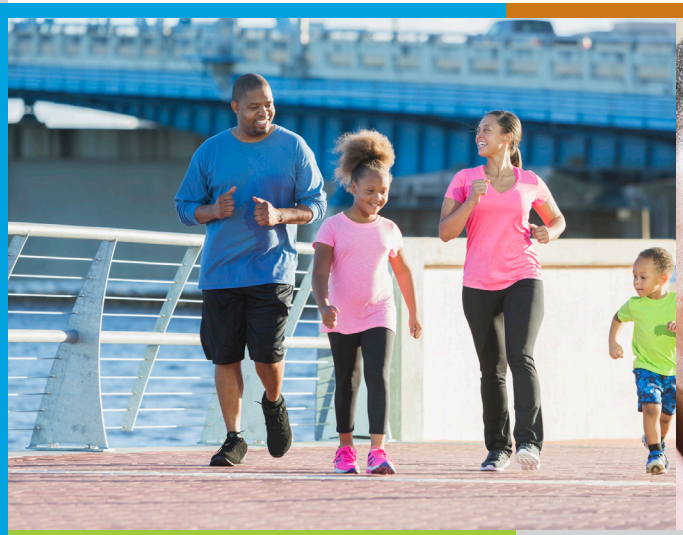
Georgia Department of Community Health



2017 ANNUAL REPORT

FY 2017 Annual Report

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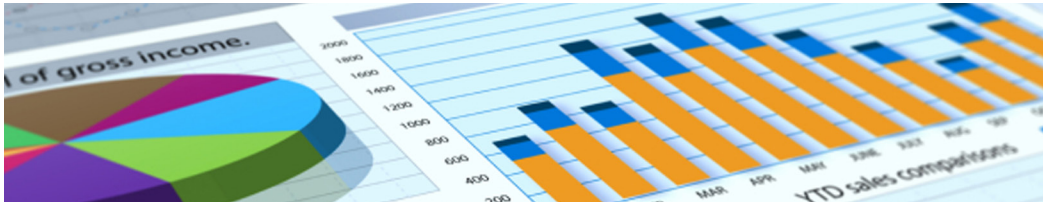


The Big Health Care Picture and Georgia

Introduction

The Georgia Department of Community Health (DCH), designated as the state agency for Medicaid and PeachCare for Kids®, provided access to healthcare for nearly 2 million Georgians. DCH also administered the State Health Benefit Plan (SHBP), providing healthcare coverage for more than 650,000 state employees, public school personnel, retirees and dependents. Combined, these two divisions provided health insurance coverage to approximately one in four people in the state, or nearly 2.6 million Georgians. Highlights of major accomplishments included:

- The Medicaid Division awarded new Care Management Organization (CMO) contracts in response to the FY 2015 CMO re-procurement. The Division also: launched CareSource Georgia Company as a new Georgia Families® (CMO), and as a fourth option for members; conducted open enrollment for new the plan year during March 2017 for all Georgia Families members; procured and awarded new service contracts, including the Georgia Families®and Georgia Families 360°contracts; continued operations of its new streamlined provider credentialing process; piloted and implemented the Integrated Eligibility System (IES), Georgia Gateway; and implemented the new Home and Community-Based Services (HCBS) Settings Rule that calls for services to be provided in an integrated setting, and in the most community-inclusive manner. In addition, the Division provided more than 3.8 million trips through the Non-Emergency Transportation program using the services of two brokers across the state.
- SHBP secured a new Pharmacy Benefit Manager (PBM) vendor, CVS Caremark. SHBP continued to offer Health Reimbursement Account (HRA) plan options (Gold, Silver, and Bronze), in addition to two statewide Health Maintenance Organization (HMO) plan options (offered through Blue Cross Blue Shield of Georgia and UnitedHealthcare); a Metro Atlanta Service Area (MASA) Regional HMO (offered through Kaiser Permanente); and a High Deducible Health Plan (HDHP) plan option (also offered through UnitedHealthcare).
- The Healthcare Facility Regulation Division (HFRD) inspected, licensed, had oversight of and regulated nearly 20,000 Georgia healthcare facilities, including hospitals, nursing homes, and personal care homes. HFRD also issued 949 licenses for new healthcare businesses in Georgia and conducted more than 3,400 inspections of existing facilities. In February of 2017, HFRD implemented an incentive program to allow employees to conduct facility inspections during non-business hours. The program, known as Work on the Weekend (WOW), dramatically increased the timeliness of complaint investigations for the nursing home program. As a result of the success of WOW, HFRD received a national

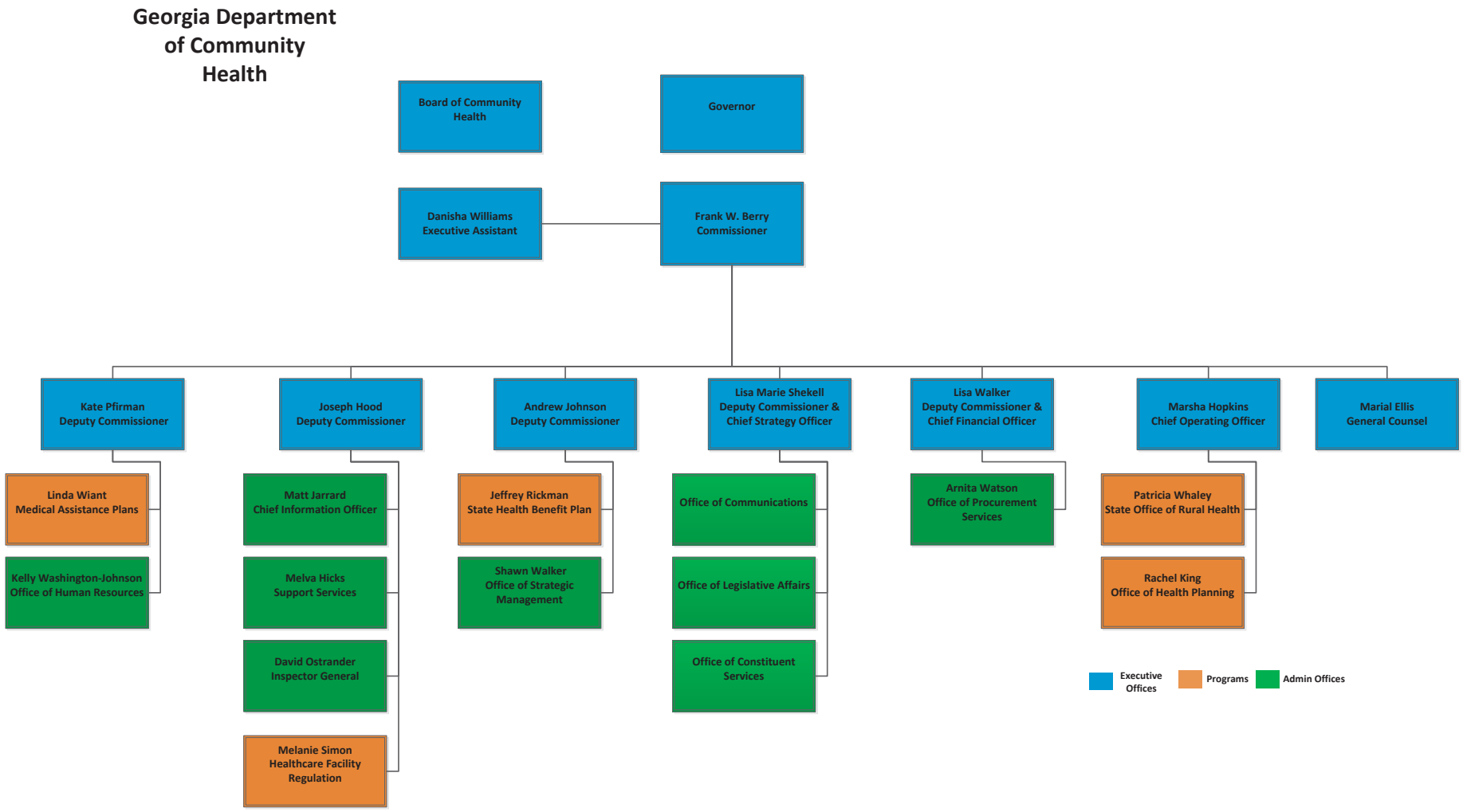
Best Practices Award from the Association of Health Facility Survey Agencies (AHFSA) for improvements in the regulatory process.

- The Office of Health Planning received 68 applications for Certificate of Need, 78 Requests for Letters of Non-Renewability, and 226 requests for Letters of Determination. Health Planning also sent 1,453 health planning surveys to regulated facilities and providers, and collected and deposited $2,981,066 in the Indigent and Charity Care Trust Fund from adjusted payments to offset shortfalls in indigent and charity care commitments.
- The Division of Health Information Technology continued its administrative oversight of the Medicaid Electronic Health Record (EHR) Incentive Program, and increased the number of program participants transitioning from AIU Payment Year one to Modified Stage two by 15.6 percent. As of June 30, 2017, the program has paid more than $287 million to Georgia healthcare providers since its inception in September 2011.
- The Office of General Counsel's Legal Section received 727 member and provider appeals. Contracts Administration generated 266 contractual documents, including amendments. The Open Records section received 310 requests for records pursuant to the Georgia Open Records Act.
- The Office of Information Technology and its partners continued planning and strategy development for the Medicaid Management Information System (MMIS) transformation and re-procurement project. The project has a completed analysis of the current state and capability of IT systems and processes that make up the MMIS. CMS will require states to implement solutions which are modular and MITA-aligned. A market scan has also been conducted to determine the state of modularity in the MMIS and Medicaid systems marketplace.
- The Office of Inspector General's Background Investigation Unit processed 1,627 criminal history records of DCH licensed facilities. The Special Investigations teams opened 465 Medicaid recipient cases, and 319 cases were closed which resulted in a cost savings of $291,330.77 for the State of Georgia. The Third Party Liability Unit (TPL) contractor recovered $39.7 million, and $1.8 million was recovered with the assistance of the Office of the Attorney General for total TPL recoveries of $41.5 million.
- Communications and Legislative Affairs responded to more than 150 media inquiries and 2,792 constituent inquires.
- In the Finance Division, Grant Administration successfully managed 97 active grants totaling $33,309,922.55 in state, federal and matching funds.
- In the Operations Division, The State Office of Rural Health (SORH) administered state and federal funds totaling $16,065,713.

In the DCH Annual Report for FY 2017, you will find descriptions of each division/office responsibilities, pertinent figures and what divisions and offices considered their greatest accomplishments for the year.

We are dedicated to A ***Healthy*** Georgia.

DCH Organizational Chart



Updated 7/11/2017

Medicaid

The Georgia Department of Community Health (DCH) serves as the single state agency for the administration of the Medicaid program under Title XIX of the Social Security Act, providing healthcare for children, pregnant women and people who were aged, blind or disabled (ABD). DCH's Medicaid Division oversaw the Georgia Medicaid programs and PeachCare for Kids® (PCK) (Georgia's Children's Health Insurance Program [CHIP] population). Medicaid and PCK members received services through either managed care (Georgia Families® or Georgia Families 360°) or fee-for-service arrangements. The Medicaid Division provided management oversight of the Medicaid and PCK programs by:

- Developing and implementing policies on allowable services and service delivery.
- Administering the Georgia Families 360° managed care program for children in foster care, receiving adoption assistance and select youth in the juvenile justice system.
- Overseeing member eligibility and enrollment into Medicaid and PCK, and enrollment into the Georgia Families Care Management Organizations (CMOs) and the Georgia Families 360° CMO.
- Overseeing the seven programs offering Home- and Community-Based Services (HCBS) alternatives over long-term institutional care.
- Collecting data and reporting the performance metrics for both the fee-for-service population and members in Georgia Families and Georgia Families 360°. The state used the Healthcare Effectiveness Data and Information Set (HEDIS) to measure performance on important dimensions of care and service.
- Developing and implementing new programs in Medicaid and PCK promoting continuity of care, care coordination and enhanced health outcomes, such as the rapid cycle process improvement projects.
- Controlling expenditures and overseeing all categories of service including capitation payments, pharmacy, inpatient hospital, outpatient hospital, nursing ,and long-term care facility and transportation.
- Addressing member needs through Medicaid and PCK provider relations and resolution services.

- Evaluating opportunities to improve efficiency and effectiveness in Medicaid operations, and implementing changes that streamline processes for providers and Medicaid and PCK members.

- Managing the performance of four CMOs responsible for providing medical services under the Georgia Families and Georgia Families 360˚ programs to 1.3 million + Medicaid and PCK members.

Major Programs and/or Initiatives

Beyond the primary role of managing Medicaid, the Division developed new and innovative programs that enhanced the effectiveness and efficiency of healthcare services offered. Georgia Medicaid continued the improvement of services through program enhancements as part of the Medicaid Redesign initiative. Medicaid Redesign began in FY 2011, and focused on improving the health of Medicaid members, while also controlling the ever-increasing expenditures of providing Medicaid services in Georgia. In FY 2017, Medicaid implemented the following:

- **Awarded new CMO contracts in response to the FY 2015 CMO re-procurement.** DCH first implemented Georgia Families, the Medicaid managed care program for Parent/Caretaker with Children Medicaid (formerly Low Income Medicaid), and PCK members in FY 2005. DCH released an RFP for new services in FY 2015 and awarded the new contracts in FY 2016. The previous contracts expired at the end of FY 2017. DCH conducted extensive implementation readiness review activities during FY 2017 with assistance from partner agencies, including the Department of Behavioral Health and Developmental Disabilities (DBHDD), the Department of Human Services (DHS), the Department of Juvenile Justice (DJJ) and the Department of Public Health (DPH). The new CMO contracts were successfully implemented with Go Live on July 1, 2017.

- **Launched CareSource Georgia Co. as a new Georgia Families Care CMO and a fourth option for members.**

- **Conducted open enrollment for new plan year during the month of March for all Georgia Families members.** In the past, Georgia Families Open Enrollment took place on the members' anniversaries. members now had the opportunity to choose from four CMOs: Amerigroup, CareSource, Peach State Health Plan and WellCare. Members had the option to make CMO selections via phone, fax or online. DCH, the CMOs, DXC Technology (DCH's fiscal agent and administrator of the GA Medicaid Management Information System (GAMMIS) and GaHIN worked collaboratively to develop a secure, electronic process of exchanging information to facilitate member transition and coordination of care.

- **Procured and awarded new service contracts,** including the Georgia Families and Georgia Families 360°contracts. Also secured a consulting firm to assist with project planning and the development of a strategic approach to re-procure the Georgia Medicaid Management Information System, and to align with new federal requirements for modularity, drive the advancement of Medicaid Information Technology Architecture (MITA) maturity, and improvements in the efficiency and effectiveness of program operations and the member and provider experience as well as leverage and interact efficiently with other systems. DCH conducts ongoing procurement and contract implementation activities to secure services and support continued Medicaid operations.

- **Piloted and implemented the Integrated Eligibility System (IES), Georgia Gateway.** Procured in FY 2015, DCH, in conjunction with other state agencies, piloted and implemented the new system in FY 2017. DCH is working closely on this project with DHS, DPH and Department of Early Care and Learning (DECAL). Gateway provides a single point of entry to serve those applying for Medicaid, PCK, Planning For Healthy Babies (P4HB), Food Stamps (SNAP), Temporary Assistance for Needy Families (TANF), Women, Infants, and Children (WIC) benefits and Child Care Services (CAPS). The pilot for Georgia Gateway began February 2017, and ran through April 2017. The pilot involved converting the entire PCK and P4HB population into Gateway, along with one Department of Family and Children Services (DFCS) County office (Henry). The pilot was extremely successful and the issues identified were quickly addressed. This led to the first full implementation wave in May, which ran through June, and involved approximately half the counties in the State. The second wave,which involves the rest of the counties in the State, was broken out into two parts, the first being implemented July and the second, incorporating DeKalb,Fulton, and Gwinnett counties, is planned for September 2017 (FY 2018). Both waves 1 and 2a were even more successful than the pilot, and have seen a quick adoption rate by both staff and the public. With the full implementation of

Gateway, incorporating all the various Medical Assistance programs in one eligibility system, there is now a seamless determination of eligibility across these programs, including Medicaid to PCK and back, which often had either a gap or overlapping coverages before.

- **Continued Operations of the Centralized Credentialing Verification Organization.** In FY 2017, DCH continued operations of its new streamlined provider credentialing process, which was first implemented during FY 2016. The Credentialing Verification Organization (CVO) is responsible for credentialing and re-credentialing Medicaid, PCK, Georgia Families, and Georgia Families 360° providers in accordance with guidelines established by the National Committee for Quality Assurance (NCQA). The CVO conducts primary source verification as well as monthly monitoring of provider fraud and abuse sanctions. The CVO has a Credentialing Committee chaired by a Medical Director, and is responsible for reviewing all credentialing and re-credentialing applications. In FY 2016, the CVO also began credentialing fee-for-service (FFS) only providers. Georgia Medicaid is one of the first state agencies in the country to use a centralized credentialing process, and to use that process to credential FFS providers. During FY 2017, more than 25,000 providers were credentialed, and more than 4,000 were re-credentialed.

- **Implementation of the new HCBS Settings Rule**. The Centers for Medicare and Medicaid Services (CMS) issued regulation in FY 2014 defining the characteristics and qualities of HCBS, and the characteristics and qualities of the settings in which services can be delivered. The regulation required the state to develop a Statewide Transition Plan describing how the state would assure compliance with the new rules that call for services to be provided in an integrated setting and in the most community-inclusive manner. Georgia's work toward compliance has included engagement of a statewide Task Force, public meetings to solicit stakeholder input on the development of the Transition Plan, and preparation of four waiver-specific Transition Plans as well as a Statewide Transition Plan (STP). Georgia's STP was formally submitted to CMS in May 2017. CMS responded with a few clarifying questions, and suggested policy revisions in July 2017. The final revised draft is awaiting approval from CMS. The work associated with implementation of the HCBS rule continues. All providers are being surveyed to ensure compliance with the rule. Technical assistance is scheduled to begin with those providers needing to gain compliance following CMS approval of the STP.

- **Non-Emergency Medical Transportation (NEMT).** Through the NEMT program, DCH provided more than 3.8 million trips to Medicaid Members across Georgia who had no other means of transportation in FY 2017. Our modes of transit included ambulatory transport, wheelchair, stretcher and the utilization of public transport. NEMT services in Georgia are managed by two Brokers under contract with DCH. The brokers sub-contract with more than 200 transportation providers and independent drivers. In addition, both brokers have begun to utilize ride share services such as Lyft in certain areas of the state. NEMT also provided services for nursing home relocations over the course of the fiscal year, partnering with DCH Healthcare Facility Regulation Division (HFRD), Adult Protective Services, the Georgia Bureau of Investigations (GBI) and local law enforcement agencies. NEMT also participated and partnered withGeorgia Emergency Mangement Agency (GEMA) and DPH) in the evacuation of members from the Georgia coast due to Hurricane Matthew.

- **Paperless Initiatives**
The Division continues to move new Categories of Service into the Centralized Prior Authorization portal. The Division implemented an online process for providers to submit and track appeals, which has improved process efficiency.

FY 2017 Table of Members and Expenditures

Measures	Medicaid[4]	Medicaid-ABD	Medicaid-LIM	PeachCare for Kids™
Members Average[1]	1,838,625	503,959	1,334,666	130,785
Member Months	22,063,499	6,047,507	16,015,992	1,569,418
Net Payment	$5,691,240,042	$5,332,665,446	$358,574,596	$9,611,019
Providers[2]	112,101	81,143	90,181	38,011
Claims Paid	52,411,523	27,286,486	25,125,037	2,044,121
Capitation Amount	$3,899,492,897	$42,917,080	$3,856,575,817	$269,327,030
Total Payment[3]	**$9,590,732,939**	**$5,375,582,527**	**$4,215,150,413**	**$278,938,050**
Total Payment Per Member Per Month	$435	$889	$263	$178

Source: Truven Health Analytics Advantage Suite, based on incurred dates July 1999 through June 2017, paid through August 2017.

[1]Members Average is the average number of members per month with any coverage type. Each member is counted once for each month they are eligible, then this count is divided by the overall number of months in the time period during which at least one member was enrolled.

[2]Unique count of providers used across the ABD and LIM populations. Providers represents multiple locations for individual providers.

[3] Includes Net Payment and Capitation Amounts.

[4] Medicaid includes Medicaid ABD and Medicaid LIM and excludes PeachCare.

Table of Historical Medicaid Members and Payments by Fiscal Year[1]

Fiscal Year	Average Members	Total Payments[2]	Payment Per Member	Percent Change in Payment Per Member
2000	947,054	$3,482,779,560	$3,677	N/A
2001	996,901	$3,822,786,433	$3,835	4.3%
2002	1,268,225	$4,461,972,245	$3,518	-8.3%
2003	1,260,795	$4,885,865,204	$3,875	10.1%
2004	1,326,909	$6,039,465,103	$4,552	17.5%
2005	1,376,730	$6,311,890,515	$4,585	0.7%
2006	1,390,497	$6,280,193,139	$4,517	-1.5%
2007	1,283,940	$6,155,158,918	$4,794	6.1%
2008	1,268,661	$6,371,942,440	$5,023	4.8%
2009	1,353,191	$6,703,774,787	$4,954	-1.4%
2010	1,447,865	$6,954,116,861	$4,803	-3.0%
2011	1,496,881	$7,464,027,216	$4,986	3.8%
2012	1,540,666	$7,813,851,582	$5,072	1.7%
2013	1,588,074	$8,047,771,351	$5,068	-0.1%
2014	1,633,977	$8,451,360,734	$5,172	2.1%
2015	1,807,586	$8,923,003,018	$4,936	-4.6%
2016	1,862,573	$9,257,891,787	$4,970	0.7%
2017	1,838,625	$9,590,732,939	$5,216	4.9%

Source: Truven Health Analytics Advantage Suite, based on incurred dates July 1999 through June 2017, paid through August 2017.

1 Medicaid includes Medicaid ABD and Medicaid LIM and excludes PeachCare.

2 Includes Net Payment and Capitation Amounts.

Medicaid Payments Distribution by Services Type: FY 2017

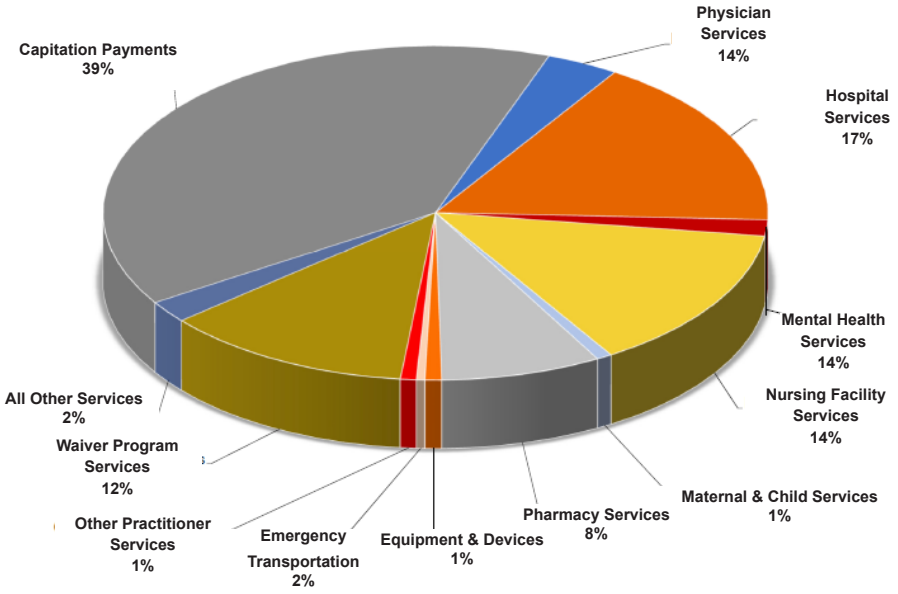


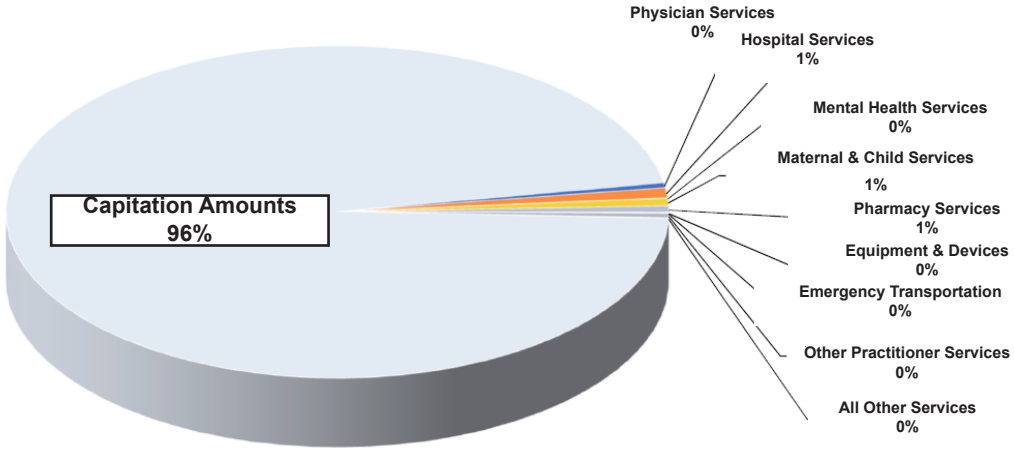
Table of Historical PeachCare For Kids™ Members and Payments by Fiscal Year

Fiscal Year	Average Members	Total Payments[2]	Payment Per Member	Percent Change in Payment Per Member
2000	8,503	$50,730,000	$5,966	--
2001	14,028	$115,931,116	$8,264	38.5%
2002	154,406	$170,916,516	$1,107	-86.6%
2003	180,953	$212,319,603	$1,173	6.0%
2004	200,562	$262,676,747	$1,310	11.6%
2005	208,185	$273,274,876	$1,313	0.2%
2006	238,330	$310,331,108	$1,302	-0.8%
2007	273,659	$432,157,786	$1,579	21.3%
2008	249,681	$345,678,006	$1,384	-12.3%
2009	205,548	$304,985,696	$1,484	7.2%
2010	202,527	$299,535,400	$1,479	-0.3%
2011	199,420	$316,597,618	$1,588	7.3%
2012	205,167	$337,832,456	$1,647	3.7%
2013	217,964	$398,513,422	$1,828	11.0%
2014	215,222	$418,500,964	$1,945	6.4%
2015	158,336	$302,361,213	$1,910	-1.8%
2016	127,940	$254,424,585	$1,989	4.1%
2017	130,785	$278,938,050	$2,133	7.2%

Source: Truven Health Analytics Advantage Suite, based on incurred dates July 1999 through June 2017, paid through August 2017.

1 Includes Net Payment and Capitation Amounts.

PeachCare for Kids TM Payments Distribution by Service Type FY 2017



1 All Other Services includes payments for laboratory services Federally Qualified Health Centers, Ambulatory Surgical Centers Psychiatric Residential Treatment Facilities (PRTF), and Rural Health Centers.

State Health Benefit Plan

The Georgia Department of Community Health (DCH) served as the State's administrator of health insurance coverage for state employees, teachers, school system employees and retirees who continued coverage (including annuitants and former employees on extended coverage), and covered dependents. This health coverage is known as the State Health Benefit Plan (SHBP).

SHBP is composed of three plans: the State Employees Plan, the Teachers Plan and the Public Schools Employees Plan. SHBP covered 650,067 lives as of June 2017.

SHBP is a self-insured, self-funded plan that pays benefits out of the premiums contributed from members (through monthly payroll deductions) and from monthly contributions from the employers that offer the SHBP (e.g., state agencies and public school systems).

SHBP also offers four fully-insured Medicare Advantage options (Standard and Premium offered by two vendors) for former employees who are continuing coverage and are enrolled at a minimum in Medicare Part B. Employer contributions and member premiums are used to purchase Medicare Advantage insurance.

In 2017, SHBP offered eligible active employees and eligible former employees under age 65 the choice of three Health Reimbursement Arrangement (HRA) plan options, Gold, Silver and Bronze; two statewide Health Maintenance Organization (HMO) plan options; one Metro Atlanta Service Area (MASA) Regional HMO plan option; and one High Deductible Health Plan (HDHP) plan option.

Structure of SHBP

Within the Division, there were five primary operating units:

- **Plan Management** developed the benefit plan and designed the plan documents, which contained the terms and conditions of the SHBP. The unit was responsible for monitoring compliance with vendor contracts and providing oversight and monitoring of vendor performance.
- **Clinical and Medical Management** provided oversight of the vendors' performance of services for clinical programs including, but not limited to: utilization management; case management; disease management; behavioral health; wellness and pharmacy management and the overall quality of these services.

- **Communications** provided information to employers and members of the Plan's benefits, eligibility, policies and procedures.
- **Employer Services** assisted participating employers with information and training about Plan coverage and billing.
- **Administrative Solutions Team** assisted members with all eligibility matters including changes and premium payment issues, as well as oversight of the eligibility vendor and member enrollment.

The SHBP operated using a calendar year for its Plan Year.

Accomplishments

In 2017, SHBP secured a new Pharmacy Benefit Manager (PBM) vendor, CVS Caremark. SHBP continued to offer HRA plan options (Gold, Silver and Bronze), in addition to two statewide HMO plan options (offered through Blue Cross Blue Shield of Georgia and UnitedHealthcare); a MASA Regional HMO (offered through Kaiser Permanente); and a HDHP plan option (also offered through UnitedHealthcare). These plan options continued to provide expanded vendor and plan design choices for active employees and their dependents.

Additionally, SHBP continued to encourage health and wellness participation to its membership. To that end, SHBP offered wellness incentive offerings through the HRA, Statewide HMOs and HDHP plan options via its wellness vendor, Sharecare, formerly known as Healthways. Members and their covered spouses were each able to earn up to 480 well-being incentive credits (up to 960 well-being incentive credits per household) by completing certain health actions; these credits could be used to reduce members' out-of-pocket costs for eligible medical and pharmacy expenses. Further, Kaiser Permanente increased its wellness program incentives for members and their covered spouses; each able to earn a $500 gift card (up to $1000 per household) by completing certain health actions.

Preventative and Wellness Campaigns as of September 2017

Health Assessment Completions

Total completions for this time period was 146,074, of which 81,199 completed by members; 22,568 were completed by spouses, and 307 were completed by dependents over 18.

Biometric Screenings

Total onsite screening events completed for this time period was 549, with 40,522 onsite screening participants. Total Physician Screening Forms submitted during this time period was 61,682.

Member Engagement

- *More Than a Number* weight challenge was targeted to 253,222 members, and a total of 6,098 members joined.
- *True Colors* nutrition challenge was targeted to 251,511 members, and a total of 4,618 members joined.

Preventive Care Campaigns

- January Cervical Cancer Awareness Month – 161,976 targeted
- March Colorectal Awareness Month – 111,202 targeted
- Women's Health Week – 199,691 targeted
- Men's Health Week – 50,503 targeted

Onsite Activities

2017 Wellness Activities

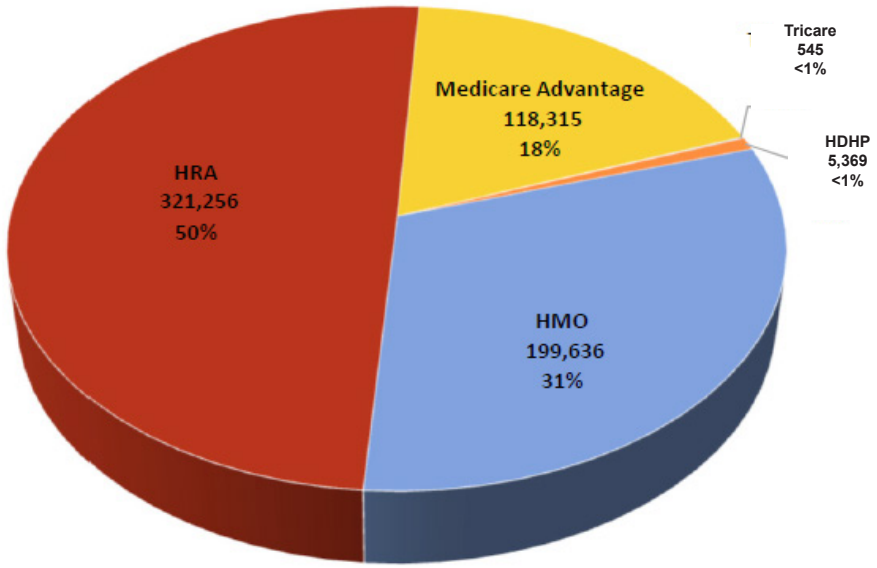
Presentation	74
Onsite Meetings/Collateral Drop	67
Walking Maps	8
New Hire Orientation	5
Benefits Fairs	56
Cooking Demo's	89
Health Assessments Days	23
Attended Biometric Screening	65
Total	**387**

Table of Historical SHBP Members and Payments by Fiscal Year[1]

Fiscal Year	Members Average	Total Payments	Payment Per Member	% Change in Payment Per Member
2000 [2]	--	--	--	--
2001	647,466	$1,110,543,053	$1,715	0.0%
2002	663,944	$1,212,072,547	$1,826	6.4%
2003	615,167	$1,099,992,138	$1,788	-2.1%
2004	627,636	$1,378,907,068	$2,197	22.9%
2005	642,553	$1,484,143,212	$2,310	5.1%
2006	647,581	$1,881,122,239	$2,905	25.8%
2007	664,251	$2,000,575,396	$3,012	3.7%
2008	684,346	$2,187,836,485	$3,197	6.1%
2009	695,484	$2,522,951,203	$3,628	13.5%
2010	691,410	$2,647,862,985	$3,830	5.6%
2011	686,776	$2,671,341,740	$3,890	1.6%
2012	677,393	$2,759,640,257	$4,074	4.7%
2013	648,242	$2,580,549,357	$3,981	-2.3%
2014	625,719	$2,956,753,454	$4,725	18.7%
2015	625,559	$3,689,680,729	$5,832	16.2%
2016	632,692	$3,689,680,729	$5,832	6.2%
2017	645,122	$3,994,652,402	$6,192	6.2%

Source: Truven Health Analytics Advantage Suite and DataProbe, based on incurred dates July 1999 through June 2017, paid through August 2017.
1 Includes Net Payments, Healthcare Reimbursement Amounts, Health Incentive amount and Capitation Amounts.
2 Data for FY 2000 is not available.

SHBP Members Average by Plan Type FY 2017



Source:Truven Health Analytics Advantage Suite, based on incurred dates July 2016 through June 2017 and paid through August 2017
1Members Average reflects entollment for the Fiscal Year, July 2016 through June 2017.

FY 2017 Table of State Health Benefit Plan Covered Lives[1]

Measures	State Active	State Retiree	Teacher Active	Teacher Retiree	NonCert Active	NonCert Retiree	COBRA/ Surviving Spouse	Total SHBP
Members Average[2]	98,640	50,580	253,653	83,700	122,312	33,106	3,131	645,122
Member Months	1,183,684	606,956	3,043,838	1,004,399	1,467,747	397,273	37,568	7,741,466
Net Payment	$496,042,896	$480,674,049	$1,024,835,456	$760,072,488	$685,332,626	$317,826,772	$30,982,860	$3,795,767,147
Providers	28,839	55,670	45,602	87,116	30,668	43,968	13,802	154,878
Claims Paid	2,484,508	3,103,876	5,473,825	4,762,987	3,347,505	2,143,809	193,314	21,509,824
Capitation Amount[3]	$28,193,928	$2,639,543	$55,599,181	$2,989,660	$35,206,909	$1,454,190	$51,080	$126,134,490
Healthcare Reimbursement Amount	$13,357,966	$3,727,583	$25,574,655	$7,688,486	$14,762,684	$1,610,845	$155,743	$66,877,962
Total Payments[4]	**$538,812,777**	**$487,294,211**	**$1,108,259,106**	**$771,231,934**	**$736,826,673**	**$321,032,871**	**$31,194,830**	**$3,994,652,402**
Payments Per Member	$455	$803	$364	$768	$502	$808	$830	$516

Source: Truven Health Analytics Advantage Suite, based on incurred dates July 1999 through June 2017, paid through August 2017.

1 The State Active group also includes the Contract Active group. The State Retiree group also includes the Contract Retiree group. The Teacher Active group also includes the County Government Active group. The COBRA group includes COBRA Continuees and Surviving Spouse/Dependents from each Employee Type Group.

2 Members Average reflects enrollment for the Fiscal Year, July 2016 through June 2017.

3 Total Payments includes Net Payment, Healthcare Reimbursement Amount. Healthcare Incentive Amount and Kaiser capitation payments (Kaiser capitation payments data provided by GA Department of Community Health) and has been ajdjusted for claims incurred but not yet reported.

4 The Total SHBP Provider count reflects a unique count across all SHBP populations (e.g, not additive across the SHBP population groups).

FY 2017 Table of State Health Benefit Plan Covered Lives[1]

Category	Members Average	Employee / Retiree	Dependent
State Employees - Active	96,920	54,097	42,823
State Employees - Retired	50,529	35,035	15,494
Teachers – Active	253,496	108,208	145,288
Teachers – Retired	83,699	57,777	25,922
School Service Personnel – Active	122,311	65,230	57,081
School Service Personnel – Retired	33,106	24,036	9,069
Contracts/Board Members	1,930	1,239	691
COBRA/Surviving Spouse	3,131	2,815	315
SHBP TOTAL	645,122	348,438	296,684

Source: Truven Health Analytics Advantage Suite, based on incurred dates July 2016 through June 2017, paid through August 2017.

[1]Members Average reflects enrollment for the Fiscal Year, July 2016 through June 2017.

Healthcare Facility Regulation

The Healthcare Facility Regulation Division (HFRD) of the Georgia Department of Community Health (DCH) served Georgia residents through the oversight of statewide healthcare facilities.

In FY 2017, HFRD inspected and licensed more than 20 types of healthcare facilities and services, such as hospitals, nursing homes, assisted living facilities, personal care homes, drug abuse treatment programs and end-stage renal disease facilities. The division certified various healthcare facilities to receive Medicaid and Medicare funds through contracts and agreements with the Centers for Medicare & Medicaid Services (CMS) and the Food and Drug Administration (FDA) of the U.S. Department of Health and Human Services (HHS).

HFRD provided ongoing monitoring of licensed healthcare facilities to ensure compliance with rules promulgated by DCH. The division reviewed and issued decisions based on facility requests for waivers or variances to these rules. Furthermore, HFRD investigated reports of unlicensed facilities, complaints against licensed facilities, adverse events, and incidents reported by citizens and health care facilities.

Accomplishments

- HFRD provided oversight to more than 20,000 facilities, providers and registrants in FY 2017.
- HFRD issued 949 licenses for new healthcare businesses in Georgia, and conducted 3,420 inspections of existing facilities.
- HFRD also responded to 2,868 complaints against healthcare facilities and reviewed nearly 9,243 incident reports.
- In October of 2016, HFRD launched an online applications portal for Private Home Care Providers to streamline the licensure process.
- In February of 2017, HFRD implemented an incentive program to allow employees to conduct facility inspections during non-business hours. The program, known as Work on the Weekend (WOW), dramatically increased the timeliness of complaint investigations for the nursing home program. As a result of the success of WOW, HFRD received a national Best Practices Award from the Association of Health Facility Survey Agencies (AHFSA) for improvements in the regulatory process.
- In May of 2017, HFRD filled 18 surveyor vacancies in the nursing home program as a result of salary increases provided through the legislative budget process.

Office of Health Planning

The Office of Health Planning (Health Planning) within the Department of Community Health (DCH) serves Georgia residents through the administration of the state's Certificate of Need (CON) program and health planning functions.

A CON is required before the offering of a statutorily defined new institutional health service by a health care facility. Health Planning reviews applications for CON issuance in accordance with the state health plan, relevant statutes, rules and regulations. Health Planning also issues Letters of Determination, which provide guidance on the applicability of CON rules for proposed projects, and Letters of Non-Reviewability (LNR) for facilities or services not requiring prior review and approval pursuant to certain CON considerations.

Health Planning conducts annual surveys of CON-regulated facilities and providers to obtain utilization and financial data for state health planning forecasts and methodologies as well as the CON review process. The Office insures compliance by health care facilities with indigent and charity care commitment percentages. Health Planning also conducts architectural plan reviews and site inspections for major renovations and construction projects in hospitals, nursing homes and ambulatory surgery centers.

Additionally, Health Planning administers the Patient's Right to Independent Review Program which provides members of health maintenance organizations and other managed care plans the right to appeal an insurer's decision denying coverage for medical services.

Accomplishments

- During FY 2017, the Office of Health Planning received 68 applications for Certificate of Need (CON), 78 requests for Letters of Non-Reviewability and 226 requests for Letters of Determination. Health Planning prepared for and participated in the appeals of 8 matters during the fiscal year.
- Health Planning sent 1,453 health planning surveys to regulated facilities and providers and received 1,254 responses, an 86 percent completion rate. Health Planning collected and deposited $2,981,066 into the Indigent and Charity Care Trust Fund from adjusted payments to offset shortfalls in indigent and charity care commitments.
- Health Planning conducted 287 plan reviews and 143 inspections at facilities under construction, travelling a total of 13,259 miles.
- As administrator of the Patient's Right to Independent Review Program, Health Planning reviewed 62 requests for independent review during the fiscal year.

Health Information Technology

During FY 2017, the Office of Health Information Technology (Health IT) continued its mission to advance the use of health information technology throughout Georgia to reduce health care disparities, improve health outcomes, increase the efficiency of health care delivery, and reduce overall health care costs. Health IT's objectives included:

- **Administering the Medicaid Electronic Health Record (EHR) Incentive Program.** Health IT continued its administrative oversight of the Medicaid EHR Incentive Program, including eligibility, registration and attestation for the distribution of incentive payments to eligible Medicaid providers. The 100 percent federally funded payments were made to Eligible Professionals (EPs), Eligible Hospitals (EHs) and Critical Access Hospitals (CAHs) that adopted, implemented, upgraded or demonstrated meaningful use of certified EHR technology to improve patient care and reduce health care disparities. As of June 30, 2017, the program has paid more than $287 million to Georgia healthcare providers since its inception in September 2011.

  The Medicaid EHR Incentive Program consists of two stages of meaningful use (Modified Stage 2 and Stage 3). Each stage has its own set of requirements which focus on advancing the use of certified EHR technology to support health information exchange (HIE) and interoperability, and maximizing clinical effectiveness and quality measures. All providers are required to attest to a single set of objectives and measures. For Modified Stage 2, EPs must meet 10 objectives and EHs and CAHs must meet nine objectives. For Stage 3, all Medicaid EHR Incentive Program participants (EPs, EHs and CAHs) are required to meet eight objectives.

- **Demonstrating e-health in Medicaid services and supports.** DCH successfully completed the third year of the National Testing Experience and Functional Assessment Tools (TEFT) grant. DCH was awarded the four-year grant by the Centers for Medicare & Medicaid Services (CMS) to field test a cross-disability experience of care survey and a set of functional assessment items, demonstrate personal health records, and create an electronic Long-Term Services and Supports (eLTSS) service plan standard. This fiscal year, Georgia was awarded a supplemental grant to augment the eLTSS scope of work with CMS and the Office of the National Coordinator for Health Information Technology. This will allow for the development of a data standard to share

information across the LTSS ecosystem. DCH completed the second phase of the Consumer Assessment of Healthcare Providers and Systems Experience of Care (CAHPS EoC) Survey for Georgia, which elicits feedback on beneficiaries' experience with the services they receive in Medicaid Community-Based Long-Term Services & Supports (CB-LTSS) programs. Additionally, DCH completed the requirements for the personal health record tool which can encourage a more active role for beneficiaries/caregivers in managing care and result in better outcomes through more efficient management of services

- **Supporting the Statewide Health Information Exchange (HIE).** The Georgia Health Information Network (GaHIN) is Georgia's statewide HIE and the State-Designated Entity. Created as a public-private partnership under the leadership of DCH, GaHIN electronically connects Georgia hospitals, physicians, clinicians, payers, wellness partners and other health care stakeholders to exchange patient health information through a secure network. DCH has furthered this public-private collaboration model to seek opportunities to provide technology support for Medicaid programs and policies.

- **Advancing the use of EHR technology through quality improvement.** The Georgia Clinical Quality Measures System (CQMS) was created to improve health outcomes for Medicaid members. Health IT, in partnership with DXC Technology and HealthTech Solutions, is taking a phased-approach in deploying the CQMS to better track the quality outcomes of Medicaid providers for many of the chronic diseases affecting Georgia's population. The popHealth component of the CQMS solution evaluates and presents provider-supplied measurements against industry-standard measures.

Accomplishments

- Increased the number of Medicaid EHR Incentive Program participants transitioning from AIU Payment Year 1 to Modified Stage 2 by 15.6 percent.
- Administered the CAHPS EoC Survey to CB-LTSS beneficiaries for the TEFT grant. Results will be used to assess and improve quality in the Medicaid CB-LTSS programs.
- Launched the Georgia Medicaid Management System (GAMMIS) Clinical Viewer; allows Medicaid providers to access GaHIN clinical patient information with a single sign-on into the GAMMIS system.
- Provided ongoing support and monthly webinars to assist GaHIN Clinical Viewer users with accessing the system and Georgia providers with meeting meaningful use requirements for the Medicaid EHR Incentive Program.

Financial Management

In FY 2017, the Financial Management Division provided financial support to the Georgia Department of Community Health (DCH). Four sections performed the division's work: Financial and Accounting Services, the Budget Office, Reimbursement Services, and Procurement Services and Grant Administration.

Financial and Accounting Services

The Financial and Accounting Services section paid providers, vendors and employees, as well as processed federal, state and other fund source receipts. The section performed cash management analysis to ensure adequate funding for the agency. In addition, the section prepared annual financial statements and budgetary compliance reports, as well as financial reports that secured Medicaid, PeachCare for Kids® (PCK) and other federal funding. This section also includes Medicaid Benefits Recovery, which is responsible for the collection of outstanding accounts receivable balances for Georgia Medicaid providers.

The Budget Office

The Budget Office developed, requested, maintained and monitored the DCH's budget. During budget development, the Budget Office prepared budget and cash projections for Medicaid, PCK and State Health Benefit Plan (SHBP) programs. In addition, the Budget Office, supported by the Financial and Accounting Services section, ensured funding was available for departmental operations before liabilities were incurred. The Budget Office also has the State Health Benefit Plan (SHBP) Audit section which is responsible for the administrative and financial analysis of payments made to the SHBP. Finally, the Budget Office provided analytical support on program and policy changes impacting Medicaid, PCK and the SHBP.

Reimbursement Services

The Reimbursement Services section set payment rates for nursing homes, long-term care facilities, hospitals and non-institutional providers seeking reimbursement from the Medicaid and PCK programs. In addition, working with actuaries, the section determined Medicaid and PCK Care Management Organization (CMO) capitation rates. The section also was responsible for supplemental hospital, nursing home, and physician payments through the federal Upper Payment Limit (UPL) and

Disproportionate Share Hospital (DSH) programs. Also in 2017, Reimbursement Services initiated significant changes to Hospital Inpatient reimbursement by establishing a Graduate Medical Education pool and increasing funding for hospitals with Indirect Medical Education cost, as well as for hospitals that treat a high proportion of Medicaid recipients.

Procurement Services and Grant Administration

Procurement Services used strategic sourcing to procure quality goods and services at the lowest reasonable cost and at the best value to the state. In FY 2017, Procurement Services managed 11 procurements with an estimated fiscal year value of $2.7 million through competitive bids. Procurement analyzed 341 forecasted purchases to identify services that must be either sourced through the competitive bidding process, exempt from competitive bidding or approved for renewal, extension, termination and/or substantive changes through the amendments of existing contracts. Grants Administration successfully managed 97 active grants totaling $33,309,922.55 in state, federal and in-kind matching funds. In conjunction with DCH business owners, Grants Administration developed performance-based deliverables for all grant awards.

Office of General Counsel

In FY 2017, the Office of General Counsel provided legal guidance and support to the Commissioner, the Board of Community Health, and all divisions and offices of the Department. The Office prepared contracts; drafted and monitored proposed legislation; analyzed and researched healthcare policy issues, and state and federal laws; provided support in various court cases; and prepared policies, resolutions, rules and regulations for Department Community Health (DCH). The Office also monitored compliance with HIPAA Privacy and Security, provided regulatory compliance guidance and administered the Georgia Open Records Act on the Department's behalf. Through its Legal Services section, the Office handled administrative hearings before the Office of State Administrative Hearings and the internal Hearing Officer designated by the Commissioner. The Office maintained a close working relationship with various governmental agencies, including but not limited to its sister agencies consisting of the Department of Behavioral Health and Developmental Disabilities (DBHDD), the Department of Human Services (DHS) and the Department of Public Health (DPH) to ensure an open line of communication supporting DCH's programs, goals and missions. Four sections in the Office, along with other members of the Office, assisted in the above efforts:

- Legal Services
- Contracts Administration
- HIPAA Privacy & Security
- Open Records

Accomplishments

- The Legal Services section received 727 member and provider appeals.
- The Contracts Administration section responded to the contract needs of every division and office in DCH. Contracts Administration coordinated with program staff, DCH leadership and vendors to generate 266 contractual documents, including amendments.
- The HIPAA Privacy & Security section assisted with the "Refreshed and Ready" training program, during which DCH workers, including DCH employees and contractors, completed online training about targeted DCH policies and procedures.
- The Open Records section received 310 requests for records pursuant to the Georgia Open Records Act.

Information Technology

In FY 2017, the Office of Information Technology (OIT) was composed of the following business units:

- **The Medicaid Management Information System (MMIS) unit,** which supported the various systems used for processing, collecting, analyzing and reporting information needed for all Medicaid and PeachCare for Kids® claim payment functions.
- **The Office of Health Information and Analytics (OHIA)**, which supported the Georgia Department of Community Health (DCH) Decision Support System and provided analytical and reporting services to DCH for the Medicaid, PeachCare for Kids® (PCK) and State Health Benefit Plan (SHBP) populations.
- **The Information Technology Infrastructure (ITI) unit,** which provided end-user computing support and information technology oversight for the entire agency.
- **The Office of Information Security,** which ensured information and technology security compliance for DCH systems.
- **The Medicaid Information Technology Architecture (MITA) unit,** which implemented Georgia's MITA framework including the State Self-Assessment, Business Architecture, Information Architecture and the initiation of business process projects that will allow Georgia to mature along the MITA framework.

Accomplishments

- OIT and its partners continued planning and strategy development for the MMIS Transformation and Re-procurement project. The project has completed analysis of the current state and capability of IT systems and processes that make up the MMIS. The Centers for Medicaid and Medicare Services (CMS) will require states to implement solutions which are modular and MITA-aligned. A market scan has also been conducted to determine the state of modularity in the MMIS and Medicaid systems marketplace.
- OIT worked with agency and vendor partners to complete a variety of IT and security-related tasks associated with preparing for Georgia Gateway go live and participated in successful go live activities for the new system.
- The IT Infrastructure Unit added resources to fully support remotely-located staff and locations using the Cordele office. The unit worked closely with other DCH divisions to consolidate IT support functions as part of a functional alignment strategy.
- The IT Infrastructure Unit also consolidated and decommissioned legacy servers and storage in order to create savings in infrastructure costs.

- The MMIS Unit worked closely with Medicaid managed care teams and vendor partners to implement the systems components required to successfully onboard a fourth Care Management Organization (CMO).
- Working closely with vendor and agency partners, the MMIS Unit completed testing and interfacing work between GAMMIS and the new Georgia Gateway system in time for system go live.
- The Office of Information Security developed and began to execute a security and risk assessment plan to improve information security, better guard against cyber-security threats and identify security risks.
- The MITA Unit continued to identify and develop projects and strategies to improve automation and advance DCH in MITA maturity. The MITA team participated in several important projects and procurements to ensure MITA-alignment and improve results.
- The Office of Health Information and Analytics completed the evaluation of proposals associated with the Enterprise Data Solution (EDS) procurement which, when implemented, will provide DCH with a modern, powerful data warehouse and analytical resource.

Office of Inspector General

The Office of Inspector General (OIG) is a major asset in safeguarding the integrity of the Georgia Department of Community (DCH) from risks internally and externally. Detecting fraud, waste and abuse is the office's clear charge. The OIG rigorously reviewed, investigated and audited Medicaid providers and recipients to uncover criminal conduct, administrative wrongdoing, poor management practices and other fraud, waste and abuse. The OIG also recovered the cost of medical expenditures from liable third parties when members were involved in a personal injury action. Additionally, the OIG provided Department oversight and audit services.

In FY 2017, the office had seven units:

- **Background Investigations Unit (BIU)**-Performs state criminal background investigations for DCH employment, contractors and applicants for Purchasing Cards. Additionally, the Background Investigations Unit conducts state and federal background checks of owners, directors and employees of various licensed healthcare facilities.
- **Data Integrity and Analysis Team (DIAT)** – Generates data reports and claim information to support provider and member analysis and audits/reviews for the OIG. DIAT also performs research analysis to support the detection of fraud, waste and abuse of Medicaid Programs and to support the Georgia Department of Law, Medicaid Fraud Control Unit (MFCU) and requests from the federal Health and Human Services (HHS), Office of Inspector General.
- **OIG Legal/SHBP Fraud Team (OL/SHBP)** – Reviews legal correspondence, consults and represents the OIG at administrative hearings. The State Health Benefit Program (SHBP) Fraud Team is responsible for oversight of fraud, waste and abuse within SHBP's health plans.
- **Office of Audits (OA)** – Conducts internal operational and financial audits and reviews of DCH business units for compliance with department policies
- **Program Integrity (PI)** – Ensures that eligible Medicaid members have access to healthcare facilities and healthcare professionals to receive quality care. PI educates providers about compliance regulations in accordance with the policies and procedures established by state and federal guidelines. The core function of the unit is to guard against fraud, abuse and deliberate waste to ensure that taxpayer funds are used in a responsible manner.
- **Third Party Liability (TPL)** – Identifies, maintains and recovers third-party resources

that are liable for the cost of medical expenditures of the Medicaid members.

- **Special Investigations Unit/Internal Investigations (SIU/II)** – Conducts provider and member investigations to ensure compliance with state and federal laws, and investigates allegations of misconduct by DCH employees, contractors and vendors.

Accomplishments

- The Background Investigations Unit (BIU) processed 302 background checks for the Office of Human Resources. A total of 1,627 criminal background checks were completed for DCH's Healthcare Facility Regulation Division (HFRD) for licensed facilities. Of those, 1,339 satisfactory determinations were issued.
- During FY 2017, the Data Integrity and Analysis Team (DIAT) Unit was successful in compiling 312 data requests which assisted in the identification of fraud, waste and abuse. Additionally, DIAT identified improvements and tested modifications on the Ad Hoc reporting system of the Medicaid Management Information System (MMIS). Three provider cases were submitted to the MFCU for potential provider fraud.
- DIAT conducted data analysis reviews of thirty-three (33) Qui-Tam cases representing more than $300 million dollars for which the amount of recovery is to be determined. DIAT also provided data reporting, analysis and support to the federal U.S. attorneys and the MFCU to settle a major Qui Tam which resulted in recoveries of more than $120 million.
- In FY 2017, the Office of Audits monitored and tracked PI recoveries which totaled $20.5 million. The office also performed 11 operational and financial audits of various agency business units; provided financial data and/or advice when requested by the OIG staff or DCH staff; and, facilitated Federal and DOAA external audits and/or data requests to ensure timely responses by DCH staff.
- The PI Unit opened 403 cases and closed 591 cases in FY 2017. In addition, the OIG continued to engage providers in informally resolving issues identified during PI reviews. The Department has used discretion in reducing overpayments identified that are attributable to simple errors, and do not affect the quality of care the member received. During FY 2017, PI recouped $20.5 million.

The Third Party Liability Unit (TPL)

For FY 2017, a total of 10,375 cases were opened and 10,981 cases were closed/settled. TPL also opened 2,061 applications resulting from the Health Insurance Premium Payment Program (HIPP) and Children's Health Insurance Program Reauthorization Act (CHIPRA), of which 1,851 applications were denied. For FY 2017, DCH's TPL contractor recovered $39.7 million, and $1.8 million was recovered with the assistance of the Office of the Attorney General, for total TPL recoveries of $41.5 million.

Special Investigations Unit (SIU) Internal Investigations (II)

In FY 2017, 465 Medicaid recipient and provider cases were opened and 319 cases were closed which resulted in a cost savings of $291,330.77 for the State of Georgia. Twenty-two (22) member cases were also presented to various District Attorney's for prosecution for allegations of fraud. These members were ordered to pay restitution, and were sentenced to probation resulting in a recoupment of $29,698. Thirty-one (31) Medicaid provider referrals were sent to the Medicaid Fraud Control Unit (MFCU) for further investigation.

SIU also assisted HFRD with conducting investigations of unlicensed Personal Care Homes. For FY 2017, SIU assisted Healthcare Facility Regulation Division (HFRD)with conducting 200 investigations of unlicensed Personal Care Homes.

Communications & Legislative Affairs

The Office of Communications and Legislative Affairs was the primary point of contact and outreach for all Department of Community Health (DCH) internal and external communications, and all legislative activities with the Georgia General Assembly. The Office's three main programs include communications, legislative affairs and constituent services. The office handled all media and public relations for the Department, responding to the department's diverse communications needs with tools like the DCH website, press releases, e-newsletters, social media channels, Intranet and more. Legislative Affairs staff served as the liaison to government officials, lobbyists, patient advocacy groups and health-related organizations to support departmental initiatives and programs. Constituent Services staff were customer service agents for the department, interacting daily with members, providers, legislators and others to help Georgians understand the Medicaid and State Health Benefit Plan programs, as well as the department's business functions as a whole. In FY 2017, DCH Constituent Services responded to and sought outcomes for 2,792 constituent inquiries.

During FY 2017, communications staff wrote and distributed 11 news releases/ advisories and responded to more than 150 media inquiries. Media interest focused on the State Health Benefit Plan (SHBP), Medicaid, Healthcare Facilities Regulation Division (HFRD), the launch of the Georgia STABLE program and other various issues with requests received from state, regional and national media outlets.

Communications continued to produce several publications that have become vital sources of Department news and updates. This included 10 editions of DCH-i, the agency's external newsletter, and 12 editions of DCHNOW, an internal monthly e-newsletter for DCH staff. Communications also sent numerous special email bulletins to stakeholders informing them of upcoming changes, deadlines and other important DCH news. DCH social media channels, including a Facebook page and a Twitter feed, communicated news and information to interested citizens. Communications also continued building a new DCH Intranet Sharepoint site for greater user accessibility and ease of use.

Operations

The Operations Division continued its efforts to improve the quality and efficacy of service to its external and internal customers. The Division's administrative offices consisted of the Office of Strategic Management (OSM), which had oversight of Vendor, Grantee Management and Support Services; the Office of Human Resources (OHR); the Office of Procurement Services and the State Office of Rural Health (SORH). Collectively, these Offices focused primarily on further enhancing developed process improvement initiatives that allowed for shortened process times for requests; removal of duplicate or superfluous procedures to streamline activities; and the identification of systematic workflows to improve efficiency. These administrative offices support each of the agency's divisions as well as the stakeholders who assist the Department in improving the health status of Georgians.

The Office of Strategic Management

OSM has oversight of Vendor and Grantee Management and the Strategic Management unit. These administrative areas are charged with ensuring the agency is exercising its fiduciary responsibility with respect to its contracted agreements with vendors and grantees. Further, OSM collaborates with internal partners to identify and manage the agency's strategic initiatives to make certain we are operating effectively in furthering the agency's mission and goals.

The Strategic Management Unit

During state FY 2017, the Strategic Management unit utilized the agency dashboard to report on the execution of 12 strategic initiatives so that potential barriers to successful achievement could be effectively addressed in a timely manner. Also, this area facilitated the realignment of the agency's three-year strategic plan (FY 2018 – 2020).This updated plan included three agency-wide goals and more than 20 innovative strategies that govern how these goals will be met. The Strategic Management unit also coordinated the update and approval of more than 100 statewide performance measures for the agency and its attached agencies.

Additionally, the Strategic Management unit continued its critical assignment of reviewing agency-wide policies to ensure they contained current and accurate information. Many of these policies address state or federal mandates, so it is imperative that we align these policies with governing guidance.

The Office of Vendor Management

The Office of Vendor Management provides critical oversight of the agency's contracted vendors by providing continuous, effective assessments of the vendors' performance. During FY 2017, Vendor Management continued its efforts to provide enhanced monitoring of agency vendors through the issuance of Performance Assessment Reports which outline whether the vendor is compliant or non-compliant with its contractual obligations. Vendor Management issued more than 240 Performance Assessments with an average vendor compliance rating of 93.4 percent through 3rd quarter 2017.

The Office of Support Services

The Office of Support Services handles various functions for the Department, including: mail services, asset management, business continuity/disaster recovery, facility and space management, telecommunications, records management, fleet management, real estate leases, audiovisual equipment operation, safety, and Support Services administrative and accounting functions. During FY 2017, Support Services completed more than 458 work order requests; submitted 44 Agency Transfer Requests which involved more than 1,874 pieces of Property via Asset Works/DOAS Surplus Property; metered 130,649 pieces of outgoing mail and sorted and delivered more than 300,000 pieces of incoming mail; administered 124 leases; transferred 46 boxes of records to the State Record Center; provided audiovisual services for approximately 50 meetings; processed two fleet purchases and transfers; conducted 24 safety training sessions for new employees; completed facility modifications, staff relocations and other infrastructure requests to support all the divisions and attached Agencies of the Department.

Office of Human Resources

OHR provides human resources support to a workforce of just under 1,100 employees. OHR is committed to supporting the agency through effective recruitment, retention and training strategies that help ensure DCH's workforce is equipped to handle the mission and goals of the Department. During FY 2017, the employee turnover rate for the Department was 16 percent compared to the state's FY 2017 rate of 19.95 percent. There were 25 retirements which represented 13.8 percent of the 181 employees who left the Department during FY 2017. Innovative recruitment, retention, succession planning, effective training and employee work life balance continues to be a focus of HR services. The Office on-boarded 202 new employees during FY 2017. In addition, HR is committed to supporting the Commissioner's teamwork and customer service focus by developing and implementing innovative training methods and opportunities for employee growth and development.

The State Office of Rural Health

In FY 2017, SORH administered state and federal funding totaling $16,065,713. The SORH linked Georgia's 109 rural counties with state and federal resources to develop long-term solutions to address healthcare delivery issues and improve health status. The focus of funding continues to be initiatives to facilitate the work of the Rural Hospital Stabilization Committee to support rural hospitals in improving financial stability, increasing number of school-based telehealth sites, placing physicians and allied health professionals in underserved communities, and identifying creative ways to make healthcare more accessible in Georgia's underserved rural and urban areas. The SORH facilitated improved access to primary healthcare in all underserved areas of Georgia by using education, information, technology and collaboration among the multi-levels of health providers. Programs include Federally Qualified Health Center Start Up, Rural Health Networks, Area Health Education Centers, Health Professional Shortage Designations, J1 Visa Waiver Programs, the National Health Service Corps, Georgia Breast Cancer Tag Program, and Erlanger & GA Department of Public Safety (Camilla) Air Ambulance Projects; the Rural Swing Bed Education and Training program for critical access and PPS small rural hospitals that includes Best Practices for Compliance & Efficiency. Additional programs include: Rural Georgia Behavioral Health Environmental Scan Grant, Georgia Rural Hospital External Peer Review Network, Georgia Rural Hospital Board Education, Patient Centered Medical Home Program as well as the Georgia Farmworker Health Program, Healthcare for the Homeless, Southeastern Firefighters Burn Foundation, Georgia Charitable Care Network, Strengthening Rural Communities through Child Abuse Education and Horizons Community Solutions Grant.

Attached Agencies

The Georgia Boards of Pharmacy and Dentistry

The Georgia Board of Dentistry is responsible for the protection of the public's health through the regulation of the practice of dentistry and the enforcement of standards of practice. The Georgia Board of Dentistry issues licenses to qualified dentist and dental hygiene applicants. It also identifies, investigates and sanctions those licensees who practice below the accepted standards of the profession (or without the necessary qualifications). It also distinguishes between safe and dangerous dental practices through its rules and policies.

The Georgia Board of Pharmacy regulates pharmacy personnel and pharmacy facilities in Georgia. The Georgia Board of Pharmacy reviews applications, administers examinations, licenses qualified pharmacists, pharmacy interns, pharmacy technicians and pharmacy facility applicants, and regulates the practice of licensees. Complaints are investigated through its affiliated agency, the Georgia Drugs and Narcotics Agency, and if warranted, disciplinary action may be taken by the Board.

Accomplishments

In FY 2017, the Georgia Board of Pharmacy adopted an emergency rule regarding the standing order for the prescription of Naloxone issued through the Department of Public Health (DPH). This expanded access to naloxone, a life-saving drug for overdose prevention as the nation tries to stem the impact of an opioid epidemic. The Board also began working on the transition of the Prescription Drug Monitoring Program from Georgia Drugs and Narcotics to the Department Public Health (DPH). In further collaboration, the Board has made itself available as a resource to the DPH as it works on its Strategic National Stockpile Transportation Security Plan.

In FY 2017, the Georgia Board of Dentistry adopted a rule regarding expedited licenses for service members and military spouses. Additionally, the Board continued to streamline processes regarding investigations and applications processing.

- **Georgia Composite Medical Board** licenses physicians, physician assistants, respiratory care professionals, perfusionists, acupuncturists, orthotists, prosthetists, auricular (ear) detoxification specialists, residency training permits, cosmetic laser practitioners and pain management clinics. The Medical Board investigates complaints and disciplines those who violate The Medical Practice Act or other laws governing the professional behavior of its licensees.
- **Georgia Board for Physician Workforce (GBPW)** strives to identify the physician workforce needs of Georgia communities and to meet those needs through the

support and development of medical education programs.

- **Georgia Drugs and Narcotics Agency** protects the health, safety and welfare of the public by ensuring all of the laws pertaining to pharmacy, dangerous drugs, and controlled substances are followed by both registrants and any others who handle or possess pharmaceuticals.

Appendix

Below is a list of the auxiliary charts and maps for the FY 2017 Department of Community Health Annual Report. To access the charts and maps, please visit to https://dch.georgia.gov/annual-reports.

- MEDICAID MEMBERS AVERAGE BY COUNTY MAP
- MEDICAID NET PAYMENTS AND CAPITATION AMOUNT BY COUNTY MAP
- PEACHCARE FOR KIDS® AVERAGE MEMBERS BY COUNTY
- PEACHCARE FOR KIDS® NET PAYMENTS AND CAPITATION AMOUNTS BY COUNTY MAP
- SOURCES OF REVENUE - INDIGENT CARE TRUST FUND
- SHBP AVERAGE MEMBERSHIP BY COUNTY
- SHBP PAYMENTS BY COUNTY