommends that DCH provide additional guidance to the CMOs and consider an audit of CMO denials for members regarding the EPSDT program to ensure that members are receiving appropriate care and services.

Performance Improvement Projects

- HSAG recommends that DCH implement processes that require all CMOs to share PIP results, including successes and lessons learned, improvement strategies, and interventions that were successful and resulted in improvement. The sharing should include CMOs pursuing avenues for spreading effective interventions beyond the initial scope of the rapid cycle PIP such as identifying new populations, facilities, or outcomes that could be positively impacted by the interventions.

- HSAG recommends that DCH require all CMOs to share PIP results that *did not* demonstrate real improvement. In addition, DCH should require the CMOs to convene key PIP team members and stakeholders to review the key driver diagram, process map, and FMEA. Based on the PIP results, the CMO should explore additional barriers, gaps, or failures to address in future improvement efforts.
- HSAG recommends that DCH require the CMO's key staff members (chief medical officer, QI director, PIP team leaders) to complete training related to rapid cycle improvement efforts and/or quality improvement science methods to ensure an understanding of the PIP process and to develop champions for the PIP topics.
- HSAG recommends that DCH work with the CMOs to develop internal processes to discuss, support, and report PIP outcomes. The CMO should consider developing cross-functional PIP teams and select PIP topic leadership champions.
- HSAG recommends that DCH select future PIP topics for the CMOs based on an analysis of recent performance measure data and input from key stakeholders, members, and providers.

Performance Measure Validation

- HSAG recommends that the CMOs review results of performance measure validation and use data to make decisions for quality improvement strategies. Any area where a CMO is not meeting DCH targets or experiences a rate decline is a potential area for focused quality improvement activities or interventions.
- HSAG recommends that DCH develop a process to match the member counts in the Georgia Medical Care Foundation (GMCF) file, which is used to determine gestational age and parity, against the CMOs' claims system data for live births and identify and correct any data discrepancies.
- HSAG recommends that DCH require the CMOs to routinely obtain data from the GMCF file and resolve data discrepancies throughout the year. DCH should consider requiring the CMOs to consistently use the GMCF file for both maternity performance measure rate calculation and maternity performance improvement work.
- HSAG recommends that DCH review its provider files and ensure that providers are only able to submit claims or encounters with codes that are appropriate for the provider type to improve the accuracy of performance measure reporting.

CAHPS

- Based on the results of the CAHPS survey, DCH should identify opportunities to coordinate CMO activities with those of public health related to smoking and tobacco use cessation.
- HSAG recommends that DCH work with the CMOs to identify why parents and/or caretakers of child members were less satisfied with the specialist their child saw most often, their child's personal doctor, and the overall healthcare their child received and identify opportunities to improve these ratings.

- Based on CAHPS survey results, HSAG recommends that the CMOs identify opportunities to improve adult members' access to needed care such as appointment availability, office hours, clinics, after-hour appointments, or provider network expansion.

Appendix A. Technical Methods of Data Collection and Analysis

The Balanced Budget Act of 1997 (BBA), Public Law 105-33, requires states to prepare an annual technical report that describes how data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the state's managed care organizations (MCOs). The data come from activities conducted in accordance with the Code of Federal Regulations (CFR) at 42 CFR §438.358. To meet these requirements, the State of Georgia, Department of Community Health (DCH), contracted with Health Services Advisory Group, Inc. (HSAG), an external quality review organization (EQRO).

From all the data collected, HSAG summarizes each CMO's strengths and weaknesses and provides an overall assessment and evaluation of the quality, timeliness of, and access to, care and services that each CMO provides.

Review of Compliance With Standards

The following description of how HSAG conducted—in accordance with 42 CFR §438.358—the external quality review of compliance with standards for the DCH Georgia Families (GF) program and the GF 360° CMOs addresses HSAG's:

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

HSAG followed standardized processes in conducting the review of the CMOs' performance.

Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs regarding compliance with State and federal requirements. HSAG assembled a team to:

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

HSAG develops and uses 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 DCH and the CMOs 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.

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

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

Pre-on-site review activities include:

- Developing the compliance review tools.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the two-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents.

On-site review activities: HSAG reviewers conduct an on-site review for the CMOs, which includes:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.
- A review of the documents HSAG requested that the CMOs have available on-site.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Feb 19, 2018.

- A review of the case files HSAG requested from the CMOs.
- Interviews conducted with the CMOs' key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

Description of Data Obtained

To assess the CMOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtains 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

Data Aggregation and Analysis

HSAG uses scores of *Met* and *Not Met* to indicate the degree to which the CMOs' performance complies with the requirements. A designation of *NA* is used when a requirement is not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-2] The protocol describes the scoring as follows:

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

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

Not Met indicates noncompliance defined as *one or more* of the following:

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

[A-2] Ibid.

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

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

HSAG determines 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 aggregates and analyzes the data resulting from its desk and on-site review activities. The data that HSAG aggregates and analyzes include:

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

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

Validation of Performance Improvement Projects (PIPs)

The DCH requires its CMOs to conduct PIPs annually. For the SFY 2016–2017 PIP validation cycle, Amerigroup 360° conducted three clinical PIPs and the other three GF CMOs conducted two clinical PIPs and two nonclinical PIPs. Table A-1 summarizes the PIP topics addressed by each CMO.

Table A-1—SFY 2016–2017 PIP Topics

CMO	PIP Topics
Amerigroup 360°	*7-Day Inpatient Discharge Follow-up*
	Adolescent Well-Child Visits
	Appropriate Use of ADHD Medications
Amerigroup	*Bright Futures*
	Member Satisfaction
	Postpartum Care
	Provider Satisfaction
Peach State	*Annual Dental Visits*
	Avoidable Emergency Room Visits
	Member Satisfaction
	Provider Satisfaction
WellCare	*Appropriate Use of ADHD Medications*
	Comprehensive Diabetes Care
	Member Satisfaction
	Provider Satisfaction

PIP Components and Process

The key concepts of the rapid cycle PIP framework include forming a core PIP team, setting aims, establishing measures, determining interventions, testing interventions, and spreading successful changes. The core component of this approach involves testing changes on a small scale, using a series of PDSA cycles, and applying rapid cycle learning principles over the course of the improvement project to adjust intervention strategies so that improvement can occur more efficiently and lead to long-term sustainability. The duration of rapid cycle PIPs conducted by the GF CMOs was 12 months.

HSAG developed five modules with an accompanying companion guide. Prior to issuing each module, HSAG held technical assistance sessions with the CMOs to educate them about application of the modules. The five modules are defined as follows:

- **Module 1—PIP Initiation:** Module 1 outlines the framework for the project. The framework includes the topic rationale and supporting data, building a core PIP team, setting aims (Global and SMART), and completing a key driver diagram.
- **Module 2—SMART Aim Data Collection:** In Module 2, the SMART Aim measure is operationalized, and the data collection methodology is described. SMART Aim data are displayed using a run chart.

- **Module 3—Intervention Determination:** In Module 3, there is increased focus into the quality improvement activities reasonably thought to impact the SMART Aim. Interventions in addition to those in the original key driver diagram are identified using tools such as process mapping, failure modes and effects analysis (FMEA), Pareto charts, and failure mode priority ranking, for testing via PDSA cycles in Module 4.
- **Module 4—Plan-Do-Study-Act:** The interventions selected in Module 3 are tested and evaluated through a thoughtful and incremental series of PDSA cycles.
- **Module 5—PIP Conclusions:** In Module 5, the CMO summarizes key findings and presents comparisons of successful and unsuccessful interventions, outcomes achieved, and lessons learned.

Approach to PIP Validation

For the CY 2016 PIPs, HSAG obtained the data needed to conduct the PIP validation from the CMO's module submission forms. These forms provided detailed information about each of the PIPs and the activities completed in each module.

The CMOs submitted Modules 1 through 3 for each PIP throughout calendar year 2016. The CMOs initially submitted Modules 1 and 2, received feedback and technical assistance from HSAG, and resubmitted these modules until all validation criteria were met. The CMOs followed the same process for Module 3. Once Module 3 was approved, the CMOs initiated intervention testing for each PIP in Module 4, which continued through the end of 2016. The CMOs submitted Modules 4 and 5 to HSAG on January 31, 2017, for annual validation.

The goal of HSAG's PIP validation is to ensure that the DCH and key stakeholders can have confidence that any reported improvement is related to, and can be directly linked to, the quality improvement strategies and activities the CMO conducted during the life of the PIP. HSAG's scoring methodology evaluates whether the CMO executed a methodologically sound improvement project and confirms that any achieved improvement can be clearly linked to the quality improvement strategies implemented by the CMO.

PIP Validation Scoring

HSAG assigned a score of Achieved or Failed for each of the criteria in Modules 1 through 5. Any validation criteria not applicable (N/A) were not scored. Using a standardized scoring methodology, HSAG assigned a level of confidence and reported the overall validity and reliability of the findings as one of the following:

- ***High confidence*** = The PIP was methodologically sound, achieved the SMART Aim, and the demonstrated improvement was clearly linked to the quality improvement processes implemented.
- ***Confidence*** = The PIP was methodologically sound, achieved the SMART Aim, and some of the quality improvement processes were clearly linked to the demonstrated improvement; however,

there was not a clear link between all quality improvement processes and the demonstrated improvement.

- ***Low confidence*** = (A) the PIP was methodologically sound; however, the SMART Aim was not achieved; or (B) the SMART Aim goal was achieved; however, the quality improvement processes and interventions were poorly executed and could not be linked to the improvement.
- ***Reported PIP results were not credible*** = The PIP methodology was not executed as approved.

Performance Measure Validation/NCQA HEDIS Compliance Audit (PMV)

The DCH requires its CMOs to conduct PMV annually. The DCH required the CMOs to report rates in SFY 2017 for 50 HEDIS and non-HEDIS measures. The measure list consisted of clinical quality measures, utilization measures, and health plan descriptive information measures. Many of the measures included multiple indicators or age stratifications. The measurement period was identified by DCH as CY 2016 for all measures except the two Child Core Set dental measures. The dental measures were reported for federal fiscal year (FFY) 2016, which covered the time frame of October 1, 2015, through September 30, 2016, according to CMS requirements. All performance measure rates were reported by the CMOs in June 2017.

The DCH allowed the CMOs to contract with individual licensed organizations to conduct NCQA HEDIS Compliance Audits. As such, the HEDIS measure rates were validated by the CMOs' contracted licensed organizations, and the non-HEDIS measure rates were validated by HSAG.

For the GF 360° population, DCH required Amerigroup to report 42 HEDIS and non-HEDIS measures for CY 2017. Similar to the GF rate reporting, DCH allowed Amerigroup to contract with an individual licensed organization to conduct an NCQA HEDIS Compliance Audit for the GF 360° population. The non-HEDIS measure rates for this population were validated by HSAG.

To assess the CY 2016 reported rates, DCH established performance targets for the GF population and for the GF 360° population. Performance targets for CY 2017 data were based on the NCQA national Medicaid HEDIS percentiles and the Nationwide Inpatient Sample (NIS) for the Agency for Healthcare Research and Quality (AHRQ) measures.

Approach to PMV Validation

HSAG conducted the validation activities as outlined in the CMS publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-3] Pre-on-site activities and document review were

[A-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: March 18, 2018.

conducted, followed by an on-site visit to each CMO that included interviews with key staff and system demonstrations. Finally, post-review follow-up was conducted with each CMO on any issues identified during the site visit. Information and documentation from these processes were used to assess the validity of the performance measures.

HSAG performed an audit of the CMOs' HEDIS reporting for the GF and GF 360° programs. Methods and information sources used by HSAG to conduct the audit included:

- Teleconferences with the MCOs' personnel and vendor representatives, as necessary.
- Detailed review of the MCOs' completed responses to the NCQA Roadmap.
- On-site meetings, including the following:
  - Staff interviews
  - Live system and procedure demonstration
  - Documentation review and requests for additional information
  - Primary HEDIS data source verification
  - Programming logic review and inspection of dated job logs
  - Computer database and file structure review
  - Discussion and feedback sessions
- Detailed evaluation of computer programming used to access administrative data sets, manipulate medical record review data, and calculate HEDIS measures.
- Detailed evaluation of encounter data completeness.
- Re-abstraction of sample medical records selected by the auditors, with a comparison of results to each MCO's review determinations for the same records, if the hybrid method was used.
- Requests for corrective actions and modifications related to HEDIS data collection and reporting processes and data samples, as necessary, and verification that actions were taken.
- Accuracy checks of the final HEDIS rates completed by the MCOs.
- Interviews with a variety of individuals whose department or responsibilities played a role in the production of HEDIS data. Representatives of vendors who provided or processed HEDIS 2014 (and earlier historical) data may also have been interviewed and asked to provide documentation of their work.

In addition, activities conducted prior to on-site meetings with CMO representatives included written and email correspondence explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of the certified measures approved by NCQA; and a detailed review of 14 non-HEDIS measures calculated and reported by the CMOs for the GF program and eight non-HEDIS measures calculated and reported by Amerigroup for the GF 360° program. Most of the non-HEDIS measures were Adult or Child Core Set measures; a few were AHRQ measures. The primary objectives of HSAG's performance measure validation process were to:

- Evaluate the accuracy of the performance measure data collected by the CMOs.
- Determine the extent to which the specific performance measures calculated by the CMOs followed the specifications established for each performance measure.

In addition, activities conducted prior to on-site meetings with the CMO representatives included written and email correspondence explaining the scope of the audit, methods used, and time frames for major audit activities; a compilation of a standardized set of comprehensive working papers for the audit; a determination of the number of sites and locations for on-site meetings, demonstrations, and interviews with critical personnel; the preparation of an on-site agenda; a review of the certified measures approved by NCQA; and a detailed review of a select set of HEDIS and non-HEDIS measures that the DCH requires for reporting.

The IS capabilities assessment consisted of the auditor's findings on IS capabilities, compliance with each IS standard, and any impact on HEDIS reporting. Assessment details included facts on claims and encounter data, enrollment, provider data, medical record review processes, data integration, data control, and measure calculation processes.

To validate the medical record review portion of the audit, NCQA policies and procedures require auditors to perform two steps: (1) an audit team review of the medical record review processes employed by the MCOs, including a review of staff qualifications, training, data collection instruments and tools, interrater reliability (IRR) testing, and the method used to combine medical record review data with administrative data; and (2) a re-abstraction of selected medical records and a comparison of the audit team's results to abstraction results for medical records used in the hybrid data source measures.

The analysis of the validation of performance measures involved tracking and reporting rates for the measures required for reporting by DCH for the GF and GF 360° programs. The audited measures (and the programs to which they apply) are presented in Table A–1.

HSAG began performance measure validation of the non-HEDIS measures and completed validation in June 2017. HSAG provided final performance measure validation reports to the CMOs and DCH in August 2017. These reports contain validation findings generated by HSAG regarding its performance measure validation of the non-HEDIS measures and the corresponding validated rates. In addition, these reports also contain the validated HEDIS rates obtained from the CMOs' licensed organizations.

CAHPS Survey

The surveys administered by each CMO's vendor included a set of standardized items (58 items for the CAHPS 5.0H Adult Medicaid Health Plan Survey and 48 items for the CAHPS 5.0H Child Medicaid Health Plan Survey without the Children with Chronic Conditions [CCC] measurement set) that assess members' perspectives on care. To support the reliability and validity of the findings, the CMOs' vendors followed standardized sampling and data collection procedures to select members and distribute surveys. These procedures were designed to capture accurate and complete information to promote both

the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis by each CMO's vendor. The CAHPS Survey results, produced by each CMO's survey vendor, were provided to HSAG to include in this report.

Two populations were surveyed for Amerigroup, Peach State, and WellCare: adult Medicaid and child Medicaid. One population was surveyed for Amerigroup 360°: child Medicaid. DSS Research, an NCQA-certified vendor, administered the 2017 CAHPS surveys for Amerigroup and Amerigroup 360°. Morpace, an NCQA-certified vendor, administered the 2017 CAHPS surveys for Peach State. SPH Analytics, an NCQA-certified vendor, administered the 2017 CAHPS surveys for WellCare.

The technical method of data collection was through the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (without the CCC measurement set) to the child Medicaid population. Amerigroup, WellCare, and Amerigroup 360° used a mixed-mode methodology for data collection (i.e., mailed surveys followed by telephone interviews of non-respondents). Peach State used a mixed-mode and Internet protocol methodology (i.e., mailed surveys with an Internet link included on the cover letter followed by telephone interviews of non-respondents) for data collection. Respondents were given the option of completing the survey in Spanish for all CMOs except WellCare.

The survey questions were categorized into various measures of satisfaction. These measures included four global ratings, five composite scores, and three Effectiveness of Care measures for the adult population only. The global ratings reflected patients' overall satisfaction with their personal doctor, specialist, health plan, and all health care. The composite scores were derived from sets of questions to address different aspects of care (e.g., getting needed care and how well doctors communicate). The Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted with a cross (+).

For each of the four global ratings, the percentage of respondents who chose the top satisfaction ratings (a response value of 8, 9, or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box response).

For each of the five composite scores, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) Never, Sometimes, Usually, or Always; or (2) No or Yes. A positive or top-box response for the composites was defined as a response of Usually/Always or Yes. The percentage of top-box responses is referred to as a global proportion for the composite scores. For the Effectiveness of Care measures, responses of Always/Usually/Sometimes were used to determine if the respondent qualified for inclusion in the numerator. The rates presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results. A substantial increase or decrease is denoted by a change of 5 percentage points or more.

The following are the four global rating measures and five composite measures evaluated through the CAHPS 5.0 Surveys:

CAHPS Global Rating Measures:

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

CAHPS Composite Measures:

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

For each CMO, the 2017 adult and child CAHPS scores were compared to 2017 NCQA national adult and child Medicaid averages, respectively. In addition to the CMO-specific results, HSAG provided an overall statewide average score for the adult and child Medicaid populations and compared the scores to 2017 NCQA national Medicaid averages.[A-4] These comparisons were performed on the four global ratings and five composite measures.

[A-4] Quality Compass® 2017 data serve as the source for the 2017 NCQA national adult and child Medicaid averages.

Readiness Review Results

The Georgia Department of Community Health (DCH), in partnership with its agent Myers & Stauffer, conducted an on-site readiness review of the CMOs that were awarded contracts for the Georgia Families (GF) program for CY 2018. The on-site readiness assessment focused on the GF contract deliverables, the CMO's ability to comply with the terms of the contract, and the CMO's ability to perform all administrative functions resulting in high-quality services for GF members. The following tables present the results of the readiness review.

Amerigroup

The DCH notified Amerigroup during the readiness review process that all requirements were met.

Peach State

Table B-1—CY 2017 Readiness Review Results
Peach State Health Plan

Contract Section	Category	Deficiency	Required Action
4.3.2	Member Services	Section 4.3.2 of the Contract requires Peach State to make all written materials available in a manner that takes into consideration the Member's needs, including those who are visually impaired or have limited reading proficiency. Further, Peach State shall notify all Members that information is available in alternative formats and how to access those formats. While Peach State acknowledged its responsibility to make written materials available in varying formats and demonstrated that Members could make a request for the materials, Peach State was unable to provide a specific time frame for when such materials would be developed and delivered to its members.	Section 4.3.2 of the Contract requires Peach State to provide written materials in alternative formats for members with special needs. Peach State is required to do the following: *Peach State must develop policies and procedures that outline the time period for distributing written materials in alternative formats upon request by its Members.*
4.3.8	Member Services	Section 4.3.8 of the Contract requires Peach State to develop and maintain a web site, which includes Member and Planning for Healthy Babies (P4HB®) webpages that provide general and up-to-date information about the GF program, including but not limited to the following:	

Contract Section	Category	Deficiency	Required Action
4.3.8.1.1.	Member Services	During the readiness review, Peach State provided a demonstration of its website and the online Member Handbook. Currently, the only method in which a GF Member may search the online handbook is by selecting "Control F" on a keyboard or by scrolling through multiple pages of the handbook to locate specific content. The online handbook, in its present state, lacks many of the common industry standard search tools or functionality such as hyperlinks or bookmarks which would grant a Member easy access to the various sections of the Member handbook. While the new contract does not specifically require hyperlinks or bookmarks, the requirement for a "searchable online handbook" necessitates the use of such common industry standard search tools.	Section 4.3.8 of the Contract requires Peach State to develop and maintain a website which includes Member and P4HB® webpages that provide general and up-to-date information about the GF program. This includes a searchable Member handbook. Based on the foregoing comments, Peach State is required to do the following: • *Update its online Member Handbook to include common industry search tools or functionality such as hyperlinks or bookmarks which would allow a Member to easily* access *the various sections of the Member Handbook.* • *Revise its webpages and submit proof in writing. The revised webpages must include the following changes:* - *Include instructions on how to search the website; include visible links to access all network providers.* - *Change all references to "Health Babies" to "Planning for Healthy Babies®";* - *Include a viewable Pharmacy Preferred Drug List;*

Contract Section	Category	Deficiency	Required Action
			- *Include Pharmacy Conditions for Coverage and Utilization Limits;* - *Include a "What's New" link;* - *Include a viewable "Reminder Information about Medicaid Eligibility Redeterminations" link;* - *Include a visible link that will allow members to access the DCH Enrollment Broker's website;* - *Include information concerning the 1095-B Health Insurance Tax Form;* - *Include easily accessible links on the homepage regarding how to file a grievance/appeal; and* - *Ensure Member Rights and Responsibilities are readily accessible to members.*
4.3.8.1.1.	Member Services	Additionally, the member webpages require a number of updates including a mechanism to clearly identify the following: (1) new member information, (2) information regarding annual Medicaid member redeterminations, (3) pharmacy drug listings, (4) pharmacy conditions for coverage and utilization limits, (5) 1095-B Health Insurance Tax Forms, (6) primary care provider responsibilities, (7) dental home responsibilities, (8) Member Rights and Responsibilities, (9) the process for grievances and appeals, and (10) frequently asked questions.	

Contract Section	Category	Deficiency	Required Action
4.3.8.1.3	Member Services	Section 4.3.8.1.3 of the Contract requires Peach State to have a portal that allows Members to access a searchable provider directory. During Peach State's demonstration of its provider directory, DCH noted that Peach State's provider directory did not identify all the Family Planning providers or the health departments that provide family planning services. Accordingly, the provider directory is incomplete.	
	Covered Services & Special Covered Services (P4HB®)	The Contract requires that Peach State provide services to P4HB® Members. This includes Family Planning services, lnterpregnancy Care services, and Resource Mother Outreach services.	
	Covered Services & Special Covered Services (P4HB®)	As part of the on-site readiness review, Peach State representatives were expected to adequately discuss the benefits and services available under the P4HB® Demonstration. Specifically, Peach State representatives were expected to discuss the following in detail: 1. Exclusions or limitations under each P4HB® Demonstration component; 2. Services provided under the Family Planning component; 3. Services provided under the lnterpregnancy component; 4. Services provided under the Resource Mother Outreach component; 5. How P4HB® enrollees may access other benefits and services not available or covered under the P4HB® Demonstration. OCH interviewed Peach State representatives during the on-site readiness review. During the interview process, Peach State representatives were unable to adequately discuss the benefits and services available under the P4HB® Demonstration. The interview process revealed the lack of understanding as well as the lack of or insufficient staff training as it relates to services provided under the P4HB® Demonstration.	The Contract requires Peach State to provide services to P4HB® members. These members receive Family Planning services, lnterpregnancy Care services, and Resource Mother Outreach services. Based on the foregoing comments, Peach State is required to do the following: • *Develop a training program and submit all training materials to DCH for approval; train its employees, including call center staff, on all P4HB® program requirements. Staff will be expected to:* - *Demonstrate strong familiarity with the P4HB® program, eligibility requirements, available services and exclusions;* - *Demonstrate the process to refer*

Contract Section	Category	Deficiency	Required Action
			Family Planning only members to a primary care provider; - *Demonstrate an understanding of the Georgia Association for Primary Health Care providers; and* - *Demonstrate how P4HB® enrollees may access other benefits and services not available from or not covered by the CMO under the Demonstration.*
16.1.5	Ombudsman Staff	Section 16.1.5 of the Contract requires Peach State to have the following key staff: Ombudsman Staff including an Ombudsman Coordinator and an Ombudsman Liaison(s). The "Ombudsman Coordinator" is defined as an employee of the Contractor who is responsible for coordinating services with local community organizations and working with local advocacy organizations to assure that Members have access to Covered Services and Non-covered Services. The "Ombudsman Liaison" is defined as an employee of the Contractor who is responsible for collaborating with DCH's designated staff in the identification and resolution of issues. Such collaboration includes working with OCH staff on issues of access to healthcare services, and identifying the communication and education needs of Members, Providers and caregivers. The Ombudsman Liaison must assist Members and Providers in coordinating services with local community organizations. During the on-site readiness review, Peach State identified the individual who would serve as the Ombudsman Coordinator, although it was readily apparent that this designation was "off the cuff"	Section 16.1.5 of the contract requires Peach State to have an Ombudsman Coordinator and the appropriate number of Ombudsman Liaisons. In accordance with the provisions of the contract, Peach State is required to do the following: • *Submit a detailed plan outlining its proposed hiring date; onboarding schedule, which includes an employee-training plan; and the job and program description.*

Contract Section	Category	Deficiency	Required Action
		and without any forethought. The staff person was not prepared or knowledgeable regarding the "assigned" duties and responsibilities as the Ombudsman Coordinator.	
4.8.23	Benefits Management	Section 4.8.23 of the Contract requires Peach State to have policies in place to guide staff in authorizing out-of-plan services when medically necessary services are not available through the plan's network. Some services needed by GF members are provided by specialty providers who are reimbursed through fee-for-service Medicaid. During the on-site readiness review, Peach State did not demonstrate an understanding of community-based services, specifically, those services provided by the Department of Behavioral Health and Developmental Disabilities (DBHDD) or other State agencies such as the Department of Public Health (DPH).	Peach State is required to have policies in place to guide staff in authorizing out-of-plan services when medically necessary services are not available through the CMO's network. Accordingly, the following is required: • *Peach State must demonstrate that there is a process for authorizing out-of-plan services as well as an in-depth understanding of the community resources offered through State agencies such as DBHDD and DPH.*
4.14	Benefits Management	Section 4.14 of the Contract requires Peach State to have an appeals system in place that provides timely notification to members and providers. During the on-site readiness review, Peach State's webpage did not clearly identify member and provider links which would allow for easy access to file a complaint or grievance.	Peach State is required to have an appeals system in place that provides timely notification to members in various formats. Accordingly, Peach State is required to do the following: • *Modify the webpage to allow ease of use for members and providers to file a complaint or grievance by including links on the homepage of the website.*
4.12	Quality Management	Section 4.12 of the Contract requires Peach State to develop and implement a quality improvement plan and process that identifies how Peach State gathers, analyzes, tracks, monitors, and coordinates care for members with disabilities and chronic conditions. While Peach State adequately demonstrated its ability to perform these functions,	Section 4.12 of the Contract requires Peach State to develop and implement a quality improvement plan and process that identifies how Peach State gathers, analyzes, tracks, monitors,

Contract Section	Category	Deficiency	Required Action
		Peach State did not demonstrate how this information is disseminated throughout the various units within the organization. The Quality unit appeared to operate in a silo with no collaboration. Consequently, data obtained and analyzed by the Quality unit did not appear to permeate the various units such as the member call center and care management staff.	and coordinates care for members with disabilities and chronic conditions. While Peach State adequately demonstrated its ability to perform these functions, Peach State did not demonstrate how this information is disseminated throughout the various units within the organization. Accordingly, Peach State is required to do the following: • *Develop policies and procedures that outline how information obtained by the Quality unit will be disseminated throughout the agency.*
	Vendor Monitoring and Oversight	Peach State delegates the responsibility for many of its core functions to its subcontractors and vendors. These delegated functions include, but are not limited to Behavioral Health, Disease Management, Vision, Dental, and Pharmacy. While these functions have been delegated to subcontractors/vendors, Peach State remains accountable for the delegated services and thus is responsible for monitoring the performance of its delegated vendors. Peach State's Vendor Monitoring and Oversight Program Description states that the Compliance Department, in conjunction with the Quality Department and the business area staff (i.e., subject matter experts), ensures ongoing oversight of vendors which includes both national and local vendors contracted by Peach State. Additionally, the organization chart presented by Peach State as supporting documentation indicates that vendor monitoring and oversight fall under the Compliance Department. However, during the on-site readiness review, Peach State's staff indicated that the Finance Unit, not the Compliance Department, has oversight over the Vendor	Peach State Health Plan is required to have policies and procedures for its Vendor Monitoring and Oversight Program. While Peach State was able to demonstrate that it possessed written policies and procedures for its Vendor Monitoring and Oversight Program, Peach State was unable to demonstrate full adherence to either the program description or the policies and procedures. Accordingly, the following corrective actions are required: • *Develop policies and procedures that clearly identify the differences between the duties and responsibilities of Centene Corporation*

Contract Section	Category	Deficiency	Required Action
		Monitoring and Oversight Program. Thus, Peach State is not complying with its documented internal policies and procedures. Peach State presented its Vendor Monitoring and Oversight Program Description and its policies and procedures (Ga.Comp.VM.17) as supporting documentation. According to Peach State's policies and procedures (Ga. Comp.VM.17), monitoring and oversight occur through reporting and evaluation activities. As these functions have a direct impact on member care, quality, and outcomes, adequate monitoring and oversight are paramount. During the on-site readiness review, Peach State was unable to adequately demonstrate that it maintained and has continuous oversight over its subcontractors/vendors' utilization reporting and evaluation activities. The reports presented as evidence during the on-site readiness review were not specific to the Medicaid program, and they were not current or complete. Peach State's Vendor Monitoring and Oversight Program Description describes some of the duties of the vendor oversight staff to include: • Tracking, monitoring, and analyzing vendor adherence to performance standards for all products (Medicaid and Duals) defined in the vendor agreement. • Documenting oversight evidence in the C360 Third Party Risk Module. • Ensuring the vendor is trained on all products (Medicaid and Duals) and understands requirements. • Coordinating with other business areas to conduct training. • Tracking vendor completion of required training, including but not limited to mandatory CMS Compliance and Fraud, Waste and Abuse training. • Conducting Joint Oversight Committee (JOC) meetings with vendor and entity	*versus Peach State Health Plan as they relate to vendor monitoring and oversight.* • *Develop a training program and submit all training materials to DCH for approval, and train its employees on all vendor monitoring and oversight requirements.* • *Develop policies and procedures which are specific to monitoring and oversight for Envolve vendors.*

Contract Section	Category	Deficiency	Required Action
		representatives in accordance with the Vendor Risk Exposure policy as outlined in CC.COMP.21.07. • Participating in Corporate JOC meetings (for those national vendors participating in the Corporate JOC). • Reviewing annual audit results for local and national vendors and communicating results to appropriate business owners. • Notifying the vendor in writing if performance requirements are not met and outlining next steps that will be taken if the issues are not resolved. • Reviewing vendor performance during Quality Improvement Committee meetings. Despite this non-exhaustive list of duties and responsibilities, Peach State representatives indicated during the on-site readiness review that the Vendor Monitoring and Oversight team consisted of one manager who had one, recently hired direct report. Accordingly, staffing is undoubtedly insufficient. The Contract requires that Peach State have sufficient staff in all departments.	
	Vendor Monitoring and Oversight	Although Peach State has a written Vendor Monitoring and Oversight Program Description as well as written policies and procedures, Peach State representatives were unable to clearly delineate the responsibilities of its parent company, Centene, from the responsibilities of the local health plan (Peach State). Staff were unable to adequately describe the day-to-day functions, duties, and responsibilities of the Vendor Monitoring and Oversight Unit. Further, it appeared that staff had not received sufficient training on their respective duties and responsibilities or the role of the unit.	
	Vendor Monitoring and Oversight	**Subcontractors/Vendors are wholly owned subsidiaries of Centene, the parent company of Peach State Health Plan.** Centene Corporation recently incorporated some of its services under its Envolve brand name. These include Envolve Pharmacy Solutions (US Script), Envolve PeopleCare (Cenpatico	

Contract Section	Category	Deficiency	Required Action
		Behavioral Health: NurseWise and Nutur), and Envolve Benefit Options (OptiCare and Dental Health and Wellness). Accordingly, Centene Corporation now controls the activities of both Peach State and Peach State's vendor, Envolve. The relationship between Peach State, Envolve, and their parent company Centene, raises serious concerns about Peach State's ability to adequately and sufficiently monitor Envolve in an objective manner. As Centene is now the parent company of both entities, there is concern that Peach State may encounter difficulties, pressures, or resistance in its monitoring and oversight efforts. At this time, there are no existing policies or procedures that provide assurances that Peach State will not be derelict in its monitoring and oversight responsibilities as a result of this restructuring.	
4.16.3	Claims Processing and Encounter Data	As noted in Section 4.16.3 of the Contract, the GF program utilizes encounter data to evaluate the quality of care rendered to Members, budget available resources, set capitation rates, monitor utilization, and detect potential fraud. Peach State's policy specifies that its delegated vendors are responsible for creating encounter data and submitting the data directly to OCH without further processing. Accordingly, there was no evidence that Peach State conducts quality checks of its vendor's encounter data to ensure accuracy.	Peach State is required to ensure the accuracy of all encounter claims submissions. Accordingly, Peach State must do the following: • *Submit policies and procedures that demonstrate the quality assurance and monitoring process of all encounter data submitted by subcontractors.*

WellCare

The DCH notified WellCare during the readiness review process that all requirements were met.