HEALTH WEALTH CAREER

2017 EXTERNAL QUALITY REVIEW

MEDICAID MANAGED CARE ORGANIZATION PERFORMANCE REPORT

STATE OF DELAWARE, DIVISION OF MEDICAID & MEDICAL ASSISTANCE

MARCH 30, 2018

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INTRODUCTION

PURPOSE OF REPORT

The State of Delaware (State) Division of Medicaid & Medical Assistance (DMMA) contracted with Mercer Government Human Services Consulting (Mercer) to conduct an external quality review (EQR) of the managed care organizations (MCOs), Highmark Health Options (HHO) and United Healthcare Community Plan (UHCP) participating in the State of Delaware's Medicaid health care service programs. This document presents a summary evaluation of the MCOs' performance based on data collected through as part of the annual EQR. This report aims to assess MCO performance in accordance with goals identified in DMMA's current Quality Management Strategy (QMS)[1]:

- **Goal 1:** Improve timely access to appropriate care and services for adults and children with an emphasis on primary and preventive care, and to remain in a safe and least-restrictive environment.
- **Goal 2:** Improve quality of care and services provided to Diamond State Health Plan (DSHP), DSHP Plus and Children's Health Insurance Program (CHIP) members.
- **Goal 3:** Control the growth of health care expenditures.
- **Goal 4:** Assure member satisfaction with services.

In addition to evaluating MCO performance with respect to DMMA's QMS goals, this report offers a summary of the corrective action plan (CAP) review based on the Centers for Medicare and Medicaid Services (CMS) EQR requirements under 42 CFR 438.358. Based on findings of the descriptive and comparative analyses, Mercer identified MCO strengths and opportunities for improved performance in the delivery of health care services for enrollees in Delaware's managed Medicaid programs.

[1] Division of Medicaid & Medical Services. (2014, April). Delaware Statewide Quality Management Strategy. New Castle: Delaware Department of Health and Social Services.

EQR

CMS mandates a state-level Quality of Care EQR for participating MCOs.[2] Federal regulations under 42 CFR Part 438, subpart E set forth parameters the State must follow when conducting EQRs of a contracted MCO. The EQR is a systematic analysis and evaluation by a qualified External Quality Review Organization (EQRO). The evaluation requires aggregated information about the quality, timeliness and access to health care services that an MCO or its contractors provide under contract for Medicaid recipients.

Part of the EQR service includes validation of information furnished to complete the analysis. This includes a review of descriptive information and a review of data and procedures used to determine the extent to which they are accurate, reliable and free from bias, in accord with national standards for data collection and analysis.

Quality, as it pertains to the EQR, refers to the degree to which an MCO increases the likelihood of desired health outcomes of its enrollees through its structure and operations. Quality also accounts for how this is accomplished through the provision of health services that are consistent with current professional knowledge and widely-established best practices.[3]

Recent changes by CMS to EQR protocols address significant changes in national healthcare policy, which offer new opportunities for measuring and improving quality of health care delivery. This includes changes effected by the Children's Health Insurance Program Reauthorization Act of 2009, the American Recovery and Reinvestment Act and the Affordable Care Act.

METHODOLOGY

Primary data sources for analysis in this report include the Consumer Assessment of Healthcare Providers and Systems survey (CAHPS), the National Committee for Quality Assurance's (NCQA's) Healthcare Effectiveness Data and Information Set (HEDIS) and the 2017 Delaware CAP EQR. The performance improvement projects (PIPs) and performance measures (PMs) DMMA selected for validation were based on DMMA's QMS goals noted above.

Results for the two Delaware Medicaid MCOs have been de-identified, and respective scores for HEDIS and CAHPS performance measures are reported in comparison to national percentiles from

[2] Medicaid & Medical Services. (2014, April). Delaware Statewide Quality Management Strategy. New Castle: Delaware Department of Health and Social Services

[3] National Quality Strategy. Content last reviewed April 2015. Agency for Healthcare Research and Quality, Rockville, MD. http://www.ahrq.gov/research/findings/nhqrdr/nhqdr14/key3.html; (iv) U.S. Department of Health and Human Services, Agency for Healthcare Research and Quality. Quality Indicators. Available at http://www.qualityindicators.ahrq.gov/

NCQA's Quality Compass.[4] Results are grouped into a rating system of five stars (90th percentile), three stars (50th–89th percentile) or two stars (below 50th percentile). The EQRO evaluated MCO compliance with Medicaid and the CHIP managed care regulations and is presenting them in four domains: enrollee rights and protections, quality assessment and performance improvement, grievances and appeals, certification and program integrity. A similar star scoring approach was used to present results of the validation of performance measures and PIPs. See Tables 1–3, below to interpret star ratings throughout the remainder of the report.

Table 1. CAHPS and HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS/CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

Table 2. EQR Compliance Score Scale

Compliance Points Earned	EQR Report Score
90% + of possible points	★★★★★
75%–89% of possible points	★★★
< 75% of possible points	★★

[4] Quality Compass provides a database of national averages among organizations submitting data to NCQA. Benchmark data comes from accredited and non-accredited organizations and consists of publicly and privately reported performance metrics. Available at: www.qualitycompass.org.

Table 3. PM and PIP Validation Score Scale	
PIP/Validation Evaluation	**EQR Report Score**
Fully compliant	★★★★★
Substantially compliant	★★★
Not compliant	★★

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CAHPS

MEMBER PERCEPTION OF HEALTHCARE SERVICES

One of the goals described in the Delaware Medicaid QMS is to "Assure member satisfaction with services." The State understands the importance of perception of service experience of Medicaid enrollees. Enrollees who exhibit confidence in services delivered to them will engage those services more effectively and more often, increasing the likelihood of a healthier membership. CAHPS surveys (adult and pediatric) target enrollees' viewpoint and evaluation of their own experiences with health care delivery. The survey covers topics important to enrollees and focuses on aspects of quality they are best qualified to assess, such as the communication skills of providers and ease of access to health care services. The following results and subsequent ratings are based on the CAHPS composite scores developed by combining individual survey questions into broader topics. A star rating was assigned to each composite measure according to the following scale.

Table 4. CAHPS and HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS/CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

CAHPS PERFORMANCE EVALUATION

CAHPS performance varied across domain and by population within each MCO. A side-by-side comparison of both MCOs shows differences in performance as well.

Table 5. 2016 MCO CAHPS Compliance Ratings — Adult		
Measure Description	**MCO A**	**MCO B**
Rating of personal doctor	★★★	★★★
Rating of specialist	★★	★★★★★
Rating of all health care	★★★	★★★
Rating of health plan	★★★	★★★
Getting needed care	★★★	★★★★★
Getting care quickly	★★★	★★★
How well doctors communicate	★★★	★★★

Table 6. 2016 MCO CAHPS Compliance Ratings — Child		
Measure Description	**MCO A**	**MCO B**
Rating of personal doctor	★★★	★★★★★
Rating of specialist	★★★	★★★
Rating of all health care	★★★★★	★★★
Rating of health plan	★★★	★★
Getting needed care	★★★	★★★
Getting care quickly	★★	★★★★★
How well doctors communicate	★★	★★★★★

OVERALL MEMBER EXPERIENCE WITH CARE

Both MCOs had moderately good ratings for the adult areas: rating of health care, getting care quickly, and how well doctors communicate. Both MCOs also had moderately good ratings for the child areas: rating of specialist and getting needed care. MCO B had strong results on the adult measure rating their specialist while MCO A results were low. MCO B had strong results on the adult measure getting needed care while MCO A results were moderate. MCO B had strong results for the child measure of rating of all health care.

MCO A performed moderately well on both the adult and child CAHPS survey. MCO A performed at or above the benchmark for the 50th percentile for CAHPS metrics nationwide for adult measures with the exception of the rating of specialist that scored lower than the 50th national percentile. Plan members who completed the CAHPS survey scored six adult metrics as moderate (rating of personal doctor, rating of all health care, rating of health plan, getting needed care, getting care quickly and how well doctors communicate). While there were positive results within the adult CAHPS survey, the child survey results for MCO A highlight opportunities for improvement. Plan members who completed the CAHPS survey scored one child metric as high (rating of all health care), four child metrics as moderate (rating of personal doctor, rating of specialist, rating of health plan and getting needed care), and two child metrics as low (getting care quickly and how well doctors communicate). (Tables 5 and 6)

Members rated MCO B's performance at or above the 90th percentile benchmark for two of the adult measures (rating a specialist and getting needed care) as well as three of the child measures (rating of personal doctor, getting care quickly and how well doctors communicate). An area in need of improvement for MCO B is the child measure for rating of health plan (lower than the 50th percentile). All other metrics reveal moderate performance between the 50th and 90th percentiles for MCO B.

Comparing MCO A to MCO B suggests some opportunities for improvement at both MCOs. Primary concerns for MCO A revealed by this year's reporting include the rating of adult specialists, getting care quickly and how well doctors communicate. Primary concerns for MCO B include the child metric for rating of health care.

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HEDIS RESULTS

This section provides an overview of two critical domains for evaluation: Access to Care and Quality of Care. Analysis using HEDIS for performance evaluation is industry standard for external reporting in the managed care industry. HEDIS is developed and maintained by NCQA. Data used for calculating HEDIS results include information from medical charts and provider claims (i.e., encounter data from electronic health records, claims data from billing systems, etc.) within Delaware's Medicaid managed care network. NCQA originally designed HEDIS to allow consumers to compare health plan performance against the quality of other health plans, as well as national and regional benchmarks. A star rating was assigned as follows for each composite measure:

Table 7. CAHPS and HEDIS Performance Measure Score Scale

National Percentile Score as Reported by HEDIS/CAHPS	EQR Report Score
90th percentile or higher	★★★★★
50th–89th percentile	★★★
Lower than 50th percentile	★★

EVALUATION OF EFFECTIVENESS AND ACCESS TO HEALTH CARE

The Delaware QMS prioritizes improvement of timely access to appropriate care and services for adults and children, with an emphasis on primary preventive care and remaining in a safe and least-restrictive environment. Providing timely access to preventive and primary care services promotes the goal of a comprehensive health care delivery system for Delaware Medicaid.

Timely Access to Primary and Preventive Services

Medicaid enrollees who utilize primary and preventive services have been found to be better equipped to manage acute and chronic medical conditions, versus those who do not have access to these services. Patients with adequate access to primary care are more likely to have preventive care, as well as consistent care for chronic conditions. Both have been shown to reduce unnecessary emergency department visits and inpatient hospital admissions. MCO A was at or above the 50th percentile on five of the seven timely access to primary and preventive services

measures. The MCO was below the 50th percentile in older adult and children (ages 12 months to 24 months) access to preventive services. MCO B was at or above the 50th percentile on six of the seven timely access to primary and preventive services measures. The MCO was below the 50th percentile in older adult access to preventive services.

Table 8. Timely Access to Primary and Preventive Services

HEDIS Performance Measure Description	MCO A	MCO B
Children's access to primary care physician (PCP) (Ages 12 months–24 months)	★★	★★★
Children's access to PCP (Ages 25 months–6 years)	★★★	★★★
Children's access to PCP (Ages 7 years–11 years)	★★★	★★★
Adolescent's access to PCP (Ages 12 years–19 years)	★★★	★★★
Adult's access to preventive/ambulatory health services (Ages 20 years–44 years)	★★★	★★★
Adult's access to preventive/ambulatory health services (Ages 45 years–64 years)	★★★	★★★
Adult's access to preventive/ambulatory health services (Ages 65+ years)	★★	★★

Access to Maternal and Pregnancy Services

Early and consistent access to quality prenatal care services can improve chances of delivering healthy babies. Providing access to comprehensive maternal and prenatal services impacts MCO service delivery significantly, and constitutes effective means of preventing lifelong disability via healthy deliveries. Both MCOs performed below the 50th percentile for access to maternal and pregnancy services during 2016.

Table 9. Access to Maternal and Pregnancy Services

HEDIS Performance Measure Description	MCO A	MCO B
Prenatal and postpartum care — timeliness of prenatal care	★★	★★
Prenatal and postpartum care — postpartum care	★★	★★

OVERALL ACCESS PERFORMANCE

HEDIS results provide a litmus test for evaluating patient access to care. The comparisons of reportable-HEDIS data between MCOs and against the national benchmarks, above, indicate both MCOs need to focus quality improvement strategies for accessing preventive and maternity care.

EVALUATION OF QUALITY OF CARE

The Delaware Medicaid QMS includes goals of improving quality of care and services provided to DSHP, DSHP Plus and CHIP members. Quality-related performance measures describe attributes of health services provided to members. These PMs provide an overview of the effectiveness of a health care delivery system by looking at service utilization, patients' health outcomes and comprehensiveness of disease management services for common causes of morbidity and mortality.

Evaluation of Neonatal Services

Effective preventive care begins early in life. Healthier children will be more likely to remain healthier as adults. High-quality health care in early stages of life promotes a healthier membership pool. As shown in the following table, MCO A performed at or above the 50th percentile for quality of early life services for each of the performance measures below, while MCO B performed below the 50th percentile.

Table 10. Quality of Early Life Services

HEDIS Performance Measure Description	MCO A	MCO B
Childhood immunization status (Combination 2)	★★★	★★
Sufficient (6+) well-child visits in first 16 months of life	★★★	★★
Well-child visits in years 3–6	★★★	★★

Evaluation of Early Detection Services

Routine screenings and early detection services allow providers to identify and address health concerns at an early stage, often preventing costly and invasive interventions associated with later detection. As shown below, MCO A performed at or above the 50th percentile for both breast cancer screening and cervical cancer screening. MCO B performed at the 90th percentile or higher for breast cancer screening; however, it performed below the 50th percentile for cervical cancer screening.

Table 11. Early Detection Service Quality		
HEDIS Performance Measure Description	**MCO A**	**MCO B**
Breast cancer screenings	★★★	★★★★★
Cervical cancer screenings	★★★	★★

Quality of Diabetes Management Services

Diabetes mellitus has a strong association with morbidity and mortality in the United States. Often associated with inadequate diabetes management, comorbidities such as hypercholesterolemia (high cholesterol), hypertension (high blood pressure), and other chronic conditions merit attention. Comprehensive care for this disease includes a variety of monitoring services. As shown below, both MCOs' HEDIS scores indicate need for improvement in diabetes care.

Table 12. Quality of Diabetes Management		
HEDIS Performance Measure Description	**MCO A**	**MCO B**
Comprehensive diabetes care — HbA1c testing	★★	★★
Comprehensive diabetes care — dilated retinal eye exam	★★	★★

Weight and Nutrition Management Quality

Also associated with morbidity and mortality in the United States is obesity and its related health conditions. Expenditures attributed to these conditions are also on the rise. When initiated early in life, proper nutrition, physical activity and weight assessment and control effectively prevent obesity and the associated disease burden. Nutrition counseling is an important means of educating individuals in order to help them lead healthier, more productive lives. Both MCOs are below the 50th percentile for adult Body Mass Index (BMI) assessment. MCO B is also below the 50th percentile for both counseling for nutrition and physical activity among children. MCO A is above the 50th percentile for counseling for nutrition and physical activity among children.

Table 13. Clinical Quality of Weight and Nutrition Management		
HEDIS Performance Measure Description	**MCO A**	**MCO B**
Adult BMI Assessment	★★	★★
Counseling for nutrition	★★★	★★
Counseling for physical activity	★★★	★★

*Small Denominator. The organization followed the specifications, but the denominator was too small (<30) to report a valid rate.

OVERALL QUALITY PERFORMANCE

Strengths and Opportunities

Both MCOs have operated at or above the 50th percentile for several of the timely access to primary and preventive services. MCO B has achieved the 90th percentile in breast cancer screenings. MCO A has operated at or above the 50th percentile for each of the child/adolescent quality of care measures reported. These preventive services as well as services to the young and vulnerable population are keys to improving the health outcomes of the Delaware Medicaid population.

Both MCOs scored low to moderate for overall performance on measures pertaining to quality of care. Both MCO's have opportunities for significant improvement with early detection and service intervention as well as with diabetes management. This topic has been an ongoing theme targeted by DMMA's Quality Improvement Initiative task force and MCO quality committees. Improved performance in these areas could dramatically improve the quality of life, morbidity and mortality of Delaware Medicaid enrollees.

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EQR: COMPLIANCE

COMPLIANCE SCORING

As required by CMS under federal regulation, Mercer, acting as the EQRO, completed a CAP review of the MCOs using the CMS protocol "Assessment of Compliance with Medicaid Managed Care Regulations." A CAP review is focused on following up on items that were found to be not fully compliant during the previous review. The review has been grouped into the follow compliance areas below:

- Enrollee rights & protections
- Quality assessment & performance improvement
- Grievances and appeals
- Certifications and program integrity

The EQRO compliance evaluation assigns the MCO a score for each metric that makes up these four review areas. The assessment of "Met", "Partially Met" and "Not Met" is given a score, and an equal weighting was assigned to each of the four standards. Regulation mandates MCOs develop a required corrective action plan for all metrics resulting in a "Partially Met" or "Not Met" rating. All corrective action plans are reviewed and approved for implementation by DMMA prior to integration. A star rating was assigned to each MCO based on their overall compliance score according to the rating scale below:

Table 14. 2016 EQR Compliance Scoring Scale

Compliance Points Earned	EQR Report Score
90% + of possible points	★★★★★
75%–89% of possible points	★★★
< 75% of possible points	★★

COMPLIANCE EVALUATION

MCO A scored above 90% in the areas of enrollee rights and protections, quality assessment and performance improvement and certifications and program integrity. The one area in need of most improvement for MCO A is grievances and appeals. MCO B scored 90% in the areas of quality assessment and performance improvement, grievances and appeals and certifications and program integrity. The area in need of the most improvement for MCO B is enrollee rights and protections.

Table 15. 2016 MCO Overall Compliance Ratings

	MCO A			MCO B		
Content Area	**Possible Points**	**Points Scored**	**Percent**	**Possible Points**	**Points Scored**	**Percent**
Enrollee Rights and Protections	25	23.44	93.8%	25	21.25	85.0%
Quality Assessment and Performance Improvement	25	22.92	91.7%	25	22.92	91.7%
Grievances and Appeals	25	21.09	84.4%	25	23.44	93.8%
Certifications and Program Integrity	25	25.00	100.0%	25	25.00	100.0%
Total	***100***	***92.45***	***92.4%***	***100***	***92.61***	***92.6%***
Total Compliance Rating	★★★★★			★★★★★		

OVERALL COMPLIANCE PERFORMANCE

Strengths and Opportunities

Both of Delaware's Medicaid MCOs performed well overall in 2017, scoring in the highest compliance-rating tier. Both MCOs attained greater than 90% of possible points in three of the four scoring areas. MCO A earned greater than 80% of possible points in the area of grievances and appeals. MCO B earned greater than 80% in the area of enrollee rights and protections. These results indicate that both MCOs are compliant with the majority of federal regulations and state contract expectations.

Findings of the CAP review indicated room for improvement at MCO A for Grievance and Appeals. MCO A was found to be not fully compliant in the areas of training contractors and other general requirements. Most of these opportunities for improvement were rooted in the heavy transactional approach to issue decisions on prior authorization requests as well as grievance or appeal decisions. As a result, there is limited engagement in the value-added activities that are a hallmark of strong member-centric, customer-focused business models.

Findings of the CAP review indicated room for improvement at MCO B for Enrollee Rights and Protections metrics. Most of these opportunities for improvement were around the member handbook. The member handbook is a critical resource to ensure members have a full understanding of the Medicaid program, services available to them and how to appropriately access those services. It is critical that all pieces of information be communicated accurately and in a manner that is easily understood by members. The DSHP Plus Member Handbook was available in Spanish when requested; but was not available online at the time of the review.

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PERFORMANCE MEASUREMENT

VALIDATION OF PERFORMANCE MEASURES

Performance measurement uses robust tools and methodologies to collect information about large complex health care delivery systems. The objective of the performance measure validation in the compliance process is to validate accuracy of Medicaid, CHIP and DSHP/DSHP Plus PMs reported by the MCOs to DMMA. The review process includes application of the CMS protocol entitled "Validating Performance Measures," which is aimed at assessing compliance with specifications for each performance measure.

The measures reviewed for 2017 were mandated by the State and used technical specifications developed as part of the Quality Care Management Monitoring Report and CMS Adult and Pediatric Core Measure reporting. To validate the PMs, Mercer referenced the annual compliance review and Information Systems Capabilities Assessment Request for Information responses with supporting documentation. During onsite meetings, Mercer facilitated discussions about data management processes, report generation, data validation and data submission. After all audit elements were assessed, a validation finding for each measure was determined based on the magnitude of errors detected in the review. The following table summarizes the scale used to evaluate performance measure compliance.

Table 16. Performance Measure Validation Scoring Scale

PIP/Validation Evaluation	EQR Report Score
Fully compliant	★★★★★
Substantially compliant	★★★
Not compliant	★★

The following table shows a breakdown of PMs that were validated for 2017:

Table 17. Performance Measures Validated

Measure Description	Reporting Frequency	Reporting Format
Annual monitoring for patients on persistent medication	Annual	CMS Core Measure
Well child visits (3, 4, 5, 6 years)	Annual	CMS Core Measure
PQI 01: Diabetes short-term complications admission rate	Annual	CMS Core Measure
Developmental screening in the first three years of life	Annual	Quality and Care Management Measurement Reporting Templates (QCMMR)
Health risk assessments	Monthly	QCMMR
Percent of DSHP Plus members receiving behavioral health (BH) services	Monthly	QCMMR

VALIDATION OF PERFORMANCE MEASURE FINDINGS

The validation process reveals that both MCO A's and MCO B's reported performance measurement was fully compliant. The following table shows a side-by-side comparison of the results for both MCOs:

Table 18. Performance Measure Validation Ratings

Measure Description	MCO A	MCO B
Annual monitoring for patients on persistent medication	★★★★★	★★★★★
Well child visits (3, 4, 5, 6 years)	★★★★★	★★★★★
PQI 01: Diabetes short-term complications admission rate	★★★★★	★★★★★
Developmental screening in the first three years of life	★★★★★	★★★★★
Health risk assessments	★★★★★	★★★★★
Percent of DSHP Plus members receiving BH services	★★★★★	★★★★★

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PERFORMANCE IMPROVEMENT PROJECTS

VALIDATION OF PERFORMANCE IMPROVEMENT PROJECTS

The CMS regulations require each state MCO to establish PIPs as part of their quality assurance program. These PIPs, which are validated using the CMS Protocol, are intended to evaluate and improve upon the processes and outcomes associated with specified health care targets. DMMA has mandated that each MCO conduct three PIPs. The State selected all three PIPs for independent validation by the EQRO during the 2017 compliance review cycle. The first PIP was a State-mandated study topic and study question. The second PIP was a State-mandated topic, but MCO-developed study questions. The third required PIP allows for a topic selected by the individual MCO that is relevant to its population and approved by DMMA as relevant to the needs of Delaware's Medicaid and CHIP populations. Table 19 below includes the study topics validated and confidence in the reported results:

Table 19. PIP Validation Score

Measure Description	MCO A Confidence in Reported Results	MCO B Confidence in Reported Results
Oral health for DSHP Plus long term services and supports membership	Low	Moderate
Improve screening for depression by MCO A network primary care practitioners using the PHQ-9 screening tool	Low	
Developmental screening in the first 36 months of life of the MCO A member population	Low	
Achieving primary care visits and medication adherence for MCO B PROMISE members with a diagnosis of hypertension		Moderate
Reducing pediatric 10-day readmissions at MCO B's children's hospital through implementation of a single point of contact strategy		Moderate

ASSESSMENT FOR MCO A

Throughout 2015, there was a significant investment by DMMA in technical assistance to MCO A to ensure there was a solid foundation for assessment of the baseline year of the PIPs at the time of the 2016 EQR. In 2016, the EQR reported that there was moderate to low confidence in the reported results at the conclusion of the EQR. Unfortunately, there was little progress and an overall lack of clarity and direction for moving the PIPs forward through 2016.

ASSESSMENT FOR MCO B

As stated above, throughout 2015 there was a significant investment by DMMA in technical assistance to MCO B to ensure there was a solid foundation for assessment of the baseline year of the PIPs. In 2016, the EQR reported that the PIPs were clearly written, detailed and aligned with identified population health concerns. At the time of the 2016 EQR evaluation, MCO B demonstrated a high degree of confidence moving from foundational to well-developed with an emphasis on continuous quality improvement. While there was strong confidence in the foundation of the PIPs in 2016, in 2017 the results indicated challenges in data collection and calculation of results for the PIPs overall. This led to only a moderate level of confidence in the PIPs in 2017.

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