

Attachment B.24.a
EQRO Reports for WellCare of Georgia



Georgia Department of Community Health

Validation of Performance Measures

for
WellCare of Georgia, Inc.

September 2010



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Validation of Performance Measures	1
Validation Overview	1
Care Management Organization (CMO) Information	1
Performance Measures Validated.....	2
Description of Validation Activities	3
Pre-audit Strategy.....	3
Validation Team	3
Technical Methods of Data Collection and Analysis.....	4
On-site Activities.....	4
Data Integration, Data Control, and Performance Measure Documentation	6
Data Integration	6
Data Control	6
Performance Measure Documentation	6
Validation Results	7
Medical Service Data (Claims/Encounters)	7
Enrollment Data.....	7
Provider Data.....	7
Medical Record Review Process.....	7
Supplemental Data	7
Data Integration.....	7
Performance Measure Specific Findings.....	8
Validation Findings	9
Appendix A—Data Integration and Control Findings	A-i
Appendix B—Denominator and Numerator Validation Findings	B-i
Appendix C—Performance Measure Results	C-i
Appendix D—Final Audited HEDIS Results	D-i
Appendix E—Audited CY 2009 HEDIS Utilization Measure Results	E-i

Validation of Performance Measures

for WellCare of Georgia, Inc.

Validation Overview

Validation of performance measures is one of three mandatory external quality review (EQR) activities that the Balanced Budget Act of 1997 (BBA) requires state Medicaid agencies to perform. Health Services Advisory Group, Inc. (HSAG), the external quality review organization (EQRO) for the Department of Community Health (DCH), conducted the validation activities. DCH contracts with three care management organizations (CMOs) to provide services to Medicaid and PeachCare for Kids enrollees. DCH identified a set of performance measures that were calculated and reported by the CMOs for validation. HSAG conducted the validation activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Measures: A Protocol for Use in Conducting External Quality Review Activities*, Final Protocol, Version 1.0, May 1, 2002 (CMS performance measure validation protocol).

Care Management Organization (CMO) Information

HSAG validated performance measures calculated and reported by **WellCare of Georgia, Inc. (WellCare)**. Information about **WellCare** appears in Table 1.

Table 1—WellCare Information	
CMO Name:	WellCare of Georgia, Inc.
CMO Location:	211 Perimeter Center Parkway, Suite 800 Atlanta, GA 30346
CMO Contact:	Michael Cotton
Contact Telephone Number:	(866) 300-1411
Contact E-mail Address:	Michael.Cotton@wellcare.com
Site Visit Date:	May 4 and 5, 2010

Performance Measures Validated

HSAG validated performance measures identified and selected by DCH for validation. Four performance measures were selected from the Agency for Healthcare Research and Quality (AHRQ) Quality Indicator set and one performance measure was developed by a DCH-contracted vendor, Thomson Reuters (TR). The measurement period was identified by DCH as calendar year (CY) 2009. Table 2 lists the performance measures validated and who calculated the performance measure.

Table 2—List of CY 2009 Performance Measures for WellCare		
	Performance Measure	Calculation by:
1.	Cesarean Delivery Rate— <i>AHRQ measure</i>	WellCare
2.	Low Birth Weight Rate— <i>AHRQ measure</i>	WellCare
3.	Asthma ED/Urgent Care Visits— <i>TR-developed measure</i>	WellCare
4.	Diabetes Short-Term Complications Admission Rate— <i>AHRQ measure</i>	WellCare
5.	Asthma Admission Rate— <i>AHRQ measure</i>	WellCare

In addition, each CMO was required to report a selected set of Healthcare Effectiveness Data and Information Set (HEDIS[®]) measures to DCH. The CMOs were required to contract with an NCQA-licensed audit organization and undergo a NCQA HEDIS Compliance Audit[™]. Final audited HEDIS measure results were submitted to DCH via NCQA’s Interactive Data Submission System (IDSS) and provided to HSAG. HSAG will use these results in addition to the measures validated and displayed within this report as data sources for the annual EQR technical report. Appendices D and E display the final audited HEDIS 2009 results for all required measures.

[®] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA)
 NCQA HEDIS Compliance Audit[™] is a trademark of the National Committee for Quality Assurance (NCQA)

Description of Validation Activities

Pre-audit Strategy

HSAG conducted the validation activities as outlined in the CMS performance measure validation protocol. In order to complete the validation activities for **WellCare**, HSAG obtained a list of the measures that were selected by DCH for validation.

HSAG then prepared a document request letter that was submitted to **WellCare** outlining the steps in the performance measure validation process. The document request letter included a request for a completed Information Systems Capabilities Assessment Tool (ISCAT), or Appendix Z of the CMS protocol; source code for each performance measure; the HEDIS 2010 Roadmap; and any additional supporting documentation necessary to complete the audit. HSAG responded to ISCAT/Roadmap-related questions directly from **WellCare** during the pre-on-site phase.

For the on-site visit, HSAG prepared an agenda describing all visit activities and indicating the type of staffing needed for each session. HSAG provided the agenda to WellCare approximately one week prior to the on-site visit. HSAG also conducted a pre-on-site conference call with WellCare to discuss any outstanding ISCAT/Roadmap questions and on-site visit activity expectations.

Validation Team

The HSAG Performance Measure Validation Team was composed of a lead auditor and validation team members. HSAG assembled the team based on the skills required for the validation and requirements of **WellCare**. Some team members, including the lead auditor, participated in the on-site meetings at **WellCare**; others conducted their work at HSAG’s offices. **WellCare**’s validation team was composed of the following members in the designated positions. Table 3 lists the validation team members, their positions, and their skills and expertise.

Name / Role	Skills and Expertise
Margaret Ketterer, RN, BSN, CHCA <i>Audit Director/Lead Auditor</i>	Auditing expertise, performance measure development, managed care operations
Allen Iovannisci, MS, CHCA <i>Secondary Auditor</i>	Auditing expertise, data analysis, programming, systems review
David Mabb, MS, CHCA <i>Associate Director/Audits</i>	Source code review management
Dan Moore <i>Source Code Reviewer</i>	Source code review
Tammy Gianfrancesco <i>Administrative Assistant</i>	Communications

Technical Methods of Data Collection and Analysis

The CMS performance measure validation protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG conducted an analysis of these data:

- ◆ **Information Systems Capabilities Assessment Tool (ISCAT):** A modified version of the ISCAT was requested and received from **WellCare**. In preparing the ISCAT document, HSAG removed questions that were already addressed in **WellCare**'s National Committee for Quality Assurance (NCQA) Roadmap. Upon receipt by HSAG, the ISCAT underwent a cursory review to ensure all sections were completed and all attachments were present. The validation team then reviewed all ISCAT documents, noting issues or items that needed further follow-up. The validation team used information included in the ISCAT to complete the review tools, as applicable.
- ◆ **NCQA's HEDIS 2010 Roadmap:** **WellCare** completed and submitted its Roadmap for review by the validation team. The validation team combined the responses from the ISCAT review and Roadmap to complete the pre-on-site systems assessment.
- ◆ **Source code (programming language) for performance measures:** HSAG requested source code from CMOs that calculate their performance measures by using automated computer code. HSAG requested and received source code from **WellCare**. The validation team completed a line-by-line code review and observation of program logic flow to ensure compliance with State measure definitions during the on-site visit. Source code reviewers identified areas of deviation and shared them with the lead auditor to evaluate the impact of the deviation on the measure and assess the degree of bias (if any).
- ◆ **Supporting documentation:** HSAG requested any documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. The validation team reviewed all supporting documentation, identifying issues or clarifications for further follow-up.

On-site Activities

HSAG conducted an on-site visit with **WellCare** on May 4 and 5, 2010. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, primary source verification, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- ◆ **Opening meeting:** The opening meeting included an introduction of the validation team and key **WellCare** staff members involved in the performance measure activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- ◆ **Evaluation of system compliance:** The evaluation included a review of the information systems assessment, focusing on the processing of claims and encounter data, patient data, and inpatient data.

Additionally, the review evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

- ◆ **Review of ISCAT/Roadmap and supporting documentation:** The review included processes used for collecting, storing, validating, and reporting performance measure data. This session was designed to be interactive with key **WellCare** staff members so that the validation team could obtain a complete picture of all the steps taken to generate the performance measures. The goal of the session was to obtain a confidence level as to the degree of compliance with written documentation compared to actual process. HSAG conducted interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and ascertain that written policies and procedures were used and followed in daily practice.
- ◆ **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measures. HSAG performed primary source verification to further validate the output files and reviewed backup documentation on data integration. HSAG also addressed data control and security procedures during this session.
- ◆ **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT/Roadmap and the on-site visit, and revisited the documentation requirements for any post-visit activities.

HSAG conducted several interviews with key **WellCare** staff members who were involved with performance measure reporting. Table 4 lists key **WellCare** interviewees:

Table 4—List of WellCare Interviewees	
Name	Title
Bob Klopotek	Vice President, IT Core Systems
Brian Pogue	Senior Manager, Claims
Carl Zumbano	Manager, Applications Development/EDI
Dana French	Senior Director of Operations
David Jeans	Vice President, IT Data Warehouse and Regulatory Reporting
Debbie Prosser	Manager, HEDIS
Jessica Belser	Manager, QI Analytics
Kendra Graham	Senior Compliance Auditor
Sharon Nisbet	Senior Director, Informatics
Thomas Clegg	HEDIS Specialist

Data Integration, Data Control, and Performance Measure Documentation

There are several aspects crucial to the calculation of performance measures. These include data integration, data control, and documentation of performance measure calculations. Each of the following sections describes the validation processes used and the validation findings. For more detailed information, see Appendix A of this report.

Data Integration

Accurate data integration is essential to calculate valid performance measures. The steps used to combine various data sources (including claims/encounter data, eligibility data, and other administrative data) must be carefully controlled and validated. HSAG validated the data integration process used by **WellCare**, which included a review of file consolidations or extracts, a comparison of source data to warehouse files, data integration documentation, source code, production activity logs, and linking mechanisms. Overall, the validation team determined that the data integration processes in place at **WellCare** were:

- Acceptable
- Not acceptable

Data Control

The organizational infrastructure of a CMO must support all necessary information systems. Each CMO's quality assurance practices and backup procedures must be sound to ensure timely and accurate processing of data, and to provide data protection in the event of a disaster. HSAG validated the data control processes used by **WellCare**, which included a review of disaster recovery procedures, data backup protocols, and related policies and procedures. Overall, the validation team determined that the data control processes in place at **WellCare** were:

- Acceptable
- Not acceptable

Performance Measure Documentation

Sufficient, complete documentation is necessary to support validation activities. While interviews and system demonstrations provided supplementary information, the majority of the validation review findings were based on documentation provided by **WellCare**. HSAG reviewed all related documentation, which included the completed ISCAT/Roadmap, job logs, computer programming code, output files, work flow diagrams, narrative descriptions of performance measure calculations, and other related documentation. Overall, the validation team determined that the documentation of performance measure calculations by **WellCare** was:

- Acceptable
- Not acceptable

Validation Results

The validation team evaluated **WellCare**'s data systems for processing of each type of data used for reporting the DCH performance measures. General findings are indicated below:

Medical Service Data (Claims/Encounters)

WellCare used the Paradigm System to process claims. The system only accepted standard codes and principal codes were identified appropriately. In the Paradigm System, only standard submission forms were used. Most data were submitted via an electronic data interchange (EDI). Encounter data were received, processed, and stored in an operational data store (ODS). Sufficient edit checks were in place to ensure valid and complete encounter data. Institutional claims were reimbursed fee-for-service, ensuring completeness of data submission. The validation team evaluated the lag time for submission of inpatient facility claims and found it to be minimal. The validation team determined that the data were complete at the time the performance measures were calculated.

Enrollment Data

WellCare received all enrollment and eligibility data from the State. Sufficient control procedures and validation were demonstrated to ensure that the receipt and processing of the enrollment files met standards. Manual updates/changes to any member-related data (such as address changes and primary care provider selections) were audited and monitored.

Provider Data

Provider data processing and identification were not relevant to the measures under review.

Medical Record Review Process

WellCare reported all measures using administrative data only. Medical record review was not performed and therefore not evaluated under the scope of this review.

Supplemental Data

WellCare did not use any supplemental data sources for reporting the selected performance measures.

Data Integration

The data integration and measure calculation process was well-documented using Statistical Analysis Software (SAS) scripts. The programmer responsible for the measure calculations was able to maneuver well through data files and demonstrate sound data control and validation processes. Some interpretation was required due to lack of clarity within the measure specifications.

The validation team reviewed the decision logic and interpretation of the specifications and verified with DCH any areas that needed clarification. Primary source verification was performed to validate measure output files during the on-site visit. WellCare made the necessary adjustments to the measure calculations prior to producing the final performance measure results.

Performance Measure Specific Findings

Based on all validation activities, the HSAG Validation Team determined validation results for each performance measure. Table 5 displays the key review results. For detailed information, see Appendix B of this report.

Table 5—Key Review Results for WellCare		
	Performance Measures	Key Review Findings
1.	Cesarean Delivery Rate— <i>AHRQ measure</i>	No concerns identified
2.	Low Birth Weight Rate— <i>AHRQ measure</i>	No concerns identified
3.	Asthma ED/Urgent Care Visits— <i>TR-developed measure</i>	No concerns identified
4.	Diabetes Short Term Complications Admission Rate— <i>AHRQ measure</i>	No concerns identified
5.	Asthma Admission Rate— <i>AHRQ measure</i>	No concerns identified

Validation Findings

The CMS performance measure validation protocol identifies four validation findings for each performance measure, which are defined in Table 6:

Table 6—Validation Findings Definitions	
Fully Compliant (FC)	Indicates that the performance measure was fully compliant with DCH specifications.
Substantially Compliant (SC)	Indicates that the performance measure was substantially compliant with DCH specifications and had only minor deviations that did not significantly bias the reported rate.
Not Valid (NV)	Indicates that the performance measure deviated from DCH specifications such that the reported rate was significantly biased. This designation is also assigned to measures for which no rate was reported, although reporting of the rate was required.
Not Applicable (NA)	Indicates that the performance measure was not reported because the CMO did not have any Medicaid consumers who qualified for that denominator.

According to the Protocol, the validation finding for each measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be not met. Consequently, it is possible that an error for a single audit element may result in a designation of Not Valid (NV) because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, resulting in a measure designation of Substantially Compliant (SC).

Table 7 shows the final validation findings for **WellCare** for each performance measure. For additional information regarding performance measure results, see Appendix C of this report.

Table 7—Validation Findings for WellCare		
	Performance Measures	Validation Finding
1.	Cesarean Delivery Rate— <i>AHRQ measure</i>	Fully Compliant
2.	Low Birth Weight Rate— <i>AHRQ measure</i>	Fully Compliant
3.	Asthma ED/Urgent Care Visits— <i>TR-developed measure</i>	Fully Compliant
4.	Diabetes Short-Term Complications Admission Rate— <i>AHRQ measure</i>	Fully Compliant
5.	Asthma Admission Rate— <i>AHRQ measure</i>	Fully Compliant

Appendix A. **Data Integration and Control Findings**

for WellCare of Georgia, Inc.

Appendix A, which follows this page, contains the data integration and control findings for **WellCare**.

Appendix A. Data Integration and Control Findings

for WellCare of Georgia, Inc.

Documentation Worksheet

CMO Name:	WellCare of Georgia, Inc.
On-Site Visit Date:	May 4 and 5, 2010
Reviewers:	Margaret Ketterer, RN, BSN, CHCA, and Allen Iovannisci, MS, CHCA

Data Integration and Control Element	Met	Not Met	N/A	Comments
Accuracy of data transfers to assigned performance measure data repository				
The CMO accurately and completely processes transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the calculations of the performance measures have been completed and validated.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Samples of data from the performance measure data repository are complete and accurate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Accuracy of file consolidations, extracts, and derivations				
The CMO's processes to consolidate diversified files and to extract required information from the performance measure data repository are appropriate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Actual results of file consolidations or extracts are consistent with those that should have resulted according to documented algorithms or specifications.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Some clarifications were needed and appropriate adjustments were made prior to final calculation.
Procedures for coordinating the activities of multiple subcontractors ensure the accurate, timely, and complete integration of data into the performance measure database.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Computer program reports or documentation reflect vendor coordination activities, and no data necessary to performance measure reporting are lost or inappropriately modified during transfer.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If the CMO uses a performance measure data repository, its structure and format facilitates any required programming necessary to calculate and report required performance measures.				
The performance measure data repository's design, program flow charts, and source codes enable analyses and reports.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Proper linkage mechanisms are employed to join data from all necessary sources (e.g., identifying a member with a given disease/condition).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Data Integration and Control Element	Met	Not Met	N/A	Comments
Assurance of effective management of report production and of the reporting software.				
Documentation governing the production process, including CMO production activity logs and the CMO staff review of report runs, is adequate.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Prescribed data cutoff dates are followed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The CMO retains copies of files or databases used for performance measure reporting in case results need to be reproduced.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The reporting software program is properly documented with respect to every aspect of the performance measure data repository, including building, maintaining, managing, testing, and report production.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The CMO's processes and documentation comply with the CMO standards associated with reporting program specifications, code review, and testing.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Appendix B. **Denominator and Numerator Validation Findings**

for WellCare of Georgia, Inc.

Appendix B, which follows this page, contains the denominator and numerator validation findings for **WellCare**.

Appendix B. Denominator and Numerator Validation Findings

for WellCare of Georgia, Inc.

Reviewer Worksheets

CMO Name:	WellCare of Georgia, Inc.
On-Site Visit Date:	May 4 and 5, 2010
Reviewers:	Margaret Ketterer, RN, BSN, CHCA, and Allen Iovannisci, MS, CHCA

Table B-1—Denominator Validation Findings for WellCare

Audit Element	Met	Not Met	N/A	Comments
For each of the performance measures, all members of the relevant populations identified in the performance measure specifications are included in the population from which the denominator is produced.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Adequate programming logic or source code exists to appropriately identify all relevant members of the specified denominator population for each of the performance measures.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The CMO correctly calculates member months and member years if applicable to the performance measure.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	Member-month and year calculations were not required for the measures under review.
The CMO properly evaluates the completeness and accuracy of any codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes are appropriately identified and applied as specified in each performance measure.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
If any time parameters are required by the specifications of the performance measure, they are followed (e.g., cutoff dates for data collection, counting 30 calendar days after discharge from a hospital, etc.).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exclusion criteria included in the performance measure specifications are followed.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Systems or methods used by the CMO to estimate populations when they cannot be accurately or completely counted (e.g., newborns) are valid.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Table B-2—Numerator Validation Findings for WellCare				
Audit Element	Met	Not Met	N/A	Comments
The CMO uses the appropriate data, including linked data from separate data sets, to identify the entire at-risk population.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Qualifying medical events (such as diagnoses, procedures, prescriptions, etc.) are properly identified and confirmed for inclusion in terms of time and services.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
The CMO avoids or eliminates all double-counted members or numerator events.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Any nonstandard codes used in determining the numerator are mapped to a standard coding scheme in a manner that is consistent, complete, and reproducible, as evidenced by a review of the programming logic or a demonstration of the program.	<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	WellCare did not use any non-standard codes.
If any time parameters are required by the specifications of the performance measure, they are followed (i.e., the measured event occurred during the time period specified or defined in the performance measure).	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Appendix C. **Performance Measure Results**
for WellCare of Georgia, Inc.

Appendix C, which follows this page, contains **WellCare**'s performance measure results.

Appendix C. Performance Measure Results *for WellCare of Georgia, Inc.*

Indicator 1—Cesarean Delivery Rate

Table C-1—Indicator 1 <i>for WellCare of Georgia, Inc.</i>			
	Denominator	Numerator	Rate
Cesarean Delivery Rate	26,030	7,928	30.46%

Indicator 2—Low Birth Weight Rate

Table C-2—Indicator 2 <i>for WellCare of Georgia, Inc.</i>			
	Denominator	Numerator	Rate
Low Birth Weight Rate	28,482	1,962	6.89%

Indicator 3—Asthma Emergency Department/Urgent Care Visits

Table C-3—Indicator 3 <i>for WellCare of Georgia, Inc.</i>			
	Denominator	Numerator	Rate
Asthma ED/Urgent Care Visits	656,341	9,459	1.44%

Indicator 4—Diabetes Short-Term Complications Admission Rate

Table C-4—Indicator 4 <i>for WellCare of Georgia, Inc.</i>			
	Denominator	Numerator	Rate (per 100,000)
Diabetes Short-Term Complications Admission Rate	307,747	88	28.59

Indicator 5—Asthma Admission Rate

Table C-5—Indicator 5 <i>for WellCare of Georgia, Inc.</i>			
	Denominator	Numerator	Rate (per 100,000)
Asthma Admission Rate	490,801	514	104.73

Appendix D. **Final Audited HEDIS Results**
for WellCare of Georgia, Inc.

Appendix D, which follows this page, contains the final audited HEDIS results for **WellCare**.

Appendix D. Final Audited HEDIS Results

for WellCare of Georgia, Inc.

CMO Audited Calendar Year 2009 HEDIS Performance Measure Report—WellCare			
Measure	Numerator	Denominator	CMO Rate
Well-Child Visits in the First 15 Months of Life - Zero Visits ¹	8	411	1.95% Hybrid
Well-Child Visits in the First 15 Months of Life - One Visit	11	411	2.68% Hybrid
Well-Child Visits in the First 15 Months of Life - Two Visits	22	411	5.35% Hybrid
Well-Child Visits in the First 15 Months of Life - Three Visits	23	411	5.60% Hybrid
Well-Child Visits in the First 15 Months of Life - Four Visits	45	411	10.95% Hybrid
Well-Child Visits in the First 15 Months of Life - Five Visits	66	411	16.06% Hybrid
Well-Child Visits in the First 15 Months of Life - Six or More Visits	236	411	57.42% Hybrid
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	242	411	58.88% Hybrid
Adolescent Well-Care Visits	135	411	32.85% Hybrid
Childrens and Adolescents Access to Primary Care Providers - Ages 12-24 Months	23,797	24,605	96.72%
Childrens and Adolescents Access to Primary Care Providers - Ages 25 Months - 6 Years	88,972	97,160	91.39%
Childrens and Adolescents Access to Primary Care Providers - Ages 7-11 Years	41,858	45,918	91.16%
Childrens and Adolescents Access to Primary Care Providers - Ages 12-19 Years	43,635	49,412	88.31%
Adults Access to Preventive/Ambulatory Health Services - Ages 20-44 Years	19,221	22,701	84.67%
Childhood Immunization Status - Combo 2	333	411	81.02% Hybrid
Lead Screening in Children	277	411	67.40% Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile (Total)	150	411	36.50% Hybrid

CMO Audited Calendar Year 2009 HEDIS Performance Measure Report—WellCare			
Measure	Numerator	Denominator	CMO Rate
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition (Total)	174	411	42.34% Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity (Total)	159	411	38.69% Hybrid
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase	2,113	4,875	43.34%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase	432	840	51.43%
Annual Dental Visit - Ages 2-3 Years	16,345	40,455	40.40%
Annual Dental Visit - Ages 4-6 Years	42,691	58,297	73.23%
Annual Dental Visit - Ages 7-10 Years	48,936	64,324	76.08%
Annual Dental Visit - Ages 11-14 Years	36,409	53,000	68.70%
Annual Dental Visit - Ages 15-18 Years	24,670	42,112	58.58%
Annual Dental Visit - Ages 19-21 Years	938	2,496	37.58%
Annual Dental Visit - Total	169,989	260,684	65.21%
Cervical Cancer Screening	271	411	65.94% Hybrid
Breast Cancer Screening	1,247	2,432	51.27%
Comprehensive Diabetes Care - HbA1c Testing	431	548	78.65% Hybrid
Comprehensive Diabetes Care - HbA1c Poor Control ¹	298	548	54.38% Hybrid
Comprehensive Diabetes Care - HbA1c Good Control <8.0	212	548	38.69% Hybrid
Comprehensive Diabetes Care - HbA1c Good Control <7.0	146	457	31.95% Hybrid
Comprehensive Diabetes Care - Eye Exam	204	548	37.23% Hybrid

CMO Audited Calendar Year 2009 HEDIS Performance Measure Report—WellCare			
Measure	Numerator	Denominator	CMO Rate
Comprehensive Diabetes Care - LDL-C Screening	379	548	69.16% Hybrid
Comprehensive Diabetes Care - LDL-C Level	128	548	23.36% Hybrid
Comprehensive Diabetes Care - Medical Attention to Nephropathy	388	548	70.80% Hybrid
Comprehensive Diabetes Care - Blood Pressure Control <130/80	139	548	25.36% Hybrid
Comprehensive Diabetes Care - Blood Pressure Control <140/90	293	548	53.47% Hybrid
Use of Appropriate Medications for People with Asthma - Ages 5-11 Years	2,783	3,033	91.76%
Use of Appropriate Medications for People with Asthma - Ages 12-50 Years	1,528	1,762	86.72%
Use of Appropriate Medications for People with Asthma - Total	4,311	4,795	89.91%
Follow-Up After Hospitalization for Mental Illness - 30-Day Follow-Up	3,436	3,897	88.17%
Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up	3,103	3,897	79.63%
Inpatient Utilization—General Hospital/Acute Care	Rates reported in separate table		
Prenatal and Postpartum Care - Timeliness of Prenatal Care	338	411	82.24% Hybrid
Prenatal and Postpartum Care - Postpartum Care	286	411	69.59% Hybrid
Frequency of Ongoing Prenatal Care - <21 Percent	57	411	13.87% Hybrid
Frequency of Ongoing Prenatal Care - 21-40 Percent	13	411	3.16% Hybrid
Frequency of Ongoing Prenatal Care - 41-60 Percent	21	411	5.11% Hybrid
Frequency of Ongoing Prenatal Care - 61-80 Percent	39	411	9.49% Hybrid
Frequency of Ongoing Prenatal Care - 81+ Percent	281	411	68.37% Hybrid

CMO Audited Calendar Year 2009 HEDIS Performance Measure Report—WellCare			
Measure	Numerator	Denominator	CMO Rate
Weeks of Pregnancy at Time of Enrollment - <0 Weeks	51	411	12.41% Hybrid
Weeks of Pregnancy at Time of Enrollment - <1-12 Weeks	42	411	10.22% Hybrid
Weeks of Pregnancy at Time of Enrollment - <13-27 Weeks	244	411	59.37% Hybrid
Weeks of Pregnancy at Time of Enrollment - <28 or More Weeks	61	411	14.84% Hybrid
Weeks of Pregnancy at Time of Enrollment - Unknown	13	411	3.16% Hybrid
Weeks of Pregnancy at Time of Enrollment - Total	411	411	100% Hybrid
Appropriate Treatment For Children With Upper Respiratory Infection ²	8,617	38,793	77.79%
Mental Health Utilization	Rates reported in separate table		
Call Abandonment ¹	9,444	590,022	1.60%
Antibiotic Utilization	Rates reported in separate table		
Outpatient Drug Utilization - Average Cost of Prescriptions Per Member Per Month	NA		\$24.52
Outpatient Drug Utilization - Average Number of Prescriptions Per Member Per Month	NA		7.77
Race/Ethnicity Diversity of Membership	Rates reported in separate table		
Language Diversity of Membership	Rates reported in separate table		

¹ Note: Lower rate is better

² Note: The measure is reported as an inverted rate. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed). The rate is calculated as 1 minus the numerator divided by the eligible population.

Appendix E. Audited CY 2009 HEDIS Utilization Measure Results for **WellCare of Georgia, Inc.**

Appendix E, which follows this page, contains **WellCare**'s audited CY 2009 HEDIS utilization measure results.

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)

Inpatient Utilization--General Hospital/Acute Care: Total (IPUA)

WellCare of Georgia, Inc. (Medicaid/Peachcare Kids)

Age	Member Months
<1	526,817
1-9	2,957,429
10-19	1,921,096
20-44	723,855
45-64	72,283
65-74	537
75-84	17
85+	0
Unknown	0
Total	6,202,034

Total Inpatient

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	4011	7.61	24038	45.63	5.99
1-9	4184	1.41	12932	4.37	3.09
10-19	8472	4.41	25130	13.08	2.97
20-44	29053	40.14	83369	115.17	2.87
45-64	1105	15.29	5055	69.93	4.57
65-74	3	5.59	8	14.90	2.67
75-84	0	0.00	0	0.00	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	46,828	7.55	150,532	24.27	3.21

Medicine

Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	3212	6.10	12880	24.45	4.01
1-9	3202	1.08	8411	2.84	2.63
10-19	1271	0.66	4091	2.13	3.22
20-44	1763	2.44	6191	8.55	3.51
45-64	585	8.09	2183	30.20	3.73
65-74	2	3.72	7	13.04	3.50
75-84	0	0.00	0	0.00	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	10,035	1.62	33,763	5.44	3.36

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Inpatient Utilization - General Hospital/Acute Care: Total (IPUA)

Surgery					
Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
<1	799	1.52	11158	21.18	13.96
1-9	982	0.33	4521	1.53	4.60
10-19	746	0.39	3892	2.03	5.22
20-44	1641	2.27	7480	10.33	4.56
45-64	499	6.90	2811	38.89	5.63
65-74	1	1.86	1	1.86	1.00
75-84	0	0.00	0	0.00	NA
85+	0	NA	0	NA	NA
Unknown	0		0		NA
Total	4,668	0.75	29,863	4.82	6.40
Maternity*					
Age	Discharges	Discharges / 1,000 Member Months	Days	Days / 1,000 Members Months	Average Length of Stay
10-19	6455	3.36	17147	8.93	2.66
20-44	25649	35.43	69698	96.29	2.72
45-64	21	0.29	61	0.84	2.90
Unknown	0		0		NA
Total	32,125	11.82	86,906	31.98	2.71

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Mental Health Utilization: Total (MPTA)

Mental Health Utilization: Total (MPTA)												
WellCare of Georgia, Inc. (Medicaid/Peachcare Kids)												
Age	Member Months (Any)			Member Months (Inpatient)			Member Months (Intensive Outpatient/Partial Hospitalization)			Member Months (Outpatient/ED)		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
0-12	2130264	2082436	4,212,700	2130264	2082436	4,212,700	2130264	2082436	4,212,700	2130264	2082436	4,212,700
13-17	490822	514848	1,005,670	490822	514848	1,005,670	490822	514848	1,005,670	490822	514848	1,005,670
18-64	144615	838495	983,110	144615	838495	983,110	144615	838495	983,110	144615	838495	983,110
65+	42	512	554	42	512	554	42	512	554	42	512	554
Unknown	0	0	0	0	0	0	0	0	0	0	0	0
Total	2,765,743	3,436,291	6,202,034	2,765,743	3,436,291	6,202,034	2,765,743	3,436,291	6,202,034	2,765,743	3,436,291	6,202,034

Age	Sex	Any Services		Inpatient		Intensive Outpatient/Partial Hospitalization		Outpatient/ED	
		Number	Percent	Number	Percent	Number	Percent	Number	Percent
		0-12	M	13090	7.37%	1359	0.77%	2251	1.27%
	F	7438	4.29%	797	0.46%	1035	0.60%	7265	4.19%
	Total	20,528	5.85%	2,156	0.61%	3,286	0.94%	20,001	5.70%
13-17	M	5042	12.33%	722	1.77%	1019	2.49%	4860	11.88%
	F	4739	11.05%	769	1.79%	924	2.15%	4598	10.72%
	Total	9,781	11.67%	1,491	1.78%	1,943	2.32%	9,458	11.29%
18-64	M	1010	8.38%	178	1.48%	215	1.78%	926	7.68%
	F	6885	9.85%	956	1.37%	1849	2.65%	6372	9.12%
	Total	7,895	9.64%	1,134	1.38%	2,064	2.52%	7,298	8.91%
65+	M	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	F	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	Total	0	0.00%	0	0.00%	0	0.00%	0	0.00%
Unknown	M	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA
Total	M	19,142	8.31%	2,259	0.98%	3,485	1.51%	18,522	8.04%
	F	19,062	6.66%	2,522	0.88%	3,808	1.33%	18,235	6.37%
	Total	38,204	7.39%	4,781	0.93%	7,293	1.41%	36,757	7.11%

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Antibiotic Utilization: Total (ABXA)

Antibiotic Utilization: Total (ABXA)

WellCare of Georgia, Inc. (Medicaid/Peachcare Kids)

Pharmacy Benefit Member Months			
Age	Male	Female	Total
0-9	1763808	1720438	3,484,246
10-17	857278	876846	1,734,124
18-34	105738	640246	745,984
35-49	32181	169707	201,888
50-64	6696	28542	35,238
65-74	41	496	537
75-84	1	16	17
85+	0	0	0
Unknown	0	0	0
Total	2,765,743	3,436,291	6,202,034

Antibiotic Utilization								
Age	Sex	Total Antibiotic Scrips	Average Scrips PMPY for Antibiotics	Total Days Supplied for All Antibiotic Scrips	Average Days Supplied per Antibiotic Scrip	Total Number of Scrips for Antibiotics of Concern	Average Scrips PMPY for Antibiotics of Concern	Percentage of Antibiotics of Concern of all Antibiotic Scrips
0-9	M	238887	1.63	2201533	9.22	115589	0.79	48.39%
	F	229969	1.60	2147719	9.34	103591	0.72	45.05%
	Total	468,856	1.61	4,349,252	9.28	219,180	0.75	46.75%
10-17	M	59611	0.83	580583	9.74	28252	0.40	47.39%
	F	79854	1.09	731211	9.16	34877	0.48	43.68%
	Total	139,465	0.97	1,311,794	9.41	63,129	0.44	45.27%
18-34	M	8645	0.98	80886	9.36	3473	0.39	40.17%
	F	112222	2.10	877778	7.82	37883	0.71	33.76%
	Total	120,867	1.94	958,664	7.93	41,356	0.67	34.22%
35-49	M	3636	1.36	33057	9.09	1589	0.59	43.70%
	F	29493	2.09	247775	8.40	12688	0.90	43.02%
	Total	33,129	1.97	280,832	8.48	14,277	0.85	43.10%
50-64	M	795	1.42	7136	8.98	377	0.68	47.42%
	F	4144	1.74	35457	8.56	2072	0.87	50.00%
	Total	4,939	1.68	42,593	8.62	2,449	0.83	49.58%
65-74	M	2	0.59	45	22.50	0	0.00	0.00%
	F	41	0.99	352	8.59	21	0.51	51.22%
	Total	43	0.96	397	9.23	21	0.47	48.84%
75-84	M	0	0.00	0	NA	0	0.00	NA
	F	1	0.75	10	10.00	0	0.00	0.00%
	Total	1	0.71	10	10.00	0	0.00	0.00%
85+	M	0	NA	0	NA	0	NA	NA
	F	0	NA	0	NA	0	NA	NA
	Total	0	NA	0	NA	0	NA	NA
Unknown	M	0	NA	0	NA	0	NA	NA
	F	0	NA	0	NA	0	NA	NA
	Total	0	NA	0	NA	0	NA	NA
Total	M	311,576	1.35	2,903,240	9.32	149,280	0.65	47.91%
	F	455,724	1.59	4,040,302	8.87	191,132	0.67	41.94%
	Total	767,300	1.48	6,943,542	9.05	340,412	0.66	44.36%

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Antibiotic Utilization: Total (ABXA)

Antibiotics of Concern Utilization															
Age	Sex	Total Quinolone Scrips	Average Scrips PMPY for Quinolones	Total Cephalosporin 2nd-4th Generation Scrips	Average Scrips PMPY for Cephalosporins 2nd-4th Generation	Total Azithromycin and Clarithromycin Scrips	Average Scrips PMPY for Azithromycins and Clarithromycins	Total Amoxicillin/Clavulanate Scrips	Average Scrips PMPY for Amoxicillin/Clavulanates	Total Ketolides Scrips	Average Scrips PMPY for Ketolides	Total Clindamycin Scrips	Average Scrips PMPY for Clindamycins	Total Misc. Antibiotics of Concern Scrips	Average Scrips PMPY for Misc. Antibiotics of Concern
0-9	M	84	0.00	32650	0.22	43500	0.30	37150	0.25	0	0.00	2179	0.01	26	0.00
	F	99	0.00	30308	0.21	38637	0.27	32544	0.23	0	0.00	1981	0.01	22	0.00
	Total	183	0.00	62,958	0.22	82,137	0.28	69,694	0.24	0	0.00	4,160	0.01	48	0.00
10-17	M	488	0.01	4482	0.06	14604	0.20	7415	0.10	0	0.00	1245	0.02	18	0.00
	F	1433	0.02	5639	0.08	18119	0.25	8078	0.11	0	0.00	1594	0.02	14	0.00
	Total	1,921	0.01	10,121	0.07	32,723	0.23	15,493	0.11	0	0.00	2,839	0.02	32	0.00
18-34	M	578	0.07	247	0.03	1634	0.19	646	0.07	0	0.00	358	0.04	10	0.00
	F	8939	0.17	2476	0.05	17672	0.33	5426	0.10	0	0.00	3335	0.06	35	0.00
	Total	9,517	0.15	2,723	0.04	19,306	0.31	6,072	0.10	0	0.00	3,693	0.06	45	0.00
35-49	M	432	0.16	87	0.03	594	0.22	283	0.11	0	0.00	172	0.06	21	0.01
	F	3970	0.28	776	0.05	5090	0.36	1850	0.13	0	0.00	956	0.07	46	0.00
	Total	4,402	0.26	863	0.05	5,684	0.34	2,133	0.13	0	0.00	1,128	0.07	67	0.00
50-64	M	129	0.23	24	0.04	145	0.26	42	0.08	0	0.00	30	0.05	7	0.01
	F	772	0.32	114	0.05	797	0.34	288	0.12	0	0.00	90	0.04	11	0.00
	Total	901	0.31	138	0.05	942	0.32	330	0.11	0	0.00	120	0.04	18	0.01
65-74	M	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
	F	10	0.24	2	0.05	9	0.22	0	0.00	0	0.00	0	0.00	0	0.00
	Total	10	0.22	2	0.04	9	0.20	0	0.00	0	0.00	0	0.00	0	0.00
75-84	M	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
	F	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
	Total	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
85+	M	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
Unknown	M	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
Total	M	1,711	0.01	37,490	0.16	60,477	0.26	45,536	0.20	0	0.00	3,984	0.02	82	0.00
	F	15,223	0.05	39,315	0.14	80,324	0.28	48,186	0.17	0	0.00	7,956	0.03	128	0.00
	Total	16,934	0.03	76,805	0.15	140,801	0.27	93,722	0.18	0	0.00	11,940	0.02	210	0.00

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Antibiotic Utilization: Total (ABXA)

All Other Antibiotics Utilization																	
Age	Sex	Total Absorbable Sulfonamide Scrrips	Average Scrrips PMPY for Absorbable Sulfonamides	Total Aminoglycoside Scrrips	Average Scrrips PMPY for Aminoglycosides	Total 1st Generation Cephalosporin Scrrips	Average Scrrips PMPY for 1st Generation Cephalosporins	Total Lincosamide Scrrips	Average Scrrips PMPY for Lincosamides	Total Macrolides (not azith. or clarith.) Scrrips	Average Scrrips PMPY for Macrolides (not azith. or clarith.)	Total Penicillin Scrrips	Average Scrrips PMPY for Penicillins	Total Tetracycline Scrrips	Average Scrrips PMPY for Tetracyclines	Total Misc. Antibiotic Scrrips	Average Scrrips PMPY for Misc. Antibiotics
0-9	M	11080	0.08	1	0.00	13587	0.09	0	0.00	554	0.00	97819	0.67	50	0.00	207	0.00
	F	17195	0.12	13	0.00	13411	0.09	0	0.00	481	0.00	94510	0.66	55	0.00	713	0.00
	Total	28,275	0.10	14	0.00	26,998	0.09	0	0.00	1,035	0.00	192,329	0.66	105	0.00	920	0.00
10-17	M	3978	0.06	2	0.00	5755	0.08	0	0.00	332	0.00	16763	0.23	4259	0.06	270	0.00
	F	8230	0.11	4	0.00	6244	0.09	0	0.00	439	0.01	21096	0.29	4629	0.06	4335	0.06
	Total	12,208	0.08	6	0.00	11,999	0.08	0	0.00	771	0.01	37,859	0.26	8,888	0.06	4,605	0.03
18-34	M	826	0.09	0	0.00	843	0.10	0	0.00	109	0.01	2409	0.27	823	0.09	162	0.02
	F	10305	0.19	11	0.00	7863	0.15	0	0.00	1057	0.02	21583	0.40	7791	0.15	25729	0.48
	Total	11,131	0.18	11	0.00	8,706	0.14	0	0.00	1,166	0.02	23,992	0.39	8,614	0.14	25,891	0.42
35-49	M	387	0.14	0	0.00	364	0.14	0	0.00	44	0.02	854	0.32	296	0.11	102	0.04
	F	3094	0.22	2	0.00	2126	0.15	0	0.00	314	0.02	5346	0.38	2117	0.15	3806	0.27
	Total	3,481	0.21	2	0.00	2,490	0.15	0	0.00	358	0.02	6,200	0.37	2,413	0.14	3,908	0.23
50-64	M	86	0.15	0	0.00	79	0.14	0	0.00	9	0.02	157	0.28	54	0.10	33	0.06
	F	429	0.18	3	0.00	364	0.15	0	0.00	24	0.01	685	0.29	267	0.11	300	0.13
	Total	515	0.18	3	0.00	443	0.15	0	0.00	33	0.01	842	0.29	321	0.11	333	0.11
65-74	M	2	0.59	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
	F	2	0.05	0	0.00	3	0.07	0	0.00	0	0.00	4	0.10	4	0.10	7	0.17
	Total	4	0.09	0	0.00	3	0.07	0	0.00	0	0.00	4	0.09	4	0.09	7	0.16
75-84	M	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
	F	1	0.75	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
	Total	1	0.71	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00	0	0.00
85+	M	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
Unknown	M	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	F	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
	Total	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA	0	NA
Total	M	16,359	0.07	3	0.00	20,628	0.09	0	0.00	1,048	0.00	118,002	0.51	5,482	0.02	774	0.00
	F	39,256	0.14	33	0.00	30,011	0.10	0	0.00	2,315	0.01	143,224	0.50	14,863	0.05	34,890	0.12
	Total	55,615	0.11	36	0.00	50,639	0.10	0	0.00	3,363	0.01	261,226	0.51	20,345	0.04	35,664	0.07

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Race/Ethnicity Diversity of Membership (RDM)

Race/Ethnicity Diversity of Membership (RDM)									
WellCare of Georgia, Inc. (Medicaid/Peachcare Kids)									
Eligible Population									
Category	Value								
Total unduplicated membership during the measurement year	751398								
Data Source	NR								
Race	Sex	Hispanic or Latino (any race)		Not Hispanic or Latino		Unknown Ethnicity		Total	
		Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
White	M	0	0.00%	15029	2.00%	141452	18.83%	156,481	20.83%
	F	0	0.00%	14016	1.87%	184356	24.54%	198,372	26.40%
	Total	0	0.00%	29,045	3.87%	325,808	43.36%	354,853	47.23%
Black or African American	M	0	0.00%	5723	0.76%	131959	17.56%	137,682	18.32%
	F	0	0.00%	5764	0.77%	192859	25.67%	198,623	26.43%
	Total	0	0.00%	11,487	1.53%	324,818	43.23%	336,305	44.76%
American-Indian and Alaska Native	M	0	0.00%	199	0.03%	0	0.00%	199	0.03%
	F	0	0.00%	285	0.04%	0	0.00%	285	0.04%
	Total	0	0.00%	484	0.06%	0	0.00%	484	0.06%
Asian	M	0	0.00%	6023	0.80%	0	0.00%	6,023	0.80%
	F	0	0.00%	6655	0.89%	0	0.00%	6,655	0.89%
	Total	0	0.00%	12,678	1.69%	0	0.00%	12,678	1.69%
Native Hawaiian and Other Pacific Islanders	M	0	0.00%	0	0.00%	0	0.00%	0	0.00%
	F	0	0.00%	1	0.00%	0	0.00%	1	0.00%
	Total	0	0.00%	1	0.00%	0	0.00%	1	0.00%
Some Other Race	M	0	0.00%	3413	0.45%	0	0.00%	3,413	0.45%
	F	0	0.00%	3617	0.48%	0	0.00%	3,617	0.48%
	Total	0	0.00%	7,030	0.94%	0	0.00%	7,030	0.94%
Two or More Races	M	0	0.00%	0	0.00%	3	0.00%	3	0.00%
	F	0	0.00%	0	0.00%	1	0.00%	1	0.00%
	Total	0	0.00%	0	0.00%	4	0.00%	4	0.00%
Unknown	M	8190	1.09%	0	0.00%	12246	1.63%	20,436	2.72%
	F	8033	1.07%	0	0.00%	11574	1.54%	19,607	2.61%
	Total	16,223	2.16%	0	0.00%	23,820	3.17%	40,043	5.33%
Total	M	8,190	1.09%	30,387	4.04%	285,660	38.02%	324,237	43.15%
	F	8,033	1.07%	30,338	4.04%	388,790	51.74%	427,161	56.85%
	Total	16,223	2.16%	60,725	8.08%	674,450	89.76%	751,398	100.00%
Totals									
Measure	Percentage								
Percentage of plan members with known race information	94.67%								
Percentage of plan members with known ethnicity information	10.24%								

Department of Community Health, State of Georgia
 Audited CY 2009 HEDIS Utilization Measure Results for WellCare of Georgia, Inc.
 Language Diversity of Membership (LDM)

Language Diversity of Membership (LDM)			
WellCare of Georgia, Inc. (Medicaid/Peachcare Kids)			
Eligible Population			
Category	Value		
Total unduplicated membership during the measurement year:	751398		
Data Source	NR		
Demand for Language Interpretation Services			
Demand for Language Interpretation Services	Sex	Number	Percentage
Need/want an interpreter? Yes	M	0	0.00%
	F	0	0.00%
	Total	0	0.00%
Need/want an interpreter? No	M	0	0.00%
	F	0	0.00%
	Total	0	0.00%
Need/want an interpreter? Unknown	M	324237	43.15%
	F	427161	56.85%
	Total	751,398	100.00%
Total	M	324,237	43.15%
	F	427,161	56.85%
	Total	751,398	100.00%
Percentage of members with known interpretation needs			0.00%
Spoken Language at Home			
Spoken Language at Home	Sex	Number	Percentage
English	M	281510	37.46%
	F	383943	51.10%
	Total	665,453	88.56%
Spanish (or Spanish Creole)	M	19667	2.62%
	F	20036	2.67%
	Total	39,703	5.28%
Other Indo-European Languages (e.g., French or French Creole, Italian, Portuguese or Portuguese Creole, German, Yiddish, Scandinavian languages, Greek, Russian, Polish, Serbo-Croatian, Armenian, Persian, Gujarathi, Hindi, Urdu)	M	295	0.04%
	F	383	0.05%
	Total	678	0.09%
Asian and Pacific Island Languages (e.g., Chinese, Japanese, Korean, Mon-Khmer, Cambodian, Miao, Hmong, Thai, Laotian, Vietnamese, Tagalog and Other Pacific Island languages)	M	92	0.01%
	F	154	0.02%
	Total	246	0.03%
Other Languages (e.g., Navajo, Other Native North American languages, Hungarian, Arabic, Hebrew, African languages)	M	214	0.03%
	F	501	0.07%
	Total	715	0.10%
Unknown	M	22459	2.99%
	F	22144	2.95%
	Total	44,603	5.94%
Total	M	324,237	43.15%
	F	427,161	56.85%
	Total	751,398	100.00%
Percentage of members with known spoken language			94.06%

State of Georgia



Department of Community Health
Georgia Families Program

WellCare of Georgia, Inc.

**PERFORMANCE IMPROVEMENT
PROJECTS REPORT
FY 2011**

November 2010



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TABLE OF CONTENTS

1. BACKGROUND	1-1
CMO Overview	1-2
Study Rationale	1-2
Study Summary	1-2
Validation Overview	1-4
2. FINDINGS	2-1
Aggregate Validation Findings	2-1
Study Design	2-2
Study Implementation	2-2
Study Outcomes	2-2
PIP-Specific Outcomes	2-3
Analysis of Results	2-3
Barriers/Interventions	2-5
3. STRENGTHS	3-1
Individual PIP Strengths	3-1
Global Strengths Across all PIPs	3-1
4. OPPORTUNITIES FOR IMPROVEMENT	4-1
Individual PIPs	4-1
Global Issues	4-1
Appendix A. PIP-SPECIFIC VALIDATION SCORES	A-1

CAHPS[®] refers to the Consumer Assessment of Healthcare Providers and Systems and is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

HEDIS[®] refers to the Healthcare Effectiveness Data and Information Set and is a registered trademark of the National Committee for Quality Assurance (NCQA).

NCQA HEDIS Compliance Audit[™] is a trademark of NCQA.

1. BACKGROUND

The Code of Federal Regulations (CFR), specifically 42 CFR 438.350, requires states that contract with managed care organizations to conduct an external quality review (EQR) of each entity. An EQR includes the analysis and evaluation by an external quality review organization (EQRO) of aggregated information on health care quality, timeliness, and access. In Georgia, the EQR analyzes and evaluates the health care services that a care management organization (CMO) or its contractors furnish to Georgia Families recipients. At a minimum, the State must report EQRO findings to the federal government on the following mandatory activities:

- ◆ Evaluation of CMO Compliance with Managed Care Regulations
- ◆ Validation of CMO Performance Measures
- ◆ Validation of CMO Performance Improvement Projects (PIPs)

These three mandatory activities work together to ensure that Georgia Families' Program and the CMOs are providing quality care to their members. While a CMO's compliance with managed care regulations provides the organizational foundation for the delivery of quality health care, the calculation and reporting of performance measures provides a barometer of the quality and effectiveness of care. When performance measures highlight areas of low performance, the Department of Community Health (DCH) and the CMOs employ PIPs to improve the quality of health care in targeted areas. PIPs are a key tool in the CMOs' overall quality strategy; they provide the framework for monitoring, measuring, and improving the delivery of health care.

This is the third year Health Services Advisory Group, Inc. (HSAG), as the State's EQRO, conducted a validation of the CMOs' PIPs. HSAG reviewed each submitted PIP using the Centers for Medicare & Medicaid Services (CMS) validation protocol¹ and evaluated two key components of the quality improvement process, as follows:

- 1) HSAG evaluated the technical structure of the PIPs to ensure the CMOs designed, conducted, and reported PIPs in a methodologically sound manner that met all State and federal requirements. HSAG's review determined whether a PIP's design (e.g., the study indicators, data collection methodology, and analysis plan) was based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and are capable of measuring sustained improvement.
- 2) HSAG evaluated the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic identification of barriers and the subsequent development of relevant interventions. This component evaluates how well a CMO improved

¹ The Centers for Medicare & Medicaid Services. *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol Version 1.0, May 1, 2002.

its rates through implementation of effective processes (i.e., barrier analyses, intervention design, and evaluation of results). A primary goal of HSAG's PIP validation is to ensure that DCH and key stakeholders can have confidence that any reported improvement in outcomes is related to a given PIP.

CMO Overview

DCH contracted with WellCare of Georgia, Inc. (WellCare) beginning in 2006 to provide services to the Georgia Families program (Medicaid and PeachCare for Kids™) population. WellCare, a CMO, currently serves the eligible population in all geographic regions of Georgia—Atlanta, Central, East, North, Southeast, and Southwest.

Study Rationale

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

In fiscal year (FY) 2009, DCH chose three PIP topics for validation (i.e., *Provider Satisfaction*, *Well-Child Visits*, and *Lead Screening in Children*). While similar to national, standardized Healthcare Effectiveness Data and Information Set (HEDIS®) measures, these PIPs were based on State-defined methodology. In FY 2010, DCH incorporated three additional PIP topics (i.e., *Childhood Immunizations*, *Member Satisfaction*, and *Adults' Access to Care*) for a total of six PIPs. DCH modified the methodology used by the CMOs to reflect the National Committee for Quality Assurance's (NCQA's) HEDIS technical specifications. The incorporation of national, standardized methodologies allowed comparisons to national benchmarks. The second-year validation results for the performance measures included the same four HEDIS measures represented by the PIPs; therefore, improvement in the PIP study outcomes would also be seen in the performance measure results.

Using the results from prior PIP and performance measure outcomes, DCH directed the CMOs to continue their PIPs on the current topics. The CMOs were required to report both baseline and first remeasurement period data using the HEDIS hybrid method, where applicable. The hybrid method required data to be collected from member medical records, as well as administrative data sources (e.g., claims and encounters). The study topics selected by DCH addressed CMS' requirements related to quality outcomes—specifically, the quality and timeliness of, and access to, care and services.

Study Summary

As noted in its Quality Strategic Report Plan Update (March 2009), DCH identified the improvement of performance measures in the PIP studies as a key objective. The current PIP submission included three clinical PIPs (i.e., *Lead Screening in Children*, *Childhood*

Immunizations, and Well-Child Visits) and three nonclinical PIPs (i.e., *Adults' Access to Care, Member Satisfaction, and Provider Satisfaction*).

The three clinical PIP topics were based on HEDIS specifications and addressed children's preventive health (i.e., *Lead Screening in Children, Childhood Immunizations, and Well-Child Visits*). Children's primary health care is a vital part of the effort to prevent, recognize, and treat health conditions that can result in significant developmental and health status consequences for children and adolescents. These PIP topics represent a key area of focus for improvement.

The study indicator for the *Adults' Access to Care* PIP was also a HEDIS measure. This PIP topic represents an essential component in developing a relationship with a health care provider and establishing a medical home. Table 1–1 outlines the key study indicators incorporated in these four PIPs.

Table 1–1—HEDIS-based PIP Study Indicators

HEDIS Measure/Study Indicator	HEDIS Measure Description
<i>Lead Screening in Children</i>	The percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday.
<i>Childhood Immunization Status—Combo 2</i>	The percentage of children two years of age who had four diphtheria, tetanus, and acellular pertussis (DTaP); three polio (IVP); one measles, mumps, and rubella (MMR); two H influenza type B (Hib); three hepatitis B; and one chicken pox (VZN) by their second birthday.
<i>Well-Child Visits in the First 15 Months of Life (Six or More Visits)</i>	The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a primary care provider (PCP) during their first 15 months of life.
<i>Adults' Access to Preventive/Ambulatory Health Services</i>	The percentage of members 20–44 years of age who had an ambulatory or preventive care visit.

The remaining two PIPs addressed member and provider satisfaction. Table 1–2 outlines the key study indicators incorporated in these PIP topics.

The *Member Satisfaction* PIP corresponded to the specifications of the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Health Plan Survey 4.0H, Child Version measures. These measures provided information on parents' experiences with their child's provider and the care management organization. The plan measured the percentage of members responding favorably to select questions on the Member Satisfaction Survey.

The final State-mandated PIP topic was *Provider Satisfaction*, an area that represented an opportunity for improvement for the CMOs. Each CMO contracted with a vendor to produce and administer this survey, and the CMOs submitted their second remeasurement period data this year. The plan measured the percentage of providers responding favorably (i.e., "Excellent" or "Very Good") to the selected Provider Satisfaction Survey questions.

Table 1–2—Satisfaction-based PIP Study Indicators

Survey Type	Identifier	Survey/Study Question
Member	Q24	“Using any number from 0 to 10, where 0 is the worst doctor possible and 10 is the best doctor possible, what number would you use to rate your child’s personal doctor?”
Member	Q23	“In the last 6 months, how often did your child’s personal doctor seem informed and up to date about the care your child got from other doctors/providers?”
Provider	Q11*	“Specialist network has an adequate number of high quality specialists to whom I can refer my patients.”
Provider	Q5*	“Timeliness to answer questions and/or resolve problems.”
Provider	Q15*	“Timeliness of UM’s precertification process.”

* Providers were requested to respond if they agreed with the statement regarding the CMO.

Validation Overview

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

- ◆ Measurement of performance using objective quality indicators.
- ◆ Implementation of systematic interventions to achieve improvement in quality.
- ◆ Evaluation of the effectiveness of the interventions.
- ◆ Planning and initiation of activities for increasing or sustaining improvement.

HSAG obtained the data needed to conduct the PIP validation from the CMO’s PIP Summary Forms. These forms provided detailed information about each CMO’s PIPs related to the activities they completed and HSAG evaluated for the FY 2011 validation cycle.

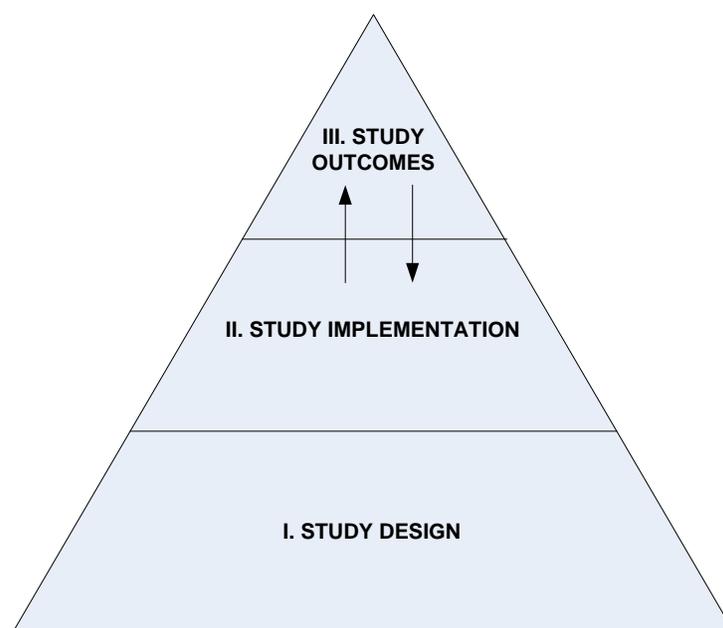
Each required activity was evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scored each evaluation element within a given activity as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designated some of the evaluation elements deemed pivotal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

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

score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

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

Figure 1–1—PIP Stages



Once a CMO establishes its study design, the PIP process moves into the Study Implementation stage. This stage includes data collection, sampling, and interventions. During this stage, the CMOs collect measurement data, evaluate and identify barriers to performance, and develop interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve PIP outcomes. The final stage is Study Outcomes, which involves data analysis and the evaluation of real and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistical improvement over time and multiple measurements. This stage is the culmination of the previous two stages. If the study outcomes do not improve, the CMOs investigate the data they collected to ensure that they have correctly identified the barriers and implemented appropriate and effective interventions. If they have not, the CMOs revise their interventions and collect additional data to remeasure and evaluate outcomes for improvement. This process becomes cyclical until sustained statistical improvement is achieved.

Aggregate Validation Findings

HSAG organized, aggregated, and analyzed WellCare's PIP data to draw conclusions about the CMO's quality improvement efforts. The PIP validation process evaluated both the technical methods of the PIP (i.e., the study design) and the outcomes associated with the implementation of interventions. Based on its technical review, HSAG determined the overall methodological validity of the PIPs.

Table 2–1 displays the combined validation results for all six WellCare PIPs evaluated during FY 2011. This table illustrates the CMO's overall understanding of the PIP process and its success in implementation of the study. Each activity is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 2–1 show the percentage of applicable evaluation elements that received a *Met* score by activity. Additionally, HSAG calculated an overall score across all activities. Appendix A provides the detailed validation scores for each of the six PIPs.

Table 2–1—FY 2011 Performance Improvement Project Validation Results for WellCare of Georgia, Inc. (N=6 PIPs)

Stage	Activity		Percentage of Applicable Elements		
			<i>Met</i>	<i>Partially Met</i>	<i>Not Met</i>
Study Design	I.	Appropriate Study Topic	100% (32/32)	0% (0/32)	0% (0/32)
	II.	Clearly Defined, Answerable Study Question(s)	100% (12/12)	0% (0/12)	0% (0/12)
	III.	Clearly Defined Study Indicator(s)	100% (36/36)	0% (0/36)	0% (0/36)
	IV.	Correctly Identified Study Population	100% (18/18)	0% (0/18)	0% (0/18)
Study Implementation	V.	Valid Sampling Techniques (if sampling was used)	100% (30/30)	0% (0/30)	0% (0/30)
	VI.	Accurate/Complete Data Collection	100% (51/51)	0% (0/51)	0% (0/51)
	VII.	Appropriate Improvement Strategies	95% (18/19)	5% (1/19)	0% (0/19)
Study Outcomes	VIII.	Sufficient Data Analysis and Interpretation	98% (52/53)	2% (1/53)	0% (0/53)
	IX.	Real Improvement Achieved	63% (15/24)	8% (2/24)	29% (7/24)
	X.	Sustained Improvement Achieved*	100% (1/1)	0% (0/1)	0% (0/1)
Percentage Score of Applicable Evaluation Elements <i>Met</i>			96% (265/276)		
* Only the <i>Provider Satisfaction</i> PIP had progressed to this phase in the review period and was assessed for sustained improvement.					

Overall, 96 percent of the evaluation elements across all six PIPs received a score of *Met*. While WellCare's strong performance in the Study Design and Study Implementation phases indicated that each PIP was designed and implemented appropriately to measure outcomes and improvement, it was less successful in achieving the desired outcomes. The following subsections highlight HSAG's validation findings associated each of the three PIP stages.

Study Design

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

Study Implementation

WellCare met 100 percent of the requirements for both the sampling and data collection activities in the Study Implementation phase; however, the CMO did not meet all of the requirements for the third activity of this phase, implementation of improvement strategies. Five individual PIPs received a *Met* score for 100 percent of the evaluation elements while the *Well-Child Visits* PIP only received a *Met* score for 67 percent of the evaluation elements. These results produced an overall aggregate score of 95 percent of the applicable elements receiving a *Met* score for this activity. These findings suggested that while the CMO accurately documented and executed the implementation of the study design, WellCare's process for developing interventions in its *Well-Child Visits* PIP continued to be an area for improvement. With the successful implementation of appropriate improvement strategies, the CMO could achieve improved outcomes in the future.

Study Outcomes

WellCare met the requirements for two of the three activities in the Study Outcomes stage. The CMO correctly conducted analyses and interpreted its results as demonstrated in Activity VIII (i.e., Sufficient Data Analysis and Interpretation) with individual PIP scores ranging from 89 percent to 100 percent. However, as seen in Table 2–2 and Table 2–3, not all of the PIPs demonstrated statistically significant improvement related to Activity IX (i.e., Real Improvement Achieved). Individual PIP scores ranged from 25 percent to 100 percent. Consequently, the aggregated results for Activity IX across all six PIPs reflected this deficiency (63 percent of the evaluation elements received a *Met* score) even though the Adults' *Access to Care* PIP scored considerably higher (100 percent). To be successful, the PIPs must show real, or statistical, improvement in their study indicators.

Only the *Provider Satisfaction* PIP had progressed to the point of reporting a second remeasurement period and demonstrated sustained improvement for two of the three study indicators.

PIP-Specific Outcomes

Analysis of Results

Table 2–2 and Table 2–3 display outcome data for WellCare’s six PIPs. The CMO submitted Remeasurement 1 data for five of the PIPs and Remeasurement 2 data for the *Provider Satisfaction* PIP.

Table 2–2—HEDIS-based Performance Improvement Project Outcomes for WellCare of Georgia, Inc.

PIP #1—Lead Screening in Children				
PIP Study Indicator	Baseline Period (1/1/08–12/31/08)	Remeasurement 1 (1/1/09–12/31/09)	Remeasurement 2 (1/1/10–12/31/10)	Sustained Improvement
The percentage of children 2 years of age who received one blood lead test (capillary or venous) on or before their second birthday.	65.9%	67.4%	‡	‡
PIP #2—Childhood Immunizations				
The percentage of children who received the recommended vaccinations based on the <i>Childhood Immunization Status—Combo 2</i> (4:3:1:2:3:1) guidelines.	75.9%	81.0%	‡	‡
PIP #3—Well-Child Visits				
The percentage of children who had six or more well-child visits with a PCP during their first 15 months of life.	57.4%	57.4%	‡	‡
PIP #4—Adults’ Access to Care				
The percentage of members 20–44 years of age who had an ambulatory or preventive care visit.	78.6%	84.7%*	‡	‡
‡ The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement.				
* Designates statistically significant improvement over the prior measurement period (p value < 0.05).				
† Designates a statistically significant decrease in performance over the prior measurement period (p value < 0.05).				

Table 2-3—Satisfaction-based Performance Improvement Project Outcomes for WellCare of Georgia, Inc.

PIP #5—Member Satisfaction				
PIP Study Indicator	Baseline Period (2/1/09–5/31/09)	Remeasurement 1 (2/1/10–5/31/10)	Remeasurement 2 (2/1/11–5/31/11)	Sustained Improvement
1) The percentage of members responding with either a “9” or “10” to Q24—“Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your child’s personal doctor?”	72.2%	71.2%	‡	‡
2) The percentage of eligible members responding with either “Always” or “Usually” to Q23—“In the last 6 months, how often did your child’s personal doctor seem informed and up to date about the care your child got from other doctors/providers?”	77.1%	78.4%	‡	‡
PIP #6—Provider Satisfaction				
PIP Study Indicator[^]	Baseline Period (10/1/06–9/30/07)	Remeasurement 1 (10/1/07–9/30/08)	Remeasurement 2 (10/1/08–9/30/09)	Sustained Improvement
1) The percentage of providers answering “Excellent” or “Very Good” to Q11—“Specialist network has an adequate number of high quality specialists to whom I can refer my patients.”	22.2%	19.7%	24.7%	‡
2) The percentage of providers answering “Excellent” or “Very Good” to Q5—“Timeliness to answer and/or resolve problems.”	22.2%	29.6%*	31.3%	Yes
3) The percentage of providers answering “Excellent” or “Very Good” to Q15—“Timeliness of UM’s pre-certification process.”	22.5%	25.5%	29.3%	Yes
[^] Providers were requested to respond if they agreed with the statements regarding the CMO. [‡] The PIP did not progress to this phase during the review period and could not be assessed for real or sustained improvement. [*] Designates statistically significant improvement over the prior measurement period (p value < 0.05). [†] Designates a statistically significant decrease in performance over the prior measurement period (p value < 0.05).				

The *Adults’ Access to Care* PIP demonstrated statistically significant improvement from Baseline to Remeasurement 1. The percentage of adult members that accessed ambulatory or preventive care increased by approximately six percentage points to 84.7 percent. Statistically significant improvement is the standard for assessing real improvement and supports the conclusion that the improvement was not due to chance. Although WellCare’s performance improved, it remained 0.1 percentage points below the DCH target (84.8 percent) and fell

between the national 2009 HEDIS Medicaid 50th and 75th percentiles (81.44 percent and 85.58 percent).

Additionally, the performance for three PIPs—i.e., *Lead Screening in Children*, *Childhood Immunizations*, and the second study indicator for the *Member Satisfaction* PIP (“How often did your child’s personal doctor seem informed and up to date about the care your child got from other doctors/providers?”), increased from Baseline to Remeasurement 1. However, the increases were not statistically significant and, therefore, not considered real improvement. Both the *Lead Screening in Children* and *Childhood Immunizations* study indicator rates remained above the DCH target rates for these measures (65.9 percent and 72.0 percent, respectively). The Remeasurement 1 rate for *Lead Screening in Children* was below the 50th national 2009 HEDIS Medicaid percentile (70.21 percent) while the Remeasurement 1 rate for *Childhood Immunizations* was above the national 2009 HEDIS Medicaid 50th percentile (78.01 percent).

WellCare’s performance for the *Well-Child Visits* study indicator (57.4 percent) did not change from Baseline to Remeasurement 1 and remained 8 percentage points below the DCH target of 65.4 percent and fell between the 25th and 50th national 2009 HEDIS Medicaid percentiles (51.58 percent and 60.52 percent).

The first study indicator for the *Member Satisfaction* PIP (“...what number would you use to rate your child’s personal doctor?”) was the only study indicator rate of any of the PIPs that decreased during the most recent measurement period. The rate decreased by one percentage point; however, the decrease was not statistically significant.

Rates for all three of the *Provider Satisfaction* PIP’s study indicators increased from the first to the second remeasurement. More importantly, the second and third study indicators demonstrated sustained improvement since they improved between all measurement periods. These findings highlight success in the implementation of quality strategies for improving overall satisfaction. The first study indicator, though, will require another measurement period before HSAG can assess it for sustained improvement because the rate had initially decreased from Baseline to Remeasurement 1. However, the increase observed during Remeasurement 2 suggests that WellCare’s interventions and quality improvement processes will positively affect the outcome for this indicator.

Barriers/Interventions

The identification of barriers through barrier analysis and the subsequent selection of appropriate interventions to address those barriers are necessary steps to improve outcomes. The CMO’s choice of interventions, the combination of intervention types, and the sequence of the implementation of the interventions are all essential to the CMO’s overall success.

WellCare identified the lack of provider and member knowledge regarding the required screenings and immunization schedules as primary barriers for three of its PIPs—i.e., *Childhood Immunizations*, *Lead Screening in Children*, and *Well-Child Visits*. While WellCare documented more than nine ongoing interventions for each of these PIPs, the CMO implemented very few new interventions. New or modified interventions are needed to improve rates during the PIP

process since ongoing interventions are associated with current rates and not associated with rate changes during the PIP study period. The lack of significant improvement of outcomes for these PIPs was also due in part to the timing of the interventions as described below.

For the *Well-Child Visits* PIP, the CMO did not initiate any new interventions until July 2009. The interventions included distributing the HEDIS Provider Toolkit and noncompliant member lists to providers. The CMO also conducted telephone outreach to noncompliant members. The 2009 improvement strategies required more time to have any effect on the CY 2009 results; however, they could affect both CY 2010 HEDIS rates and PIP remeasurement rates. In March 2010, the CMO distributed the provider letter and well-child billing guide developed by the CMO Well-Child Collaborative to providers.

Similarly, for the *Lead Screening in Children* PIP, WellCare initiated one new provider education intervention in 2008 that educated staff on the Georgia Childhood Lead Poisoning Prevention Program (GCLPPP). The CMO also initiated two interventions during the second half of 2009: (1) distribution of the HEDIS Provider Toolkit and noncompliant member lists to providers and (2) telephone outreach to noncompliant members; however, the result of these interventions was limited since they were only in effect for six months of the year. The full effect of these strategies would potentially be demonstrated in both calendar year (CY) 2010 HEDIS rates and PIP remeasurement rates.

WellCare used the same improvement strategy for the *Childhood Immunizations* PIP as it used for the *Lead Screening in Children* PIP. The CMO initiated one new provider education intervention in 2008 that included sending a blast fax to all providers in reference to the 2008 childhood immunization schedule. Additionally, the CMO initiated two interventions in the second half of 2009: (1) distribution of the HEDIS Provider Toolkit and noncompliant member lists to providers and (2) telephone outreach to noncompliant members. As with the *Lead Screening in Children* PIP, these 2009 strategies required more time to have any effect on the CY 2009 results; however, they could affect both CY 2010 HEDIS rates and PIP remeasurement rates.

Conversely, for the *Adults' Access to Care* PIP, the timing of the interventions affected the remeasurement period rates reported in CY 2009 and led to an increase of approximately 6 percentage points. The CMO initiated interventions in both 2008 and 2009. In 2008, the CMO identified the provider's lack of understanding regarding the need to provide services as the primary barrier. WellCare implemented sequential interventions specifically targeted to the barrier, including the following:

- 1) Reviewed medical records to identify providers noncompliant with adult preventive health care guidelines
- 2) Updated adult preventive health care guidelines
- 3) Distributed adult preventive health care guidelines through the provider handbook
- 4) Distributed adult preventive health care guidelines through the member newsletter
- 5) Posted the adult preventive health care guidelines on the Web site and included information in the provider newsletter

In the last quarter of 2009, the CMO distributed the 2009 adult preventive health care guidelines through both the member newsletter and the member handbook. Additionally in 2009, the CMO conducted its quarterly quality improvement meeting and identified through a cause and effect diagram that members were going to the emergency room (ER) instead of a PCP; therefore, preventive services were not being performed. The CMO implemented a two-pronged approach to address this pattern. First, the CMO initiated system interventions ensuring that members had access to preventive services. Second, the CMO realigned staff resources so it could conduct focused member outreach to members within 48 hours of an ER visit. The outreach consisted of member education on the PCP's role and assistance with care and/or transportation needs. The CMO also created a database to track member contacts.

The *Member Satisfaction* PIP outcomes remained unchanged from the baseline period. WellCare did not initiate any interventions in CY 2008. Additionally, of all the interventions that the CMO implemented in CY 2009, only one directly related to the study outcomes—the CMO distributed a Patient Safety Tip Sheet to providers addressing the lack of coordination between primary care providers and specialists. However, the timing of the intervention was such that it could not affect the current PIP cycle, and it will not likely affect rates until the second remeasurement period. The CMO's other interventions dealt with barriers such as the prior-authorization process, members unaware of translation services, provider directories not available on the Web portal, members not understanding how to change providers, coordination of care, etc. Even if these interventions affect identified barriers, they will not affect the outcomes for the PIP study indicators.

Conversely, for the *Provider Satisfaction* PIP, WellCare implemented numerous targeted interventions that linked directly to the identified barriers. Examples of the CMO's interventions addressing "timeliness to answer and/or resolve problems" and "timeliness of UM's pre-certification process" included the following:

- ◆ Documenting provider concerns and feedback identified by provider relations representatives in a database, then training representatives on how to trend provider dissatisfaction
- ◆ Opening a Customer Service Call Center for providers
- ◆ Implementing a new prior-authorization checklist
- ◆ Employing a reconsideration process for authorization requests that included a peer-to-peer process
- ◆ Incorporating a new database to enhance timeliness and tracking of prior authorizations

The CMO educated staff and providers on all initiatives. The study outcomes for the second and third study indicators for this PIP increased over time, demonstrating both real and sustained improvement. WellCare, as part of its quarterly barrier analysis, prioritized the identified barriers to provider satisfaction. The reevaluation of quality strategies allowed the CMO to address changes in PIP outcomes more effectively. For the first study indicator ("specialist network has an adequate number of high quality specialists to whom I can refer my patients"), the CMO responded to the decrease in the remeasurement result and implemented focused interventions that used provider feedback and referral patterns to recruit needed specialists. The result was an upward trend by the second remeasurement period.

Overall, WellCare exhibited a strong understanding of the key steps necessary for ensuring improvement. However, the execution of intervention strategies across the six PIPs was inconsistent, resulting in the improvement of some outcomes, but not all.

Individual PIP Strengths

The *Adult's Access to Care* PIP received a *Met* score for 100 percent of the evaluation elements in all three PIP validation stages—Study Design, Study Implementation, and Study Outcomes. The outcome for the *Adults' Access to Care* PIP, which improved significantly from the baseline to the first remeasurement, reflected the effects of a strong quality strategy. Although the performance was 0.1 percentage points below the DCH target (84.8 percent) and 0.9 percentage points below the national 2009 HEDIS 75th percentile of 85.58 percent, WellCare's success on this PIP could continue to improve the CMO's general performance on the *Adults' Access to Preventive/Ambulatory Health Services* HEDIS measure.

WellCare was successful in achieving real and sustained improvement for two of the three study indicators in the *Provider Satisfaction* PIP. The CMO responded to the decline in the first study indicator's Remeasurement 1 results and implemented revised, targeted interventions that positively affected the outcome. Moreover, WellCare's implementation of the revised *Provider Satisfaction* interventions suggested that the CMO may be successful in achieving real and sustained improvement in the future.

Global Strengths Across all PIPs

All six PIPs received an overall *Met* validation status, which represented an area of strength for WellCare and provided confidence in the technical aspects of the studies. The performance on these PIPs suggested a thorough understanding of the PIP Study Design stage. The sound study design of the PIPs created the foundation for the CMO to progress to subsequent PIP stages—i.e., implementing improvement strategies and accurately assessing study outcomes. The CMO appeared to understand and appropriately conduct the sampling and data collection activities of the Study Implementation stage. These activities ensured that the studies properly defined and collected the necessary data to produce accurate study indicator rates. Additionally, WellCare appropriately documented improvement strategies, an activity which ensured that study outcomes could improve. Furthermore, in the Study Outcomes stage, the CMO properly analyzed and interpreted the results.

Individual PIPs

The *Well-Child Visits* and *Member Satisfaction* PIPs had the lowest validation scores for the Study Outcomes stage (69 and 77 percent, respectively); therefore, to improve study outcomes in the future, WellCare should focus on implementing new and/or enhanced quality strategies for these PIPs. The past and ongoing interventions have not yielded improved results. Specifically, the study outcome for the *Well-Child Visits* PIP remained unchanged during remeasurement and was below the DCH target of 65.4 percent and the national 2009 HEDIS Medicaid 50th percentile of 60.52 percent. WellCare's process for developing interventions in its *Well-Child Visits* PIP continued to be an area for improvement. Similarly, the study outcome for the *Lead Screening in Children* PIP was also statistically unchanged and remained below the national 2009 HEDIS Medicaid 50th percentile of 70.21 percent. However, the outcome for this PIP was above the DCH target rate (65.9 percent). To increase the measurable effects of its quality improvement activities, WellCare should ensure that the implementation of interventions occurs early enough in the measurement period to provide sufficient time for the outcomes to be affected and demonstrate improvement.

Global Issues

While WellCare exhibited a strong understanding of the key steps necessary for ensuring improvement, the execution of intervention strategies across the six PIPs was inconsistent. WellCare should plan and implement its improvement strategies more efficiently, providing enough time for the interventions to affect study outcomes. Additionally, the CMO should analyze its data to determine if any subgroup within its population has a disproportionately lower rate that negatively affected the overall rates. This "drill-down" type of analysis should be conducted both before and after the implementation of any intervention. For example, WellCare should evaluate whether rates differ by geographic region, gender, race/ethnicity, age, etc. The CMO could then target its interventions to those subgroups with the lowest rates, allowing the implementation of more precise, concentrated interventions. The process of targeting interventions to the appropriate subgroups is more efficient and effective.

The CMO should be mindful that the submission of PIPs for validation will be an annual activity without an opportunity to resubmit. WellCare should carefully complete all necessary documentation. The CMO should refer to the PIP Validation Tool and address all *Points of Clarification* and all *Partially Met* and *Not Met* scores in the FY 2012 submission.

Appendix A. PIP-Specific Validation Scores

for WellCare of Georgia, Inc.

Table A-1—WellCare’s FY 2011 PIP Performance

Review Step	Lead Screening in Children	Childhood Immunizations	Well-Child Visits	Adults’ Access to Care	Member Satisfaction	Provider Satisfaction
Study Design	17/17 (100%)	17/17 (100%)	17/17 (100%)	16/16 (100%)	16/16 (100%)	15/15 (100%)
I. Review the Selected Study Topic(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	5/5 (100%)	5/5 (100%)	4/4 (100%)
II. Review the Study Question(s)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)	2/2 (100%)
III. Review the Selected Study Indicator(s)	6/6 (100%)	6/6 (100%)	6/6 (100%)	6/6 (100%)	6/6 (100%)	6/6 (100%)
IV. Review the Identified Study Population	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)	3/3 (100%)
Study Implementation	19/19 (100%)	19/19 (100%)	18/19 (95%)	8/8 (100%)	18/18 (100%)	17/17 (100%)
V. Review Sampling Methods	6/6 (100%)	6/6 (100%)	6/6 (100%)	0/0	6/6 (100%)	6/6 (100%)
VI. Review Data Collection Procedures	10/10 (100%)	10/10 (100%)	10/10 (100%)	5/5 (100%)	8/8 (100%)	8/8 (100%)
VII. Assess Improvement Strategies	3/3 (100%)	3/3 (100%)	2/3 (67%)	3/3 (100%)	4/4 (100%)	3/3 (100%)
Study Outcomes	12/13 (92%)	12/13 (92%)	9/13 (69%)	12/12 (100%)	10/13 (77%)	13/14 (93%)
VIII. Review Data Analysis and Study Results	9/9 (100%)	9/9 (100%)	8/9 (89%)	8/8 (100%)	9/9 (100%)	9/9 (100%)
IX. Assess for Real Improvement	3/4 (75%)	3/4 (75%)	1/4 (25%)	4/4 (100%)	1/4 (25%)	3/4 (75%)
X. Assess for Sustained Improvement	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	<i>Not Assessed</i>	1/1 (100%)
Percentage Score for Applicable Evaluation Elements <i>Met</i>	98%	98%	90%	100%	94%	98%
Percentage Score for Applicable Critical Elements <i>Met</i>	100%	100%	100%	100%	100%	100%
Validation Status	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>	<i>Met</i>

State of Georgia



Department of Community Health (DCH)

FY 2011
EXTERNAL QUALITY REVIEW
OF COMPLIANCE WITH STANDARDS
for
WELL CARE OF GEORGIA, INC.

February 2011



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1. Overview	1-1
Background	1-1
Description of the FY 2011 External Quality Review of Compliance With Standards	1-1
2. Performance Strengths and Areas Requiring Corrective Action	2-1
Summary of Overall Strengths and Areas Requiring Corrective Action	2-1
Standard I—Practice Guidelines	2-3
Areas Requiring Corrective Action	2-4
Standard II—Quality Assessment and Performance Improvement	2-6
Strengths	2-6
Areas Requiring Corrective Action	2-7
Standard III—Health Information Systems	2-8
Strengths	2-8
Areas Requiring Corrective Action	2-9
3. Corrective Action Plan Process	3-1
Appendix A. Review of the Standards	A-1
Appendix B. On-Site Review Participants	B-1
Appendix C. Review Methodology	C-1

Background

State Medicaid and licensing agencies, private accreditation organizations, and the federal Medicare program all recognize that having standards is only the first step in promoting safe, accessible, timely, and quality services. The second step is ensuring compliance with the standards.

According to the Code of Federal Regulations (CFR) at 42 CFR 438.358, a review must be conducted within each three-year period to determine compliance with state standards by state-contracted managed care organizations (MCOs) and prepaid inpatient health plans (PIHPs). This review must be conducted by a state Medicaid agency, its agent that is not an MCO or PIHP, or an external quality review organization (EQRO). Based on 42 CFR 438.204(g), these standards must be as stringent as the federal Medicaid managed care standards described in 42 CFR 438—Managed Care, which addresses requirements related to access, structure and operations, and measurement and improvement. The State of Georgia Department of Community Health (DCH) contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO, to:

- ◆ Conduct compliance reviews for its Georgia Families MCOs, which are care management organizations (CMOs) in the State of Georgia.
- ◆ Prepare a report of findings with respect to each CMO's performance strengths and areas requiring corrective action to improve performance related to the quality and timeliness of, and access to, care and services.

Description of the FY 2011 External Quality Review of Compliance With Standards

For the third year of a three-year cycle of external quality reviews, HSAG performed a desk review of **WellCare of Georgia, Inc.'s (WellCare's)** documents and an on-site review that included reviewing additional documents and conducting interviews with key CMO staff members. HSAG evaluated the degree to which **WellCare** complied with federal Medicaid managed care regulations and the associated DCH contract requirements in three performance categories (i.e., standards). The three standards included requirements associated with federal Medicaid managed care measurement and improvement standards found at 42 CFR 438.236–438.242. The standards HSAG evaluated were:

- ◆ Practice Guidelines
- ◆ Quality Assessment and Performance Improvement
- ◆ Health Information Systems

Following its review, HSAG prepared an initial draft report of its findings and forwarded it to DCH and **WellCare** for their review prior to issuing the final report. In addition to this section, the report includes the following sections and appendices:

- ◆ Section 2—A summary of HSAG’s findings regarding **WellCare**’s performance results, strengths, and areas requiring corrective action.
- ◆ Section 3—A description of the process and timeline **WellCare** must follow for submitting to DCH its corrective action plan (CAP) addressing each requirement for which HSAG scored the CMO’s performance as either partially complying or not complying.
- ◆ Appendix A—The completed review tool HSAG used to:
 - Structure its evaluation of **WellCare**’s performance in complying with each of the requirements contained within the three standards.
 - Document its findings, the scores it assigned to **WellCare**’s performance, and, when applicable, corrective actions required to bring the CMO’s performance into compliance with the requirements.
- ◆ Appendix B—The date of the on-site review and a list of HSAG reviewers and all other individuals who attended the review, including **WellCare**’s staff members who participated in the interviews that HSAG conducted.
- ◆ Appendix C—A description of the methodology HSAG used to prepare for and conduct the review and to draft its report of findings.

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

The following table provides information on **WellCare**'s scores for each of the standard areas included in this year's compliance review.

Appendix C—Review Methodology includes a detailed description of the scoring methodology.

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# Met	# Partially Met	# Not Met	# Not Applicable	Total Compliance Score
I	Practice Guidelines	10	10	10	0	0	0	100%
II	Quality Assessment and Performance Improvement	29	29	29	0	0	0	100%
III	Health Information Systems	8	8	8	0	0	0	100%
	Totals	47	47	47	0	0	0	
	***Total Compliance Score Across the Three Standards							100%

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

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

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

WellCare demonstrated strong performance in complying with the requirements related to the federal Medicaid managed care measurement and improvement standards and the associated DCH contract requirements for the CMOs. The standards addressed requirements related to the CMOs':

- ◆ Adoption and use of practice guidelines to help shape quality provider practices.
- ◆ Quality assessment and performance improvement (QAPI) programs and activities.
- ◆ Health information systems' capabilities.

HSAG's findings and conclusions drawn from its review of **WellCare**'s documentation and discussions with the CMO staff members from both the corporate and the **WellCare of Georgia** CMO were that the CMO's performance for each of the 47 applicable requirements across the three standards was sufficient to result in a score of *Met*. **WellCare** had ample written documentation describing its processes, practices, action plans, and performance results/outcomes related to each requirement. During the interviews, staff members' responses to HSAG's questions, including their descriptions and examples of the CMO's processes and practices for ensuring compliance with the requirements, were consistent with and expanded upon the information in the documentation. In combination, the documentation and information staff presented during the interview was sufficient to demonstrate that **WellCare** was in compliance with each of the requirements at the time of HSAG's desk- and on-site review activities.

The remainder of this section describes for each of the three standards **WellCare**'s performance strengths and any areas where HSAG encouraged **WellCare** to further enhance its documentation and/or processes.

Standard I—Practice Guidelines

Strengths

WellCare had well-established processes and programs associated with its practice guidelines, and knowledgeable and proactive staff at both the corporate and local levels provided progressive and creative leadership related to the CMO's approach to developing and using its practice guidelines.

WellCare developed preventive and clinical guidelines for its network providers and, for many of the conditions addressed by the guidelines, developed related informational materials written in easy-to-understand language for its members. The CMO's guidelines for providers addressed several member health conditions, including asthma, diabetes, and chronic kidney disease, and described best practices in managing member care and providing services. Documentation demonstrated that the CMO made the guidelines readily available to its providers, including a clinical practice guideline policy for providers, the provider handbook, provider newsletters, and the CMO's Web site portal for providers.

Evidence that the CMO made information and educational materials available to members in easy-to-understand language included member newsletters, the member handbook, the CMO's Member Educational Materials policy, a copy of a chronic kidney disease (CKD) guideline for members, the CMO's practice guidelines policy, the Member Educational Guidelines policy, and a written description of the CMO's work flow for developing and making the guidelines available to providers and, upon request, to members. During the interview, staff members described the way in which the CMO responded to members' requests for guides to ensure that the member received the information, to discuss with the member the reason he or she is requesting the guides, and to ensure that the member understood the information and received timely access to any needed care and services.

Information staff members presented during the interviews and documentation available for HSAG's review (including member demographic reports, Healthcare Effectiveness Data and Information Set [HEDIS[®]]²⁻¹ results, and results of the CMO's medical record reviews) were consistent in demonstrating that as part of its QAPI program, **WellCare** identified the need for and adopted practice guidelines based on: (1) its members' needs and health care conditions using data such as the most frequently occurring diagnoses and (2) its performance in meeting those needs.

In developing or adopting new or revising existing guidelines, **WellCare** followed a rigorous process through both the corporate and regional structures. The process included conducting extensive reviews of the most current professional literature in the related field when selecting the sources for its guidelines. This process ensured that the information presented was based on current, valid, and reliable clinical evidence and/or the current consensus of health care professionals in a given field. The diabetes, asthma, chronic kidney disease guidelines included the source references. During the interview, staff members described in detail the national and Georgia CMO committee structure and membership involved in making decisions when adopting and reviewing/revising the guidelines.

²⁻¹ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

Through a comprehensive committee structure and review processes at both the national and regional levels, **WellCare** ensured that appropriate representatives from the CMO's local network providers had input into and a decision-making role in adopting and revising clinical practice guidelines. A March 30, 2010, presentation for the CMO Medicaid Quality Improvement (QI) Committee included the CMO's performance results, barriers to improved performance, improvement actions implemented and those planned, and goals for improving performance across a broad range of clinical, access, and quality indicators. The results included those generated from data mining and reporting, conducting provider medical record reviews, and barriers identified to members accessing services. Utilization Medical Advisory Committee (UMAC) meeting minutes included the committee's discussion regarding the methods the CMO used to evaluate its performance related to the guidelines. During the interview, staff members described the CMO's medical record review (MRR) process, which had been occurring for several years using a vendor to conduct the reviews; use of HEDIS performance results, and plans to enhance the MRR tool to ensure that in addition to the current indicators it also included the applicable HEDIS measures. Staff members described the CMO's and its vendor's aggressive work with providers to improve their performance and initiation of a provider pay-for-performance program. Staff members also described their work with members to improve their knowledge about the importance of and ability to access needed services as some of the ways it was working to improve practices and service delivery consistent with the guidelines.

The CMO maintained a tracking log that documented the dates the guidelines were reviewed; when the guidelines were revised/updated, as applicable; and when the next review was due.

WellCare conducted annual reviews of the consistency between its practice guidelines and any associated authorization guidelines, member educational materials, and other areas to which the guidelines were applicable. A screen print from **WellCare**'s electronic data systems illustrated the ease with which case managers conducting the medical comprehensive assessment could easily access the Clinical Practice Guidelines while performing the assessment of a member, educating members, and developing the plans of care. During the interview, **WellCare**'s manager of clinical policy development, who was responsible for ensuring that the consistency reviews occurred, described his activities for ensuring that as guidelines are adopted and revised, other vital and related processes, decisions, and documents are consistent or revised to ensure consistency with the guidelines.

Areas Requiring Corrective Action

None.

Note: While HSAG did not assess **WellCare**'s performance as requiring corrective action, it did emphasize to **WellCare** staff the importance of continuing and completing its activities related to one of the requirements. **WellCare** had recently made a decision and revised its practice guideline policy to reflect a change in the minimum time frame within which it had to review and, as applicable, revise its guidelines. The decision was to change from the previous policy of "as needed, but no less than annually," to "as needed, but no less than every two years." During the interview, staff acknowledged in response to HSAG's findings that several of the documents that contained information about the guidelines (the provider handbook, previous provider newsletters,

WellCare's March 2010 QAPI Program Description) continued to include the revision timeline as "as needed, but no less than annually." Staff members stated that with the revised policy now final, the CMO was beginning to conduct a review of all applicable documents to ensure that they contained the revised timeline for reviewing/revising the guidelines.

Standard II—Quality Assessment and Performance Improvement

Strengths

WellCare demonstrated that it had comprehensive QI program processes, systems, and dedicated staff in place at the corporate and local levels through which the CMO conducted meaningful and relevant (high-volume, high-risk, and/or problem-prone) quality improvement initiatives. These population-specific initiatives were designed to achieve, through ongoing measurement and intervention, sustained and significant improvement in aspects of clinical care and nonclinical services.

Through interviews with staff and review of documented procedures and reports, **WellCare** provided evidence that its QI program functions were well-integrated. **WellCare** fulfilled the requirements related to the QAPI program contained in its contract with DCH through the CMO's continual quality improvement framework, which was demonstrated in the structure of the QI program's committees and subcommittees, the QI Program Description (QIPD), the QI Work Plan and the QI Program Evaluation.

WellCare's QI program included tracking and trending of results for the quality indicators to ensure that measure results were reported, outcomes were analyzed, and goals were attained. The CMO used contractual requirements/standards, evidence-based practice guidelines, and nationally recognized sources (e.g., the Consumer Assessment of Healthcare Providers and Systems [CAHPS[®]]²⁻² and HEDIS) to establish the CMO's performance/metric indicators, standards, and benchmarks. Indicators were objective, measurable, and based on current knowledge and clinical experience (as applicable). The indicators reflected the following parameters of quality:

- ◆ Structure, process, or outcomes of care
- ◆ Administrative and care systems
- ◆ Acute and chronic condition management
- ◆ Utilization management (UM)
- ◆ Credentialing
- ◆ Member and provider satisfaction
- ◆ Medical record review
- ◆ Member complaints and appeals
- ◆ Practitioner availability and accessibility
- ◆ Plan accessibility
- ◆ Member safety
- ◆ Preventive care
- ◆ Disparities in care

²⁻² CAHPS[®] is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

To facilitate collaboration across all departments, the CMO used an automated quality improvement work plan that tracked performance measures for each activity or project undertaken throughout the year. The CMO's work plan provided a centralized document in which activities were aligned with contractual, accreditation, and/or regulatory requirements and identified the measurements to assess progress toward the associated goals.

The CMO's processes encouraged member participation in the QI programs and services through the dissemination of information. This information was designed to engage members in managing, maintaining, and/or improving their current health status through preventive/wellness activities, disease management programs, case management, and other chronic care initiatives. The CMO's newsletters provided a mechanism for members, providers, various health care associations, and community agencies to receive updates. The newsletters also provided ways to offer suggestions, concerns, and recommendation regarding the CMO's quality programs and activities.

Areas Requiring Corrective Action

None.

Standard III—Health Information Systems

Strengths

WellCare demonstrated that it had processes, systems, and dedicated staff in place at the corporate and local levels to ensure that the CMO could collect, store, track, analyze, and report data as necessary to support its business needs and to fulfill the requirements of its contract with DCH. Through interviews with staff and review of documented procedures and reports, HSAG found evidence that **WellCare**'s information management functions were well integrated and supported other functions of the organization, such as quality management and improvement, provider management, service authorization, claims payment, utilization management, care coordination, and member eligibility and enrollment.

In its QIPD, the CMO included the important role of its information system in supporting the QI program. The QI Work Plan described goals and objectives based on multiple metrics that were dependent on the information system's capability to retrieve various types of data to evaluate the CMO's performance and progress.

The UM program description and evaluation described the information available to UM staff, including member eligibility and benefits, clinical data, utilization history, authorization status, and physician and provider network participation status. Using **WellCare**'s health information system, the CMO's UM staff members were able to flag cases for scheduled review, perform case management duties, refer cases for medical director review, and assign authorization numbers and lengths of stay. The system also generated reports of UM activities, including adverse determination tracking, authorizations by type, length of stay vs. average length of stay, bed day utilization, and pended cases. The WellCare of Georgia UM Reports Scorecard provided an example of a comprehensive report containing several aspects of utilization data. Minutes of the UMAC meeting illustrated how **WellCare** used the utilization data for decision making and designing QI and UM improvement activities.

In addition to quality and utilization management data, **WellCare** provided evidence that the health information system collected and reported information on the following:

- ◆ Grievances and appeals (including tracking and trending by category)
- ◆ Disenrollments for reasons other than loss of Medicaid eligibility
- ◆ Member characteristics (including demographics, language spoken, and primary care provider)
- ◆ Provider characteristics (including the specialty, board certification, languages spoken, and credentialing status)
- ◆ Services furnished to members

The CMO had sufficient processes in place to ensure the timeliness, accuracy, and completeness of the service data it collected from providers. Procedures included use of front-end edits, verification of member eligibility/enrollment, and date stamping as an indicator of timely receipt of the claim/encounter.

Areas Requiring Corrective Action

None.

3. Corrective Action Plan Process

Because **WellCare** met all standards that were evaluated during the compliance review, there is no requirement for development or implementation of a corrective action plan.

Appendix A. Review of the Standards

Following this page is the completed review tool that HSAG used to evaluate **WellCare's** performance and to document its findings, the scores it assigned associated with the findings, and corrective actions required, when applicable, to bring **WellCare's** performance into full compliance.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The CMO has a minimum of three practice guidelines. <div style="text-align: right;"><i>42CFR438.236(b)</i></div> Contract: 4.12.7.1	When reviewing this Documentation Request and Evaluation Form with the Evidence, please reference the electronic PDF page numbers. Asked for DCH direction and HSAG will review the Asthma, Diabetes and Chronic Kidney Disease (CKD) guidelines. <ul style="list-style-type: none"> ◆ Provider Guideline - CKD ◆ Provider Guideline - Asthma ◆ Provider Guideline - Adult Diabetes ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, p. 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
Findings: Information in multiple WellCare documents was consistent with the information staff members described during the interview and demonstrated that the CMO had adopted several practice guidelines, including those that focused on managing chronic kidney disease, asthma, and adult diabetes.		
Required Actions: None.		
2. The guidelines: <div style="text-align: right;"><i>42CFR438.236(b)</i></div> Contract: 4.12.7.1		
a) Are based on the health needs and opportunities for improvement identified as part of the quality assessment and performance improvement (QAPI) program. Contract: 4.12.7.1	Analyses of WellCare’s top diagnosis findings support the need for practice guidelines for the disease states of Asthma, Diabetes and CKD. <ul style="list-style-type: none"> ◆ Report – Member Demographic Assessment, pp. 17-18 A new Practice Guideline, focusing on Pediatric Diabetes was developed based on the growing need to address this important condition in our child population. WellCare identified the need for a pediatric guideline and also used it to train Corporate Case Mangers (CM) as they manage children with type 1 diabetes. <ul style="list-style-type: none"> ◆ Provider Guideline - Pediatric Diabetes ◆ Minutes – UMAC 8-25-10, p.10 WellCare also bases guidelines on the health needs and opportunities identified in the Quality Improvement Program Description (QIPD).	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Program – 2010 QIPD, pp. 10, 14 ◆ Provider Handbook - Section 12 Quality Improvement, p. 6 ◆ Provider Handbook – Section 13 Medical Records, p. 12 	
<p>Findings: WellCare used multiple sources of data to identify the preventive and clinical practice guidelines that it needed to have in place to ensure that members received clinically appropriate and timely care and services. Detailed minutes of its quality and utilization management committee meetings documented the committees’ work in reviewing the data, including information about member demographics and health needs/top diagnoses, and the CMO’s performance in providing timely and clinically appropriate care (e.g., HEDIS performance results and results of medical record reviews). During the interview, staff members described their processes and gave specific examples.</p>		
<p>Required Actions: None.</p>		
<p>b) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field.</p> <p>Contract: 4.12.7.1</p>	<p>This Annual Consistency Review validates that utilization management, member communication, benefits and other internal documents have been checked to ensure consistency with the guidelines. This Annual Consistency Review is signed by Medical Directors and other leadership every December; hence, the last report was signed December 2009.</p> <ul style="list-style-type: none"> ◆ Report - 2009 CPG Annual Content Consistency Review p. 1 <p>This work flow shows our step by step process for guideline creation and approval.</p> <ul style="list-style-type: none"> ◆ Workflow – Practice Guideline Development and Approval, p. 1 ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, pp. 1- 2 ◆ Provider Handbook - Section 12 Quality Improvement, pp. 3, 6, 7 ◆ Provider Handbook - Section 13 Medical Records, p.12 ◆ Provider Guideline – CKD, p. 2 ◆ Provider Guideline - Asthma, p. 6 ◆ Provider Guideline – Adult Diabetes, p. 2 <p>These minutes show how guidelines are based on consensus of healthcare professionals.</p> <ul style="list-style-type: none"> ◆ Minutes – UMAC 3-24-10, p. 8 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Minutes – UMAC 8-25-10, p. 10 ◆ Minutes – UMAC 9-21-10, p. 2 	

Findings: WellCare’s practice guidelines policy and written description of its process and work flow for adopting them stated that guidelines are based on relevant information from medical societies, association statements and guidelines, medical journal articles, valid and reliable clinical evidence, and other materials. Examples of the CMO’s guidelines and associated provider and member educational information referenced the national or other resources used in developing the guidelines. Minutes of the UMAC meetings documented that the clinical practice guidelines and recommended changes were based on research of best practices. Information and examples staff presented during the interview were consistent with the written documentation.

Required Actions: None.

<p>c) Consider the needs of the CMO’s members.</p> <p>Contract: 4.12.7.1</p>	<p>The following policy addresses how WellCare considers the needs of their members.</p> <ul style="list-style-type: none"> ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, pp. 1-2 <p>This Annual Consistency Review validates that utilization management, member communication, benefits and other internal documents have been checked to ensure consistency with the guidelines. This Annual Consistency Review is signed by Medical Directors and other leadership every December; hence, the most recent report was signed December 2009.</p> <ul style="list-style-type: none"> ◆ Report - 2009 CPG Annual Content Consistency Review p. 1 <p>Member Education Guidelines are used to inform members what was communicated to providers via their practice guidelines.</p> <ul style="list-style-type: none"> ◆ Policy – C7QI-025 Member Educational Guidelines Guideline, p. 1 <p>Analyses of WellCare’s top diagnosis findings support the need for practice guidelines for the disease states of Asthma, Diabetes, and CKD.</p> <ul style="list-style-type: none"> ◆ Report – Member Demographic Assessment, pp. 17-18 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
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Findings: WellCare’s practice guidelines policy and several sections of its 2010 QAPI Program Description (Clinical Practice Guideline Development and Review, Disease Management Programs, and Medical Record Reviews) stated that when adopting/developing and revising the guidelines, WellCare



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>considered:</p> <ul style="list-style-type: none"> ◆ The needs of members identified through an analysis of market-specific member demographic assessments, performance on quality measures, conditions with the highest rate of diagnosis, or regulatory requirements. ◆ Provider performance in meeting those needs. <p>During the interview, staff members described numerous examples of having used data about the members' health care needs, (e.g., top diagnoses, age, demographics) to determine which guidelines were needed to assist the CMO and providers in effectively meeting member needs.</p>		
Required Actions: None.		
<p>d) Are adopted in consultation with network providers.</p> <p>Contract: 4.12.7.1</p>	<p>WellCare utilizes UMAC for this function as network providers are committee members. UMAC committee members are from the following specialty types: Pediatrics, OB/Gyn; Maternal-Fetal Medicine; Psychiatry; Internal Medicine; Family Practice and Dental.</p> <ul style="list-style-type: none"> ◆ Minutes – UMAC 3-24-10, pp. 8 ◆ Minutes – UMAC 8-25-10, p.10 ◆ Minutes – UMAC 9-21-10, pp. 1-2 ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, pp. 1-2 ◆ Policy – C7QI-044 Georgia Medical Record Review, p.3 ◆ Provider Handbook Section 12 Quality Improvement, p. 7 ◆ Provider Handbook –Section 13 Medical Records, p.12 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The Quality Improvement section of WellCare's provider handbook described how the CMO involved physicians and obtained input from community providers on the development of practice guidelines. Several documents HSAG reviewed were consistent in stating that through providers' participation on the UMAC, guidelines were adopted in consultation with providers. The practice guideline policy also stated, and staff members described examples demonstrating that, as needed, the UMAC would consult with affiliated physician specialists if they were not represented on the committee. Detailed minutes of the UMAC meetings confirmed active provider participation, as did the information staff provided during the interview.</p>		
Required Actions: None.		
<p>e) Are reviewed and updated periodically, as appropriate.</p> <p>Contract: 4.12.7.1</p>	<ul style="list-style-type: none"> ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, p. 2 ◆ Minutes – UMAC 3-24-10, p. 8 ◆ Report– 2010 CPG Update and Development Log, All Tabs ◆ Minutes – UMAC AdHoc 9-21-10, pp. 1-2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
 for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>Findings: WellCare’s Provider Clinical Practice Guidelines policy stated that at least every two years, WellCare would review/revise clinical practice guidelines and described the review and approval process. WellCare’s 2010 Clinical Practice Guidelines Update Log documented for numerous guidelines, including those addressing CKD, asthma, and diabetes, the review and approval process. Detailed minutes of the March 24, 2010, meeting of the UM Committee included a presentation and committee discussion on three updated clinical practice guidelines and the committee’s approval of the guidelines with the recommended changes. Minutes of the March 2010 Medicaid Quality Improvement Committee (QIC) documented the committee’s approval. However, other documents HSAG reviewed (e.g., the provider handbook and newsletter and the CMO’s QAPI report) stated that the revisions were to occur as needed but no less than annually. During the interview, staff members stated that WellCare, through its final July 2010 policy revision, changed the review/revision period to one of “as needed, but no less than every two years.” The CMO was then able to proceed in reviewing and revising all other documentation that contained the previous time period of “as needed but no less than annually.” Staff stated that even though the revised policy allowed for a longer period between reviews, WellCare’s experience is that policies are reviewed and revised more frequently based on advances and changes in best practices and published professional guidelines.</p> <p>Required Actions: None.</p> <p><i>Note: HSAG did not consider the gap between when the policy was revised and when the CMO planned to revise related documents (e.g., the provider handbook) as rising to the level of compromising the CMO’s performance for this standard and requiring corrective action. It was clear that during the review period, the CMO did review and revise its guidelines annually. During the interview, HSAG emphasized the importance of WellCare following through with its plans to review and ensure that all documentation that references the practice guideline review and revision timeline is consistent with current revised policy.</i></p>		
<p>3. The practice guidelines include a methodology for measuring and assessing compliance.</p> <p>Contract: 4.12.7.2</p>	<p>In the “Procedure” section of the Georgia Medical Record Review policy there is an explanation of how the practice guidelines will be assessed as part of the MRR process.</p> <ul style="list-style-type: none"> ◆ Policy – C7QI-044 Georgia Medical Record Review, pp. 3-6 ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, p. 2 ◆ Tool – 2010 Medical Record Review Tool, Data Collection Tool Tab, Rows (41-48) Diabetes, Rows (51-56) Asthma, Rows (59-60) CKD ◆ Provider Handbook - Section 13 Medical Records, pp. 12-13 ◆ Provider Guideline – CKD, p. 2 ◆ Provider Guideline - Asthma, pp. 5-6 ◆ Provider Guideline – Adult Diabetes, p. 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: WellCare’s practice guidelines included the evaluation methodologies and the indicators used for measuring and assessing compliance with the</p>		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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guidelines. The procedure section of WellCare’s record review policy included the elements that were being used or planned to evaluate provider performance. WellCare used its performance on HEDIS measures and the results of its medical record reviews to measure provider compliance with the guidelines. During the interview, staff members provided consistent and more detailed information about its processes for measuring and improving provider performance.

Required: None.

<p>4. The CMO disseminates the guidelines to all affected providers, and upon request, to members.</p> <p style="text-align: right; margin-right: 20px;"><i>42CFR438.236(c)</i></p> <p>Contract: 4.12.7.3</p>	<p><u>Providers</u> Provider practice guidelines are disseminated through the provider handbook and website.</p> <ul style="list-style-type: none"> ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, p. 2 ◆ Newsletter – Fall 2009 Provider Newsletter, p.1 ◆ Newsletter – Winter 2009 Provider Newsletter, pp 1- 2, 8 ◆ Newsletter – Q2 2010 Provider Newsletter, p. 1 ◆ Fax Blast - GA Provider Newsletter Fax Blast, p. 1 ◆ Case Example – Provider Website and Banner Communication ◆ Provider Handbook –Section 12 Quality Improvement, p. 7 <p><u>Members</u> Member educational guidelines are disseminated to enrollees when appropriate or when requested through customer service. The education guidelines can also be accessed the member web- portal http://georgia.wellcare.com/member/default</p> <ul style="list-style-type: none"> ◆ Member Handbook, p. 24 ◆ Newsletter – 1Q 2010 Member Newsletter pp. 1,4 -5 ◆ Case Example - Member Website Screen Shot ◆ Member Guideline - CKD ◆ Policy - C7QI-025 Member Educational Guidelines pp. 1-2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
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Findings: Documentation and information staff members described during the interview were consistent in demonstrating that WellCare made its preventive and clinical practice guidelines readily available to its network providers, including having them on the Web site portal for providers. For many of the conditions addressed by the guidelines, the CMO had and provided to its members informational materials written in easy-to-understand language. The CMO had well-established processes in place for working with members who requested a copy of the clinical or preventive guidelines.

Required Actions: None.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>5. The CMO ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.</p> <p style="text-align: right;"><i>42CFR438.236(d)</i></p> <p>Contract: 4.12.7.4</p>	<p>This Annual Consistency Review validates that utilization management, member communication, benefits and other internal documents have been checked to ensure consistency with the guidelines. This Annual Consistency Review is signed by Medical Directors and other leadership every December; hence, the most recent report was signed December 2009.</p> <ul style="list-style-type: none"> ◆ Report - 2009 CPG Annual Content Consistency Review p. 1 <p>The steps taken to create, approve and distribute guidelines are within this workflow.</p> <ul style="list-style-type: none"> ◆ Workflow – Practice Guideline Development and Approval, pp. 1-2 <p>Educational materials are reviewed by the literature committee for consistency with the Practice Guidelines and are utilized for member’s education.</p> <ul style="list-style-type: none"> ◆ Minutes – Literature Committee 4-28-10, p. 2 ◆ Asthma Member Education Materials <p>Once the Literature Committee approves the materials, they are ordered for members via this Member Screen Shot in EMMA. This is an example of how WellCare ensures that member education decisions are consistent with the guidelines.</p> <ul style="list-style-type: none"> ◆ Case Example - Member Screen Shot in EMMA, p. 1 <p>This case example shows how CM staff can access the guidelines to ensure consistency with decisions. The purpose of having the link available from the Medical Comprehensive Assessment is to provide disease specific standards and guidance to perform education with the member and develop the plan of care.</p> <ul style="list-style-type: none"> ◆ Case Example – CM Staff Utilizing Guidelines 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA </p>



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<p>This case example shows that all staff can access the guidelines to ensure other areas to which the guidelines apply are consistent with the guidelines.</p> <ul style="list-style-type: none"> ◆ Case Example – Staff Access to CPG ◆ Policy – C7QI-026 Provider Clinical Practice Guidelines, pp. 2-3 ◆ Minutes – UMAC 5-26-10, p. 8 	
<p>Findings: As described in WellCare’s documentation and during the staff interview, the WellCare Literature Committee conducted annual reviews of member materials and the CMO reviewed its criteria for utilization review decisions and benefit/service determinations to ensure that the information contained in the documentation and the criteria and processes the CMO followed when reviewing requests for and providing services to members were consistent with the guidelines. The 2009 Annual Clinical Practice Guidelines Consistency Review document stated that benefit determination language and case disease management educational materials had been reviewed and were consistent with the provider and member versions of the guidelines. During the interview, WellCare’s manager of clinical policy development described the steps he followed to ensure consistency across the CMO’s documents and decisions.</p>		
<p>Required Actions: None.</p>		
<p>6. In order to ensure consistent application of the guidelines, the CMO encourages providers to utilize the guidelines and measures compliance with the guidelines until 90 percent or more of the providers are consistently in compliance.</p> <p>Contract: 4.12.7.5</p>	<p>This policy explains how guidelines will be assessed as part of the MRR process.</p> <ul style="list-style-type: none"> ◆ Policy – C7QI-044 Georgia Medical Record Review, p. 3 <p>WellCare utilizes a vendor, Managed Care Outsource, to conduct quarterly reviews. This MRR tool is used to collect data and the policy includes definitions. WellCare develops the tool utilized by the vendor in conducting these reviews. The tool reflects the CPG content related to how a practitioner will be assessed to the guidelines.</p> <ul style="list-style-type: none"> ◆ Tool – 2010 Medical Record Review Tool, Data Collection Tool Tab, Rows 41-48 (Diabetes), Rows 51-56 (Asthma), Rows 59-60 (CKD) <p>The vendor conducts the reviews and as needed, will provide additional reference information to providers on appropriate</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard I—Practice Guidelines

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<p>application of clinical practice guidelines. This information includes:</p> <ul style="list-style-type: none"> ◆ Reference – Diabetes Education ◆ Reference – CKD Education ◆ Reference – Asthma Action Plan Example ◆ Reference – Suggested Websites on Asthma <p>WellCare has recognized the following opportunities upon assessment of practitioner compliance to the guidelines.</p> <ul style="list-style-type: none"> ◆ Presentation – QIC 03-30-10, slide 49 ◆ Minutes – QIC 03-30-10, pp. 29-31 ◆ Presentation – QIC AdHoc 09-08-10, slides 2-4 ◆ Minutes – QIC AdHoc 09-08-10, p. 2 <p>In addition to the medical record reviews, the Plan also uses Health Employer Data Information Set (HEDIS) results to assess provider compliance to guidelines.</p> <ul style="list-style-type: none"> ◆ Report – Performance Measures HEDIS 2010 Rates ◆ Case example – Provider Guideline Compliance HEDIS Diabetes 	

Findings: WellCare used its Web site, provider handbook, and newsletters to inform providers about the guidelines and the importance of using them to guide their practices. Minutes of WellCare’s March 30, 2010, QIC meeting presented a detailed analysis of performance findings and barriers by type (member, provider, and system) related to appropriate management of a number of conditions, the CMO’s targeted actions designed to improve performance, and its plans for continuing to address the barriers and improve member access and provider performance. In addition to using and analyzing encounter data and reporting its performance on select HEDIS measures, WellCare’s documentation and information staff presented during the interview demonstrated that the CMO had other mechanisms, including conducting medical record reviews, to evaluate provider performance.

Required Actions: None.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Results for Standard I—Practice Guidelines						
Total	Met	=	10	X	1.00	= 10
	Partially Met	=	0	X	.05	= 0
	Not Met	=	0	X	.00	= 0
	Not Applicable	=	0	X	NA	= 0
Total Applicable		=	10	Total Score	=	10
Total Score ÷ Total Applicable = 100%						



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>1. The CMO provides for the delivery of quality care, which includes identifying members at risk of developing conditions, implementing appropriate interventions, and designating adequate resources to support the intervention(s).</p> <p>Contract: 4.12.1.1</p>	<p>When reviewing this Documentation Request and Evaluation Form with the Evidence, please reference the electronic PDF page numbers.</p> <p>The CMO's QAPI program description is referenced hereafter as the Quality Improvement Program Description (QIPD).</p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, pp. 3-5 ◆ Program – 2010 QIPD Appendix D Resources, p.32 ◆ Program – 2009 QI Program Evaluation, Entire Document ◆ Minutes – QIC 3-30-10, pp. 5-28, 31 ◆ Minutes – QIC 6-22-10, pp. 22-31 <p>The HEDIS Action Plan outlines interventions by measure that the health plan is undertaking to impact HEDIS rates.</p> <ul style="list-style-type: none"> ◆ Action Plan – HEDIS GA 2010 Medicaid, Entire Document ◆ Report – HEDIS Steering Committee Charter, p. 1 ◆ Presentation – HEDIS Steering Committee, slide 1 ◆ Presentation – Performance Measures HEDIS Effectiveness ◆ Report – Performance Measures HEDIS 2010 Rates 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO had a comprehensive QI program that outlined the process through which clinical and operational performance was continually measured, opportunities for improvement were identified, meaningful interventions were initiated, and the results of actions taken to improve outcomes were evaluated. The interview with the CMO confirmed that the cross-functional team used multiple inputs to identify members at risk through discussion of the case management algorithms and HEDIS results. Committee meeting minutes documented barrier analysis cause and effect diagrams for opportunities for improvement and identified resources required for implementing interventions. The CMO developed multipronged interventions (e.g., telephonic, direct mail, and provider and member outreach) to target improvements.</p>		
<p>Required Actions: None.</p>		
<p>2. The CMO seeks input from and works with members, providers, and community resources and agencies to actively improve the quality of care provided to members.</p>	<p>Members</p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, pp. 4, 6, 12, 17 ◆ Minutes – UMAC 5-26-10, p. 8 ◆ Minutes – UMAC 8-25-10, p. 8 ◆ Presentation – 2010 CAHPS Member Satisfaction Survey 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Contract: 4.12.1.2	<p>Results, Entire Document</p> <ul style="list-style-type: none"> ◆ Report – 2010 CAHPS Child Member Satisfaction Survey Results, Entire Document ◆ Report – 2010 CAHPS Adult Member Satisfaction Survey Results, Entire Document <p><u>Providers</u></p> <p>This is from the final report on Provider Satisfaction which contains provider comments on what the health plan could do to improve services.</p> <ul style="list-style-type: none"> ◆ Report – 2010 Provider Recommendations for Improvements, Entire Document ◆ Program – 2010 QIPD, pp. 4, 6, 14, 17 ◆ Minutes – UMAC 8-25-10, pp. 2, 10 ◆ Presentation – 2010 Provider Satisfaction Survey Results, Entire Document ◆ Report – 2010 Provider Satisfaction Survey Results, Entire Document <p><u>Community Resources and Agencies</u></p> <p>These documents show how we seek input from and work with community resources and agencies through our Prenatal Program, ZAP Asthma and Diabetes education.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, p. 4 ◆ Minutes – QIC 03-30-10, p. 18 ◆ Member Handbook, p. 40 ◆ Report - Hypertension Joint Community Outreach May 2010, p.1 <ul style="list-style-type: none"> ◆ Report – Prenatal Community Education Overview, p. 1 ◆ Presentation - Community Prenatal Education ◆ Program – 2010 Prenatal Program Description p. 3 	



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Case Example – EMMA Screen Shot Care Plan Community Resources, p. 1-2 ◆ Training - ZAP Asthma in House Education ◆ WorkFlow – Member Outreach Asthma Population Partner with Zap Asthma ◆ Presentation – The ABCs of Diabetes ◆ Script – Diabetes Community Ed Invite 	

Findings: The CMO’s 2010 QIPD included the processes for members, providers, community-based organizations, and various health care agencies to receive updates and to offer suggestions, concerns, and recommendations regarding improving quality of care to Medicaid and PeachCare for Kids membership. The CMO annually surveyed satisfaction of the membership (adult and child) and providers through a National Committee for Quality Assurance (NCQA)-certified vendor. During the interview, staff members stated that WellCare used member and provider comments and complaints as one source of data to direct interventions to improve their experiences with providing and receiving services. The CMO tracked and trended member satisfaction when each case management or disease management encounter was closed. WellCare demonstrated coordination with community resources through its work with public/private partnership organizations such as the local, Atlanta-based ZAP Asthma organization or the national Text4Baby organization. Through its participation in the Hypertension Awareness Outreach program in May 2010, the CMO also collaborated with the Georgia chapter of the American Heart Association and the American Diabetes Association.

Required Actions: None.

<p>3. The CMO has a multidisciplinary Quality Oversight Committee to oversee all quality functions and activities. This committee meets at least quarterly, but more often if warranted.</p> <p>Contract: 4.12.1.3</p>	<ul style="list-style-type: none"> ◆ Program – 2010 QIPD Appendix C Committee Structure, pp. 23-25 ◆ Minutes – QIC 12-8-09, p. 1 ◆ Minutes – QIC 03-30-10, p. 1 ◆ Minutes – QIC 06-22-10, pp.8, 22 ◆ Minutes – Adhoc QIC 06-23-10, p. 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
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Findings: The CMO’s 2010 QIPD listed the multiple disciplines represented on the QIC. In describing the committee structure, the program description stated that “Member or Member advocate and Network Provider” representation may be through QIC membership or as a member of a plan subcommittee. During the interview, CMO staff stated that the WellCare QIC or subcommittees do not have member or member advocate representation. While it is not a DCH requirement that the CMO include member input on committees, the CMO was encouraged to update the QIPD to accurately reflect current practice. Network provider representation was noted on the Utilization Management, Medical Advisory, and Pharmacy and Therapeutics subcommittees. The QIC minutes provided evidence of quarterly meetings.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
4. The CMO supports and complies with the Georgia Families Quality Strategic Plan by: <i>42CFR438.240(b)(1)through (4)</i> Contract: 4.12.2.1		
a) Monitoring and evaluating its service delivery system and provider network, as well as its own processes for quality management and performance improvement. Contract: 4.12.2.2	The QI Work Plan is a master report that includes multiple scorecards (tabs), when opening up this document you will see that each scorecard has barriers and analysis (B&A) next to it. When reviewing the entire project, please reference the metric tab (scorecard) and the B&A tabs. <ul style="list-style-type: none"> ◆ Program – 2010 QI Work Plan, Appt Timeliness, GeoAccess Tabs ◆ Program – 2009 QI Program Evaluation, pp. 5,19,24 ◆ Minutes – QIC 03-30-10, pp. 6-8 ◆ Minutes – QIC 06-22-10, pp. 23, 28 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
Findings: The WellCare Georgia CMO's 2010 QI Work Plan documented the range of measurements the CMO used to evaluate its performance and its improvement processes and results (e.g., timely access to care for members; network adequacy for preventive, primary care, and specialty services; and Agency for Healthcare Research and Quality [AHRQ] and HEDIS performance measurement trending). During the interview, the CMO quality team members described several components and numerous examples of the CMO's evaluation activities and the data WellCare used. Examples included using geographic access data to evaluate member access to care and network adequacy.		
Required Actions: None.		
b) Implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members. Contract: 4.12.2.2	The Barriers & Analysis Tabs show action plans and activities to correct metrics and improve quality care to members. <ul style="list-style-type: none"> ◆ Program – 2010 QI Work Plan, Barriers & Analysis (B&A) Tabs ◆ Program – 2009 QI Program Evaluation, pp. 18, 44 ◆ Minutes – UMAC 5-26-10, p. 11 ◆ Minutes - QIC 6-22-10, pp. 31-32 The HEDIS Action Plan outlines interventions by measure for 2010 that the health plan is undertaking to impact HEDIS rates.	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Action Plan – HEDIS GA 2010 Medicaid, Entire Document <p>These interventions are examples listed within the HEDIS Action Plan.</p> <ul style="list-style-type: none"> ◆ Report – Member Outreach HEDIS 2010, p. 1 ◆ Report – Prenatal Community Education Overview, p. 1 	
<p>Findings: WellCare’s 2010 QI Work Plan described the CMO’s ongoing analysis of quantitative and qualitative measures, which included examination of barriers and the development of meaningful interventions that address identified opportunities to improve the level of health care and service delivery. The CMO used a scorecard approach to track each metric finding, and interventional strategies were modified to reflect analysis and improve connectivity with members. The 2009 QI Program Evaluation documented the annual review of the CMO’s performance. Information staff provided during the interview when describing the CMO’s processes and tools for evaluating its performance, the performance results it had obtained, and the strategies implemented or planned to improve performance was consistent with and expanded on the written documentation.</p>		
<p>Required Actions: None.</p>		
<p>c) Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, and utilization management reviews.</p> <p>Contract: 4.12.2.2</p>	<p><u>Monitoring activities</u> Child immunizations and lead screening are two performance improvement projects (PIPs) that address monitoring activities, improvements are noted within our preventive health topics. Program – 2009 QI Evaluation, pp. 3, 27-33</p> <ul style="list-style-type: none"> ◆ Program – 2010 QI Work Plan, All Tabs <p><u>Reviews of complaints and reviews of allegations of abuse</u> Billing and Financial trends were identified through monitoring complaints via our Work Plan.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QI Work Plan, Complaints B&A Tab ◆ Project – Grievance Balance Billing, slide 1 ◆ Minutes – CSQIC 5-27-10, pp. 7-8 ◆ Minutes – QIC 3-30-10, pp. 10-11 <p><u>Provider credentialing and profiling</u> The Provider Grievance Data, a new automatically generated report,</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<p>provides information for the Credentialing Department to use during Credentialing Committee meetings to discuss any providers with three or more complaints logged against them in a rolling six month period. This report replaces a manual process.</p> <ul style="list-style-type: none"> ◆ Report – Provider Grievance Data, Details Tab ◆ Report – Rolling 6 Month Complaints Credentialing Committee, p. 1 ◆ Minutes – Credentialing Committee 7-26-10, pp. 7-8 <p>When OmniFlow was launched it replaced another manual process and created an electronic transfer of provider’s credentialing applications from entry to the credentialing department. OmniFlow contains triggers to automatically move applications to the correct department and continues to initiate performance improvements.</p> <ul style="list-style-type: none"> ◆ Project - OmniFlow Enhancing Flow of Credentialing Applications ◆ Minutes - CSQIC 1-28-10 OmniFlow, p. 7 <p>The 2010 Medical Record Review Tool contains a question asking if the nurse reviewer found any evidence of a QOC concern that should be investigated. This question can be found on the third tab of the tool.</p> <ul style="list-style-type: none"> ◆ Tool – 2010 Medical Record Review Tool, Pg 3 Score Results and Signature Tab <p><u>Utilization management reviews</u></p> <p>This Emergency Room Outreach project was based on the review of ER utilization data.</p> <ul style="list-style-type: none"> ◆ Report - ER Outreach Program Summary, Entire Document ◆ Minutes – UMAC 5-26-10, p. 13 	

Findings: The CMO’s documents provided detailed information about the processes and mechanisms WellCare used to monitor and evaluate trends related to the required components. Work plans and the integrated program tracking tools were very detailed in identifying the QAPI goals, the CMO’s strategies



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
 for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>for achieving the goals, and describing outcomes (goals achieved and those still in process). During the interview, staff members described several impressive examples of having used systematic processes to monitor multiple inputs to ensure that quality of care concerns and complaints were investigated and that the CMO responded by following continual quality improvement steps to improve performance across the domains of health care quality, access, and timeliness.</p>		
<p>Required Actions: None.</p>		
<p>d) Describing in the CMO’s QAPI program description how the CMO complies with federal, State, and Georgia Families requirements.</p> <p>Contract: 4.12.2.2</p>	<p>The QI Work Plan is a master report that includes multiple scorecards (tabs), when opening up this document you will see that each scorecard has barriers and analysis (B&A) next to it. When reviewing the entire project, please reference the metric tab (scorecard) and the B&A tabs. The columns listed below show how metrics are linked to Federal, State and Georgia Families requirements, by labeling which standard is connected to each metric.</p> <ul style="list-style-type: none"> ◆ Program – QI Work Plan, All Metrics Tabs, Columns E F G H. ◆ Program – 2010 QIPD, pp. 4, 17 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO 2010 QI Work Plan provided detailed descriptions of the comprehensive process WellCare used to link the CMO’s metrics to the DCH contract/Georgia Families requirements, NCQA accreditation standards, and 42 CFR 438 federal requirements. The <i>Compliance 360</i> application captured the CMO’s on-going monitoring activities. During the interview staff members described the mechanism the CMO used to capture updates to requirements and the integration and communication of the changes into the organization’s workflow and processes.</p>		
<p>Required Actions: None.</p>		
<p>e) Coordinating with State registries.</p> <p>Contract: 4.12.2.2</p>	<p>The Georgia Registry of Immunization Transactions and Services (GRITS) and Lead are two state registries that coordinate with WellCare. The following documents show the steps on how we coordinate with the state registries.</p> <ul style="list-style-type: none"> ◆ Specifications- GRITS Flat File Specification, pp. 1-21 ◆ Specifications – GRITS HL7 General Transfer Specification, pp. 1-49 ◆ Training - GRITS HMO Query for HEDIS Reporting, pp. 1-15 ◆ Project - LEAD Load BRD, pp. 7-11 ◆ Workflow – GRITS from GA to WCG, p.1 ◆ Workflow- LEAD feed from State to WCG, p.1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>Findings: The CMO demonstrated that, through its documented processes, it coordinated with the Georgia Registry of Immunization Transactions and Services (GRITS) and followed the Georgia Childhood Lead Poisoning Prevention Program (GCLPPP) screening, lab submission, and reporting guidelines. During the interview, staff discussed quality improvement activities it had generated to improve data submission.</p>		
<p>Required Actions: None.</p>		
<p>f) Including CMO executive and management staff members in the quality management and performance improvement processes.</p> <p>Contract: 4.12.2.2</p>	<ul style="list-style-type: none"> ◆ Program – 2010 QIPD, p. 5 ◆ Program – 2010 QIPD Appendix B Personal, pp. 20-22 ◆ Minutes – QIC 3-30-10, p. 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: WellCare’s written 2010 QIPD described the role and responsibilities of executive leadership within both corporate and Georgia CMO leadership structures. At the corporate level, under the leadership of the senior vice president of health care delivery and the vice president of quality and accreditation, the role of executive leadership was to set the strategic direction for QI programs by guiding the application of process improvement tools/techniques to achieve provider/customer satisfaction and continual improvement in care delivery, as well as to reduce total costs. At the Georgia health plan level, the role of the senior medical director; vice president of field health services; and director of quality improvement were described as providing leadership and direction for the day-to-day operations of the QI program.</p>		
<p>Required Actions: None.</p>		
<p>g) Including in the development and implementation of quality management programs information from provider participation and information from members, their families, and their guardians.</p> <p>Contract: 4.12.2.2</p>	<p>Providers This document is from the final report on Provider Satisfaction which contains provider comments on what the health plan could do to improve services.</p> <ul style="list-style-type: none"> ◆ Report – 2010 Provider Recommendations for Improvements, Entire Document ◆ Program – 2010 QIPD, pp. 4, 6, 14, 17 ◆ Minutes – UMAC 8-25-10, pp. 2, 13-14 ◆ Presentation – 2010 Provider Satisfaction Survey Results, slides 10-14 ◆ Report – 2010 Provider Satisfaction Survey Results, Entire Document ◆ Minutes – QIC 09-29-09, pp. 7-9 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<p><u>Members</u></p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, pp. 4, 6, 12, 17 ◆ Presentation – 2010 CAHPS Member Satisfaction Survey Results, slides 3-11 (Adult) ◆ Report – 2010 CAHPS Adult Member Satisfaction Survey Results, Entire Document ◆ Minutes – QIC 09-29-09, pp. 9-10 ◆ Agenda – QIC 09-28-10, p. 1 <p><u>Families and their Guardians</u></p> <p>The Child Satisfaction Survey is completed by members’ families and their guardians. These surveys are included in the development and implementation of quality management programs.</p> <ul style="list-style-type: none"> ◆ Presentation – 2010 CAHPS Member Satisfaction Survey, Results, slides 12 – 19 (Child) ◆ Report – 2010 CAHPS Child Member Satisfaction Survey Results, Entire Document <p>The satisfaction surveys are presented to QIC annually. These minutes confirm that the surveys were presented on 9-29-10 and the QIC Agenda shows that they will again be presented on 9-28-10.</p> <ul style="list-style-type: none"> ◆ Minutes – QIC 9-29-09, pp. 9-10 ◆ Agenda – QIC 9-28-10, pp. 1 	

Findings: The CMO’s QI program was comprehensive, systematic, and continual. It applied to all Medicaid member demographic groups, care settings, and types of services. CMO policies supported a process for members, providers, various health care associations, and community agencies to receive updates and offer suggestions, concerns, and recommendations regarding the QI program and activities. The adult and child membership was formally surveyed annually to assess satisfaction with the CMO. During the interview, staff provided an example within the QI work plan in which member feedback was analyzed and an action plan developed and implemented to address the areas identified as needing improvement, including pediatric coverage. The performance results and action plan were presented to the QIC for approval and recommendations.

Required Actions: None.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>h) Using best practices for performance and quality improvement.</p> <p>Contract: 4.12.2.2</p>	<p>The rates within this presentation show how we benchmark.</p> <ul style="list-style-type: none"> ◆ Presentation – Performance Measures HEDIS Effectiveness <p>Many sources we access are used to determine best practices and these are some of those sources.</p> <ul style="list-style-type: none"> ◆ Presentation – Best Practices in Medicaid Resources <p>The ER project was based off a study conducted by UCLA and Johnson & Johnson.</p> <ul style="list-style-type: none"> ◆ Report - ER Outreach Program Summary, p. 4 <p>In the course of the planning and development of the Member Incentive Program, best practice resources were researched.</p> <ul style="list-style-type: none"> ◆ Presentation – QIC 09-28-10 Member Incentive Best Practices, slides 1-2 ◆ Minutes – UMAC 3-24-10, p. 8 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO used established, recognized benchmarks that reflected local, state, or national norms established through comparative data in setting its targets and monitoring performance on HEDIS measures. During the interview, staff described examples of the evidence-based resources it used in planning improvement intervention strategies (e.g., the Center for Health Care Strategies was used for providing member incentives to enhance participation in preventive health services). Documentation of the emergency room project supported using a proven, multistate Medicaid intervention framework, and it was adapted for use by the Georgia WellCare CMO.</p>		
<p>Required Actions: None.</p>		
<p>5. The CMO complies with Georgia Families quality management requirements to improve member health outcomes by using DCH-established performance measures to document results.</p> <p style="text-align: right;"><i>42CFR438.240(b)(2)</i></p> <p>Contract: 4.12.3.1</p>	<p>The QI Work Plan is a master report that includes multiple scorecards (tabs), when opening up this document you will see that each scorecard has barriers and analysis (B&A) next to it. When reviewing the entire project, please reference the metric tab (scorecard) and the B&A tabs.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QI Work Plan, DCH+NCQA Performance Measures Tabs ◆ Report – CMO Performance Measures and Target FY10 ◆ Report – Analysis for DCH Performance Measures 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Report – Performance Measures AHRQ Rates ◆ Report – Performance Measures HEDIS 2010 Rates ◆ Presentation – Performance Measures HEDIS Effectiveness ◆ Minutes – QIC 6-22-10, pp. 13-20 	
<p>Findings: WellCare’s documents provided detailed descriptions of the CMO’s use of DCH-established performance measures to monitor and evaluate its performance in providing accessible, timely, and quality services to its members.</p> <p>Required Actions: None.</p>		
<p>6. The CMO has an ongoing QAPI program for the services it furnishes to its members.</p> <p style="text-align: right;"><i>42CFR438.240(a)</i></p> <p>Contract: 4.12.5.1</p>	<ul style="list-style-type: none"> ◆ Program - 2010 QIPD, pp. 4, 6, 8 ◆ Policy - C7QI-033 Quality Improvement Program, pp. 1-2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO’s 2010 QIPD established and described WellCare’s quality improvement processes for ensuring that it had a comprehensive, integrated, systemwide plan to assess and improve the quality of clinical care and services it provides to members. During the interview, staff described the QAPI structure and the broad range of activities it included.</p> <p>Required Actions: None.</p>		
<p>7. The CMO’s QAPI program is based on the latest available research in the area of quality assurance.</p> <p>Contract: 4.12.5.2</p>	<p>Many sources we access are used to determine best practices and these are some of those sources.</p> <ul style="list-style-type: none"> ◆ Presentation – Best Practices in Medicaid Resources ◆ Program – 2010 QIPD, p. 7 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: WellCare had documentation that described the CMO’s continual process of analyzing data and acting to ensure consistency in practices across the company in an effort to become more efficient and effective. The on-site interview confirmed that the CMO used the Plan-Do-Check-Act (PDCA) method of continual quality improvement. Under the PDCA approach, performance on multiple indicators of quality of care and service were reviewed and analyzed against evidence-based benchmarks of quality clinical care and service delivery. When variations were noted, the CMO conducted root cause analysis, developed and implemented action plans, and conducted remeasurement to ensure progress toward established goals. WellCare reviewed documented best practices and proven strategies established by industry leaders and research-based organizations in developing its intervention strategies focused on improving processes and results. Staff stated that WellCare had adopted team training that emphasized using Six Sigma methodologies to enhance process reliability.</p> <p>Required Actions: None.</p>		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>8. The CMO’s QAPI program includes mechanisms to detect both underutilization and overutilization.</p> <p style="text-align: right;"><i>42CFR438.240(b)(3)</i></p> <p>Contract: 4.12.5.2</p>	<ul style="list-style-type: none"> ◆ Program – 2010 QIPD, p. 12 ◆ Program – 2010 QIPD Appendix F UM Program Description, pp. 63-64 ◆ Program – 2009 UM Program Evaluation, pp. 1-2 ◆ Report - 2010 Corporate UM Work Plan, Lines 9-14 ◆ Report – 2010 Georgia UM Scorecard, Lines 3-21 ◆ Minutes – QIC 6-22-10 p. 8 ◆ Minutes – UMAC 3-24-10, p. 13 ◆ Minutes – UMAC 5-26-10, p. 5 ◆ Minutes – UMAC 8-25-10, p.13 ◆ Policy - C7UM MD-1.2 Under and Over Utilization of Services, p. 1 ◆ Presentation – CM Utilization Q2 2010 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO provided documents detailing the utilization management activities that WellCare conducted to ensure that members receive appropriate and timely health care services in the most cost-effective setting. Minutes of UMAC meetings documented monitoring of quarterly utilization data for indicators, including bed days per thousand, pharmacy utilization, neonatal intensive care unit (NICU) utilization, readmissions, and average length of stay (ALOS). During the interview, staff members representing the Quality Improvement and Utilization Management departments discussed their collaborative approach to monitoring utilization patterns across practices and provider sites, including primary care physicians and high-volume specialists. These activities included monitoring to identify potential quality issues related to over- or underutilization of services. Evaluation of care delivered at the practitioner office was also monitored through medical record review.</p>		
<p>Required Actions: None.</p>		
<p>9. The CMO’s QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs.</p> <p style="text-align: right;"><i>42CFR438.240(b)(4)</i></p> <p>Contract: 4.12.5.2</p>	<p>Case Management (CM) evidence is one of our mechanisms to assess the quality and appropriateness of care furnished to members.</p> <ul style="list-style-type: none"> ◆ Program - 2010 CMPD, pp. 5-7 ◆ Policy- C7CM MD 8.23 Case Management Comprehensive Assessment and Planning, p. 2 ◆ Program – 2009 Case Management Annual Evaluation GA, pp. 5-17 ◆ CM Algorithm ◆ CM Case Examples 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Minutes – UMAC 5-26-10, p.5 ◆ Program – 2010 QIPD, p.15 ◆ Program – 2010 QIPD Appendix F UM Program Description, p. 48 ◆ Tool – 2010 Medical Record Review Tool, Data Collection ◆ Case Example - Provider Guideline Compliance HEDIS Imm Lead WellChild ◆ Case Example – Provider Guideline Compliance HEDIS Diabetes 	
<p>Findings: The Case Management Department staff described the process of assisting the member in coordination of care, education, transition of care, and overall member advocacy. Case managers used medical directors to review the appropriateness of care a member received. The medical director was available to provide peer-to-peer consultation with any treating provider. The CMO worked with providers to maximize appropriate utilization of services and the delivery of quality health care through the efficient and appropriate use of resources. The CMO documented its integrated approaches to identifying members with special health care needs. Utilization management activities identified members with potential or high-risk disease states, high resource use, or a high-cost diagnosis. The Case Management Department staff described the algorithmic predictive modeling approach as one method it used to stratify and identify members with specific disease states and/or needs to ensure compliance with all State and federal regulations and contracts.</p> <p>Required Actions: None.</p>		
<p>10. The CMO’s QAPI program includes written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically assessed for efficacy.</p> <p>Contract: 4.12.5.2</p>	<p>This policy establishes a uniform program for the creation, revision and management of policies and supporting documents and processes.</p> <ul style="list-style-type: none"> ◆ Policy – C13CP-001 Policy Program Administration, p. 4 ◆ Policy – C7QI 033 Quality Improvement Program, p. 2 ◆ Policy C7UM MD – UM Program Description, p. 2 ◆ Program – 2010 QIPD, pp. 5, 14, 17 ◆ Report – QI Policy Ownership 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: WellCare provided detailed information about its uniform program for the creation, revision, and management of policies and supporting documents and processes. The program established protocols for the development, approval, and implementation of policies and supporting documents and processes. Policies defined the CMO’s QI program through three key documents: the QIPD, the QI Work Plan, and the QI Program Evaluation. Each of these documents was reviewed, updated, and revised annually to ensure continual quality improvement of the care and services provided to members.</p> <p>Required Actions: None.</p>		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>11. The CMO’s QAPI program includes designated staff members with expertise in quality assessment, utilization management, and continuous quality improvement.</p> <p>Contract: 4.12.5.2</p>	<ul style="list-style-type: none"> ◆ Program – 2010 QIPD Appendix B Personnel, pp. 20-22 ◆ Program – 2010 QIPD Appendix F Utilization Management Program Description, pp. 50-54 ◆ Report – Health Services Qualifications and Experience May 2010 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO provided documentation of quality program staff qualifications outlining certifications, professional education, and work experience. WellCare described its quality improvement staff as cumulatively having 559 years of health care experience, 225 years of managed care experience, 190 years of Medicaid experience, and 72 years in quality-related activities. Job descriptions available for HSAG’s review for each of the key positions described the duties and responsibilities and minimum qualifications. During the interview, staff described the forums and team training it had used to create a culture of continual improvement and flexibility.</p> <p>Required Actions: None.</p>		
<p>12. The CMO’s QAPI program includes reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members.</p> <p>Contract: 4.12.5.2</p>	<p>The QI Work Plan is a master report that includes multiple scorecards (tabs), when opening up this document you will see that each scorecard has barriers and analysis (B&A) next to it. When reviewing the entire project, please reference the metric tab (scorecard) and the B&A tabs.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QI Work Plan, Analysis and Barriers (A&B) Tabs ◆ Newsletter – Winter 2009 Provider Newsletter, p. 11 ◆ Newsletter – 2Q 2010 Provider Newsletter, pp. 8-9 ◆ Newsletter – Fall 2009 Member Newsletter, p. 3 ◆ Newsletter – 1Q 2010 Member Newsletter, pp. 1-2 ◆ Minutes – QIC 03-30-10, p. 6 ◆ Minutes – UMAC 08-25-10, pp. 14-15 ◆ Program – 2009 UM Program Evaluation, p. 12 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO QI Work Plan presented the framework for the performance reports monitored by the QIC and the Utilization Management Advisory Committee. The CMO provided newsletters for HSAG’s review as evidence of having provided feedback on the CMO’s performance to members and providers. One of the provider newsletters included the 2008 Early and Periodic, Screening, Diagnostic, and Treatment (EPSDT) findings, against which the providers could compare their performance, and recommendations to improve performance. The CMO Member Satisfaction Survey results were</p>		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>communicated to members in a newsletter that described the CMO’s efforts to improve member satisfaction. A copy of the QIPD was available to members and providers by fax or by calling a toll-free telephone number to request a copy.</p> <p>Required Actions: None.</p>		
<p>13. The CMO’s QAPI program includes a methodology and process for conducting and maintaining provider profiling.</p> <p>Contract: 4.12.5.2</p>	<ul style="list-style-type: none"> ◆ Program – 2010 QIPD, p.13 ◆ Program 2010 QIPD, Appendix C Committee Structure, pp. 23-24 ◆ Minutes – Credentialing Committee 7-26-10, pp. 7-8 ◆ Policy - C7QI-053 QOC Issues, pp. 4-5, 14-15 ◆ Policy – C7CR-002 Re-Credentialing, pp.1-2,17 ◆ Policy – C7CR-019 Credentialing Committee-Peer Review, p. 2 ◆ Report – QI Report Template Provider Profile John Doe ◆ Case Example – QI Report 9 Provider Profiles 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO designated the Credentialing and Peer Review Committee as the mechanism to uniformly apply credentialing and recredentialing criteria to ensure that qualified providers are approved and maintained as participating providers. The information gathered on individual providers through the CMO QI program was compiled in a provider profile and submitted to the Credentialing Department for recredentialing. The information included results of clinical performance monitoring activities, utilization review, risk management, and resolution and monitoring of member grievances. The committee conducted peer review of provider quality of care, quality of service, adverse events, and complaints, and conducted a review of trends related to them.</p> <p>Required Actions: None.</p>		
<p>14. The CMO’s QAPI program includes ad-hoc reports to the CMO’s multidisciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations, and implemented system changes.</p> <p>Contract: 4.12.5.2</p>	<p>Dr. Carson of DCH is a regular attendee to our QIC and the QIPD explains how an AdHoc QIC meeting can be convened.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, pp. 8, 13 <p>Two instances within the 6-22 QIC minutes document the need for the 6-23 AdHoc QIC.</p> <ul style="list-style-type: none"> ◆ Minutes – QIC 6-22-10, pp. 8, 22 ◆ Minutes – AdHoc QIC 6-23-10, p. 1 <p>This is WellCare’s response to DCH request related to Lead Care II Analyzer.</p> <ul style="list-style-type: none"> ◆ Minutes – DCH QI Quality Medical Management (QMM) 4-07- 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	10, p. 2 <ul style="list-style-type: none"> ◆ Minutes – DCH QI Quality Medical Management (QMM) 4-28-10, p. 2 ◆ Provider Communication - Blood Lead Level Testing Requirement 	
<p>Findings: The CMO 2010 QIPD and the 2010 Work Plan included detailed descriptions of the scheduled and ad hoc reporting mechanisms WellCare used to communicate its performance related to contract requirements to DCH and for QIC oversight. The CMO provided written examples for HSAG’s review in which the CMO had used ad hoc reports to further discuss a significant issue initiated in a quarterly QIC meeting. The minutes from a Quality Medical Management biweekly meeting with DCH addressed updates to the blood lead level testing requirement and the CMO’s response in communicating the new requirements to providers. Staff descriptions of the processes during the interview were consistent with the policy.</p>		
<p>Required Actions: None.</p>		
15. The CMO has a process for evaluating the impact and effectiveness of the QAPI program. <div style="text-align: right;"><i>42CFR438.240(b)(3)</i></div> Contract: 4.12.5.2	One example of how we have evaluated the impact of our program is by monitoring the statistical significance seen within this presentation. We also have Performance Improvement Projects (PIPs) to assess our impact and effectiveness of the QI Program. <ul style="list-style-type: none"> ◆ Presentation – Performance Measures HEDIS Effectiveness ◆ Program - 2010 QIPD, pp. 6, 8-9, 17 ◆ Policy – C7QI 033 Quality Improvement Program, p. 2 ◆ Program – 2009 QI Program Evaluation, Entire Document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO’s documents provided detailed information about the role of the HEDIS steering committee in data oversight to determine the impact and effectiveness of the care/services the CMO provided to members, including, as applicable, the level of statistical significance for the results and trends. The work plans for each PIP and focused study were exceptionally detailed in identifying the QAPI goals and the strategies for achieving the goals, and in describing outcomes (goals achieved and those still in process).</p>		
<p>Required Actions: None.</p>		
16. The CMO conducts focused studies that examine a specific aspect of health care for a defined point in time. These studies are usually based on information extracted from medical records or contractor administrative data such as enrollment files and	<ul style="list-style-type: none"> ◆ Program – 2009 QI Program Evaluation, pp. 34-35 ◆ Focus Study – 2010 Dental, Entire Document ◆ Focus Study – 2010 Childhood Obesity, Entire Document 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
 for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
encounter/claims data. Contract: 4.12.8.1		
<p>Findings: DCH contractually required two studies: one focused on obesity and one on dental health. WellCare had focused studies that addressed both areas (e.g., <i>Improving Dental Visit Rates for Members Aged 2–21</i> and <i>Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents</i>). The CMO provided evidence of having met the requirement related to the obesity study through its documentation of measures for increasing the rate/percentage of members 3–17 years of age who had a body mass index (BMI) percentile documentation, counseling for nutrition, and counseling for physical activity during the measurement year. The dental-related study the CMO provided was for members 2–21 years of age who had at least one dental visit.</p>		
<p>Required Actions: None.</p>		
17. The CMO follows a structured process for conducting the focused studies, which includes: <ul style="list-style-type: none"> ◆ Selecting the study topic(s). ◆ Defining the study question(s). ◆ Selecting the study indicator(s). ◆ Identifying a representative and generalizable study population. ◆ Documenting sound sampling techniques utilized (if applicable). ◆ Collecting reliable data. ◆ Analyzing data and interpreting study results. Contract: 4.12.8.1	<ul style="list-style-type: none"> ◆ Program – 2009 QI Program Evaluation, pp. 34-35 ◆ Focus Study – 2010 Dental, pp. 2, 5, 7-9, 15, 16 ◆ Focus Study – 2010 Childhood Obesity, pp. 2-15, 21-22 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO provided documentation of the framework of its studies, which outlined the structured process for the DCH-required dental and childhood obesity focused studies. The documentation addressed all required activities as listed in the requirement.</p>		
<p>Required Actions: None.</p>		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>18. The CMO has a structured patient safety plan to address concerns or complaints regarding clinical care, which includes written policies and procedures for processing member complaints regarding the care they received.</p> <p>Contract: 4.12.9.1</p>	<p>The QI Work Plan is a master report that includes multiple scorecards (tabs), when opening up this document you will see that each scorecard has barriers and analysis (B&A) next to it. When reviewing the entire project, please reference the metric tab (scorecard) and the B&A tabs.</p> <ul style="list-style-type: none"> ◆ Program - QI Work Plan, Patient Safety Tabs ◆ Program – 2010 QIPD Appendix E Patient Safety Plan, pp. 39, 43 ◆ Policy - C7QI -053 QOC Issues, p. 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: Information staff members presented during the interview was consistent with information presented in the CMO’s Patient Safety Plan, which included written policies and procedures describing how member concerns or complaints were managed individually at a member level as “substantiated” or “unsubstantiated” findings, depending on whether there was evidence of deviation from the standard of care. The plan also outlined the processes the CMO followed in maintaining an accurate and consistent means of identifying, investigating, tracking, trending, and reporting potential and/or actual quality of care issues.</p> <p>Required Actions: None.</p>		
<p>19. Patient safety plan policies and procedures include:</p> <p>Contract: 4.12.9.1</p>		
<p>a) A system for classifying complaints according to severity.</p> <p>Contract: 4.12.9.1</p>	<ul style="list-style-type: none"> ◆ Program - QI Work Plan, Patient Safety Tabs, Rows 17-19 ◆ Program – 2010 QIPD Appendix E Patient Safety Plan, pp. 39-41 ◆ Policy – C7QI-053 QOC Issues, p. 2 ◆ Case Example – PPIR Form Minor QOC ◆ Case Example – PPIR Form Critical QOC 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO’s Patient Safety Plan included written policies and procedures that defined the seriousness of the quality of care concern by the following severity codes:</p> <ul style="list-style-type: none"> ◆ 0 None – There is no impact on the quality, performance, or functionality of a patient. ◆ 1 Minor – A low-to-medium impact problem that allows the patient to continue to function. This may be a minor issue with limited loss or no loss of functionality or impact to the patient. ◆ 2 Major – A problem in which the patient's system is functioning but in a severely reduced capacity. The situation is causing significant impact to portions of the patient's health. The patient’s system is exposed to potential loss or interruption. 		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>◆ 3 Critical – A catastrophic problem that may severely impact the patient. The CMO provided additional documentation demonstrating the application of severity codes consistent with policy.</p> <p>Required Actions: None.</p>		
<p>b) A review by the medical director.</p> <p>Contract: 4.12.9.1</p>	<ul style="list-style-type: none"> ◆ Policy – C7QI-053 QOC Issues, pp. 3-7 ◆ Case Example – PPIR Form Minor QOC ◆ Case Example – PPIR Form Critical QOC 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO’s policy and procedure that defined the medical director’s process for reviewing quality of care concerns classified the severity codes as 1 – 3. The CMO provided additional documentation of the medical director’s review of a minor (Severity Code 1) quality of care concern, which was consistent with policy.</p> <p>Required Actions: None.</p>		
<p>c) A mechanism for determining which incidents will be forwarded to the peer review and credentials committees.</p> <p>Contract: 4.12.9.1</p>	<ul style="list-style-type: none"> ◆ Policy – C7QI-053 QOC Issues, pp. 1-3-7, 16-17 ◆ Policy – C7QI – 044 Medical Record Review, p. 3 ◆ Policy – C7CR-019 Credentialing Committee-Peer Review, p. 2 ◆ Program – 2010 QIPD Appendix E Patient Safety Plan, pp. 40-42 ◆ Minutes – Credentialing Committee 7-26-10, pp. 7-8 ◆ Report – QI Report Template Provider Profile John Doe ◆ Case Examples – QI Report 9 Provider Profiles 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO policies and procedures documented the CMO’s work flow in which incidents, including grievances and quality of care concerns, were tracked and trended to be included as part of the provider profiles prepared for review by the Credentialing and Peer Review Committee.</p> <p>Required Actions: None.</p>		
<p>d) A summary of incident(s), including the final disposition, included in the provider profile.</p> <p>Contract: 4.12.9.1</p>	<p>Page 43 of the Patient Safety Plan references WellCare’s metrics on a summary of incident(s) that are included in the provider profile.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, Appendix E Patient Safety Plan, pp. 39-40, 43 <p>This report contains information given to the Credentialing Department for insertion into the QI Report which goes into the provider profile. This information is then presented to the Credentialing Committee at the time the providers are under consideration for re-credentialing.</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard II—Quality Assessment and Performance Improvement

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> ◆ Report – Q3 2010 Re-credentialing List <p>This report is an automated enhancement from the Q3 2010 Re-credentialing report above.</p> <ul style="list-style-type: none"> ◆ Report – Provider Grievance Data, Details and Provider Grievance Tabs ◆ Policy – C7CR-002 Re-credentialing, pp. 1- 2, 17 ◆ Policy – C7QI-053 QOC Issues, pp. 6, 12, 19 ◆ Report – QI Report Provider Profile John Doe ◆ Case Example – QI Report 9 Provider Profiles 	
<p>Findings: WellCare’s Patient Safety Plan stated that the CMO included provider quality of care concerns, with detailed records of complaints, in its provider profiling. HSAG reviewed an example of a report. The process staff described during the interview was consistent with the documentation related to the CMO’s process and the types of data it used.</p>		
<p>Required Actions: None.</p>		

Results for Standard II—Quality Assessment and Performance Improvement						
Total	Met	=	29	X	1.00	= 29
	Partially Met	=	0	X	.05	= 0
	Not Met	=	0	X	.00	= 0
	Not Applicable	=	0	X	NA	= 0
Total Applicable		=	29	Total Score	=	29
Total Score ÷ Total Applicable						= 100%



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>1. The CMO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data.</p> <p style="text-align: right;"><i>42CFR438.242(a)</i></p> <p>Contract: 4.12.5.2</p>	<p>When reviewing this Documentation Request and Evaluation Form with the Evidence, please reference the electronic PDF page numbers.</p> <p>As outlined in the QIPD, WellCare’s Health Information System is maintained by the Information Technology department and encompasses both the processes used to analyze data in addition to the systems used to house the data.</p> <ul style="list-style-type: none"> ◆ Program – 2010 QIPD, p. 5 ◆ Program – 2010 QIPD Appendix D Resources, pp. 34-35 ◆ Workflow - Health Information System Overview <p>The QI Work Plan is a master report that includes multiple scorecards (tabs), when opening up this document you will see that each scorecard has barriers and analysis (B&A) next to it. When reviewing the entire project, please reference the metric tab (scorecard) and the B&A tabs.</p> <ul style="list-style-type: none"> ◆ Program – 2009 QI Work Plan, All Tabs 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: The CMO had a QIPD with a program goal “to collaborate with various internal stakeholders to ensure the health plan’s information system supports the collection, tracking, analysis, reporting and historical record keeping of relevant QI program related data.” WellCare provided documented evidence of its electronic software programs and systems used to track member eligibility/enrollment and to perform and report on CMO responsibilities such as member and provider management, clinical authorization, claims adjudication, data analysis, and other technical tasks. During the interview, WellCare’s information technology (IT) and QI staff provided additional details regarding the functionality of the health information system.</p> <p>Required Actions: None.</p>		
<p>2. The CMO’s health information system provides information on areas including:</p> <p style="text-align: right;"><i>42CFR438.242(a)</i></p>		



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems		
Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
a) Utilization.	<ul style="list-style-type: none"> ◆ Program - 2010 QI PD Appendix F UM Program Description, p. 66 ◆ Report – 2010 Georgia UM Scorecard ◆ Case Example - Service Authorization Screen Shot ◆ Minutes – UMAC 05-26-10, p. 5 ◆ Program – 2009 UM Program Evaluation, pp. 5-6 ◆ Workflow – EMMA Data Flow Diagram 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
<p>Findings: WellCare’s UM Program Description and UM Program Evaluation addressed the types of data support and information the electronic UM data system (Peradigm) and the Enterprise Medical Management Application (EMMA) provided. The Health Information Systems Overview diagram depicted the flow and integration of member and service data and the programs/systems used to provide utilization information. During the interview, WellCare’s IT and QI staff provided additional details regarding the system’s processing and reporting capabilities.</p> <p>Required Actions: None.</p>		
b) Grievances and appeals.	<p>Grievance and Appeals data is housed in the Grievance and Appeals database (Sidewinder) and this data is collected, analyzed and reported on an ongoing basis through the CSQIC, UMAC and QIC to ensure trends are identified and issues are resolved.</p> <p><u>Grievances</u> Page one of the policy supports that we have a system which we use to collect, track and report grievance data. Page two provides at minimum the data elements collected for tracking and the analysis of grievances.</p> <ul style="list-style-type: none"> ◆ Policy - C6GR-007 Grievance Reporting Policy, pp. 1-2 ◆ Program – 2010 QI Work Plan, Complaints Tab ◆ Minutes – QIC 03-30-10, pp. 9-11 <p><u>Appeals</u></p> <ul style="list-style-type: none"> ◆ Policy – C7AP-028 Quarterly and Annual Reporting to Regulatory Agencies, pp. 1-2 ◆ Report – Monthly Appeals Metrics 08 2010, Medicaid Tabs ◆ Minutes – UMAC 8-25-10, p.10 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
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	<p>This screen shot captures the category, sub-category and in some cases super category of every grievance and appeal filed with the department. This information is shared across all business functions and serves as an intake channel for the credentialing department; along with many other departments.</p> <ul style="list-style-type: none"> ◆ Case Example – Sidewinder Field Entry Job Aid, All Tabs 	
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Findings: The Quarterly and Annual Reporting to Regulatory Agencies policy and the Grievance Reporting policy described the information maintained in WellCare’s internally developed grievances and appeals database (Sidewinder). The Medicaid QIC meeting minutes demonstrated that the Compliance Report with trending and analysis information was presented for discussion and intervention planning. During the interview, an inconsistency in the CMO’s categorization and reporting of appeals was discussed. The monthly appeals metrics report listed “quality of care, access, billing/financial, attitude/service, and quality of practitioner office site” as appeal categories for reporting. The CMO stated that these were the categories listed in the NCQA 2010 accreditation standards. However, these categories were found to be more descriptive of grievance reasons, according to federal managed care regulations and the definition in the CMO’s contract with DCH. Because another automated report (the Georgia Member Administrative Review OTR by Appeal Reason) documented the CMO’s ability to capture and report the appropriate types of appeal categories (lack of medical necessity, noncovered benefit, etc.), WellCare demonstrated that it did have a process for accurate tracking and reporting of appeal types. The CMO was encouraged to ensure that it used consistent categories across its various reports used for tracking and trending appeal activity and to differentiate the categories from grievance information.

Required Actions: None.

<p>c) Disenrollments for other than loss of Medicaid eligibility.</p>	<p>This E2F health information system provides information on disenrollments for other than loss of Medicaid eligibility.</p> <ul style="list-style-type: none"> ◆ WorkFlow – GA Disenrollment Process Flow ◆ Report - Disenrollment_Report-2010-09-07 ◆ Case Example - Screenshot GA Member Disenrollment 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA
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Findings: The Work Flow Diagram for the disenrollment process provided decision trees and information to staff for member disenrollment from WellCare. The disenrollment report for August 2010 from the E2F (Enrollment to Fulfillment) system demonstrated the CMO’s capability for tracking and reporting disenrollments and included the reason codes. During the interview, staff also discussed the daily and supplemental termination files received from the State for processing member disenrollments from the CMO.

Required Actions: None.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
3. The CMO collects data on: <p style="text-align: center;"><i>42CFR438.242(b)(1)</i></p>	Paradigm is WellCare’s core system application that supports claims processing, provider capitation, premium billing, provider contract and pricing, membership and customer service. Paradigm also maintains Member and Provider demographics.	
a) Member characteristics.	<p>Member characteristics first come to WellCare in the format of an 834 file from DCH and it is then inputted in our Paradigm system. Paradigm houses information on member characteristics including: Age, Date of Birth, Sex, Address, Phone, Benefits, Enrollment and Disenrollment, Primary Care Provider, and language preferences.</p> <ul style="list-style-type: none"> ◆ Case Example – 824 File Detailed Member Characteristics ◆ Case Example – 824 File and Paradigm Screens <p>In addition to the internal collection of member characteristics, WellCare also collects and compares external data on member characteristics through this annual report.</p> <ul style="list-style-type: none"> ◆ Report – 2010 Member Demographic Assessment, p. 2 <p>This case example shows how WellCare collects member characteristics, provider characteristics and services furnished to members through encounter submissions.</p> <ul style="list-style-type: none"> ◆ Case Example – Member and Provider and Services Furnished Encounter Data, slide 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA

Findings: The CMO demonstrated that it maintained a database (Paradigm) containing information on member characteristics. The Georgia 2010 Medicaid/PeachCare for Kids Demographic Assessment provided an example of an analysis of WellCare’s member demographic information compared to the State of Georgia’s demographic distribution. During the interview, staff also discussed how the system’s ability to store historical member information when changes are made (e.g., maiden name, married name, new address) greatly assists them in member identification and matching processes.

Required Actions: None.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>b) Provider characteristics.</p>	<p>For information collected from providers via their application this occurs. When a provider’s application arrives, the provider’s characteristics are entered into OmniFlow and the application is scanned into OmniFlow. Once this information is entered, OmniFlow sends the information to corporate credentialing for processing. Paradigm houses information for Providers information on Name, Address, Phone, Contract, Specialty, Board Certification and languages spoken are maintained. While our application has a field for documentation of race / ethnicity, this is not required due to the Equal Opportunity Employer.</p> <ul style="list-style-type: none"> ◆ Workflow – OmniFlow Cactus Paradigm ◆ Case Example – Completed Provider Credentialing Application ◆ Case Example – OmniFlow Provider Characteristics ◆ Policy - Internal Policy for Incoming Provider Information <p>This case example shows how WellCare collects member characteristics, provider characteristics and services furnished to members through encounter submissions.</p> <ul style="list-style-type: none"> ◆ Case Example – Member and Provider and Services Furnished Encounter Data, slide 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA

Findings: WellCare’s Omniflow/Cactus/ Peridigm Workflow diagram depicted how information the CMO entered into Cactus and Omniflow (credentialing and contracting databases) flowed to Peridigm, where provider characteristics such as name, provider type, specialty, gender, and languages spoken were captured and stored, along with pricing and other provider demographic information. Staff also described the CMO’s ability to produce information for the provider directory from the Paradigm system.

Required Actions: None.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>c) Services furnished to members.</p>	<p>WellCare utilizes multiple reports which detail services furnished to members.</p> <p><u>HEDIS collection.</u></p> <ul style="list-style-type: none"> ◆ Report – Performance Measures HEDIS 2010 Rates <p><u>EPSDT reports (July 2010)</u></p> <ul style="list-style-type: none"> ◆ EPSDT Report – CMS 416 Medicaid ◆ EPSDT Report – CMS 416 PeachCare ◆ EPSDT Report – Informing Activity ◆ EPSDT Report – Initial Screening <p><u>The 837I & 837P Claims Data Transaction</u></p> <p>These reports provide guidance to our providers on our standard reporting format for claims/encounters reporting whether electronically or paper submissions method. Peradigm is a repository used to collect data from claims/encounters for services provided to members.</p> <ul style="list-style-type: none"> ◆ Guide - Claims GA Institutional Claims Encounter Guide, p. 4 ◆ Guide - Claims Encounter GA Professional Guide, p. 4 <p>This case example shows how WellCare collects member characteristics, provider characteristics and services furnished to members through encounter submissions.</p> <ul style="list-style-type: none"> ◆ Case Example – Member and Provider and Services Furnished Encounter Data, slides 1- 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Partially Met <input type="checkbox"/> Not Met <input type="checkbox"/> NA

Findings: WellCare staff stated that information on services provided to members is received from providers via claims (paper and electronic) and processed through the Peradigm system (for claims adjudication and payment). The referral and service authorization system (EMMA) also feeds data to Peradigm. The Performance Measures HEDIS 2010 Report and the EPSDT reports provided examples of service information reports obtained from the Peradigm system via the CMO’s data warehouse.



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
<p>4. The CMO’s health information system includes a mechanism to ensure that data received from providers are accurate and complete by:</p> <ul style="list-style-type: none"> ◆ Verifying the accuracy and timeliness of reported data. ◆ Screening the data for completeness, logic, and consistency. ◆ Collecting service information in standardized formats to the extent feasible and appropriate. <p style="text-align: right;"><i>42CFR438.242(b)(2)</i></p> <p>Contract: 4.17.3.6</p>	<p>This gives an overview of our mechanisms to ensure that claims/encounters data received from providers are accurate and complete.</p> <ul style="list-style-type: none"> ◆ Workflow – Claims and Encounter Data Integration <p>WellCare’s Provider Contracts ensure that Providers submit consistent data on accurately and on a timely basis. The Provider contract also requires that claims must be received within 180 days from date of service. The Provider contract also ensures the timeliness of encounter data submission. Services in the form of Encounter data is housed in ODS which allows for receipt of data in standard 837 HIPAA Compliant format.</p> <ul style="list-style-type: none"> ◆ Contract – 2010 Physician Contract <p>This document in its entirety displays the internal processes that are applied when claims/encounters are received and data is verified for accuracy and standardization through SNIP edits (Front End Edits).</p> <ul style="list-style-type: none"> ◆ Guide - E2E Encounters Reengineering Front-End Edits <p>The 837I & 837P Claims Data Transaction Guides provides guidance to our providers on our standard reporting format for claims/encounters reporting whether electronically or paper submissions method. Although the 837I/P Implementation Guides provides industry standard in reporting claims data, our companion guides provides more state specific guidance based on the direction provided by our regulatory agency.</p> <ul style="list-style-type: none"> ◆ Guide - Claims GA Institutional Claims Encounter Guide, p. 4 ◆ Guide - Claims Encounter GA Professional Guide, p. 4 <p>This case example shows how WellCare collects member characteristics, provider characteristics and services furnished to</p>	<p><input checked="" type="checkbox"/> Met</p> <p><input type="checkbox"/> Partially Met</p> <p><input type="checkbox"/> Not Met</p> <p><input type="checkbox"/> NA</p>



State of Georgia
Department of Community Health (DCH)
2010-2011 External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
for WellCare of Georgia, Inc.

Standard III—Health Information Systems

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<p>members through encounter submissions.</p> <ul style="list-style-type: none"> ◆ Case Example – Member and Provider and Services Furnished Encounter Data, slides 1- 2 <p>Peradigm is also the core system for claims adjudication system which houses the services furnished to members from a fee for service basis for inpatient, outpatient and emergency room services.</p> <ul style="list-style-type: none"> ◆ Case Example – Provider Claim Encounter Screen Example ◆ Guide - E2E Member Match Business Rules, Column C ◆ Policy – C6CL GAIP-049 Timely Filing, pp. 1-2 ◆ Policy – C6CL GA-001 GA Claims Process and Finalize Flow, pp. 5-8. 	

Findings: The flow diagrams attached to the GA Claims Process and Finalize Flow policy described the CMO’s process for capturing both electronic and paper claim information, applying electronic edits, resolving errors, and adjudicating the claims. The FiXIT E2E Encounters Reengineering Guide described the electronic front-end edits built into the claims processing program, which included edits for data accuracy, data completeness, a standardized data format, and validity. The CMO staff also described the processes for monthly oversight of its delegated vendor’s submission of service data (dental) through review of cash disbursement journals to ensure completeness of claims/encounters received.

Required Actions: None.

Results for Standard III—Health Information Systems					
Total 29	Met	=	8	X	1.00 = 8
	Partially Met	=	0	X	.05 = 0
	Not Met	=	0	X	.00 = 0
	Not Applicable	=	0	X	NA = 0
Total Applicable		=	8	Total Score	= 8
Total Score ÷ Total Applicable					= 100%

Appendix B. On-Site Review Participants

The document following this page includes the date of HSAG’s on-site review, the names/titles of the HSAG reviewers, and the names/titles of other individuals who participated in some or all of the on-site review activities, including **WellCare**’s key staff members interviewed by HSAG.

Review Date

The following table shows the date of HSAG’s on-site visit to **WellCare**.

Table B-1—Review Date	
Date of On-Site Review	October 25, 2010

Participants

The following table lists the participants in HSAG’s FY 2011 on-site review for **WellCare**.

Table B-2—HSAG Reviewers and WellCare Participants		
HSAG Review Team		Title
Team Leader	Diane Christensen, MC, LPC	Director, State & Corporate Services
Reviewer	Bonnie Marsh, BSN, MA	Executive Director, State & Corporate Services
Reviewer	Lisa Carhuff, RN, MSN	GMCF/Consultant
WellCare Participants		Title
Chuck Beeman		Director of Encounters
Wintana Berhe		Quality Improvement Specialist
Tracy Brown		Manager, Clinical Compliance and Audit
Adam Campbell		Manager, Clinical Policy Development
Neana Cannon		Quality Improvement Coordinator
Bernard Cohen		Senior Medical Director
Katrina Davis		Operations Compliance Specialist
Jose Hernandez		Senior IT Compliance Auditor
Jean Holmes		Director, Credentialing
James Johnson		Manager, IT and Ops
Robin Johnson		Quality Improvement Specialist, Magellan SECMC
Jennifer Jones		Quality Improvement Project Manager
Bob Klopotek		Vice President, Information Systems
Lisa Maleski		Quality Improvement Project Manager
Janett Moore		Senior Manager, Provider Ops
Deb Prosser		HEDIS Manager
Lisa Schottroff		Manager, Field Health Services
Linda Simmons		Quality Improvement Director
Rebecca Spice		Vice President, Field Quality Improvement
Gwen Wyles		Senior Quality Improvement Analyst
Annette Zerbe		Senior Manager, Regulatory Affairs

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the DCH Georgia Families CMOs addresses HSAG’s:

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

HSAG followed standardized and identical processes in conducting the review of each CMO’s performance.

Objective of Conducting the Review of Compliance With Standards

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

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

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

- ◆ Standard I—Practice Guidelines
- ◆ Standard II—Quality Assessment and Performance Improvement
- ◆ Standard III—Health Information Systems

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

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

The FY 2011 review represented the third year of a three-year cycle of CMO compliance reviews that HSAG conducted as the DCH-contracted EQRO.

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

Before beginning the compliance review, HSAG developed a data collection tool to guide and document the review. The requirements in the tool were selected based on applicable federal and State regulations and laws and on the requirements in the contract between DCH and the CMOs, as they related to the scope of the review.

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

Pre-on-site review activities: HSAG's pre-on-site activities included:

- ◆ Developing the compliance review tool.
- ◆ 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 one-day, on-site review.
- ◆ Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate their preparation for HSAG's review.
- ◆ Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH and of documents the CMOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification, and begin compiling information before the on-site review.

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

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

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

Table C-1 presents a more detailed, chronological description of the above activities that HSAG performed throughout its review.

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	HSAG...
Step 1:	Established the review schedule.
	Before the review, HSAG coordinated with DCH and the CMOs to set the schedule and assigned HSAG reviewers to the review team.
Step 2:	Prepared the data collection tool for review of the three standards and submitted it to DCH for review and comment.
	To ensure that all applicable information was collected, HSAG developed a compliance review tool consistent with CMS protocols. HSAG used the requirements in the contract between DCH and the CMOs to develop the standards (groups of requirements related to broad content areas) to be reviewed. HSAG also used the federal Medicaid managed care regulations described at 42 CFR 438 with revisions issued June 14, 2002, and effective August 13, 2002. Additional criteria used in developing the monitoring tool included applicable State and federal requirements. Prior to finalizing the tool, HSAG submitted the draft to DCH for its review and comments.
Step 3:	Prepared and submitted the Desk Review Form to the CMOs.
	HSAG prepared and forwarded a Desk Review Form to the CMOs and requested that they submit specific information and documents to HSAG within a specified number of days of the request. The Desk Review Form included instructions for organizing and preparing the documents related to the review of the three standards, submitting documentation for HSAG’s desk review, and having additional documents available for HSAG’s on-site review.
Step 4:	Forwarded a Documentation Request and Evaluation Form to the CMOs.
	HSAG forwarded to the CMOs, as an attachment to the Desk Review Form, a Documentation Request and Evaluation Form containing the same standards and DCH contractual requirements as the tool HSAG used to assess the CMOs’ compliance with each of the requirements within the standards. The Desk Review Form included instructions for completing the “Evidence/Documentation as Submitted by the CMO” portion of this form. This step: (1) provided the opportunity for the CMOs to identify for each requirement the specific documents or other information that provided evidence of their compliance with the requirement, and (2) streamlined the ability of HSAG’s reviewers to identify all applicable documentation for their review.
Step 5:	Developed an on-site review agenda and submitted it to the CMOs.
	HSAG developed an agenda to assist the CMOs’ staff members in planning for their participation in HSAG’s on-site review, assembling requested documentation, and addressing logistical issues. HSAG considers this step essential to performing an efficient and effective on-site review and minimizing disruption to the organizations’ day-to-day operations. An agenda sets the tone and expectations for the on-site review so that all participants understand the process and time frames.

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	HSAG...
Step 6:	Provided technical assistance.
	As requested by the CMOs, and in collaboration with DCH, HSAG staff members conducted a conference call with DCH and the CMOs to respond to questions the CMOs had about the requirements for which HSAG would evaluate their performance.
Step 7:	Received the CMOs’ documents for HSAG’s desk review and evaluated the information before conducting the on-site review.
	<p>HSAG reviewers used the documentation received from the CMOs to gain insight into the organizations’ structure, provider network, services, operations, resources, and delegated functions, if applicable, and to begin compiling the information and preliminary findings before the on-site portion of the review.</p> <p>During the desk review process, reviewers:</p> <ul style="list-style-type: none"> ◆ Documented findings from the review of the materials submitted by the CMOs as evidence of their compliance with the requirements. ◆ Identified areas and issues requiring further clarification or follow-up during the on-site interviews. ◆ Identified information not found in the desk review documentation to be requested during the on-site reviews.
Step 8:	Conducted the on-site portion of the review.
	<p>During the on-site review, staff members from the CMOs were available to answer questions and to assist the HSAG review team in locating specific documents or other sources of information. HSAG’s activities completed during the on-site review included the following:</p> <ul style="list-style-type: none"> ◆ HSAG conducted an opening conference that included introductions, HSAG’s overview of the on-site review process and schedule, the CMOs’ overview of their structure and processes, and a discussion about any changes needed to the agenda and general logistical issues. ◆ HSAG conducted interviews of the CMOs’ staff to obtain a complete picture of the CMOs’ compliance with the federal Medicaid managed care regulations and associated DCH contract requirements, explore any issues not fully addressed in the documents that HSAG reviewed, and increase HSAG reviewers’ overall understanding of the CMOs’ performance. ◆ HSAG reviewed additional documentation while on-site and used the review tool to identify relevant information sources and to document its review findings. Documents reviewed on-site included written policies and procedures, minutes of key committee or other group meetings, and data and reports across a broad range of areas. ◆ As a final step, HSAG conducted a closing conference to provide the CMOs’ staff members with a high-level summary of HSAG’s preliminary findings. For each of the three standards, the findings included HSAG’s assessment of the CMOs’ strengths and, when applicable, the areas requiring corrective action.

Table C-1—Compliance Review Activities HSAG Performed	
For this step,	HSAG...
Step 9:	Calculated the individual scores and determined the overall compliance score for performance.
	HSAG evaluated the CMOs’ performance in complying with the requirements in each of the three standards contained in the review tool.
Step 10:	Prepared a report of findings and required corrective actions.
	After completing the documentation of findings and scoring for each of the three standards, HSAG prepared a draft report for each of the CMOs that described HSAG’s compliance review findings, the scores it assigned for each requirement within the three standards, and HSAG’s assessment of the CMO’s strengths and any areas requiring corrective action. HSAG forwarded the reports to DCH and the CMOs for their review and comment. Following DCH’s approval of the draft reports, HSAG issued the final reports to DCH and the CMOs.

Description of Data Obtained

To assess the CMOs’ compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CMOs, including the following:

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

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

Table C-2 lists the major data sources HSAG used in determining the CMOs’ performance in complying with requirements and the time period to which the data applied.

Table C-2—Description of the CMOs’ Data Sources	
Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during the on-site review	October 1, 2009–September 30, 2010
Information obtained through interviews	October 1, 2009–last day of on-site review

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

Met indicates full compliance defined as both of the following:

- ◆ All documentation listed under a regulatory provision, or component of the provision, is present.
- ◆ Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

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

- ◆ There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.

- ◆ Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.

Not Met indicates noncompliance defined as either of the following:

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

Data Aggregation and Analysis

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

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

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

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

Based on the results of the data aggregation and analysis, HSAG prepared a report of its external quality review findings for each of the CMOs.