Florida Healthy Kids Program
Performance Improvement Project Validation
Reporting on PIPs Implemented During the 2011-2012 Evaluation Period

Prepared for the
Florida Healthy Kids Corporation

Prepared by the
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I. INTRODUCTION

The Florida Healthy Kids Program (FHKP) provides health and dental coverage for children ages 5 through 18 years who are at or below 200% of the federal poverty level (FPL) and eligible for premium assistance under Title XXI of the Social Security Act, the Children's Health Insurance Program (CHIP). The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) requires that states have a system-wide quality program for their CHIP-contracting managed care organizations (MCOs), including an annual external quality review (EQR) of the quality of care provided by the MCOs.[1] Validation of performance improvement projects (PIPs) is one of three required external quality review activities. The Centers for Medicare and Medicaid Services (CMS) have developed detailed protocols for implementing and validating PIPs.[2]

What are PIPs?

Overall Goal: improve health care processes and outcomes

Topic: based on an identified needed area of improvement

Population: should affect a significant portion of all enrollees or target high-risk conditions or populations

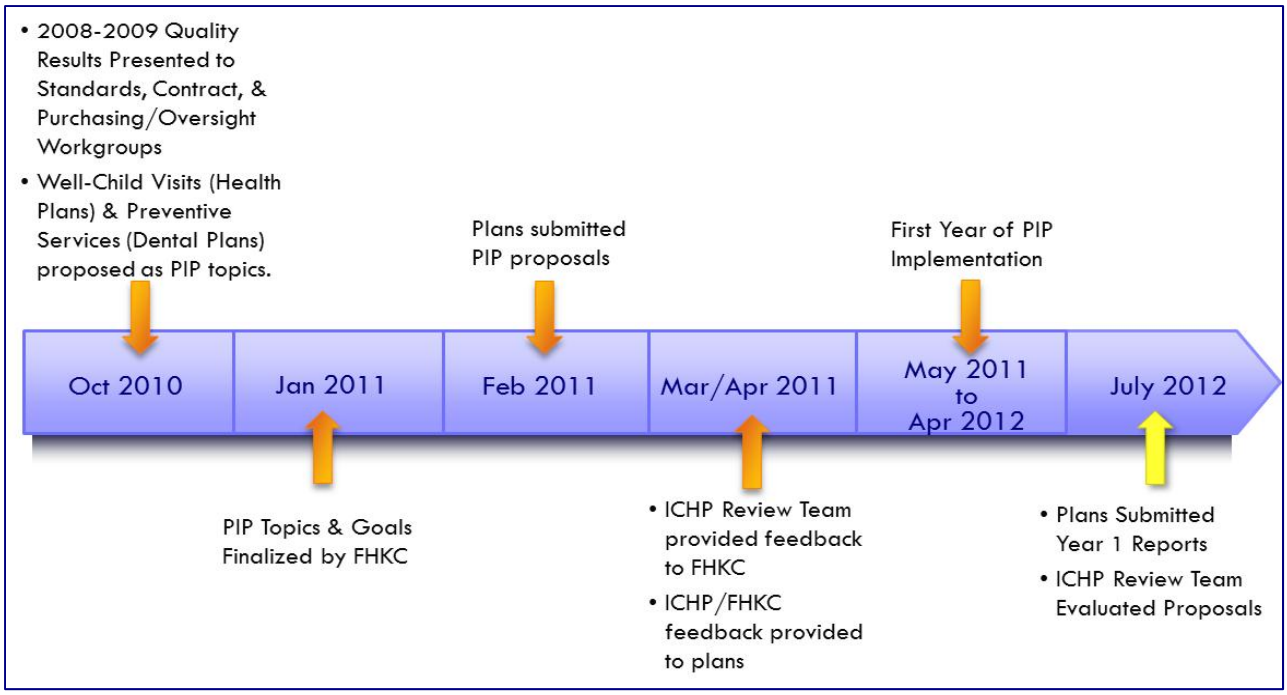
Phases: baseline data and measurement, intervention period, and re-measurement

Validation: structured assessment and scoring

PIPs are central to quality improvement. The overall aim of a PIP is to improve health care outcomes and processes. PIPs should target improvement in relevant areas of clinical care and non-clinical services. Topics selected for study should reflect the plan's FHKP enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease. The study topic for the PIP should address a significant portion of enrollees or target high-risk conditions or populations with the potential to significantly affect enrollee health, functioning, or satisfaction. States can allow plans to select the study topic, or the state may select the study topic.

Figure 1 provides the timeline for implementing PIPs in the FHKP. In October 2010, the ICHP presented quality of care results for the 2008-2009 evaluation period to several FHKP Board of Directors' workgroups.[3] Based on the recommendations of these workgroups, the FHKP Board of Directors selected well-child visits for the health plan PIPs and preventive dental visits for the dental plan PIPs. In February 2011, the plans submitted their PIP proposals to the FHKP. The ICHP EQR team reviewed the proposals and provided feedback to the FHKP in March 2011, which then provided feedback to the plans in April 2011. Plans were to revise their PIPs based on the feedback and begin implementation in May 2011. The period May 2011 through April 2012 represented the first year of PIP implementation. During this time, plans submitted quarterly progress reports. Plans submitted a comprehensive Year 1 report in July 2012, which the ICHP EQR team evaluated. This report summarizes the evaluation process and findings.

Figure 1. FHKP PIP Implementation Timeline



II. TOPICS

Based on the 2008-2009 quality of care findings, the FHKP Board of Directors selected well-child visits as the focus of the PIPs for the health plans and preventive dental visits as the focus of the PIPs for the dental plans. The ultimate goal of the board was to have all plans meet or exceed the national Medicaid mean. Because of the wide variation in plan performance, however, plans were given different targets for the initial implementation year based on their 2008-2009 rates for these measures. The specific performance goals are summarized in Figure 2.

Figure 2: PIP Performance Goals

Well-Child Visits	Preventive Dental Services
Performance Indicator: HEDIS® Well-Child Visits in the 3rd, 4th, 5th, & 6th Years of Life	**Performance Indicator:** Percentage of children receiving preventive dental services.
Performance Goal: ☐ Plans performing 10 or more percentage points below the FHKP mean: improve performance to the FHKP mean. ☐ Plans performing within 10 percentage points of the FHKP mean but 10 or more percentage points below the national Medicaid HEDIS® mean: improve performance to the national mean. ☐ For plans performing within 10 percentage points of the national Medicaid HEDIS® mean: improve performance to the national mean or to 110% of current rate, whichever is greater.	**Performance Goal:** ☐ Improve percentage of children receiving any preventive dental services (CDT codes D1000-D1999), by at least 6 percentage points for children enrolled (a) any length of time, (b) at least 6 months continuously, and (c) at least 12 months continuously. ☐ Identify baseline measures for the percentage of children who received age-appropriate preventive dental services based on established clinical guidelines. ☐ Increase the percentage of children in each age category receiving age-appropriate preventive services by at least six percentage points.

III. METHODS

The CMS identifies ten steps for validating PIPs. Within each of these steps, there are identified standards that should be addressed. Appendix 1 lists the standards associated with each step that were considered in the evaluation. In identifying the standards, the ICHP included (1) the recommended standards in the sample Validation Worksheet in the CMS PIP Validation Protocol, (2) additional standards based on the detailed guidance provided for each of the ten steps provided in the CMS PIP Validation Protocol, and (3) standards identified in the proposed revisions to the CMS protocols.[4] Plans were not scored lower if they did not address standards in the third category because these are newly proposed standards. An example of a newly proposed standard is whether interventions are culturally and linguistically appropriate. However, the newly proposed standards were used to identify areas that plans should consider incorporating into their PIPs going forward both to enhance their projects and in anticipation of implementation of the proposed revisions.

A multidisciplinary review team evaluated each plan's PIP according to the standards identified in Appendix 1. The review team included a pediatrician, a pediatric dentist and individuals with expertise in quality improvement methods and assessment, program evaluation, child health services research, and applied methods. The review team provided detailed comments and feedback for each of the ten PIP validation steps.

10 Steps in Validating PIPs

1. Review the Selected Study Topics
2. Review the Study Questions
3. Review the Study Indicators
4. Review the Identified Study Population
5. Review Sampling Methods (if applicable)
6. Review Data Collection Procedures
7. Assess Improvement Strategies
8. Review Data Analysis & Interpretation of Results
9. Assess Likelihood that Reported Improvement is "Real" Improvement
10. Assess Sustainability of Documented Improvement

Because this was the first year that plans have implemented PIPs in the FHKP and most interventions were underway for less than one year at the time of the evaluation, plans were rated on their performance on each of the ten validation steps as having Met, Partially Met, or Not Met the associated standards. The ICHP prepared detailed written feedback for each plan and is holding face-to-face meetings with each of the plan's quality improvement staff to conduct a careful, joint review of their PIPs. A more detailed scoring methodology will be applied to future PIP validations.

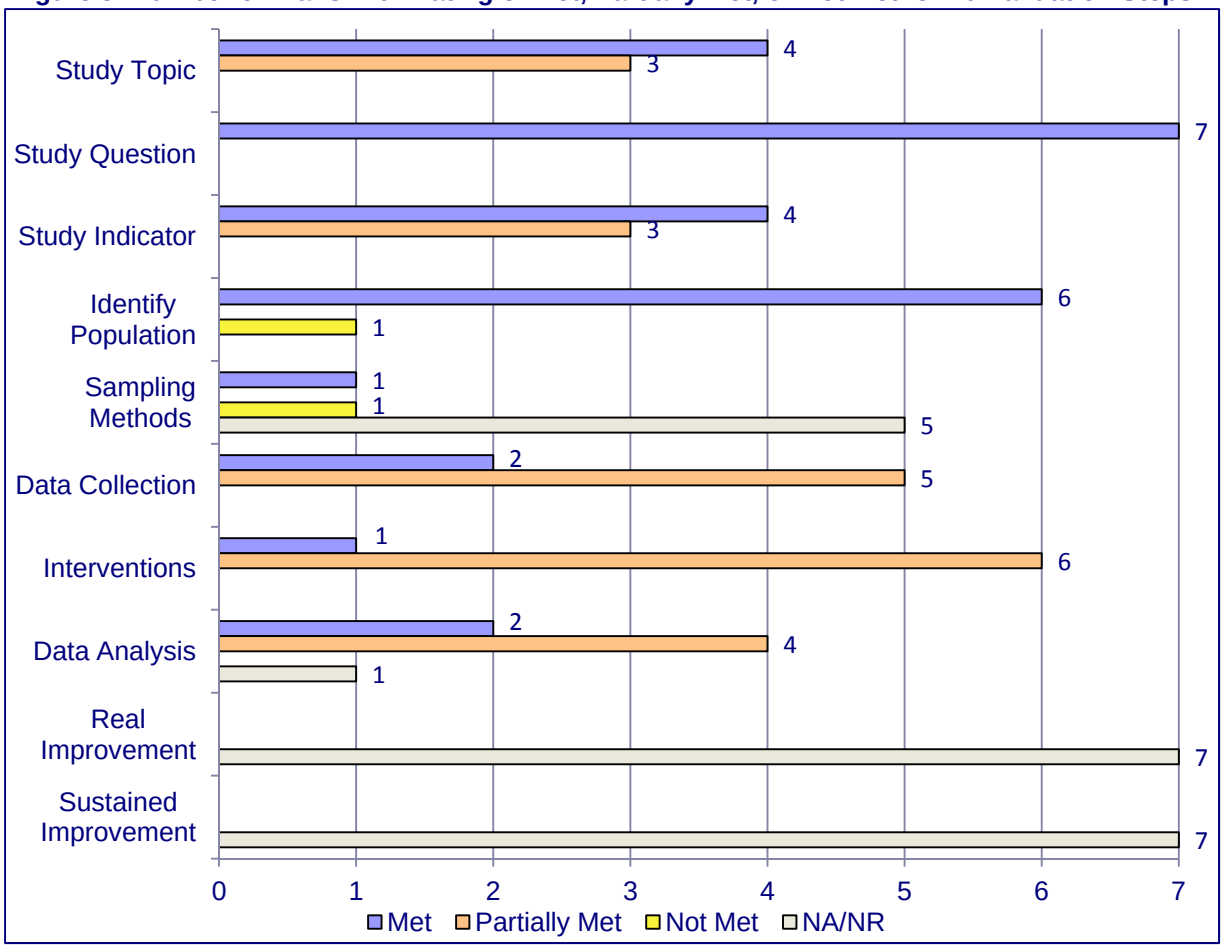
IV. RESULTS – HEALTH PLANS

A. Performance on 10 Validation Steps

This section summarizes the plans' performance for each of the ten validation steps. Appendix 2 provides individual plan profiles that summarize the plans' interventions, main strengths, opportunities for improvement, and the ratings for each step. Plans were provided with additional detailed feedback. Figure 3 summarizes the number of plans with a rating of Met, Partially Met, or Not Met for each of the ten validation steps.

1. Review the Selected Study Topic. The study topic should reflect the plan's enrollment in terms of demographic characteristics, prevalence of disease, and the potential consequences (risks) of the disease. Although the study topic was selected by the FHKP, plans were asked to address the relevance of the topic for their FHKP membership and to conduct a background analysis of their 5-6 year old members to inform the development of interventions. Four plans met and three plans partially met the standards for this step. Among the strengths were the thoughtful narratives provided by the plans about the importance of well-child visits to promoting child health and avoiding future health problems. Some plans analyzed the well-child visit rates by child and geographic characteristics to determine if interventions needed to be tailored to certain populations or areas. All plans were encouraged to conduct a more detailed background analysis of their FHKP membership 5-6 years old and to evaluate the implications of that analysis in developing and implementing interventions.

Figure 3: Number of Plans with Rating of Met, Partially Met, or Not Met for 10 Validation Steps



NA/NR: Not Applicable or Not Rated

2. Review the Study Question. All plans met the standards for this activity, which were to have a clearly stated and measureable study question. The plans developed similar study questions related to the performance goal of improving the rates for the measure HEDIS Well-Child Visits in the 3rd, 4th, 5th and 6th Years of Life, noting that this measure applies to children 5-6 years old since FHKP eligibility begins at age 5. All plans clearly stated a measureable study question related to this performance goal. The EQR team encouraged all plans to consider making the study question more specific to the plan's membership and interventions.

3. Review the Selected Study Indicators. Four plans met and three plans partially met the standards for this step, which were to have clear, objective, and measureable study indicators. The main study indicator, HEDIS Well-Child Visits, was specified by the board. Most plans appropriately identified the HEDIS measurement criteria for this measure, and most identified appropriate baseline measurement and re-measurement periods. Some plans, however, did not clearly or accurately identify their performance goal as specified by the FHKP Board which resulted in a rating of "partially met". Although plans were permitted to identify additional study indicators, most elected not to do so.

4. Review the Identified Population. This step involves identifying the members to whom the study question and indicators are relevant. All but one plan clearly identified the eligible population for the HEDIS measure. BCBS elected to target interventions for a sample of its population, but it did not clearly identify the population.

5. Review Sampling Methods. This step applied to only two plans. WellCare elected to include as an additional study indicator the hybrid measurement of Well-Child Visits, which includes medical record review data and relies on a sample of the eligible population. WellCare followed the sampling specifications indicated in the HEDIS technical specifications. BCBS targeted its interventions to a sample of its 5-6 year old members, but it did not provide sufficient detail about its sampling methodology.

6. Review Data Collection Procedures. Two plans met and five plans partially met the standards for this step, which focuses on data collection procedures that promote valid and reliable measurement of the study indicators. Plans that received a rating of Partially Met had one or more of the following limitations: (1) insufficient detail in analysis plan, (2) no method for testing statistically significant improvement over time, (3) insufficient information provided about internal processes for assessing data completeness and quality and the qualifications of the personnel responsible for collecting and analyzing the data.

7. Assess Intervention and Improvement Strategies. The CMS identifies interventions as critical to the success of the PIP, noting that improvements in care depend on "thorough analysis and implementation of appropriate solutions."[2] To develop effective interventions, plans should first undertake a barrier analysis to identify the member, provider, and systems barriers to members' receipt of annual well-child visits. The interventions should be designed to address these barriers and change member, provider, or plan behavior or processes. The interventions should be reasonably expected to induce measureable and permanent change. One plan met and six plans partially met the standards associated with this validation step. A critical first step is to undertake a barrier analysis. The plan that fully met the standards (United Healthcare) provided a detailed barrier analysis, identified the highest priority barriers to target, adopted multi-faceted interventions at the member, provider and systems levels and effectively demonstrated how the interventions were designed to address the identified barriers. Most plans provided insufficient detail about their barrier analysis and/or it was not clear how the interventions addressed the identified barriers.

Collectively, the plans used a range of member, provider, and plan/systems-level strategies designed to increase the percentage of their FHK members, 5-6 years old, who have an annual well-child visit. Table 1 summarizes the interventions used and the number of plans that implemented each intervention.

Member interventions:

Most plans (four of seven) provided families with educational material about the importance of preventive care and preventive care guidelines. Three plans updated their websites to include preventive care information and resources for their FHKP members. Five of the seven health plans used letters or postcards to remind families of the importance of scheduling preventive care visits with their children's primary care provider. The letters may have been timed with the child's birthday or targeted to members who had not yet had a well-child visit during the year. Most plans used live or automated phone class to remind members to schedule a well-child visit. Some plans provided assistance with scheduling appointments during these calls. Coventry and WellCare implemented systems that allow the plan's customer service representatives to identify children due for visits so that they could address gaps in care during inbound calls to the plan. BCBS undertook a careful evaluation of its member materials and determined that it could improve the readability of its materials to better meet the literacy needs of its members and more effectively highlight wellness visits and subsequently revised member materials accordingly. Florida Health Care Plans developed a member survey to evaluate families' experiences with scheduling and keeping well-child visits and to assess the barriers that families face. WellCare and United Healthcare either implemented or were in the process of implementing member incentives, such as gift cards, for getting a well-child visit.

Provider interventions:

All plans provided lists of members due for well-child visits to providers. Some plans provided these lists through mailings or electronic transmission while others had plan staff deliver the lists to the provider offices. Some plans, such as Coventry and United Healthcare, delivered these lists in person as part of a comprehensive strategy of provider site visits to educate providers about well-child visits and HEDIS measurement, review members due for visits, conduct medical record reviews, and review quality of care issues and coding processes. Florida Health Care Plans incorporated follow-up processes by requesting that provider office staff track which members on the list they scheduled for appointments and which they were unable to contact. However, many of the plans did not describe whether or how they followed up with providers to determine if and how the providers used the members-due-for-visits lists. Coventry and WellCare enhanced their provider portals to allow providers to look up their patients' well-child visit status. United Healthcare supplied provider offices with pre-printed postcards to mail to members due for visits. Two plans, Amerigroup and WellCare, implemented or were in the process of implementing provider incentives based on their performance on different quality metrics, including well-child visits.

Plan/System Interventions:

Plans also examined their own processes and systems for improvement. Some of the interventions that resulted from this targeted members and providers and are identified above. Coventry implemented plan staff training related to performance measures, emphasizing the ways that plan staff can impact those measures. United Healthcare enhanced its database to allow for more effective tracking of well-child visits. Four plans have implemented initiatives to assess encounter data completeness and identify opportunities to capture more complete and accurate data from providers.

Summary of intervention strengths:

In general, the EQR team found that all plans had implemented reasonable and sustainable interventions to address identified barriers. All plans had multi-faceted interventions that targeted both members and providers, and many addressed plan-level barriers as well.

Opportunities for improvement:

The review team was concerned that most of the interventions were not sufficiently targeted and/or intensive to bring about measureable and lasting change. General community events and educational materials while generally beneficial may not be focused or targeted enough to induce an increase in well-child visit rates. Reminder letters and automated phone calls may be easily overlooked by families. Giving providers lists of members due for visits was considered to be more effective when delivered in person as part of a more intensive provider intervention and when followed-up to determine whether/how providers use the lists and subsequent dispositions for member visits. More direct and targeted interventions, such as member incentives, direct provider contact and site visits, and provider incentives, were considered to hold greater potential for significant impact. Many plans provided insufficient detail about their interventions and did not quantify interventions when possible. Some plans also had numerous interventions without apparent consideration about which were likely to have a greater potential for impact. The EQR team recommended to these plans that they consider conducting such an evaluation and focusing more effort on a subset of the interventions identified as having greater potential for impact. The EQR team also recommended that plans identify interventions with an evidence base in the published literature or other demonstrated effectiveness and to consider using or adapting existing toolkits from nationally recognized sources such as the American Academy of Pediatrics and the Agency for Healthcare Research and Quality Innovations Exchange.

Table 1: Summary of Interventions

INTERVENTION	# of Plans
MEMBER LEVEL	
Educational Material	4
Reminder Letters/Postcards	5
Automated Phone Outreach	2
Live Phone Outreach	4
List of Members Due for Well-Child Visits Provided to Customer Service Staff	2
Website Enhancements with Preventive Care Information	3
Community Events/Education	1
Improve Readability of Materials	1
Member Surveys	1
Incentives	2
PROVIDER LEVEL	
Educational Material	5
List of Members Due for Well-Child Visits Distributed to Providers	7
Phone Outreach	2
Site Visits	3
Provider Portal Enhancements to Include Well-Child Visit Status Look-Up	2
Provider Report Cards	1
Supply Member Reminder Postcards to Provider Offices	1
Incentives	2
Medical Record Reviews	2
PLAN/SYSTEM LEVEL	
Plan Staff Training about Performance Measures and Their Ability to Impact	1
Database Enhancements for Tracking Well-Child Visits	1
Investigate/Improve Encounter Data Completeness	4

8. Review Data Analysis Plan. In this step, plans are to conduct a data analysis according to the data analysis plan that they prospectively specified. The plan should (1) clearly and accurately present numerical results for each study indicator that include initial and repeat measurements, (2) assess whether there was a statistically significant change between the two measurement periods, (3) identify factors that could influence the comparability of the two measures, (4) identify internal and external threats to validity, (5) provide an accurate interpretation of the results and assessment of the overall success of the PIP, and (6) identify opportunities for improvement and follow-up activities based on the findings. Two plans met and four plans partially met the standards in this step. Simply was not rated in this area because it began program participation in July 2010 and, therefore, only had a baseline measure and no re-measurement. Most plans clearly reported their baseline and first re-measurement, used an appropriate test of statistical significance to compare the initial and repeat measurements, and appropriately interpreted the findings of their analysis. Some plans did not focus specifically on their progress toward meeting the performance goals identified by the board. The plans that had a rating of Partially Met were lacking sufficient information in one or more of the following areas: (1) identifying factors that influence comparability of baseline and repeat measurements, (2) identifying internal or external threats to validity, and (3) providing an overall assessment of the PIP's success, opportunities for improvement, and follow-up activities.

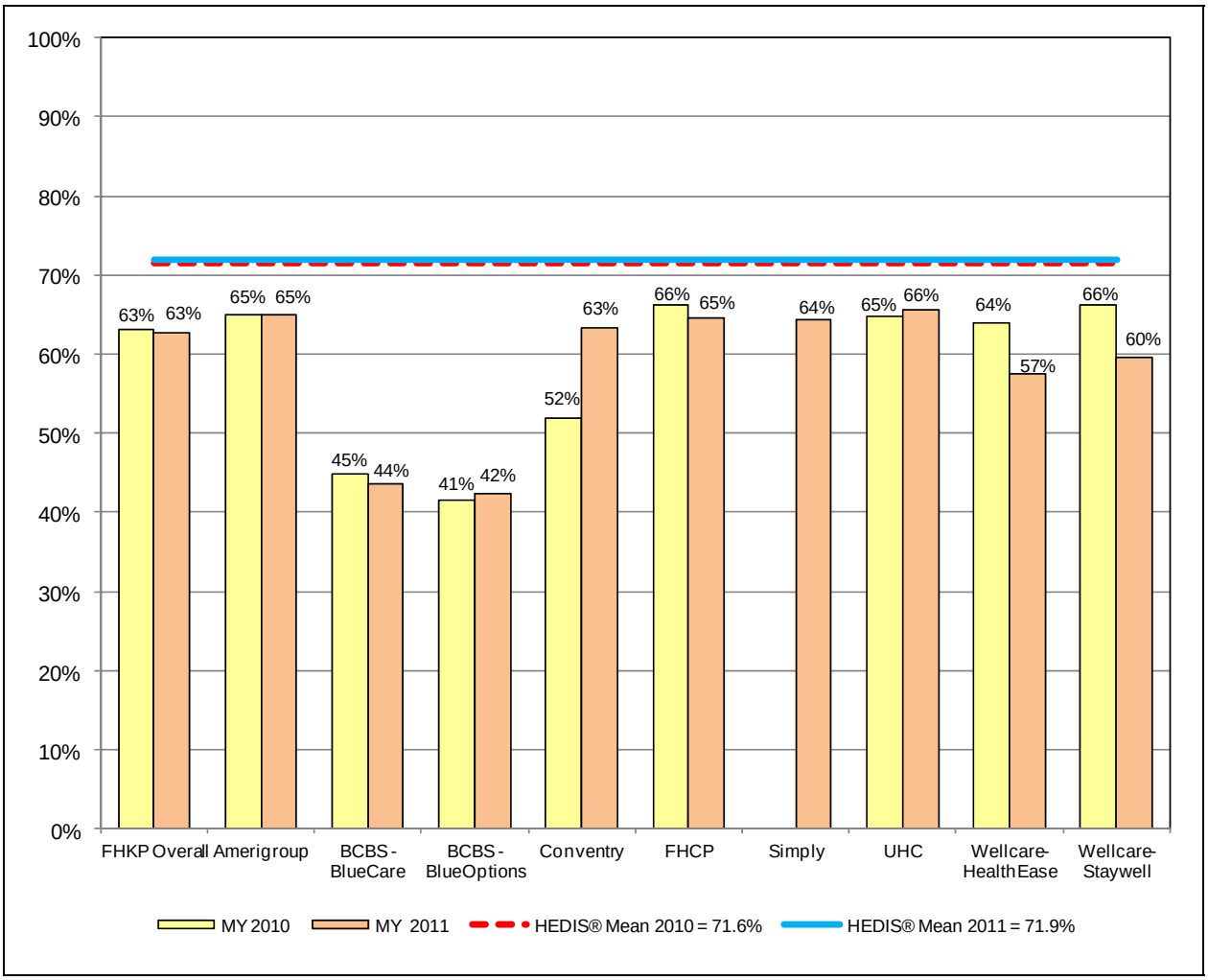
9. Assess "Real" Improvement. This step assesses the probability that reported improvement represents true improvement and not a change unrelated to the interventions or due to random chance. Because the interventions had been implemented for less than one year at the first re-measurement, this step was not rated. However, the ICHP requested that each plan describe how it planned to conduct such assessments, and the ICHP provided feedback on the proposed approach.

10. Assess Sustained Improvement. The last step in the validation process is assessing whether demonstrated improvement was sustained over time. Demonstration of sustained improvement typically involves demonstrating a statistically significant improvement over baseline that was sustained for two or more repeat measurement periods. Because this step requires at least two repeat measurements, this step was not rated. However, the ICHP requested that each plan provide information about its processes for assessing sustained improvement and how it will use data findings to feed back into quality improvement processes.

B. Outcomes

Figure 4 summarizes the ICHP-calculated Well-Child Visit rates for MY 2010 and MY 2011. Plans began implementing their interventions mid-2011. Therefore, MY 2010 served as the baseline period and MY 2011 was the first re-measurement. In addition to monitoring the ICHP-calculated rates, many plans also calculate their own rates following the HEDIS technical specifications. The program overall did not demonstrate a statistically significant increase in rates between MY 2010 and MY 2011. Only Coventry demonstrated a statistically significant increase in the ICHP-reported rates between baseline and re-measurement. None of the other plans reported a statistically significant increase in either the ICHP-reported rates or their internally-generated rates between baseline and re-measurement. The two WellCare plans exhibited a decline in the ICHP-reported rates, which were lower than their internal rate calculations for which there were no statistically significant differences between baseline and the first re-measurement. WellCare and ICHP are jointly investigating the reasons for the differences in the plan-reported rates and ICHP-reported rates. The lack of statistically significant improvement between base and the first re-measurement for the program overall and the individual plans is not surprising given that the plans interventions were in place less than one year at the time of the first re-measurement.

Figure 4: Well-Child Visits for MY 2010 and MY 2011



IV. RESULTS – DENTAL PLANS

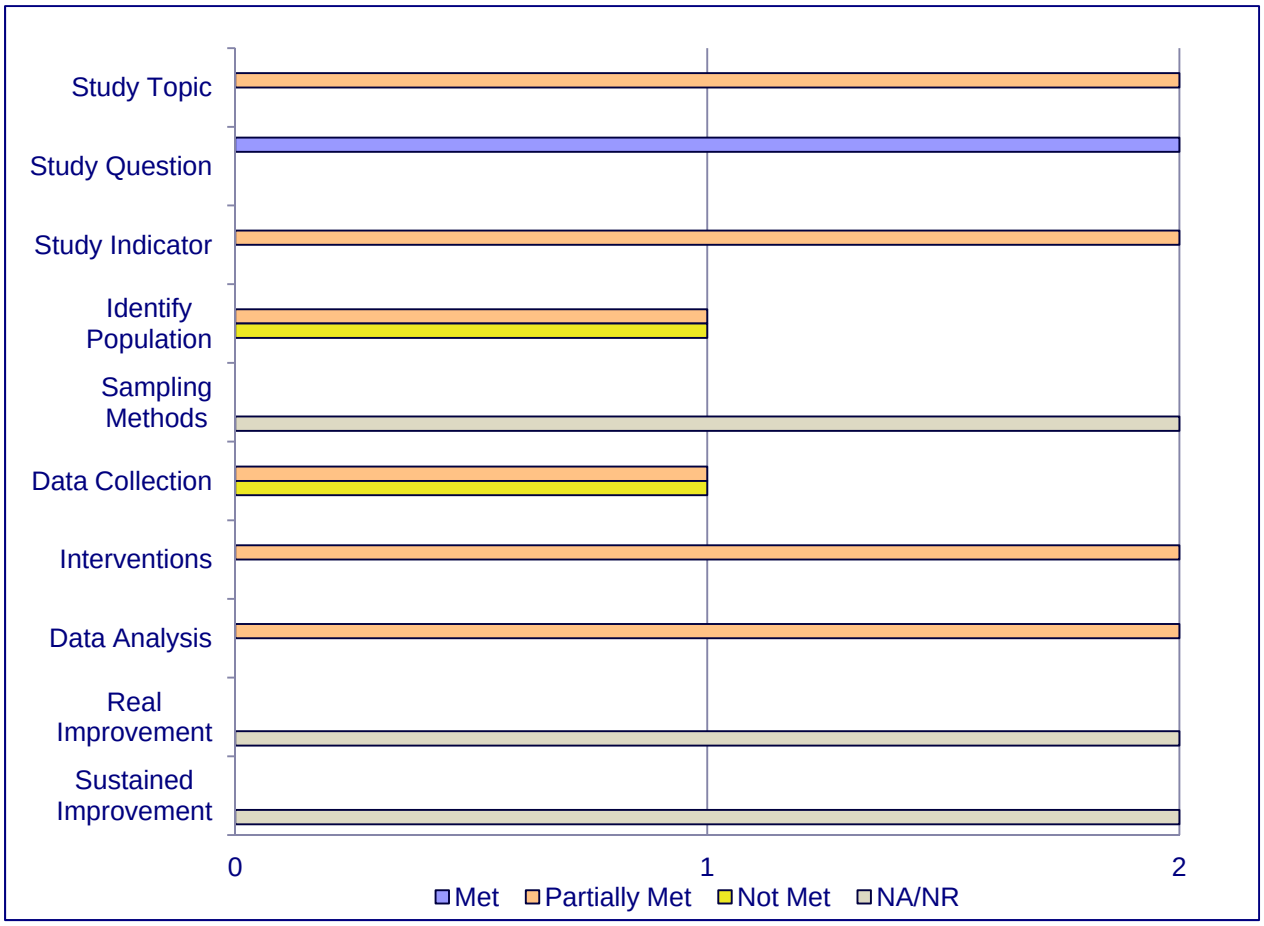
A. Performance on 10 Validation Steps

This section summarizes the dental plans' performance for each of the ten validation steps. Appendix 2 provides individual plan profiles that summarize the plans' interventions, main strengths, opportunities for improvement, and the ratings for each step. Plans were provided with additional detailed feedback. Figure 5 summarizes the number of plans with a rating of Met, Partially Met, or Not Met for each of the ten validation steps.

1. Review the Selected Study Topic.

Although the main study topic of improving the percentage of members who receive preventive dental services was selected by the FHKC, the plans were asked to address the relevance of the topic for their FHKP membership, to conduct a background analysis their members to inform the development of interventions, and to identify an age-appropriate preventive dental service to focus on. Both plans partially met the standards for this step. Among the strengths were the thoughtful narratives provided by both plans about the importance of preventive dental visits to promoting child oral health and overall health. Both plans were encouraged to conduct a more detailed background analysis of their FHKP membership and to evaluate the implications of that analysis in developing and implementing interventions.

Figure 5: Number of Plans with Rating of Met, Partially Met, or Not Met for 10 Validation Steps



NA/NR: Not Applicable or Not Rated

2. Review the Study Question. Both plans met the standards for this activity, which were to have a clearly stated and measureable study question. Both plans had measurable study questions that were aligned with the FHKP's goal of improving the percentage of children with preventive dental services in general and age-appropriate services in particular. Both plans selected improving sealant receipt as a more specific indicator of whether members are receiving recommended, age-appropriate preventive services. The selection of sealants was viewed positively by the EQR team because there is a strong evidence base that sealants are an effective preventive measure for reducing tooth decay in children. MCNA added a third study question related to reducing the percentage of children needing restorative services, and DentaQuest added a third study question related to the cost effectiveness of interventions. However, neither plan indicated in subsequent sections how they were incorporating these study questions into their overall PIP.

3. Review the Selected Study Indicators. Both plans partially met the standards for this step. The main study indicator, preventive dental services, was specified by the FHKP. Both plans had several study indicators, and both had opportunities for improvement in their specifications of the study indicators. Both plans needed to provide more specificity around their measurements. Both also needed to clearly specify their baseline value and further evaluate the appropriateness of the identified benchmarks. Both plans were encouraged to think through how to effectively measure sealant receipt. Unlike preventive services, such as topical fluoride application, sealant receipt is "lumpy." For example, a child in the age range 10-14 years may receive sealants in only one or two of those years. Thus, there is the potential that a child who is compliant with clinical guidelines may not be enrolled with the plan during the period in which s/he received sealants. Thus, the plans may want to think about different methods for assessing their progress in improving sealant receipt among their FHKP members. Neither plan developed study indicators for their third study question (MCNA – restorative services; DentaQuest – intervention cost effectiveness).

4. Review the Identified Population. Both plans had limitations with respect to clearly identifying the eligible population for each study indicator. MCNA appropriately identified the eligible population for preventive service receipt. However, MCNA's population description for sealants was inconsistent with its proposed measurement in Step 3. MCNA did not identify a population for its third study indicator related to restorative services. DentaQuest elected to conduct a pilot of its interventions on its FHKP membership in a single county (Lee), but it did not provide a rationale for the county selection. DentaQuest also did not clarify whether there were any enrollment length requirements to identify the study population.

5. Review Sampling Methods. MCNA did not use sampling so this activity was not applicable. Although DentaQuest focused on a single county, it included all members within that county. Therefore, most of the criteria in this activity did not apply. As noted above, however, the rationale for selecting that county were needed.

6. Review Data Collection Procedures. Both plans had one or more of the following limitations: (1) insufficient detail in the data analysis plan, (2) no method for testing statistically significant improvement over time, and (3) insufficient information provided about internal processes for assessing data completeness and quality and the qualifications of the personnel responsible for collecting and analyzing the data.

7. Assess Intervention and Improvement Strategies. The CMS identifies improvement strategies as critical to the success of the PIP. To develop effective interventions, plans should first undertake a causal/barrier analysis to identify the member, provider, and systems barriers to members' receipt of preventive dental services. The interventions should then be designed to address these barriers and to bring about a change in member, provider, or plan behavior or processes. The

interventions also should be reasonably expected to induce measureable and permanent change. Neither plan provided a detailed barrier analysis and effectively demonstrated how the interventions were designed to address the identified barriers. Both plans were encouraged to undertake a barrier analysis to identify the member, provider and plan/systems barriers and to identify those barriers that are most significant and actionable.

MCNA had two main interventions: (1) community outreach and education in Broward, Duval, Miami-Dade, and Polk counties and (2) provider outreach and education in Miami-Dade and Palm Beach counties. One of the more novel aspects of provider outreach involved requesting that providers report members who regularly break appointments to MCNA so that the case management department could work with those members; this intervention was viewed positively by the EQR team. Overall, however, the EQR team considered the interventions to be insufficiently targeted to induce significant and lasting improvement and encouraged MCNA to develop more targeted, intensive interventions.

DentaQuest's interventions included member outreach for its members in Lee county due for visits using reminder postcards and telephone calls designed to encourage scheduling preventive visits. These strategies may be useful for improving compliance if members are effectively reached through these interventions. However, the EQR team recommended that DentaQuest identify more intensive interventions. DentaQuest acknowledged the potential limitations of phone calls and mailings and appears to be exploring new technologies and mediums for communicating with members. Both plans could engage key stakeholders in the development and assessment of interventions.

8. Review Data Analysis Plan. Both plans partially met the standards for this step. Both plans need to develop a significantly more detailed analysis plan that clearly lays out their baseline measurement period and values, performance goals, re-measurement periods, and methods for assessing significant improvement over time. Neither plan included its respective third study question as part of the analysis plan. Both plans need a clearer and more effective approach for assessing progress over time.

9. Assess "Real" Improvement. This step assesses the probability that reported improvement represents true improvement and not a change unrelated to the interventions or due to random chance. Because the interventions had been implemented for less than one year at the first re-measurement, this step was not rated. However, the ICHP requested that each plan describe how it planned to conduct such assessments, and the ICHP provided feedback on the proposed approach.

10. Assess Sustained Improvement. The last step in the validation process is assessing whether demonstrated improvement was sustained over time. Demonstration of sustained improvement typically involves demonstrating a statistically significant improvement over baseline that was sustained for two or more repeat measurement periods. Because this step requires at least two repeat measurements, this step was not rated. However, the ICHP requested that each plan provide information about its processes for assessing sustained improvement and how it will use data findings to feed back into quality improvement processes.

B. Overall Summary of Strengths and Opportunities for Improvement

The following summarizes the key strengths and opportunities for improvement for the dental plans' PIPs:

Strengths:

- Both plans identified the importance of preventive dental visits to children's oral health and overall general health.
- Both plans selected sealant receipt as their age-appropriate preventive service, which is an excellent choice due to the strong evidence base for sealants as a preventive measure.
- Both plans included a third study question in addition to those required by the Board.

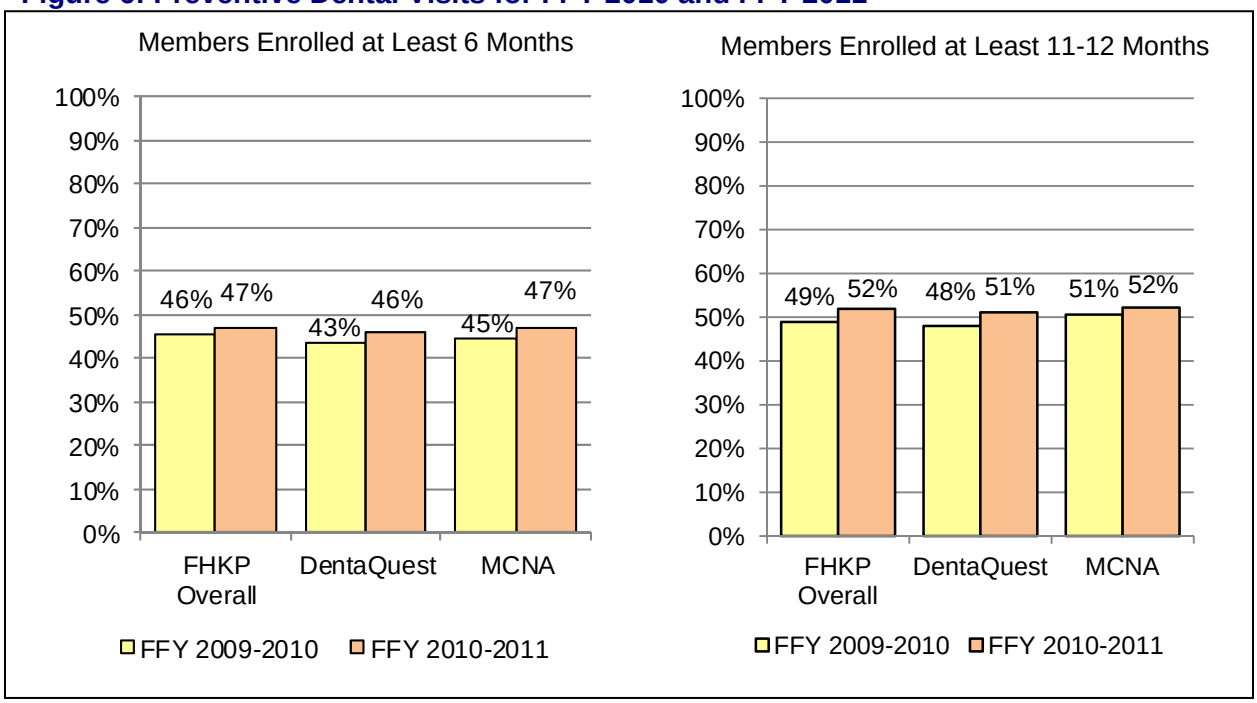
Opportunities for Improvement:

- Both plans need to develop a clearer and more detailed data analysis plan to guide their approach and allow for an effective evaluation of their progress in meeting performance goals.
- Both plans need to conduct a careful barrier analysis to identify the member, provider and plan/system barriers to FHKP members' receipt of preventive dental services.
- Both plans should pursue more intensive and targeted interventions with greater potential for significant and lasting impact.

C. Outcomes

Figure 6 summarizes preventive visit rates for Federal Fiscal Year (FFY) 2010 and FFY 2011 for children enrolled at least 6 months and for children enrolled 11-12 months. Plans began implementing their interventions in mid-to-late 2011. Therefore, FFY 2010 can be used as the baseline period and FFY 2011 can serve as the first re-measurement. The program overall experienced a statistically significant increase in rates between FFY 2010 and FFY 2011 for children enrolled 11-12 months. Both plans demonstrated improvement in the percentage of children receiving preventive dental visits based on the ICHP-calculated rates. Preventive dental visit rates have consistently increased over time in the FHKP in recent years; therefore, the observed increase likely reflects time trends rather than the implemented interventions, which were very limited in scope.

Figure 6: Preventive Dental Visits for FFY 2010 and FFY 2011



V. CHALLENGES ENCOUNTERED BY PLANS AND RECOMMENDATIONS

Plan Challenges and Recommendations

The ICHP solicited feedback from the plans about challenges they encountered during the PIP process. The plans identified the following issues:

Challenge 1. Lack of accurate contact information (phone numbers, addresses) for the plans' FHKP members hindered their ability to reach members due for visits.

Recommendation. The FHKP could work with the new enrollment vendor and plans to (1) identify whether there are ways to improve contact information accuracy and (2) explore whether there are effective mechanisms that could be put into place for plans to report invalid contact information to the enrollment vendor for follow up.

Challenge 2. The time frame for PIP implementation (May 2011 – April 2012) did not correspond to the standard time frames used for measuring outcome (e.g., calendar year), which created both confusion and difficulty in assessing improvement.

Recommendation. The FHKP and the ICHP work together with the plans to better align the PIP cycle with standard measurement cycles.

Challenge 3. Plans were unclear about the expectations for PIP reporting and the specific components that should be included.

Recommendation. The ICHP provide additional guidance and training related to PIPs. The ICHP is in the process of creating a web-based "Collaboration Hub" that will serve as a place for plans to obtain resources for the PIPs and other evaluation activities. In addition, the ICHP has proposed to the FHKP that it provide training opportunities on a period basis during each evaluation period.

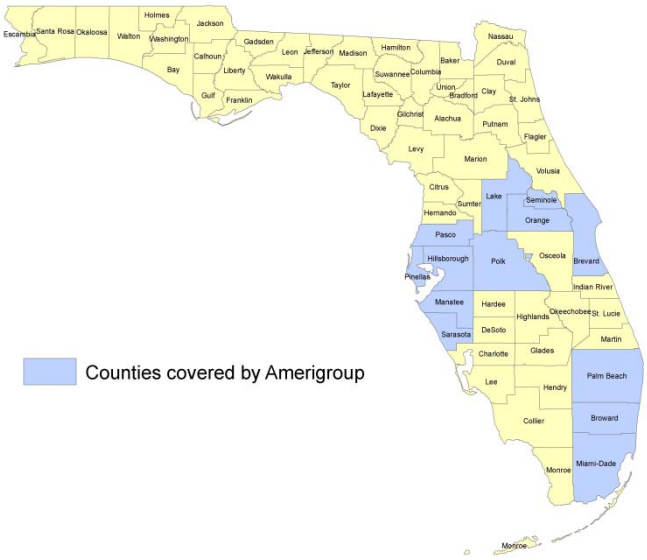
Other Recommendations

The ICHP offers the following additional recommendations:

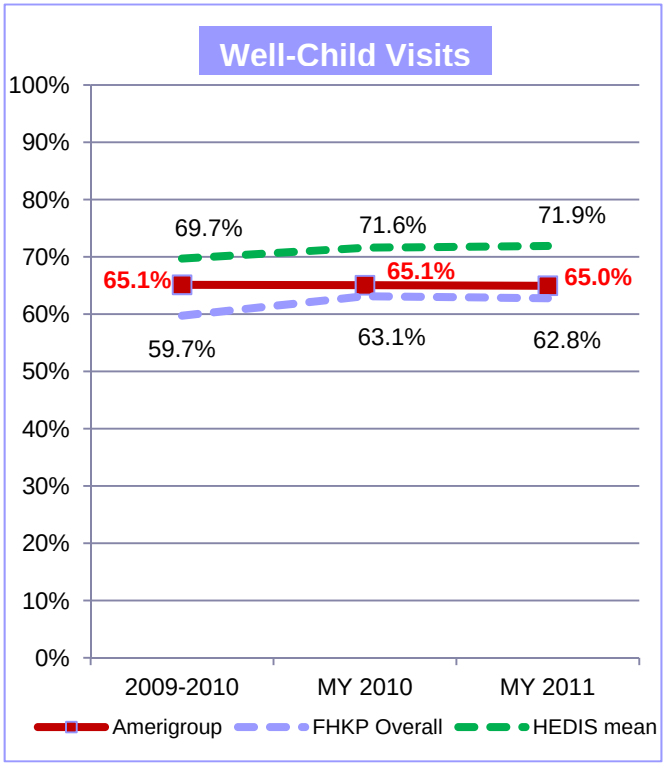
- Continue with well-child visit PIPs for health plans and preventive services PIPs for dental plans. Allow at least 3 years for plans to continue to implement and refine interventions and to demonstrate sustained improvement.
- Consider expanding the topic area for the health plan PIPs to encompass "preventive services" more generally and to include a broader range of study indicators.
- In general, identify core priority areas and health domains to focus the FHKP's quality efforts and to guide the selection of new PIP topics.
- Consider providing the plans with greater flexibility to tailor the PIP topics/study questions to their FHKP members and provider network, but require that they use nationally-recognized performance measures to evaluate their progress.
- Allow plans to test novel interventions among certain sub-populations or providers as long as they provide an acceptable rationale for the proposed approach.

APPENDIX 1: INDIVIDUAL PLAN SUMMARIES

AMERIGROUP



Members	
Total Members, December 2011	**5-6 Year Olds Eligible for HEDIS Well-Child Visit**
74,435	2,129



Summary of Interventions

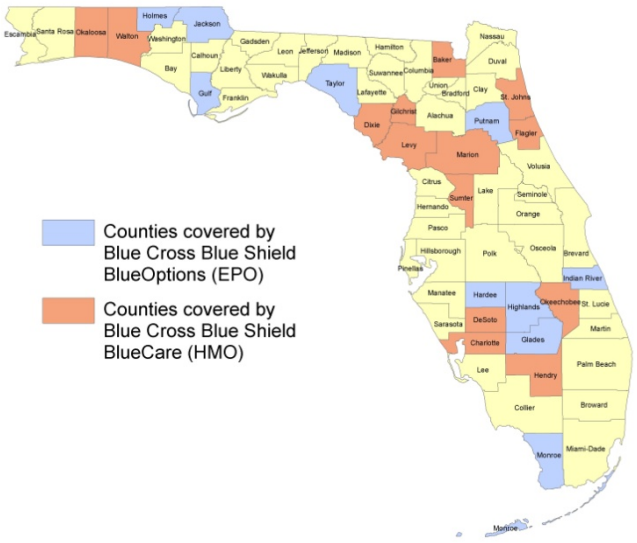
Type	Interventions
Member Level	• Live calls to members without WCV
Provider Level	• Quality Incentive Program • List of members without WCV delivered by plan staff to providers • Educational material
Systems	• Evaluate completeness of encounters submitted by providers

Strengths	Opportunities for Improvement
Inter-departmental workgroup that identified member, provider and systems barriers	Provide more detail about the process for identifying barriers and which are most significant and actionable
Reasonable and appropriate interventions targeting members, providers and systems	More clearly identify the performance goal
Clear data analysis plan and good interpretation of data findings	Develop additional interventions with potential for high impact and provide more detail about interventions
Clear presentation of information	Provide more detail about how data findings feed back into quality improvement processes

PIP Component	Rating
1. Appropriate Study Topic	Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Partially Met
4. Appropriately Identified Population	Met
5. Valid and Reliable Sampling (if applicable)	N/A- No Sampling
6. Valid and Reliable Data Collection	Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: Performance goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

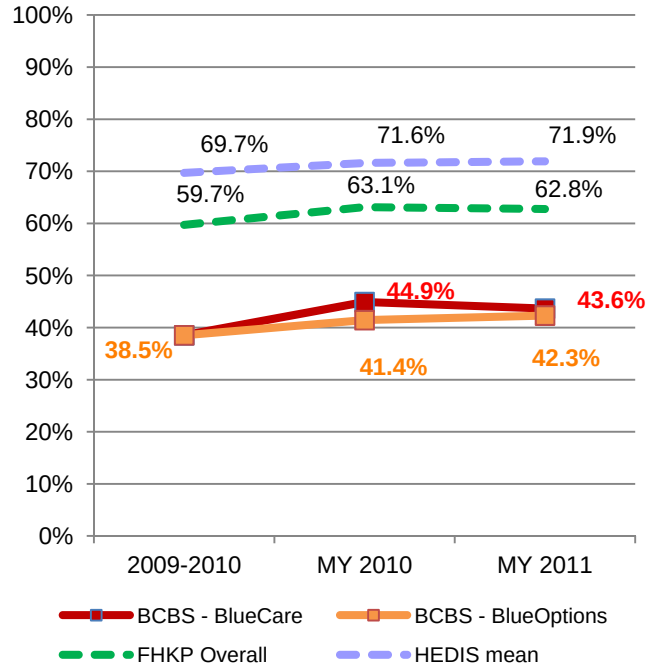
BLUE CROSS BLUE SHIELD



Members

	Total Members, December 2011	5-6 Year Olds Eligible for HEDIS Well-Child Visit
BlueCare	4,194	110
BlueOptions	2,605	78

Well-Child Visits



Summary of Interventions

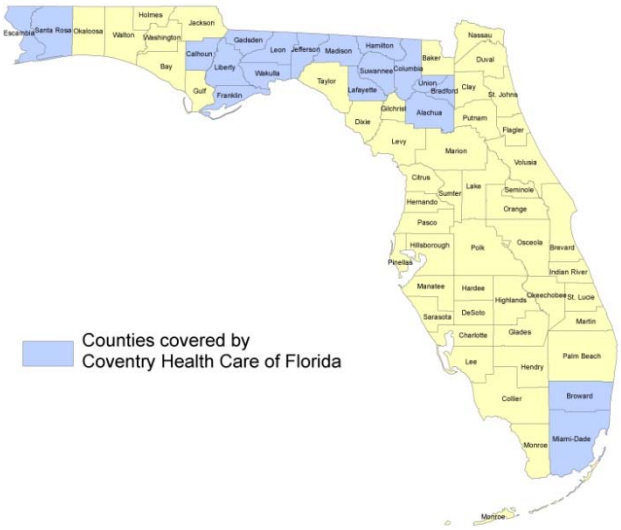
Type	Interventions
Member Level	• Revised Welcome Brochure to highlight WCVs and educate families that no co-pay is required • Added FHKP dedicated page on plan website with benefit information and preventive care resources • Reminder mailings and calls to parents of members without a WCV
Provider Level	• Phone outreach to providers with higher numbers of members without WCV • List of members without WCV mailed to providers • Provider newsletters and fax blasts with care guidelines and highlighting no member co-pay for wellness visits

Strengths	Opportunities for Improvement
Thoughtful identification of member/provider barriers	Clarify measurement of study indicators and performance goals
Interventions address identified barriers; well-designed materials	Clarify identification and analysis of test and control groups
Identified and acted on ways to improve member materials and processes	Provide a more detailed data analysis plan to evaluate performance
Thoughtful identification of barriers to implementing interventions and strategies to overcome those barriers	Strengthen approaches for analyzing and reporting performance over time

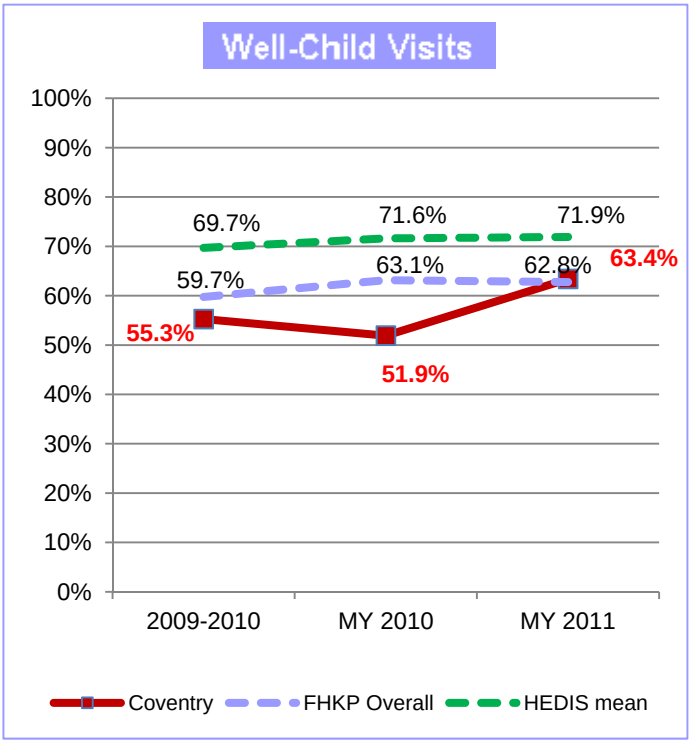
PIP Component	Rating
1. Appropriate Study Topic	Partially Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Partially Met
4. Appropriately Identified Population	Not Met
5. Valid and Reliable Sampling (if applicable)	Not Met
6. Valid and Reliable Data Collection	Partially Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Partially Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: Goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

COVENTRY



Members	
Total Members, December 2011	**5-6 Year Olds Eligible for HEDIS Well-Child Visit**
23,615	713



Summary of Interventions

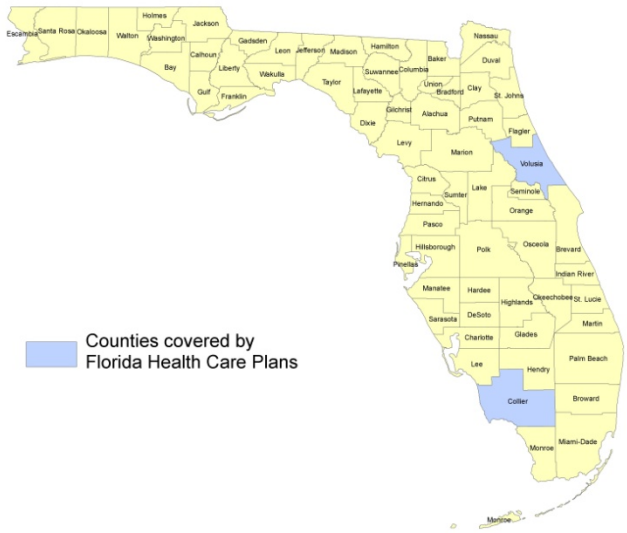
Type	Intervention
Member Level	• Members due for WCV accessible to customer service staff to address during inbound calls • Letters and automated calls to members without WCV • Website links to preventive care information and resources • Community outreach events
Provider Level	• Face-to-face visits with targeted providers: HEDIS education and review members due for WCV • List of members without WCV sent to all providers • Provider portal with information about members needing WCV
Systems	• HEDIS training for plan staff to improve member outreach efforts • Evaluate completeness/accuracy of encounters submitted by providers

Strengths	Opportunities for Improvement
Clear identification of study indicators and results	Increase specificity of performance goal
Strong interventions that are multifaceted and address identified member, provider, and plan barriers	Incorporate greater provider/member engagement in developing and evaluating interventions
Significant improvement in ICHP-reported rate	Prioritize interventions that have greater potential for impact

PIP Component	Rating
1. Appropriate Study Topic	Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Met
4. Appropriately Identified Population	Met
5. Valid and Reliable Sampling (if applicable)	N/A-No Sampling
6. Valid and Reliable Data Collection	Partially Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Partially Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: Performance goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

FLORIDA HEALTH CARE PLANS

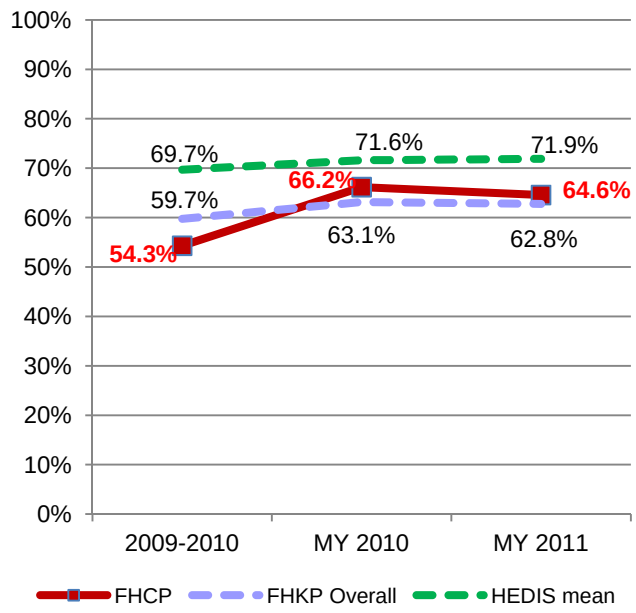


Members	
Total Members, December 2011	**5-6 Year Olds Eligible for HEDIS Well-Child Visit**
5,142	144

Summary of Interventions

Type	Intervention
Member Level	• Birthday reminder letters for annual WCV • Surveys to assess barriers to getting WCV • Newsletters with educational information about well visits
Provider Level	• List of members without WCV given to providers and feedback solicited from provider offices about members scheduled or unable to contact • Educational resources on wellness/prevention

Well-Child Visits

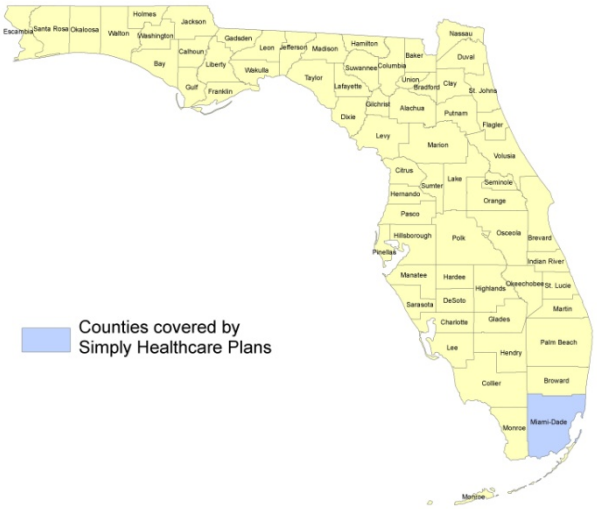


Strengths	Opportunities for Improvement
Member surveys used to assess barriers and intervention effectiveness	Provide a more detailed barrier analysis; refine survey instrument and methodology
Interventions target members and providers and are well described	Identify methods to evaluate statistically significant changes in performance
Detailed feedback sought from providers regarding provider follow-up with members due for WCV	Consider more intensive interventions and involving providers in developing interventions

PIP Component	Rating
1. Appropriate Study Topic	Partially Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Met
4. Appropriately Identified Population	Met
5. Valid and Reliable Sampling (if applicable)	N/A-No Sampling
6. Valid and Reliable Data Collection	Partially Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Partially Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

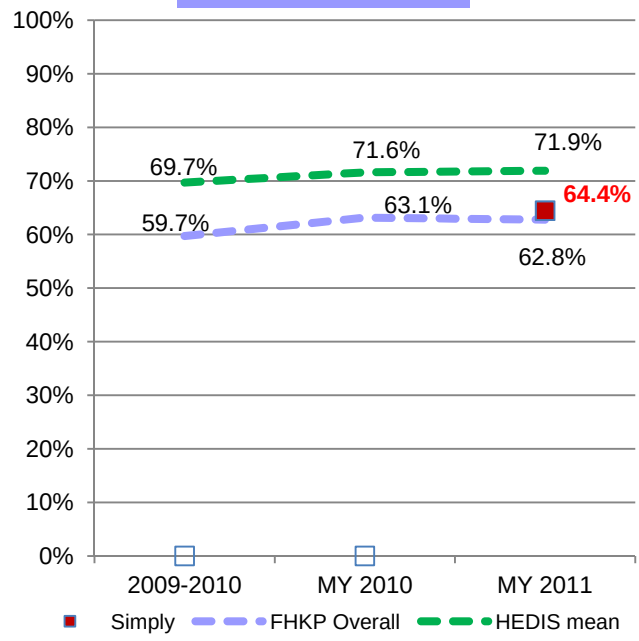
Overall Assessment: Performance goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

SIMPLY



Members	
Total Members, December 2011	**5-6 Year Olds Eligible for HEDIS Well-Child Visit**
1,900	45

Well-Child Visits



Summary of Interventions

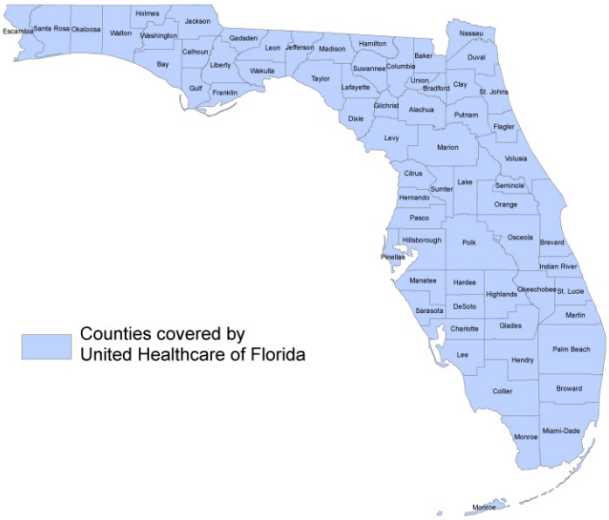
Type	Intervention
Member Level	• Outreach calls to members without WCV to provide education about well-child check-ups, assess reasons for not scheduling appointments, and assist with scheduling appointments • Remind parents of upcoming appointments
Provider Level	• Notify providers of patients due for WCV

Strengths	Opportunities for Improvement
Clear data analysis plan	Provide a more detailed barrier analysis
Member outreach to assess reasons why members do not have well-child visits	Provide more information about data quality, data collection, and internal HEDIS measurement
Interventions target both members and providers	Identify additional and more intensive interventions

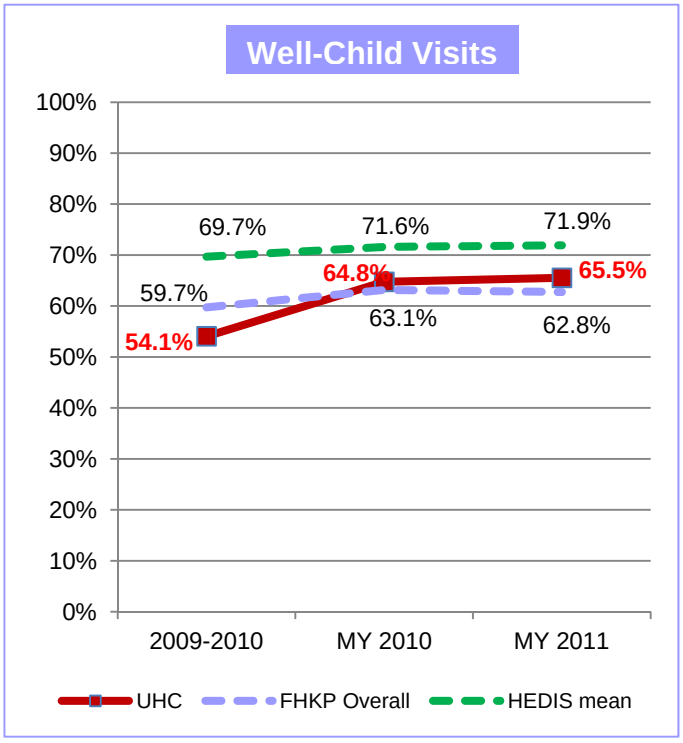
PIP Component	Rating
1. Appropriate Study Topic	Partially Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Met
4. Appropriately Identified Population	Met
5. Valid and Reliable Sampling (if applicable)	N/A-No Sampling
6. Valid and Reliable Data Collection	Partially Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Not Rated
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: Performance goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

UNITED HEALTHCARE



Members	
Total Members, December 2011	**5-6 Year Olds Eligible for HEDIS Well-Child Visit**
51,266	1,294



Summary of Interventions

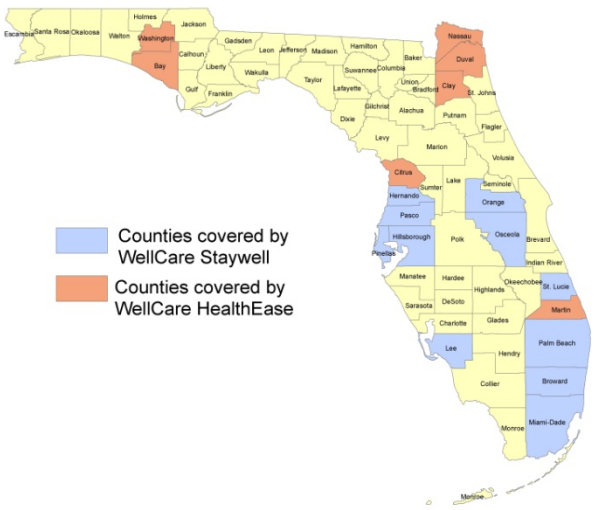
Type	Intervention
Member Level	• Birthday postcard reminders • Live & automated reminder calls to members due for WCV; welcome calls • Incentive program in development • Newsletter education
Provider Level	• Clinical Practice Consultant visits to large-panel provider offices: HEDIS education, review members due for WCV, share best practices • Print and online preventive care guidelines and resources • Pre-printed postcards provided to PCPs to send to members due for WCV
Systems	• Database updates to track members due for WCV & generate provider reports • Evaluate completeness/accuracy of encounters submitted by providers

Strengths	Opportunities for Improvement
Careful and thorough barrier analysis with barriers prioritized	Monitor ICHP-calculated rates as well as plan-calculated rates
Multifaceted and creative interventions that address barriers at member, provider, and plan levels	Quantify intervention activities where possible
Ongoing process of quality assessment and improvement	Consider placing greater emphasis on more innovative aspects of PIP such as incentive program and Clinical Practice Consultants

PIP Component	Rating
1. Appropriate Study Topic	Partially Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Met
4. Appropriately Identified Population	Met
5. Valid and Reliable Sampling (if applicable)	N/A- No Sampling
6. Valid and Reliable Data Collection	Partially Met
7. Intervention Strategies Likely to Induce Permanent Change	Met
8. Appropriate Data Analysis & Interpretation of Results	Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: Performance goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

WELLCARE

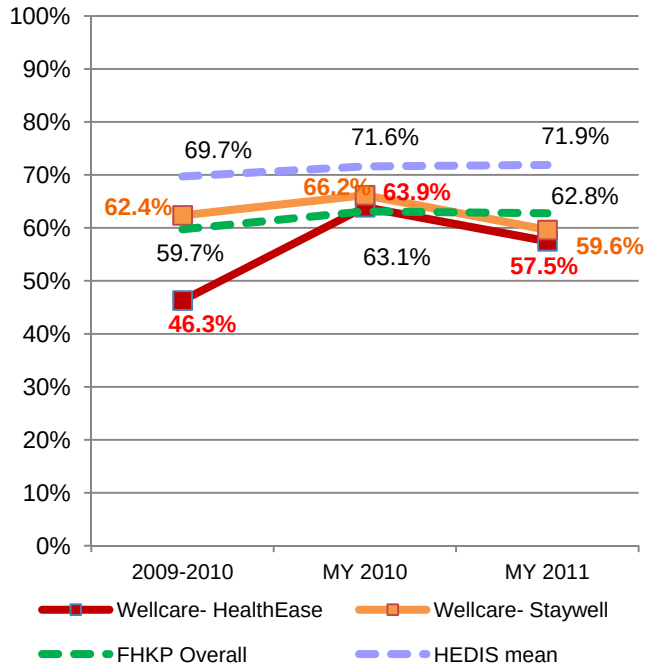


Members		
	Total Members, December 2011	**5-6 Year Olds Eligible for HEDIS Well-Child Visit**
HealthEase	10,439	301
StayWell	49,125	1,379

Summary of Interventions

Type	Intervention
Member Level	• Letters encouraging retaining coverage • Incentive program - gift card for scheduling and keeping WCV appointment • Outreach calls with education about WCV and scheduling assistance • Members due for WCV accessible to customer service staff to address during inbound calls • Reminder birthday letters
Provider Level	• Office visits with providers with higher rates of members due for WCV • Pay for Performance program based on meeting specific performance thresholds • Lists of members due for WCV delivered to providers • Newsletter with preventive care guidelines • Provider portal with information about members needing WCV
Systems	• Evaluate completeness/accuracy of encounters submitted by providers

Well-Child Visits

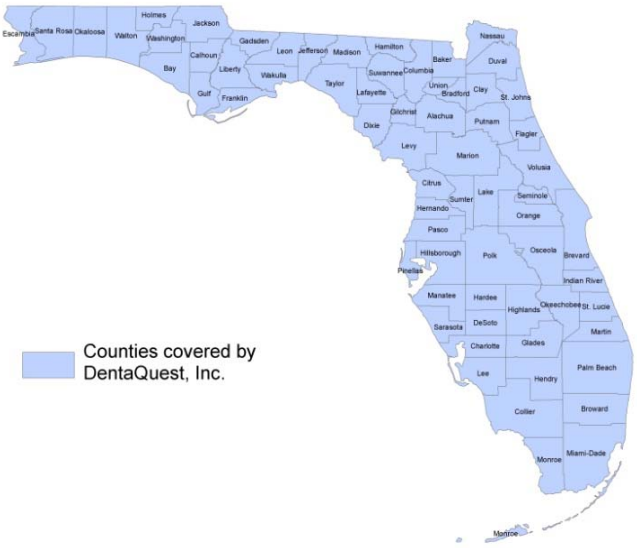


Strengths	Opportunities for Improvement
WCV compliance evaluated by county and language	Provide more detail about the barrier analysis process and findings
Clear data analysis and appropriate interpretation of findings	Provide more detail about each intervention
Broad range of interventions, including innovative strategies such as member and provider incentives	Consider a greater focus on a more limited set of interventions with the greatest potential for impact

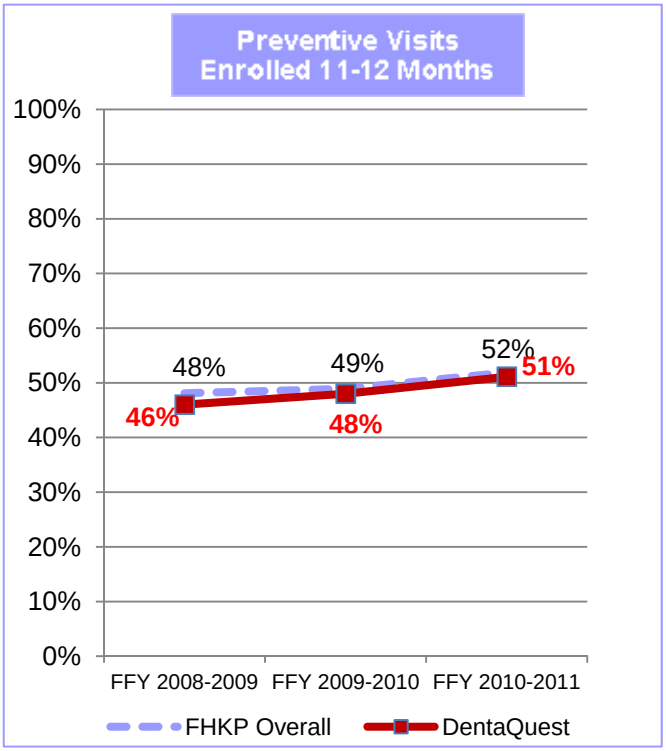
PIP Component	Rating
1. Appropriate Study Topic	Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Partially Met
4. Appropriately Identified Population	Met
5. Valid and Reliable Sampling (if applicable)	Met
6. Valid and Reliable Data Collection	Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Partially Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: Performance goals for PIP have not been met. However, the PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

DENTAQUEST



Members	
Total Members, December 2011	**Number Members Enrolled 11-12 Months**
119,404	75,392



Summary of Interventions

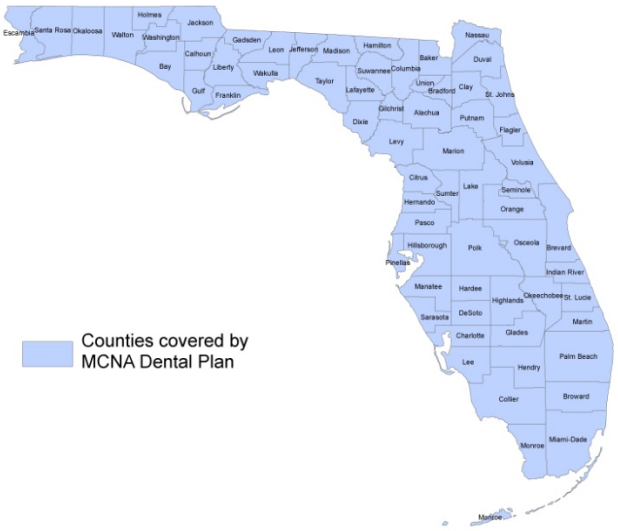
Type	Intervention
Member Level	• Reminder mailings to members due for visits • Phone calls to members due for visits

Strengths	Opportunities for Improvement
Plan provided thoughtful narrative about the relevance of preventive dental care to child oral health and overall health	Provide rationale for selection of pilot county; identify appropriate comparison county
Selection of dental sealants as study topic for age-appropriate preventive services – strong evidence base	More precisely define study indicators and performance goals and develop a more detailed data analysis plan
Plan examined rates over several years to place overall results in a larger context	Conduct a careful barrier analysis that forms the basis for interventions at member, provider and plan levels

PIP Component	Rating
1. Appropriate Study Topic	Partially Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Partially Met
4. Appropriately Identified Population	Not Met
5. Valid and Reliable Sampling (if applicable)	N/A
6. Valid and Reliable Data Collection	Not Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Partially Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: The PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

MCNA DENTAL PLAN

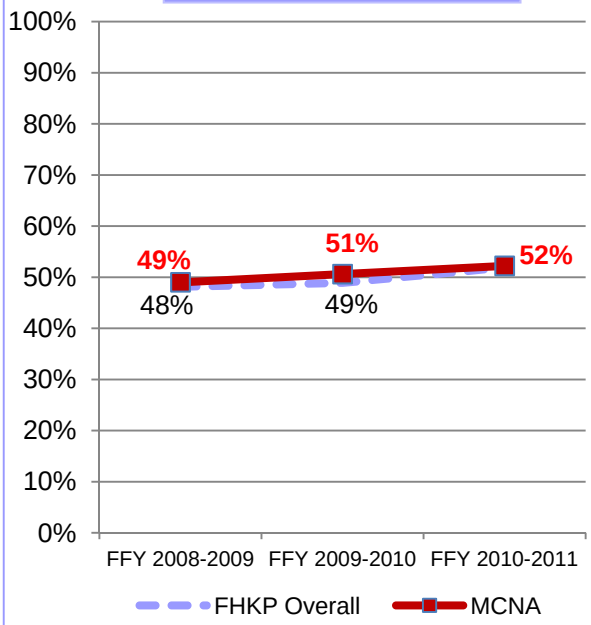


Members	
Total Members, December 2011	**Number Members Enrolled 11-12 Months**
101,348	60,086

Summary of Interventions

Type	Intervention
Member Level	• Community outreach in Broward, Duval, Miami-Dade and Polk counties promoting good oral health behaviors and stressing importance of dental check-ups
Provider Level	• Provider outreach to selected provider offices in Miami-Dade and Palm Beach counties with education about: preventive services, caregiver counseling, AAPD guidelines, effective recall systems, dental records, and referring members who repeatedly break appointments to Case Management for follow-up

Preventive Visits Enrolled 11-12 Months



Strengths	Opportunities for Improvement
Thoughtful narrative about importance of preventive dental services and low use among low-income populations	Refine and clarify data analysis plan and measurement approaches
Selection of dental sealants as study topic for age-appropriate preventive services – strong evidence base	Develop more targeted and more intensive interventions based on a careful barrier analysis
Plan solicits information from providers about members who repeatedly miss scheduled appointments so case management can provide assistance	Address identified inconsistencies in study indicators and measurement

PIP Component	Rating
1. Appropriate Study Topic	Partially Met
2. Clear, Measureable Study Question	Met
3. Objective, Measureable Indicators	Partially Met
4. Appropriately Identified Population	Partially Met
5. Valid and Reliable Sampling (if applicable)	N/A – No Sampling
6. Valid and Reliable Data Collection	Partially Met
7. Intervention Strategies Likely to Induce Permanent Change	Partially Met
8. Appropriate Data Analysis & Interpretation of Results	Partially Met
9. "Real" Improvement Documented	Not Rated
10. "Real" Improvement Sustained	Not Rated

Overall Assessment: The PIP has only been in place for one year. Identified issues should be addressed and additional time and monitoring are warranted.

APPENDIX 2: PERFORMANCE IMPROVEMENT PROJECT VALIDATION STEPS AND STANDARDS

1. Review the Selected Study Topics

- The topic was selected through data collection and analysis of comprehensive aspects of enrollee needs, care and services.
- The plan described the relevance of the topic to its FHKP membership and/or provider network.
- The plan provided plan-specific background research on the population, including demographic data, and described the relevance of this information for its PIP.
- The PIP, over time, addressed a broad spectrum of key aspects of enrollee care and services (e.g., preventive, chronic, acute, coordination of care, inpatient, etc.).
- The plan explained how its approach was inclusive of all populations within the targeted population (i.e., that no subgroups of children – such as those with special health care needs - were consistently excluded).

2. Review the Study Questions

- The study questions were stated clearly.
- The study question was measurable.

3. Review the Study Indicators

- The PIP identified objective, clearly defined, measurable indicators.
- It is clear how each indicator was measured (numerator, denominator).
- The baseline measurement period was identified.
- The baseline is appropriate, valid, and reliable.
- The performance goals for the PIP were clearly specified.
- The indicators track performance over a specified period of time, and re-measurement periods were identified.
- Benchmarks were identified and appropriate.
- The indicator(s) are adequate to answer study the question.

4. Review the Identified Study Population

- The plan clearly identified the FHKP enrollees to whom the study question and indicators are relevant.
- If the entire applicable population was studied (versus a sample), the data collection approach captured all enrollees to whom the study question applied.
- If there was more than one study question/indicator, the plan described the populations/samples for each question/indicator.
- Enrollment length requirements (if applicable) for identifying the study population were identified and appropriate.
- If a sample was used, the rationale for sampling was provided and is appropriate.

5. Review Sampling Methods (if applicable)

- The sampling techniques considered and specified the true (or estimated) frequency of occurrence of the event. (If true prevalence or incidence rate is not ascertainable, the plan should use the maximum sample size to establish a statistically valid baseline for the project indicators.)
- The sampling techniques considered and specified the confidence interval to be used.
- The sampling techniques considered and specified the acceptable margin of error.
- The plan employed valid sampling techniques that protect against bias.
- The sample contained a sufficient number of enrollees.

6. Review Data Collection Procedures

- Overall, the study design was clearly described.
- The study design clearly specified the data to be collected.
- The study design clearly specified the sources of data and the completeness and quality of those data.
- The study design specified a systematic method of collecting valid and reliable data that represents the entire population to which the study's indicators apply.
- The instruments for data collection were identified and provide for consistent, accurate data collection over the time periods studied.
- The study design prospectively specified a data analysis plan.
- Qualified staff and personnel were used to collect the data.

7. Assess Improvement Strategies

- The interventions are reasonable for addressing the problems/needs identified in Activity 1 and are appropriate for the target population.
- The interventions were designed to address causes/barriers identified by the plan through data analysis and QI processes.
- It is clear how the proposed interventions were designed to change behavior at a member, practitioner, or systems level.
- The interventions are described in detail, including number of members or providers reached.
- Literacy and cultural needs were assessed and incorporated into the design of the interventions (not part of scoring, but recommended).
- The intervention(s) are sufficient to be expected to improve processes or outcomes.
- The interventions are likely to be sustainable over time and induce permanent change.

8. Review Data Analysis & Interpret Results

- The analysis of findings was performed according to the data analysis plan.
- Numerical results, including initial and repeat measurements (with numerators, denominators and rates), were presented clearly and accurately.
- The analysis assessed statistical significance, using appropriate tests.
- The analysis identified factors that influence comparability of initial and repeat measurements (such as changes in technical specifications, member population, response rates, changes in data collection approaches, etc.).
- The analysis identified factors that threaten internal and external validity.
- The analysis included appropriate comparison benchmarks.
- Strategies for evaluating the relative effectiveness of different interventions were described.
- The analysis of study data included an accurate interpretation as to whether or not the PIP was successful and appropriate follow up activities were identified.

9. Assess Likelihood that Reported Improvement is "Real" Improvement

- The plan described how it will assess whether "real" improvement has been achieved – improvement that is meaningful and that is attributable to the intervention and not other factors or random chance.
- The same methodology as the baseline measurement was used when measurement was repeated.
- There was documented, quantitative improvement in care processes or outcomes.
- The reported improvement in performance has "face" validity (i.e., the improvement in performance appears to be the result of the planned quality improvement intervention).
- There was a statistically significant improvement over baseline for at least one of the indicators.

10. Assess Sustainability of Documented Improvement

- The plan described how it will assess and document sustained improvement over time.
- The plan described how it will use data findings to feed back into QI processes.
- Sustained improvement was demonstrated through repeated measurements over comparable time periods.
- Statistically significant improvements over baseline were sustained for at least one additional reporting period.

End Notes

[1] Children's Health Insurance Program Reauthorization Act of 2009. Public Law 111-3. Available at: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_public_laws&docid=f:publ003.111.

[2] Centers for Medicare and Medicaid Services. 2002. *Validating Performance Improvement Projects.* Final Protocol Version 1.0. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html.

[3] Herndon J.B., Shenkman E. "Quality of Care: Health and Dental Plan Performance Measures, Health Plan Contract Year 2008-2009." Prepared for the Florida Healthy Kids Corporation. September 2010. 49 Pages.

[4] Centers for Medicare and Medicaid Services 2012. CMCS Informational Bulletin: Medicaid Lead Screening and EQRO Protocols. Available at: http://medicaid.gov/new-and-notable.html.