STATE OF GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2021–2023 Quality Strategy

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

The Georgia draft Quality Strategy was submitted to the Centers for Medicare & Medicaid Services on May XX, 2021.

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Introduction and Overview

Executive Summary

The Georgia Department of Community Health (DCH), created in 1999 by the Georgia General Assembly through the consolidation of four health agencies serving the State's growing population of almost 10 million people, serves as Georgia's lead agency for healthcare planning, purchasing, and oversight. The DCH is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. Both programs include fee-for-service (FFS) and managed care (care management) components. The single State agency for Medicaid, DCH is governed by a nine-person board, the Board of Community Health, whose members are appointed by the Governor. In 2003, DCH identified unsustainable Medicaid growth and projected that without a change to the system, the Medicaid program would require 50 percent of all new State revenue by 2008, with Medicaid utilization driving more than 35 percent of the State's annual growth.

For those reasons, DCH decided to employ a care management approach to organize its fragmented system of care, enhance access, achieve budget predictability, explore possible cost containment opportunities, and focus on systemwide performance improvements. The DCH believed that managed care would continuously improve the quality of healthcare and services provided to eligible members and improve efficiency by using both human and material resources more efficiently and effectively. In 2004, the DCH Division of Managed Care and Quality submitted a State Plan Amendment to implement a full-risk mandatory managed care program called Georgia Families (GF) for Medicaid and PeachCare for Kids® members. PeachCare for Kids® is the State's standalone CHIP program. The DCH implemented the GF program in 2006.

The DCH designed the GF program to serve specific Medicaid-eligible and PeachCare for Kids® members. Georgia requires mandatory enrollment of specific Medicaid beneficiaries into the GF program in accordance with Section 1932(a) (1) (A) of the Social Security Act which is referenced in Georgia's State Plan Amendment for Managed Care. The specific beneficiary categories include Low Income Medicaid (LIM), transitional Medicaid, pregnant women in Right from the Start Medicaid (RSM), children in RSM, newborns of Medicaid-covered women, women with breast or cervical cancer under age 65, and refugees. In August 2010, DCH received approval from the Centers for Medicare & Medicaid Services (CMS) to allow children under 19 years of age who were receiving foster care or adoption assistance under Title IV-E to enroll in managed care. Georgia refers to its health maintenance organizations (HMOs) as care management organizations (CMOs).

In July 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to the concerns that the Patient Protection and Affordable Care Act (ACA), the national recession, and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high-quality care in a cost-effective manner.

As of December 2020, DCH managed the care of over 1.7 million members under the GF and GF 360º programs. The majority of members are under 18 years of age. The contracted CMOs strive to contain health expenditures, improve access to care, and improve quality of care through activities such as utilization management, provider contracting, case and disease management programs, and performance improvement projects (PIPs).

The DCH developed this Quality Strategy in accordance with 42 Code of Federal Regulations (CFR) §438.200 et. seq. The DCH developed the Quality Strategy to continually monitor, assess, and improve the timeliness and delivery of quality healthcare to all Medicaid and CHIP members served by the Georgia Medicaid managed care and FFS programs. The DCH's Quality Strategy provides the framework to accomplish DCH's mission of providing Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight.

The Quality Strategy's purpose, goals, scope, assessment of performance, interventions, and annual assessment are detailed in this Quality Strategy. Documents referenced in the Quality Strategy include:

The Annual External Quality Review (EQR) Technical Report

https://dch.georgia.gov/search?search=quality+strategy&sm_site_name=dch

The Medicaid State Plan

https://dch.georgia.gov/medicaid-state-plan

Medicaid Care Management Organization Contracts and Amendments

Georgia Families:
https://medicaid.georgia.gov/search?search=contracts&sm_site_name=medicaid

Georgia Families 360º:
https://medicaid.georgia.gov/search?search=contracts&sm_site_name=medicaid

The DCH remains committed to a culture of quality. Across the Department, attention to outcomes, process improvement, and sustainability are important to achieving the goals of the DCH Quality Strategy. The DCH maintains ultimate authority and responsibility for the maintenance and annual evaluation of the Quality Strategy. The DCH updates the Quality Strategy as needed based on CMO performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Georgia Medicaid program.

This Quality Strategy aims to guide Georgia's Medicaid program by establishing clear aims and goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding care management entities accountable for desired outcomes. The Quality Strategy serves as the roadmap for developing a dynamic approach to assessing, monitoring outcomes, and improving the quality of healthcare and services furnished by the care management and FFS entities and providers.

To demonstrate compliance with CMS' Quality Strategy Toolkit for States, DCH created a crosswalk (Appendix A) that lists each of the required and recommended elements of state quality strategies, and the corresponding section of the DCH Quality Strategy and/or DCH/CMO contract that addresses the required or recommended elements.

Purpose, Scope, and Goals of the Quality Strategy

Purpose of the Quality Strategy

Consistent with its mission, the purpose of DCH's Quality Strategy is to establish and describe:

- Quality performance measures with targets for the CMOs related to access, utilization, service quality, and appropriateness.
- Value-based purchasing (VBP) performance metrics for the GF 360° program that align with some of the State's key focus areas for improved care and member outcomes.
- The DCH's processes for assessing, monitoring, and reporting on the CMOs' performance, progress, and outcomes related to the State's strategic goals and areas of focus.
- Adoption of innovative quality improvement (QI) strategies and ensuring DCH and the CMOs are in tune with the latest advances in QI science through participation in QI trainings and technical assistance sessions sponsored by CMS and those hosted by the external quality review organization (EQRO).
- Numerous collaborative efforts by DCH that include interagency coordination and participation of other key stakeholders, along with the CMOs and provider community, to leverage the talent and resources needed to address shared challenges that impede improved performance.

Scope of the Quality Strategy

The following are included in the scope of the Quality Strategy:

- All Medicaid and CHIP managed care members in all demographic groups and in all service areas for which the CMOs are approved to provide Medicaid and CHIP care management services.
- All aspects of care—including accessibility, availability, level of care, continuity, appropriateness, timeliness, and clinical effectiveness of care and services covered by DCH's Medicaid care management and CHIP programs.
- All aspects of the CMOs' performance related to access to care, quality of care, and quality of service, including networking, contracting, credentialing, and medical record-keeping practices.
- All services covered—including preventive care services, primary care, specialty care, ancillary care, emergency services, chronic disease, special needs care, dental services, mental health services, diagnostic services, pharmaceutical services, skilled nursing care, home healthcare, and prescription drugs.
- All professional and institutional care in all settings, including inpatient, outpatient, and home settings.
- All providers and any other delegated or subcontracted provider types.
- All aspects of the CMOs' internal administrative processes related to service and quality of care—including customer services, enrollment services, provider relations, confidential handling of medical records and information, case management services, utilization review activities, preventive health services, health education, information services, and QI.

Strategic Overview

Quality Strategy Aims and Goals

The DCH's program aims to accomplish the following Key Goals:

- Improve the health status of Georgians by promoting healthy lifestyles, preventive care, disease management, and disparity elimination.
- Improve access to quality healthcare at an affordable price.
- Ensure value in healthcare contracts.
- Move health plans administered by DCH toward being financially solvent to meet the needs of members.
- Increase effectiveness and efficiency in the delivery of healthcare programs.
- Ensure DCH has enough workers with the necessary skills and competencies to meet the current and future demand.

The DCH Pillars

The DCH has identified four pillars under which it aligns the Quality Strategy's Key Goals.

Pillar One: Quality

- Improve the health status of Georgians by promoting healthy lifestyles, preventive care, disease management, and disparity elimination.

Pillar Two: Stewardship

- Move health plans administered by DCH toward being financially solvent to meet the needs of members.
- Ensure value in healthcare contracts.
- Increase effectiveness and efficiency in the delivery of healthcare.

Pillar Three: Access

- Improve access to quality healthcare at an affordable price.

Pillar Four: Service (Patient Experience)

- Ensure DCH has enough workers with the necessary skills and competencies to meet the current and future demand.

The Quality Strategy is intended to guide Georgia's Medicaid care management program by establishing clear aims and goals to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions and details the standards and mechanisms for holding CMOs accountable for desired outcomes. The Quality Strategy is a roadmap through which DCH will use the care management infrastructure to facilitate improvements in health and healthcare through programmatic innovations, whole-person care, health equity, provider supports, and steps to address health-related unmet resource needs. This vision is distilled into three central aims:

1. Improve health, services, and experience
2. Smarter spending
3. Home and Community-based Services-Long-term Services and Supports (HCBS-LTSS): Improve Health and Services

Included within each of these three aims is a series of goals, intended to highlight key areas of expected progress and quality focus. Together, as is shown in Table 1, these create a framework through which Georgia defines and drives the overall vision for advancing the quality of care provided to Medicaid members in the State of Georgia. These aims and goals were designed to align closely with CMS' Quality Strategy, adapted to address Georgia's local priorities, challenges, and opportunities for its Medicaid program. The

DCH capitalizes on strategic community partnerships and leverage of CMOs to achieve the goals of the Quality Strategy. The DCH's quality measures and targets may be found in Appendix B.

Table 1—Quality Strategy Aims and Goals

Aims	Goals	Pillar
 **Aim 1:** Improve Health, Services & Experience	**Goal 1.1:** Improve Access to Care	**Access**
	Goal 1.2: Increase Wellness and Preventive Care	**Quality**
	Goal 1.3: Improve Outcomes for Chronic Diseases	**Quality**
	Goal 1.4: Improve Maternal and Newborn Care	**Quality**
	Goal 1.5: Improve Behavioral Health Care Outcomes	**Quality** **Access**
	Goal 1.6: Enhance Member Experience	**Service**
 **Aim 2:** Smarter Spending	**Goal 2.1:** Increase Appropriate Utilization of Levels of Care	**Stewardship**
	Goal 2.2: Effective Medical Management of Care	**Stewardship**
 **Aim 3:** HCBS-LTSS: Improve Health and Services	**Goal 3.1**: Improve Health and Well-Being of Persons Receiving Community-Based Services	**Quality**

Note: Each goal has targeted metrics to measure progress, as well as outlined interventions to advance the goals. See Appendix D.

To accomplish the goals, specific performance measures are used to track the progress of the implementation of interventions. This approach provides for data-driven decision making to drive interventions, inform priority setting, and facilitate efficient and effective deployment of resources.

Development of the Quality Strategy Aims and Goals

The Quality Strategy describes DCH's mission, which is to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH's vision is that the Department will be a lean and responsive State agency that promotes the health and prosperity of its citizens through innovative and effective delivery of quality healthcare programs. The Quality Strategy aims and goals described in Table 1 are focused on achieving the DCH mission and vision.

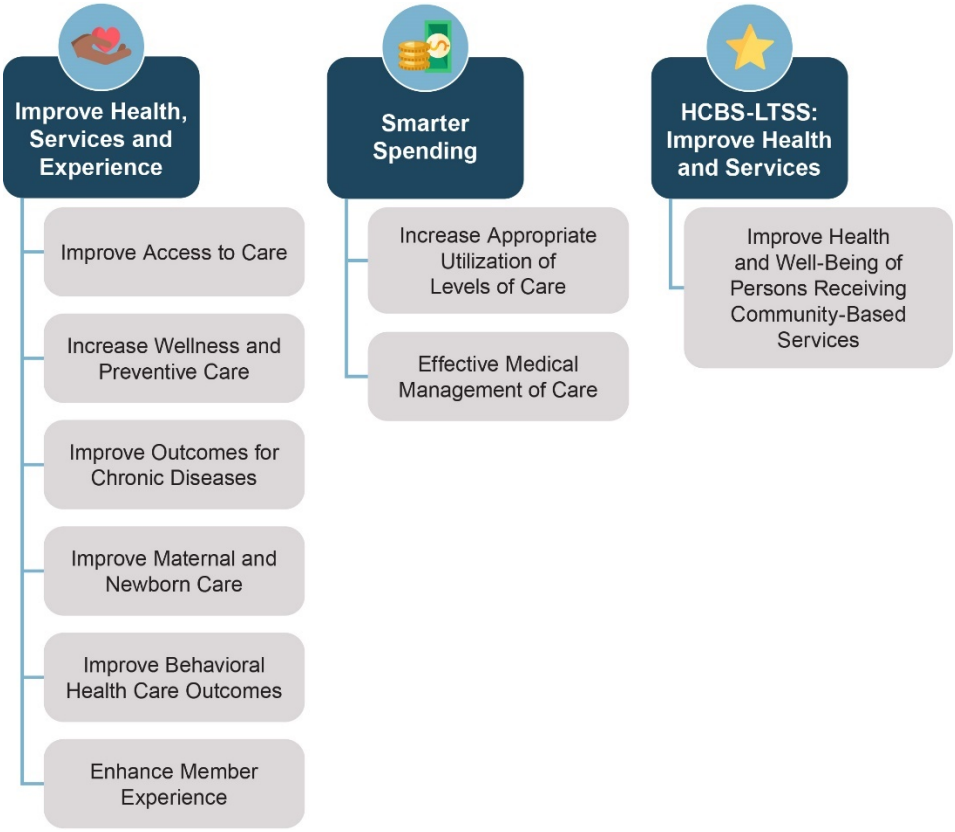
The Quality Strategy goals reflect significant community and stakeholder input as well as thoughtful consideration of the quality issues that are most important in Georgia. The DCH additionally considered the quality areas of greatest importance to Georgia's Medicaid population, and where current data indicated an opportunity for targeted improvement. The goals are similarly aligned to ensuring beneficiary access to services.

Each of the nine goals are tied to focused interventions used to drive improvements within and, in many cases, across the goals and objectives set forth in this Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(2), these interventions are tied to a set of metrics by which progress is assessed.

As updated data related to the Medicaid program performance become available, DCH intends to further refine these objectives to target specific improvement goals, including additional metrics that address disparities in health. CMOs are required to maintain systems that collect, analyze, integrate, and report encounter data that are timely, accurate, and complete. These data are used for several purposes and will be key to assessing the quality, access, and timeliness of Georgia's Medicaid managed care program. The EQRO will play a critical role in ensuring the validity of CMOs' reported encounter data, as well as in the validation and calculation of quality measures. The DCH is committed to using these reports to assess opportunities for continued improvement and how priorities may evolve over time.

Together, this framework represents a comprehensive plan for delivering high-quality, accessible, timely care to Medicaid managed care beneficiaries (Figure 1).

Figure 1—Georgia's 2021–2023 Quality Strategy Framework



Strategy for Meeting Goals

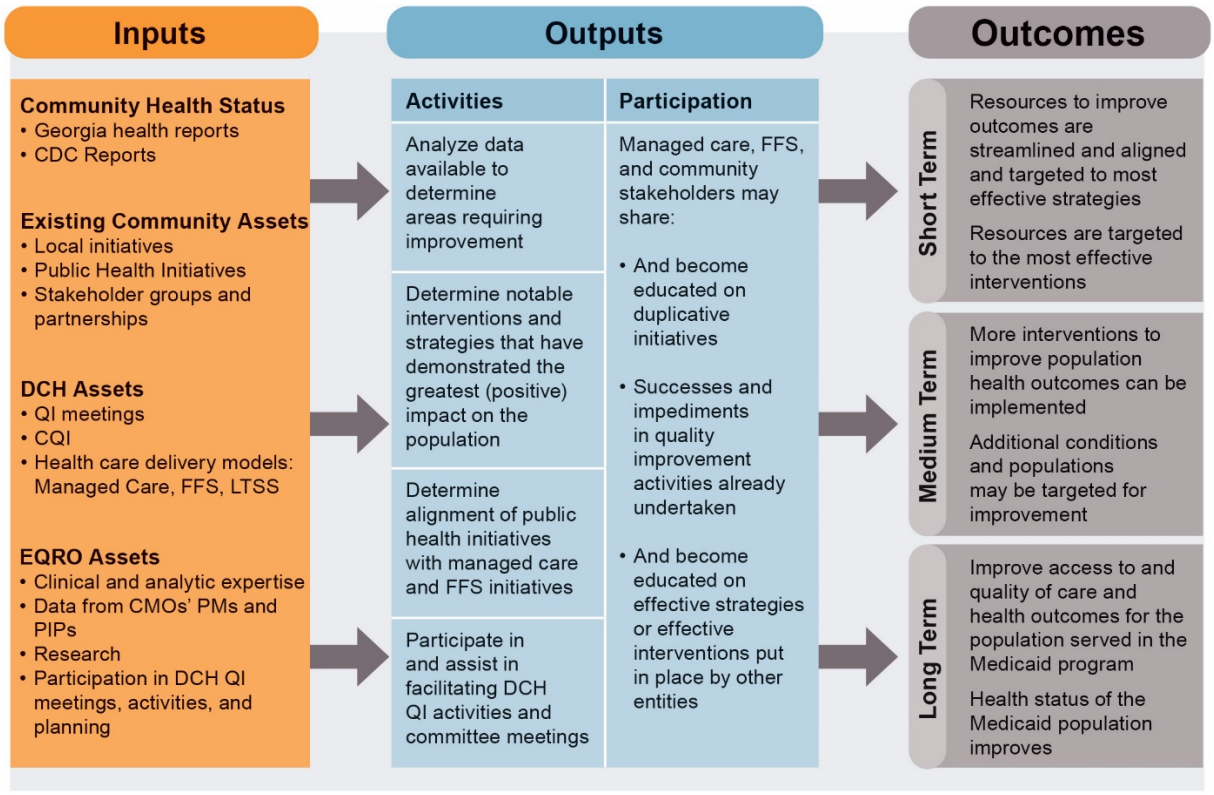
The methods employed by DCH to achieve these goals include:

- Developing and maintaining collaborative strategies among State agencies, community resources, and external partners to improve health education and health outcomes, manage vulnerable and at-risk members, and improve quality of care and access to services for all Georgia Medicaid members.
- Using additional performance measures, PIPs, contract compliance monitoring, and emerging practice activities to drive improvement in member healthcare outcomes.
- Strengthening evidence-based prevention, wellness, and health management initiatives to improve members' health status and achievement of personal health goals.
- Enhancing member services and member satisfaction with services.

- Improving health information technology (HIT) to ensure that information retrieval and reporting are timely, accurate, and complete.

The logic model contained in Figure 2 depicts the DCH strategy for improving health outcomes.

Figure 2—Quality Strategy Logic Model



Abbreviations used in the logic model: CDC—Centers for Disease Control and Prevention; CQI—continuous quality improvement; HCBS—home and community-based services; PM—performance measure

Background and Structure of Georgia's Medicaid Program

History of Medicaid in Georgia

Georgia Medicaid adopted managed care in 1993. In 1999, the State created the Georgia Department of Community Health (DCH) as the single State agency to manage and have oversight of the Medicaid program. In 2003, DCH identified unsustainable Medicaid growth and projected that without a change to the system, the Medicaid program would require 50 percent of all new State revenue by 2008, with Medicaid utilization driving more than 35 percent of the State's annual growth. For those reasons, DCH decided to employ a managed care approach to organize its fragmented system of care, enhance access, achieve budget predictability, explore possible cost containment opportunities, and focus on systemwide performance improvements.

In 2004, the DCH Division of Managed Care and Quality submitted a State Plan Amendment to implement a full-risk mandatory managed care program called Georgia Families (GF) for Medicaid and PeachCare for Kids® (the State's standalone CHIP program) members which received CMS approval.

In 2006 DCH transitioned to a statewide managed care system known as Georgia Families (GF). The program was designed to serve specific Medicaid-eligible and PeachCare for Kids® members. Georgia requires mandatory enrollment of specific Medicaid beneficiaries into the GF program in accordance with Section 1932(a) (1) (A) of the Social Security Act which is referenced in Georgia's State Plan Amendment for Managed Care. The specific beneficiary categories include LIM, transitional Medicaid, pregnant women in RSM Medicaid (RSM), children in RSM, newborns of Medicaid-covered women, women with breast or cervical cancer under age 65, and refugees. Georgia refers to its HMOs as CMOs.

The Children and Families Task Force was one such group established in 2012 to study ways to improve care for children in foster care, adoption assistance, and certain children in the juvenile justice system. The group met throughout 2013 and into 2014. The GF 360° program, a managed care program specifically for the foster care, adoption assistance, and juvenile justice populations, was the result of that collaboration. Seven State child-serving agencies came together to develop a plan to transition these members from a FFS environment to a managed care environment. Approximately 27,000 children in foster care, adoption assistance, and juvenile justice youth in non-secure community residential placements transitioned to managed care for their healthcare coverage on March 3, 2014.

In August 2010, DCH received CMS approval to allow children under 19 years of age who were receiving foster care or adoption assistance under Title IV-E to enroll in managed care. Beginning in 2011, DCH initiated a very inclusive and transparent process to analyze Medicaid redesign options and in designing a program specific to youth in foster care, juvenile justice, and adoption assistance. The DCH and its agent facilitated public input through statewide stakeholder focus groups, two public hearings, an online survey, and task forces. The DCH also allowed for submission of comments through a "MyOpinion" mailbox.

In July 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to the concerns that ACA, the national recession, and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high-quality care. Subsequent to the delivery of the comprehensive assessment and recommendations in 2012, DCH engaged several stakeholder groups to obtain feedback while considering Medicaid redesign options. The stakeholder groups included DCH, the Department of Human Services Division of Family and Children Services (DFCS), the Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD), the Department of Public Health, the Department of Juvenile Justice, the Department of Education, and the Department of Early Care and Learning.

The DCH compiled a table of stakeholder group comments and recommendations which covered such areas as DCH program administration, provider credentialing, copayments, claims, reimbursement, prior authorizations, benefits and services, care coordination, data collection, electronic medical records, data sharing, monitoring and oversight, provider networks, access to care, and QI. Examples of the comments and recommendations pertinent to the development of this Quality Strategy are included in Table 2.

Table 2—Quality Strategy Stakeholder Comments and Recommendations

Comments and Recommendations	
Provide centralized credentialing	Align monitoring, PIPs, and focused performance measure targets
Provide a medical home for members	Improve management of psychotropic medications
Provide additional medication management	Provide care coordination services to meet member needs
Provide a dental home for all members	Collect data to monitor success
Ensure timely prior authorization (PA) decisions	Provide members and providers access to Medicaid data
Centralize the PA process	Provide an outside entity to monitor quality
Provide all screenings in compliance with the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) standards	

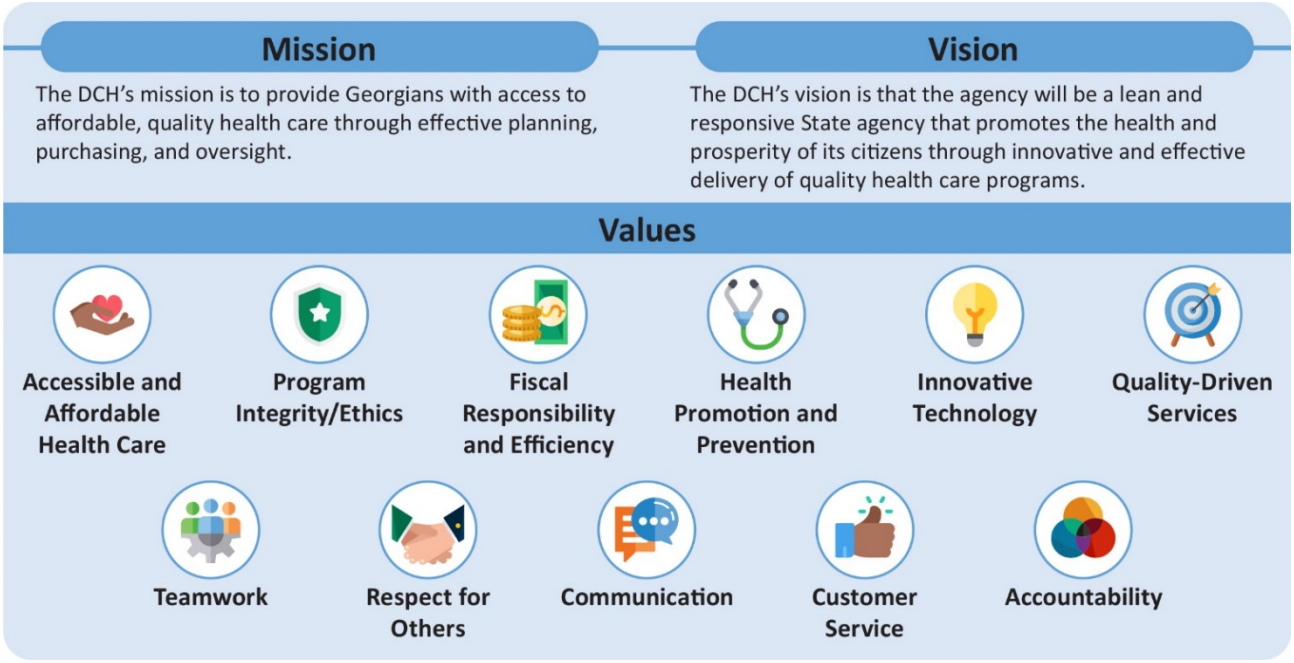
Since 2006, GF has evolved from a startup program focused on operations to a more mature program focusing on quality of care, CMO accountability, and member outcomes. The DCH has regularly gathered meaningful stakeholder feedback about the program and has used this feedback to enhance the program. For example, in 2011, DCH conducted over 30 focus groups with members and advocates, providers, vendors, and legislators; solicited feedback through online surveys; and convened three task forces and one workgroup. Through this collaborative process, DCH worked with the CMOs to implement a variety of QI initiatives to improve quality and health outcomes of members, broadened its GF monitoring and oversight activities, and has implemented or is currently implementing administrative simplifications to improve the member and provider experience. The CMOs strive to contain health expenditures, improve access to care, and improve quality of care through activities such as utilization management, provider contracting, case and disease management programs, and PIPs.

As of May 2020, Georgia Medicaid has nearly 1.7 million members enrolled who receive care under these CMOs: Amerigroup, Peach State Health Plan, CareSource, and WellCare of Georgia. The majority of Georgia Medicaid and CHIP members are 18 years of age and under.

The DCH Mission and Vision

The DCH is committed to upholding its core mission and vision. The DCH's mission, vision, and values, in which the Department's focus on quality is emphasized, are included in Figure 3.

Figure 3—The DCH Mission, Vision, and Values



The DCH Organizational Structure

The DCH maintains a strong organizational structure that is committed to the implementation and oversight of programs that service DCH members. The Quality Strategy's implementation is overseen by the DCH Executive Management Team with specific responsibility assigned to each division within DCH.

The Board of Community Health

The Georgia DCH is governed by a nine-person board appointed by the Governor. The Board of Community Health maintains two committees. The Audit Committee assists the board in fulfilling its oversight responsibilities by reviewing the independent audit process and the independent audit reports. The Care Management Committee provides insight and advice to the Board about the care management activities of all DCH health plans, including Medicaid, PeachCare for Kids®, and the State health benefit plan.

Georgia also has the Georgia Board for Physician Workforce, comprising 15 members: five primary care physicians, five non-primary care physicians, three people from non-teaching hospitals, one member of the business community, and one consumer with no connection to the practices of medicine. Physicians represent a diversity of medical disciplines, including women's health, geriatrics, and children's health. Members serve six-year terms, are appointed by the Governor, and are confirmed by the State Senate. The Board develops medical education programs through financial aid to medical schools and residency programs. The Board also administers medical scholarships and loans to promote medical practice in rural communities.

The DCH Organizational Structure

The DCH's organizational structure responsible for implementing the Quality Strategy is composed of the Medical Assistance Plans (MAP) leadership team and four offices that include:

- MAP Performance and Care Management Office
- MAP Policy, Compliance and Operations Office
- MAP Service Delivery and Administration Office
- MAP Eligibility and Enrollment Office

The DCH's MAP Organizational Charts are found in Appendix G.

Waiver Programs

CMS approves Section 1115 demonstrations and waiver authorities in Section 1915 of the Social Security Act as vehicles that states may use to test new or existing ways to deliver and pay for healthcare services in the Medicaid and CHIP programs.

Waiver programs help people who are elderly or have disabilities and need help to live in their home or community instead of an institution such as a nursing home or intermediate care facility for people with intellectual or developmental disabilities. Each program offers several "core" services:

- Service coordination (help with managing care needs and services)
- Personal support (assistance with daily living activities; i.e., bathing, dressing, meals, and housekeeping)
- Home health services (nursing, home health aide, and occupational, physical, and speech therapy)
- Emergency response systems
- Respite care (caregiver relief)

Additional services are available under each program. The following is a list of waiver programs in Georgia.

Service Options Utilizing Resources in a Community Environment (SOURCE)

The SOURCE Waiver links primary medical care and case management with approved long-term health services in a person's home or community. All SOURCE members must be eligible for full Medicaid and meet nursing home level of care. SOURCE provides home- and community-based services to frail elderly and physically disabled people who meet the intermediate nursing home level of care. Available services include core Medicaid services, personal support services; assisted living services; extended home health; home delivered meals; adult day health care; emergency response services; and 24-hour medical access to a case manager and primary care physician.

Community Care Services Program (CCSP)

The CCSP is a Medicaid home and community-based waiver services program that provides community-based social, health and support services to eligible consumers as an alternative to placement in a nursing home. DCH contracts with Georgia's 12 Area Agencies on Aging (AAAs) to administer the program. Available services include adult day health; alternative living services; emergency response services; home delivered meals; home-delivered services; out-of-home respite care; and personal support services.

New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program (COMP)

The NOW and COMP Waiver Programs provide services and support for people with intellectual or developmental disabilities. The Georgia DBHDD provides day-to-day operations in these programs through six regional field offices. These programs offer an array of services designed specifically for the population such as support employment, residential services, specialized medical equipment and supplies, vehicle adaptation, and behavior support services.

Independent Care Waiver Program (ICWP)

The ICWP offers services to a limited number of adults who apply between the ages of 21 and 64. Eligibility for ICWP is based on either a nursing facility or hospital level of care for adults with severe physical disabilities or traumatic brain injury (TBI). Available services include personal support, home health services, specialized medical equipment and supplies, counseling, emergency response systems, and home modifications.

Georgia Pediatric Program (GAPP)

The GAPP serves eligible children under 21 years of age who are medically fragile and in need of medically necessary skilled nursing care and/or medically necessary personal care support. Available services in-home skilled nursing and personal care services including assistance with daily living activities such as bathing, meals, and housekeeping; monitoring vital signs; assistance with ambulation and transfers; intravenous therapies; wound care; tube feedings; and gastrointestinal disorders.

Patients First Act

Governor Brian P. Kemp signed the Patients First Act into law on March 27, 2019. The Act authorizes DCH to submit a Section 1115 Medicaid Waiver request to CMS and also authorizes the Governor to submit a Section 1332 Waiver to identify innovative health insurance coverage solutions for the commercial health insurance marketplace. In December 2019, DCH submitted an 1115 and a 1332 Waiver request aimed at developing a plan to restructure Georgia's Medicaid program to include partial Medicaid expansion to 100 percent of the Federal Poverty Level (FPL). If approved, the 1115 Medicaid Expansion Waiver would allow approximately 200,000 single, low-income adults to qualify for Medicaid.

Planning for Healthy Babies® (P4HB®)

The DCH offers P4HB® to reduce Georgia's low birth weight rate. P4HB® fills a critical gap in healthcare for underinsured and uninsured women by expanding Medicaid eligibility to those who qualify for family planning services.

Grants

Georgia Money Follows the Person (GaMFP)

Authorized in Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171), as amended by Section 2403 of ACA (P.L. 111-148), the Medicaid Extenders Act of 2019 (P.L. 116-3), the Medicaid Services Investment and Accountability Act of 2019 (P.L. 116-16), the Sustaining Excellence in Medicaid Act of 2019 (P.L 116-39), Sec 205: Further Consolidated Appropriations Act, 2020 (P.L. 116-94), and Sec 3811: Coronavirus Aid, Relief, and Economic Security Act, 2020 (P.L. 116-136) the Money Follows the Person (MFP) demonstration supports State efforts for rebalancing its LTSS system so that individuals have a choice of where they live and receive services. MFP was made possible by an 11-year grant to states from CMS. This grant was designed to help individuals who are institutionalized in inpatient facilities like nursing facilities, hospitals, and intermediate care facilities for individuals with intellectual and developmental disabilities (ICF/IDD) return to their homes and communities.

The overall program goals are to:

- Increase the use of HCBS and reduce the use of institutionally based services.
- Eliminate barriers in State law, State Medicaid plans, and State budgets that restrict the use of Medicaid funds to enable Medicaid-eligible individuals to receive support for appropriate and necessary LTSS in the settings of their choice.
- Strengthen the ability of Medicaid programs to provide HCBS to people who choose to transition out of institutions.
- Put procedures in place to provide quality assurance and improve HCBS.

With an initial award date of May 2007, the State to date has been awarded $159,170,550. The DCH implemented MFP on September 1, 2008, through partnerships with the Department of Human Services/Division of Aging Services, the DBHDD, the Department of Community Affairs, and other State and local agencies and organizations, Under the GaMFP, DCH has transitioned 3,290 persons from institutional settings, far exceeding its initial goal of transitioning 2,754 individuals. GaMFP also provides diversion services to over 3,000* monthly.

The MFP program is designed for people with developmental disabilities, physical disabilities (under age 65 years), traumatic brain injury, older adults, and youth with a mental health diagnosis. Before and after transition from an institution, MFP services enable participants to pay for things not typically covered by Medicaid (i.e., security and utility deposits, furnishings and basic household items, moving costs, environmental modifications to make a home or apartment accessible, connections with peer supports, and other community services).

Other Programs

Right from the Start Medical Assistance Group (RSM)

Right from the Start Medical Assistance Group is a doorway for certain people in need of healthcare coverage. The mission of RSM is to enable children under 19 years of age, pregnant women, low income families, and women with breast or cervical cancer to receive comprehensive health services through Medicaid and related programs. RSM eligibility specialists help these working and low-income families obtain access to no-cost and low-cost healthcare coverage.

TEFRA/Katie Beckett

TEFRA provides Medicaid benefits to eligible children through the TEFRA/Katie Beckett Medicaid program under §134 of the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982 (P.L. 97-248). The Katie Beckett Medicaid Program (KB) permits the State to ignore family income for certain children who are disabled. It provides benefits to certain children 18 years of age or younger who qualify as disabled individuals under §1614 of the Social Security Act and who live at home rather than in an institution. These children must meet specific criteria to be covered.

Qualification is not based on medical diagnosis; instead, it is based on the institutional level of care the child requires. Title 42 CFR outlines the criteria used to determine eligibility.

Populations Served in Managed Care

Georgia Families

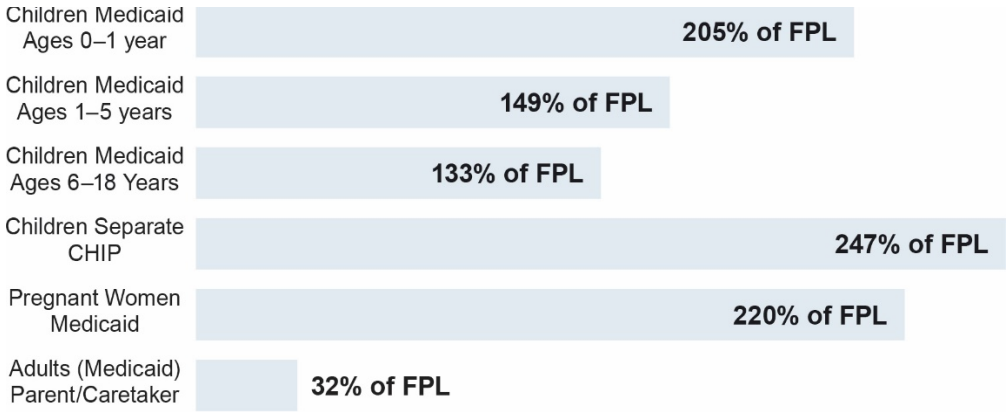
Georgia Families (GF) is a program that delivers healthcare services to members of Medicaid and PeachCare for Kids®. The program is a partnership between DCH and private CMOs. GF provides members a choice of health plans, allowing them to select a healthcare plan that fits their needs.

Georgia Families 360º

GF 360° is Georgia's care management program for approximately 27,000 children, youth, and young adults in foster care, children and youth receiving adoption assistance, and select youth involved in the juvenile justice system. The GF 360º program launched on March 3, 2014, with one of the State's contracted Medicaid CMOs, providing healthcare coverage for these populations.

The income limits for the GF managed care program are included in Figure 4.

Figure 4—Georgia Managed Care Medicaid Income Limit



Populations Not Included in Managed Care

Fee-for-Service (FFS)

While the vast majority of Georgia's Medicaid populations are managed under a CMO, approximately 30 percent are under FFS management. FFS is the traditional healthcare payment system in which physicians and other providers receive a payment for each unit of service they provide. Under the FFS model, Georgia pays providers directly for each covered service received by a Medicaid beneficiary. In general, Georgia set provider payments under FFS. Section 1902(a)(30)(A) of the Social Security Act requires that such payments be consistent with efficiency, economy, and quality of care, and are sufficient to provide access equivalent to the general population. The DCH is responsible for the clinical, administrative, and claims functions of the FFS population. The members of the FFS population include those Medicaid covered groups in the CMS and Georgia Pediatric Program (GAPP) programs; the aged, blind, or disabled; and individuals receiving LTSS or HCBS.

Process for Quality Strategy Development, Review, and Revision

A Roadmap for the Future

The DCH developed this comprehensive Quality Strategy to continually improve the delivery of quality healthcare to all Medicaid and CHIP members served by the Georgia Medicaid managed care and FFS programs. The DCH's Quality Strategy provides the roadmap to accomplish its dynamic approach to achieving its overarching goal of designing, implementing, improving, and assessing the quality of healthcare and services furnished through Georgia's coordinated and comprehensive system. The Quality Strategy promotes the identification of creative initiatives to continually monitor, assess, and improve access to care and the quality, satisfaction, and timeliness of services for Georgia Medicaid and CHIP members.

The DCH's vision for quality extends beyond the 2021–2023 Quality Strategy. The mechanisms for assessing quality, timeliness, and access to care will vary across the Medicaid programs in Georgia; therefore, the Quality Strategy is tailored to incorporate these variances while ensuring an integrated strategy overall. The Quality Strategy requires a succession of incremental steps that DCH will pursue to achieve these quality objectives. The actions and plans outlined herein lay the necessary groundwork for an evolving approach by establishing a strong foundation for quality governance.

With input provided by Georgia Medicaid CMOs, external stakeholders, and the Medical Care Advisory Committee (MCAC), DCH identified goals and objectives for the Georgia Medicaid program. Those goals are supported by performance measures (each performance measure serves as a metric) used to measure performance in achieving the goals identified in the Quality Strategy. The DCH uses the National Committee for Quality Assurance (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS®)[1] and the CMS Core Measure Sets to develop, collect, and report performance measures, in addition to DCH-developed performance metrics.

Initial Quality Strategy and History

42 CFR §438.340

The Quality Strategy is developed by the DCH Managed Care and Quality team with input from the CMOs and stakeholders under guidance from the EQRO (HSAG). The strategy is grounded on the three overarching aims of the National Quality Strategy from which the DCH created its four guiding pillars: quality, access, member experience, and stewardship. Against this framework, the Quality Strategy is developed with the strong focus on improving access to quality care and services in a member-friendly and cost-effective manner. The DCH leadership reviews the Quality Strategy before presenting it for review by the MCAC. The Quality Strategy is then posted for public comment. After review and incorporation of appropriate public comments, the Quality Strategy is submitted to CMS for approval.

The DCH fosters a multidisciplinary approach to developing, reviewing, and revising the Quality Strategy. The approach involves input from the public, medical, oral, and behavioral health providers, stakeholders, member advocates, and community partners who have a direct concern for—and impact on—access, quality of care, and quality of service. All stakeholders may comment on the quality goals and objectives highlighted in the Quality Strategy.

There have been five quality strategic plan revisions completed for the GF program—the original in June 2007 and approved by CMS in February 2008; the second, a revision in February 2010; the third, a revision in November 2011; the fourth, a revision in February 2016, and the fifth, a revision in March 2021. Revisions were submitted to CMS for review and approval and followed the CMS 2006 Quality Strategy Toolkit for

[1] HEDIS® is a registered trademark of NCQA.

States. This 2021 Quality Strategic Plan follows the outline contained in the 2012 Quality Strategy Toolkit for States.

In July 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to concerns that ACA, the national recession, and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high-quality care in a cost-effective manner.

Subsequent to the delivery of the comprehensive assessment and recommendations in 2012, DCH engaged several stakeholder groups to obtain feedback while considering Medicaid redesign options. The original Quality Strategic Plan for the GF program was developed by the DCH Managed Care and Quality Team and reviewed and commented on by 17 entities through the Georgia public comment process authorized by the Official Code of Georgia (O.C.G.A) Sec. 49-4-142(a). The DCH addressed each original comment and amended the original Quality Strategic Plan accordingly. Table 3 lists the original Quality Strategy Plan focus areas.

Table 3—The DCH Original Quality Strategy Focus Areas

Original Quality Strategy Focus Areas	
Promotion of an organization-wide commitment to quality of care and service	Improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance
Promotion of a system of healthcare delivery that provides coordinated and improved access to comprehensive healthcare, and enhanced provider and client satisfaction	Promotion of acceptable standards of healthcare within care management programs by monitoring internal/external processes for improvement opportunities

In 2014, DCH and the CMOs participated in QI training offered by CMS and training led by Georgia's contracted EQRO that specifically targeted rapid-cycle process improvement. The DCH also began working on a request for proposal to reprocure the GF and GF 360º managed care contractors. The trainings assisted the DCH Performance, Quality and Outcomes (PQO) Unit in designing the quality-related requirements for the managed care contracts that were implemented following the reprocurement.

In January 2015, Georgia's EQRO provided a one-half day training to DCH staff and the CMOs' medical management, quality, and leadership staff on strategic planning and rapid-cycle performance improvement. With these new tools in hand, DCH's PQO unit, in association with the Aging and Special Populations unit, updated the Quality Strategic Plan for the GF and GF 360º programs. During strategy development sessions, the group used the DCH mission, vision, and goals as the anchors for the Quality Strategy and incorporated input from the task forces previously mentioned into the strategy development. The DCH solicited input from the DCH MCAC and the Georgia Chapter of the American Academy of Pediatrics. The final draft of the Quality Strategic Plan was posted for public comment, in late December 2015, for 30 days. The DCH received written comments from the CMOs' staff members and verbal comments from a member of the public. As appropriate, the comments were incorporated into the 2016 Quality Strategic Plan.

The DCH mission in the 2016 Quality Strategy Plan was to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH's vision was that the Department would be a lean and responsive State agency that promoted the health and prosperity of its citizens through innovative and effective delivery of quality healthcare programs.

The DCH Key Goals in the 2016 Quality Strategic Plan were to:

- Improve the health status of Georgians by promoting healthy lifestyles, preventive care, disease management, and disparity elimination.
- Improve access to quality healthcare at an affordable price.
- Ensure value in healthcare contracts.
- Move health plans administered by DCH toward being financially solvent to meet the needs of the members.
- Increase effectiveness and efficiency in the delivery of healthcare programs.
- Ensure DCH has enough workers with the necessary skills and competencies to meet the current and future demand.

The 2016 Quality Strategic Plan combined five of the DCH Key Goals into two focus areas: improving the health status of Georgians and smarter spending of each Medicaid dollar. The resulting objectives, strategies, and interventions were identified in the body of the strategic plan. Since the implementation of the GF and GF 360º managed care contracts occurred in SFY 2017, the 2016 Quality Strategy was designed to extend through the end of CY 2020, allowing DCH the opportunity to review the performance metric reports based on CY 2019 data in 2020. This time frame allowed for three full years of operation under the new contract that incorporated elements of the Quality Strategy.

This Addendum was the result of the 2016 release of the Final Managed Care rule that modernized and updated the federal Medicaid managed care regulations. It addressed the progression of, and impending changes to, managed care quality in Georgia. The fourth edition was finalized by DCH on February 1, 2016, for calendar years (CYs) 2016 through 2020.

In August 2020, DCH contracted with its EQRO to update the Quality Strategy. The DCH reviewed and considered the performance metric reports based on CY 2019 data reported in CY 2020 in the development and updating of the Quality Strategy. DCH's updated Department mission is to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH's vision is that the Department will be a lean and responsive State agency that promotes the health and prosperity of its citizens through innovate and effective delivery of quality healthcare programs. The DCH also incorporated its 11 Department values throughout the Quality Strategic Plan (accessible and affordable healthcare, program integrity/ethics, fiscal responsibility and efficiency, health promotion and prevention, innovative technology, quality-driven services, teamwork, respect for others, communication, customer service, and accountability).

This document is the fifth edition of DCH's Medicaid and CHIP Managed Care Quality Strategy for CYs 2021–2023. It builds on the Quality Strategic Plan currently in place. This fifth edition aligns with the requirements detailed in the revised federal regulations, 42 CFR §438.340. The final rule issued by CMS, Health and Human Services (HHS) was published in the Federal Register on May 6, 2016 and is hereinafter referred to as the "federal regulations." This final rule was updated with changes to continue the commitment to promote flexibility, strengthen accountability, and maintain and enhance program integrity in Medicaid and CHIP. The changes reflect a broader strategy to relieve regulatory burdens; support State flexibility and local leadership; and promote transparency, flexibility, and innovation in care delivery. The federal regulations advance DCH's mission to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. According to 42 CFR, the federal regulation (Final Rule):

… modernizes the Medicaid managed care regulations to reflect changes in the usage of managed care delivery systems. The final rule aligns, where feasible, many of the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; implements statutory provisions; strengthens actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promotes the quality of care and strengthens efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It also ensures appropriate beneficiary protections and enhances policies related to program integrity. This final rule also implements provisions of the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.[2]

The federal regulations expand the scope of the Quality Strategy to address the additional requirements in the following five areas:[3]

- Plan for improving quality of care and services
- Standards for network adequacy and availability of services
- Transition of care policy
- Identifying, evaluating, and reducing health disparities
- Identifying persons needing LTSS and persons with special needs

The DCH submits both updates and revisions of its Quality Strategy to CMS for review and approval.

For purposes of updating and revising the Quality Strategy, "significant change" is defined as:

- A pervasive pattern of quality deficiencies identified through analysis of the quality performance data submitted by the CMOs that results in a change to the goals or objectives of the Quality Strategy;
- Overarching changes to quality standards resulting from regulatory authorities or legislation at the State or federal level; or
- A change in membership demographics or the provider network of 50 percent or greater within one year.

Changes to formatting, dates, or other similar edits are defined as "insignificant," as well as regulatory/legislative changes that do not change the intent or content of the requirements contained within the Quality Strategy. Changes to the details included in the Appendices of the Quality Strategy will also be considered insignificant. Appendices will be regularly updated as needed in the version of the Quality Strategy posted online.

Updates and Revision of the Quality Strategy

42 CFR §438.340

Updates to the Quality Strategy will be a part of Georgia's CQI process and, as required by 42 CFR §438.340(c)(2)(iii), will consider the recommendations provided by the EQRO for (1) improving the quality of healthcare services provided by each CMO; and (2) how DCH can target goals and objectives in the Quality

[2] The Centers for Medicare & Medicaid Services. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability. Available at: https://www.federalregister.gov/documents/2016/05/06/2016-09581/medicaid-and-childrens-health-insurance-program-chip-programs-medicaid-managed-care-chip-delivered. Accessed on: Feb 1, 2021.

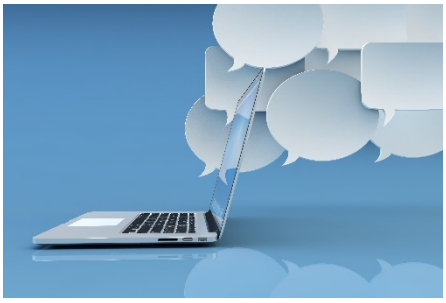
[3] The Centers for Medicare & Medicaid Services. Medicaid and CHIP Managed Care Final Rules. Available at: https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-final-rule/index.html Accessed on: Feb 1, 2021.

Strategy to better support improvement in the quality, timeliness, and access to healthcare services provided to Medicaid beneficiaries.

The DCH updates the Quality Strategy, at least triennially, based on each CMO's performance; stakeholder input and feedback; achievement of goals; changes resulting from legislative, State, federal, or other regulatory authority; and/or significant changes to the programmatic structure of the Georgia Medicaid program. Each revised Quality Strategy is submitted to CMS. The DCH solicits feedback from Georgia Medicaid stakeholders, including the advisory committees, and the public during the revision phase of the Quality Strategy.

Obtaining Public Comment

42 CFR §438.340



The DCH has several processes to obtain and consider public comment on the Quality Strategy. The MCAC receives feedback from the statewide provider community. The DCH posts the draft Quality Strategy to its website and ensures stakeholder groups are made aware of the public comment period. The DCH does not have federally recognized Tribes and therefore does not use a Tribal consultation process regarding updates made to the Quality Strategy.

The DCH posted the draft Quality Strategy for public comment on its website from March 1, 2021, through March 31, 2021. A summary table of changes made to the Quality Strategy is provided in Appendix F.

Medical Care Advisory Committee

The DCH MCAC consists of board-certified physicians, other health professionals, consumer group advocates, Medicaid members, Public Health Department representatives, and additional member specialties as needed.

The MCAC works collaboratively to provide input on Medicaid health policy; cultivate a better understanding between the healthcare provider, payers, and consumers of care; and partner with DCH to promote its goals and objectives to enhance the delivery of healthcare to its Medicaid members. The MCAC also promotes the partnership between the healthcare community and DCH, so as to improve the delivery of healthcare to Medicaid recipients. The committee operates in accordance with 42 CFR §431.12 and CFR Section 1902(a)(4).

Beneficiary and Stakeholder Input

The DCH obtains input from members and other stakeholders on the Quality Strategy. Internal and external key stakeholders are invited to review the strategy during the public comment period, before it is considered final. The DCH posts the final draft of the Quality Strategy on the DCH website for public comment, allowing a minimum of 30 days for stakeholder input and written feedback. Internal and external public input and feedback is considered after the public comment period is closed.

The DCH considers written feedback received during the public comment period. All recommendations are shared with appropriate departments within DCH for consideration and are incorporated into the final version of the Quality Strategy as determined appropriate by DCH.

Consulting With Tribes

42 CFR §438.340

Georgia does not have any tribes with which to consult on the Quality Strategy.

Submitting the Quality Strategy to CMS

42 CFR §438.340

CMS Review and Approval

If significant changes are made to the 2021–2023 edition of the Quality Strategy, the revision(s) will include a public comment period, CMS review and approval, and a resultant new edition. Insignificant changes would not warrant the need for a new edition.

Posting the Final CMS-Approved Edition on the Website

42 CFR §438.340

After review and approval by CMS, DCH provides members, providers, and other internal and external stakeholders access to the organization's Quality Strategy by posting the final version on DCH's website.

Georgia's Quality Assessment and Performance Improvement

The DCH requires that CMOs, in compliance with 42 CFR §438.330 and additional DCH requirements, establish and implement an ongoing comprehensive quality assessment and performance improvement (QAPI) program that is reviewed annually and approved by DCH. The DCH requires that each CMO has in effect a process for a self-evaluation of the impact and effectiveness of its QAPI program. Each CMO's QAPI program includes:

- Completion of DCH-specified PIPs (DCH and CMO PIP topics are included in Appendix C).
- Collection and submission of all designated quality performance measurement data.
- Mechanisms to detect both under- and overutilization of services.
- Mechanisms to assess the quality and appropriateness of care for beneficiaries with special health care needs (SHCN).
- Mechanisms to assess and address health disparities.
- Mechanisms to assess the quality and appropriateness of care provided to beneficiaries needing LTSS, including assessment of care between settings and a comparison of services and supports received with those set forth in the member's treatment/service plan.
- Participation in efforts by the State to prevent, detect, and remediate critical incidents.

The DCH QI program embodies a CQI process and problem-solving approach applied to specific and measurable performance indicators and operational activities. The CQI process is used to (1) monitor access to care, timeliness and quality of care, and operational performance; (2) identify opportunities for improvement that exist throughout the Georgia Medicaid program; (3) implement intervention strategies to improve outcomes and performance; (4) evaluate interventions to determine successfulness; and (5) reassess performance through measurement to identify new opportunities for improvement. To ensure that a consistent process for CQI is applied, DCH has adopted the W. Edwards Deming cycle of performance improvement—Plan-Do-Study-Act (PDSA).[4] The PDSA cycle follows a systematic series of steps for gaining knowledge about how to improve a process or outcome. The PDSA cycle is discussed below and depicted in Figure 5.

1. **Plan:** Define the objective, interventions, questions, and hypotheses that will answer the following questions: *Who? What? Where? When?* Data collection should be targeted toward answering the questions.
2. **Do:** Carry out the plan (and interventions) by collecting data and beginning data analyses.
3. **Study:** Complete the data analysis and compare results to predictions to determine if interventions were successful or if opportunities for improvement still exist. Summarize what was learned.
4. **Act:** Plan the next cycle. If interventions were successful, plan to extend or standardize them. If interventions were not successful, replace them with new interventions intended to bring about truly improved processes or outcomes.

Figure 5—PDSA Cycle

[4] Deming WE. *The New Economics for Industry, Government, Education*. 2nd ed, Cambridge, MA: The MIT Press; 2000.

The DCH uses several key interventions to drive QI in the Georgia Medicaid program, which include:

- Maintaining a robust QI framework that encompasses a CQI approach, as described above.
- Using HEDIS and the CMS Core Measure Sets and other performance measures to continually assess each CMO's achievement of the DCH goals.
- Implementing PIPs, which measure and assess targeted performance improvement interventions on specific topics.
- Monitoring Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[5] results and other satisfaction survey data to determine how satisfied Georgia Medicaid members are with the care and services they receive.
- Monitoring the CMOs' QI activities and compliance with contractual requirements to verify if the CMOs are appropriately implementing federal and State contractual standards.
- Facilitating cross-agency collaborative meetings to identify opportunities to improve service delivery and to leverage resources to achieve common goals.
- Trending performance measure results to ensure that the CMOs' performance is improving over time.
- Implementing other initiatives, as needed, to adhere to changes in federal policy.
- Studying the healthcare disparities among racial and ethnic groups to implement targeted and culturally competent interventions to ensure that Medicaid members have access to high-quality care.
- Studying the healthcare disparities among members with SHCN as well as by age, sex, or disability status to implement targeted interventions to ensure that all Medicaid members have access to high-quality care.

So that DCH may monitor and ensure the accuracy of CMO reporting and assess performance against those measures on a CMO-specific and program-wide basis, the CMOs:

- Provide all quality data, at minimum, annually to DCH.
- Provide to DCH all accreditation reports.
- Provide all information required by the EQRO, in compliance with the protocols set forth by CMS.

CMOs develop a process to evaluate the impact and effectiveness of their own QAPI programs. A description of this CMO process is submitted to and approved by DCH with submission of the QAPI program itself and is closely aligned to this Quality Strategy.

CMOs participate in ongoing cross-CMO meetings with DCH and CMO quality directors, which are designed to exchange and build on CMO-identified best practices, discuss arising issues, and plan for upcoming projects. CMOs are also required to participate in DCH QI meetings. The QI meetings serve as a key DCH interface with CMOs and are driven by the data collected throughout the assessment process.

Quality Strategy: Interventions

Georgia has developed a series of interventions aligned closely to this Quality Strategy and designed to build an innovative, person-centered, coordinated system of care that addresses both medical and nonmedical drivers of health. These interventions drive progress toward the Quality Strategy aims and goals, described in Table 1.

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

Member and Provider Experience Assessments

The DCH has established the MCAC to provide a formal method for members' voices to be included in the DCH decision-making process and to inform DCH change management strategies. This diverse committee is composed of representatives from across the State and includes the following:

- Physicians
- Dentists
- Pharmacists
- Federally Qualified Health Centers/Regional Health Centers
- Hospitals
- Long-Term Care Inpatient
- Long-Term Care Community
- Three members that represent the following:
  - Recipients of Medicaid Services
  - Consumer Advocate Groups
  - Others as approved by the Medicaid Chief
- Medicaid and PeachCare for Kids® managed care organization representation
- Nonvoting but impacted State agencies or departments may be invited to participate:
  - Department of Education
  - Department of Behavioral Health and Developmental Disabilities
  - Department of Early Care and Learning
  - Department of Human Services, Division of Family and Child Services
  - Department of Human Services, Division of Aging
  - State Office of Rural Health
  - State Medical Boards

The MCAC's purpose is to obtain the insight and recommendations of Georgia's Medicaid members in order to help DCH improve the overall experience for all Georgia Medicaid applicants and members. The committee members examine and provide input on the impact of DCH policy, services, and programs. Committee members serve for at least one year. Scheduled quarterly meetings are open to the public, with a comment period reserved in each meeting. Each CMO is also required to have a MCAC to provide a platform for member input.

Member Outreach and Engagement

All member outreach, marketing, and promotional activities comply with relevant federal and State laws. This includes both the Anti-Kickback Statute and the Civil Monetary Penalty law, which prohibits inducements to beneficiaries. The DCH reviews all member correspondence in order to ensure compliance with regulations, readability, interpretation and translation availability, and format accessibility to all members. The DCH has updated the DCH website across the different programs and divisions in order to provide detailed information to members. The goal of these updates is to improve members' understanding of their rights and responsibilities, including appeals, as well as to support members' choices during the enrollment process. The DCH also has reviewed member eligibility notices to ensure compliance with federal law, readability, updated appeals language, as well as language taglines and nondiscrimination inserts.

Provider Outreach and Engagement

All provider outreach, marketing, and promotional activities (including provider promotional activities) comply with relevant federal and State laws. This includes both the Anti-Kickback Statute and the Civil Monetary Penalty law, which prohibits inducements to beneficiaries. The DCH reviews all provider outreach and engagement materials in order to ensure compliance with regulations, readability, and availability of technical documentation and support for Medicaid providers. The DCH has updated the Department website across the different programs and divisions in order to provide detailed information to providers. The goal of these updates is to support the understanding of provider processes, appeals, credentialing, education and trainings, and payment systems.

Value-Based Purchasing

The DCH's VBP model is an enhanced approach to purchasing and program management that focuses on value over volume. It is part of a cohesive strategy that aligns incentives for members, providers, CMOs, and the State to achieve the program's overarching goals. The DCH has implemented VBP in the GF 360º program. The impact of initiatives is measured in terms of access, outcomes, quality of care, and savings. The DCH has incorporated rapid-cycle feedback as a key to the success of the VBP model. The DCH withholds 5 percent of the GF 360º CMO's capitation payments for the VBP program. The DCH uses the withhold as an incentive payment to the CMO based on achievement of VBP performance targets.

Drug Utilization Review Program

The DCH maintains a Drug Utilization Review Board (DURB) whose membership is appointed by the Commissioner of DCH. DURB members are recommended by professional organizations and academic institutions or are self-nominated. DURB members are appointed for three-year terms. The DCH establishes guidelines for drugs requiring prior authorization for the FFS program. The DURB reviews drugs, makes recommendations for DCH coverage, and publishes decisions to the DCH website.

In accordance with 42 CFR §438.3, each CMO develops and maintains a drug utilization review (DUR) program that complies with the DUR program standards as described in Section 1927(g) of the Social Security Act and 42 CFR §456 Subpart K, including prospective DUR and retrospective DUR.

Connecting to Care

The DCH requires each CMO to demonstrate that all members have access to all services covered under its benefit in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under the FFS program. The DCH also requires CMOs to monitor and report critical incidents, as well as to implement plans to address potential and actual quality of care and/or health and safety issues in healthcare settings.

The DCH works with the CMOs to ensure that their delivery systems provide adequate numbers of facilities, accessible locations, and qualified personnel for the provision of covered services, including emergency services provided 24 hours a day, seven days a week. The CMOs' provider networks are required to meet or exceed federal network adequacy standards as detailed at 42 CFR §438.68. The CMOs are also required to have sufficient types and numbers of traditional and specialty providers in their networks to meet the historical need and also add providers to meet increased member needs in specific geographic areas. The DCH assesses network adequacy by evaluating a number of factors, including number of providers, mix of provider types, hours of operation, ratio of providers not accepting new patients, accommodations for individuals with physical disabilities (wheelchair access), barriers to communication (translation services), and geographic proximity to beneficiaries (providers to members or members to providers).

The DCH monitors CMO network adequacy through mandatory CMO reporting. CMO report submissions include adequacy and capacity reports and timely access reports. The DCH may require corrective actions such as implementation of an approved corrective action plan (CAP) or payment of liquidated damages if a CMO is not meeting contractually required access requirements.

When increased CMO membership is expected, DCH will work with CMOs to ensure that the provider networks meet or exceed the CMO's contractual requirements. The DCH will conduct a readiness review prior to approving the CMO for the increase in membership.

The CMOs also provide emergency, urgent, and nonemergency transportation services to ensure that members have necessary access to and from providers of covered medical, behavioral health, and dental services, needed in a manner that ensures the member's health, safety, and welfare as required by 42 CFR §440.170(a).

Management of At-Risk Children

Children and youth with SHCN are those members up to 21 years of age who have or are at increased risk for chronic physical, developmental, behavioral, or emotional condition(s) and may need health and related services of a type or amount over and above those usually expected for the child's age. These include, but are not limited to, the children in the Medicaid eligibility categories of foster care and adoption assistance, youth who have aged out of the foster care system, children involved with the juvenile justice system, children and youth with significant behavioral health conditions, and others as identified through the CMO's assessment or by DCH. The DCH assesses the quality of care provided to these at-risk children in the following areas: program development, enrollment procedures, assessments and referrals, provider network, care coordination, and access to specialists.

Core Quality Improvement Activities

Improving Maternal and Birth Outcomes Imperative

Georgia continues its focus and efforts on improving maternal and infant health and eliminating racial disparities in maternal mortality. Georgia ranks at the bottom in maternal mortality rates in the United States, with the worst outcomes for black mothers. Latest available data show that the maternal death rate for black women in Georgia is twice that for white women in Georgia and six times the rate for white women nationally. The preterm birth rate among black women is 45 percent higher than the rate among all other women. Local studies show that 70 percent of pregnancy related deaths were preventable, black and non-Hispanic women were almost three times more likely to die from pregnancy-related causes than white and non-Hispanic women. At least half of Georgia's 159 counties have no Obstetricians and 40 percent of care facilities, including hospitals have been closed over the past 20 years. DCH is aware of the challenges and is working to improve data availability and analysis, DCH is also working on improving maternal and birth outcomes through CMO initiatives and on-going collaboration with community-based organizations and stakeholders. DCH is committed to working together to improve outcomes through innovative interventions, utilization of the latest clinical practice guidelines and delivery of patient-centric care.

Plan to Address Health Disparities

The DCH uses the Centers for Disease Control and Prevention and the World Health Organization (WHO) definitions for "health equity":

- Social determinants of health (SDoH)—Defined by WHO as "the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces: economics, social policies, and politics."
- Health disparity and health inequity—Health disparity is defined as the difference in health outcomes between groups within a population. While the terms may seem interchangeable, "health disparity" is different from "health inequity." "Health disparity" denotes differences, whether unjust or not. "Health inequity," on the other hand, denotes differences in health outcomes that are systematic, avoidable, and unjust.

Health disparities are the metrics DCH uses to measure progress toward achieving health equity.

- Health equity is the principle underlying a commitment to reduce—and, ultimately, *eliminate*—disparities in health and in its determinants, including social determinants.
- Health equity means social justice in health (i.e., no one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged).

Addressing Health Disparities

The DCH identifies member characteristics including age, race, ethnicity, sex, primary language, and disability status and provides the information to the CMOs at the time of enrollment and in enrollment change files. The DCH identifies, evaluates, and plans to reduce, to the extent practicable, health disparities as follows:

- The DCH created its Planning for Healthy Babies program (P4HB®) which provides access to family planning services for program participants along with interpregnancy care services for women who previously delivered a very low birth weight infant. The initial outreach for the P4HB® program targeted areas within the State with the highest low birth weight rates. Most women enrolled in the P4HB® program are African American, thus the program serves to reduce racial disparity and promote equity in maternal and newborn care.
- As a means of addressing language or cultural disparities, CMOs are contractually obligated to provide culturally competent service to all members. For CMO members whose first language is other than English, CMOs are required to provide interpretive services by way of having on-site interpreters or by using a language line that provides access to real time interpretation. In addition, translation of educational resources and other member informational materials is available in the primary language of the member.

The DCH plans to engage the CMOs in expanded efforts to address disparities by focusing on populations whose care ratings fall below State and/or national averages. For example, DCH anticipates focusing QI efforts on decreasing any disparity in health outcomes between the Medicaid and commercial populations. The DCH has shared its plan with the QOC to task the CMOs with working toward adoption of best practices for collecting race, ethnicity, gender, language, and special needs data for the sake of reducing health disparities on a larger scale.

To further enable these efforts, DCH has identified CAHPS surveys, claims data, and HEDIS measures as several data sources that could be used to identify such disparities. The DHC will begin data analysis in 2021. Measure data will be stratified by age, race, ethnicity, gender, and geographic location. Findings resulting from the data analysis will be shared with the CMOs. CMOs will use the data analysis results to create QI activities to address the identified disparities.

Partnerships Focused on Health Equity

The DCH acknowledges, through deeper engagement, that it will continue to learn and grow in its understanding of the people it serves. Georgians are living longer than before, and medical care is only part of the reason. The DCH understands that people are dealing with complicated life issues while at the same time dealing with healthcare concerns. The DCH's members have a holistic view of health, and they are challenging the Department to adapt and adopt a more comprehensive approach to addressing their needs. The DCH focuses CMOs on addressing the DCH priorities which include work toward health equity.

The DCH aspires to increase synergy between DCH and local, state, and national healthcare QI stakeholders by aligning initiatives and leveraging their work. One approach to increase synergy involves partnerships among CMOs and the State. The DCH also has developed strategic partnerships with the American Academy of Pediatrics, members, and vendors.

Social Determinants of Health

The DCH aligns its guiding pillars with the National Quality Strategy. Through its aims, DCH seeks to demand and facilitate activities to address SDoH to improve health outcomes. Efforts to address the SDoH are evident in the various programs and initiatives across the population streams. By holding the CMOs accountable for providing programs such as case management for members with chronic diseases and high-risk pregnancies; the provision of transportation to appointments; and integrated access to physical and behavioral care, DCH demonstrates its engagement in addressing the SDoH.

Each CMO participates in DCH's efforts to promote the delivery of services in a culturally competent manner to all enrollees, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds, disabilities, and regardless of gender, sexual orientation, or gender identity.

Health-Related Social Needs (HRSNs)

Central to the State's effort to improve access, quality, and timeliness of care is a commitment to address the social and environmental factors that directly impact health outcomes and cost, or, the HRSNs. HRSNs disproportionately impact Medicaid members, increase the risk of developing chronic conditions, drive healthcare costs, and are closely tied to health outcomes.

The HRSNs include the environment and conditions in which people are born, grow, live, work, and age. Food insecurity, housing instability, safety, violence, trauma, and transportation challenges are considered critical barriers to an individual's health status.

The DCH, working with the CMOs, is addressing the HRSNs that are impacting members in several ways, including:

- Screening members for food insecurity, housing instability, transportation needs, and interpersonal violence.
- Providing resources and assistance in securing health-related services and resource navigation to members identified with unmet health-related needs.
- Supporting public-private evidence-based interventions designed to reduce costs and improve health by addressing eligible Medicaid members' housing instability, transportation insecurity, food insecurity, and interpersonal violence.
- Identifying areas of high disparity to guide resources and to work with communities to address HRSNs.
- Maintaining a resource platform accessible to members both online and through the CMO's call center.

Oversight and Governance of the Quality Strategy

Quality Oversight Committee

The DCH Quality Oversight Committee (QOC) is the main platform for the CMOs and DCH to share lessons learned, best practices, and potential solutions to common opportunities for improvement. The collaborative is facilitated by the DCH staff members and meets monthly in Atlanta.

Reviewing and Evaluating the Effectiveness of the Quality Strategy

42 CFRs §438.10 and §438.340

Data collection and analysis and other evaluation activities are used in the evaluation of the effectiveness of the interventions described in the Quality Strategy. Included within the analysis are trends and comparisons with established goals and benchmarks. Examples of these data include results of compliance reviews, performance measures, PIPs, network adequacy studies, and data reported by CMOs.

The Quality Strategy is considered a companion document to the EQR technical reports. The annual EQR technical reports encompass specific details of the assessment, results, and recommendations related to the goals and strategies found in the Quality Strategy. This information is used to assess the ongoing effectiveness of the currently stated goals and strategies and provides a roadmap for potential changes and the development of new goals and strategies. Quality Strategy effectiveness, progress, and updates are also reported in Georgia's CMS waiver reports. Results of the review are made available on the DCH website.

Annual EQR technical reports are required by CMS and are one venue for assessing aspects of the Quality Strategy. The EQRO findings on the quality, access, and timeliness of DCH's managed care delivery system are included in the EQRO's annual technical report. An assessment of the effectiveness of the State's Quality Strategy as represented by DCH's progress on its Quality Strategy goals and objectives is found in Appendix F.

Community Involvement for Quality Development

Ensuring that the voice of the community is heard is important to DCH. Quality is a community process that is continuously informed and shaped by the voices and choices made by internal and external stakeholders. The DCH ensures transparency and the inclusion of community feedback into its Quality Strategy development through community and specialty association involvement in the MCAC.

Medicaid Contract Provisions

42 CFRs §438.66 and §438.340

Contract Compliance

The DCH monitors each CMO's compliance with its contract, and with the goals identified in the Quality Strategy, via an internal quality assurance program (IQAP) and through on-site reviews of compliance with various quality assessment and improvement standards. The DCH's EQRO conducts the compliance reviews at least once every three years. The purpose of the reviews is to determine a CMO's understanding

and application of the CMS Managed Care Rule and contractually required standards from a review of documents, observation, and interviews with key CMO staff members, as well as file reviews conducted during the review. The compliance review also includes an assessment of each CMO's QI structure. This structure is necessary to facilitate QI and ongoing assessment of performance measures and PIPs. This process enables DCH and the CMOs to assess each CMO's performance in achieving quality goals specified in the Quality Strategy. The compliance review report enables each CMO to implement remediation plans to correct any areas of deficiency found during the compliance review. The report also helps DCH determine each CMO's compliance with the CMS Managed Care Rule and DCH's contract and to identify areas of the contract that need to be modified or strengthened to ensure that a CMO complies with the requirements. The DCH reviews all deliverables submitted by the CMOs and, as applicable, requires revisions. The DCH approves the deliverables as complete when fully compliant with the contract.

Use of National Performance Measures and Performance Measure Reporting

42 CFR §438.330

Performance Measure Reporting

In September 2011, HHS Secretary Kathleen Sebelius recognized Georgia 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 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. In alignment with CMS' internal goals for quality measurement and improvement, Georgia reported Child and Adult Core Set measures for both the CHIP and Medicaid populations in 2020.

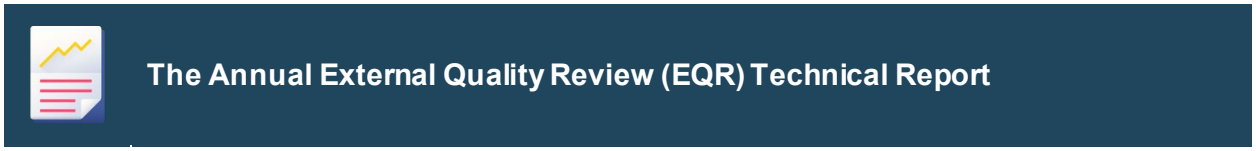
The DCH uses HEDIS and the CMS Child and Adult Core Set whenever possible to measure the CMOs' performance with specific indices of quality, timeliness, and access to care. The DCH's EQRO conducts CMS Core Measure Sets validation audits of the CMOs annually and reports the results to DCH. The DCH is implementing processes and CMO requirements in order to report all CMS Child Core Set measures and all Adult Behavioral Health measures in the CMS Core Measure Set by 2024.

The DCH relies on annually validated performance measures to report data in relation to the Quality Strategy. The DCH tracks, trends, and analyzes each measure. The DCH then compares its performance to national benchmarks and determines which measure to prioritize based on its Quality Strategy goals. The DCH requires monthly focused reporting by each CMO with appropriate breakouts to monitor CMO progress on achieving Quality Strategy goals and objectives. The DCH may also develop PIPs based on a root cause analysis and driver diagrams for the metrics DCH hopes to improve.

In addition, CMOs report performance measure results to the QOC. Low performance on any measure requires the CMO to implement remedial or corrective actions that are approved and monitored by DCH. When the CMO's corrective action includes an action plan, DCH assists with the development of the action plan, and the DCH/EQRO will conduct performance monitoring and review to assess for the implementation and effectiveness of the action plan.

As part of the annual EQR technical report, the EQRO trends each CMO's rates over time and also performs a comparison of the CMOs' rates and a comparison of each CMO's rates to selected national benchmarks. The EQRO uses trending to compare rates year-over-year when national benchmarks are not available to determine if improvement in the related measures is occurring.

The DCH posts the quality measures and performance outcomes annually online at the following location:



https://dch.georgia.gov/search?search=quality+strategy&sm_site_name=dch

Children's Health Insurance Program Reauthorization Act

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) reauthorized CHIP under Title XXI of the Social Security Act. Section 2108(a) of the Social Security Act provides that states must assess the operation of the State CHIP in each federal fiscal year (FFY), and report to the Secretary, by January 1 following the end of the FFY, on the results of the assessment. The DCH submits the Medicaid CHIP performance measure rates and other data to CMS as part of its annual CHIPRA reporting activities. The annual EQR technical report also includes an assessment of the operation of Georgia's CHIP program.

Medicaid and CHIP Program System Reporting

The DCH reports the results for child, adult, and maternal and infant health quality measures it collects in the Medicaid and CHIP Program (MACPro) system annually. The DCH continually works with CMS to report all available data as part of CMS' state quality reporting initiatives.

State Monitoring and Evaluation of CMOs' Contractual Compliance

42 CFR §438.66

Compliance Review

42 CFRs §438.358 and §438.330

According to 42 CFR §438.358, which describes the activities related to EQRs, a state or its EQRO must conduct a review within a three-year period to determine a Medicaid CMO's compliance with standards established by the state for access to care, structure and operations, and quality measurement and improvement. The review must include those standards detailed in 42 CFR §438 Subpart D as well as those detailed in 42 CFR §438.330. To meet this requirement, DCH contracts with its EQRO to perform a comprehensive review of compliance of the CMOs. Compliance reviews adhere to guidelines detailed in *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations,* October 2019.[6]

The purpose of the compliance review is to determine the extent to which Medicaid and CHIP CMOs are in compliance with federal standards. The 11 compliance standards are derived from requirements in the CFR CMS Managed Care Rule. The 11 mandatory compliance standards are listed below:

- Availability of services (42 CFR §438.206)

[6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance With Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 22, 2021.

- Assurances of adequate capacity and services (42 CFR §438.207)
- Coordination and continuity of care (42 CFR §438.208)
- Coverage and authorization of services (42 CFR §438.210)
- Provider selection (42 CFR §438.214)
- Confidentiality (42 CFR §438.224)
- Grievance and appeal systems (42 CFR §438.228)
- Subcontractual relationships and delegation (42 CFR §438.230)
- Practice guidelines (42 CFR §438.236)
- Health information systems (HIS) (42 CFR §438.242)
- QAPI program (42 CFR §438.330)

The DCH, with CMS encouragement, uses other monitoring processes, review of deliverables, and expands the scope of the reviews to cover compliance with federal and State requirements beyond those specified in 42 CFR §438. These include other State statutory, regulatory, or contractual requirements such as the following areas:

- Accessibility, including physical accessibility of service sites and medical and diagnostic equipment; accessibility of information (compliance with web-based information, literacy levels of written materials, and alternate formats); and other accommodations.

Results from compliance reviews assist DCH in determining each CMO's compliance with federal and State requirements. The compliance review results also assist DCH in identifying any areas of the contract that need modification or strengthening to ensure that the CMOs can achieve the goals identified in the Quality Strategy. The DCH's EQRO also assists DCH with a review of remediation plans submitted by the CMOs to correct areas found during the compliance review to be deficient.

Using Incentives and Intermediate Sanctions to Drive Improvement

42 CFR §438.340

Managing Spending in Georgia's Medicaid Program

The DCH cultivates a culture of collaboration with the CMOs. The DCH recognizes the importance of having a Medicaid and CHIP managed care delivery system that is firmly accountable to provide accessible, timely, and quality focused healthcare. The contract between the State and each CMO is designed to delineate the regulatory and State-specific performance expectations of the CMO. The DCH monitors each CMO's compliance with the contract and responds promptly and effectively if a CMO fails to meet certain standards.

The DCH imposes intermediate sanctions if performance or noncompliance with the provision of covered, medically necessary benefits and services becomes an impediment to meeting the healthcare needs of members and/or the ability of providers to adequately attend to those healthcare needs. Such sanctions may disallow further Medicaid and CHIP enrollment and may also include adjusting auto-assignment formulas used for member enrollment.

Intermediate Sanctions

42 CFR §438.340

The DCH Intermediate Sanctions Policy

The DCH has developed an intermediate sanctions policy that is based on Section 1932(e)(1)(A) of the Social Security Act and requirements found in 42 CFR §438.340. Accordingly, intermediate sanctions may be imposed if the CMO:

- Fails to substantially provide medically necessary items and services that are required (under law or under the CMO's contract with the State) to be provided to a member covered under the contract;
- Imposes premiums or charges members in excess of the premiums or charges permitted by Title XIX of the Social Security Act;
- Acts to discriminate among enrollees on the basis of their health status or requirements for healthcare services, including expulsion or refusal to reenroll an individual, except as permitted by Title XIX of the Social Security Act, or engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment with the CMO by eligible individuals whose medical condition or history indicates a need for substantial future medical services;
- Misrepresents or falsifies information that it furnishes to CMS or the State;
- Misrepresents or falsifies information that it furnishes to a member, a potential member, or a healthcare provider; or
- Fails to comply with the physician incentive requirements under Section 1903(m)(2)(A)(x) of the Social Security Act.

In addition to intermediate sanctions, there are provisions in the CMO contract that address sanctions if a CMO repeatedly fails to meet certain standards and provisions that give DCH the authority to terminate the contract. The CMO contracts include five categories of intermediate sanctions that are included in Table 4 through Table 9.

Table 4—Category 1—Liquidated Damages Up To $100,000 Per Day

Applicable Standards and Provisions
Failure to go live by the operational start date
Failure to meet readiness and/or annual review requirements

Table 5—Category 2—Liquidated Damages Up To $100,000 Per Violation

Applicable Standards and Provisions
Acts that discriminate among members on the basis of their health status or need for healthcare services
Misrepresentation of information or false statements furnished to CMS or the State
Failure to implement requirements
Failure to provide an adequate provider network in order to assure member access to all covered services
Failure to achieve the performance target for each quality performance measure
Failure to comply with the 80 percent screening ratio for periodic EPSDT visits

Applicable Standards and Provisions
Failure to deliver effective Demonstration services that reduce low-birth weight and very low-birth weight rates
Failure to achieve the annual targeted reduction in the pregnancy rate
Failure to fulfill duties to report member abuse, neglect, or exploitation

Table 6—Category 3—Liquidated Damages Up To $25,000 Per Violation

Applicable Standards and Provisions
Substantial failure to provide medically necessary services
Misrepresentation of information or false statements furnished to members, potential members, or healthcare providers
Failure to comply with the requirements for physician incentive plans (42 CFR §422.208 and §422.210)
Distribution of non-approved marketing materials
Violation of any applicable requirement of Section 1903(m) or 1932 of the Social Security Act
Failure to assume full operation of its contractual duties
Imposition of premiums or charges on members in excess of those permitted under the Medicaid program
Failure to resolve member appeals and grievances within the required time frames
Failure to ensure confidentiality in accordance with 45 §CFR 160 and 45 CFR §164
Violation of subcontracting requirements
Failure to provide notice of any conflicts of interest

Table 7—Category 4—Liquidated Damages Up To $5,000 Per Day

Applicable Standards and Provisions
Failure to submit required reports and deliverables
Submission of incorrect or deficient deliverables or reports
Failure to comply with claims processing standards
Failure to provide an initial visit within 14 calendar days for all newly enrolled women who are pregnant
Failure to comply with the Notice of Proposed Action and Notice of Adverse Action requirements
Failure to comply with any CAP
Failure to seek, collect, and/or report third party information
Failure to comply with staffing requirements
Failure to issue written notice to members of provider's notice of termination from the CMO
Failure to comply with federal law regarding sterilizations, hysterectomies, and abortions
Failure to submit acceptable member and provider materials or documents

Applicable Standards and Provisions
Failure to comply with the required Demonstration reports and deliverables
Failure to conduct, provide, and submit attestations to DCH regarding quarterly validation of provider demographic data

Table 8—Category 5—Additional Sanctions

Applicable Standards and Provisions
Failure to implement business continuity-disaster recovery (BC-DR) plan: $5,000–$50,000 per day
Unscheduled system unavailability: $125–$500 for each 30 minutes up to a maximum of $25,000
Confirmation of CMO enrollment or electronic claims management system downtime: $250–$1,000 for each 30 minutes up to a maximum of $50,000
Failure to make available readable, valid encounter information extracts: $500–$2,000 per day
Failure to correct a system problem not resulting in system unavailability: $250–$1,000 per day
Failure to meet telephone hotline performance standards: • $1,000 for each percentage point that is below the target answer rate • $1,000 for each percentage point that is below the target blocked call rate • $1,000 for each percentage point that is below the target abandoned call rate
Failure to make available readable, valid neonatal intensive care supplemental payment reports: $500–$2,000 per day
Failure to have office space procured and operational by the operational start date: $1,000 per day
Failure to be in full compliance with geographic access standards and submit electronic provider network reporting: .25 percent of the monthly capitation payment for provider types not meeting the geographic access standards
Failure to test and ensure the information systems are fully operational: $10,000 per calendar day

Table 9—Other Remedies

Applicable Standards and Provisions
Appointment of temporary management (42 CFR §438.706; 1903 [m] or section 1932 of the Social Security Act)
Granting members the right to terminate enrollment without cause
Suspension of all new enrollment, including default enrollment
Suspension of payment for member enrolled after the effective date of remedies until CMS or DCH is satisfied that the reason for the imposition of the remedies no longer exists
Termination of the contract
Civil monetary fines in accordance with 42 CFR §438.704
Additional remedies allowed under State statute or State regulation (42 CFR §438.700)
Referral to appropriate State licensing agency for investigation
Referral to the Office of Attorney General for investigation

Clinical Efficiencies

Value-Based Payments—Performance Withhold Program

The DCH recognizes that the VBP program is of strategic importance to the Quality Strategy, which is why this program is one of the key interventions implemented by DCH. The DCH has implemented VBP in the GF 360º program. The DCH withholds 5 percent of the GF 360º CMO's capitation payments for the VBP purchasing program. The DCH may return all, part, or none of the withheld funds to the CMO as incentive payments based on the CMO's achieving identified VBP performance targets. The DCH describes VBPs as an enhanced approach to purchasing and program management that focuses on value or volume. It is part of a comprehensive strategy that aligns incentives for members, providers, the CMO, and the State to achieve the program's overarching goals. The impact of VBP initiatives is measured in terms of access, outcomes, quality of care, and savings.

The VBP includes a broad set of payment strategies intended to improve healthcare quality, outcomes, and efficiency by linking financial incentives to performance. Measurement is based on a set of defined outcome metrics of quality, cost, and patient-centered care. The DCH has created a roadmap to overhaul the GF 360º value-based program by:

1. Selecting measures that provide sufficient room for improvement.
2. Strategically amending the pay-out process such that each measure is at risk.
3. Subjecting the selected measures to external quality review by the 2022 reporting season.

Assessment

Procedures for Age, Sex, Race, Ethnicity, Disability Status, and Primary Language Data Collection and Communication

42 CFR §438.340

To comply with the regulatory requirement for state procedures for race, ethnicity, and primary language spoken (CFR §438.206–§438.210), DCH requires the CMOs to participate in Georgia's efforts to promote the delivery of service in a culturally competent manner to all members, including those with LEP and those with diverse cultural and ethnic backgrounds. CMOs are required to have a comprehensive written cultural competency plan describing how the CMO will ensure that services are provided in a culturally competent manner to all members, including those with LEP, hearing impairment, a speech or language disorder, physical disabilities, differential abilities, or diverse cultural and ethnic backgrounds. The DCH uses the Social Security Administration's (SSA) definitions of "disability":

> *Adults: Disability is the inability to engage in any substantial gainful activity (SGA) by reason of any medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.*
>
> *Children: Under Title XVI, a child under age 18 will be considered disabled if he or she has a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations, and that can be expected to cause death or that has lasted or can be expected to last for a continuous period of not less than 12 months.*

The DCH continually monitors how age, sex, race, ethnicity, disability status, and the primary language of members are collected, coded, and entered into the system to ensure that this information is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and with CMS requirements to improve the delivery of services in a culturally competent manner. The DCH provides demographic information for age, sex, race, ethnicity, disability status, and primary language spoken to the CMOs as part of the member eligibility file. CMOs are required to use the data in their efforts to identify and overcome health disparities and to effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each member.

Identification of Members With Special Health Care Needs

42 CFRs §438.208 and §438.340

The DCH defines members with SHCN as any member who:

- Ranges in age from birth up to but not including age 21 years.
- Requires regular, ongoing therapeutic intervention and evaluation by Medicaid enrolled healthcare professionals.
- Has a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least 12 continuous months or more.
- Has an illness, condition, or disability that significantly limits activities of daily living or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development.

For children with SHCN, Georgia's early intervention services (as described in 20 U.S.C. §1471 and 34 CFR §303.12, Part C) provide services to children from birth through 2 years of age with a disability in any one or more of the following areas: physical, cognitive, communication, social or emotional, or adaptive development, based on federal regulations of the Individuals with Disabilities Education Improvement Act of 2004 (IDEA).

CMOs are required to ensure that members of any age with a SHCN are assessed by an appropriate healthcare professional. For members of all ages who are identified as having SHCN, the CMOs must develop treatment plans in collaboration with the member's primary care provider (PCP), with member participation, and in consultation with any specialists providing care and services to the member. The DCH requires CMOs to ensure that members have direct access to specialists able to treat their needs. The treatment or care plan must be approved in a timely manner by the CMO. The DCH requires the CMOs to share with other CMOs serving the member with SHCN the results of its identification and assessment to prevent duplication of services.

The DCH also requires CMOs to identify members with special circumstances including those situations included in Table 10.

Table 10—Members With Special Circumstances

Special Circumstances
Pregnancy
Major organ or tissue transplantation services
Chronic illness which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities
Significant medical conditions that require ongoing care of specialist appointments
Members who are in treatment such as chemotherapy, radiation therapy, or dialysis
Members with ongoing needs such as durable medical equipment, home health services, medically necessary transportation on a scheduled basis, or prescription medications

School-Based Services

All eligible Medicaid and CHIP children may receive school-based services through the DCH FFS program. School districts may serve as the medical provider by signing an inter-local agreement with DCH, which makes payments directly to the school districts for services provided.

Eligibility

- Students must be eligible for Medicaid on the date of service.
- Students must be 3 to 21 years of age.
- Students must be eligible for IDEA special education, with treatment services written in the Individual Education Plan (IEP).
- All treatment services must relate to a medical diagnosis and be medically necessary.

All services billed to Medicaid must be included in the current IEP. The IEP must contain the diagnosis (disability), desired outcome (goals), nature of treatment (type of therapy), frequency of treatment (minutes/number per week), and duration (length of time).

The CMOs coordinate healthcare services for Medicaid and CHIP members who are identified as children with SHCN and who remain voluntarily enrolled in the CMO.

External Quality Review and Annual Independent Review of Access to and Quality and Timeliness of Care

42 CFRs §438.340, §438.350, §438.356, and §438.358

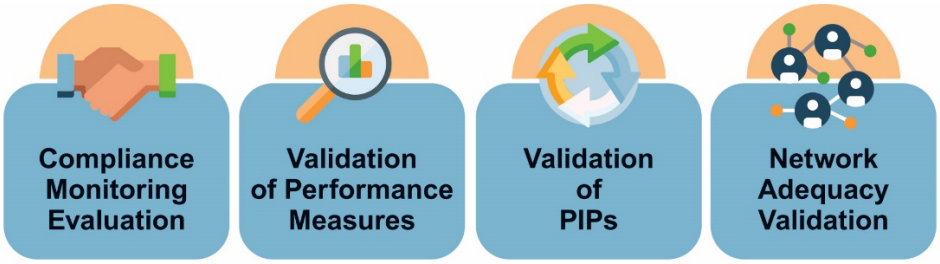
In accordance with 42 CFR §438.356, DCH contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. HSAG has been DCH's EQRO since 2008. HSAG's current EQRO contract that began in 2018 is for one year with four consecutive one-year renewal options. The conducting of EQR activities is a core feature of Georgia's Medicaid managed care quality initiative. The Medicaid managed care quality assessment activities are conducted for DCH by its EQRO. The DCH contracts with a CMS quality improvement organization (QIO), which is also a CMS Network of Quality Improvement and Innovation Contractor (NQIIC), to serve as the EQRO for Georgia. Consistent with CMS guidance, the EQRO conducts the mandatory and optional activities using CMS published protocols.

Mandatory EQR Activities

42 CFR §438.358

To assess the quality and timeliness of, and access to, the services covered under the CMO contract, DCH's EQRO conducts mandatory EQR activities for the Georgia Medicaid and CHIP programs. The DCH has determined that the mandatory activities completed by the EQRO do not duplicate activities performed through private accreditation. The DCH has contracted with its EQRO to perform the mandatory activities included in Figure 6.

Figure 6—EQRO Mandatory Activities



- **Compliance monitoring evaluation.** The DCH's EQRO conducts comprehensive, on-site reviews of compliance, called compliance reviews, of the CMOs at least once in a three-year period. The DCH's EQRO reviews CMO compliance with federal standards and those established by the State for access to care, structure and operations, and quality measurement and improvement. The State standards are as stringent as the federal Medicaid managed care standards described in 42 CFR §438.358(b)(iii), which address requirements related to access, structure and operations, and measurement and improvement. Compliance is also determined through a review of individual files to evaluate CMO implementation of standards.
- **Validation of performance measures.** In accordance with 42 CFR §438.340(b)(3)(ii), DCH requires CMOs to submit performance measurement data as part of their QAPI programs. To comply with 42 CFR §438.358(b)(1)(ii), DCH requires the CMOs to be NCQA accredited and complete NCQA HEDIS Compliance Audits™.[7] The DCH's EQRO validates the non-HEDIS performance measures, including non-HEDIS CMS Child and Adult Core Set measures through CMO performance measure validation audits. The NCQA HEDIS Compliance Audits and the EQRO performance measure validation activities focus on the ability of the CMOs to accurately process claims and encounter data, pharmacy data, laboratory data, enrollment (or membership) data, and provider data. The DCH's EQRO validates the performance measures identified by the State to evaluate their accuracy as reported by, or on behalf of,

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

the CMO. As part of EQRO performance measure validation audits, DCH's EQRO also explores the issue of completeness of claims and encounter data to improve rates for the performance measures.

- **Validation of PIPs.** As described in 42 CFR §438.340(b)(3)(i), DCH requires CMOs to conduct PIPs in accordance with 42 CFR §438.330(d). PIPs must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction in clinical and nonclinical areas through ongoing measurement and intervention. In accordance with 42 CFR §438.358(b)(1)(i), the DCH's EQRO validates PIPs required by the State to comply with the requirements of 42 CFR §438.330(d). The DCH's EQRO validation determines if PIPs were methodologically sound and designed to achieve improvement in clinical and nonclinical areas, and if the PIPs would have a favorable effect on health outcomes and enrollee satisfaction.
- **Network adequacy validation.** In accordance with 42 CFR §438.358(b)(1)(iv), DCH will be using its EQRO to perform validation of CMO network adequacy. The analysis will evaluate three dimensions of access and availability:
  - Capacity—provider-to-member ratios for Georgia's provider networks as defined by each CMO contract
  - Geographic network distribution—time/distance analysis for applicable provider specialties and average distance (miles) to the closest provider as defined by each CMO contract
  - Appointment availability—average length of time (number of days) to see a provider as defined by each CMO contract.

Optional EQR Activities

42 CFR §438.358

- The DCH's EQRO conducts the following optional EQR activities for the Georgia Medicaid program:
  - Quality strategy update
  - Aggregate report

EQR Technical Report

42 CFR §438.364

The Balanced Budget Act, Public Law 105-33, (a.k.a. CMS Managed Care Rule), last updated in 2016, requires states to use an EQRO to prepare an annual technical report that describes the manner in which data were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care and services furnished by the states' CMOs. The DCH's EQRO produces the EQR technical report, which presents all mandatory and optional EQR activities performed.

The EQR technical reports include a review of members' access to care and the quality of services received by members of Title XIX, Medicaid, and Title XXI, CHIP. In accordance with 42 CFR §438.364, the report includes the following information for each mandatory activity conducted:

- Assessment of the quality and timeliness of, and access to the care furnished by the CMO
- Activity objectives
- Technical methods of data collection and analysis
- Description of data obtained
- Conclusions drawn from the data
- Assessment of CMO strengths and weaknesses, as well as recommendations for improvements
- Methodologically appropriate comparative information about all CMOs in the program

The DCH uses the information obtained from each of the EQR activities, as well as the information presented in the EQR technical report, to make programmatic changes and modifications to the Quality Strategy. The EQR technical report also contains a description of the EQRO's assessment of the effectiveness of the Quality Strategy. Follow-up on EQRO technical report recommendations can be found in Appendix E. The most recent EQR technical report may be accessed at: https://dch.georgia.gov/search?search=quality+strategy&sm_site_name=dch.

Non-Duplication of Mandatory Activities—Methodology for Determining Comparability

42 CFRs §438.350 and §438.360

The CMS Managed Care Rule addresses the nonduplication of mandatory activities with Medicare or accreditation reviews. The CMS Managed Care Rule allows states to use information obtained from a Medicare or national accreditation review for the mandatory EQR activities when the state requires the CMOs to be accredited by a private accrediting organization recognized by CMS, when the accreditation standards are at least as stringent as those required by CMS (§422.158); are comparable to standards established through the EQR protocols (§438.352 and §438.358); and the CMOs provide the state with all reports, findings, and results of the private accreditation review activities.

The DCH requires all the Georgia Medicaid CMOs to be accredited by NCQA. As such, DCH deems certain EQR-related activities that crosswalk to CMS requirements. There is some overlap between NCQA's quality standards the CMOs must meet to maintain accreditation and the four CMS-mandated quality activities performed by DCH's contracted EQRO.

The DCH deems some of the duplicative CMS-EQR requirements as being met (hereafter referred to as "deeming") as long as the CMO meets the accreditation standards. The criteria for deeming is supported in 42 CFR §438.360 (nonduplication of mandatory activities).

State Standards for Access, Structure, and Operations

State Monitoring and Evaluation of CMO Requirements

42 CFR §438.340

Performance Measures Used to Assess Members' Timely Access to Appropriate Healthcare

42 CFR §438.330

The DCH selected standard performance measures that CMOs are required to measure and report to DCH. Consistent with DCH's desire to benchmark its progress against other states' performance and assess key priorities to drive CQI efforts, nearly all of these measures are nationally recognized and include the NCQA HEDIS, CMS Child Core Set, and CMS Adult Core Set measures and the Agency for Healthcare Research and Quality (AHRQ) quality and health improvement measures.

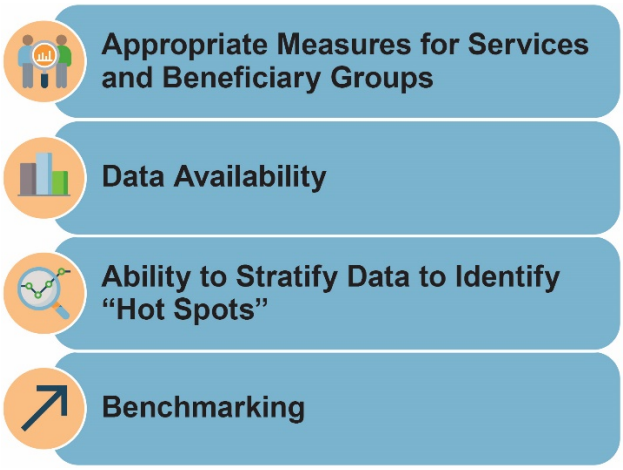
Criteria for Selecting Access Measures

42 CFR §438.206

The DCH selects a mix of measures related to access to acute, primary, and specialty services. These include access metrics specific to physical health, mental health, and oral health. The care management programs cover diverse populations—such as children, pregnant women, and adults—and the access metrics address each of these groups.

Figure 7 describes performance measure selection dependencies.

Figure 7—Performance Measure Dependencies



Standards for Access to Care

42 CFRs §438.206–§438.210

The DCH contracts with a qualified EQRO to perform an annual EQR of each CMO to determine CMO compliance with network adequacy and access requirements, confirm the adequacy of each CMO's network, and validate the CMO's network data. Georgia's CMO contracts include robust requirements to ensure that CMOs meet and, in some cases, exceed the standards outlined in 42 CFR Part 438 Subpart D and standards specified by DCH. These standards are detailed throughout this section of the Quality Strategy and include requirements related to member access to care such as network adequacy, availability of services, access to care during transitions of coverage, assurances of adequate capacity and services, coordination and continuity of care, and coverage and authorization of services. These requirements relate to the structure and operations that CMOs must have in place in order to ensure the provision of high-quality care including provider selection requirements, practice guidelines, information made available to beneficiaries, enrollment and disenrollment processes, confidentiality, appeals and grievance systems, subcontractual relationships and delegation, and the information technology used by the CMOs.

The contracts between DCH and the CMOs detail Georgia's Medicaid standards for access to care, and as outlined in Subpart D of the CMS Managed Care Rule. The DCH's standards are at least as stringent as those specified in 42 CFR §438.206–§438.210. The CMOs are required to implement the following standards for access to care:

- Availability of services (42 CFR §438.206)
- Assurances of adequate capacity and services (42 CFR §438.207)
- Coordination and continuity of care (42 CFR §438.208)
- Coverage and authorization of services (42 CFR §438.210)

Availability of Services

42 CFR §438.206

The DCH ensures that all services covered under the Medicaid State Plan are available and accessible to CMO members in a timely manner. The DCH also ensures that the CMO provider network for services covered under the contract meet DCH's network adequacy standards defined in each managed care contract. CMO provider contracts require providers to offer hours of operation for Medicaid members that are no less than the hours of operation offered to commercial members or Medicaid FFS members, and that services are available to members 24 hours a day, seven days a week. The DCH also requires the CMOs to provide care as expeditiously as the member's health condition requires. CMOs are required to adequately and timely cover services that are not available within their managed care network. In cases where a member receives services from an out-of-network provider, DCH requires the CMOs to coordinate with the provider for payment. The CMOs are required to meet and not exceed the wait times by provider type included in Table 11.

Table 11—Network Adequacy Standards

CMO Network Adequacy Standards	GF	GF 360°
Anticipated Medicaid enrollment	✓	✓
Expected utilization of services	✓	✓
Characteristics and healthcare needs of specific Medicaid populations covered in the CMO contract	✓	✓
Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services	✓	✓

CMO Network Adequacy Standards	GF	GF 360°
Numbers of network providers who are not accepting new Medicaid patients	✓	✓
Geographic location of network providers and Medicaid enrollees, considering distance, travel time, and the means of transportation ordinarily used by Medicaid enrollees	✓	✓
Ability of network providers to communicate with LEM enrollees in their preferred language	✓	✓
Ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid enrollees with physical or mental disabilities	✓	✓
Availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions	✓	✓

Assurances of Adequate Capacity and Services

42 CFRs §438.207, §438.3, and §456 Subpart K, and Section 1927(g) of the Social Security Act

The DCH reviews CMOs' policies, procedures, and processes used to evaluate medical necessity, the criteria used, the information source, and processes for approval and denial of essential services. The DCH also reviews the CMOs' mechanisms to detect under- and overutilization of care and services. The DCH requires the CMOs to develop and maintain a DUR program that consists of prospective and retrospective DUR. The DCH reviews the CMOs' implementation of their policies and procedures by requiring the CMOs to demonstrate that all members have access to all services covered under the Medicaid State Plan in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services as provided under the DCH FFS Medicaid program.

The DCH considers quality to be the foundation of CMO operations and requires the CMOs to monitor and report critical incidents and for QI plans to address potential and actual quality of care and/or health and safety issues.

Coordination and Continuity of Services

42 CFRs §438.206, §438.208, and §438.210

CMOs have overall responsibility for ensuring that all members have an ongoing source of care, according to their needs, and that they communicate this responsibility to the member along with a CMO point of contact. CMO contracts require the CMO to cover the same services as are required in the Medicaid State Plan and the Medicaid FFS program. The DCH requires the CMOs to maintain and monitor a contracted provider network that is sufficient to provide adequate access to all services covered under the contract for all members, including those with LEP or physical or mental disabilities. CMOs are required to provide female enrollees with direct access to a women's health specialist within the provider network for women's routine and preventive healthcare services. CMOs are required to provide for a second opinion from a network provider or arrange for the member to obtain a second opinion outside the network, at no cost to the member. The DCH also requires CMOs to coordinate care and service delivery with the services the member receives from any other CMO or prepaid inpatient health plan.

The CMOs establish systems to monitor the provider network to ensure that the access standards are met, regularly monitor the network to determine compliance, take corrective action when there is a failure to comply, and demonstrate that the access standards are met. CMOs expand provider networks to ensure access to care standards are met.

Accessing Continued Services Upon Transition in Care

42 CFR §438.62

The DCH makes its transition of care policy publicly available and provides instructions to members on how to access continued services during a transition when the member could suffer serious detriment to his or her health or be at risk of hospitalization or institutionalization upon transition from one CMO to another CMO. To ensure that there is no interruption of any covered service, DCH requires the CMOs to allow members to use their current providers for up to 30 calendar days or for the duration of the service authorizations issued prior to the transition, and to receive continued prescription refills for at least 30 calendar days or through the expiration date of the prescription. The DCH also requires CMOs to transfer service authorizations and other pertinent information to a CMO to which the member is transitioning to ensure continuity of care and services. The DCH Transition of Care requirements are included in the CMO contract and made available to the public at: https://medicaid.georgia.gov/programs/all-programs/georgia-families.

Coverage and Authorization of Services

42 CFRs §438.68 and §438.210

The DCH implemented standardized prior authorization request forms and an electronic portal through which providers submit all prior authorization requests. The form information is provided to the member's CMO for review. The CMOs retain the authority for prior authorization of services for their members. The disposition of the authorization request is returned to the common portal and is available to the provider. In instances when a member transitions from one CMO to another CMO, the prior authorization information is available to the member's new CMO for review and approval.

The DCH requires the CMOs to identify, define, and specify the amount, duration, and scope of each service. CMOs are required to furnish services in an amount, duration, and scope that is no less than those furnished to beneficiaries under Georgia's Medicaid FFS program. In addition, CMOs are required to ensure that the services are authorized in amount, duration, and scope so that they are reasonably expected to achieve the purpose for which they are furnished. The DCH ensures that the CMOs do not deny or reduce a service because of the member's diagnosis, type of illness, or condition. CMOs are, however, able to place appropriate limits on a service, such as due to a medical necessity determination. The DCH has provided the CMOs with a definition of what constitutes a "medically necessary service." Medical necessity criteria are incorporated into the CMOs' prior authorization policies and procedures. CMOs have implemented interrater reliability processes to ensure consistent application of authorization review criteria. CMO authorization processes also require an appropriate healthcare professional to make any decision to deny or reduce a service authorization request and to provide timely notice of the decision. CMOs are not allowed to compensate individuals or entities that conduct utilization management activities with incentives to deny, limit, or discontinue medically necessary services.

The DCH requires that the CMOs' networks meet or exceed federal network adequacy standards and have sufficient types and numbers of providers in their networks to meet historical needs and that the CMOs add providers to meet increased member needs in specific provider types or geographic areas.

Standards for Structure and Operations

42 CFRs §438.10, §438.54, §438.214, and §438.242

The contracts between DCH and the CMOs detail Georgia's Medicaid standards for CMO structure and operations. The DCH's standards are at least as stringent as those specified in the CMS Managed Care Rule. The DCH requires the CMOs to implement the following standards for structure and operations:

- Provider selection and credentialing (42 CFR §438.214)
- Enrollee information (42 CFR §438.10)
- Confidentiality (42 CFR §438.224)
- Enrollment and disenrollment (42 CFR §438.54 and §438.56)
- Grievance systems (42 CFR §438.228 and 42 CFR §438 Subpart F)
- Subcontractual relationships and delegation (42 CFR §438.230)

Provider Selection and Credentialing

42 CFRs §438.68, §438.214, and §440.170(a)

Since 2015, DCH has contracted with a single credentialing verification organization (CVO) to implement an NCQA-certified centralized credentialing verification process. The CVO conducts credentialing and recredentialing of providers for Medicaid and the contracted CMOs. The CVO's functionality is available on the Georgia Medicaid Management Information System (GAMMIS) website and streamlines through administrative simplification, the time frame that it takes for a provider to be fully credentialed. The process prevents inconsistencies and the need for a provider to be credentialed or recredentialed multiple times. The CVO's one-source application:

- Saves time.
- Increases efficiency.
- Eliminates duplication of data needed for multiple CMOs.
- Shortens the time period for providers to receive credentialing and recredentialing decisions.

Providers must enroll with Medicaid by submitting an electronic application and supporting documentation through the CVO's web-based provider credentialing portal. The CVO performs primary source verification; checks federal and state databases; obtains information from Medicare's Provider Enrollment, Chain, and Ownership System (PECOS); checks required medical malpractice insurance; confirms Drug Enforcement Agency (DEA) numbers; etc. A Credentialing Committee renders a decision regarding the provider's credentialing status.

CMOs do not conduct their own credentialing processes and are required to accept the CVO's credentialing and recredentialing determinations. CMOs remain responsible for the delegated credentialing and recredentialing for independent practice associations (IPAs) and provider hospital organizations (PHOs).

CMO provider networks include sufficient types and numbers of traditional and specialty providers to meet the historical needs of members. CMOs continually assess their contracted provider network and, when needs are identified, CMOs add providers to meet increased member needs in specific geographic areas. The DCH has developed processes to assess CMO network adequacy by evaluating a number of factors, including:

- Number of providers.
- Mix of provider types.
- Hours of operation.
- Ratio of providers not accepting new patients.
- Accommodations for individuals with physical disabilities.
- Barriers to communication.
- Geographic proximity to members.

To ensure access to care, CMOs provide emergency, urgent, and nonemergency transportation services to and from providers of covered medical, behavioral health, dental, and rehabilitative medical services needed.

Development of Network Adequacy Standards

42 CFRs §438.68, §438.207, §438.214, and §438.340

The DCH works with the CMOs to ensure that their delivery systems provide adequate numbers of facilities, accessible locations, and qualified personnel for the provision of covered services, including emergency services 24 hours a day, seven days a week.

The DCH ensures that CMOs maintain written policies and procedures for the selection and retention of providers. CMO policies, procedures, and provider contracts include processes to verify that providers excluded from federal healthcare programs do not contract with or provide services to CMO members. The DCH ensures that the CMO policies and procedures do not discriminate against providers that serve high-risk populations or specialize in conditions that require costly treatment.

CMOs develop and enforce network adequacy standards that include time and distance standards for provider types, which include adult and pediatric primary care, obstetrics and gynecology, behavioral health, adult and pediatric specialists, hospitals, enhanced dental benefits, and pharmacies.

CMOs maintain a network of providers sufficient in number, mix, and geographic distribution to meet the needs of their members. CMOs offer an appropriate range of preventive, primary care, and specialty services.

Provider-Specific Wait and Return Call Standards

42 CFRs §438.68 and §438.207

In addressing standards for network adequacy and availability requirements, DCH considers elements supporting the member's choice of provider and strategies supporting community integration of the member. To ensure member access to care, DCH requires wait time standards rather than time and distance standards. In addition, other elements in the best interest of members who need LTSS are taken into consideration. In the CMO contract, DCH requires that the CMO meet wait times by provider type, wait times by appointment type, and return call response times.

The DCH developed wait time standards to ensure that all covered Medicaid services delivered through contracted CMOs are available and accessible to members with an adequate CMO provider network. The standards address providing timely access to the full scope of Medicaid and CHIP services, having timely access to services, and providing services in a culturally competent manner.

The DCH establishes wait and response time standards based on provider type and the characteristics and special needs of specific Medicaid populations as illustrated in Table 12. The DCH establishes waiting times by appointment type as illustrated in Table 13. The DCH establishes return call response times as illustrated in Table 14.

Table 12—Wait Times by Provider Type

Provider Type		Waiting Time
	Primary Care Provider (routine visit)	Not to exceed fourteen (14) calendar days
	Primary Care Provider (adult sick visit)	Not to exceed twenty-four (24) clock hours
	Primary Care Provider (pediatric sick visit)	Not to exceed twenty-four (24) clock hours

Provider Type		Waiting Time
	Maternity Care	First Trimester: Not to exceed fourteen (14) calendar days Second Trimester: Not to exceed seven (7) calendar days Third Trimester: Not to exceed three (3) business days
	Specialists	Not to exceed thirty (30) calendar days
	Therapy: Physical Therapists; Occupational Therapists; Speech Therapists; Aquatic Therapists	Not to exceed thirty (30) calendar days
	Vision Providers	Not to exceed thirty (30) calendar days
	Dental Providers (routine visits)	Not to exceed twenty-one (21) calendar days
	Dental Providers (urgent care)	Not to exceed forty-eight (48) clock hours
	Elective Hospitalizations	Not to exceed thirty (30) calendar days
	Mental Health Providers	Not to exceed fourteen (14) calendar days
	Urgent Care Providers	Not to exceed twenty-four (24) clock hours
	Emergency Providers	Immediately (twenty-four [24] clock hours a day, seven [7] days a week) and without prior authorization

Table 13—Waiting Times by Appointment Type

Appointment Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-in Appointments	Waiting times shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Table 14—Returned Call Response Times

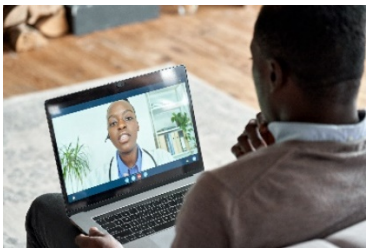
Appointment Type	Waiting Time
Urgent Calls	Shall not exceed twenty (20) minutes
Other Calls	Shall not exceed one (1) hour

Exceptions Process

42 CFRs §438.66 and §438.68

If DCH permits an exception to any of the provider-specific network standards, the standard by which the exception will be evaluated and approved is specified in the CMO contract based on the number of providers in that specialty practicing in the CMO service area.

Telehealth



The DCH encourages CMOs to implement the use of telehealth services including electronic information and telecommunications to support remote and long-distance healthcare services. Georgia defines "telehealth" as different from telemedicine in that it refers to a provider in a healthcare facility that provides or receives consultation from an external health professional. The DCH encourages CMOs to ensure their networks include behavioral health professionals, particularly in rural and other hard-to-access areas.

Telemedicine

The DCH defines "telemedicine" as provider-to-provider with a member present and provider-to-member live interactions. The DCH's telemedicine policy does not currently recognize store-and-forward interactions of any kind. The DCH encourages telemedicine visits in situations where members do not have easy access to a provider, such as for members in rural areas. Providers are also encouraged to use telemedicine to consult with each other and share their expertise for the benefit of treating members. Telemedicine services are provided in a manner that meets the needs of vulnerable and emerging high-risk populations and are consistent with integrated care delivery.

As a result of the coronavirus disease 2019 (COVID-19) pandemic, DCH created additional access points via telemedicine. The DCH plans to retain many of those telemedicine services even as provider offices reopen.

Enrollee Information

42 CFR §438.10

To ensure the capacity for Medicaid managed care education, DCH procured an enrollment broker to facilitate outreach, education, and enrollment activities to members and potential members. Informational materials developed by DCH, the enrollment broker, the Ombudsman Program, and CMOs are available in formats and languages that ensure their accessibility, including that materials are provided at an appropriate reading level and comply with member information requirements of §438.10.

Confidentiality

45 CFRs §160 and §164; 42 CFRs Part 431 Subpart F, Part 2; §438.208(b)(4) and §438.224

CMO contracts require that the CMO ensures that network providers and subcontractors comply with HIPAA and its implementing regulations, the Health Information Technology for Economic and Clinical Health Act of 2009 and its implementing regulations (collectively, "HITECH"), and all applicable federal and state privacy laws that are more restrictive. Individually identifiable health information is disclosed only in accordance with

federal privacy requirements. Accordingly, members are notified of any inappropriate disclosures as required by law. CMOs and providers are required to protect member privacy when coordinating care.

Enrollment and Disenrollment

42 CFRs §438.54 and §438.56

In designing the managed care enrollment and disenrollment policies, Georgia recognizes the importance of ensuring Medicaid applicants and their families experience a simple, streamlined eligibility and enrollment process that ensures a timely and accurate determination of Medicaid eligibility and a user-friendly CMO and PCP selection process. The DCH and the enrollment broker maintain responsibility for effectuating enrollment and disenrollment requirements and limitations in §438.56.

Grievance and Appeal Systems

42 CFRs §438.228, §438.230 Subpart F, §438.400, and §438.402

The DCH is committed to ensuring that members are able to address their problems quickly and with minimal burden. The DCH's contracts with CMOs do not allow delegation of member notices of adverse benefit determination. Georgia is committed to honoring and supporting the right of members to pursue a formal appeal of an adverse benefit determination through their CMO, or upon exhaustion of the CMO appeal process, through timely access to a State fair hearing. Additionally, members and applicants are also able to appeal enrollment and disenrollment determinations made by the enrollment broker under a similar process. Members are provided the opportunity to file a grievance with their CMO to express dissatisfaction with any issue that does not relate to an adverse benefit determination (e.g., concerns and expressions of dissatisfaction). The DCH requires CMOs to report on their appeal and grievance processes and outcomes, monitors CMO performance to ensure compliance with related requirements, and addresses any issues that may arise.

Adverse Benefit Determination

42 CFRs §438.210, §438.400, and §438.404

CMOs are required to notify members of an adverse benefit determination and explain the reasons for the determination. The notice of adverse benefit determination must be provided by the CMO as expeditiously as the member's condition requires but may not exceed 14 calendar days following the receipt of the request for service, unless an extension is allowed, and is in the best interest of the member. For termination, suspension, or reduction of previously authorized covered services, the notice of proposed action must be provided by the CMO at least 10 calendar days before the proposed action.

Member Grievances

42 CFRs §438.402 and §438.406

Members may file a grievance, which DCH has labeled the administrative review process, with a CMO at any time, either orally or in writing. CMOs are required to acknowledge receipt of each grievance and must resolve the grievance within 45 calendar days from the date the CMO receives the grievance. In instances in which the grievance relates to the denial of an expedited appeal request, CMOs are required to resolve the grievance and provide notice to all affected parties within three working days from the date the CMO received the grievance.

Member Appeals

42 CFRs §438.402, §438.406, §438.408, and §438.420

Federal law establishes the specific standards for member rights for appeals which all CMOs are expected to follow. Specifically, in Georgia, members or authorized representatives may appeal a notice of adverse benefit determination within 60 calendar days from the date on the notice of adverse benefit determination. The CMO resolves and provides notice to the member as expeditiously as the member's health condition requires, and no longer than 30 calendar days from the initial date of receipt of the appeal.

Expedited Appeals

42 CFRs §438.402, §438.406, §438.408, and §438.420

The DCH requires CMOs to maintain an expedited appeal process in cases when a member requests or the provider indicates that the time expended in a standard resolution could seriously jeopardize the member's life; health; or ability to attain, maintain, or regain maximum function. The DCH requires the CMOs to issue decisions for expedited appeals as expeditiously as the member's health condition requires but may not exceed 72 clock hours from the initial receipt of the appeal.

Subcontractual Relationships and Delegation

42 CFRs §438.230 and §438.6

CMOs remain accountable for all contract terms which are performed by subcontractors or through delegation agreements. CMOs are required to complete pre-delegation assessments or reviews prior to the delegation effective date to assess the subcontractor's readiness to perform the subcontracted or delegated functions. CMO delegation subcontractor agreements specify the activities and report responsibilities delegated to the subcontractor and provide for revocation of delegation or imposing sanctions if the subcontractor's performance is inadequate. The DCH confirms that CMOs have the necessary policies, procedures, and documents to demonstrate compliance, including processes for periodically performing audits of the subcontractor's and delegate's compliance, and implementing corrective actions for identified deficiencies or identified areas of improvement during the term of the contract.

Standards for Measurement and Improvement

42 CFRs §438.230, §438.236, and §438.242

The contracts between DCH and the CMOs detail Georgia's Medicaid standards for measurement and improvement. The DCH's standards are at least as stringent as those specified in the CMS Managed Care Rule. The CMOs are required to implement the following standards for measurement and improvement:

- Practice guidelines (42 CFR §438.236)
- QAPI program (42 CFR §438.330)
- HIS (42 CFR §438.242)

Practice Guidelines

42 CFR §438.236

The DCH includes in its contracts with the CMOs required evidence-based clinical practice guidelines. The DCH requires CMOs to adopt a minimum of three evidence-based clinical practice guidelines. The CMO practice guidelines are based on valid and reliable clinical evidence or a consensus of providers in the particular field; consider the needs of members; are adopted in consultation with contracting healthcare professionals; and are reviewed and updated periodically, as appropriate. CMOs disseminate practice guidelines to all providers, and upon request, to members.

In addition, CMOs submit to DCH for review and prior approval and as updated thereafter all clinical practice guidelines. The CMO's submission includes the methodology for measuring and assessing compliance as part of the QAPI program. CMOs are required to disseminate the guidelines to all affected provides, and, upon request, to members. The DCH requires that the CMO ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

The DCH requires the CMOs to monitor provider implementation and use of the practice guidelines until at least 90 percent of providers are consistently in compliance with the practice guidelines. The DCH also requires CMOs to perform a review of a minimum random sample of 50 members' medical records per evidence-based clinical practice guideline each quarter.

Quality Assessment and Performance Improvement Program

42 CFR §438.330

Each CMO is required to have an ongoing QAPI program. The DCH developed and uses a quality framework that leverages existing sets of standards and requirements for providing and continuously improving the quality of its managed care delivery system. The QAPI program is established using strategic planning principles with defined goals, objectives, strategies, and measures of effectiveness for the strategies implemented to achieve the defined goals. The CMO's QAPI program is based on the latest available research in the area of quality assurance and, at a minimum, includes the requirements listed in Table 15.

Table 15—CMO QAPI Program Requirements

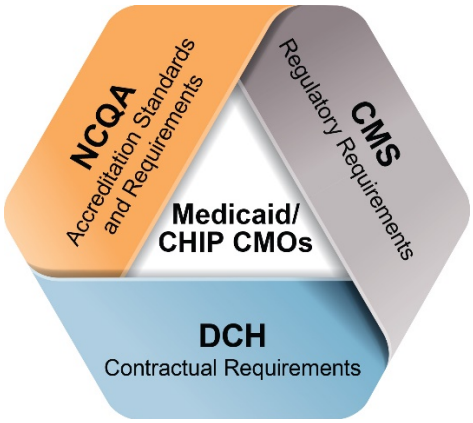
CMO QAPI Program Requirements
A method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and overutilization of services), including those with SHCN
Written policies and procedures for quality assessment, utilization management, and continuous QI that are periodically assessed for efficacy
A HIS sufficient to support the collection, integration, tracking, analysis, and reporting of data
Designated staff with expertise in quality assessment, utilization management, and care coordination
Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members
A methodology and process for conducting and maintaining provider profiling
Ad hoc reports to the CMO's multidisciplinary QOC and DCH on results, conclusions, recommendations, and implemented system changes; and annual PIPs that focus on clinical and nonclinical areas
Integration of the results from annual PIPs, performance measure rate monitoring, and compliance with federal and State standards
The impact of the CMO's member demographics on its ability to improve health outcomes
A process for evaluation of the impact and assessment of the CMO's QAPI program

The CMO also conducts PCP and other provider profiling activities as part of its QAPI program. Provider profiling includes multidimensional assessments of PCPs or provider's performance using clinical, administrative, and member satisfaction indicators of care that are accurate, measurable, and relevant to members.

The CMO submits annually and within 60 days if changes are made, its QAPI plan to DCH for review and approval. The CMO also submits annually a comprehensive QAPI report to tell the story of the effectiveness of the CMO's QAPI plan in meeting defined goals and objectives and achieving improved health outcomes for the CMO's members.

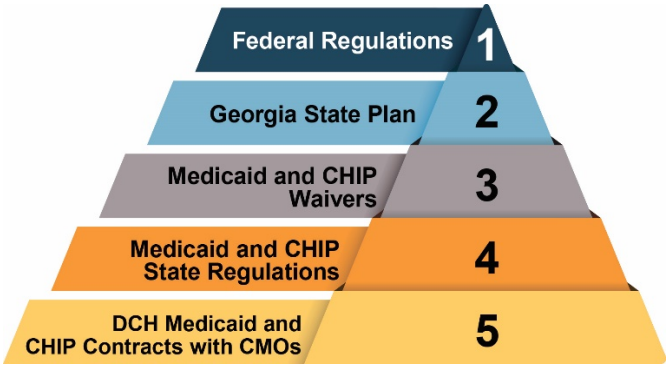
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 8.

Figure 8—Georgia's Medicaid/CHIP Managed Care Quality Framework



The DCH's contracts with each CMO provide for the legal order of precedence, as shown in Figure 9:

Figure 9—Georgia's Legal Order of Precedence



Should there be any conflicting requirements or standards between CMS, DCH, or NCQA, this legal order of precedence is followed.

Establishing Quality Metrics and Performance Targets Used for Measuring Performance and Improvement

The DCH has identified clinical quality, access, and utilization measures for the GF and GF 360º programs. The DCH includes a subset of HEDIS measures to track and trend CMO performance and to establish benchmarks for improving the health of Medicaid and CHIP populations served through the managed care delivery system. The measures listed in the Quality Strategy are prioritized for continuous improvement and

selected based on the needs of the populations served and the favorable health outcomes that result when relevant clinical guidelines are adhered to by each CMO's provider network. Additionally, when selecting measures for the specific needs of the populations, DCH considers the availability and reliability of the data used to calculate the measures.

The DCH selects the same measures for a number of years to enable statistically sound trending of data. Trending provides DCH and the CMOs the opportunity to further realize the impact of ongoing QI initiatives, rather than basing the effectiveness on just one year's worth of data.

The DCH and the CMOs recognize that effective QI includes:

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

The DCH requires each CMO to achieve annual improvement in HEDIS performance measures until the CMO is performing at least at the 50th percentile for CMOs as reported in NCQA's Quality Compass. Thereafter, DCH requires the CMOs to sustain performance at the Medicaid 50th percentile and establishes the goal for the CMOs to set goals to attain the 75th percentile for each of the HEDIS measures. NCQA's Quality Compass report provides up to three years of performance trending of HEDIS and CAHPS measures for publicly reporting plans and includes comparative and descriptive performance information on hundreds of commercial, Medicaid, and Medicare health plan submissions as well as national, regional, and State benchmarks.

Ongoing Review of Performance Improvement

42 CFRs §438.330 and §438.358

The DCH uses multiple approaches to review the Quality Strategy on an ongoing basis. The CMOs are required to track their own ongoing performance and to report achievements and opportunities for improvement in an CMO quality evaluation, which is submitted annually to DCH by each CMO.

The DCH requires the CMOs to conduct PIPs annually. PIPs must be designed to achieve significant and sustained improvement in clinical and nonclinical areas through ongoing measurement and intervention, and to have a favorable effect on health outcomes and enrollee satisfaction. The DCH's EQRO validates the PIPs that are required by the State annually. The DCH selects PIP topics that address CMS requirements and have the potential to impact the quality and timeliness of, and/or access to care and services.

The objective of PIP validation is to determine compliance with federal requirements and to ensure that DCH, CMOs, and key stakeholders can have confidence that reported improvement can be linked to the QI strategies and activities conducted during the PIP. The EQRO's validation of PIPs includes the following key components:

- Evaluation of the technical structure to determine whether the PIP design (i.e., aim statement, population, performance indicator(s), sampling methods, and data collection methodology) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component helps ensure that reported PIP results are accurate and capable of measuring improvement.
- Evaluation of the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions.
- Evaluation of whether statistically significant and/or clinical or programmatic significant improvement was achieved and sustained, and that interventions implemented for the PIP could reasonably be linked to the improvement.

The results of the CMO PIP validation are reported to DCH in an annual report. The DCH uses PIP results to assess each CMO's achievement of goals and to make any necessary modifications to the Quality Strategy based on each CMO's performance. PIP topics, aim statement(s), performance indicator(s), a description of the PIP outcomes, and any results that are available are included in Appendix C.

Member Satisfaction With Experience of Care

Annually, the CMOs administer a CAHPS survey. The primary objective of the CAHPS survey is to obtain information on the level of satisfaction members have with their healthcare experiences. CAHPS surveys ask members to report on and evaluate their experiences with healthcare; these surveys cover topics important to members, such as the communication skills of providers and the accessibility of services.

The CMOs conduct a CAHPS 5.0H Adult Medicaid Health Plan survey to the adult population, and the CAHPS 4.0H Child Medicaid Health Plan Survey (without the children with chronic conditions [CCC] measurement set) for a statewide sample of GF and GF 360° members, which is representative of the entire population of children covered by Georgia's Medicaid and CHIP managed care programs. The DCH uses 2019 CAHPS survey information to measure CMO and provider performance, member satisfaction with services provided and program characteristics, member access to care, and member expectations. The DCH's EQRO summarizes the findings of each CAHPS survey and incorporates the summary in the annual EQR technical report.

Health Information Systems and Information Technology

42 CFR §438.242

The DCH is committed to increasing its information technology (IT) infrastructure and data analytics capabilities. Georgia's HIS and other technology initiatives support the overall operation and review of the Quality Strategy. The State's IT approach is based on a strategy that spans all stakeholders and considers current and future plans, policies, processes, and technical capabilities.

In July 2016, DCH initiated the Medicaid Enterprise System Transformation (MEST) Program which includes the replacement the Department's legacy MMIS with a new Medicaid Enterprise System (MES). With the MES, DCH seeks a transformation to a modern, modular solution which is highly scalable, adaptable, and capable of driving the advancement of Medicaid Information Technology Architecture (MITA) maturity and improvements in the efficiency and effectiveness of program operations, the member and provider experience, and health outcomes.

Medicaid Enterprise System Transformation

Changes in federal regulations and guidance advance a modular approach to Medicaid IT system procurement and implementation. The modular approach involves packaging a business process or group of business processes into a distinct "module" with open interfaces that can be easily integrated with other modules to create a flexible service-oriented architecture.

The modular approach offers many benefits, including:

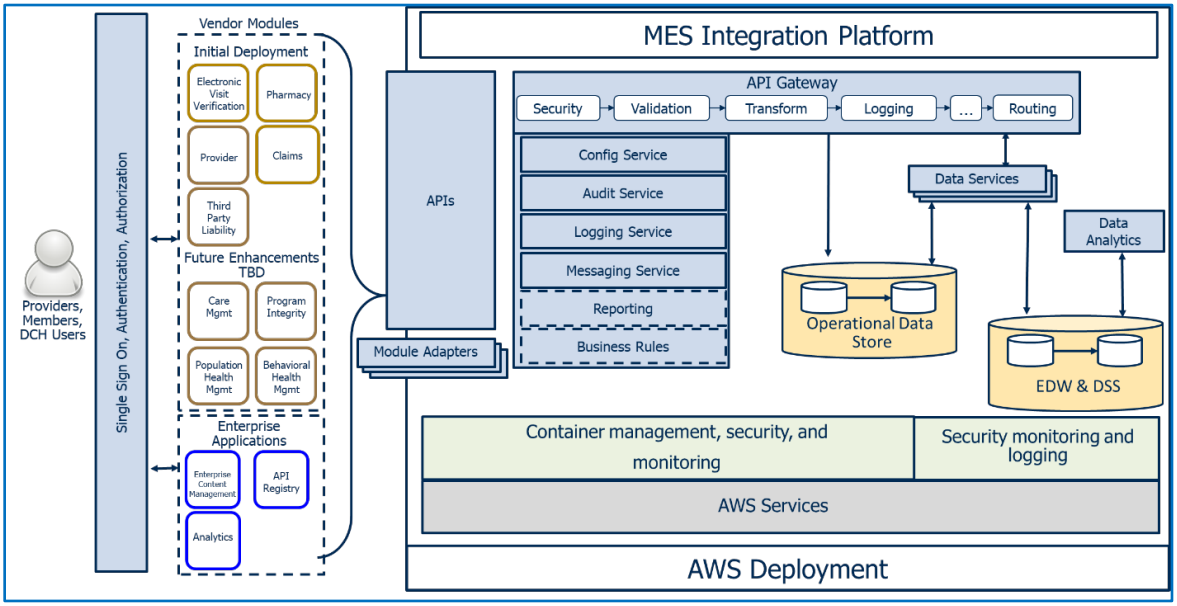
- The ability to adapt to changes in policy, programs, initiatives, and technology in a timely and cost-effective manner
- The use of common components and shared services
- Greater market innovation and competition
- Increased system integration and interoperability with state (Georgia and other) and federal agency partners

The initial release of the MES, planned for July 2023, will include the MES integration platform, shared services, an Operational Data Store (ODS), and the following five modules:

- Claims and Financial Management Module
- Provider Services Module
- Electronic Visit Verification Module
- Third Party Liability Services Module
- Pharmacy Benefits Management Module

Figure 10 depicts the high-level architecture of the planned Medicaid Enterprise System.

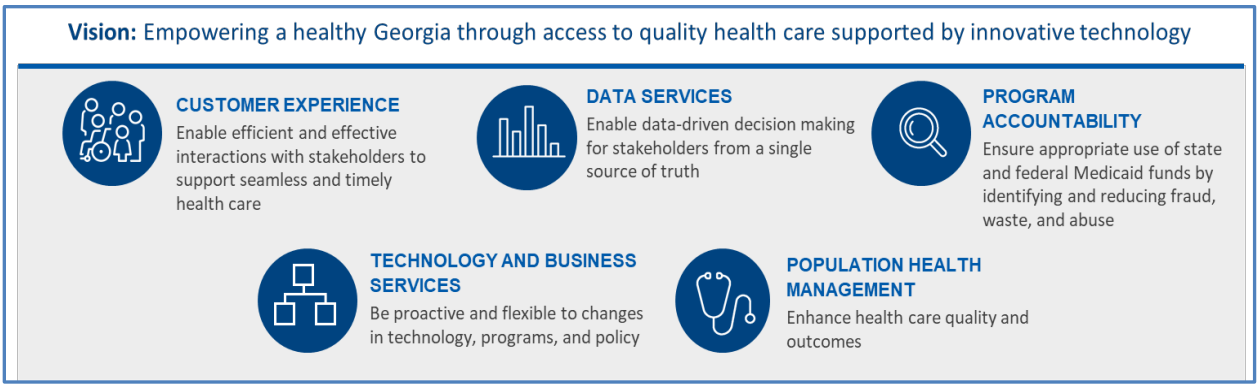
Figure 10—Medicaid Enterprise System High-Level Architecture



Note:
API=application programming interface
EDW-enterprise data warehouse
DSS=decision support system
AWS=Amazon Web Services

As part of the MEST Program Planning activities, insights and perspectives were gathered from across the organization to identify current and future needs and objectives of the Medicaid Enterprise that the future MES must enable and support. This information was used by the Department to define its vision, goals, and objectives for the new MES. The vision and strategic goals are shown in Figure 11.

Figure 11—Medicaid Enterprise System Vision and Goals



The strategic goals for the MES in support of Georgia's Medicaid Program are described in Table 16.

Table 16—Medicaid Enterprise System Strategic Goals

Vision Goal	Strategy
Customer Experience ***Goal: Enable efficient and effective interactions with stakeholders to support seamless and timely health care.***	The future MES will enable DCH to provide a more unified customer experience for Medicaid members and providers through specific interactions and touchpoints, enhancing the Department's ability to securely provide valuable information about healthcare access and services. Additionally, well-designed, intuitive self-service options now expected by members and providers will improve customer satisfaction and also drive operational efficiencies, lessening demand on State and contractor resources and allowing them to focus on more critical and complex activities.
Data Services ***Goal: Enable data-driven decision making for stakeholders from a single source of truth.***	The future MES will improve data access, quality, and analysis; support outcome measurement and data-driven decision-making; and further personal health record initiatives allowing members to better manage their health. As part of the MES implementation, the Department will establish an integration platform, operational data store, and data standards, achieving a single source of truth and enabling a trust in data that will be used to provide DCH and stakeholders with valuable insight and evidence on the efficacy of programs, initiatives, and services.
Technology and Business Services ***Goal: Be proactive and flexible to changes in technology, programs, and policy.***	Technology and a modular architecture must be an enabler, not an inhibitor, for the effective and efficient operation of the MES and serve as a driving force for advancing MITA maturity. Further, the MES architecture will comply with the Medicaid IT Standards and Conditions and enable interoperability, supporting the exchange of clinical and administrative data across the Medicaid Enterprise to improve care management and delivery of services.
Population Health Management ***Goal: Enhance health care quality and outcomes.***	The future MES will support a sustainable, scalable Population Health Management (PHM) program that will bring healthcare providers, community partners, and public health agencies together to improve overall health outcomes in Georgia. The system will provide a robust operational and analytical infrastructure that enables DCH to coordinate, share, pull, process, and actively monitor large amounts of data from a broad spectrum of different sources in a timely manner and more efficiently to support PHM.
Program Accountability ***Goal: Ensure appropriate use of state and federal Medicaid funds by identifying and reducing fraud, waste, and abuse.***	The future MES will provide innovative tools and accessible, accurate, and timely data to allow DCH to further enhance its ability to prevent the misuse of funds, measure quality issues, and review payments over multiple provider networks, CMOs, and claim types, thereby safeguarding program resources to serve and improve health outcomes for its members. The system will use front-end technologies, analytics, and automation to protect sensitive healthcare data, including the use of strong customer authentication processes to validate the identity of members and providers.

The DCH participates in the National Association of State Procurement Officials (NASPO) ValuePoint cooperative. NASPO is a unified, nationally focused cooperative alliance aggregating the demand of all 50 states, the District of Columbia, and the United States Territories, working together to pursue cooperative

contracting opportunities and to conduct competitive solicitations through the development of multistate sourcing teams. According to the NASPO website, NASPO ValuePoint provides the highest standard of excellence in public cooperative contracting. By leveraging the leadership and expertise of all states with the purchasing power of their public entities, NASPO ValuePoint delivers best value, reliable, competitively sourced contracts that offer public entities outstanding pricing and value adds. The DCH's first contracting opportunity focused on a claims and financial management module.

Claims & Financial Management Module

Integral to DCH's MEST strategy is the procurement of a core claims and financial management module. To acquire this solution, DCH is using the NASPO ValuePoint procurement cooperative. For the claims and financial management module, the DCH team adopted a collaborative approach, gathering and analyzing input and insights from numerous stakeholders including business/policy owners, IT subject matter experts, provider representation, DCH executive leadership, other state Medicaid agencies, and vendors to drive the following activities:

- **Market scan phase:** For the claims and financial management module procurement, the project team conducted a market scan covering both industry and state approaches to MMIS modernization and modularization. The outputs included a summary of market, vendor, and industry trends for healthcare technology covering four areas of interests—modularity approach, best practices, innovation, and lessons learned. The results produced key insights and recommended next steps.
- **Requirements definition phase:** For the claims and financial management module procurement, requirements were developed either through the NASPO ValuePoint procurement cooperative process or through a DCH state-specific process. Fifteen workgroups were established to solicit feedback on requirements, eight which were related to core claims and financial management functionality, and a further seven related to DCH's state-specific business and operational functionality resulting in a comprehensive requirements matrix.
- **Procurement phase:** In the recently completed master agreement phase, qualified vendors were being sought through a request for proposal process. Future activities include the facilitation of Georgia's participating addendum process to select and negotiate down to a selected vendor during 2021.

By participating in the NASPO cooperative procurement, DCH has had the opportunity to collaborate with other states to develop solution requirements reflecting state best practices and innovations, increase buying power, attract more vendor interest and participation in the procurement, and achieve greater negotiating flexibility for the State.

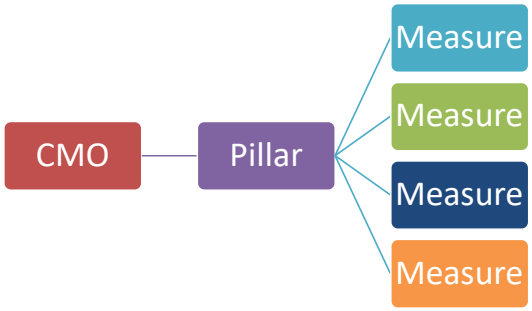
Translating Data Into Action

The DCH builds its analytic and visualization capacity through use of Microsoft (MS) Excel and Tableau. The DCH strategically realigned its vision and activities around four strategic pillars: access, quality, service (patient experience), and stewardship. Within those pillars, Georgia selected measures to monitor and improve performance of its CMOs. It also designed and developed dashboards in Tableau for CMOs, providers, and the general public.

Georgia uses select validated rates from their annual quality measures.

The DCH developed a template to organize deidentified data pertaining to its CMOs and member populations in a comprehensive MS Excel workbook, organized in a narrow and long format to ensure smooth integration into Tableau. Use of MS Excel as a starting point allowed Georgia to solidify the dashboard structure (shown in Figure 12) and key data elements to support performance improvement among the CMOs.

Figure 12—Georgia's Dashboard Structure



In addition to information on CMO member populations, such as age, geography, race and ethnicity, Medicaid eligibility group, and risk group, the final Tableau dashboard presents the following elements for each quality measure selected quarterly, with the ability to filter by CMO:

- Numerator and denominator
- Validated value
- Change from the previous year
- Statewide average
- National average (used for non-HEDIS measures without a benchmark)
- Mean and median

Use of these analytic tools have allowed Georgia to identify trends in CMOs' performance and areas for improvement to ensure high-quality care and better outcomes among the Medicaid populations.

Goals Tracking Table

To continually track the progress of achieving the goals outlined in the Quality Strategy, DCH developed a goals tracking table (Appendix D). The tracking table lists each of the goals and corresponding performance measures used to measure achievement of the goals. The DCH updates the tracking table quarterly. The DCH monitors the CMOs' progress in meeting the Quality Strategy goals and is able to proactively identify performance data that may indicate a need for performance review or discussions with the CMO.

Annually, DCH uses the information in the tracking table, which includes each CMO's performance measure results, to determine what additional QI efforts CMOs should make to improve quality of care and the health outcomes of the Medicaid population. PIP performance is also considered when determining the focus of the following year's QI activities.

CMO Health Information Technology

42 CFR §438.242

Each CMO maintains a HIS that collects data and ensures that data are accurate, valid, reliable, and complete. Georgia requires each CMO to maintain a HIS that collects, analyzes, integrates, and reports encounter data and other types of information to support utilization, grievances and appeals, and disenrollment for reasons other than the loss of Medicaid eligibility. Each CMO's HIS collects data on member and provider characteristics and on the services furnished to members. Each HIS also supports effective and efficient care management and coordination.

Appendix A. Quality Strategy and Regulatory Reference Crosswalk

Georgia Quality Strategy
Crosswalk to CMS Toolkit

The following table lists the required and recommended elements for State Quality Strategies, per 42 CFR §438.340(b) and corresponding sections in the Georgia Quality Strategy which address each required and recommended element.

Section I: Introduction

Table 17—Introduction

Regulatory Reference	Description	Page Reference
Optional	Include a brief history of the state's Medicaid and CHIP managed care programs.	Page 11
Optional	Include an overview of the quality management structure that is in place at the state level. For example, how is the leadership team structured, are there any quality task forces, an MCO collaborative, etc.?	Page 13 Appendix G
Optional	Include general information about the state's decision to contract with MCOs/PIHPs (e.g., to address issues of cost, quality, and/or access). Include the reasons why the state believes the use of a managed care system will positively impact the quality of care delivered in Medicaid and CHIP.	Page 4
Optional	Include a description of the goals and objectives of the state's managed care program. This description should include priorities, strategic partnerships, and quantifiable performance driven objectives. These objectives should reflect the state's priorities and areas of concern for the population covered by the MCO/PIHP contracts. For example, "the state will demonstrate a 10 percent improvement in childhood immunization rates over the next three years" or "through expansion of the primary care network, as evidenced by geographical reporting, the state will demonstrate a 5 percent improvement in member access to primary care".	Page 8 Appendix D
§438.340	Include a description of the formal process used to develop the quality strategy.	Page 19
§438.340(c)(1)(i)	Include a description of how the state obtained the input of beneficiaries and other stakeholders in the development of the quality strategy.	Page 23

Regulatory Reference	Description	Page Reference
§438.340(c)(1)	Include a description of how the state made (or plans to make) the quality strategy available for public comment before adopting it in final.	Page 23
§438.340(c)(2)(i)	Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	Appendix D
§438.340(b)(11) and (c)(3)(ii)	Include a timeline for modifying or updating the quality strategy. If this is based on an assessment of "significant change," include the state's definition of "significant change".	Page 22

Section II: Assessment

Table 18—Assessment

Regulatory Reference	Description	Page Reference
§438.330(3)(b)(4)	Summarize state procedures that assess the quality and appropriateness of care and services furnished to all Medicaid members under the MCO and PIHP contracts, and to individuals with special health care needs.	Page 45
§438.330(e)(b)(4)	Include the state's definition of special health care needs.	Page 41
§438.340(b)(6)	Detail the methods or procedures the state uses to identify the race, ethnicity, and primary language spoken of each Medicaid member. States must provide this information to the MCO and PIHP for each Medicaid member at the time of enrollment.	Page 40
Optional	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in healthcare.	Page 30

Table 19—National Performance Measures

Regulatory Reference	Description	Page Reference
§438.330(c)(1)(i)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders.	Page 34
Optional	Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP.	Page 34 Appendix D

Regulatory Reference	Description	Page Reference
	If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting.	

Table 20—Monitoring and Compliance

Regulatory Reference	Description	Page Reference
§438.66	Detail procedures that account for the regular monitoring and evaluation of MCO and PIHP compliance with the standards of subpart D (access, structure and operations, and measurement and improvement standards). Some examples of mechanisms that may be used for monitoring include, but are not limited to: Member or provider surveys; HEDIS results; Report Cards or profiles; Required MCO/PIHP reporting of performance measures; Required MCO/PIHP reporting on PIPs; Grievance/Appeal logs, etc.	Page 33 Page 34 Page 43 Page 45 Page 54 Page 59 Appendix B Appendix C Appendix D

Table 21—External Quality Review (EQR)

Regulatory Reference	Description	Page Reference
§438.350(a)	Include a description of the state's arrangements for an annual, external independent quality review of the quality, access, and timeliness of the services covered under each MCO and PIHP contract. Identify what entity will perform the EQR and for what period of time.	Page 42
Optional	Identify what, if any, optional EQR activities the state has contracted with its External Quality Review Organization (EQRO) to perform. The five optional activities include: 1. Validation of encounter data reported by an MCO or PIHP;	Page 43

Regulatory Reference	Description	Page Reference
	2. Administration or validation of consumer or provider surveys of quality of care; 3. Calculation of performance measures in addition to those reported by an MCO or PIHP and validated by an EQRO; 4. Conduct PIPs in addition to those conducted by an MCO or PIHP and validated by an EQRO; and 5. Conduct of studies on quality that focus on a particular aspect of clinical or nonclinical services at a point in time.	
§438.350(c)	Identify the standards for which the EQR will use information from Medicare or private accreditation reviews. This must include an explanation of the rationale for why the Medicare or private accreditation standards are duplicative to those in 42 CFR §438.204(g).	Page 44
438.360(a)(2)	If applicable, for MCOs or PIHPs serving only dual eligibles, identify the mandatory activities for which the state has exercised the non-duplication option under §438.360(c) and include an explanation of the rationale for why the activities are duplicative to those under §§ 438.358(b)(1) and (b)(2).	NA

Section III: State Standards

Table 22—State Standards

Regulatory Reference	Description	Page Reference
§438.206	**Availability of Services**	
§438.206(b)(1)	Maintains and monitors a network of appropriate providers	Page 46 Page 47 Page 49 Page 51
§438.206(b)(2)	Female members have direct access to a women's health specialist	Page 48
§438.206(b)(3)	Provides for a second opinion from a qualified healthcare professional	Page 48
§438.206(b)(4)	Adequately and timely coverage of services not available in network	Page 51
§438.206(b)(5)	Out-of-network providers coordinate with the MCO or PIHP with respect to payment	Page 48

Regulatory Reference	Description	Page Reference
§438.206(b)(6)	Credential all providers as required by §438.214	Page 50
§438.206(c)(1)(i)	Providers meet state standards for timely access to care and services	Page 51
§438.206(c)(1)(ii)	Network providers offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service	Page 47
§438.206(c)(1)(iii)	Services included in the contract available 24 hours a day, 7 days a week	Page 28
§438.206(c)(1)(iv)-(vi)	Mechanisms to ensure compliance by providers	Page 28
§438.206(c)(2)	Culturally competent services to all members	Page 30
§ 438.207	**Assurances of Adequate Capacity and Services**	
§438.207(a)	Assurances and documentation of capacity to serve expected enrollment	Page 47
§438.207(b)(1)	Offer an appropriate range of preventive, primary care, and specialty services	Page 51
§438.207(b)(2)	Maintain network sufficient in number, mix, and geographic distribution	Page 28
§ 438.208	**Coordination and Continuity of Care**	
§438.208(b)(1)	Each member has an ongoing source of primary care appropriate to his or her needs	Page 48
§438.208(b)(2)	All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	Page 48
§438.208(b)(4)	Share with other MCOs, PIHPs, and PAHPs serving the member with special health care needs the results of its identification and assessment to prevent duplication of services	Page 42
§438.208(b)(6)	Protect member privacy when coordinating care	Page 54
§438.208(c)(1)	State mechanisms to identify persons with special health care needs	Page 41
§438.208(c)(2)	Mechanisms to assess members with special health care needs by appropriate healthcare professionals	Page 42
§438.208(c)(3)	If applicable, treatment plans developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member; approved in a timely manner; and in accord with applicable state standards	Page 42
§438.208(c)(4)	Direct access to specialists for members with special health care needs	Page 42
§ 438.210	**Coverage and Authorization of Services**	
§438.210(a)(1)	Identify, define, and specify the amount, duration, and scope of each service	Page 48

Regulatory Reference	Description	Page Reference
§438.210(a)(2)	Services are furnished in an amount, duration, and scope that is no less than the those furnished to beneficiaries under fee-for-service Medicaid	Page 48
§438.210(a)(3)(i)	Services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished	Page 48
§438.210(a)(3)(ii)	No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	Page 49
§438.210(a)(4)(i)	Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	Page 49
§438.210(C)(5)	Specify what constitutes “medically necessary services”	Page 49
§438.210(D)(b)(1)	Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	Page 49
§438.210(D)(b)(2)(i)	Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	Page 49
P§438.210(D)(b)(d)	Any decision to deny or reduce services is made by an appropriate healthcare professional	Page 49
§438.210(D)(b)(d)	Each MCO/PIHP must notify the requesting provider, and give the member written notice of any decision to deny or reduce a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested	Page 49
§438.210(d)	Provide for the authorization decisions and notices as set forth in §438.210(d)	Page 54
§438.210(e)	Compensation to individuals or entities that conduct utilization management activities does not provide incentives to deny, limit, or discontinue medically necessary services	Page 49

Table 23—Structure and Operations Standards

Regulatory Reference	Description	Page Reference
§438.214	**Provider Selection**	
§438.214(a)	Written policies and procedures for selection and retention of providers	Page 51
§438.214(b)(1)	Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	Page 50
§438.214(b)(2)	Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	Page 50
§438.214(c)	Provider selection policies and procedures do not discriminate against providers serving high-risk populations or specialize in conditions that require costly treatment	Page 51

Regulatory Reference	Description	Page Reference
§438.214(d)	MCOs/PIHPs may not employ or contract with providers excluded from Federal healthcare programs	Page 51
§438.214(e)	Comply with any additional requirements established by the state	Page 50
§438.10	**Member Information**	
§438.10	Incorporate member information requirements of §438.10	Page 53
§438.224	**Confidentiality**	
§438.224	Individually identifiable health information is disclosed in accordance with Federal privacy requirements	Page 53
§438.56	**Enrollment and Disenrollment**	
§438.56	Each MCO/PIHP contract complies with the enrollment and disenrollment requirements and limitations set forth in §438.56	Page 54
§438.228	**Grievance Systems**	
§438.228(a)	Grievance systems meet the requirements of Part 438, subpart F	Page 54
§438.228(b)	If applicable, random state reviews of notice of action delegation to ensure notification of members in a timely manner	NA
§438.230	**Subcontractual Relationships and Delegation**	
§438.230(b)(1)	Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	Page 55
§438.230(b)(1)	Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	Page 55
§438.230(c)(1)(i)	Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	Page 55
§438.230(c)(1)(iii)	Monitoring of subcontractor performance on an ongoing basis	Page 55
§438.230(c)(1)(iii)	Corrective action for identified deficiencies or areas for improvement	Page 55

Table 24—Measurement and Improvement Standards

Regulatory Reference	Description	Page Reference
§ 438.236	**Practice Guidelines**	
§438.236(b)	Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of healthcare professionals in the particular field; 2) consider the needs of members; 3) are adopted in consultation with contracting healthcare professionals; and 4) are reviewed and updated periodically, as appropriate.	Page 56
§438.236(c)	Dissemination of practice guidelines to all providers, and upon request, to members	Page 56
§ 438.330	**Quality Assessment and Performance Improvement Program**	
§438.330(a)(3)	Each MCO and PIHP must have an ongoing quality assessment and performance improvement program	Page 56
§438.330(b)(1)	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy	Page 56
§438.330(b)(2)	Each MCO and PIHP must submit performance measurement data as specified by the state	Page 57
	List out performance measures in the quality strategy	Appendix D
§438.330(b)(3)	Each MCO and PIHP must have mechanisms to detect both underutilization and overutilization of services	Page 25 Page 56
§438.330(b)(4)	Each MCO and PIHP must have mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs	Page 25
§438.330(e)	Annual review by the state of each quality assessment and performance improvement program. If the state requires that an MCO or PIHP have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program, indicate this in the quality strategy.	Page 56
§ 438.242	**Health Information Systems**	
§438.242(a)	Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data	Page 63
§438.242(b)(2)	Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	Page 63
§438.242(b)(2)	Each MCO and PIHP must ensure data received is accurate and complete	Page 63

Section IV: Improvement and Interventions

Table 25—Improvement and Interventions

Regulatory Reference	Description	Page Reference
Optional	Describe, based on the results of assessment activities, how the state will attempt to improve the quality of care delivered by MCOs and PIHPs through interventions such as, but not limited to: Cross-state agency collaborative; Pay-for-performance or VBP initiatives; Accreditation requirements; Grants; Disease management programs; Changes in benefits for members; Provider network expansion, etc.	Cross-state agency collaborative; page 6 Pay-for-performance or value-based purchasing initiatives; page 28 Accreditation requirements; page 43 Grants; page 15 Disease management programs; page 4 Changes in benefits for members; NA Provider network expansion, etc.; page 50
Optional	Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	Appendix D

Table 26—Intermediate Sanctions

Regulatory Reference	Description	Page Reference
§438.340(b)(7)	For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 C.F.R. Part 438, subpart I.	Page 36
Optional	Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	Page 37

Table 27—Health Information Technology

Regulatory Reference	Description	Page Reference
§438.340	Detail how the state's information system supports initial and ongoing operation and review of the state's quality strategy.	Page 59
Optional	Include any HIT initiatives that will support the objectives of the state's quality strategy.	Page 59

Section V: Delivery System Reforms

Table 28—Delivery System Reforms

Regulatory Reference	Description	Page Reference
Optional	Describe the reasons for incorporating this population/service into managed care. Include a definition of this population and methods of identifying members in this population.	Page 4
Optional	List any performance measures applicable to this population/service, as well as the reasons for collecting these performance measures.	Page 6 Appendix D
Optional	List any PIPs that are tailored to this population/service. This should include a description of the interventions associated with the PIPs.	Appendix C
Optional	Address any assurances required in the state's Special Terms and Conditions (STCs), if applicable.	NA

Section VI: Conclusions and Opportunities

Table 29—Conclusions and Opportunities

Regulatory Reference	Description	Page Reference
Optional	Identify any successes that the state considers to be best or promising practices.	NA
Optional	Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	Appendix F

Regulatory Reference	Description	Page Reference
Optional	Include a discussion of challenges or opportunities with data collection systems, such as registries, claims or enrollment reporting systems, pay-for-performance tracking or profiling systems, electronic health record (EHR) information exchange, regional health information technology collaborative, telemedicine initiatives, grants that support state HIT/EHR development or enhancement, etc.	NA
Optional	Include recommendations that the state has for ongoing Medicaid and CHIP QI activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care members, if applicable.	NA

Appendix B. Performance Measure Metrics

Table 30—Performance Measure Metrics

Measure Name	Data Source	Measure Steward *(if applicable)*
AIM 1: Improve Health, Services & Experience:		
Goal 1.1: Improve Access to Care		
1.1.a: Increase number of persons enrolled in health benefits under the Pathway program by enrolling a minimum of 15,000 new members per year in CY 2022 and 2023	CMS Waiver Approval; DCH Reports; HEDIS; CMS Children's Core Measure Set	CMS; DCH; NCQA
1.1.b: Increase annual number of postpartum care visits to perform at or above the 50th percentile by the end of CY 2023	HEDIS, CMS Children's Core Measure Set	CMS; DCH; NCQA
1.1.c: Increase number of children receiving well-child and preventive visits to perform at or above the HEDIS 50th percentile by the end of CY 2023	HEDIS; CMS Children's Core Measure Set	CMS; DCH; NCQA
1.1.d: Increase number of adults receiving well- and preventive visits to perform at or above the HEDIS 50th percentile by the end of CY 2023	HEDIS;	NCQA
1.1.e: Increase percentage of membership with access to primary and specialty care providers to 90% by the end of CY 2023	CMO Reports	DCH
1.1.f: Increase by 5% the number of eligible women enrolled in family planning services under the Health Babies program by the end of CY 2023	P4HB Enrollment Number	DCH
1.1.g: Increase by 5% the number of eligible women enrolled in IPC/RM services under the Healthy Babies program by CY 2023	P4HB Enrollment Number	DCH
Goal 1.2 Increase Wellness and Preventive Care		
1.2.a: Increase the percentage of children less than 21 years of age that receive preventive oral health services to perform at or above the CMCS 75th percentile by the end of CY 2023	HEDIS; CMS Children's Core Measure Set	CMS, NCQA
Objective 1.2.b: Increase overall rate of immunizations vaccination across all ages and populations to perform at or above the HEDIS 90th percentile by the end of CY 2023	HEDIS; CMS Adult Core Measure Set; CMS Children's Core Set	CMS; NCQA
Objective 1.2.c: Increase the number of breast cancer screenings for qualified women to perform at or above the HEDIS 75th percentile by the end of CY 2023	HEDIS	NCQA
1.2.d: Increase the number of qualified women receiving cervical cancer screenings at or above the HEDIS 75th national percentile by the end of 2023	HEDIS; CMS Adult Core Set	CMS; NCQA
Goal 1.3: Improve Outcomes for Chronic Diseases		
1.3.a: Increase the number of members with controlled HbA1c to perform at or above the HEDIS national 50th percentile by the end of 2023	HEDIS; CMS Adult Core Measure Set	CMS; NCQA
1.3.b: Decrease annual hospital admission rate to perform at or above the CMCS 75th percentile by the end of CY 2023	CMS Adult Core Measure Set	CMS
1.3.c: Increase number of members with controlled high blood pressure to perform at or above the HEDIS national 50th percentile by the end of CY 2023		

Measure Name	Data Source	Measure Steward *(if applicable)*
Goal 1.4: Improve Maternal and Newborn Care		
1.4.a: Decrease annual maternal mortality rate by 3% by the end of 2023	DCH Reports	DCH
1.4.b: Decrease number of live babies with low birth weight to perform at or above he CMCS 75th percentile by the end of CY 2023	CMS Children's Core Measure Set	CMS
Goal 1.5: Improve Behavioral Health Care Outcomes		
1.5.a: Decrease annual behavioral health 30-day readmission rate to perform at or above the HEDIS 50th percentile by the end of CY 2023	HEDIS; CMS Adult Core Measure Set; CMS Children's Core Measure Set	CMS; NCQA
1.5.b: Increase the number of adolescents screened for follow-up for depression to perform at or above the HEDIS 50th percentile by the end of CY 2023	CMS Children's Core Measure Set;	CMS
1.5.c: Increase the number of adults screened and receiving follow-up for depression to perform at or above the HEDIS 50th percentile by the end of CY 2023	HEDIS; CMS Adult Core Measure Set	CMS; NCQA
Goal 1.6: Enhance Member Experience		
1.6.a: Increase annual CAHPS Overall *Rating of Health Pla*n by 5% by the end of CY 2023	AHRQ CAHPS	AHRQ
AIM 2: Smarter Spending		
Goal 2.1: Increase Appropriate Utilization of Levels of Care		
2.1.a.: Decrease hospitalizations and ER utilization rates to perform at or above the HEDIS 50th percentile by the end of CY 2023	HEDIS	NCQA
Goal 2.2: Effective Medical Management of Care		
2.2.a: Increase by 10% telemedicine visits for members residing in select Medically Underserved Areas (MUA) by the end of CY 2022	HEDIS; CMS Adult Core Measure Set; CMS Children's Core Measure Set	CMS; NCQA
AIM 3: HCBS-LTSS: Improve Health and Service: s		
Goal 3.1: Improve Health and Well-Being of Persons Receiving Community-Based Services		
3.1.1: Increase by 3% the number of Waiver participants receiving timely follow-up post hospitalization by the end of CY 2023	HEDIS; CMS Adult Core Measure Set—Long Term Services and Supports	CMS; NCQA

Appendix C. Performance Improvement Topics

Table 31—Georgia Families Performance Improvement Projects 2021

Georgia Families					
CMO	**PIP Topic**	**PIP Aim Statement**	**Performance Indicator(s)**	**Implemented Interventions**	**Intervention Evaluation**
Amerigroup Community Care	Timely prenatal care visits				
	Member engagement in OB case management for pregnant members identified as complex case				
CareSource	Timely prenatal care visits				
	Member engagement in OB case management for pregnant members identified as complex case				
Peach State Health Plan	Timely prenatal care visits				
	Member engagement in OB case management for pregnant members identified as complex case				
WellCare of Georgia	Timely prenatal care visits				
	Member engagement in OB case management for pregnant members identified as complex case				

Table 32—Georgia Families 360° Performance Improvement Projects 2021

Georgia Families 360°					
CMO	**PIP Topic**	**PIP Aim Statement**	**Performance Indicator(s)**	**Implemented Interventions**	**Intervention Evaluation**
Amerigroup 360°	Emergency Room Redirection				
	Timeliness of Prenatal Care				

Appendix D. Goals Tracking Table

Table 33—Goals Tracking Table

AIM	Goal	Objective (CY: Calendar Year)	Measure Name	Metric specifications (CMO report, DCH report, Core Measure Set, HEDIS)	Baseline Performance RY 2019
AIM 1: Improve Health, Services & Experience	**GOAL 1.1:** Improve Access to Care *Pillar Three: Access*	**Objective 1.1.a:** Increase number of persons enrolled in health benefits under the Pathway program by enrolling a minimum of 15,000 new members per year by the end of CY 2023	**Metric:** • Number of members enrolled in the Pathway program	DCH Enrollment Report	New program beginning 7/1/2021—no members enrolled
		Objective 1.1.b: Increase annual number of postpartum care visits to perform at or above the HEDIS 50th percentile by the end of CY 2023	**Metric:** • Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC; PPC-CH)	• HEDIS • CMS Children's Core Measure Set	PPC: 77.28%
		Objective 1.1.c: Increase number of children receiving well-child and preventive visits to perform at or above the HEDIS 50th percentile by the end of CY 2023	**Metric:** • Well Child Visits in the First 15 Months of Life (W15-CH) • Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life (W34-CH) • Adolescent Well-Care Visits (AWC) • Well-Child Visits in the First 30 Months of Life (W30) • Child and Adolescent Well-Care Visits (WCV)	• HEDIS • CMS Children's Core Measure Set	*W15: 65.19%* *W34: 71.37%* *AWC 57.71%* *W30: TBD MY 2020:* *WCV: TBD MY 2020*
		Objective 1.1.d: Increase number of adults receiving well- and preventive visits to perform at or above the HEDIS 50th percentile by the end of CY 2023	**Metric:** • Adults' Access to Preventive/Ambulatory Health Services (AAP)	• HEDIS	AAP: AAP Ages 20–44 Years: 77.19%

AIM	Goal	Objective (CY: Calendar Year)	Measure Name	Metric specifications (CMO report, DCH report, Core Measure Set, HEDIS)	Baseline Performance RY 2019
					AAP Ages 45-64 Years: 83.50%
		Objective 1.1.e: Increase percentage of members *Getting Needed Care* to perform at or above the 67th percentile by the end of CY 2023	**Metric:** • CAHPS *Getting Needed Care*	• CAHPS	Adult CAHPS: 80.67% Child CAHPS: 87.15%
		Objective 1.1.f: Increase by 5% the number of eligible women enrolled in family planning services under the Health Babies program by the end of CY 2023	**Metric:** • P4HB Enrollment Number	• P4HB enrollment numbers compared to population Eligible in Community using American Community Survey (annual census updates/estimates)	2019 P4HP Enrollment Number
		Objective 1.1.g: Increase by 5% the number of eligible women enrolled in IPC/RM services under the Healthy Babies program by CY 2023	**Metric:** • P4BH Enrollment Number	• P4HB enrollment numbers compared to population Eligible in Community using American Community Survey (annual census updates/estimates)	2019 P4HB Enrollment Number
	GOAL 1.2: Increase Wellness and Preventive Care *Pillar One: Quality*	**Objective 1.2.a:** Increase the percentage of children less than 21 years of age that receive preventive oral health services to perform at or above the CMCS 75th percentile by the end of CY 2023	**Metric:** • Annual Dental Visit—Total (ADV) • Percentage of Eligibles Who Received Preventive Dental Services (PDENT-CH)	• HEDIS • CMS Children's Core Measure Set	ADV: *66.46%* PDENT: 50.69% *(exceeded CMCS's national 50th percentile)*

AIM	Goal	Objective (CY: Calendar Year)	Measure Name	Metric specifications (CMO report, DCH report, Core Measure Set, HEDIS)	Baseline Performance RY 2019
		Objective 1.2.b: Increase overall rate of immunizations and vaccinations across all ages and populations to perform at or above the HEDIS 90th percentile by the end of CY 2023	**Metric:** • Childhood Immunization Status (CIS; CIS-CH) • Immunizations for Adolescents (IMA; IMA-CH) • Flu Vaccinations for Adults 18-65 (FVA; FVA-AD) • Flu Vaccinations for Adults Ages 65 and Older (FVO) • Pneumococcal Vaccination Status for Older Adults (PNU)	• HEDIS • CMS Adult Core Measure Set • CMS Children's Core Measure Set	CIS: 59.56% IMA: Combo 1: 91.74% Combo 2: 34.57%
		Objective 1.2.c: Increase the number of breast cancer screenings for qualified women to perform at or above the HEDIS 75th percentile by the end of CY 2023	**Metric:** • Breast Cancer Screening (BCS)	• HEDIS	BCS: 62.64%
		Objective 1.2.d: Increase the number of qualified women receiving cervical cancer screenings at or above the HEDIS 75th national percentile by the end of 2023	**Metric:** • Cervical Cancer Screening (CCS; CCS-AD)	• HEDIS • CMS Adult Core Measure Set	CCS: 67.45%
	GOAL 1.3: Improve Outcomes for Chronic Diseases *Pillar One: Quality*	**Objective 1.3.a:** Increase the number of members with controlled HbA1c to perform at or above the HEDIS national 50th percentile by the end of 2023	**Metric:** • Comprehensive Diabetes Care—HbA1c Poor Control (>9.5) (CDC, CDC-AD)	• HEDIS • CMS Adult Core Measure Set	CDC HbA1c—Poor Control: (>9.5%): 57.55% (RY 2020)
		Objective 1.3.b: Decrease annual hospital admission rate for members with heart failure to perform at or above the CMCS 75th percentile by the end of CY 2023	**Metric:**	• CMS Adult Core Measure Set	PQ108: 7.56 % *(exceeded CMCS's national 50th percentile)*

AIM	Goal	Objective (CY: Calendar Year)	Measure Name	Metric specifications (CMO report, DCH report, Core Measure Set, HEDIS)	Baseline Performance RY 2019
			• PQI 08: Heart Failure Admission Rate (PQ108-AD)		
		Objective 1.3.c: Increase number of members with controlled high blood pressure to perform at or above the HEDIS national 50th percentile by the end of CY 2023	**Metric:** • Controlling High Blood Pressure (CBP; CBP-AD)	• HEDIS • CMS Adult Core Measure Set	CBP: 45.99% (RY2020)
	Goal 1.4: Improve Maternal and Newborn Care *Pillar One: Quality*	**Objective 1.4.a:** Decrease annual maternal mortality rate by 3% by the end of CY 2023	**Metric:** DPH Reported Maternal Mortality Rate	• DCH report	Maternal mortality rate 2012-2016: 45.5%
		Objective 1.4.b: Decrease number of live babies with low birth weight to perform at or above the CMCS 75th percentile by the end of CY 2023	**Metric:** Live Births Weighing Less Than 2,500 Grams (LBW-CH)	• CMS Children's Core Measure Set	LBW: 9.05% *(exceeded CMCS's national 50th percentile)*
	Goal 1.5: Improve Behavioral Health Care Outcomes *Pillar One: Quality* *Pillar Three: Access*	**Objective 1.5.a:** Decrease the annual behavioral health 30-day readmission rate to perform at or above the HEDIS 50th percentile by the end of CY 2023	**Metric:** Follow-Up After Hospitalization for Mental Illness – 7-Day (FUH) Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	• HEDIS • CMS Adult Core Measure Set • CMS Children's Core Measure Set	FUH: MY 45.39% AD-CDF: 17.61%
		Objective 1.5.b: Increase the number of adolescents screened for follow-up for depression to perform at or above the HEDIS 50th percentile by the end of CY 2023	**Metric:** • Screening for Depression and Follow-Up Plan: Ages 12-17 (CDF-CH)	• CMS Children's Core Measure Set	CDF-CH: 17.61%
		Objective 1.5.c: Increase the number of adults screened and receiving follow-up for depression to perform at or above the HEDIS 50th percentile by the end of CY 2023	Metric: • Screening for Depression and Follow-Up Plan 18 an Older (CDF)	• HEDIS • CMS Adult Core Measure Set	CDF: 17.61%

AIM	Goal	Objective (CY: Calendar Year)	Measure Name	Metric specifications (CMO report, DCH report, Core Measure Set, HEDIS)	Baseline Performance RY 2019
	Goal 1.6: Enhance Member Experience *Pillar Four: Service*	**Objective 1.6.a:** Increase annual CAHPS Overall *Rating of Health Plan* by 5% by the end of 2023	**Metric:** CAHPS Overall *Rating of Health Plan* (CPA-AD)	• AHRQ: CAHPS	CPA-AD: 74.95%
AIM 2: Smarter Spending	**Goal 2.1:** Increase Appropriate Utilization of Levels of Care *Pillar Two: Stewardship*	**2.1.a:** Decrease hospitalizations and ER utilization rates to perform at or above the HEDIS 50th percentile by the end of CY 2023	**Metric:** • Acute Hospital Utilization (AHU) • Emergency Department Utilization (EDU) • Hospitalization for Potentially Preventable Complications (HPC) • Plan All-Cause Readmissions (PCR; PCR-AD)	• HEDIS	AHU: MY 2020 Rate EDU: 56.06 HPC: MY 2020 Rate PCR Total: 10.02% PCR Ratio Total: 0.73
	Goal 2.2: Effective Medical Management of Care *Pillar Two: Stewardship*	**2.2.a:** Increase telemedicine visits by 10% for members residing in select Medically Underserved Areas (MUA) by the end of CY 2022	**Metric:** • Number of Telemedicine Visits	• Telemedicine Claims Data	Baseline year CY 2020
AIM 3: HCBS-LTSS: Improve Health and Services	**Goal 3.1:** Improve Health and Well-Being of Persons Receiving Community-Based Services *Pillar One: Quality*	**Objective 3.1.a:** Increase the number of Waiver participants receiving timely follow-up post hospitalization by 3% by the end of CY 2023	**Metric:** • CMS mandatory reporting • Plan All-Cause Readmissions (PCR)	• CMS Adult Core Measure Set • HEDIS • Incident Management Service • IDD Connects • Harmony (chart reviews) • Internal databases	PCR: 10.02% PCR Ratio Total: 0.73 Follow-Up After Hospitalization: 94%

Appendix E. EQRO Findings and Recommendations

EQRO Findings and Recommendations

EQRO Annual Technical Report Recommendations

DCH makes the EQRO Annual Technical Report available to CMOs. Annually, CMOs are required to submit information on actions taken to address the recommendations contained in the EQRO Annual Technical Report. Annually, DCH's EQRO collects and reviews the actions taken by the State and by the CMOs in relation to the EQR recommendations contained in the report. QI work conducted by the State and the CMOs is included in each Annual Technical Report.

Table 34 includes the EQRO findings, recommendations and DCH's intended follow-up actions on the recommendations.

Table 34—Quality Strategy Recommendations

EQRO Findings	EQRO Recommendations	DCH Actions
Compliance with Standards		
• For the GF populations, the CMOs' lowest-scoring standards in the Compliance With Standards reviews were Standard VI—Subcontractual Relationships and Delegation (80.00 percent) and Standard X—Grievance and Appeal Systems (86.67 percent).	• HSAG recommends that the CMOs focus QI efforts in areas that did not receive a score of *Met* during the Compliance With Standards reviews, including ensuring all requirements are included in subcontractor and vendor agreements and meeting the grievance notification and resolution timelines and the notice of adverse benefit determination (NABD) timelines.	DCH continues to work with the CMOs to address the EQRO recommendations. DCH will continue to monitor the CMO CAPs.
Performance Measures		
• The following HEDIS 2019 measures were determined to indicate low performance for the GF program (i.e., the	• HSAG recommends that the CMOs develop and implement interventions and	DCH continues to work with the CMOs to address the EQRO recommendations. The DCH QOC tracks,

EQRO Findings	EQRO Recommendations	DCH Actions
rates for one or fewer reportable CMO measures exceeded the 50th percentile and the GF average fell below the 50th percentile). – *Comprehensive Diabetes Care—HbA1c Control (<8.0%)* – *Percentage of Live Births Weighing Less than 2,500 Grams* – *Colorectal Cancer Screening* – *Prenatal and Postpartum Care—Timeliness of Prenatal Care* – *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	activities aimed at improving rates for the following performance measures. • HSAG recommends that the CMOs also focus QI efforts on the performance measure scores that exhibited a substantial decrease from HEDIS 2018 to HEDIS 2019 and were at least 5 percentage points less than the NCQA adult or child Medicaid national 50th percentile.	monitors, and measures the CMO interventions to improve performance.
Performance Improvement Projects		
For the GF population (overall)	• HSAG recommends that the CMOs regularly review their data to identify opportunities for improvement early and implement interventions, using the small tests of change process used for PIPs.	DCH continues to work with the CMOs to address the EQRO recommendations.
For the GF population and GF 360 population	• HSAG recommends that the CMOs apply lessons learned and knowledge gained from its efforts and HSAG's feedback throughout the PIP process to final modules, future PIPs, and other QI activities. • HSAG recommends that the CMOs ensure they address all documentation requirements for each module. The CMOs should use HSAG's Rapid-Cycle PIP Reference Guide and the module-specific instructions within each module as modules are completed and the CMOs progress through the PIP process.	DCH continues to work with the CMOs to address the EQRO recommendations.

EQRO Findings	EQRO Recommendations	DCH Actions
For the GF 360 population	• HSAG recommends that key staff complete training related to rapid-cycle improvement efforts and/or QI science methods to ensure understanding of the PIP process. • HSAG recommends that the CMOs develop cross-functional PIP teams and select champions and subject matter experts appropriate for each PIP topic.	DCH continues to work with the CMOs to address the EQRO recommendations.
Member Experience of Care Survey		
• For the Child Medicaid Plan CAHPS Survey, the *Rating of Health Plan* measure score for one CMO exhibited a statistically significant decrease compared to the Georgia CMO program average.	• HSAG recommends that the CMO identify reasons for the low score and develop and implement interventions focused on improving the member's experience with the CMO to improve the *Rating of Health Plan* score.	DCH continues to work with the CMOs to address the EQRO recommendations.

Appendix F. Effectiveness of the State's Prior Quality Strategy

Georgia State Quality Strategy

The U.S. Department of Health and Human Services (HHS) Centers for Medicare & Medicaid Services (CMS) Medicaid managed care regulations at Title 42 of the Code of Federal Regulations (CFR) §438.340 require Medicaid state agencies that operate Medicaid managed care programs to develop and implement a written quality strategy to assess and improve the quality of healthcare services offered to Medicaid members. The written strategy must describe the standards that a state and its contracted CMOs and prepaid inpatient health plans must meet. This section outlines the annual evaluation of the Quality Strategy for SFY 2020.

Quality Strategy Goals and Objectives

DCH's mission is to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing and oversight. DCH's vision is that the Department will be a lean and responsive State agency that promotes the health and prosperity of its citizens through innovative and effective delivery of healthcare programs. DCH's values include:

- Accessible and Affordable Health Care
- Program Integrity and Ethics
- Fiscal Responsibility and Efficiency
- Health Promotion and Prevention
- Innovative Technology
- Quality-Driven Services
- Teamwork
- Respect for Others
- Communication
- Customer Service
- Accountability

Consistent with the State's mission and DCH's priorities, the purpose of the DCH's Quality Strategy is to establish and describe:

- Quality performance measures with targets for the CMOs related to access, utilization, service quality, and appropriateness.
- VBP performance metrics for the GF 360º program that align with some of the State's key focus areas for improved care and member outcomes.

- DCH's processes for assessing, monitoring, and reporting on the CMOs' performance, progress, and outcomes related to the State's strategic goals and areas of focus.
- Adoption of innovative QI strategies and ensuring DCH and the CMOs are in tune with the latest advances in QI science through participation in QI trainings and technical assistance sessions sponsored by CMS and those hosted by the EQRO.
- Numerous collaborative efforts by DCH that include interagency coordination and participation of other key stakeholders, along with the CMOs and provider community, to leverage the talent and resources needed to address shared challenges that impede improved performance.

In its contract with CMOs, DCH requires the CMOs to consider HEDIS performance measures as a priority. DCH requires the CMOs to assure annual improvement in the HEDIS measure until performing at least at the 50th percentile for "HMOs" as reported by NCQA's Quality Compass. The CMOs are also to establish goals to attain the 75th percentile.

Consistent with the National Quality Strategy, DCH established quality goals and objectives to improve the health and wellness of Georgia Medicaid and CHIP members. Table 35 details the progress made on the quality goals and objectives for the Georgia Medicaid managed care program.

Quality Strategy Evaluation

Evaluation Methodology Description

The methodology used by DCH to evaluate the effectiveness of the State's Quality Strategy included tracking and monitoring the CMOs' performance for the priority areas outlined in the DCH Quality Strategy. To track the progress of achieving the goals and objectives outlined in the 2016–2020 Quality Strategy, DCH tracked the aggregate annual results of contractual performance metrics that aligned with the performance measures included in the Quality Strategy to measure improvement.

During the 2016–2020 timeframe Georgia experienced significant programmatic changes that changed and expanded populations served, and integrated care and services. The programmatic changes resulted in DCH's reconsideration of its QI priorities and a need to reassess the goals, objectives, and performance metrics to better reflect the populations served and the programmatic changes. DCH continued to evolve its Quality Strategy priorities and associated goals, objectives, and metrics based on achievement success, lack of progress, and relevancy based on programmatic and population changes.

During the 2016–2020 Quality Strategy time frame, DCH submitted a Waiver request and/or received CMS approval of the following Waivers that resulted in programmatic changes and population changes that impacted the ability of DCH and the CMOs to determine QI results for quality strategy goals and objectives.

- New Options Waiver Program (NOW) and Comprehensive Supports Waiver Program
- Independent Care Waiver program (ICWP)
- Patients First Act
- Planning for Healthy Babies (P4HB®)

It is also important to note that some performance measure specifications, particularly the HEDIS specifications, experienced changes and updates that reduced, and in some cases, eliminated the ability to compare or trend rates from year-to-year. The performance measure rates were also not able to be compared due to the significant changes in the DCH Medicaid program and population. The DCH 2016–2020 Quality Strategy included performance metrics that were aspirational and in the development stage.

Measure Alignment

DCH has aligned most of the goals, objectives and quality metrics detailed in its Quality Strategy with CMO performance measure requirements outlined in the CMO's contract with the State. DCH requires the CMOs to be NCQA accredited and to conduct HEDIS performance measure reporting. In addition, DCH requires CMOs to undergo performance measure validation with the EQRO for CMS Core Measure Sets measures not included in HEDIS reporting.

Revisions to the Quality Strategy

DCH's initial quality strategy reflected the time period of 2016 through 2020. This quality strategy was designed to extend through the end of CY 2020, allowing DCH to review the performance metric reports based on CY 2019 data in 2020. This timeframe allowed for three full years of operation under the new CMO contract that incorporated elements of the quality strategy. DCH continues to evolve its 20 quality strategy priorities and associated goals, objectives and metrics based on achievement success, lack of progress, not achieved and relevancy based on programmatic and population changes.

The DCH baseline rates and/or remeasurement rates are not available for all measures included in the 2016–2020 Quality Strategic Plan. DCH has indicated that for measures where baseline rates or remeasurement rates were not available, the DCH priorities shifted, and in some cases the data sources became unavailable. While DCH continues to gather CMO level information on a host of measures, DCH chose to aggregate the data for a smaller subset of metrics that were high-risk, high-cost, high-volume or care or services that were problem-prone. In addition, DCH has identified overall CMO identified challenges that have impacted measure rate improvement including:

- Limited time to intervene with members
- Incorrect and quickly changing contact information due to transient Medicaid population
- Lack of literacy on healthcare and health insurance
- Competing priorities due to SDoH such as food insecurity, housing, and transportation
- High no-show rates
- Members making and keeping all appointments
- Early identification of high-risk pregnant members through notice of pregnancy by providers

Table 35 provides data for performance measures included in the DCH 2016–2020 Quality Strategy. The table identifies the goals, measures, baseline rate, and the aggregate remeasurement rate. As noted previously, the reported rates are not comparable due to programmatic and population changes.

Table 35—Georgia Medicaid Progress on Goals and Objectives

Goal 1—Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members						
Objectives	**Measure**	**MY 2014 Baseline Rate**		**Target Rate**	**MY 2019 Aggregate Rate**	
		GF	**GF 360º**		**GF**	**GF 360º**
Objective 1: Improve access to high quality physical health, behavioral health and oral healthcare for all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	Adults Access to Preventive (Ambulatory) Health Services • Ages 20–44 Years	81.23%			77.19%	
	• Ages 45–64 Years	89.27%			83.50%	
	Ages 65+	66.67%			NR	
	Children and Adolescents' Access to PCPs • Ages 12–24 Months	94.09%	95.69%		95.93%	99.23%
	• Ages 25 Months–6 Years	86.07%	85.62%		88.97%	94.36%
	• Ages 7–11 Years	88.97%	83.98%		91.55%	94.05%
	• Ages 12–19 Years	86.21%	79.43%		90.20%	90.25%
	Total	87.81%	NR		NR	NR
	Annual Dental Visits— Total Eligibles Receiving Preventive Dental Services—	69.34%	75.48%	10% relative improvement above CY 2018 rate	66.46%	74.09%
	Prenatal and Postpartum Care— Postpartum Care	65.83%	34.04%	HEDIS 2018 National 90th percentile	62.96%	72.00%
	Patient Safety Reports	NR	NR		NR*	NR*
	CAHPS Surveys *Rating of All Health Care*	NR	NR		78.28%	NR

Goal 1—Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members						
Objectives	**Measure**	**MY 2014 Baseline Rate**		**Target Rate**	**MY 2019 Aggregate Rate**	
		GF	**GF 360º**		**GF**	**GF 360º**
Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids® members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	Frequency of Ongoing Prenatal Care	55.60%	<21%: 27.66% 21-40%: 21.28% 41-60%: 19.15% 61-80%: 12.77% 81+%: 19.15%		NR	NR
	Well Child Visits First 15 Months 6+ Visits	66.19%	42.82%	HEDIS 2018 National 75th percentile	66.99%	67.64%
	Well Child Visits Ages 3–6 Years	69.39%	70.14%		72.74%	82.48%
	Adolescent Well Visits	50.27%	45.83%	HEDIS 2018 National 75th percentile	59.56%	67.34%
	Plan All Cause Readmissions Total	12.28%			5.93%	
	ER Visit Rates ED Visits per 1,000 member months (Total)		35.79%			38.81%
	CMS 416 Report Metrics					
	Dental Sealants		NM-NPR			NR*
	Childhood Immunization Rates *Rates reported are for Combo 3*	81.58%	45.37%	HEDIS 2018 National 90th percentile	61.15%	NR*
	Lead Screening Rates	80.14%	23.84%		81.31%	NR*

Goal 1—Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members						
Objectives	**Measure**	**MY 2014 Baseline Rate**		**Target Rate**	**MY 2019 Aggregate Rate**	
		GF	**GF 360º**		**GF**	**GF 360º**
	Developmental Screening: Developmental Screening in the First Three Years of Life—Total	46.64%	23.84%	Absolute 10% improvement over CY 2018 rate	58.98%	NR*
	Colorectal Cancer Screening—Total	36.68%			45.06% (RY 2019)	
	Chlamydia Screening Total	51.62%			64.46%	
	Breast Cancer Screening	70.58%			59.89%	
	Cervical Cancer Screening	70.55%			67.68%	
	Utilization Management Reports					
Objective 3: Improve care for chronic conditions for all Medicaid and PeachCare for Kids® members so that health performance metrics relative to chronic conditions will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	Medication Management for people with Asthma—Total	90.06%	0.75% 50% compliance for all ages		72.61%	NR*
	Use of Multiple Concurrent antipsychotics in Children and Adolescents		NM-NPR			0%
	Follow up After Hospitalization for Mental Illness 7-Day	46.44%	58.88%		45.39%	74.33%
	30-Day	63.71%	78.46%		65.92%	51.42%
	Follow up Care for Children Prescribed ADHD Drugs Initiation Phase	36.49%	0%		46.72%	56.98%
	Continuation Phase	50.66%	0%		64.86%	65.23%
	Controlling High Blood Pressure	77.08%			44.68%	

Goal 1—Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members						
Objectives	**Measure**	**MY 2014 Baseline Rate**		**Target Rate**	**MY 2019 Aggregate Rate**	
		GF	**GF 360º**		**GF**	**GF 360º**
	Total Ages 18-85					
	Antidepressant Medication Management Effective Continuation Phase Treatment					
	Effective Acute Phase Treatment					
	Total					
	Adherence to Antipsychotics for Individuals with Schizophrenia		0%			65.22%
	Comprehensive Diabetes Care • HbA1c Testing	83.90%	76.92%	HEDIS 2018 National 90th	80.19%	NR*
	• HbA1c Poor Control >9.0	52.60%	100%		57.55%	NR*
	• HbA1c Good Control <8.0 • HbA1c Better Control <7.0	39.40%	0%	HEDIS 2018 National 25th	35.20%	NR*
	• Eye Exam	29.13%	0%		27.23%	NR*
	• Medical Attention to Nephropathy	44.95%	30.77%	HEDIS 2018 National 75th percentile	47.25%	NR*
	• Blood Pressure Control (<140/90)	77.00%	30.77%		88.38%	NR*
		0.00%	0%		53.75%	NR*
Objective 4: Decrease the statewide LBW rate to 8.6% by December 2019 as reported in June 2020.	Low Birth Weight Rate	9.18%	66.67%	<= National Vital Statistics LBW rate published Dec or 2018	9.81%	NR*
	Weeks of Pregnancy at Time of Enrollment • 13–27 Weeks	61.69%			NR*	

Goal 1—Improved Health for Medicaid and PeachCare for Kids® (CHIP) Members						
Objectives	**Measure**	**MY 2014 Baseline Rate**		**Target Rate**	**MY 2019 Aggregate Rate**	
		GF	**GF 360º**		**GF**	**GF 360º**
	• 28 or More Weeks	17.01%			NR	
	Unknown	1.69%			NR	
	Prenatal Care Timeliness of Prenatal Care	80.95%	46.81%		77.58%	82.67%
	PCM Reports					
	P4HB® Reports—quarterly and annual reports					
	Ad hoc LARC utilization reports					
	Contraceptive utilization metric					
	Postpartum Visits	65.83%	34.04%	HEDIS 2018 National 90th percentile	62.96%	72.00%
	Early Elective Deliveries Rate	0%	NM-NPR		NR*	NR*
	Antenatal Steroid Use	0%	NM-NPR		NR*	NR*
Objective 5: Require CMOs' use of rapid cycle process improvement/plan-do-study-act principles to achieve improvements in preventive care, birth outcomes, and chronic disease management for their enrolled members as measured by a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.	HEDIS					
	AHRQ					
	CMS Adult and Child Core Sets					
	CAHPS Surveys			Relative 10% above CY 2018 rate		

Goal 2—Smarter Utilization of each Medicaid dollar						
Objective 1: Improve member's appropriate utilization of services so that improvements will be documented in ER visit rates and utilization management rates for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data.	Ambulatory Care Measure					
	Utilization Management Reports					
	Prior Authorization Reports					
	Inpatient Utilization Measure					
Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate for all Medicaid populations to 9% by the end of CY 2019 as reported in June of 2020.	Transition of Care Process in Place no Later Than the End of SFY 17					
	Care Transitions Metric—Total Timely Transmission of Transition Record	0.07%			NR*	
	Plan All Cause Readmissions Metrics—Total	12.28%			5.93%	
	Care Transitions Metric					
	Timely Transmission of Transition Record					
		0.07%			NR*	
Objective 3: Continue payment denials for identified medically induced negative outcomes and measure effectiveness through claims auditing.	Hospital-Acquired Conditions reports					
	Ad hoc EED reimbursement reports					
Objective 4: Improve access to healthcare information through collaboration with the Georgia Health Information Technology	Counts of Medicaid enrolled providers utilizing EHRs					
	Counts of Medicaid enrolled providers connected to the GaHIN					

Goal 2—Smarter Utilization of each Medicaid dollar						
Extension Center and the Georgia Health Information Network (GaHIN) until 90% of all Georgia's providers are connected to an HIE and to the GaHIN	Members' access to personal health information reports					

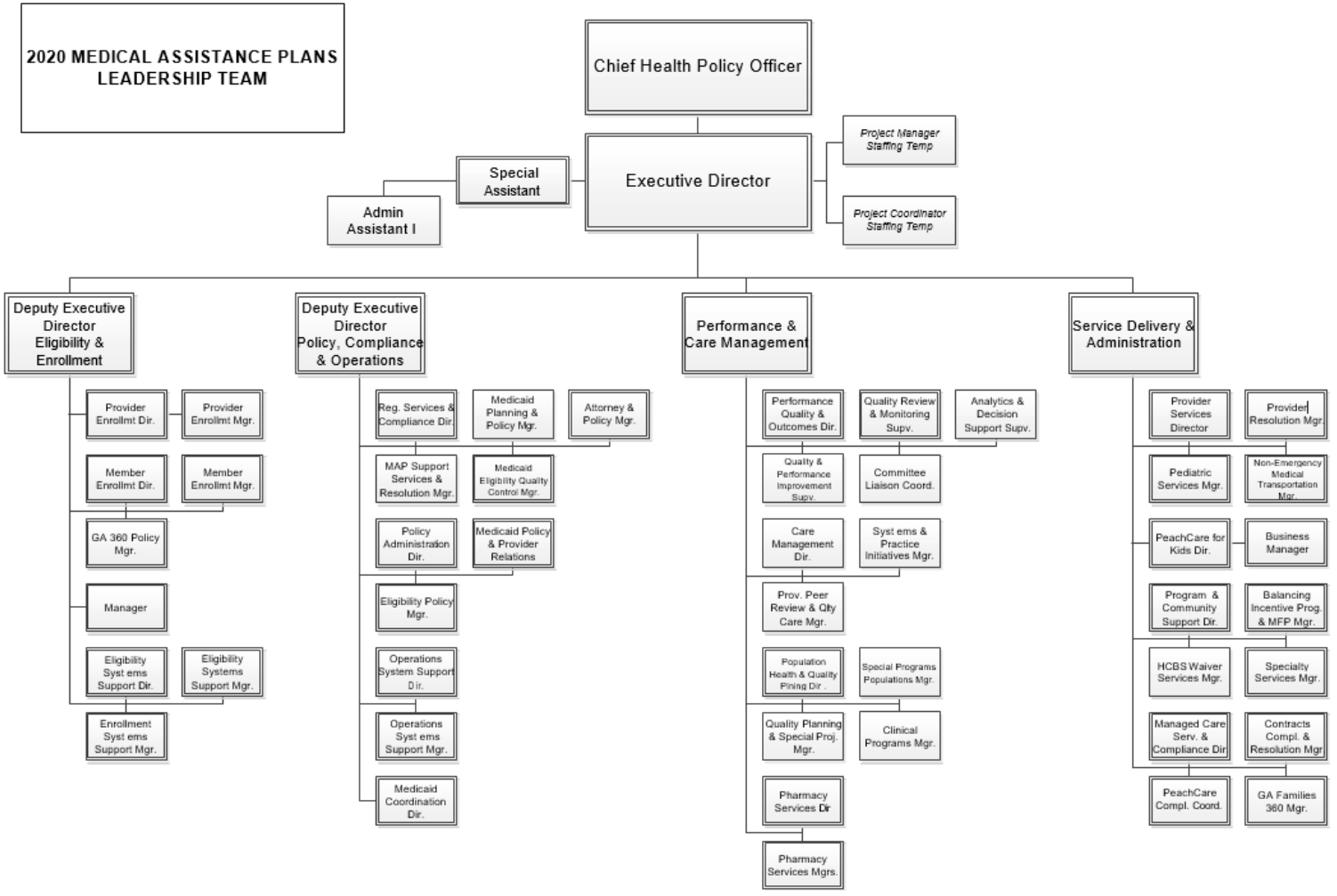
**NR: Not reported. DCH's priorities shifted and/or the data source became unavailable.*
Gray shaded boxes reflect data not provided.

Notes:

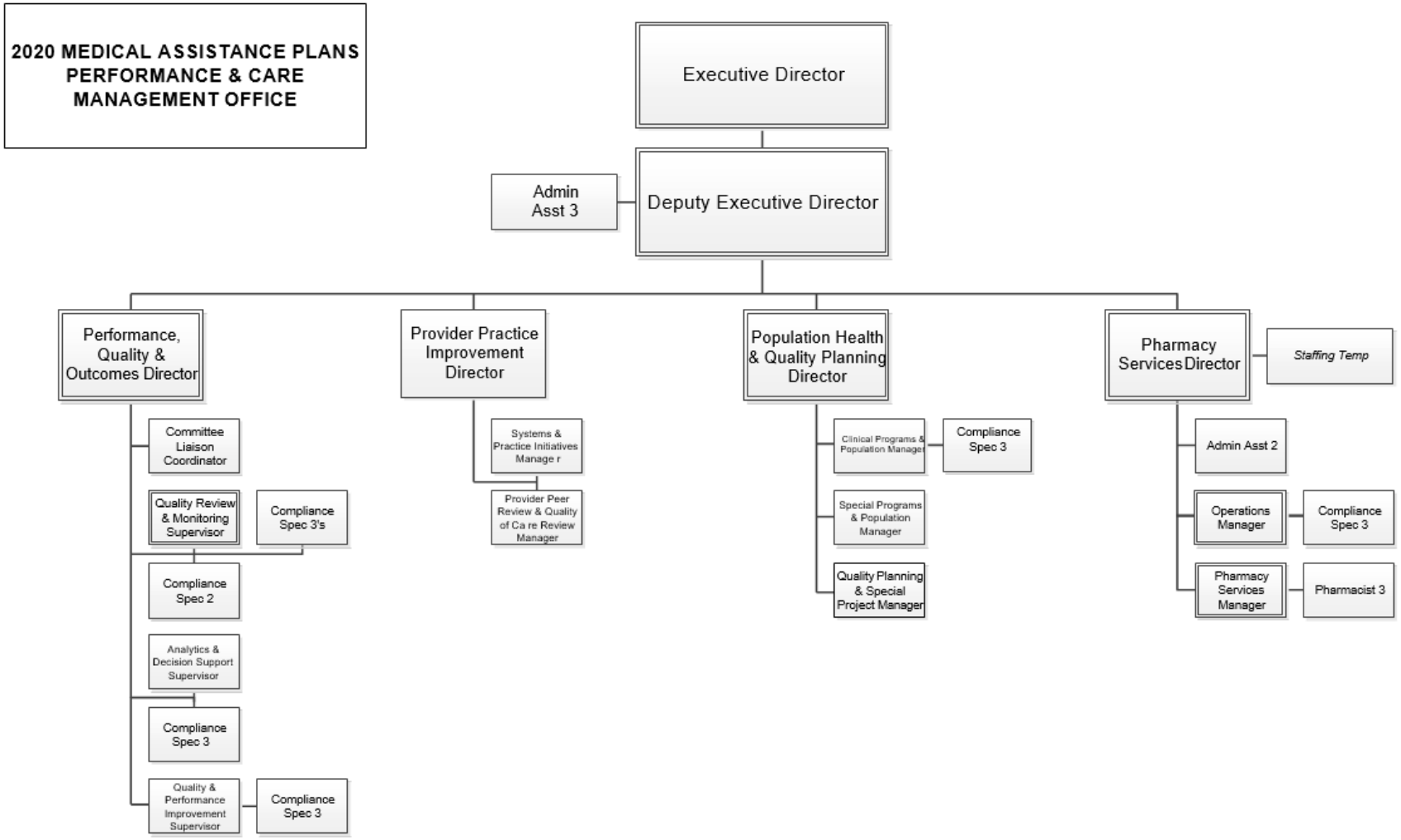
- *The GF data source is different for the two time periods.*
- *The baseline GF data is produced by DXC GF.*
- *DXC's GF rates were calculated using claims only data, even when the measure was listed as hybrid measure specifications.*
- *The remeasurement data from the most recent HSAG aggregate report was used.*
- *The baseline data and the remeasurement data are not comparable due to many factors such as different data sources, different measure specifications, and different data collection methods.*
- *Improvement may be overstated and attributable to the difference in measurement methods or measure specifications rather than the results of QI work.*

Appendix G. DCH Organizational Charts

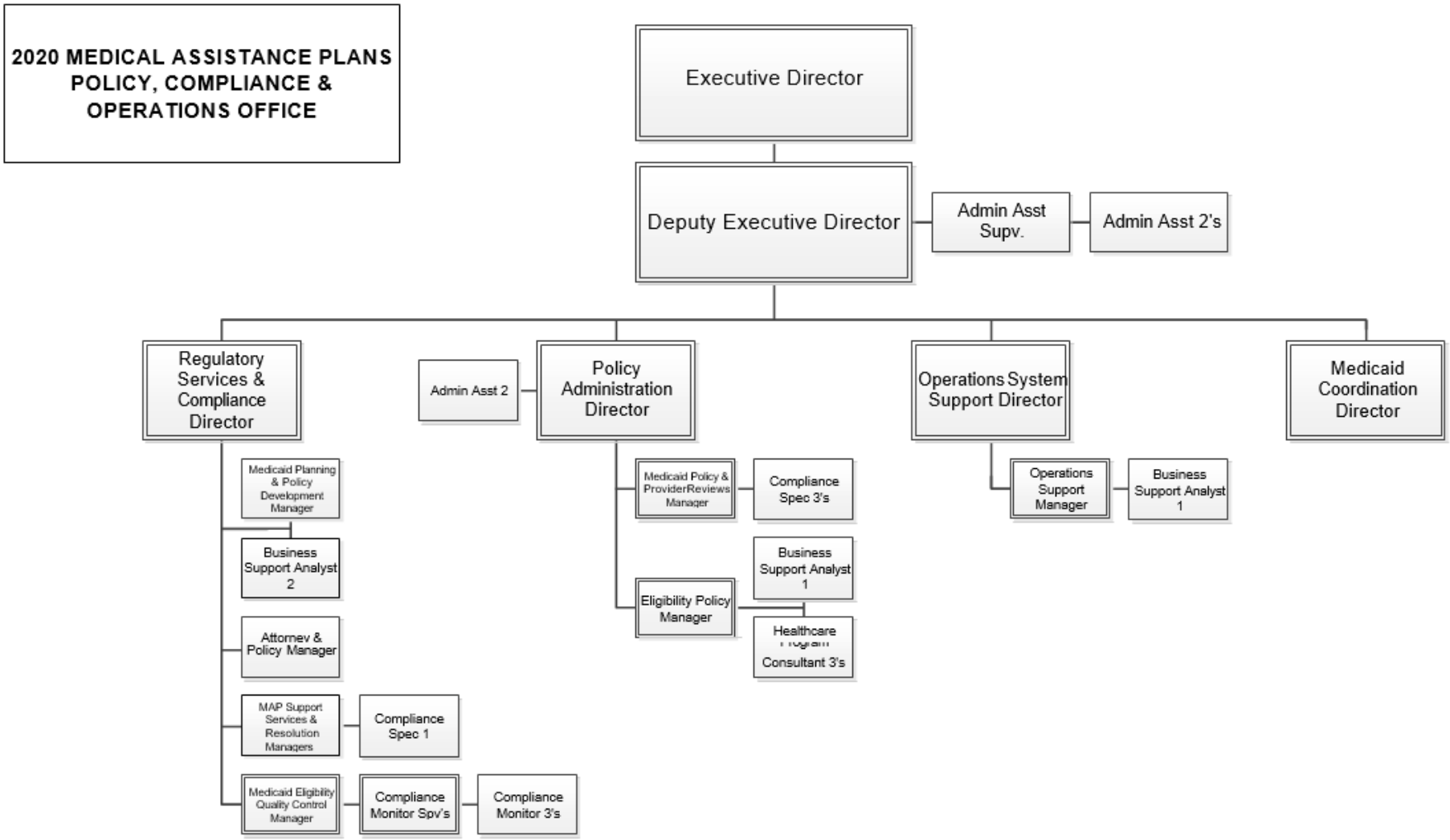
MAP Leadership Team Organizational Chart



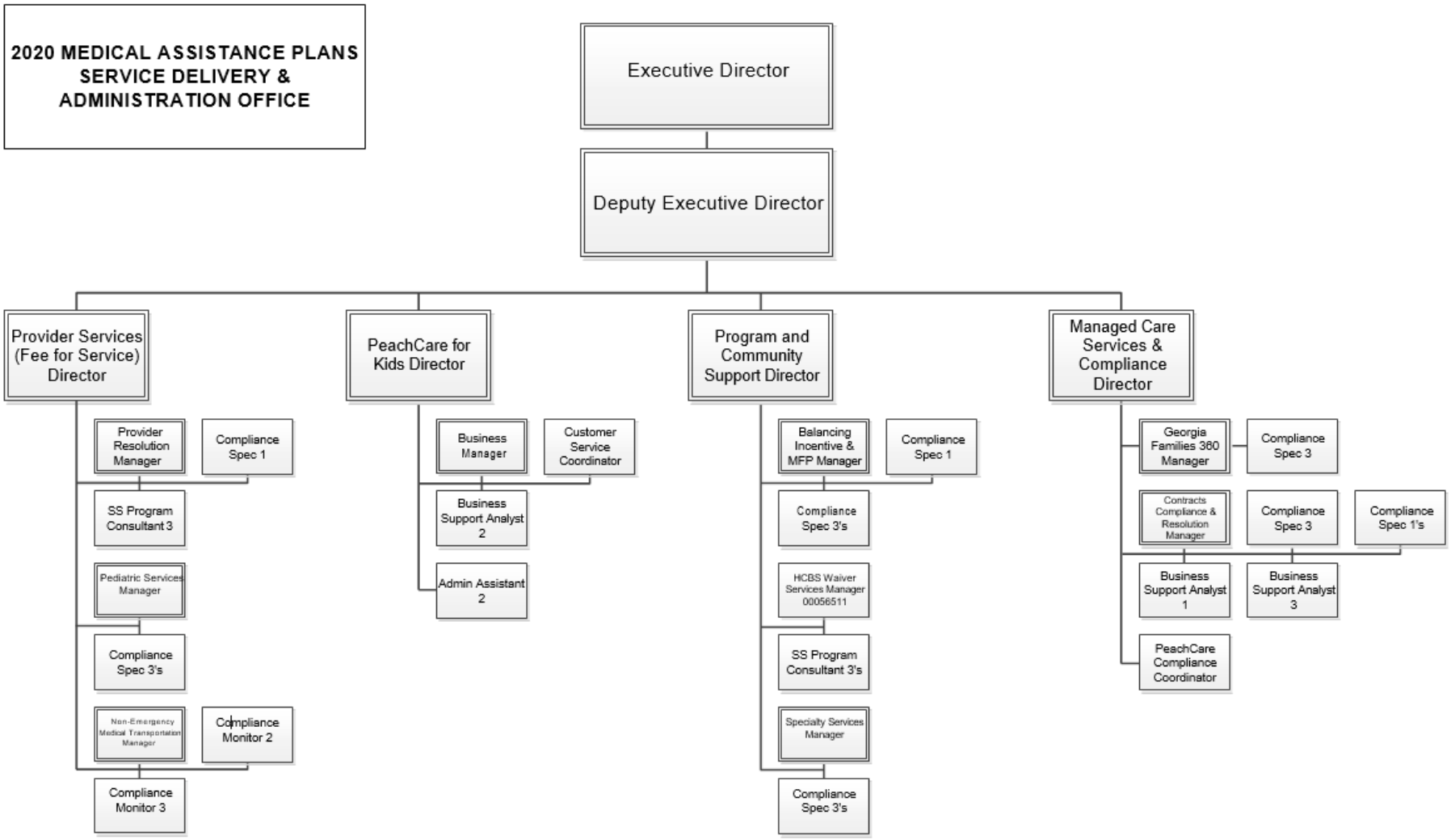
MAP Performance and Care Management Office Organizational Chart



MAP Policy, Compliance and Operations Organizational Chart



MAP Service Delivery and Administration Office Organizational Chart



MAP Eligibility & Enrollment Office Organizational Chart