Georgia Department of Community Health

Georgia Families

Choices for a Healthy Life

Quality Strategic Plan –Update

November 2011

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DCH Quality Focus

This Quality Strategic Plan was created for the Georgia Families Medicaid Managed Care Program (serving eligible members of the Medicaid and PeachCare for Kids® (CHIP) populations) by staff members of the Georgia Department of Community Health (DCH) in June 2007. The original plan received Centers for Medicare and Medicaid Services (CMS) approval in 2008. Since that time, DCH has continuously assessed the Plan and its effectiveness toward achieving the identified goals and objectives. Achievements to date have been recorded in the Plan's updates and include such noteworthy accomplishments as: the re-alignment of managed care and fee-for-service program staff members responsible for the EPSDT and related programs and; the collection of quality performance measures for both the managed care and fee-for-service populations. Since most of Georgia's Medicaid providers serve both of these populations, this re-alignment allowed staff members to educate each other about the intricacies of their programmatic operations and develop integrated strategies to drive quality initiatives. These changes also allowed DCH to communicate a common message to all providers about the quality of care to be delivered to all Medicaid and PeachCare for Kids ® recipients.

The DCH continues its strong commitment to the process of quality strategic planning and assessment. Each update to the plan will identify upcoming initiatives; acknowledge recent and previously unreported accomplishments; identify opportunities for improvement, and review and revise goals. By doing this, DCH ensures its ongoing focus will be on quality care, optimal service and improved outcomes. This current update provides details about Georgia's efforts to ensure the highest quality of health care delivery to all Medicaid and PeachCare for Kids ® members.

Mission

The Georgia Department of Community Health will provide access to affordable, quality health care to Georgians through effective planning, purchasing and oversight. We are dedicated to a healthy Georgia.

Guiding Principles

Access to affordable, quality health care in our communities
Responsible health planning and use of health care resources
Healthy behaviors and improved health outcomes

DCH Health Policy Priorities for 2012:

- Accessible and Affordable Health Care
- Innovative Technology Solutions
- Fiscal Responsibility and Efficiency

- Program Integrity/Ethics
- Health Promotion and Prevention
- Quality Driven Services
- Teamwork
- Respect for Others

DCH Organizational Changes

The Georgia Department of Community Health (DCH) was created in 1999 to serve as the lead agency for health care planning and purchasing issues in Georgia. DCH is also designated as the single state agency for Medicaid. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. In 2009, the General Assembly passed legislation to transition the Georgia Division of Public Health and the Office of Healthcare Facility Regulation to DCH from the Department of Human Services. The Public Health Emergency Preparedness Section became a separate unit under DCH. In 2011, the General Assembly passed legislation to remove the Division of Public Health and the Emergency Preparedness Section from DCH and establish a new state agency effective July 1, 2011 – the Georgia Department of Public Health. Currently, the Divisions and Offices of DCH include:

- Division of Medicaid
- State Health Benefit Plan
- Healthcare Facility Regulations
- State Office of Rural Health
- Financial Management
- Operations
- Office of Procurement Services
- Information Technology
- Office of General Counsel
- Office of Inspector General
- Office of Communications
- Office of Legislative Affairs and External Affairs
- Office of Health Information Technology (HIT)

Assessment

DCH has assessed the progress achieved under its original Georgia Families Quality Strategic Plan and identified its accomplishments and opportunities for improvement. DCH also re-evaluated its initiatives and established new goals for the future. These accomplishments, opportunities and new goals are listed below:

Major accomplishments since the last update include:

- Implementation of the new Georgia Medicaid Management Information System (GAMMIS). The new system incorporates HEDIS certified software allowing DCH to readily report on a number of the CHIPRA Initial Core Set performance measures.
- Georgia was recognized in Secretary Sebelius' 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP for reporting 18 of the 24 CHIPRA Initial Core Set measures in FFY 10 - more than any other state.
- Organization and sponsorship of the Strategic Quality Council's "Know Your Numbers" campaign to increase awareness of precursors to cardiovascular disease with the hope of reducing cardiovascular deaths
- Submission of an 1115 Demonstration application to CMS in an effort to reduce Georgia's low birth weight rates. The application was approved in October 2010 and the program, Planning for Healthy Babies (P4HB), was implemented in January 2011. The program provides family planning and family planning related services for eligible women along with interpregnancy care services for eligible women who delivered a very low birth weight baby on or after January 1, 2011. Interpregnancy care services include primary care, medications to treat chronic diseases and nurse case management/Resource Mother outreach.
- Received CMS approval for updates to the Health Check (Georgia's EPSDT Program) State Plan Amendment (SPA) that revised the payment rates for screenings and immunizations
- Aligned the EPSDT periodicity schedules for the fee-for-service (FFS) population with those of the Georgia Families managed care population. Both programs now utilize the 2008 Bright Futures Periodicity Schedule as the EPSDT periodicity schedule. Significant policy and MMIS coding changes were necessary to implement this alignment.
- Revised the EPSDT Medical Record Review process to align with the Bright Futures components.
- Received CMS approval for revisions to the Rehabilitative Services components of the EPSDT SPA. One result was the addition of a cost report and cost settlement methodology for the Children's Intervention School Services program which serves the managed care and FFS populations in the school setting.
- Aligned the HEDIS and AHRQ performance measures for the FFS and Managed Care populations.
- Established a Patient Centered Medical Home (PCMH) workgroup with the CMOs' Medical Directors to review and give feedback on the draft 2011 NCQA PCMH recognition standards and develop a plan to encourage Medicaid providers to seek recognition as patient-centered medical homes.

- Coordinated a collaborative performance improvement project (PIP) with the Georgia Families care management organizations and DCH. This PIP will focus on avoidable emergency room utilization and will be implemented in January 2012. Representatives from the Georgia Chapters of the AAP and AAFP and the HITREC along with staff members from the DCH HIE project have been working together with DCH and the CMOs to prepare for the implementation of this PIP which will require participating practitioners to offer same day routine and urgent care appointments, adopt/ implement electronic health records, educate members about the appropriate use of the ER and reduce avoidable ER use for a select group of diagnoses by 5% within the first year of implementation.
- Transitioned the Childhood Obesity and Pediatric Dental Focus Studies to Performance Improvement Projects (PIPs). Results were reported in SFY11.
- Collaborated with our EQRO to modify the scoring methodology for PIP validation. This new methodology will require the Georgia Families managed care plans to go beyond the paper compliance for PIP submissions and actually achieve documented improved outcomes.
- Initiated a "Reducing Cesarean-Section Rates" Focus Study that will be reported in SFY12.

Opportunities for Improvement:

- DCH recognizes that the required quality activities for the Georgia Families program – performance measurement, performance improvement projects and compliance with federal and state standards – must be viewed as components of a whole versus stand alone components. To that end, Georgia is working with the Georgia Families managed care plans to ensure their Quality Improvement activities incorporate all of these areas in order to drive performance improvement. As an example, the Georgia Families' performance improvement projects utilize HEDIS performance measures as the indicators of success for the PIPs. While conducting onsite compliance audits and during annual EQRO conferences, the EQRO vendor encourages the importance of compliance with federal and state standards as a means to achieve success with the performance measure and the PIPs.
- Case and disease management program reporting by the Georgia Families managed care plans did not provide sufficient detail to determine the effectiveness of those programs. DCH pressed the CMOs to collaborate in order to generate a revised standard reporting format for these program areas. DCH reviewed the initial product and requested additional revisions which were submitted in late November 2011.
- Results from the Encounter Data Validation Optional EQRO Activity indicated that while electronic encounter data were generally supported by medical record documentation, not all services documented in the members' medical records were found in the electronic data. Additionally, few medical records contained documentation of all required EPSDT services. Extensive and ongoing education about the documentation requirements for EPSDT components is now in place. Documentation requirements were updated in the EPSDT (Health Check) manual

and the EPSDT Medical Record Review tool has been updated. Instructions for this new tool are currently undergoing additional revisions to improve clarity.

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

New Goals

- In addition to the goals mentioned under the heading, "Goals and Performance Driven Objectives", found on page 12 of this Update, Georgia has undertaken a Medicaid Redesign process with the goal of identifying the most appropriate approach for providing quality health care services to its Medicaid and CHIP populations in the most cost effective manner possible. The target date for implementation of this redesigned process is SFY 2014.

I. Introduction

A. States Decision to Contract with Managed Care Organization

Georgia Families (GF) is a partnership between DCH and three (3) private Managed Care Organizations (MCO) which are full-risk Health Maintenance Organizations (HMOs) licensed by the Georgia Office of Insurance and Safety Fire. Georgia's Managed Care Organizations are referred to as Care Management Organizations (CMO). Amerigroup Community Care, Peach State Health Plan and WellCare of Georgia are the three CMOs that have managed the care of members enrolled in this program since its inception.

Georgia requires mandatory managed care enrollment for PeachCare for Kids ®, Georgia's Children's Health Insurance Program (CHIP), members and specific Medicaid eligible members. The Georgia Families Medicaid eligibility categories include Low Income Medicaid (LIM), transitional Medicaid, pregnant women and children in "Right from the Start Medicaid" (RSM), newborns of Medicaid-covered women, refugees, and women with breast and cervical cancer. Georgia's Planning for Healthy Babies Program participants also receive services via the Georgia Families Care Management Organizations.

The Georgia Families program, currently in its sixth year of implementation, strives to promote appropriate utilization of services and quality of care through activities such as utilization management, provider contracting, case and disease management programs, performance measurement and performance improvement projects. The Georgia Families program has successfully transitioned from a start-up program to a mature program. Staff members tasked with oversight of the program are constantly evaluating the program's processes, policies, procedures, operations, and organization to ensure quality improvement and improved health outcomes are achieved.

Georgia Families will continue, at a minimum and as applicable, to be in compliance with all Federal and state laws and regulations including quality assessment and improvement requirements in Title XIX of the Social Security Act and Title 42 Code of Federal Regulations (CFR) 438. The Plan's goals and objectives create the framework that guide the program to improve the health care outcomes of our members.

In SFY 2012, the Georgia Department of Community Health entered into a contract with Navigant Consulting Inc., a management consulting firm with significant experience in redesigning state Medicaid programs, to perform the following activities:

- Assess the model and structure of Georgia's current Medicaid and PeachCare for Kids® programs;
- Conduct a national environmental scan of Medicaid and Children's Health Insurance Programs (CHIP);

- Collect and evaluate ideas for innovation as well as the financing and delivery of Medicaid and PeachCare for Kids® benefits;
- Assess options for any redesign or modification of Georgia's current program to provide Medicaid and PeachCare for Kids® members access to quality care; and
- Assist in the procurement and implementation of the desired solution.

It is expected that the work of Navigant will address the most appropriate approach for providing quality health care services to Georgia's Medicaid and PeachCare for Kids® populations in the most cost effective manner.

Membership Update

The following chart displays the distribution of the membership among the CMOs as of November 1, 2011:

Region	CMO	Membership
Atlanta	AMERIGROUP	141,724
	Peach State	169,455
	WellCare	235,506
	Atlanta Region Total	**546,685**
Central	Peach State	50,042
	WellCare	83,112
	Central Region Total	**133,154**
North	AMERIGROUP	55,747
	WellCare	100,334
	North Region Total	**156,081**
East	AMERIGROUP	28,093
	WellCare	37,624
	East Region Total	**65,717**
Southeast	AMERIGROUP	33,404
	WellCare	65,777
	Southeast Region Total	**99,181**
Southwest	Peach State	76,749
	WellCare	38,192
	Southwest Region Total	**114,941**
	Georgia Families Total	**1,115,759**

Source: Georgia Families monthly adjustment summary report – November 2011

B. Comment Process

The Medicaid Managed Care Final Rule 42 CFR §438.202(a) requires that state Medicaid programs have a written Quality Assessment and Performance Improvement (QAPI) strategy for their managed care programs. 42 CFR §438.202(d) requires that state Medicaid programs "periodically" review the effectiveness of their managed care quality assessment and performance improvement (QAPI) strategies. Also, 42 CFR §438.202(e)(1) requires that state Medicaid programs submit to the Centers for Medicaid and Medicare Services (CMS) "regular" reports on the effectiveness and implementation of the QAPI strategy.

Three strategic plan assessments have been conducted for the Georgia Families program – the first in June 2007 and submitted to CMS in February 2008; the second in May 2008 and submitted to CMS in March 2009; and the third in January 2010 and submitted to CMS in February 2010. CMS evaluated and approved Georgia's QAPI strategy after finding it to be in compliance with all applicable federal requirements.

Where indicated, changes to the strategy are made and the results of the assessment are reported to CMS. DCH maintains the ultimate authority for oversight of the Quality Strategic Plan and the management and direction of the Georgia Families program. Each approved Quality Strategic Plan update is posted at the website below: http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html,

DCH accepts and addresses comments on the Quality Strategic Plan from stakeholders, advocacy groups, consumer groups, and others that review the document on an ongoing basis. The Quality Strategic Plan is updated as needed and comments are encouraged and may be submitted to managedcarequality@dch.ga.gov. This link has been set up on the website where the updated Quality Strategic Plan is posted. Opportunities for public comments are advertised and reviewed prior to any Plan updates. Responses to comments received may be reflected as updates/changes in subsequent revisions to the Plan. DCH allowed a public comment period prior to this QSP update but did not receive any comments from stakeholders regarding the QSP.

C. Goals and Performance Driven Objectives:

The goals set for the Georgia Families program reflect the State's priorities and areas of concern for the population covered by the CMOs. Quantifiable performance driven objectives have been established to demonstrate success or identify challenges in meeting intended outcomes. Many of the goals have been achieved including:

1. Promotion of an organization wide commitment to quality of care and service
   - 1.1. Design, develop and implement Georgia's new Medicaid Management Information System (MMIS). Status: Georgia's new MMIS went live on November 1, 2010.
   - 1.2. Develop and implement mechanisms to increase collaboration for quality. Status: The April 2011 EQRO Conference set the stage for and encouraged collaboration between the three Georgia Families CMOs and DCH. The three CMOs were also encouraged by the EQRO vendor to collaborate with their sister plans in other states and share best practices with each other. In January 2012, the collaborative PIP, Reducing Avoidable ER Use, will be implemented.
   - 1.3. Utilize care management and care coordination programs and processes to promote member self-care and wellness, prevention of disease complications, and cost-effective service delivery. Status: The three CMOs recently collaborated to develop standardized case and disease management reports that outline the effectiveness of those programs in: educating members about their diseases and self care and; the coordination of care for members with multiple health care issues.

2. Improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance. Items 2.2 through 2.9 are monitored using annual HEDIS performance measures results.
   - 2.1. Increased Children's Preventive Health Screenings. Status: the 2008 Bright Futures Periodicity Schedule became the standard for all Medicaid recipients ages 0 through 20 in November 2010. Preventive Health Screenings are tracked on the CMS 416 report which underwent major revisions in December 2010 and further revision in June 2011. Georgia's screening ratio decreased in FFY 10 as a result of these revisions.
   - 2.2. Increased Access to Preventive/Ambulatory Health Services. Status: Access to Preventive Health Services is a HEDIS performance measure tracked for the managed care and FFS populations.
   - 2.3. Increased Prevention and Screening for Cervical and Breast Cancer
   - 2.4. Improved Access to Oral Health Services
   - 2.5. Improvements in Birth Outcomes
   - 2.6. Improvements in Respiratory Conditions and Asthma Care
   - 2.7. Improvements in Diabetes Care and Outcomes
   - 2.8. Assurance that Individuals with Behavioral Health concerns are properly cared for

2.9. Appropriate Drug utilization

3. Promotion of a system of health care delivery that provides coordinated and improved access to comprehensive healthcare and enhanced provider and client satisfaction.
   3.1. Reducing Low Birth Weight Rates Project. Status: This project was the catalyst for the submission of the 1115 Demonstration application in 2010. The Project's workgroup monitors data generated for this program on a bi-monthly basis.
   3.2. Promotion of the Patient-Centered Medical Home concept. Status: Elements from Standard 1 of the NCQA PCMH Recognition program have been incorporated as activities in the Collaborative Avoidable ER Use PIP scheduled to be implemented on January 1, 2012.
   3.3. Improvements in member and provider satisfaction. Status: Member and Provider Satisfaction PIPs are in place for all three Georgia Families CMOs and results of those PIPs are reviewed on an annual basis.
   3.4. Enhanced Benefits - CMOs provide members with health education and prevention programs as well as expanded access to services and providers thereby giving them the tools needed to live healthier lives. Status: This is an ongoing activity for all three GF's CMOs.

4. Promotion of acceptable standards of healthcare within managed care programs by monitoring internal/external processes for improvement opportunities.
   4.1. Maintaining fiscally sound contracts, policies and procedures that adequately address quality issues and requirements. Status: The CMO restated contract was approved by CMS and issued to the CMOs in July 2010. A revised restatement has been developed in CY 2011 and is awaiting CMS approval.
   4.2. Performance Improvement Projects. Status: The list of PIPs for each CMO to track was expanded in FY 2011 from six (6) to nine (9). This list was reported on and validated in CY 2011 and the results are included in this update.
   4.3. Reviews of CMO Clinical Practice Guidelines. Status: The GFs CMOs submitted their first reports on providers' compliance with the CPGs in the summer of 2011. These reports will continue to be submitted to DCH on an annual basis.
   4.4. EQRO activities. Status: DCH worked with the EQRO vendor to develop a new scoring tool for the PIPs. This tool will be utilized during the CY 2012 PIP validation process. All mandatory EQRO activities continue to occur on an annual basis and the EQRO vendor has been contracted to validate the performance measures generated for the FFS population along with the performance measures generated for the entire Medicaid and PeachCare for Kids® populations. These validated results have been voluntarily reported to CMS using the CARTS tool since December 2010.

II. Assessment

DCH routinely assesses the quality and appropriateness of care and services delivered to enrollees. The level of CMO contract compliance is monitored continually and in accordance with federal regulations, the CMOs are subject to annual independent reviews through the EQR process.

A. Quality and Appropriateness of Care

Race, Ethnicity, and Primary Language

Member data on race, ethnicity and primary language is captured at the time the member enrolls with Medicaid or PeachCare for Kids ®. The member diversity data is then sent electronically to each CMO as part of their monthly eligibility file. The CMOs monitor and report several HEDIS diversity measures and utilize the results to develop specific interventions to address health disparities and barriers to care.

External Quality Review

The Performance, Quality and Outcomes (PQO) unit of the Medicaid Division competitively procured Health Services Advisory Group (HSAG) to work as the State's external quality review organization (EQRO) in compliance with CFR 438.204. In addition to the three mandatory EQR activities listed below, HSAG conducted an encounter data validation audit in SFY 2010 as an optional activity and also assisted DCH in the development and implementation of an auto-assignment algorithm based on quality and cost of care. The three required external quality review (EQR) activities as outlined in the Balanced Budget Act (BBA) are:

1. Validation of CMO performance improvement projects
2. Validation of CMO performance measures
3. A review, conducted within a 3-year period, to determine the CMOs' compliance with standards established by the State to comply with the requirements of 438.204(g).

Clinical Standards/Guidelines

DCH requires the CMOs to institute Clinical Practice Guidelines (CPGs). Along with these required CPGs, the CMOs have adopted additional evidence-based CPGs and disseminated them to their providers via the provider handbooks and web portals. The CMOs' provider relations' staff members visit providers to promote adherence to the CPGs. Each of the three CMOs adopted the same clinical practice guideline for Child and Adolescent Obesity and adopted a standardized Diabetes Care practice guideline.

CPGs must be disseminated to all network providers and, upon request, to members and potential members. In order to ensure consistent application of the guidelines, the CMOs encourage providers to utilize the CPGs and monitor compliance with the guidelines until 90 percent or more of the providers are consistently in compliance. The CMOs may use provider incentive strategies to improve providers' adherence to the CPGs.

Each CMO trends their providers' adherence to the CPGs by conducting medical record reviews (MRR) and tracking their providers' performance measure outcomes. On an annual basis the CMOs submit a report of CPG compliance monitoring results for at least three guidelines. Below are the aggregate compliance results for the three CPGs per CMO for CY2010.

Provider's Compliance with CPGs Monitoring Results for CY2010

	Amerigroup	Peach State	WellCare
% Compliance with Guidelines	79%	85%	86%
% Providers Scoring 80% or Above	77%	86%	79%
Total Number Records Reviewed	450	450	327
Total Number Providers Reviewed	90	90	52

B. Contract Compliance

DCH recognizes that monitoring access is the initial step to ensure members have access to appropriate providers conveniently located, thus reducing access as a barrier to care. Information on participating providers is critical to: assisting enrollees in selecting a health plan that will provide seamless continuity of care at the time of enrollment; improving health care outcomes and; improving quality of care delivered.

Access to Care

The State's contract with the CMOs requires the entities to comply with all applicable federal and state laws, rules, and regulations including but not limited to: all access to care standards in Title 42 CFR Chapter IV, Subchapter C; Title 45 CFR 95, General Grants Administration Requirements. Contract requirements regarding access to care are detailed in this section.

Maintains and Monitors a Network of Appropriate Providers

The CMO contracts require each CMO to establish and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered for the enrolled population in accordance with section 1932(b)(7) of the Social Security Act (as enacted by section 4704(a) of the BBA of 1997).

DCH requires the CMOs to submit provider network adequacy and capacity reports. These reports are reviewed to ensure the CMOs offer an appropriate range of preventive, primary care and specialty services that are adequate for the anticipated number of members for the service area and that its network of providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members in the service area. Geographic access requirements for the CMOs' networks are listed below.

	Urban	Rural
PCPs (primary care providers)	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
*Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles

Timely Access

Through its contract with the CMOs, DCH requires each CMO to monitor their network provider timeliness and take corrective action if there are compliance issues. The CMOs must ensure their network providers:

- offer hours of operation that are no less than the hours of operation offered to commercial enrollees or are comparable to those of Medicaid fee-for-service providers;
- are encouraged to offer After-Hours primary care availability during the evenings and on weekends;
- meet the state's timely access to care and services for appointment wait times, taking into account the urgency of the need for services (see below)

PCPs (routine visits)	Not to exceed 14 calendar days
PCP (adult sick visit)	Not to exceed 24 hours
PCP (pediatric sick visit)	Not to exceed 24 hours
Specialists	Not to exceed 30 Calendar Days
Dental Providers (routine visits)	Not to exceed 21 Calendar Days
Dental Providers (urgent care)	Not to exceed 48 hours
Elective Hospitalizations	30 Calendar Days
Mental health Providers	14 Calendar Days
Urgent Care Providers	Not to exceed 24 hours
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization

Additionally, the CMOs must ensure provider response times for returning calls after-hours are within the contractual standard (see below):

Urgent Calls	Shall not exceed 20 minutes
Other Calls	Shall not exceed one hour

The CMOs must also ensure "in office" wait times are within "do not exceed" state established time frames for enrolled members (see below):

Scheduled Appointments	Wait times shall not exceed 60 minutes. After 30 minutes, the patient must be given an update on the wait time with an option of waiting or rescheduling the appointment.
Work-in or Walk-In Appointments	Wait times shall not exceed 90 minutes. After 45 minutes, the patient must be given an update on the wait time with an option of waiting or rescheduling the appointment

The Georgia Department of Audits and Accounts (DoAA) conducts reviews of the GeoAccess Reports submitted by the CMOs on a quarterly basis. These reports are reviewed for compliance with the access standards outlined in the CMOs' contract. They also conduct secret shopper surveys of providers' offices to determine the accuracy of the providers' panel status as well as their compliance with appointment wait times. Their findings and recommendations for corrective actions are submitted to the Department. The Department reviews the findings and develops recommendations for corrective action to the Plans.

Direct Access to Women's Specialist

In compliance with 42 CFR 438.206(b)(2) and to promote improved health care outcomes for enrollees, the state requires the CMOs to provide female members with direct access to women's health specialists within the network for covered care. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. No referrals are needed for female members to access a women's health specialist within the networks for necessary routine and preventive health covered care including family planning services.

Each CMO is required to submit monthly geographic access reports to ensure their network is adequately staffed with women's health specialists. They must also submit a monthly PCP Assignment Report which identifies all providers (including women's health specialists) that have been selected by members as their PCP. DCH monitors this requirement by reviewing, tracking and trending the reports submitted by the CMOs.

Second Opinion

The State requires each CMO to provide and be responsible for payment of a second medical opinion when there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. Requests for a second medical opinion may be made by a member; a member's appointed representative; or any member of the health care team. The CMOs must have a procedure for enrollees to obtain a second medical opinion from a qualified health care professional within the network or arrange for the enrollee to obtain a second medical opinion outside of the network. Each plan is required to clearly state its procedure for obtaining a second

medical opinion in the member handbook. Additionally, the plan's second opinion procedure is required to be in compliance with section 42 CFR 438.206(3) (b).

DCH monitors compliance with this requirement through review of the CMOs' policies and procedures, as well as monitoring complaints regarding coverage of second opinions.

Out of Network

In compliance with 42 CFR 438.206(b)(4) the State requires that if a CMO is unable to provide a member with medically necessary services covered under the contract, the CMO must adequately and timely cover these services outside of the network for as long as the CMO is unable to provide the services. When in-network providers do not furnish the services the member needs because of moral or religious objections, the CMO must furnish these services outside of the network also. The CMO is required to coordinate with the out-of-network providers regarding payment and must ensure that the cost to the member is no greater than it would be if the covered services were furnished within the network.

In addition, the CMOs are responsible for covering care for new enrollees utilizing an out-of-network provider for chronic conditions or an active/ongoing course of treatment. In this circumstance, CMO coverage must continue for up to 30 days while transitioning the member's care to an in-network provider.

DCH monitors compliance with out-of-network coverage for unavailable medically necessary services through review of the CMOs' policies and procedures, as well as monitoring complaints regarding accessibility of providers.

Credentialing

The State requires that each CMO complies with the requirements specified in 42 CFR 438.214 which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. DCH requires the CMOs to establish and verify credentialing and re-credentialing criteria for all professional providers. At a minimum, the plans' providers must be credentialed as Medicaid providers in the State prior to enrolling as a CMO provider. Each CMO is required to credential network providers in accordance with the standards of the National Committee for Quality Assurance (NCQA), the Joint Commission on Accreditation of Healthcare Organization (JCAHO), or the Utilization Review Accreditation Commission (URAC). The CMOs are required to:

- have a system for verification and examination of the credentials of each of its providers;
- have written policies and procedures for credentialing providers to ensure compliance with all applicable federal and state regulations;
- have written policies/procedures for taking appropriate action whenever, as determined under the quality assurance program,

inappropriate or substandard services have been provided or services which should have been furnished have not been provided;
- have a written plan for conducting reviews of physicians and other licensed medical providers which includes ongoing review within the organization; and
- exercise reasonable care in assuring that delivered health care services are performed by appropriately licensed providers.

DCH conducts reviews of: the CMOs' credentialing meeting minutes; documentation of all adverse disciplinary actions recorded on the providers and; reports with expiration dates for provider licenses, certifications, insurance coverage and other documents. DCH also randomly audits the CMOs' provider listings to ensure the following provider credentials are not expired: Malpractice Insurance, Drug Enforcement Administration Registration, Board Certification Documentation and Delegated Entity lists to include coverage by county, providers' name and specialties.

Coordination and Continuity of Care

Care coordination and continuity of care facilitate the linkage of members with appropriate services and resources in a coordinated effort to achieve good health. DCH recognizes that coordination and continuity of care is important for member safety, to avoid duplication of services and to improve health care outcomes.

Ongoing Source of Primary Care

Pursuant to 42 CFR 428.208(b), the State requires the CMOs to have procedures to ensure each enrollee has an ongoing source of primary care appropriate to his or her needs. The CMOs are required to offer each member a choice of primary care providers (PCPs). The plan must inform members of: their PCP assignment; their ability to choose a different PCP; the list of providers from which to make a choice and; the procedures for making a change.

To improve continuity and coordination of care, the CMOs must attempt to perform an initial screening and assessment for all enrollees within 90 days from the date of enrollment to identify pregnancy, chronic conditions, barriers to obtaining health care (such as transportation) and special or significant health care needs. The CMOs must also have procedures to coordinate services to prevent duplication of services.

Special Needs Population

The Managed Care State Plan Amendment (SPA) identifies certain groups of members as those with "special health care needs". These members are exempt from enrolling in the Georgia Families program and include:

- Medicaid and PeachCare for Kids® members enrolled in the Children's Medical Services Program
- Children receiving services through the Georgia Pediatric Program (GAPP)
- Members residing in hospice or long term care facilities
- Individuals who are institutionalized

- Children eighteen (18) years of age or younger who are in foster care or another out-of-home placement
- Children (18) years of age or younger who are getting foster care or adoption assistance under Title IV-E of the Social Security Administration;
- Individuals enrolled in Medicaid who qualify for Medicare
- Individuals who qualify for Supplemental Security Income (SSI)

Georgia Families works with the Georgia Department of Human Services Division of Family and Children's Services (DFCS) and Maximus, the Georgia Families enrollment broker, to identify mechanisms to assist with early identification of members with significant health care needs. Methods being used include the use of standardized screening tools such as the Child and Adolescent Health Measurement Initiative (CAHMI) tool and surveys.

For Medicaid members enrolled in the Georgia Families program who have special medical needs, the CMOs have implemented mechanisms for identifying, assessing and ensuring the existence of a treatment plan for them. Mechanisms include: outreach activities; evaluation of health risk assessments; and review of historical claims data. The CMOs utilize case and disease management programs to target and improve the health outcomes for these members with special medical needs.

Georgia Families recognizes that health care outcomes for all members including those with special medical needs are improved when PCP utilization increases. A "medical home" decreases fragmented care, increases early identification and treatment of chronic health conditions, and promotes better care coordination. Georgia Families identified that members may not know the importance of PCPs and the positive effects that the use of medical homes has on health status. This barrier is being addressed by increasing member knowledge of the need for and benefit of declaring a medical home. DCH will monitor CMO requirements related to significant health care needs through case and disease management reports.

Special Access

The State requires that each CMO have a process in place that ensures members identified as needing a course of treatment or regular care monitoring have direct access to a specialist appropriate for the member's condition and needs. The CMOs must provide information to members with a condition that requires on-going care from a specialist on how to request a standing referral and how they may request and obtain access to a specialty care center. DCH monitors special access by reviewing CMO policies and procedures to ensure these provisions are in place and by monitoring complaints for evidence of non-compliance.

Coverage and authorization of services

In line with the DCH mission to provide access to affordable, quality health care through effective planning, purchasing and oversight, the CMOs must manage service utilization through utilization review, prior authorization, and case management.

Covered Services
Pursuant to 42 CFR 438.210(a), each CMO may exceed the service limits but may not provide members with services in an amount, duration, and scope that is less than the amount, duration, and scope for the same services furnished to recipients under the Georgia fee-for-service Medicaid program. For enrollees eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, the Plan must cover all medically necessary services to correct or ameliorate a defect or condition found during a screening even if the services are not covered by the Georgia State Medicaid Plan as long as they are Medicaid covered services as defined in Title XIX of the Social Security Act.

Plans are required to offer expanded services to members and to specify which expanded services are covered by the Plan. The State defines expanded services as those offered by the plan and approved by the State that are services more than or not contractually required to be covered by the CMO.

Medical Necessity
Pursuant to 42 CFR section 438.210(a)(4), DCH defines medically necessary services as those services based upon generally accepted medical practices in light of conditions at the time of treatment, and:

- appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition;
- compatible with the standards of acceptable medical practice in the community;
- provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- not provided solely for the convenience of the member or the convenience of the health care provider or facility
- not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage; and
- no other effective and more conservative or substantially less costly treatment, service and/or setting is available.

Services must be sufficient in amount, duration, and scope to reasonably achieve this purpose in accordance with 42 CFR §440.230

Authorization
The state requires that each Plan require prior authorization and/or pre-certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries. The CMOs are permitted to require prior authorization and/or pre-certification for all non-emergent and/or out-of-network services. Plans may not require prior authorization or pre-certification for emergency services, post

stabilization services, urgent care services, EPSDT screening services or family planning services.

DCH monitors CMO compliance with the contractually required authorization timeframes outlined below:

- Standard Service Authorizations (routine): within 14 calendar days from receipt of request
- Expedited Service Authorizations (urgent): within 24 hours from receipt of request
- Retro Authorizations (post service): within 30 calendar days from receipt of request

The CMOs may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the member's diagnosis, type of illness, or condition. In the event of denial of the requested amount, duration, or scope of services, the CMOs must notify the requesting provider and give the enrollee and provider written notice of the decision. All decisions to deny service authorization requests or to authorize a service in the amount, duration, or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease.

DCH ensures compliance with this requirement through CMO record reviews of prior authorization requests and reviews of complaints/appeals.

Structure and Operation

The contract with the CMOs complies with federal and state requirements related to structure and operation. DCH continuously monitors the CMOs to ensure CMO contractual compliance.

Provider Selection

The CMOs cannot require a physician to participate or accept any plan product unrelated to providing care to members as a condition of contracting with that CMO. The CMOs maintain a formal provider relations function to timely and adequately respond to inquiries, questions and concerns from network providers in addition to a mechanism for provider dispute resolution and execution of a formal system of terminating providers from the network. The CMOs are not allowed to enter into any exclusive contract agreements with providers that exclude other health care providers from contract agreements for network participation. Health care providers cannot, as a condition of contracting with a CMO, require the CMO to contract with or not contract with another health care provider. The CMOs cannot, as a condition of their contract with a provider, require the provider to also participate in any other non-Georgia Medicaid plan. The CMOs cannot discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

DCH monitors this through periodic audits of operational processes and review of provider contracts. DCH monitors the CMOs for compliance through reviews of the CMOs' provider selection policies and provider complaint reports. DCH staff members work closely with the CMOs on all received provider complaints to ensure adequate and timely responses and to track and trend for CMO provider service areas of improvement.

Member Information

The State requires the CMOs to be responsible for educating members on their rights and responsibilities at the time of their enrollment into the plan and annually. Educational activities and member information may be conveyed via mail, by telephone, and/or through face-to-face meetings. The CMOs are responsible for providing members with handbooks and identification cards within 10 calendar days of receiving the member enrollment file from DCH. The CMOs must also have written policies and procedures regarding the rights of members that comply with applicable federal and state laws and regulations.

The Plans' member handbooks are in compliance with requirements set forth in 42 CFR 438.10 and include information on:

- member rights and responsibilities
- the role of PCPs
- how to obtain care
- what to do in an emergency or urgent medical situation
- how to file a Grievance
- how to request an Appeal or Administrative Law Hearing
- how to report suspected Fraud and Abuse.

All written materials must be available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The CMOs notify all members and potential members that information is available in alternative formats and how to access those formats. The CMOs make all written information available in English, Spanish and all other prevalent non-English languages as defined by DCH.

DCH monitors the CMOs' compliance with member information requirements through its review of the CMOs': policies and procedures pertaining to enrollment; member handbooks and outreach materials; call-scripts; and other member related materials.

Enrollment and Disenrollment

DCH ensures the CMOs comply with the enrollment and disenrollment requirements and limitations set forth in 42 CFR 438.56 including: disenrollments requested by the CMOs; disenrollments requested by enrollees; and procedures for disenrollment determinations. Enrollment into Georgia Families (GF) is mandatory for members with the following eligibility categories: Low Income Medicaid

(LIM); Transitional Medicaid; Right from the Start Medicaid (RSM) for children, pregnant women, and children born to mothers with RSM; eligible women with breast or cervical cancer; refugees; and PeachCare for Kids®.

CMO Disenrollment Requests

The CMO may request member disenrollment for several reasons identified in the contract such as:

- The Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness;
- The Member's utilization of services is fraudulent or abusive;
- The Member has moved out of the service region;
- The Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for the mentally retarded;
- The Member's Medicaid eligibility category changes to a category ineligible for Georgia Families, and/or the Member otherwise; becomes ineligible to participate in Georgia Families;
- The Member has any other condition as so defined by DCH or;
- The Member has died, been incarcerated, or moved out of State, thereby making them ineligible for Georgia Medicaid.

Member Requests for CMO Disenrollment

A Member may request disenrollment from a CMO plan without cause during the ninety (90) calendar days following the date of the Member's initial enrollment with the CMO plan or the date DCH sends the Member notice of the enrollment, whichever is later. Members may request disenrollment without cause every twelve (12) months thereafter.

DCH makes final determinations on all disenrollment requests and notifies the CMO via file transfer and the member via surface mail within five (5) calendar days of making the decision.

Subcontractor Delegation

All subcontracting arrangements entered into by the CMOs must comply with 42 CFR 434.6(b) and (c). Through the contract with the CMOs, DCH requires that all subcontractors that provide care to Georgia Families members must have written contracts reviewed by DCH prior to implementation. DCH mandates that each CMO: ensures subcontracts fulfill the requirements of the contract and applicable federal and state laws and regulations; specifies the activities and reporting responsibilities delegated to the subcontractor and; has provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

DCH holds the CMOs accountable for all actions of the subcontractor and its providers. The CMOs must: perform annual and on-going monitoring of all subcontractors; notify the subcontractors of identified deficiencies or areas for

improvement and; require the subcontractors to take appropriate corrective action when applicable.

DCH requires signed attestation statements from each CMO attesting that the activities of each of their approved subcontractors are being monitored. The State requests and reviews a list of subcontractors quarterly to include dates the contracts were executed and CMO subcontractor audit reports. The CMOs must provide an immediate notice to DCH of any changes to any existing subcontractor agreements and sub-contractual issues that jeopardize access to or quality of member care.

Confidentiality
Each member's privacy is protected in accordance with the privacy requirements in 45 CFR Part 160 and 164 Subparts A and E, to the extent that they are applicable. The CMOs must maintain written policies and procedures for compliance with all applicable federal, state, and contractual privacy, confidentiality and information security requirements.

Internal Grievance System
Each CMO is required to maintain a member grievance system that includes a grievance process, an appeal process and an administrative hearing process. A grievance is defined as an expression of dissatisfaction about any matter other than an action such as the quality of services provided and rudeness of a Provider. DCH defines an "action" as the denial or limited authorization of a requested service, including the type or level of service, and an appeal is a request for review of an action. This definition of an "action" is in compliance with 42 CFR 438.400(b).

The CMOs are required to inform members of their rights and general grievance system procedures through adverse determination letters and member handbooks. The grievance process allows the enrollee, or the enrollee's authorized representative to file a grievance or an appeal.

The CMOs must notify the enrollee that he or she has 30 calendar days from the date of an adverse decision to appeal the decision by requesting a fair hearing. The CMOs must provide reasonable assistance in completing the forms for appeals and taking other procedural steps including providing toll-free numbers that have adequate TTY/TTD and interpreter capability. Members must also be informed of their right to continuation of benefits if requested and the appeal is filed timely. Members must be provided with clearly written information explaining that if the final resolution of the appeal is adverse to the member, they may be responsible for the cost of the services furnished and if the final resolution overturns the Plan's decision, the Plan must authorize, provide and pay for disputed services promptly.

The CMOs are required to acknowledge receipt of each filed grievance and appeal in writing within 10 business days of receipt and make determinations on grievances within 90 calendar days. Final decisions on appeals must be done within

45 calendar days or as expeditiously as the enrollee's health condition requires. The response must include the decision reached, the reason(s) for the decision, the policies or procedures that provide the basis for the decision, and a clear explanation of any further rights available to the enrollee. Additionally, the plan must ensure that the decision-makers for appeals are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.

The Administrative Law Hearing process provides members an opportunity for a hearing before an impartial Administrative Law Judge on all appeals upheld by the CMO. The State maintains an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (O.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 200. A member or authorized representative may request a State Administrative Law Hearing in writing within 30 calendar days of the date the Notice of Adverse Action is mailed by the Plan. The CMOs must adhere to decisions as a result of the Administrative Law Hearing process.

In compliance with federal statues, DCH requires that each CMO log and track all grievances, appeals and Administrative Law Hearing requests and maintain records of whether information was received verbally or in writing. Appeals must include a short, dated summary of the problems, the name of the aggrieved, the date of the appeal, the date of the decision and the disposition.

DCH requires each organization to process each grievance and appeal using applicable state and federal statutory, regulatory, and contractual provisions, and internal written policies and procedures. DCH monitors compliance through: review of quarterly reports submitted by each CMO; on site record reviews of CMOs and subcontractors; approval of policies and procedures; and approvals of member and provider handbooks.

Quality Measurement and Improvement

The CMO contracts require each CMO to maintain accreditation with their accrediting body. Each of the Georgia Families CMOs is accredited by the National Committee for Quality Assurance (NCQA) and in 2011, each plan achieved commendable status following their accreditation review. All three CMOs submit Healthcare Effectiveness Data and Information Set (HEDIS) performance measures as a required component of the NCQA accreditation process.

Georgia Families CMOs report HEDIS, Agency for Healthcare Research and Quality (AHRQ) and CHIPRA Initial Core Set performance measures to DCH on an annual basis. This reporting allows DCH to document the CMOs' progress toward improved health outcomes. Reported measures include both administrative and hybrid rates that DCH trends over time. Performance measure targets have been established for the CMOs based on HEDIS performance measure audit means and percentiles. These targets are updated

annually in line with the updates to the HEDIS audit means and percentiles. Liquidated damages may be levied should a CMO fail to achieve the established performance targets.

In September 2011, Georgia was recognized by HHS Secretary Kathleen Sebelius in her 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP as being the state reporting the largest number of CHIPRA Initial Core Set measures for FFY 2010. Georgia reported 18 of the 24 the CHIPRA Initial Core Set measures. The report highlighted Georgia's proactive role in designing its data systems to support quality measurement at the State level.

C. Use of Available and Evolving Health Information Technology

DCH ensures that contracting CMOs maintain health information systems that collect, analyze, integrate and report data, and achieve the objectives of the Georgia Families program. The DCH Office of Health Information Technology (HIT) oversees the Electronic Health Record (EHR) Medicaid Incentive Program (MIP) and the Statewide Health Information Exchange (HIE).

The MIP offers incentive payments to eligible Medicaid providers to adopt EHRs and meet 'meaningful use' criteria which includes significant quality measurements. The adoption of EHRs is expected to improve the overall efficiency and quality of health care. CMO Medicaid providers who meet eligibility requirements are encouraged to participate in the program.

The statewide HIE will provide a solution for the secure exchange of health information between providers, hospitals, labs and other health care entities. The ability to exchange patient health information will provide the platform for improved and more efficient health care. Medicaid providers participating in the EHR MIP will be able to use the HIE to send and receive critical health information such as lab results, continuity of care documents, and prescriptions which are criteria that must be met under 'meaningful use'. CMO Medicaid providers will be able to access the HIE to help meet these criteria.

III. Improvement

Quality Improvement is a formal approach to the analysis of performance and systematic efforts to improve it. Based on the results of the assessment activities, Georgia Families will strive to improve the quality of care delivered.

A. Improvement through Interventions and Sanctions

DCH, in collaboration with the CMOs, has implemented several interventions to improve the quality of care delivered to Georgia Families members. Interventions that are in place include:

- Quality Assessment and Performance Improvement Programs;
- Cross-State Agency Collaboratives/Initiatives;
- Family Planning 1115 Demonstration

- Performance Improvement Projects;
- Focus Studies;
- Information System or Electronic Health Record Initiatives;
- Implementation of optional EQRO Activities and;
- Assurance of complete and accurate encounter data

Quality Assessment and Performance Improvement Programs (QAPI)

DCH requires each CMO to have a QAPI program that meets contractual standards at least as stringent as those requirements specified in 42 CFR 438.236-438.242. The CMOs' ongoing program objectively and systematically monitors and evaluates the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its population.

Each QAPI program is based on the latest available research in the area of quality assurance and includes a method of monitoring, analysis, evaluation and improvement of the delivery, quality and appropriateness of health care furnished to all members (including under and over utilization of services). The state requires the plans to submit annual evaluations of and updates to their QAPI program.

Cross-State Agency Collaboratives/Initiative

Within the DCH Division of Medicaid, the Performance, Quality and Outcomes (PQO) Unit has responsibility for oversight of quality initiatives, health care utilization and medical management in the managed care program. This unit interacts internally with the DCH Medical Policy, Provider Services, Member Services and Contract Services Units to assure they meet and exceed the DCH goal of quality health care. As barriers are identified, effective solutions are sought and implemented with involvement of internal and external stakeholders.

DCH personnel and the CMOs' leadership teams have taken a lead role in reaching out to Georgia's child health providers on an individual basis and through the Georgia Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. Partnerships have also been forged with the Department of Public Health on issues related to lead exposure, childhood obesity, asthma, and low birth weight rates; with the Georgia Division of Family and Children Services to discuss issues related to eligibility and children in state custody; with the Department of Behavioral Health and Developmental Disabilities to discuss issues related to mental health services; and with the Georgia Department of Education on issues related to health care services provided in the school setting. In each of these collaborations, the aim is to improve the quality of children's health care with documented improvements in performance metrics.

In June 2009, DCH spearheaded the Strategic Quality Council. With representation from DCH business units including HITT, the Office of Health Improvement, Public Health and the State Health Benefit Plan and in partnership with the CMOs, the Council decided its strategic direction was to prevent cardiovascular deaths and

reduce Georgia's cardiovascular death rate. In 2008 the United Healthcare Foundation (UHF) ranked Georgia's cardiovascular death rate as 40th in the nation. The group identified six factors that contribute to cardiovascular deaths in Georgia: cardiovascular disease, hypertension, diabetes, hypercholesterolemia, obesity and smoking. Hypertension was found to have the highest prevalence based on the business units' claims data. To improve Georgia's UHF ranking, group members decided to support and implement initiatives to prevent, detect and appropriately manage hypertension.

The Council organized a statewide initiative in May 2010 to encourage Georgians to get their blood pressure checked and learn about the dangers of untreated hypertension. The "Know Your Numbers Campaign" was a month-long, public awareness campaign that sought to encourage behavioral changes in plan participants so that less cardiovascular disease related deaths – the leading cause of deaths in the state – would occur. Throughout the month of May 2010, plan participants were able to participate in the following activities:

- Statewide health fairs
- Worksite health screenings
- Statewide Lunch and Learns
- Cooking demonstrations

Approximately 500 individuals participated in the above mentioned events and this initiative paved the way for council participants to implement innovative approaches to drive health improvement for their plan's participants. With other priorities impacting the leadership of the Strategic Quality Council, namely the MMIS conversion and the Planning for Healthy Babies program, the Strategic Quality Council was disbanded in the fall of 2010.

Family Planning Waiver

In July 2009, the Improving Birth Outcomes Work Group was formed with the goal of reducing Georgia's low birth weight rate from 9.5% to 8.6% by 2015. The Work Group is still in existence and representatives have included participants from: the Georgia Medicaid program staff; the Georgia OB GYN Society; leadership from the three Medicaid CMOs; the Georgia State Health Benefit Plan program staff and insurers; Commercial Insurers; Private Practitioners; the Georgia Family Connections Partnership; the Hispanic Health Coalition; the Georgia State Health Policy Center; the United Way of Metro Atlanta, the Georgia Office of Health Improvement; and the Voices for Georgia's Children. The Work Group identified objectives and strategies to achieve its goal. Achieving these objectives aligns with DCH's mission and is critical to Georgia's success in reaching this goal. Objective 2 for the Work Group was to increase the number of intended and appropriately timed births to plan members. From this objective, the Work Group developed the application for an 1115 Demonstration project in February 2010. CMS approved the

project in October 2010 and in January 2011, the Planning for Healthy Babies (P4HB) Medicaid Demonstration was implemented statewide. The program enrolls women of child bearing age (18-44), who would otherwise not be eligible for Medicaid services, to increase the use of family planning services and promote the consistent use of effective contraceptive methods. P4HB's goals include:

- Reducing Georgia's low birth weight and very low birth rate rates
- Reducing the number of unintended pregnancies in Georgia
- Reducing Georgia's Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would not be eligible for Medicaid pregnancy-related services

As of November 1, 2011, 6,433 eligible women were enrolled in the program statewide.

Performance Improvement Projects (PIPs)

DCH requires the CMOs to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services. These PIPs are expected to have a favorable effect on health outcomes and member satisfaction.

Following DCH's review of the effectiveness of the PIPS in SFY 2010, DCH increased the number of required Georgia Families PIPs from six (6) to nine (9) by transitioning two Focus Studies to PIPs and transitioning the ER Utilization PIP to a formal PIP requiring EQR validation. These changes were implemented through an amendment to the CMOs' contracts which became effective July 2010. The three (3) new PIPs were implemented in January 2010. Because the study indicators for these new PIPs were HEDIS performance measures already monitored by the CMOs, the CMOs were able to provide remeasurement results in their PIP reports submitted to DCH in July and August 2011. The nine (9) PIPs include:

- Well-child visits during the first fifteen (15) months of life;
- Blood lead screening;
- Childhood immunization rates;
- Access to care for members aged 20 – 44;
- Emergency room utilization;
- Child and adolescent obesity;
- Pediatric dental care;
- Member satisfaction and;
- Provider satisfaction

All nine of the PIPs were validated by the EQRO vendor during SFY 2012 and the results of that validation process are included in the Appendix to this QSP update.

The well-child visits during the first 15 months of life PIP was identified as an area for collaborative improvement by all three CMOs. DCH enlisted the assistance of its EQRO to coordinate this collaborative performance improvement project focused on improving the number of eligible members who kept their appointments

with their primary care provider for six or more well child visits during the first fifteen months of life. The HEDIS Well Child Visits 15 months metric was the study indicator to track the effectiveness of the interventions for this PIP. The study indicator results from the three CMOs for this PIP are included in the Appendix to this QSP update. All three plans will continue their efforts to increase well child visits for this segment of their patient population.

In February 2011, a Patient Centered Medical Home (PCMH) workgroup was established inclusive of the CMOs' Medical Directors and the DCH Deputy Director for Performance, Quality and Outcomes. The purpose of the workgroup was to review and give feedback on the draft 2011 NCQA PCMH recognition standards and develop a plan to encourage Medicaid providers to seek recognition as patient-centered medical homes. As an outgrowth of this effort, a collaborative performance improvement project was initiated with the Georgia Families Care Management Organizations and DCH as the core participants in this PIP. The PIP will focus on avoidable emergency room utilization and will be implemented in January 2012. Representatives from the Georgia Chapters of the AAP and AAFP and the Health Information Technology Regional Extension Center (HITREC) along with staff members from the DCH Health Information Exchange (HIE) project have been working together with DCH and the CMOs to prepare for the implementation of this PIP. Participating practitioners will adopt/ implement electronic health records, offer same day routine and urgent care appointments, provide education to members frequenting the ER regarding the appropriate use of the emergency room and reduce avoidable ER use for a select group of diagnoses by 5% within the first year of implementation. The effectiveness of this PIP will be reported on in June 2013.

Annual PIP Validation Reports are published at the below link
http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.htm

Focus Studies

The only current Focus Study for the Georgia Families CMOs is the "Reducing the Cesarean Section Rate" study. The CMOs will report results of this Focus Study to DCH in June 2012. DCH will continue to work with the CMOs to identify and implement other focus studies as needed based on data and stakeholder input.

Information System Initiatives

In November 2010, DCH transitioned to a new Medicaid Management Information System (MMIS). In preparation for this transition, DCH staff members were engaged with the new MMIS vendor to ensure that quality metric reporting would be easily obtainable from the new system. This new system has the capacity to generate reports for both the managed care and fee for service populations based on HEDIS, AHRQ, Children's Health Insurance Program Reauthorization Act (CHIPRA) and DCH defined performance measures.

The new MMIS vendor acquired NCQA certified software to support the production of performance measure reports that meet HEDIS specifications. The MMIS vendor also contracted with a Medical Record Review Organization to assist with reporting hybrid measures. Additionally, DCH modified the contract with its EQRO vendor to allow its EQRO to validate the MMIS generated HEDIS performance measures. These validated measures will allow comparisons between the MMIS generated performance metric reports for the Georgia Families and FFS programs, the individual CMOs' performance metric reports and the NCQA audit percentiles for Medicaid Managed Care programs nationwide reporting to NCQA. This MMIS initiative supports improvements in access to and quality of care as improvements can only be driven by accurate, validated, useful and reliable data. More importantly, for quality to improve across the health care continuum, data must be monitored at all levels.

Implementation of Optional EQRO Activities

HSAG conducted an Encounter Data Validation (EDV) project, an Optional EQR Activity, during FY 2009 - FY 2010. This project focused on encounter file completeness, age and gender appropriateness of encounters, timelines of encounter data processing, utilization review, data completeness, data accuracy and EPSDT component completion. Findings from the project suggested that the overall quality of the encounter data submitted by the Georgia Families CMOs was relatively complete and accurate. Results from the medical record review component of the project indicated that while electronic encounter data were generally supported by medical record documentation, not all services documented in the members' medical records were found in the electronic data. Additionally, few medical records contained documentation of all required EPSDT services. The Georgia Families CMOs were made aware of the findings and continue to educate their provider networks about medical record documentation of required EPSDT services rendered and about appropriate claiming for services rendered. The final Encounter Data Validation Study Final Report is available online at: http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html

DCH also contracted with its EQRO to develop a quality based auto-assignment algorithm for members who were otherwise not assigned to a CMO within thirty (30) days of enrollment. The algorithm was developed with 70% of the weight assigned to quality measures and 30% of the weight assigned to cost. The quality component utilizes the HEDIS quality measures validated by the EQRO. The algorithm was incorporated into the Managed Care State Plan Amendment (SPA) and implemented in April 2010. There are two auto-assignment cycles per year and DCH's contracted EQRO calculates auto-assignment scores for both cycles on an annual basis.

Complete and Accurate Encounter Data

DCH contracts with the certified public accounting firm of Myers & Stauffer, LLC (M & S) to conduct monthly reconciliations of encounter data in the MMIS to the

CMOs' cash disbursement journals (amounts paid by the CMOs) to determine the percentage of encounters submitted by the CMOs to DCH. To hold the CMOs accountable for the timely and complete submission of encounter data, DCH established thresholds that the CMOs must meet. The CMOs are required to submit 99% of encounter data based on the reconciliation to CMO cash disbursements. M & S conducts monthly encounter reconciliations to determine if the submission target is met and any CMO failing to meet the target is subject to sanctions and liquidated damages. DCH changed fiscal agents in November of 2010 and the new fiscal agent is still making modifications to meet DCH requirements for accepting CMO encounter submissions. Until these modifications are completed, DCH has temporarily relaxed the 99% submission requirement. As shown in the chart below for the period defined, all 3 CMOs had a submission rate that exceeded 96%.

Reconciliation Time Period - November 2008 to February 2011

CMO	Submission Rate for Reconciliation Period
Amerigroup	98.13%
Peach State	96.47%
WellCare	98.89%
Combined (all CMOs)	**98.03%**

In addition to ensuring the volume of encounter data submitted by the CMOs meets DCH's standards, DCH understands that accurate and complete encounter data is critical to the success of any managed care program. DCH relies on the quality of encounter data submissions from the CMOs in order to monitor and improve the quality of care; establish performance measures and generate accurate and reliable reports; and obtain utilization and cost information. The completeness and accuracy of these data are essential for the overall management and oversight of Georgia's Medicaid program.

Sanctions

In accordance with 42 CFR 438.706, DCH may use sanctions for CMO non-compliance with state and/or federal statutory guidelines and Georgia Families contractual provisions. With the addendum to the CMOs' contracts, liquidated damages may also be levied if a CMO fails to achieve established performance targets.

DCH maintains sanctions policies that detail the requirements cited in 42 CFR 438, Subpart I for the CMOs. The policies cite the types of sanctions and subsequent monetary penalties or other types of sanctions, should a CMO not adhere to the provisions of the contractual requirements and/or state and federal regulations. Sanctions may include:

- granting members the right to terminate enrollment with the CMO without cause and notifying the affected members of their right to disenroll

- suspension of all new enrollment
- suspension of payment to the CMO
- termination of the contract and/or civil monetary fines in accordance with 42 CFR 438.704
- The State may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that there is continued egregious behavior by the plan, including but not limited to behavior that is described in 42 CFR 438.700 or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act. Additionally, the State may impose intermediate sanctions in accordance with 42 CFR 438.702.

Before imposing any intermediate sanctions, the State must give the plan timely notice according to 42 CFR 438.710. Unless the duration of a sanction is specified, a sanction remains in effect until the State is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

B. Assessing Progress

The assessment of Georgia's progress towards meeting the objectives outlined in this update is necessary for the continuous, prospective and retrospective monitoring of quality of care and improved outcomes. DCH continuously assesses whether or not the objectives have been met utilizing several methods:

- Identifying, collecting and assessing relevant data.
- Review and analysis of periodic reports: reports and deliverables are used to monitor and evaluate compliance and performance. DCH reviews these reports and provides feedback as appropriate.
- Review and analysis of program-specific Performance Measures. The CMOs submit performance measurement reports which measure each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services. Under their amended contracts, the CMOs are required to improve their performance rates to achieve specific performance targets.

In addition, Georgia Families will work to improve the quality of care provided by the CMOs by reviewing each CMO's QAPI evaluation, CAHPS and EQR Annual Report findings over time.

As required, the process intended to embark on quality improvement was addressed in the initial Quality Strategy approved by CMS in March 2008 and is available at the below link: http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html

IV. Review

As with this submission, new projects and/or strategies evolve with data collection, assessment of data, implementation of interventions and evaluation of the effectiveness of the Georgia Families Quality Strategy.

A. Frequency of Assessment

Assessment and review of the components of the Quality Strategy are ongoing processes. DCH is responsible for reporting Quality Strategic activities, findings, and actions to members, providers, stakeholders, the DCH Board and CMS.

B. Frequency of Updates

The Quality Strategy will also be revised when a significant change occurs. DCH defines a significant change as any change to the Quality Strategic Plan that may affect the delivery or measurement of the quality of health care. CMS approval on all revisions/updates will be attained by the State prior to posting on the DCH website.

C. Interim Updates

As the Quality Strategy evolves, DCH will document challenges and successes that result in changes to the Strategy, including interim performance results, as available, for each strategy objective. After internal review and approval, results of interim performance measures will be available on the DCH website below:
http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html

V. Achievements and Opportunities

This section describes various quality improvement achievements and opportunities identified by DCH.

Achievements

The Georgia Families program has achieved many successes since implementation in 2006. Most notably are activities related to community education, public informing and transparency, systems testing, meetings with stakeholders (i.e. Quality Colloquiums), identifying practice standards, performance measures and developing policies to clarify contract requirements.

Implementation of the new MMIS system was a huge undertaking but a large success in Georgia. This new system will make the generation of HEDIS, CHIPRA and DCH defined performance measurement reports easier and will reduce DCH's reliance on outside vendors to generate reports. Thus the stage is set for greater

transparency with the capability to produce and publicly share reports on quality improvement and performance measurement.

DCH staff members regularly meet with external stakeholders from the Georgia Chapters of the American Academies of Pediatrics and Family Physicians to discuss issues related to the EPSDT (Health Check) program. DCH updated its EPSDT – Health Check Manual in November 2010 to align the periodicity schedule for the fee-for-service program with that of the managed care program.

The list of accomplishments, as identified earlier in this report, is repeated below:

1. Implementation of the new Georgia Medicaid Management Information System (GAMMIS). The new system incorporates HEDIS certified software allowing DCH to readily report on a number of the CHIPRA Initial Core Set performance measures.
2. Georgia was recognized in Secretary Sebelius' 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP for reporting 18 of the 24 CHIPRA Initial Core Set measures in FFY 10 - more than any other state.
3. Organization and sponsorship of the Strategic Quality Council's "Know Your Numbers" campaign to increase awareness of precursors to cardiovascular disease with the hope of reducing cardiovascular deaths
4. Submission of an 1115 Demonstration application to CMS in an effort to reduce Georgia's low birth weight rates. The application was approved in October 2010 and the program, Planning for Healthy Babies (P4HB), was implemented in January 2011. The program provides family planning and family planning related services for eligible women along with interpregnancy care services for eligible women who delivered a very low birth weight baby on or after January 1, 2011. Interpregnancy care services include primary care, medications to treat chronic diseases and nurse case management/Resource Mother outreach.
5. Received CMS approval for updates to the Health Check (Georgia's EPSDT Program) State Plan Amendment (SPA) that revised the payment rates for screenings and immunizations
6. Aligned the EPSDT periodicity schedule for the fee-for-service (FFS) population with that for the Georgia Families managed care population. Both programs now utilize the 2008 Bright Futures Periodicity Schedule as the EPSDT periodicity schedule. Significant policy and MMIS coding changes were necessary to implement this alignment.
7. Revised the EPSDT Medical Record Review process to align with the Bright Futures components.
8. Received CMS approval for revisions to the Rehabilitative Services components of the EPSDT SPA. One result was the addition of a cost report and cost settlement methodology for the Children's Intervention School Services program which serves the managed care and FFS populations in the school setting.

9. Aligned the HEDIS and AHRQ performance measures for the FFS and Managed Care populations.
10. Established a Patient Centered Medical Home (PCMH) workgroup with the CMOs' Medical Directors to review and give feedback on the draft 2011 NCQA PCMH recognition standards and develop a plan to encourage Medicaid providers to seek recognition as patient-centered medical homes.
11. Coordinated a collaborative performance improvement project (PIP) with the Georgia Families care management organizations and DCH. This PIP will focus on avoidable emergency room utilization and will be implemented in January 2012. Representatives from the Georgia Chapters of the AAP and AAFP and the HITREC along with staff members from the DCH HIE project have been working together with DCH and the CMOs to prepare for the implementation of this PIP which will require participating practitioners to offer same day routine and urgent care appointments, adopt/ implement electronic health records, educate members about the appropriate use of the ER and reduce avoidable ER use for a select group of diagnoses by 5% within the first year of implementation.
12. Transitioned the Childhood Obesity and Pediatric Dental Focus Studies to Performance Improvement Projects (PIPs). Results were reported in SFY11.
13. Collaborated with our EQRO to modify the scoring methodology for PIP validation. This new methodology will require the Georgia Families managed care plans to go beyond the paper compliance for PIP submissions and actually achieve documented improved outcomes.
14. Initiated a Reducing Cesarean-Section Rates Focus Study that the CMOs will report on during SFY12.

Opportunities for Improvement:

- DCH recognizes that the required quality activities for the Georgia Families program – performance measurement, performance improvement projects and compliance with federal and state standards – must be viewed as components of a whole versus stand alone components. To that end, Georgia is working with the Georgia Families managed care plans to ensure their Quality Improvement activities incorporate all of these areas in order to drive performance improvement. As an example, the Georgia Families' performance improvement projects utilize HEDIS performance measures as the indicators of success for the PIPs. While conducting onsite compliance audits and during annual EQRO conferences, the EQRO vendor encourages the importance of compliance with federal and state standards as a means to achieve success with the performance measures and the PIPs.
- Case and disease management program reporting by the Georgia Families managed care plans did not provide sufficient detail to determine the effectiveness of those programs. DCH pressed the CMOs to collaborate in order to generate a revised standard reporting format for these program areas. DCH reviewed the initial

product and requested additional revisions which were submitted in late November 2011.

- Results from the Encounter Data Validation Optional EQRO Activity indicated that while electronic encounter data were generally supported by medical record documentation, not all services documented in the members' medical records were found in the electronic data. Additionally, few medical records contained documentation of all required EPSDT services. Extensive and ongoing education about the documentation requirements for EPSDT components is now in place. Documentation requirements were updated in the EPSDT (Health Check) manual and the EPSDT Medical Record Review tool has been updated. Instructions for this new tool are currently undergoing additional revisions to improve clarity.
- FFS providers are not organized under an umbrella to which DCH can direct improvement guidance. DCH continues to search for a methodology to impact improvements in FFS performance measure results.

VI. APPENDICES

Appendix A: Individual CMO PIP Performance

Reported June 30 – August 1, 2011

CMO	PIP	Validation Status
Amerigroup Community Care	Well Child Visit 15 Months	MET
	Childhood Immunization Rates	MET
	Blood Lead Screening	MET
	Access to Care for Members 20-44yrs	MET
	Member Satisfaction	MET
	Provider Satisfaction	MET
	Emergency Room Utilization	MET
	Annual Dental Visits	PARTIALLY MET
	Childhood Obesity	MET
Peach State Health Plan	Well Child Visit 15 Months	MET
	Childhood Immunization Rates	MET
	Blood Lead Screening	MET
	Access to Care for Members 20-44yrs	MET
	Member Satisfaction	MET
	Provider Satisfaction	MET
	Emergency Room Utilization	MET
	Annual Dental Visits	MET
	Childhood Obesity	MET
WellCare Georgia	Well Child Visit 15 Months	MET
	Childhood Immunization Rates	MET
	Blood Lead Screening	MET

	Access to Care for Members 20-44yrs	MET
	Member Satisfaction	MET
	Provider Satisfaction	MET
	Emergency Room Utilization	MET
	Annual Dental Visits	PARTIALLY MET
	Childhood Obesity	PARTIALLY MET

Appendix B: Individual CMO Performance Measures

Reported June 30, 2011

Performance Measure[1] Report for Georgia Medicaid[2] and PeachCare for Kids[3]

	Amerigroup			Peach State Health Plan			WellCare		
	2008[4]	2009	2010	2008[4]	2009	2010	2008[4]	2009	2010
Performance Measure[5]									
15 month olds who have had 6 or more complete check ups since birth (H)	62.25%	55.04%	60.05%	51.58%	52.31%	53.94%	57.42%	57.42%	59.12%
Three, Four, Five and Six year olds who had at least 1 complete check up in a year (H)		64.05%	70.22%		63.75%	68.45%		58.88%	64.72%
12 - 21 year olds who had at least 1 complete check up in a year (H)		40.51%	45.60%		37.23%	38.19%		32.85%	37.96%
12-24 month olds who had one PCP visit in a year		96.26%	96.77%		95.79%	94.90%		96.72%	96.62%
25 months - 6 year olds who had one PCP visit in a year		91.65%	91.64%		90.59%	90.66%		91.39%	91.11%
7-11 year olds who had one PCP visit in a year		92.86%	92.78%		90.45%	90.62%		91.16%	91.85%
12 months - 19 year olds who had one PCP visit in a year		89.72%	89.93%		87.12%	88.03%		88.31%	89.00%
20-44 year olds who had 1 PCP visit in a year	81.20%	85.54%	85.26%	78.88%	84.26%	84.33%	78.64%	84.67%	85.44%
2 year olds who are up-to-date on their shots by 2nd birthday (H)	29.84% combo 2 [6,14]	71.99% combo 2[7]	75.00% combo 3[7]	62.77% combo 2[6]	67.64% combo 2[6]	77.03% combo 3[7]	75.91% combo 2[6]	81.02% combo 2[6]	72.26% combo 3[7]

2 year olds who had at least one blood test for lead by 2nd birthday (H)	68.21%	67.82%	65.74%	57.18%	62.29%	68.45%	65.94%	67.40%	72.99%
Percent of kids whose doctor recorded their BMI[8] (H)		13.72%	28.54%		32.12%	29.00%		36.50%	30.41%
Percent of kids whose doctor talked to them about healthy eating (H)		40.70%	48.82%		36.74%	45.48%		42.34%	48.91%
Percent of kids whose doctor talked to them about exercising (H)		35.58%	30.90%		28.22%	32.02%		38.69%	30.90%
Percent of hyperactive kids having a doctor visit 30 days after a new medicine is given		37.63%	45.58%		46.99%	41.86%		43.34%	41.26%
Percent of hyperactive kids having two doctor visits within 9 months after the 30 day visit		50.70%	58.40%		57.33%	56.03%		51.43%	52.10%
Yearly Dental Visit - 2-3 year olds		42.66%	47.30%		33.76%	38.75%		40.40%	45.47%
Yearly Dental Visit - 4-6 year olds		74.87%	76.99%		69.19%	72.14%		73.23%	74.64%
Yearly Dental Visit - 7-10 year olds		77.32%	79.18%		72.09%	75.37%		76.08%	77.74%
Yearly Dental Visit - 11-14 year olds		69.56%	71.39%		63.86%	67.07%		68.70%	70.53%
Yearly Dental Visit - 15-18 year olds		59.44%	60.37%		53.11%	55.13%		58.58%	60.12%
Yearly Dental Visit - 19-21 year olds		40.28%	41.39%		35.13%	35.84%		37.58%	40.98%
Yearly Dental Visit - Total		66.73%	69.09%		60.15%	63.58%		65.21%	67.48%
Cervical Cancer Screening (21-64 yrs) (H) (Pap Smear)		70.62%	70.33%		65.45%	68.91%		65.94%	73.24%
Breast Cancer Screening (40–69 yrs) (Mammogram)		54.20%	52.95%		48.74%	51.36%		51.27%	53.39%
A1c blood testing for diabetics (18-75 yrs)(H)	74.50%	73.70%	81.85%	64.23%	74.70%	72.58%	72.26%	78.65%	82.30%

Poor blood sugar control for diabetics (18-75yrs) *Note: Lower rate is better (H)*		60.80%	52.53%		67.15%	60.06%		54.38%	52.01%
Good blood sugar control for diabetics (18-75yrs)(H)		31.49%	38.22%		27.74%	33.76%		38.69%	39.23%
Great blood sugar control for diabetics (18-75yrs)(H)		22.86%	29.86%		NR	24.19%		31.95%	29.72%
Yearly Eye Exam for diabetics (18-75yrs)(H)		43.38%	47.12%		45.99%	45.99%		37.23%	47.63%
Yearly cholesterol screening for diabetics (18-75yrs)(H)		62.81%	70.68%		64.96%	64.96%		69.16%	74.82%
Good cholesterol control for diabetics (18-75yrs)(H)		20.77%	28.45%		19.71%	19.71%		23.36%	24.64%
Kidney care follow up for diabetics (18-75yrs)(H)		67.84%	70.86%		65.45%	70.05%		70.80%	71.53%
Great blood pressure control (<130/80) for diabetics (18-75yrs)(H)		25.29%	33.68%		21.41%	24.09%		25.36%	33.39%
Good blood pressure control (<140/90) for diabetics (18-75yrs)(H)		47.91%	56.02%		44.77%	43.90%		53.47%	56.93%
Asthma patients who use the right medicine Ages 5-11 Years		92.89%	92.28%		91.82%	91.11%		91.76%	92.48%
Asthma patients who use the right medicine Ages 12-50 Years		88.81%	89.73%		89.10%	87.45%		86.72%	88.72%
Asthma patients who use the right medicine Total	91.84%	91.34%	91.32%	91.12%	90.82%	89.76%	90.58%	89.91%	91.08%
Patients who saw their doctor 30 days after they were in a mental health hospital		71.63%	70.88%		74.88%	72.83%		73.19%[9]	73.79%
Patients who saw their doctor 7 days after they were in a mental health hospital		48.58%	46.64%		59.62%	52.67%		52.8%[9]	54.00%
Pregnant women who saw the doctor within 6 weeks of getting a Medicaid Plan (H)		75.06%	90.49%		86.86%	83.02%		82.24%	84.67%
Women that follow-up with a doctor 3-8 weeks after having a baby (H)		57.43%	65.66%		67.64%	60.70%		69.59%	63.26%

Pregnant women who had less than 21 percent of recommended OB visits (H)		26.95%	6.03%		10.71%	12.09%		13.87%	16.06%
Pregnant women who had 21-40 percent of recommended OB visits (H)		9.82%	4.18%		7.30%	5.81%		3.16%	4.14%
Pregnant women who had 41-60 percent of recommended OB visits (H)		5.29%	6.03%		10.22%	6.28%		5.11%	4.14%
Pregnant women who 61-80 percent of recommended OB visits (H)		10.08%	11.14%		18.49%	11.40%		9.49%	12.65%
Pregnant women who had 81% or more of recommended OB visits (H)		47.86%	72.62%		53.28%	64.42%		68.37%	63.02%
Women who enrolled in a Medicaid plan when they were less than a week pregnant		8.34%	7.80%		9.18%	11.37%		12.41% (H)	11.16%
Women who enrolled in a Medicaid plan when they were 1-12 weeks pregnant		6.01%	7.14%		6.42%	12.76%		10.22% (H)	11.12%
Women who enrolled in a Medicaid plan when they were 13-27 weeks pregnant		58.21%	60.69%		55.97%	57.08%		59.37% (H)	59.55%
Women who enrolled in a Medicaid plan when they were 28 or more weeks pregnant		19.16%	16.30%		20.02%	16.47%		14.84% (H)	15.29%
Women who enrolled in a Medicaid plan when they were an unknown number of weeks pregnant		8.28%	8.07%		8.40%	2.32%		3.16% (H)	2.88%
Women enrolled in a Medicaid plan when they were pregnant - Total		100.00%	100.00%		100.00%	100.00%		100% (H)	100.00%
Patients using the right treatment for Upper Respiratory Infections		78.65%	80.41%		79.13%	78.96%		77.79%	77.46%
Callers who called the call center and hung up within 30 seconds (lower rate is better)		0.81%	0.87%		1.68%	1.21%		1.60%	1.72%
Percent of C-sections[10]		33.25	32.89		33.16	31.42		30.46	31.11
Percent of babies born weighing under 5 pounds 8 ounces[10]		7.66	7.81		8.19	7.45		6.89	7.53
2-17 year olds admitted to the hospital for asthma [10,11]		68.43	76.67		136.89	114.03		104.73	101.35
6-17yr olds that were admitted to the hospital for diabetes complications [10,12]		14.02	16.08		34.58	20.92		28.59	19.94
Percent of Members who went to the ER or Urgent Care for Asthma [13]		1.62%	2.21%		1.40%	1.30%		1.44%	1.27%

2008 - information from January - December 2008 reported in 2009
2009 - information from January - December 2009 reported in 2010
2010 - information from January - December 2010 reported in 2011

AMERIGROUP- Georgia Medicaid and PeachCare for Kids insurance company
Peach State Health Plan- Georgia Medicaid and PeachCare for Kids insurance company
WellCare- Georgia Medicaid and PeachCare for Kids insurance company

(H) - Hybrid - a combination of medical record reviews and what doctors sent to the insurance company
NR-Not Reported

1 Performance Measure- tools to help us understand, manage, and improve what our organizations do. A performance measure is made up of a number and a measure. The number gives us a how much and the measure tells us what
the number means. Performance measures are always tied to a goal the target. Performance measures let us know:
-How well we are doing
-If we are meeting our goals
-If and where improvements are necessary

2 Medicaid- A program funded by the U.S. federal and state governments that pays the medical expenses of people who are unable to pay some or all of their own medical expenses. The program was made to cover people with low incomes.

3 PeachCare for Kids- The Georgia program funded by the U.S. federal and state governments that pays the medical expenses of people who are unable to pay some or all of their own medical expenses. The program was made to cover uninsured children in families with incomes that are low but too high to qualify for Medicaid.

4 for 2008 ONLY:
i. Amerigroup did not review records for their shot performance measure
ii. Peach State Health Plan only included Medicaid members in all their performance measures
iii. AMERIGROUP AND WellCare included Medicaid and PeachCare for Kids members in all their performance measures

5 Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance (NCQA) 2009 measures used HEDIS 2010 specifications and 2010 measures used HEDIS 2011 specifications unless otherwise noted. To be counted in these measures, members had to stay with the insurance company for 11 out of 12 months

6 Combo 2: (4) DTaP; (3) Polio; (1) Measles/Mumps/Rubella; (3)HiB; (3) Hepatitis B; and (1) chicken pox vaccine
7 Combo 3: (4) DTaP; (3) Polio; (1) Measles/Mumps/Rubella; (3) HiB; (3) Hepatitis B; (1) chicken pox vaccine; and (4) pneumonia vaccines

8 BMI stands for body mass index, an estimate of body fat based on height and weight

9 Rate different from what was reported last year; the insurance company corrected the rate in October 2010

10 Agency for Healthcare Research and Quality© (AHRQ) Measure Specification. To be counted in these measures, members did not have to stay with the insurance company for 11 out of 12 months

11 per 100,000 5-17 yr olds in the insurance company

12 per 100,000 6-17 yr olds in the insurance company

13 Measure Designed by the Georgia Department of Community Health (DCH)

14 Only claims data reported