GEORGIA DEPARTMENT OF COMMUNITY HEALTH

STATE OF GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2024–2026 Quality Strategy

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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 June 2023, DCH managed the care of over 2.1 million members under the GF and GF 360° programs. The majority of members, 58.8 percent, 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 including value-based purchasing (VBP), 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) §438.340 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/medicaid-quality-reporting

The Medicaid State Plan

https://medicaid.georgia.gov/

Medicaid Care Management Organization Contracts and Amendments

Georgia Families:

https://medicaid.georgia.gov/programs/all-programs/georgia-families/care-management-organizations-cmo

Georgia Families 360°:

https://medicaid.georgia.gov/programs/all-programs/georgia-families/care-management-organizations-cmo

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 goals and objectives 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' June 2021 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.
- 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 DCH collaborative efforts 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 scope of the Quality Strategy includes:

- 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, 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, including delegated or subcontracted provider types.
- All aspects of the CMOs' internal administrative and operational processes related to service and quality of care—including customer service, enrollment services, provider relations, case management services, utilization review activities, preventive health services, chronic disease management, health education, health equity and disparity reduction activities, information services, and QI.
- All administrative and health information technology for the confidential handling of medical records and information.

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 address social determinants of health (SDoH).
- Improve access to quality healthcare at an affordable price.
- Ensure value in healthcare contracts.
- Ensure the financial solvency of CMOs contracted with DCH to meet the needs of members.
- Increase effectiveness and efficiency in the delivery of healthcare programs.
- Ensure DCH staff members maintain the necessary skills and competencies to meet the current and future demand of the Medicaid program.

The DCH Pillars

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

Pillar One: Quality

- Ensure the care and services provided to Georgians are consistent with evidence and most current best practices in the healthcare industry.

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)

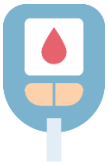
- Ensure DCH and its contractors have adequate staff with the necessary skills and competencies to deliver care that meets the needs of Georgians.

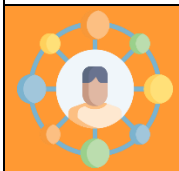
The Quality Strategy is intended to guide Georgia's Medicaid care management program by establishing clear goals and objectives to drive improvements in care delivery and outcomes, and the metrics by which progress will be measured. The Quality Strategy sets a clear direction for priority interventions 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. The DCH considers SDoH, which includes efforts to address health disparities and inequities, and embeds these as integral components of each goal and objective. This vision is distilled into seven central goals that are driven by improving health, services, and experience; smarter spending; and improving home- and community-based services (HCBS) and long-term services and supports (LTSS):

1. Improve Access to Care
2. Increase Wellness and Preventive Care
3. Improve Outcomes for Chronic Disease
4. Improve Maternal and Newborn Care
5. Improve Behavioral Health Care Outcomes
6. Enhance Member Experience

Included within each of these seven goals is a series of objectives, 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 goals and objectives 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 are identified in Appendix B.

Table 1—Quality Strategy Goals and Objectives

Goals	Objectives	Pillar
 **Goal 1: Improve Access to Care**	**Objective 1.1:** Increase the number of children receiving well-child and preventive visits.	**Quality Access**
	Objective 1.2: Increase the number of adults receiving well and preventive visits	**Quality Access**
	Objective 1.3: Increase the percentage of members *Getting Needed Care*	**Quality Experience**
 **Goal 2: Improve Wellness and Preventive Care**	**Objective 2.1:** Increase the percentage of children who receive preventive oral health services	**Quality Access**
	Objective 2.2: Increase the overall rate of immunizations and vaccinations across all ages and populations	**Quality Access**
	Objective 2.3: Increase the percentage of children/adolescents who receive weight assessment and counseling for nutrition and physical activity	**Quality**
	Objective 2.4: Increase the percentage of children who receive developmental screening in the first three years of life	**Quality**
 **Goal 3: Improve Outcomes for Chronic Diseases**	**Objective 3.1:** Decrease the annual hospital admission rate for members with heart failure	**Quality Stewardship**
	Objective 3.2: Increase the number of members participating in a remote monitoring program for management of chronic conditions	**Quality**
	Objective 3.3: Increase the percentage of members achieving appropriate asthma medication ratios	**Quality**
	Objective 3.4: Increase the number of members with a diagnosis of diabetes mellitus receiving nutritional counseling	**Quality**
	Objective 3.5: Increase the number of members with hypertension who are provided blood pressure device to monitor blood pressure	**Quality**

Goals	Objectives	Pillar
 **Goal 4: Improve Maternal and Newborn Care**	**Objective 4.1:** Increase the annual number of postpartum care visits	**Quality** **Access**
	Objective 4.2: Decrease the number of live births weighing less than 2,500 grams	**Stewardship**
	Objective 4.3: Increase the number of hospitals implementing the severe high blood pressure pregnancy safety bundle	**Quality** **Access**
	Objective 4.4: Increase the number of pregnant persons receiving prenatal services within 30 days of enrollment	**Quality**
	Objective 4.5: Increase number of postpartum persons with a diagnosis of substance use disorder (SUD) or cardiovascular condition who had provider contact within 10 days post discharge	**Quality** **Access**
 **Goal 5: Improve Behavioral Health Care Outcomes**	**Objective 5.1**: Decrease the annual behavioral health 30-day readmission rate	**Quality** **Stewardship**
	Objective 5.2: Increase the number of adolescents and adults screened for follow-up for depression	**Quality**
	Objective 5.3: Increase follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication	**Quality** **Access**
	Objective 5.4: Increase the number of children and adolescents on antipsychotics receiving metabolic monitoring	**Quality** **Access**
	Objective 5.5: Increase the percentage of children, adolescents, and adults receiving follow-up after an emergency department visit for substance use	**Quality** **Stewardship**
	Objective 5.6: Increase the percentage of children, adolescents, and adults receiving follow-up after an emergency department visit for mental illness	**Quality** **Stewardship**
	Objective 5.7: Increase the use of first-line psychosocial care for children and adolescents on antipsychotics	**Quality**
	Objective 5.8: Increase the percentage of members who initiate and engage in substance use disorder treatment	**Quality** **Access**
	Objective 5.9: Increase the percentage of individuals receiving appropriate antidepressant medication management	**Quality**
 **Goal 6: Improve Utilization of Care and Services**	**Objective 6.1:** Decrease hospital readmission rate for LTSS population	**Quality** **Stewardship**

Goals	Objectives	Pillar
 **Goal 7: Improve Member Experience**	**Objective 7.1:** Increase annual CAHPS overall *Rating of Health Plan*	**Experience**

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

To accomplish the goals and objectives, 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 goals and objectives 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 26 objectives 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)(3), 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

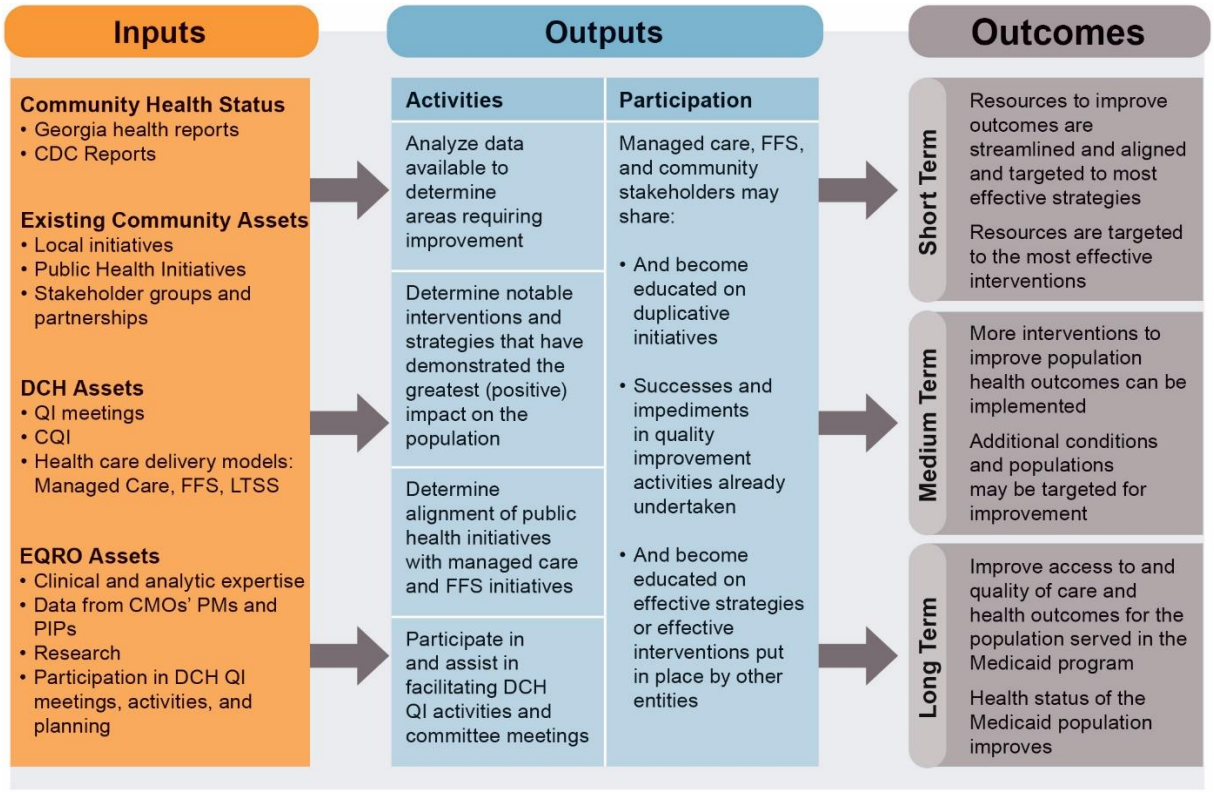
Strategy for Meeting Goals

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 an 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. As of June 2023, the GF 360º program served approximately 33,000 children.

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, task forces, and 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	

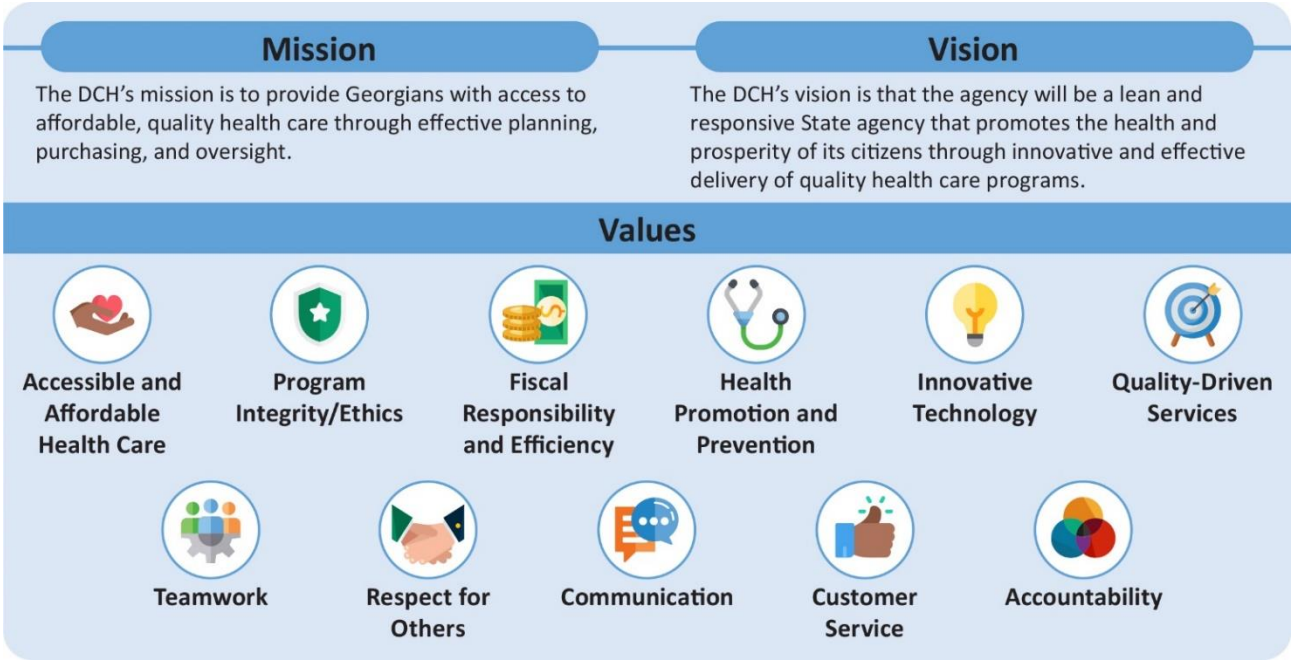
Since 2006, GF has evolved from a startup program focused on operations to a more mature program focusing on quality of care, CMO accountability, and member outcomes. The DCH has regularly gathered meaningful stakeholder feedback about the program and has used this feedback to enhance the program. For 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 June 2023, Georgia Medicaid has nearly 2.2 million members enrolled who receive care under these CMOs: Amerigroup, Peach State Health Plan, and CareSource. 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 Health Care 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 Board conducts programming to assist residents/physicians with finding a place to practice in Georgia. In addition, the Board produces data reports on the State's healthcare workforce.

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 H.

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.

Elderly and Disabled Waiver Program (EDWP)

The EDWP Waiver links primary medical care and case management with approved long-term health services in a person's home or community. The EDWP Waiver includes two components, the Service Options Utilizing Resources in a Community Environment (SOURCE), and the Community Care Services Program (CCSP).

SOURCE

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 healthcare; emergency response services; and 24-hour medical access to a case manager and primary care physician.

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. The 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.

Georgia Pathways to Coverage™ Patients First Act

Governor Brian P. Kemp signed the Patients First Act into law on March 27, 2019. The Act authorized DCH to submit a Section 1115 Medicaid Waiver request to CMS and also authorized 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). The 1115 Medicaid Expansion Waiver was approved by CMS on October 15, 2020. The Pathways program allows approximately 200,000 single, low-income adults to qualify for Medicaid.

Georgia Pathways to Coverage™ is a new program to help low-income Georgians qualify for Medicaid who otherwise would not be eligible for traditional Medicaid. Georgia Pathways to Coverage™ is an innovative program that creates a new pathway to Medicaid coverage and healthier communities. As one of Governor Kemp's key priorities, this program seeks to increase access to affordable healthcare coverage, lower the uninsured rate across Georgia, support members on their journeys to financial independence, and promote members' transition from Pathways into private coverage. This program offers Medicaid coverage to eligible

Georgians ages 19–64 who have a household income of up to 100 percent of the FPL, are not otherwise eligible for traditional Medicaid, and meet the qualifying activities threshold.

Planning for Healthy Babies® (P4HB®)

The DCH offers P4HB® to reduce Georgia's low birth weight and very low birth weight births in Georgia. 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.

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

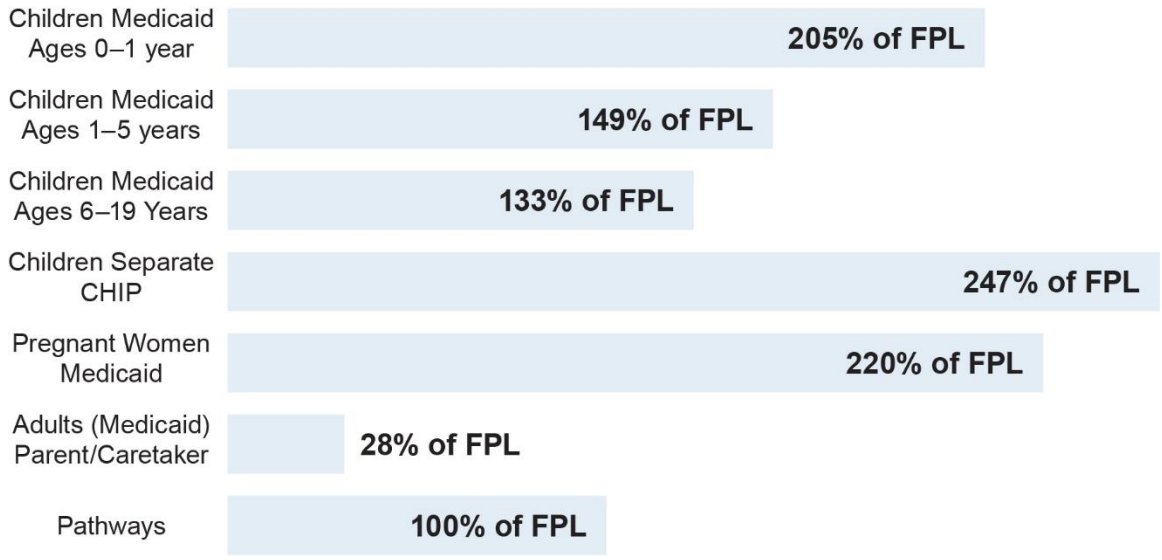
Georgia Families (GF) is a program that delivers healthcare services to members of Medicaid and PeachCare for Kids®. The program is a partnership between DCH and private CMOs. GF provides members a choice of health plans, allowing them to select a healthcare plan that fits their needs.

Georgia Families 360°

GF 360° is Georgia's care management program for approximately 33,000 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 360° 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 Limits



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 23 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 DCH's 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 2024–2026 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 six 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, the fifth, a revision in March 2021; and the sixth, a revision in April 2024. Revisions were submitted to CMS for review and approval and followed the CMS

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

2006, and later the 2021, Quality Strategy Toolkit for States. This 2024–2026 Quality Strategic Plan follows the outline contained in the June 2021 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 360° 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 360° 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 360° 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. The fourth edition was finalized by DCH on February 1, 2016, for calendar years (CYs) 2016 through 2020.

The fifth edition of DCH's Medicaid and CHIP Managed Care Quality Strategy for CYs 2021–2023 built on the 2016 Quality Strategic Plan. The fifth edition aligned 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. The 2016 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 reflected 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 advanced 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):

> *… advances CMS' efforts to streamline the Medicaid and Children's Health Insurance Program (CHIP) managed care regulatory framework and reflects a broader strategy to relieve regulatory burdens; support state flexibility and local leadership; and promote transparency, flexibility, and innovation in the delivery of care. These revisions of the Medicaid and CHIP managed care regulations are intended to ensure that the regulatory framework is efficient and feasible for states to implement in a cost-effective manner and ensure that states can implement and operate Medicaid and CHIP managed care programs without undue administrative burdens.*[2]

The federal regulations expanded 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

[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.

- 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 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. The DCH's updated Department mission was to provide Georgians with access to affordable, quality healthcare through effective planning, purchasing, and oversight. The DCH's vision was 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 Strategy (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).

In 2023, the DCH developed the 2024–2026 Quality Strategy. The DCH used the June 2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit as a guide in drafting the Quality Strategy for assessing and improving the quality of healthcare and services furnished by the CMOs and in accordance with the requirements in 438.340(a) and 438.340(b). The DCH considered the results of the evaluation of the effectiveness of the Georgia 2021–2023 Quality Strategy in achieving the DCH Medicaid mission, vision, and values in the development of the Quality Strategy. The DCH also considered the CMS 2024 Mandatory Core Set of Children's Health Care Quality Measures for Medicaid and CHIP (Child Core Set) and the behavioral health measures included in the CMS 2024 Core Set of Adult Health Care Quality measures for Medicaid in the development of the goals, objectives, and metrics contained in the 2024–2026 Quality Strategy.

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(c)(2)

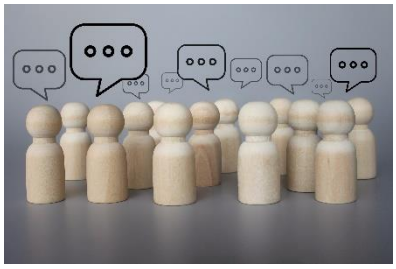
Updates to the Quality Strategy will be a part of Georgia's CQI process and, as required by 42 CFR §438.340(c)(2)(iii), will consider the recommendations provided by the EQRO for (1) improving the quality of healthcare services provided by each CMO; and (2) how DCH can target goals and objectives in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



The DCH has several processes to obtain and consider public comment on the Quality Strategy. The MCAC receives feedback from the statewide provider community. Members of the MCAC include physicians and health professionals who work with the Medicaid population; members of consumer groups, such as Medicaid beneficiaries or consumer organizations; and the director of the public welfare department or the public health department. The DCH will publicly post information related to the MAC and BAG activities.

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 April 26, 2024, through May 25, 2024. The DCH will consider the public comments as it finalizes, implements and operationalizes the Quality Strategy.

Medical Care Advisory Committee

In consideration of the proposed Rule: Ensuring Access to Medicaid Services, DCH considers the MCAC to be the Medicaid Advisory Committee (MAC). When the Final Rule is published, DCH also will establish the Beneficiary Advisory Group (BAG). 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(c)(1)(ii)

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

Submitting the Quality Strategy to CMS

42 CFR §438.340(c)(3)

CMS Review and Approval

The 2024–2026 edition of the Quality Strategy was posted to the DCH website for a minimum of a 30-day public comment period, CMS review and approval, and a resultant new edition.

Posting the Final CMS-Approved Edition on the Website

42 CFR §438.340(d)

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 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 CMOs' QAPI programs are based on the latest available research in the area of quality assurance. 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:

- A method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and over-utilization of services), including those with special healthcare needs.
- Written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically assessed for efficacy.
- A health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data.
- Designated staff members with expertise in quality assessment, utilization management, care coordination, healthcare analytics, and predictive modeling.
- Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members.
- A methodology and process for conducting and maintaining a profile for each PCP and other providers that includes multi-dimensional assessments of PCP's or provider's performance using clinical, administrative, and member satisfaction indicators of care that are accurate, measurable, and relevant to members.
- Ad hoc reports that are provided to the CMO's multi-disciplinary quality committee and DCH on results, conclusions, recommendations, and implemented system changes.
- 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.
- Evidence of effort and capability of leveraging member demographics, including without limitation SDoH, to improve health outcomes.
- A care gap plan for ensuring provision of healthcare services missed by members, including but not limited to annual preventive exams, immunizations, women's healthcare (including but not limited to prenatal and postpartum care with emphasis on those with chronic health conditions), papillomavirus, and missed services for chronic health conditions and behavioral health follow-up. The plan must clearly identify program-specific activities.
- A process for evaluation of the impact and assessment of the CMO's QAPI program.

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.

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

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

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 equitable 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.

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

- 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 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.

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;

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. 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 regularly updates 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 reviews member eligibility notices to ensure readability, compliance with federal law, inclusion of appeal language, and the inclusion of 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 prohibit 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 updates 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 providers' 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 implemented VBP in the GF 360° program. The DCH and the GF 360º CMO collaborate to implement a VBP program model that is in alignment with the Quality Strategy and the CMO's quality plan. The impact of initiatives is measured in terms of access, outcomes, quality of care, and savings. The DCH VBP program requires the CMO to collaborate with its network providers to develop and implement interventions and solutions designed to meet the VBP performance targets and to determine the frequency of VBP incentive payments to providers. The DCH incorporated rapid-cycle feedback as a key to the success of the VBP model. The DCH may withhold up to 5 percent of the GF 360° 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. CMOs only receive VBP incentive payments allotted to a VBP performance target if the CMO meets or exceeds the specified VBP performance target.

State-Directed Payment Programs

To better serve the citizens of Georgia, DCH requires CMOs to pay providers according to specific rates or methods referred to as State-directed payment programs, allowed under 42 CFR§ 438. CMS has approved the following State-directed payment programs:

Physician-Directed Payment Program (PDPP)

Georgia's PDPP provides State-directed payments to eligible physicians and other professional services practitioners who are affiliated with a governmental teaching hospital. Medicaid CMOs pay directed payments for services provided at a physician faculty practice up to the commercial equivalent. Participation in the program is voluntary and the source of non-federal funds is provided by the hospital authority or governmental entity on behalf of the eligible provider through an intergovernmental transfer (IGT) to DCH.

Hospital-Directed Payment Program (HDPP) for Public Hospitals

Georgia's HDPP provides additional Medicaid funding for eligible participating public hospitals. Public hospitals are defined as all state and non-State government hospitals, excluding Critical Access Hospitals (CAHs). This program is estimated to increase provider funding of critical services for the Medicaid population and strengthen Georgia's healthcare workforce. Under the program, eligible participating public hospitals through the Medicaid CMOs receive increased Medicaid funding via direct payment up to the Medicare equivalent. Participation in the program is voluntary and the source of non-federal funds is provided by the hospital authority or governmental entity on behalf of the eligible provider through an IGT to DCH.

Georgia's Advancing Innovation to Deliver Equity (GA-AIDE)

The GA-AIDE program authorizes State-directed payments to improve the quality of care and outcomes for patients served by Georgia's largest single provider of Medicaid services, Grady Memorial. The directed payments fund investments in initiatives designed to improve health outcomes and experiences for the medically underserved. Participation in the program is voluntary, and the source of non-federal funds is provided by the hospital authority or governmental entity on behalf of the eligible provider through an IGT to DCH.

Core quality areas of focus include:

- Improving maternal and child health.
- Preventing and reducing the impact of chronic conditions.
- Improving access to screening and prevention services.
- Addressing health equity.

Strengthening The Reinvestment of a Necessary-workforce in Georgia (GA-STRONG)

GA-STRONG is designed to address Georgia's healthcare workforce shortage through increased funding for hospitals on the front lines of workforce development. The program initially includes 21 eligible teaching hospital participants with at least five full-time equivalent residents. The program allows eligible providers to receive STRONG payments from CMOs based on a uniform percentage increase to base rates of ~50 percent of the average commercial equivalent. An increase in the current statewide hospital assessment and IGTs from participating public teaching hospitals will be used to finance the program's non-federal share required.

GA-STRONG provides foundational support to Georgia's teaching hospitals that are central to healthcare workforce redevelopment. The funds delivered through the program allows these institutions to build on and expand innovative programs specific to their communities, leading to stabilization, development, and diversification of the healthcare workforce and ultimately improve patient outcomes and advance Georgia's quality goals. As such, core quality areas of focus will be statewide improvements through:

- Workforce retention and growth across the spectrum of care.
- Incentivizing/prioritizing direct patient care.
- Geographic Shortage Areas.
- Accountability via robust hospital specific reporting.

Hospital Directed Payment Program (HDPP) for Private Hospitals

Georgia's HDPP provides additional Medicaid funding for eligible participating private hospitals. Eligible private hospitals are defined as all private, acute hospitals excluding general cancer hospitals, free-standing children's hospitals, and rehabilitative/psychiatric/long-term acute hospitals. All CAHs are excluded. This program is estimated to increase provider funding of critical services for the Medicaid population and strengthen Georgia's healthcare workforce. Under the program, eligible participating private hospitals through the Medicaid CMOs will receive increased Medicaid funding via direct payment up to the Medicare equivalent.

Drug Utilization Review Program

The DCH maintains a Drug Utilization Review Board (DURB) whose membership is appointed by the DCH Commissioner. 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(s)(4), 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.

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. The 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, and that black and non-Hispanic women were almost three times more likely to die from pregnancy-related causes than white 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. The 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 ongoing collaboration with community-based organizations and stakeholders. The 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.

According to the Georgia Department of Public Health (GDPH), 2018–2020 pregnancy-related deaths were 48.6 per 100,000 live births among non-Hispanic black women compared to 22.7 pregnancy-related deaths per 100,000 live births among non-Hispanic white women, or twice that for white women in Georgia and six times the rate for white women nationally. The GDPH 2018–2020 data indicate that in Georgia, 68 percent of pregnancy-related deaths occurring after delivery were Medicaid enrolled compared to 32 percent that were non-Medicaid.

Plan to Address Health Disparities

The DCH uses the Centers for Disease Control and Prevention (CDC) and the World Health Organization (WHO) definitions for "health equity." The DCH also uses the WHO definition for SDoH: "non-medical factors that influence health outcomes." These factors are often shaped and determined by economic, social, and/or political policies and systems. Examples of SDoH include:

- Income and social protection.
- Education.
- Unemployment and job insecurity.
- Working life conditions.
- Food insecurity.
- Housing, basic amenities, and the environment.
- Early childhood development.
- Social inclusion and nondiscrimination.
- Structural conflict.
- Access to affordable health services of decent quality.

According to the CDC health disparities are preventable differences in the burden of disease, injury, violence, or in opportunities to achieve optimal health experienced by socially disadvantaged racial, ethnic, and other population groups, and communities. The CDC defines health equity as the state in which everyone has a fair and just opportunity to attain their highest level of health. 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 engages 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 focuses 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. Measure data are stratified by age, race, ethnicity, gender, and geographic location. Findings resulting from the data analysis are shared with the

CMOs. CMOs use the data analysis results to create QI activities to address the identified disparities. Beginning in 2021, CMOs reported data for quality measures according to age, sex, ethnicity/race, and geographic location. Analysis of these data has led to the State and CMOs placing greater focus on rural spaces to the extent of launching multiple pilot programs in rural counties. For example, the State participated in the Center for Medicaid and CHIP Services (CMCS) 2023 Postpartum Affinity Group. All the activities for the project took place in rural counties of Georgia.

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 CMOs are required to have a full-time health equity director who is responsible for promoting fairness and inclusivity in healthcare. Each CMO's health equity director leads the CMO's effort to reduce disparities among diverse members, creating strategies to address social factors, such as SDoH, and ensures equitable healthcare delivery. Each CMO's health equity director is also responsible for the development and implementation of the CMO's health equity plan and any other health equity-related organizational initiatives. Each CMO's health equity director will inform decision-making around best payer practices related to disparity reductions, including the provision of health equity and SDoH resources and research to leadership and programmatic areas. Each CMO's health equity director coordinates and collaborates with enrollees, providers, local and state government, community-based organizations, and other CMOs to impact health disparities at a population level.

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 Quality Strategy goals, 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 CMO 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.

Mental Health Parity and Addiction Equity Act

The DCH includes the requirements of the Mental Health Parity and Addiction Equity Act (MHPAEA) in its contracts with the CMOs. To ensure compliance, CMOs must demonstrate parity in their care delivery such that treatment or benefits for mental health care are no less than benefits available for physical health conditions.

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 DCH-selected measures of the CMOs annually and reports the results to DCH. The DCH implemented processes and CMO requirements to report all CMS Child Core Set measures and all Adult Behavioral Health measures in the CMS Core Measure Sets by 2024 for both the Medicaid and CHIP populations.

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 also develops PIPs based on a root cause analysis and driver diagrams for the metrics DCH works 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:

The Annual External Quality Review (EQR) Technical Report

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, 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 §438.56 (disenrollment requirements and limitations), §438.100 (enrollee rights), §438.114

(emergency and poststabilization services), and §438.330 (quality assessment and performance improvement requirements). 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: A Mandatory EQR-Related Activity,* February 2023.[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 14 compliance standards are derived from requirements in the CFR CMS Managed Care Rule. The 14 mandatory compliance standards are listed below:

- §438.56 Disenrollment: Requirements and Limitations
- §438.100 Enrollee Rights
- §438.114 Emergency and Poststabilization Services
- §438.206 Availability of Services
- §438.207 Assurances of Adequate Capacity and Services
- §438.208 Coordination and Continuity of Care
- §438.210 Coverage and Authorization of Services
- §438.214 Provider Selection
- §438.224 Confidentiality
- §438.228 Grievance and Appeal Systems
- §438.230 Subcontractual Relationships and Delegation
- §438.236 Practice Guidelines
- §438.242 Health Information Systems
- §438.330 Quality Assessment and Performance Improvement Program

The DCH, with CMS encouragement, uses other monitoring processes, including a review of deliverables, and also expands the scope of the compliance 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)
- 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.

[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*, February 2023. Available at: http://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jul 10, 2023.

Using Incentives and Intermediate Sanctions to Drive Improvement

42 CFR §438 Subpart I

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 include liquidated damages, disallow further Medicaid and CHIP enrollment and may also include adjusting auto-assignment formulas used for member enrollment.

Intermediate Sanctions

42 CFR §438.340; 42 CFR §438.730

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 Subpart I. Accordingly, intermediate sanctions may be imposed if the CMO:

- Fails substantially to provide medically necessary services that the CMO is required to provide, under law or under its contract with the State, to an enrollee covered under the contract.
- Imposes on enrollees premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among enrollees on the basis of their health status or need for healthcare services. This includes termination of enrollment or refusal to re-enroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the State.
- Misrepresents or falsifies information that it furnishes to an enrollee, potential enrollee, or healthcare provider.
- Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in §§ 422.208 and 422.210 of this chapter.
- Distributed directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.
- Has violated any of the other requirements of sections 1903(m) or 1932 of the Act, or any implementing regulations; or 1905(t)(3) of the Act, or any implementing regulations.

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 categories of intermediate sanctions that are included in Appendix G.

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 360° program. The DCH withholds 5 percent of the GF 360° 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 360° 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(b)(6)

To comply with the regulatory requirement for state procedures for race, ethnicity, and primary language and disability status, 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, 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(c) 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 4.

Table 4—Members With Special Circumstances

Special Circumstances
Members who are currently hospitalized or an inpatient at a facility
Pregnant women who are high-risk and in their third trimester, or are within 30 calendar days of their anticipated delivery date
Major organ or tissue transplantation services that are in process, or have been authorized;
Chronic condition(s), which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing or other facilities
Members who are in treatment such as chemotherapy, radiation therapy, or dialysis
Members with ongoing needs such as durable medical equipment, including ventilators and other respiratory assistance equipment
Current home health services
Medically necessary transportation on a scheduled basis
Prescription drugs requiring prior authorizations
Members who are receiving other services not indicated in the State Plan, but covered by Title XIX for EPSDT eligible members

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 with local education authorities in the referral and provision of children's intervention school services provided by the LEAs to ensure medical necessity and prevent duplication of 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 §438.350, §438.356, and §438.358

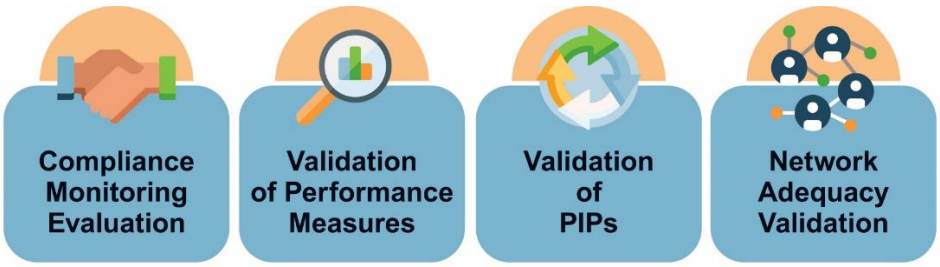
In accordance with 42 CFR §438.356, DCH contracts with HSAG as its EQRO to conduct the mandatory and optional EQR activities as set forth in 42 CFR §438.358. HSAG has been DCH's EQRO since 2008. HSAG's current EQRO contract that began in 2018 is for one year with four consecutive one-year renewal options. 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)(i), DCH requires CMOs to submit performance measurement data as part of their QAPI programs. To comply with 42 CFR §438.332, 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, 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)(ii), 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 validation of network adequacy will:
  - Geographic network distribution: Evaluate the geographic time and distance access standards by provider type stratified by urban and rural geographic designations. Provider types include:
    - PCPs.
    - Pediatricians.
    - Obstetric providers.
    - Specialists.
    - General dental providers.
    - Dental subspecialty providers.
    - Hospitals.
    - Mental health providers.
    - Pharmacists.
    - Physical, occupational, and speech therapists.
    - Vision providers.
  - Provider network information systems and data sources:
    - Information system documentation for all systems used to monitor network adequacy.
    - Network adequacy indicator rates for each standard required by DCH, including any associated data required to validate each rate.
    - Network adequacy validation source code used to calculate the rates.
  - Validate plan-submitted network adequacy data and results: Review and validate the CMO's network adequacy validation data submitted to ensure its accuracy, completeness, and consistency, including the CMO's ability to:
    - Collect, capture, and monitor valid network adequacy data.
    - Evaluate the adequacy of the provider network using sound analytic methods.
    - Produce accurate results to support CMO network adequacy monitoring.
    - Provide DCH with accurate network adequacy indicator rates for each required standard.

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

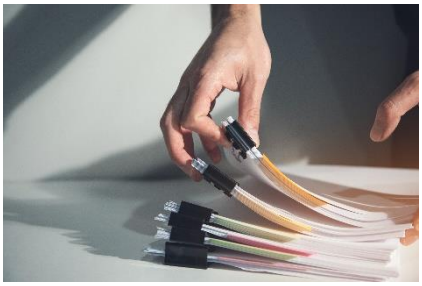
Optional EQR Activities

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 Final Rule, last updated in 2020, 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 for the quality, timeliness, and access to healthcare services furnished to Medicaid beneficiaries, as well as recommendations for improvements
- Methodologically appropriate comparative information about all CMOs in the program
- An assessment of the degree to which each MCO has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR

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/medicaid-quality-reporting.

Non-Duplication of Mandatory Activities—Methodology for Determining Comparability

42 CFR §438.360

The CMS Managed Care Rule addresses the nonduplication of mandatory activities with Medicare or accreditation reviews. Federal regulations allow DCH to exempt a CMO from a review of certain administrative functions when the CMO's Medicaid contract has been in effect for at least two consecutive

years before the effective date of the exemption, and during those two years the CMO has been subject to EQR and found to be performing acceptably for the quality of, timeliness of, and access to healthcare services it provides to Medicaid members.

DCH requires the CMOs to be NCQA accredited, which allows DCH to leverage or deem certain review findings from a private national accrediting organization that CMS has approved as applying standards at least as stringently as Medicaid under the procedures in 42 CFR §422.158. The DCH and HSAG followed the requirements in 42 CFR §438.362, which include obtaining:

- Information from a private, national accrediting organization's review findings. Each year, DCH obtains from each CMO the most recent private accreditation review findings reported on the CMO, including:
  - All data, correspondence, and information pertaining to the CMO's private accreditation review.
  - All reports, findings, and other results pertaining to the CMO's most recent private accreditation review.
  - Accreditation review results of the evaluation of compliance with individual accreditation standards, noted deficiencies, corrective action plans, and summaries of unmet accreditation requirements.
  - All measures of the CMO's performance.

Rationale

The DCH utilizes the non-duplication option to fulfill certain activities related to the required EQR compliance review in order to avoid duplicity of work and to reduce the CMOs' administrative burden. The DCH applies non-duplication as part of the compliance review process through a review of the private accrediting organization's CMO accreditation survey results, deficiencies, corrective action plans, and summaries of unmet accreditation requirements.

To determine comparability of the federal requirements and the NCQA health plan accreditation survey standards, HSAG reviews the NCQA health plan accreditation survey standards and determines which standards are at least as stringent as those required by CMS (§422.158) and are comparable to standards established through the EQR protocols (§438.352 and §438.358). HSAG reviewed and compared the CMOs' accreditation survey results with the CMS requirements and determined which standards met the conditions for deeming for the compliance review.

State Monitoring and Evaluation of CMO Requirements

42 CFR §438.66

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

42 CFR §438.206(c)(1)

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.

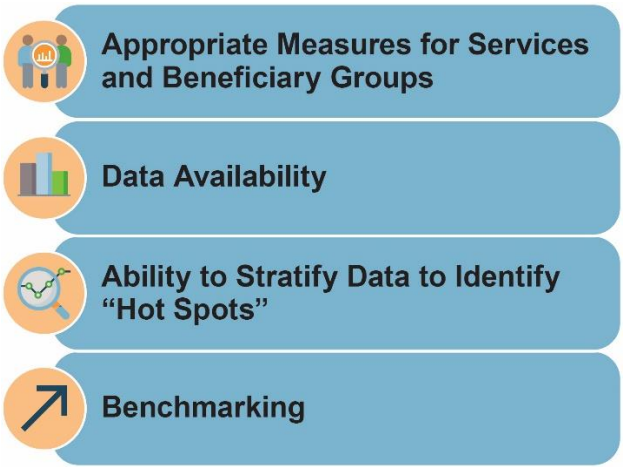
Criteria for Selecting Access Measures

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, appeal 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 and meet 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 select and retain providers in their provider networks and consider the factors included in Table 5.

Table 5—Network Selection and Retention Considerations

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	✓	✓

CMO Network Adequacy Standards	GF	GF 360°
Numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services	✓	✓
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 each CMO's provider contracts to ensure that the CMO demonstrates that it has the capacity to serve the expected enrollment in its service area. The DCH reviews the CMO's provider contracts, policies, procedures, and processes to ensure that the CMO complies with offering an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area and maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area. The DCH also reviews the CMO's 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 reviews the CMO's mechanisms to detect under- and overutilization of care and services as a method of assuring the CMO's adequate capacity 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, §438.224, §438.228, §438.230 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 (42 CFR §438.214)
- Information requirements(42 CFR §438.10)
- Confidentiality (42 CFR §438.224)
- Enrollment and disenrollment (42 CFR §438.54 and §438.56)
- Grievance and appeal systems (42 CFR §438.228 and 42 CFR §438 Subpart F)
- Subcontractual relationships and delegation (42 CFR §438.230)

Provider Selection

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 6. The DCH establishes waiting times by appointment type as illustrated in Table 7. The DCH establishes return call response times as illustrated in Table 8.

Table 6—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
	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—psychiatry—Physician/APRN/PA (routine visits)	Ten (10) calendar days
	Mental Health Providers—Psychiatry—Physician/APRN/PA (urgent care for medication refills)	Not to exceed forty-eight (48) clock hours
	Mental Health Provider—Therapy/Counseling (routine visits)	Ten (10 calendar days)
	Substance Use Disorder Provider (routine visits)	Ten (10 calendar days)
	Substance Use Disorder (urgent care for medication refills)	Ten (10 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 7—Waiting Times by Appointment Type

Appointment Type	Waiting Time
Scheduled Appointments	Waiting times shall not exceed sixty (60) minutes. After thirty (30) minutes. For mental health providers, substance use disorder providers, and autism spectrum disorder providers, waiting times shall not exceed thirty (30) 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 8—Returned Call Response Times

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

Exception 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 delivery of medical or other health services provided to a patient using real-time interactive communication equipment to exchange the patient's information from one site to another via an electronic communication system. Telehealth allows provider-to-provider and provider-to-member live interactions and is especially useful in situations where members do not have easy access to a provider, such as for members in rural areas. Providers also use telehealth to consult with each other and share their expertise for the benefit of treating members.

Information Requirements

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; §438.406; §438.408

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 90 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 72 hours 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 hours from the initial receipt of the appeal.

Subcontractual Relationships and Delegation

42 CFRs §438.230 and §438.3(k)

CMOs remain accountable for all contract terms which are performed by subcontractors or through delegation agreements. 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 §438.236, § 438.330 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 CMO contracts required use of 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 the most recent 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.

Examples of the evidence-based clinical practice guidelines include:

- **Diabetes:** *The Standards of Medical Care in Diabetes* are maintained by the American Diabetes Association (ADA).[8] The standards include ADA's current clinical practice recommendations and are intended to provide the components of diabetes care, general treatment goals and guidelines, and tools to evaluate quality of care.
- **Depression:** The *Clinical Practice Guideline for the Treatment of Depression Across Three Age Cohorts* (including major depression, subsyndromal depression, and persistent depressive disorder) was published by the American Psychological Association. The guideline addresses three developmental cohorts: children and adolescents, general adults, and older adults (ages 60 and over).
- **Prenatal Care:** The CPG incorporates information on the recommendations and standards, established by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists (ACOG), for prenatal care.[9]
- **Postpartum Care:** The CPG incorporates information on the recommendations and standards, established by ACOG, for postpartum care.[10]
- **Upper Respiratory Infection:** The American Academy of Family Physicians' respiratory tract infection guideline, which includes guidelines for the treatment of acute bronchitis, acute rhinosinusitis, bronchiolitis, common cold, croup, pharyngitis, rhinosinusitis, streptococcal pharyngitis, and strep throat.[11]

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[8] American Diabetes Association. *Standards of Medical Care in Diabetes—2021*. Available at: https://diabetesjournals.org/care/issue/44/Supplement_1. Accessed on: Jan 25, 2022.
[9] American Academy of Pediatrics. American College of Obstetricians and Gynecologists. *Guidelines for Perinatal Care, 8th Edition.* Available at: https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187c.ashx. Accessed on: Jan 31, 2024.
[10] American College of Obstetricians and Gynecologists. Optimizing Postpartum Care. May 2018. Available at: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2018/05/optimizing-postpartum-care. Accessed on: Jan 31, 2024.
[11] DeGeorge KC, Ring DJ, Dalrymple SN. Treatment of the Common Cold. *American Family Physician*, 2019 Sep 1;100(5):281-289. Available at: https://www.aafp.org/afp/2019/0901/p281.html. Accessed on: Jan 27, 2022.

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.

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 9.

Table 9—CMO QAPI Program Requirements

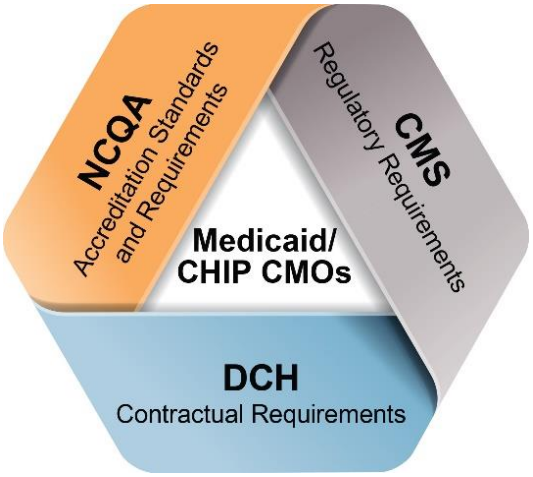
CMO QAPI Program Requirements
A method of monitoring, analysis, evaluation, and improvement of the delivery, quality, and appropriateness of healthcare furnished to all members (including under- and overutilization of services), including those with SHCN
Written policies and procedures for quality assessment, utilization management, and continuous QI that are periodically assessed for efficacy
A health information system 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 for each PCP and other providers that includes multidimensional assessments of a PCP's or provider's performance using clinical, administrative and member satisfaction indicators of care that are accurate, measurable, and relevant to members
Ad hoc reports to the CMO's multidisciplinary QOC and DCH on results, conclusions, recommendations, and implemented system changes;
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
Evidence of effort and capability of leveraging member demographics, including without limitation SDoH, to improve health outcomes
A care gap plan for ensuring provision of healthcare services missed by members, including, but not limited to, annual preventive exams, immunizations, women's healthcare (including but not limited to prenatal and postpartum care with emphasis on those with chronic health conditions), PAP, and missed services for chronic health conditions and behavioral health follow-up. The CMO's plan includes all care coordination programs in which it participates; however, it must clearly identify program-specific activities; and
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 90 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.

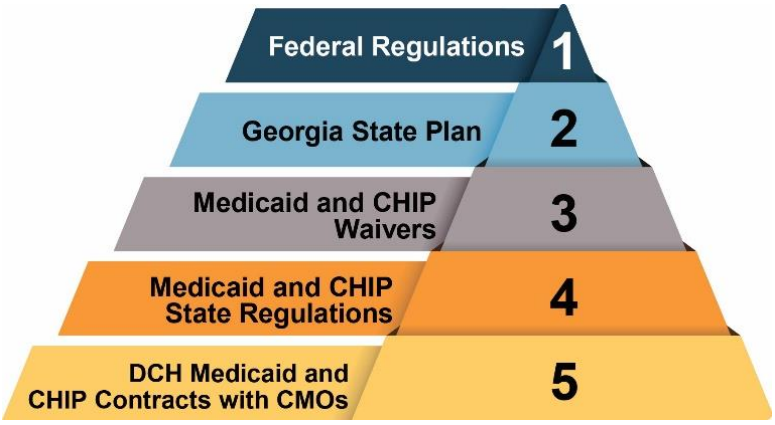
The requirements and standards serve as the basis for the Quality Strategy and are depicted in the framework in Figure 8.

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 360° programs. The DCH includes a subset of HEDIS measures and CMS Core Sets 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.

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), PIP goals, and PIP interventions 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 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 improving 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 and is consistent with CMS guidelines and regulations.

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. The MEST Program has progressed since that time from visioning to planning, to incremental implementation of the transformation roadmap.

Medicaid Enterprise System Transformation

Changes in federal regulations and guidance require a modular approach to Medicaid IT system procurement and implementation. Rather than investing in monolithic, single-vendor systems, 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

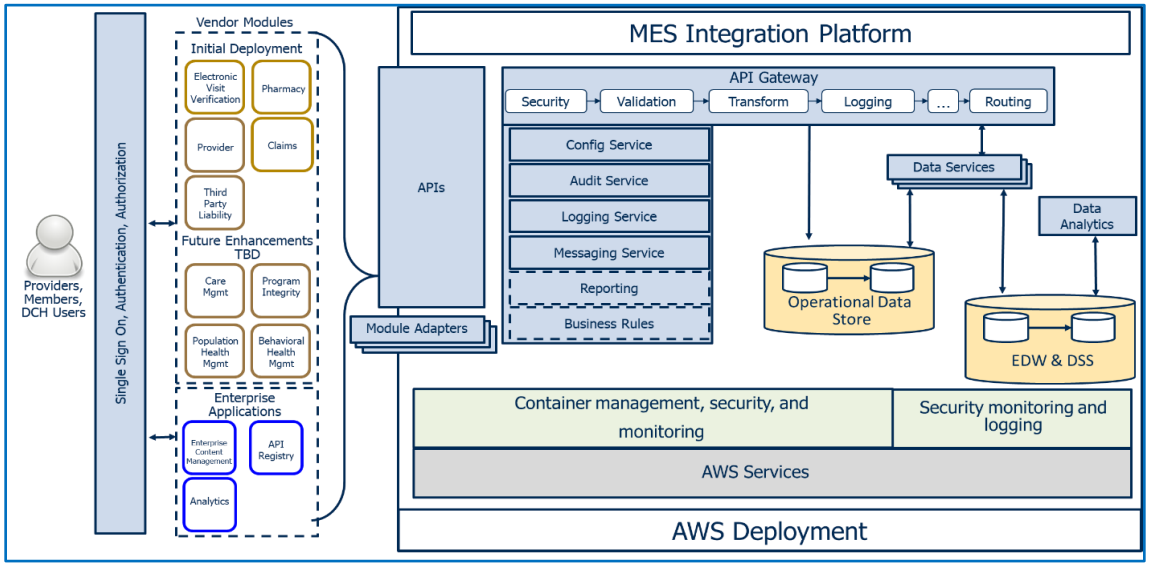
- Increased system integration and interoperability with state (Georgia and other) and federal agency partners

The launch of a modular, transformed MES was initially targeted for 2023, but will now be targeted for no earlier than 2025 and will include the MES integration platform and system integration services, shared centralized services such as change/release and incident management and enterprise content management, an API Gateway, a centralized operational data store (ODS), and data services for reference data and other data components, and will integrate with, the following five modules:

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

An additional Core module is Member Services. This module is also planned to be developed and will integrate member-related data such as eligibility data. The new system will also integrate with data analytics and other tools that will be useful to DCH teams and decision-makers. Figure 10 depicts the high-level architecture of the planned Medicaid Enterprise System.

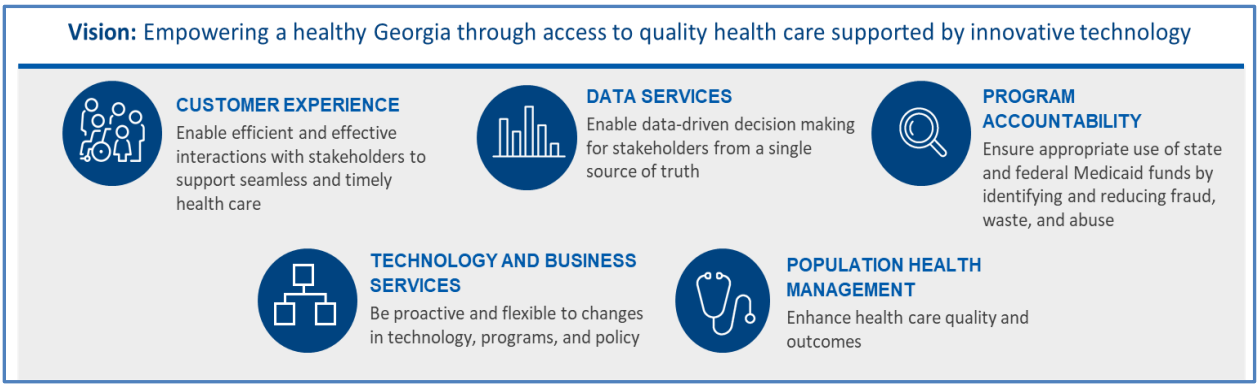
Figure 10—Medicaid Enterprise System High-Level Architecture



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 10.

Table 10—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

Vision Goal	Strategy
	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 master agreement phase, qualified vendors were sought through a request for proposal process. The multi-state consortia selected five proposals and five master agreements that were approved by CMS. Georgia down selected to one proposal, but the procurement is under protest. 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 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.

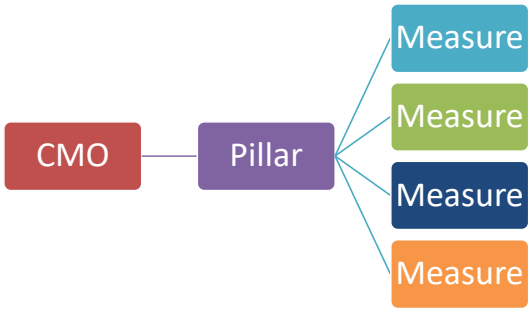
Translating Data Into Action

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.

Quality Strategy Scorecard

To continually track the progress of achieving the goals outlined in the Quality Strategy, DCH developed a Quality Strategy Scorecard (Appendix D). The scorecard lists each of the goals and corresponding performance measures used to measure achievement of the goals. The DCH updates the scorecard annually. 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 scorecard, 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 an 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 June 2021 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 11—Introduction

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(a)	II.C. Exhibit 1 42 CFR §438.340(a), applicable also to CHIP managed care programs per 42 CFR §457.1240(e)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with. **Toolkit Requirement:** • Indicate in the footer of the cover page of the initial quality strategy the date when the state submitted the quality strategy to CMS for comment and feedback. If the quality strategy is a revision of a previous version, indicate when the state published the previous version. Also indicate whether the quality strategy is an initial version or a revised version.	Cover Page
§§438.340(a), 457.1240(e) *Note: Not all requirements in the CFR are included in*	II.C. Exhibit 1 42 CFR §438.340(a), applicable also to CHIP managed care programs per 42 CFR §457.1240(e)	Include a brief history of the state's Medicaid and CHIP managed care programs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must draft and implement a written quality strategy for assessing and improving the quality of health care and	Pages 4–5 Pages 13–14

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
the Quality Strategy Toolkit.		services furnished by each MCO, PIHP, PAHP, and PCCM entity it contracts with. **Toolkit Requirement:** • Describe the types of MCPs (such as MCOs and PIHPs) that the state contracts with to deliver services to beneficiaries; the managed care authorities, including relevant state plans (for example Medicaid, CHIP) and waiver types (such as Section 1115 demonstrations), that the state uses for each MCP. • The types of benefits (such as LTSS and dental) that each MCP provides to beneficiaries. • Specify which populations are addressed; children with disabilities may be included with children or people with disabilities. • Use this information to ensure that the quality strategy addresses all plans and populations in the state's managed care programs. • Indicate whether the state's CHIP program type is expansion, separate, or combined; whether the state provides CHIP benefits through managed care; and which MCPs provide CHIP benefits. If the state provides CHIP benefits through managed care, indicate whether the quality strategy addresses the state's CHIP program.	
42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)	II.E.3 LTSS Performance Measures 42 CFR §438.340(b)(3)(i); 42 CFR §457.1240(e); §438.330(c)(1)(ii)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply. **Toolkit Requirement:** • Indicate in the quality strategy whether the state delivers LTSS through managed care. • For concurrent managed care and home and community-based services (HCBS) authorities, review HCBS quality assurance provisions required for HCBS for those programs with and without	Page 20

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		an institutional level of care found at 42 CFR 441.302(a)her), 441.303(a)-(e) 441.715(a) and 441.745(b).	
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 15–16 Appendix H
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
§438.340(b)(2)	II.D. Goals and Objectives 42 CFR §438.340(b)(2), applicable also to CHIP managed care programs per 42 CFR §457.1240(e).	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". **CFR Description:** The state must identify its goals and objectives for continuous quality improvement. These goals and objectives must be measurable and take into consideration the health status of all populations served by the state's MCPs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Include measurable goals and objectives in the quality strategy. • Goals are defined as high-level managed care performance aims that provide direction. • Objectives are defined as measurable steps toward meeting the state's goals, and typically include quality measures. • Link each goal to one or more objectives. Together, CMS recommends that the goals and objectives be specific, measurable,	Pages 6–10 Appendix B Appendix E

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		attainable, relevant, and time-bound (SMART) • Crosswalk the goals and objectives to the populations and plans included in the state's managed care program to ensure that the goals and objectives address each population and plan.	
Optional		Include a description of the formal process used to develop the quality strategy.	Pages 20–26
§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.	Pages 25–26
§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 as final.	Pages 25–26
§438.340(c)(2)(i)		Include a timeline for assessing the effectiveness of the quality strategy (e.g., monthly, quarterly, annually).	Pages 23–24 Page 37 Appendix D
§438.340(b)(10) and (c)(3)(ii)	III.A.1 Updates for State-Defined Significant Changes §438.340(b)(10) and (c)(3)(ii), §457.1240(e)	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". **CFR Description:** The state must include in its quality strategy a definition for a "significant change" for the purpose of revising the quality strategy. If such a significant change occurs, the state must update its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Consider factors to define as a significant change, such as, but not limited to: • Adding or removing goals and objectives. • Changes that trigger public comment, tribal consultation, and input from the state's Medical Care Advisory Committee. • Substantive changes to the state's managed care quality laws.	Pages 23–24 Page 37 Appendix D
§438.340(b)(10)	III.A.2 Updates for Significant Changes That Occur Within the State's Medicaid Program	**CFR Description:** In addition to updates made to reflect significant changes as defined by the state, the state must also update its quality strategy whenever significant changes occur within the state's Medicaid program.	Page 24

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	§438.340(c)(3)(ii), §457.1240(e)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** No details provided in the toolkit.	
§438.340(c)(1)	IV.A. Public and Tribal Comment Process Exhibit 18 42 CFR §§438.340her(1)(i),438.340(c)(1)(ii), cross-referencing 42 CFR §431.12, §457.1240(e).	**CFR Description:** The state must make the strategy available for public comment before submitting the strategy to CMS for review, including by obtaining input from its Medical Care Advisory Committee (Medicaid only), beneficiaries, and other stakeholders. In addition, the state must consult with Tribes in accordance with the state's Tribal consultation policy established pursuant to 1902(a)(73) of the Social Security Act, if the state enrolls American Indians and Alaska Natives (AI/ANs) in any of its MCPs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Indicate whether the state enrolls AI/ANs in managed care and whether the state has officially recognized Tribes; comply with the state's Tribal consultation policy. • Detail the public and Tribal comment process or provide a link in the quality strategy to a document posted on the state's website that details how the state addressed this requirement. • Consider including comments received during the public comment and Tribal consultation period as an appendix to the quality strategy. • Indicate when the state made the quality strategy available for public comment and Tribal consultation. If the state has not made its quality strategy available for public comment and Tribal consultation, indicate when it will do so. • Describe comments and input received, along with whether and how the state refined its quality strategy based on the comments and input.	Pages 24–26

Section II: Assessment

Table 12—Assessment

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(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 SHCN.	
§438.330(b)(4) *Note: Not required but supports the above requirement.*		Include the state's definition of SHCN.	Pages 43–44
§438.330 (b)(8) §438.208(c)(1)	II.E.7 Identification of Persons Who Need LTSS or Persons with Special Health Care Needs 42 CFR §438.340(b)(8), 42 CFR §457.1240(e), §§438.208(c)(1), 457.1230(c)	**CFR Description:** The state must describe its mechanisms to identify persons who need LTSS or persons with special health care needs. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Indicate in the quality strategy whether the state provides LTSS benefits through managed care. • In the description of the mechanisms the state uses to identify persons who need LTSS or persons with special health care needs, indicate whether the state uses its staff, the state's enrollment broker, or the state's MCPs to identify these persons.	Pages 43–44
§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 43
§438.340(b)(6); §457.1240(e) *Note: The CFR does not include the level*	II.E.6 Disparities Plan 42 CFR §§438.340(b)(6); 457.1240(e)	Document any efforts or initiatives that the state or MCO/PIHP has engaged in to reduce disparities in health care.	Pages 33–36

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
of detail included in the Quality Strategy Toolkit		**CFR Description:** The state must include its plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status. The state must include in this plan the state's definition of disability status and how the state will make the determination that a Medicaid enrollee meets the standard. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** • Include the following elements for each disparity factor (age, race, ethnicity, sex, primary language, and disability status): • Disparity identification and evaluation method, such as an analysis of health plan information, beneficiary and provider outreach, and stratifying quality metrics by eligibility and enrollment demographic data. • A description of the state's plan to reduce disparities, by target programs and populations, such as CHIP, LTSS, and beneficiaries with behavioral health needs. • A description of the state's progress towards reducing disparities. • A description of the state's progress on any initiatives described in its previous quality strategy. • Coordinate to the extent practicable with public health authorities on plans for disparities reduction implement outside of the state Medicaid and CHIP agencies. • Identify and use measures that pertain to health care conditions and/or Medicaid and CHIP populations marked by a high degree of health disparities – for instance, by linking to other available data sources such as eligibility and enrollment demographic data to stratify by race, ethnicity, sex, language, disability status, or geography. States can also collect information on sociodemographic characteristics and then stratify the measure to detect disparities.	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Capture data on social determinants of health and chronic conditions associated with disability when feasible.	

Table 13—National Performance Measures

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Herge Reference
§438.330(c)(1)(i)	II.E.1 Quality Metrics and Performance Targets Exhibit 3 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed care programs per 42 CFR §457.1240(e), cross-referencing §438.330(c)	Include a description of any required national performance measures and levels identified and developed by CMS in consultation with states and other stakeholders. **CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** If CMS specifies performance measures, include them in the EQR performance measure validation activity. Through its EQR report, the state can reference information on these measures. The state may request an exemption from including these measures by submitting a written request to CMS explaining the basis for the request.	Pages 38–39 Appendix E
§438.340(b)(3) §438.330(c)	II.E.1 Quality Metrics and Performance Targets 42 CFR §438.340(b)(3)(i), applicable also to CHIP managed care programs	**CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After	Appendix E

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Herge Reference
	per 42 CFR §457.1240(e), cross-referencing §438.330(c)	consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Indicate whether the state plans to voluntarily collect any of the CMS core performance measures for children and adults in Medicaid/CHIP. If so, identify state targets/goals for any of the core measures selected by the state for voluntary reporting. **CFR Description:** The state must include a description of the quality metrics and performance targets to be used in measuring the performance and improvement of each MCO, PIHP, PAHP, or PCCM entity with which it contracts. This must include, but is not limited to, the state's QAPI metrics. After consulting with states and other stakeholders, and providing public notice and opportunity to comment, CMS may specify national performance measures. The state must include a description of these measures in its quality strategy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.	
§§438.340(b)(3)(i); 457.1240(e)	II.E.2 Public Posting of Quality Measures and Performance Outcomes §§438.340(b)(3)(i); 457.1240(e)	**CFR Description:** The state must identify which quality measures and performance outcomes it will publish at least annually on its website. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:**	Pages 38–39 Appendix E

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Herge Reference
		• Include a link in the quality strategy to where the state publishes measures and performance outcomes online. • Consider which measures are most meaningful and responsive to stakeholders and which would best illustrate progress on the quality strategy. • Consider selecting from measures for public posting that pertain to health conditions and/or Medicaid and CHIP populations marked by a large degree of health disparity, such as sickle cell disease in children or unnecessary cesarean section for pregnant women. • Ensure that appropriate translation services are available and that websites are accessible in order to provide all information needed by beneficiaries.	
§438.340(b)(3)(i)	II.E.3 LTSS Performance Measures 42 CFR §438.340(her3)(i); 42 CFR §§457.1240(e); 438.330(c)(1)(ii)	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** If the state contracts with MCOs, PIHPs, PAHPs, and/or PCCM entities to provide LTSS, the state must describe the standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving LTSS. If the state does not provide LTSS through managed care, this requirement does not apply. **Toolkit Requirement:** Use measure results to monitor progress toward meeting the state's goals and objectives. CMS recommends that the state also review measure results when revising its quality strategy and address areas of poor performance in its goals and objectives.	NA

Table 14—Monitoring and Compliance

Regulatory Reference	2021 CMS Quality Strategy Toolkit 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). The State's system must address all aspects of the managed care program, including the performance of each MCO, PIHP, PAHP, and PCCM entity (if applicable) in at least the following areas: (1) Administration and management. (2) Appeal and grievance systems. (3) Claims management. (4) Enrollee materials and customer services, including the activities of the beneficiary support system. (5) Finance, including medical loss ratio reporting. (6) Information systems, including encounter data reporting. (7) Marketing. (8) Medical management, including utilization management and case management. (9) Program integrity. (10) Provider network management, including provider directory standards. (11) Availability and accessibility of services, including network adequacy standards. (12) Quality improvement. (13) Areas related to the delivery of LTSS not otherwise included in paragraphs (b)(1) through (12) of this section as applicable to the managed care program. (14) All other provisions of her contract, as appropriate.	Pages 48–67

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		(c) The State must use data collected from its monitoring activities to improve the performance of its managed care program, including at a minimum: (1) Enrollment and disenrollment trends in each MCO, PIHP, or PAHP. (2) Member grievance and appeal logs. (3) Provider complaint and appeal logs. (4) Findings from the State's External Quality Review process. (5) Results from any enrollee or provider satisfaction survey conducted by the State or MCO, PIHP, or PAHP. (6) Performance on required quality measures. (7) Medical management committee reports and minutes. (8) The annual quality improvement plan for each MCO, PIHP, PAHP, or PCCM entity. (9) Audited financial and encounter data submitted by each MCO, PIHP, or PAHP. (10) The medical loss ratio summary reports required by § 438.8. (11) Customer service performance data submitted by each MCO, PIHP, or PAHP and performance data submitted by the beneficiary support system. (12) Any other data related to the provision of LTSS not otherwise included in paragraphs (c)(1) through (11) of this section as applicable to the managed care program. 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;	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• Required MCO/PIHP reporting on performance improvement projects; • Grievance/Appeal logs, etc.	

Table 15—External Quality Review (EQR)

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.350(a) and §340(b)(4)		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.	Pages 45–48
§438.350(a) and §340(b)(4) *Note: The CFR does not include the detailed requirements included in the Quality Strategy Toolkit*	II.G.1 EQR Arrangements 42 CFR §438.340(b)(4), 42 CFR §§457.1240(e), 438.350, 457.1250	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; 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 of performance improvement projects (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. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must provide a description of its arrangements for annual, external, independent reviews of the quality outcomes, timeliness of, and access to the services covered under each MCO, PIHP, PAHP, and PCCM entity.	Pages 45–48

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		Toolkit Requirement: • Describe what mandatory and optional tasks the EQRO will perform and whether the state contracts with a separate EQRO for certain types of managed care, such as behavioral health. • Identify the EQRO that will perform the EQR and the length of the EQRO's contract. • Review prior EQR technical reports, paying special attention to areas of low performance. • Ensure that performance measures, PIPs, and standards related to elements in 42 CFR 438 subpart D and 438.330 are validated and then reported by an EQRO per 42 CFR 438.364.	
§438.360; and §438.340(c)(2)(iii)	III.B.2 EQRO Recommendations 42 CFR §§438.340(c)(2)(iii), 457.1240(e), cross-referencing §438.364(a)(4) and 457.1250(a).	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must ensure that updates to the quality strategy take into consideration the recommendations provided by an EQRO and should describe how updates to the quality strategy take those recommendations into consideration. **Toolkit Requirement:** • Review findings and recommendations from the state's EQR reports to develop and monitor progress toward meeting its goals and objectives. • Summarize findings and recommendations from the state's latest EQR reports and describe how the quality strategy has been updated to address them.	Appendix F
§438.350(c) and §438.360		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).	Pages 47–48
§438.360(c)	II.G.2 EQR Non-Duplication Option 42 CFR §438.340(b)(9), 42 CFR §§457.1240(e),	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). **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:**	NA

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
	438.360(c), 457.1250(a)	**CFR Description:** If the state leverages the non-duplication option described 42 CFR 438.360 to use information from an MCP review described in 438.360(a) for the annual EQR instead of conducting one or more of the mandatory EQR-related activities described in 438.358(b)(1)(i) through (iii), the state's quality strategy must: • Identify the EQR-related activities for which it has exercised this option. • Explain the rationale for its determination that the Medicare review or private accreditation activity is comparable to such EQR-related activities. **Toolkit Requirement:** • It is recommended that all states indicate in their quality strategies whether the state does or does not leverage the non-duplication option. A state that does leverage the non-duplication option must include the information discussed under the regulatory requirements section in its quality strategy. • If a state does leverage the non-duplication option, it should consider including sufficient information to establish that all information relied upon for the purposes of non-duplication meets the conditions identified in 42 CFR 438.360(a)(1) and (a)(3) in addition to the required explanation of the rationale for the determination required by 438.360(a)(2).	

Section III: State Standards

Table 16—State Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.206 Subpart D Requirements		**Availability of Services**	
§438.68 §438.206	II.F.1 Network Adequacy and Availability of Services	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:**	Pages 50–56

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
CHIP §457.1218 §457.1230(a)	4herFR §438.340(b)(1), 42 CFR §§457.1240(e), 438.68, 438.206, 457.1218, 457.1230(a)	**CFR Description:** The state must include its network adequacy and availability of services standards for MCOs, PIHPs, and PAHPs. **Toolkit Requirement:** • Provide detail for each of the state's network adequacy and availability of services standards under 42. CFR 438.68 and 438.206 for Medicaid managed care programs. These standards apply to CHIP managed care programs under 42 CFR 457.1218 and 457.1230(a). For example, detail the state's standards for each provider type included in 42 CFR 438.68, such as primary care, behavioral health, and LTSS. • Detail the state's network adequacy standards or link to standards contained in a separate document.	
§438.206(b)(1)		Maintains and monitors a network of appropriate providers	Page 51
§438.206(b)(2)		Female members have direct access to a women's health specialist	Pages 51–52
§438.206(b)(3)		Provides for a second opinion from a qualified health care professional	Page 52
§438.206(b)(4)		Adequately and timely coverage of services not available in network	Page 50
§438.206(b)(5)		Out-of-network providers coordinate with the MCO or PIHP with respect to payment	Page 50
§438.206(b)(6)		Credential all providers as required by §438.214	Page 53
§438.206(b)(7)		Demonstrate that network includes sufficient family planning providers to ensure timely access to covered services	Page 51
§438.206(c)(1)(i)		Providers meet state standards for timely access to care and services	Pages 54–56
§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 50 Page 54
§438.206(c)(1)(iii)		Services included in the contract available 24 hours a day, 7 days a week	Page 50
§438.206(c)(1)(iv)-(vi)		Mechanisms to ensure compliance by providers	Pages 54–56
§438.206(c)(2)		Culturally competent services to all members	Page 54

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.206(c)(3)		Ensure that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid enrollees with physical or mental disabilities	Page 40 Page 51
§438.207 Subpart D Requirements		**Assurances of Adequate Capacity and Services**	
§438.207(a)		Assurances and documentation of capacity to serve expected enrollment	Page 50
§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 51
§438.208 Subpart D Requirements		**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 51–52
§438.208(b)(2)		All services that the member receives are coordinated with the services the member receives from any other MCO/PIHP	Page 52
§438.208(b)(4)		Share with other MCOs, PIHPs, and PAHPs serving the member with SHCN the results of its identification and assessment to prevent duplication of services	Page 44
§438.208(b)(5)		Provider maintains and shares, as appropriate, an enrollee health record in accordance with professional standards	Page 57
§438.208(b)(6)		Protect member privacy when coordinating care	Page 57
§438.208(c)(1)		State mechanisms that identify persons with SHCN	Pages 43–44
§438.208(c)(2)		Mechanisms to assess members with SHCN by appropriate health care professionals	Pages 43–44
§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 44
§438.208(c)(4)		Direct access to specialists for members with SHCN	Page 44

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.210 Subpart D Requirements		**Coverage and Authorization of Services**	
§438.210(a)(1)		Identify, define, and specify the amount, duration, and scope of each service	Page 51
§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 52
§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 52
§438.210(a)(3)(ii)		No arbitrary denial or reduction in service solely because of diagnosis, type of illness, or condition	Page 52
§438.210(a)(4)		Each MCO/PIHP may place appropriate limits on a service, such as medical necessity	Page 52
§438.210(a)(5)		Specify what constitutes “medically necessary services”	Page 27 Page 60
§438.210(b)(1)		Each MCO/PIHP and its subcontractors must have written policies and procedures for authorization of services	Page 52
§438.210(b)(2)		Each MCO/PIHP must have mechanisms to ensure consistent application of review criteria for authorization decisions	Page 52
§438.210(b)(3)		Any decision to deny or reduce services is made by an appropriate health care professional	Page 52
§438.210(c)		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 52
§438.210(d)		Provide for the authorization decisions and notices set forth in §438.210(d)	Page 52
§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 52
§340(b)(5)		**Transition of Care Policy**	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
42 CFR §438.340(b)(5), 42 CFR §457.1240(e), cross-referencing §438.62(b)	II.E.5 Transition of Care Policy 42 CFR §438.340(b)(5), 42 CFR §457.1240(e), cross-referencing §438.62(b)	**CFR Description:** The state must include a description of its transition of care policy. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Review the transition of care policy to ensure the following requirements are addressed: • The beneficiary has access to services consistent with the access that the beneficiary previously had and is permitted to retain a current provider for a period of time if that provider is not in the MCO, PIHP, or PAHP network. • The beneficiary is referred to appropriate providers of services that are in the network. • The state (if the beneficiary was enrolled in fee-for-service (FFS) (Medicaid), or an MCO, PIHP, PAHP, PCCM, or PCCM entity will fully and timely comply with requests for historical utilization data from the new MCO, PIHP, PAHP, PCCM or PCCM entity. • Consistent with federal and state law, the enrollee's new providers are able to obtain copies of the enrollee's medical records, as appropriate. • The process for the electronic exchange of beneficiary data. • Any other necessary procedures, as specified by the state, to ensure continued access to services to 1) prevent serious detriment to the enrollee's health or 2) reduce the risk of hospitalization or institutionalization.	Page 52

Table 17—Structure and Operations Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.214 Subpart D Requirements		**Provider Selection**	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.214(a)		Written policies and procedures for selection and retention of providers	Page 54
§438.214(b)(1)		Uniform credentialing and recredentialing policy that each MCO/PIHP must follow	Page 53
§438.214(b)(2)		Documented processes for credentialing and recredentialing that each MCO/PIHP must follow	Page 53
§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 54
§438.214(d)		MCOs/PIHPs may not employ or contract with providers excluded from Federal health care programs	Page 54
§438.214(e)		Comply with any additional requirements established by the state	Page 54
§438.10		**Information Requirements**	
§438.10		Incorporate member information requirements of §438.10	Page 57
§438.224 Subpart D Requirements		**Confidentiality**	
§438.224		Individually identifiable health information is disclosed in accordance with Federal privacy requirements	Page 57
§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 57
§438.228 Subpart D Requirements		**Grievance and Appeal Systems**	
§438.228(a)		Grievance systems meet the requirements of Part 438, subpart F	Page 57
§438.228(b)		If applicable, random state reviews of notice of action delegation to ensure notification of members in a timely manner	Page 40 Page 45
§438.230 Subpart D Requirements		**Subcontractual Relationships and Delegation**	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.230(b)(1)		Each MCO/PIHP must oversee and be accountable for any delegated functions and responsibilities	Page 53 Page 58
§438.230(b)(1)		Before any delegation, each MCO/PIHP must evaluate prospective subcontractor's ability to perform	Page 58
§438.230(c)(1)		Written agreement that specifies the activities and report responsibilities delegated to the subcontractor; and provides ’or revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate.	Page 58
§438.230(c)(1)(iii) Monitoring of subcontractor performance on an ongoing basis			Page 58
§438.230(c)(1)(iii)		Corrective action for identified deficiencies or areas for improvement	Page 58

Table 18—Measurement and Improvement Standards

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.236 Subpart D Requirements		**Practice Guidelines**	
§438.236(b)		Practice guidelines are: 1) based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field; 2) consider the needs of members; 3) are adopted in consultation with contracting health care professionals; and 4) are reviewed and updated periodically, as appropriate.	Pages 59–60
§438.236(c)		Dissemination of practice guidelines to all providers, and upon request, to members	Page 60
§438.236(b)	II.F.2 Clinical Practice Guidelines 42 CFR §438.340(b)(1), 42 CFR §§457.1240(e), 438.236 and 457.1233(c)	**CFR Description:** The state must include examples of evidence-based clinical practice guidelines that it requires plans to use. **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** Detail examples of clinical practice guidelines or link to guidelines contained in a separate document.	Page 59
§ 438.330		**Quality Assessment and Performance Improvement Program**	

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(a)(3)		An ongoing quality assessment and performance improvement program	Pages 60–62
§438.330(b)(1) §438.330(b)(2) §438.330(b)(3)	II.E.4 Performance Improvement Projects (PIP) and Interventions 42 CFR §438.340(b)(3)(ii); 42 CFR §§457.1240(e); 438.330(d); 457.1240(b)	Each MCO and PIHP must conduct PIPs List out PIPs in the quality strategy **2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit:** **CFR Description:** The state must identify the PIPs to be implemented in accordance with the state's QAPI program, including a description of any interventions it proposes to improve access, quality, or timeliness of care for beneficiaries enrolled in an MCO, PIHP, PAHP, or PCCM entity. If CMS has specified a PIP, the state must include a description of PIPs required by CMS. **Toolkit Requirement:** • For each PIP that MCPs implement, consider including information on the PIP topic, aim, and intervention. • All PIPs should be included in the EQR PIP validation activity. Therefore, the state can reference its EQR reports for information on them.	Page 60 Pages 62–63
§438.330(d)		Conduct performance improvement projects, including any performance improvement projects required by CMS, that focus on both clinical and nonclinical areas: • Measurement of performance using objective quality indicators • Implementation of interventions to achieve improvement in the access to and quality of care • Evaluation of the effectiveness of the interventions based on the performance measures in the quality strategy • Planning and initiation of activities for increasing or sustaining improvement	Pages 62–63
§438.330(d)(3)		Report the status and results of each project conducted, not less than once per year	Pages 62–63
§438.330(b)(2)		Measure and report to the state on its performance using the standard measures or performance data as specified by the state	Page 62 Appendix E

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.330(c)(i)		Identify standard performance measures, including those performance measures that may be specified by CMS	Appendix E
§438.330(c)(ii)		In the case of an MCO, PIHP, or PAHP providing long-term services and supports: Identify standard performance measures relating to quality of life, rebalancing, and community integration activities for individuals receiving long-term services and supports	NA
§438.330(b)(3)		Mechanisms to detect both underutilization and overutilization of services	Page 51
§438.330(b)(4)		Mechanisms to assess the quality and appropriateness of care furnished to members with SHCN	Pages 43–44
§438.330(b)(5)(i) §438.330(b)(5)(ii)		For MCOs, PIHPs, or PAHPs providing long-term services and supports: Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan, if applicable; and Participate in efforts by the State to prevent, detect, and remediate critical incidents (consistent with assuring beneficiary health and welfare that are based, at a minimum, on the requirements on the State for home and community-based waiver programs per §441.302(h).	NA
§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. The review must include: • Performance on the measures on which it is required to report • The outcomes and trended results of performance improvement projects • The results of any efforts to support community integration for enrollees using long-term services and supports	Pages 60–63

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
		• *May* require a developed process to evaluate the impact and effectiveness of its own quality assessment and performance improvement program	
§ 438.242 Subpart D Requirements		**Health Information Systems**	
§438.242(a)		Each MCO and PIHP must maintain a health information system that can collect, analyze, integrate, and report data and is not limited to utilization, claims, grievance and appeals, and disenrollments for other than loss of Medicaid eligibility	Pages 63–66
§438.242(b)(2)		Each MCO and PIHP must collect data on member and provider characteristics and on services furnished to members	Page 68
§438.242(b)(3)		Each MCO and PIHP must ensure data received, including capitated data, is accurate and complete, screened for data completeness, logic and consistency, and is collected in standardized formats including secure information exchanges and technologies	Page 68
§438.242(c)(1)		Each MCO collects and maintains sufficient enrollee encounter data to identify the providers who deliver any items or services to enrollees	Page 68
§438.242(c)(2)		Each MCO submits enrollee encounter data to the state at a frequency and level of detail specified by CMS or the State based on program administration, oversight, and program integrity needs	Page 68
§438.242(c)(3)		Each MCO submits enrollee encounter data, including allowed amount and paid amount, to the state	Page 68
§438.242(c)(4)		Specifications for submitting encounter data to the State in standardized ASC X12N 837 and NCPDP formats, and the ASC X12N 835 format as appropriate	Page 68
Optional		Include any health information technology (HIT) initiatives that will support the objectives of the state's quality strategy.	Pages 63–68

Section IV: Improvement and Interventions

Table 19—Improvement and Interventions

Regulatory Reference	2021 CMS Quality Strategy Toolkit 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: 1. Cross-state agency collaborative; 2. Pay-for-performance or value-based purchasing initiatives; 3. Accreditation requirements; 4. Grants; 5. Disease management programs; 6. Changes in benefits for members; 7. Provider network expansion, etc.	Page 4 Page 6 Page 14 Page 18 Pages 30–32 Page 37 Page 45 Page 48
Optional		Describe how the state's planned interventions tie to each specific goal and objective of the quality strategy.	Page 62–63 Appendix E

Table 20—Intermediate Sanctions

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
§438.340(b)(7) 42 CFR Part 438, subpart I		For MCOs, detail how the state will appropriately use intermediate sanctions that meet the requirements of 42 CFR Part 438, subpart I.	Pages 41–42
Optional		Specify the state's methodology for using intermediate sanctions as a vehicle for addressing identified quality of care problems.	Pages 41–42 Appendix G
§438.340(b)(7) 42 CFR Part 438, subpart I *Note: The CFR does not include*	II.F.3 Intermediate Sanctions 42 CFR §438.340(b)(7), 42 CFR §457.1240(e), Part 438 Subpart I	**2021 Medicaid and CHIP Managed Care Quality Strategy Toolkit: CFR Description:** For MCOs, the state must include appropriate use of intermediate sanctions that, at a minimum, meet the sanctions requirements in Part 438 subpart I. **Toolkit Requirement:**	Pages 41–42 Appendix G

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
the level of detail that is included in the Quality Strategy Toolkit.		• Indicate whether the state applied any intermediate sanctions to any MCP in the past three years, the number and types of those sanctions, and for what reasons. The state can determine whether to describe the sanctions it applied at the MCP level or the aggregate level. • Describe other actions taken in the past three years to enforce MCP compliance with state and federal rules, such as corrective action plans.	

Section VI: Conclusions and Opportunities

Table 21—Conclusions and Opportunities

Regulatory Reference	2021 CMS Quality Strategy Toolkit Reference	Description	Page Reference
Optional		Identify any successes that the state considers to be best or promising practices.	Appendix F
Optional		Include a discussion of the ongoing challenges the state faces in improving the quality of care for beneficiaries.	Appendix F
Optional		Include recommendations that the state has for ongoing Medicaid and CHIP quality improvement activities in the state. Highlight any grants received that support improvement of the quality of care received by managed care members, if applicable.	Appendix F

Appendix B. Performance Metrics

Table 22—Performance Metrics

Goal, Objective, Pillar*	Metric	Data Source	Measure Steward
Goal 1: Improve Access to Care			
Objective 1.1: *(Pillars One and Three):* Increase the number of children receiving well-child and preventive visits	• Well-Child Visits in the First 30 Months of Life (W30 and W30-CH) • Child and Adolescent Well-Care Visits (WCV and WCV-CH)	• HEDIS • CMS Children's Core Measure Set	• NCQA • CMS •
Objective 1.2: *(Pillars One and Three)*: Increase the number of adults receiving well- and preventive visits	• Adults Access to Preventive and Ambulatory Care (AAP)	• HEDIS	• NCQA
Objective 1.3: *(Pillars One and Four)*: Increase the percentage of members *Getting Needed Care*	• CAHPS (CPC and CPC-CH)	• CAHPS • CMS Children's Core Measure Set	• NCQA • CMS
Goal 2: Improve Wellness and Preventive Care			
Objective 2.1: *(Pillars One and Three)*: Increase the percentage of children that receive preventive oral health services	• Oral Evaluation, Dental Services (OEV-CH) • Topical Fluoride for Children (TFL-CH) • Sealant Receipt on Permanent Molars (SFM-CH)	• CMS Children's Core Measure Set	
Objective 2.2: *(Pillars One and Three):* Increase the overall rate of immunizations and vaccinations across all ages and populations	• Childhood Immunization Status (CIS and CIS-CH) • Immunizations for Adolescents (IMA and IMA-CH)	• HEDIS • CMS Children's Core Set	• NCQA • CMS
Objective 2.3: *(Pillar One)*: Increase the percentage of children/adolescents that receive weight assessment and counseling for nutrition and physical activity	• Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC and WCC-CH)	• HEDIS • CMS Children's Core Set	• NCQA • CMS
Objective 2.4: *(Pillar One):* Increase the percentage of children who receive developmental screening in the first three years of life	• Developmental Screening in the First Three Years of Life (DEV and DEV-CH)	• HEDIS • CMS Children's Core Set	• NCQA • CMS
Goal 3: Improve Outcomes for Chronic Diseases			
Objective 3.1: *(Pillars One and Two)*: Decrease the annual hospital admission rate for members with heart failure	• PQI-08: Heart Failure Admission Rate (PQI08-AD)	• CMS Adult Core Measure Set	• AHRQ • CMS
Objective 3.2: *(Pillar One)*: Increase the number of members participating in a remote	• Avoidance of Antibiotic Treatment for Acute	• HEDIS	• NCQA • CMS

Goal, Objective, Pillar*	Metric	Data Source	Measure Steward
monitoring program for management of chronic conditions	Bronchitis/Bronchiolitis (AAB) • Ages 3 Months to 17 Years: AAB-CH) • Age 18 and Older: AAB-AD	• CMS Children's Core Set • CMS Adult Core Measure Set	
Objective 3.3: *(Pillar One)*: Increase the percentage of members achieving appropriate asthma medication ratios	• Asthma Medication Ratio (AMR) • Ages 5 to 18: AMR-CH • Ages 19 to 64: AMR-AD	• HEDIS • CMS Children's Core Set • CMS Adult Core Measure Set	• NCQA • CMS
Objective 3.4: *(Pillar One):* Increase the number of members with a diagnosis of diabetes mellitus receiving nutritional counseling	• Hemoglobin A1c Control for Patients With Diabetes (HBD and HBD-AD)	• HEDIS • CMS Adult Core Measure Set	• NCQA • CMS
Objective 3.5: *(Pillar One):* Increase the number of members with HTN who are provided blood pressure device to monitor blood pressure	• Controlling High Blood Pressure (CBP and CBP-AD)	• HEDIS • CMS Adult Core Measure Set	• NCQA • CMS
Goal 4: Improve Maternal and Newborn Care			
Objective 4.1: *(Pillars One and Three):* Increase the annual number of postpartum care visits	• Prenatal and Postpartum Care (PPC) • Under Age 21: PPC2-CH • Age 21 and Older: PPC2-AD	• HEDIS • CMS Children's Core Set • CMS Adult Core Measure Set	• NCQA • CMS
Objective 4.2: *(Pillars One, Two, and Three)*: Decrease the number of live births weighing less than 2,500 grams	• Live Births Weighing Less than 2,500 grams (LBW-CH)	• CMS Children's Core Measure Set	• CMS
Objective 4.3: *(Pillar One)*: Increase the number of hospitals implementing the severe HBP pregnancy safety bundle	• Prenatal and Postpartum Care (PPC) • Under Age 21: PPC2-CH • Age 21 and Older: PPC2-AD	• CMS Children's Core Set • CMS Adult Core Measure Set	• CMS
Objective 4.4: *(Pillar One):* Increase the number of pregnant persons receiving prenatal services within 30 days of enrollment	• Prenatal and Postpartum Care (PPC)–Prenatal Care • Under Age 21: PPC2-CH	• CMS Children's Core Set	• CMS

Goal, Objective, Pillar*	Metric	Data Source	Measure Steward
Objective 4.5: *(Pillar One and Two):* Increase the number of postpartum persons with a diagnosis of SUD or cardiovascular condition who had provider contact within 10 days post discharge	• Prenatal and Postpartum Care (PPC)–Postpartum Care • Under Age 21: PPC2-CH	• CMS Children's Core Set	• CMS
Goal 5: **Improve Behavioral Health Care Outcomes**			
Objective 5.1: *(Pillars One and Two)*: Decrease the annual behavioral health 30-day readmission rate	• Follow-Up After Hospitalization for Mental Illness (FUH) • Ages 6 to 17: FUH-CH • Age 18 and Older: FUH-AD	• HEDIS • CMS Children's Core Measure Set • CMS Adult Core Measure Set	• NCQA • CMS
Objective 5.2: *(Pillar One)*: Increase the number of adolescents and adults screened for follow-up for depression	• Screening for Depression and Follow-Up Plan • Ages 12 to 17 Years: CDF-CH • Age 18 and Older: CDF-AD	• CMS Children's Core Measure Set • CMS Adult Core Measure Set	• CMS
Objective 5.3: *(Pillars One and Three)*: Increase follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication	• Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD and ADD-CH)	• CMS Children's Core Measure Set	• CMS
Objective 5.4: *(Pillars One and Three)*: Increase the number of children and adolescents on antipsychotics receiving metabolic monitoring	• Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM and APM-CH)	• HEDIS • CMS Children's Core Measure Set	• NCQA • CMS
Objective 5.5: *(Pillars One and Two)*: Increase the percentage of children, adolescents, and adults receiving follow-up after an emergency department visit for substance use	• Follow-Up After Emergency Department Visit for Substance Use (FUA) • Ages 13 to 17: FUA-CH • Ages 18 and Older: FUA-AD)	• HEDIS • CMS Children's Core Measure Set • CMS Adult Core Measure Set	• NCQA • CMS
Objective 5.6: *(Pillars One and Two)*: Increase the percentage of children, adolescents, and adults receiving follow-up	• Follow-Up After Emergency Department Visit for Mental Illness (FUM)	• HEDIS • CMS Children's Core	• NCQA • CMS

Goal, Objective, Pillar*	Metric	Data Source	Measure Steward
care after an emergency department visit for mental illness	• Ages 13 to 17: FUM-CH • Ages 18 and Older: FUM-AD	Measure Set • CMS Adult Core Measure Set	
Objective 5.7: *(Pillar One):* Increase the use of first-line psychosocial care for children and adolescents on antipsychotics	• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP and APP-CH)	• HEDIS • CMS Children's Core Measure Set •	• NCQA • CMS
Objective 5.8: *(Pillars One and Three)*: Increase the percentage of members that initiate and engage in substance use disorder treatment	• Initiation and Engagement of Substance Use Disorder Treatment (IET and IET-AD)	• HEDIS • CMS Adult Core Measure Set	• NCQA • CMS
Objective 5.9: *(Pillar One):* Increase the percentage of individuals receiving appropriate antidepressant medication management	• Antidepressant Medication Management (AMM and AMM-AD)	• HEDIS • CMS Adult Core Measure Set	• CMS
Goal 6: Improve Utilization of Care and Services			
Objective 6.1: *(Pillars One and Two)*: Decrease hospital readmission rate for LTSS population	• Plan All-Cause Readmission	• HEDIS	• NCQA
Goal 7: Improve Member Experience			
Objective 7.1: *(Pillar Four)*: Increase annual CAHPS overall *Rating of Health Plan*	• CAHPS (CPC and CPC-CH)	• CAHPS	• AHRQ

**Pillars*

- *Pillar One: Quality*
- *Pillar Two: Stewardship*
- *Pillar Three: Access*
- *Pillar Four: Experience*

Appendix C. Performance Improvement Topics

Table 23—Georgia Families Performance Improvement Projects 2023

CMO	PIP Topic	PIP AIM Statement	PIP Goals	PIP Interventions
	Georgia Families			
Amerigroup Community Care **CareSource** **Peach State Health Plan**	Member enrollment in complex or high-risk obstetric (OB) case management	Improving maternal health outcomes for women by second quarter 2023	Increase the percentage of pregnant women identified as high-risk or complex cases who enroll in complex case management (CCM)	1. Initiated targeted live telephonic outreach to members who did not complete the OB Screener. Unable to reach members are referred to community health workers who will then perform visits to those members' homes. 2. Initiated targeted live telephonic outreach to members who did not complete the OB Screener. A warm transfer process occurs when members from different referral sources are outreached by CMO staff and enrolled into OB case management. 3. OB practice consultant identified high-volume obstetric providers and enrolled them in the plans' obstetric quality incentive program. 4. Weekly telephonic outreach to members offering information on case management and support for meeting complex needs/removing barriers. 5. Provided telephonic outreach to all identified pregnant members regardless of risk stratifications, offer enrollment into case management, and provide education on the rewards program. 6. The Wellframe app [application] was used to outreach to eligible members. The app allows members to communicate with

CMO	PIP Topic	PIP AIM Statement	PIP Goals	PIP Interventions
	Georgia Families			
				the CMO using preferred technology easily and conveniently. Wellframe allows members to learn about and sign up for HROB.
	Timely prenatal care		Increase the percentage of pregnant members who receive a prenatal care visit within 42 days of confirmation of pregnancy or RSM enrollment by Q2 2022 and sustain improvement through Q2 2023	1. Initiated targeted live telephonic outreach to members to educate on the importance of the timely prenatal visit and assisted with appointment scheduling. 2. Increased timely perinatal care visits by sending new pregnant members an appointment reminder as soon as they are eligible with the CMO. This intervention is completed weekly. 3. OB PC staff identified six providers with low performance for timeliness of prenatal care to measure their submission of the notification of pregnancy (NOP). 4. Weekly telephonic outreach to members offering information on the importance of visit/rewards and support for completing prenatal visits. 5. Weekly interactive text message to members reminding of the importance of a prenatal visit, rewards information, and support for completing care. 6. Provided a $100 incentive for providers who submit an early NOP form prior to the second trimester of pregnancy.

CMO	PIP Topic	PIP AIM Statement	PIP Goals	PIP Interventions
	Georgia Families 360°			
Amerigroup 360°	Behavioral Health Readmissions	Reduce 30-day readmission	Decrease percentage of readmissions to a psychiatric or acute care hospital with a behavioral health primary diagnosis within 30 days of initial discharge.	1. Complex care coordinators outreach assigned members within five days of discharge from inpatient with a behavioral health primary diagnosis. Complex care

CMO	PIP Topic	PIP AIM Statement	PIP Goals	PIP Interventions
	Georgia Families 360°			
				coordinators will complete an NCQA-approved assessment form to ensure successful discharge and stabilization within the community.
	Increasing Transition Age Youth (TAY) Membership		Increase Chafee and Former Foster Care membership by 6% by the end of Q1 2023.	1. Care coordinators received a monthly list of members currently enrolled in foster care who are at or approaching 17.5 years of age. Care coordinators attempted telephonic outreach to identified members, educating them on their benefits once they turn 18 years of age.

Appendix D. Evaluation of the Effectiveness of the 2021–2023 Quality Strategy

Georgia Quality Strategy Scorecard

The Georgia 2021–2023 Quality Strategy includes goals and metrics focused on process improvement and achieving health outcomes. The Quality Strategy includes focused interventions to drive improvement within and across the Quality Strategy goals. The interventions are tied to metrics by which progress is assessed. Georgia uses the results included in the scorecard for data-driven decision making to drive interventions, inform priority setting, and to facilitate efficient and effective deployment of resources.

Legend	
Met	
Within Range*	
Not Met	

Performance Metric	MY 2020 Rate *(Baseline Rate)*	Target Rate	MY 2022 Rate *(Performance)*	MY 2022 Rate Compared to Target
Goal 1.1: Improve Access to Care				
• Prenatal and Postpartum Care: Postpartum Care	70.62%	At or above the HEDIS 50th Percentile	69.28%	
• Well-Child Visits in the First 30 Months of Life	First 15 Months: 56.83% 15-30 Months: 73.26%	At or above the HEDIS 50th Percentile	First 15 Months: 66.35% 15-30 Months: 59.22%	
• Child and Adolescent Well-Care Visits	Total: 50.96%	At or above the HEDIS 50th Percentile	47.94%	
• Adults' Access to Preventive/Ambulatory Health Services	20-44 Years: 73.02% 45-64 Years: 78.50%	At or above the HEDIS 50th Percentile	20-44 Years: 66.14% 45-64 Years: 74.11%	
• CAHPS *Getting Needed Care*	Adult CAHPS: 80.85% Child CAHPS: 86.06%	At or above the CAHPS 67th percentile	Adult CAHPS: 76.39% Child CAHPS: 81.22%	
• Chlamydia Screening in Women Ages 16 to 20	16-20 Years: 61.24%		16-20 Years: 59.58%	

Performance Metric	MY 2020 Rate *(Baseline Rate)*	Target Rate	MY 2022 Rate *(Performance)*	MY 2022 Rate Compared to Target
	21-24 Years: 66.70%	At or above the HEDIS 50th Percentile	21-24 Years: 63.54%	
Goal 1.2: Increase Wellness and Preventive Care				
• Annual Dental Visit	51.53%	At or above the CMCS 75th percentile	*Retired measure*	NC
• Oral Evaluation, Dental Services—Total	*New Measure*		42.13%	NC
• Percentage of Eligibles Who Received Preventive Dental Services	2019: 50.69%	At or above the CMCS 75th percentile	NR	NR
• Childhood Immunization Status	Combination 7: 62.04%	At or above the HEDIS 90th percentile	Combination 7: 53.92%	
• Immunizations for Adolescents	Combination 1: 85.73% Combination 2: 35.09%	At or above the HEDIS 90th percentile	Combination 1: 83.63% Combination 2: 30.80%	 
• Breast Cancer Screening	53.26%	At or above the HEDIS 75th percentile	48.39%	
• Cervical Cancer Screening	63.66%	At or above the HEDIS 75th percentile	60.16%	
Goal 1.3: Improve Outcomes for Chronic Disease				
• Hemoglobin A1c Control for Patients with Diabetes	33.34%	At or above the HEDIS 50th percentile	39.84%	
• PQI 08: Heart Failure Admission Rate	Total: 7.13	At or above the CMCS 75th percentile	Total: 7.17]	**NC**
• Controlling High Blood Pressure	Total: 45.83%	At or above the HEDIS 50th percentile	Total: 50.57% NA	

Performance Metric	MY 2020 Rate *(Baseline Rate)*	Target Rate	MY 2022 Rate *(Performance)*	MY 2022 Rate Compared to Target
Goal 1.5: Improve Behavioral Health Care Outcomes				
• Screening for Depression and Follow-Up Plan: Ages 12 to 17	2.15%	At or above the CMCS 50th percentile	3.83% NC	**NC**
• Screening for Depression and Follow-Up Plan: Age 18 and Older	3.29%	At or above the CMCS 50th percentile	2.36% NC	**NC**
Goal 1.6: Enhance Member Experience				
• CAHPS Overall *Rating of Health Plan*	Adult: 75.27% Child: 86.79%	Increase by 5% by MY 2025	Adult: 74.25% Child: 85.00%	 
Goal 2.1: Increase Appropriate Utilization of Services				
• Acute Hospital Utilization	Total Inpatient Discharges: 4.40 Total Inpatient ALOS: 3.48	At or above the HEDIS 50th percentile	Total Inpatient Discharges: 48.84 Total Inpatient ALOS: 3.61	 
• Emergency Department Utilization: Total	34.91	At or above the HEDIS 50th percentile	513.71	
• Plan All-Cause Readmissions	Total Observed Readmissions: 7.96% PCR O/E Ratio Total: 0.99	At or above the CMCS 50th percentile	Total Observed Readmissions: 7.11% PCR Ratio Total: 0.9008	**NC** 
Goal 3.1: Improve Health and Well-Being of Persons Receiving Community-Based Services				
• Plan All-Cause Readmissions	Total Observed Readmissions: 7.96% PCR O/E Ratio Total: 0.99	At or above the HEDIS 50th percentile	Total Observed Readmissions: 7.11% PCR O/E Ratio Total: 0.9008	NC 

**Rate in the percentile below the target percentile*

NC indicates that a comparison is not appropriate, or the measure did not have an applicable benchmark.
NA indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NR indicates the rate not reported.

Appendix E. Goals Tracking Table

Goal and Objective	Metric	Baseline Rate (GF MY 2022)	2026 Remeasurement Rate
Goal 1: Improve Access to Care			
Objective 1.1: Increase the number of children receiving well-child and preventive visits	• Well-Child Visits in the First 30 Months of Life (W30 and W30-CH) • Child and Adolescent Well-Care Visits (WCV and WCV-CH)	W30: • First 15 Months: 59.22% • 15 Months to 30 Months: 66.35% WCV: • Total: 47.94%	
Objective 1.2: Increase the number of adults receiving well- and preventive visits	• Adults Access to Preventive and Ambulatory Care (AAP)	• 66.93%	•
Objective 1.3: Increase the percentage of members *Getting Needed Care*	• CAHPS (CPC and CPC-CH)	• Adult: 76.39% • Child: 81.22%	•
Goal 2: Improve Wellness and Preventive Care			
Objective 2.1: Increase the percentage of children that receive preventive oral health services	• Oral Evaluation, Dental Services (OEV-CH) • Topical Fluoride for Children (TFL-CH) • Sealant Receipt on Permanent Molars (SFM-CH)	Oral Evaluation, Dental Services: • Total: 42.13% Sealant Receipt: • At Least One: 47.78% • All Four Molars: 31.83%	
Objective 2.2: Increase the overall rate of immunizations and vaccinations across all ages and populations	• Childhood Immunization Status (CIS and CIS-CH) • Immunizations for Adolescents (IMA and IMA-CH)	CIS: • Combination 7: 53.92% • IMA Combo 1: 83.63% • Combo 2: 30.80%	•
Objective 2.3: Increase the percentage of children/adolescents that receive weight assessment and counseling for nutrition and physical activity	• Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC and WCC-CH)	• BMI Percentile Total: 80.57% • Counseling for Nutrition Total: 73.25% • Physical Activity Total: 71.15%	•
Objective 2.4: Increase the percentage of children who receive developmental screening in the first three years of life	• Developmental Screening in the First Three Years of Life (DEV and DEV-CH)	• Total: 54.82%	•
Goal 3: Improve Outcomes for Chronic Diseases			

Goal and Objective	Metric	Baseline Rate (GF MY 2022)	2026 Remeasurement Rate
Objective 3.1: Decrease the annual hospital admission rate for members with heart failure	• PQI-08: Heart Failure Admission Rate (PQI08-AD)	• Total: 7.17	•
Objective 3.2: Increase the number of members participating in a remote monitoring program for management of chronic conditions	• Hemoglobin A1c Control for Patients With Diabetes (HBD and HBD-AD) Controlling High Blood Pressure (CBP and CBP-AD)	• HbA1c: 39.84% • CBP Total: Total: 50.57%	•
Objective 3.3: Increase the percentage of members achieving appropriate asthma medication ratios	• Asthma Medication Ratio (AMR) • Ages 5 to 18: AMR-CH • Ages 19 to 64: AMR-AD	• 5-11 Years: 77.41% • 12-18 Years: 73.46% • 19-50 Years: 57.20% • 51-64 Years: 63.18%	•
Objective 3.4: Increase the number of members with a diagnosis of diabetes mellitus receiving nutritional counseling	• Hemoglobin A1c Control for Patients With Diabetes (HBD and HBD-AD)	• 39.84%	•
Objective 3.5: Increase the number of members with HTN who are provided blood pressure device to monitor blood pressure	• Controlling High Blood Pressure (CBP and CBP-AD)	• Total: 50.57%	•
Goal 4: Improve Maternal and Newborn Care			
Objective 4.1: Increase the annual number of postpartum care visits	• Prenatal and Postpartum Care (PPC) • Under Age 21: PPC2-CH • Age 21 and Older: PPC2-AD	• Timeliness of Prenatal Care: 79.26% • Postpartum Care: 69.28%	•
Objective 4.2: Decrease the number of live births weighing less than 2,500 grams	• Live Births Weighing Less than 2,500 grams (LBW-CH)	• 12.9	•
Objective 4.3: Increase the number of hospitals implementing the severe HBP pregnancy safety bundle	• Prenatal and Postpartum Care (PPC) • Under Age 21: PPC2-CH •	• Timeliness of Prenatal Care (all ages): 79.26%	•
Objective 4.4: Increase the number of pregnant persons receiving prenatal services within 30 days of enrollment	• Prenatal and Postpartum Care (PPC)—Prenatal Care • Under Age 21: PPC2-CH	• Timeliness of Prenatal Care (all ages): 79.26%	•
Objective 4.5: Increase the number of postpartum persons with a diagnosis of	• Prenatal and Postpartum Care (PPC)—Postpartum Care	• Postpartum Care (all ages): 69.26%	•

Goal and Objective	Metric	Baseline Rate (GF MY 2022)	2026 Remeasurement Rate
SUD or cardiovascular condition who had a provider contact within 10 days post discharge	• Under Age 21: PPC2-AD		
Goal 5: **Improve Behavioral Health Care Outcomes**			
Objective 5.1: Decrease the annual behavioral health 30-day readmission rate	• Follow-Up After Hospitalization for Mental Illness (FUH) • Ages 6 to 17: FUH-CH • Age 18 and Older: FUH-AD	• 7-Day 6-17 Years: 45.34% • 30-Day 6-17 Years: 69.03% • 7-Day 18-64 Years: 30.73% • 30-Day 18-64 Years: 47.91% • 7-Day 65 and Older: NA • 30-Day 65 and Older: NA	•
Objective 5.2: Increase the number of adolescents and adults screened for follow-up for depression	• Screening for Depression and Follow-Up Plan • Ages 12 to 17 Years: CDF-CH • Age 18 and Older: CDF-AD	• 12-17 Years: 3.83% • 18-64 Years: 2.36% • 18 and Older: 3.20%	•
Objective 5.3: Increase follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication	• Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD and ADD-CH)	• Initiation Phase: 45.70% • Continuation and Maintenance Phase: 62.76%	•
Objective 5.4: Increase the number of children and adolescents on antipsychotics receiving metabolic monitoring	• Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM and APM-CH)	• Blood Glucose Testing Total: 51.07% • Cholesterol Testing: 31.25% • Blood Glucose and Cholesterol Testing Total: 28.33%	•
Objective 5.5: Increase the percentage of children, adolescents, and adults receiving follow-up after an emergency department visit for substance use	• Follow-Up After Emergency Department Visit for Substance Use (FUA) • Ages 13 to 17: FUA-CH • Ages 18 and Older: FUA-AD)	• 7-Day 18-64 Years: 17.16% • 30-Day 18-64 Years: 25.09% • 7-Day 65 and Older: NA • 30-Day 65 and Older: NA	•

Goal and Objective	Metric	Baseline Rate (GF MY 2022)	2026 Remeasurement Rate
Objective 5.6: Increase the percentage of children, adolescents, and adults receiving follow-up care after an emergency department visit for mental illness	• Follow-Up After Emergency Department Visit for Mental Illness (FUM) • Ages 13 to 17: FUM-CH • Ages 18 and Older: FUM-AD	• 7-Day 6-17 Years: 45.34% • 30-Day 6-17 Years: 69.03% • 7-Day 18-64 Years: 30.73% • 30-Day 18-64 Years: 47.91% • 7-Day 65 and Older: NA • 30-Day 65 and Older: NA	•
Objective 5.7: Increase the use of first-line psychosocial care for children and adolescents on antipsychotics	• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics (APP and APP-CH)	• Total: 58.40%	•
Objective 5.8: Increase the percentage of members that initiate and engage in substance use disorder treatment	• Initiation and Engagement of Substance Use Disorder Treatment (IET and IET-AD)	• Initiation of SUD Treatment 18-64 Years Total: 40.83% • Initiation of SUD Treatment 65 and Older: NA • Engagement of SUD Treatment 18-64 Years Total: 9.02% • Engagement of SUD Treatment 65 and Older Total: NA	•
Objective 5.9: Increase the percentage of individuals receiving appropriate antidepressant medication management	• Antidepressant Medication Management (AMM and AMM-AD)	• Acute Phase Treatment 18-64 Years: 45.22% • Acute Phase Treatment 65 Years and Older: NA • Continuation Phase Treatment 18-64 Years: 26.32% • Continuation Phase Treatment 65 and Older: NA	•

Goal and Objective	Metric	Baseline Rate (GF MY 2022)	2026 Remeasurement Rate
Goal 6: Improve Utilization of Care and Services			
Objective 6.1: Decrease hospital readmission rate for LTSS population	• Plan All-Cause Readmission	• Observed Readmissions—Total: 6.52% • Expected Readmissions—Total: 7.88% • O/E Ratio—Total: 0.8273 • Outliers—Total: 24.40	
Goal 7: Improve Member Experience			
Objective 7.1: Increase annual CAHPS overall *Rating of Health Plan*	• CAHPS (CPC and CPC-CH)	• Adult: 74.25% • Child: 85.00%	•

Appendix F. 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 24 includes the EQR Quality Strategy recommendations and DCH's intended follow-up actions.

Table 24—2023 Quality Strategy Recommendations

EQR Recommendations	Associated Georgia 2021–2023 QS Goal and Objective	DCH Actions
To improve program-wide performance in support of Goal 1.1, Objective 1.1.b, and improve the use of prenatal and postpartum care, HSAG recommends that DCH: • Require the CMOs to identify access- and timeliness-related PM indicators such as *Prenatal and Postpartum Care: Postpartum Care* and *Timeliness of Prenatal Care* that fell below the HEDIS MY 2021 NCQA Quality Compass®,[1-1] national Medicaid HMO 25th percentile and focus QI efforts on identifying the root cause and implementing interventions to improve access to care. • Require the CMOs to identify healthcare disparities within the access-related PM data to focus QI efforts on a disparate population. The DCH should also require the CMOs to identify best practices for ensuring prenatal and postpartum care and ensuring that members receive all	**Goal 1.1:** Improve Access to Care *Pillar Three: Access* **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.	Recently concluded participation in Postpartum Affinity activities revealed some basic challenges that DCH and its CMOs are taking steps to address: • **Provider-level***:* A need for education and/or practice reminder was identified. Providers were unsure of coding practices for PPC visits beyond global billing. It was determined that providers should be provided resources, continuing education and support to facilitate utilization of the most current clinical best practices as well as State Medicaid policies and covered benefits. • **Member-level:** A knowledge deficit was identified as a challenge. Members lacked interest and/or knowledge of the value of pre-and postpartum visits. Members entered care late in pregnancy and/or no showed for postpartum care. • **Social determinants of Health:** Members lacked resources and knowledge to access care or

[1-1] Quality Compass® is a registered trademark of the National Committee for Quality Assurance

EQR Recommendations	Associated Georgia 2021–2023 QS Goal and Objective	DCH Actions
prenatal and maternity care according to recommended schedules. Require the CMOs to identify best practices to improve care and services according to evidence-based guidelines.		needed resources for self-management of care. • In addition to the HSAG recommendations, the DCH deployed ACOG-informed clinical practice guidelines and audit tools to review and encourage utilization of latest obstetrical clinical practice guideline and recommendations for the provision of pre- and post-partum care statewide. • DCH ramped up its technical assistance and support to CMOs in carrying out PIPs and other QI initiatives around maternal health. • DCH approved blood pressure monitoring devices as covered benefits. • On-going participation in the State's MMRC with the primary purpose of identifying DCH-related opportunities for improvement. • DCH challenged CMOs to initiate or expand resources and programs to address SDoH across the State. DCH continued efforts to educate/announce its Postpartum Extension State Plan Amendment launched November of 2022. Extending to 12 months is expected to improve continuity of care and better assist those individuals with chronic conditions such as diabetes and hypertension. **Metric: PPC: Timeliness of Prenatal Care** • 2021: 77.80% • 2022: 79.26% **Metric: PPC: Postpartum Care** • 2021: 66.44% • 2022: 69.28%
To improve program-wide performance in support of Goal 1.1,	**Goal 1.1:** Improve Access to Care	Some known challenges impacting this goal included:

EQR Recommendations	Associated Georgia 2021–2023 QS Goal and Objective	DCH Actions
Objective 1.1.c, and Goal 1.2, Objective 1.2.b and improve preventive services and well-child visits for members under the age of 21 years, HSAG recommends that DCH: • Require the CMOs to identify best practices for ensuring children receive all preventive vaccinations and well-child services according to recommended schedules. • Require CMOs to conduct a root cause analysis to identify barriers that their members are experiencing in accessing well-child and preventive care and services. • Require the CMOs to identify best practices to improve care and services according to the Bright Futures guidelines.	*Pillar Three: Access* **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. **Goal 1.2:** Increase Wellness and Preventive Care *Pillar One: Quality* **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.	• Immunization- vaccine hesitancy • No show for appointments Aspects of SDOH, e.g., lack of transportation • The DCH utilized HSAG's recommendations. CMO quality improvement initiatives are included in Appendix D. • The DCH continued to hold monthly quality-focused meetings with the CMOs. During the meetings, CMOs reported on performance data and related improvement activities. • The DCH continued to track and monitor CMO performance via quarterly population health reports on care coordination and improvement actions for missed targets or gaps in care. • The DCH requested and subsequently received approval from CMS to initiate a multi-year, value-based program called GA-AIDE which authorizes state directed payments to improve quality of care and outcomes for patients served by Georgia's largest single provider of Medicaid services, Grady Memorial, and Georgia's state-owned Academic Medical Center, Augusta University Medical Center. GA-AIDE funds investments in initiatives designed to improve health outcomes and experiences for the medically underserved, such as maternal and child health, preventing and reducing the impact of chronic conditions, and addressing health equity. Participation in GA-AIDE is voluntary and the source of non-federal funds is provided by the hospital authority or governmental entity on behalf of the eligible provider through an

EQR Recommendations	Associated Georgia 2021–2023 QS Goal and Objective	DCH Actions
		IGT to DCH. GA-AIDE is subject to annual review by the state and approval by CMS and will deliver over $340 million in combined federal and non-federal funds to the two providers in FY 2023. PMV results showed: **Metric** WCC**:** Child and Adolescent Well-Care Visits -Total • 2021: 49.13% • 2022: 47.94% **Metric** W30**:** Well-Care Visits in the First 30 Months of Life -First 15 Months • 2021: 59.50% • 2022: 59.22% **Metric** W30**:** Well-Care Visits in the First 30 Months of Life -Age 15 Months – 30 Months • 2021: 67.62% • 2022: 66.35% **Metric** CIS**:** Childhood Immunization Status – Combination 7__ • 2021: 55.59% • 2022: 53.92% **Metric** IMA**:** Immunizations for Adolescents Combination 1__ • 2021: 82.42% • 2022: 87.48% **Metric** IMA**:** Immunizations for Adolescents Combination 2__ • 2021: 32.83 % • 2022: 33.92%

Appendix G. Intermediate Sanctions

Table 25—Performance Guarantees and Liquidated Damages

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
General Performance Guarantees	
The CMO shall notify DCH thirty (30) calendar days prior to performance guarantee due date(s) of anticipated failure to comply. CMO's written notice must include at a minimum, the identified resolution to the issue causing the delay and a revised detailed timeline. Approval of the revised timeline is subject to DCH approval.	$500 per calendar day or any part thereof
The CMO must implement requirements or assurances stated in the CMO's proposal, the eRFP, this Contract, or other material failures in the CMO's duties, responsibilities, and obligations pursuant to same.	$100,000 per violation
The CMO shall notify the DCH project leader in writing ten (10) business days after receiving initial correspondence from DCH for services the CMO believes to be outside of the scope of services for this contract.	$500 per business day or any part thereof.
The CMO shall have, obtain, and maintain in good standing any licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this contract. Within sixty (60) calendar days prior to the operational start date, the CMO shall provide DCH with certified copies of all licenses, certificates and permits necessary to perform services under this contract. The CMO shall notify DCH, within fifteen (15) calendar days of any accrediting organization noted deficiencies or changes to statuses.	$1,000 per calendar day or any part thereof.
The CMO shall complete initial and renewal background screenings of CMO personnel prior to the performance of any services under this contract and on an annual basis. The CMO agrees that it shall not permit any of its employees or its subcontractors' employees to perform services under this contract unless and until they pass a background check as outlined in the contract. Within sixty (60) calendar days prior to the operational start date. CMO shall submit to DCH a report which demonstrates compliance with the minimum background check requirements for all staff performing services	The CMO shall pay DCH $500 per occurrence that CMO fails to meet this requirement. If CMO fails to complete background screenings for designated employees or subcontractors after receiving written notice from DCH, CMO shall pay $500 per calendar day (or any part thereof) per employee or subcontractor that CMO remains in noncompliance.

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
under this contract, including subcontractor staff; annually thereafter.	
The CMO must submit all required reports and deliverables in the timeframes prescribed by the contract and "Attachment X – Table of Deliverables." The CMO must not submit incorrect, incomplete, or deficient reports or deliverables as determined by DCH in its sole discretion, including but not limited to the submission of reports or deliverables in a format unacceptable to DCH.	$5,000 per business day or any part thereof per report or deliverable.
The CMO must comply with the CMO staffing requirements and any other conditions (e.g., valid credentials, staffing levels, qualifications, etc.) prescribed within the contract and–Attachment X - Key Staff Roles and Qualifications, with the exception of requirements for care managers.	$5,000 per business day or any part thereof.
The CMO must comply with federal and state law and regulations regarding sterilizations, hysterectomies, and abortions as prescribed by the contract.	$5,000 per violation.
The CMO must not violate any other applicable requirements of Section 1903(m) or 1932 of the Social Security Act and any implementing regulations.	$25,000 per violation.
The CMO must comply with any corrective action plan and any deadlines set forth therein.	$5,000 per business day or any part thereof.
The CMO must submit an Annual Compliance Plan in a form reasonably acceptable to DCH during readiness review and by September 1st of each year during the term of the contract.	$500 for missing the September 1st deadline and $100 per business day or any part thereof until the plan has been submitted and accepted by DCH.
The CMO must provide notice of any known or suspected conflicts of interest within 24 hours of discovery.	$25,000 per violation
The CMO must not discriminate against individuals on any basis which is unlawful or contrary to the policies of DCH.	$100,000 per violation
The CMO must not misrepresent information or make false statements to CMS or the State.	$100,000 per violation
Implementation Phase Performance Guarantees	
Within sixty (60) days of operational start date, the CMO shall establish and maintain a primary, non-residential business office in the State of Georgia within thirty-five (35) miles of 2 Martin Luther King Jr. Drive, Southwest Atlanta, GA 30303. All documentation must reflect the address of the location identified as the legal, duly licensed, central business office. This	CMO shall pay DCH $2,500 for each calendar day, or any part thereof, that CMO fails to meet this requirement.

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
business office must be open at least between the hours of 8:00 a.m. and 5:30 p.m. EST, Monday through Friday with the exception of State holidays. The central business office must be accessible for foot and vehicle traffic. The CMO shall ensure that the office(s) are adequately staffed to ensure that members and providers receive timely and accurate responses to inquiries. The CMO must have at least one (1) satellite office serving no less than two (2) contiguous service regions.	
The CMO must implement the Business Continuity and Disaster Recovery (BCDR) Plan by the agreed upon date.	$5,000 per business day or any part thereof, up to day 2; $10,000 per business day or any part thereof beginning with day 3 and up to business day 5; $25,000 per business day or any part thereof beginning with business day 6 and up to day 10; $50,000 per business day or any part thereof beginning with business day 11.
The CMO must test and ensure the information systems are fully operational and meet all RFP and contract requirements, as determined by DCH in its reasonable discretion, prior to the operational start date	$10,000 per calendar day, or any part thereof, beginning on the day after the operational start date
The CMO must establish and maintain a surveillance and utilization review program	$500 per day or any part thereof.
The CMO meet the readiness and/or annual review requirements.	$100,000 per day or any part thereof
Operational Performance Guarantees	
The CMO must be fully operational by the operational start date (a/k/a “go live”).	$100,000 per day or any part thereof.
Grievances and Appeals	
The CMO must resolve appeals within the timeframes specified in the contract, including but not limited to standard resolution of an administrative review within thirty (30) calendar days and resolution of an expedited appeal within seventy-two (72) hours.	$25,000 per violation
The CMO must issue written disposition of member grievances in accordance with the contract but no later than ninety (90) calendar days from the date the CMO receives the grievance.	$250 per month (or any part thereof) per incident until disposition
The CMO must issue written disposition of provider grievances or complaints within thirty (30) calendar days from the date the complaint is received by the CMO.	$1,000 per month (or any part thereof) per incident until disposition

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
CMO must comply with all notice requirements to members and providers set forth in the grievances and appeals contract section.	$5,000 per violation.
Claims Processing	
The CMO must process and finalize to a paid or denied status 97% of all clean claims within fifteen (15) business days from date of receipt.	$5,000 per month or any part thereof (calculated after 15 business days).
The CMO must pay providers interest at a 12% annual rate calculated daily for the full period during which a clean, unduplicated claim is not adjudicated within the established claims processing deadlines.	$5,000 per calendar day or any part thereof.
The CMO must seek, collect and/or report third party information, including making reasonable efforts to determine third party liability and avoiding payments for services subject to payment from a third party. DCH may determine whether the CMO complies with this requirement by inspecting source documents for timeliness of billing and accounting for third party payments.	$5,000 per business day or any part thereof.
The CMO will process, and if appropriate pay, within 45 calendar days 99% of all pharmacy claims and 99% for all other covered services.	$10,000 per month or any part thereof
The CMO must resolve all appealed claims within 30 calendar days from the date the appealed claim is filed with the CMO.	First occurrence: $1,750 per month or any part thereof and per claim; Subsequent occurrences: $8,500 per month or any part thereof and per claim.
Care Management Performance	
The CMO shall have adequate capacity such that any new member who is pregnant is able to have an initial visit with an obstetric provider within fourteen (14) calendar days of enrollment.	$7,000 per calendar day or any part thereof, per qualified member
The CMO must comply with the 80% screening ratio for periodic visits per EPSDT on the CMO's CMS-416 report or other such report in use by CMS.	$25,000 per region for screening rate between 76%-79%; $50,000 per region for screening rate from 72% to 75%; $75,000 for screening rate below 72%.
The CMO must comply with the 60% screening ratio for health risk assessment (HRA) completion per population health management report.	$25,000 per region for screening rate between 56%-59%; $50,000 per region for screening rate from 52% to 55%; $75,000 for screening rate below 52%.
The CMO must comply with the 80% screening ratio for both the CCFA medical assessment report and the health risk screening report to be submitted to DFCS or DCH.	Statewide rates: $100,000 for screening rate below 70%; $65,000 for screening rate of 71%-75%

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
	$35,000 for screening rate of 76%-79% Regional rates: $35k per region for screening rate below 80%
The CMO must comply with the 85% screening ratio for trauma assessment report to be submitted to DFCS or DCH.	Statewide rates: $100,000 for screening rate below 85% Regional rates: $45,000 per region for screening rate below 85%
Failure to provide a written discharge plan to member that meets contract requirements following member's discharge from an institutional/inpatient clinical setting. Such discharge plan must be provided to member immediately upon discharge but no later than seven (7) days following discharge.	$1,000 per calendar day or any part thereof following seven (7) days after discharge.
CMO shall submit its discharge planning program plan, inclusive of staffing, to DCH for initial review and approval within 30 calendar days of contract execution as well as 60 calendar days prior to implementation of any updates thereto.	$5,000 per month
The CMO must comply with the staffing requirements and any other conditions (e.g., valid credentials, qualifications, in-person location) prescribed in the staffing plan for the CMO's care management program(s), discharge planning program, and case management program, including, but not limited to, requirements regarding maximum caseloads, staffing ratios, and ability to meet program targets and outcomes.	$50,000 per business day or any part thereof
Encounter Data	
The CMO must make available to the State and/or its agent readable, valid extracts of encounter information for a specific month within fifteen (15) calendar days after the last day of the	$2,000 per calendar day or any part thereof.
The CMO must comply with all encounter data submission requirements, submitting encounter data that meets established DCH quality standards defined by DCH and revised as necessary to ensure continuous quality improvement	$25,000 per occurrence
The CMO must complete weekly encounter file submissions.	$4,000 per day or any part thereof, capped at five percent (5%) of the CMO's monthly capitation rate.

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
The CMO must resubmit erred encounter files within seven (7) calendar days.	$5,000 per day or any part thereof, capped at five percent (5%) of the CMO's monthly capitation rate.
The CMO must resubmit erred encounter records within thirty (30) calendar days.	$5.00 per day per encounter over thirty (30) calendar days, capped at five percent (5%) of the CMO's monthly capitation rate.
The CMO must submit encounter files with at least ninety-nine percent (99%) of the claims within thirty (30) calendar days from the claim payment date.	$5,000 per day overall, and/or $1,000 per day for delegated vendors only, late fee calculated for each day the CMO does not meet the requirement for the reconciliation period. Penalties for encounter completeness and timeliness shall be capped at $150,000 for the CMO overall and $30,000 for the delegated vendors per reconciliation period.
Submission of an encounter file must not exceed a five (5%) percent threshold error rate.	$1,000 per encounter file error, capped at five percent (5%) of the CMO's monthly capitation rate.
Member and Provider Call Centers	
The CMO must meet the telephone hotline performance standards of an answer rate of 80% in 30 seconds, blocked call rate of 1%, and abandoned call rate of 5%	Per percentage point above/below the target $1,000 per % point below the target answer rate of 80% in 30 seconds $1,000 per % point above the target of a 1% blocked call rate $1,000 per % point above the target 5% abandoned call rate
The CMO must operate a toll-free nurse hotline that providers, members, DHS staff if applicable, caregivers, and medical consenters can call 24 hours a day, seven days a week	$500 for each full hour that the hotline is not available
The CMO must have a behavioral health services hotline can call 24 hours a day, seven days a week.	$1,000 for each full hour that the hotline is not available
The CMO's systems help desk must be in operation between the hours of 7:00 a.m. and 7:00 p.m. eastern time and answer rate of 80% in 30 seconds, the call abandonment rate is five percent (5%) or less, the average hold time is two (2) minutes or less, and the blocked call rate does not exceed one percent (1%)	$500 for each full hour that the systems help desk is not available; $500 per % point the target answer rate is below 80%; $500 per % point the abandonment rate is above 5%; $1,000 per minute the average hold time is above two (2) minutes; and $1,000 per % point the blocked call rate is above 1%.
Office of Inspector General (OIG)	
The CMO must terminate a provider, employee, owner, or managing employee	Per incident of non-compliance $1,000 for the first incident,

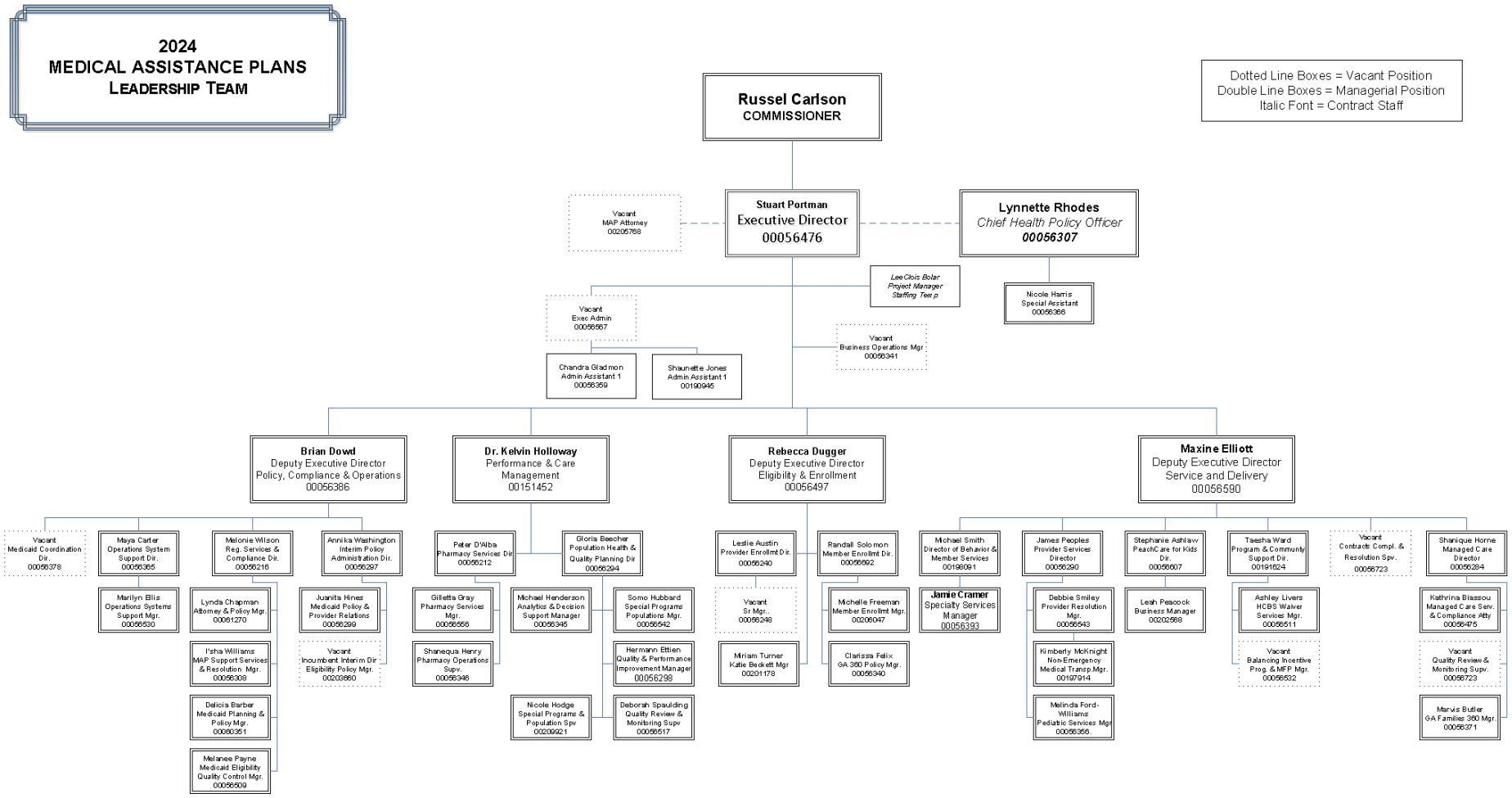
Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
who has been excluded from participating in any federal health care program	$5,000 for the second incident, $10,000 for the third incident, $25,000 for any subsequent incidents
The CMO must suspend provider payments for a credible (as determined by DCH in its reasonable discretion) allegation of fraud	$1,000/day or any part thereof; $5,000/day or any part thereof after 4th time Per incident of non-compliance
The CMO must provide reasonable and prompt cooperation, as determined by DCH in its reasonable discretion, in an investigation	Per incident of non-compliance $1,000/day or any part thereof
The CMO must establish and maintain at least one full time staff member of their Special Investigator's Unit in the Georgia office of the CMO	Per day of non-compliance $1,000/day or any part thereof
The CMO must submit accurate reports on fraud, waste, abuse, or overpayment, including investigations and suspected cases	Per day of late/inaccurate submission $1,000/day per report is not submitted/ late/ inaccurate; $5,000/day after 4th time
The CMO must respond to OIG requests for information in the timeframe, manner, and format requested	Per day of late/inaccurate submission $1,000/day or any part thereof information is not submitted/ late/ inaccurate; $5,000/day or any part thereof after 4th time
The CMO must submit claims data as prescribed by OIG	Per day of late/inaccurate submission $1,000/day data is not submitted/ late/ inaccurate; $5,000/day after 4th occurrence
The CMO must perform pre-payment review for identified providers as directed by OIG within 30 business days after notification	Per day per incident $1,000/day per incident
The CMO must submit a fraudulent practices referral to OIG within 30 business days of receiving a report of possible fraud, waste, and abuse.	$1,000/day report is not submitted/ late/ inaccurate; $5,000/day after 4th time
Management Information Systems (MI)	
The CMO must correct a system problem not resulting in system unavailability within the allowed timeframe	$250/ calendar day 1-15; $500/ calendar day 16-30; $1,000/ calendar day 31+
The CMO must avoid unscheduled system unavailability (other than CCE and ECM functions) occurring during a continuous 5 calendar day period	2 <= X < 12 clock hours cumulative: up to $125/ 30min 12 <= X < 24 clock hours cumulative: up to $250/ 30min 24 <= X clock hours cumulative: up to $500/ 30min up to a maximum of $25,000 per occurrence
The CMO must avoid confirmation of CMO enrollment (CCE) or electronic claims management (ECM) downtime	2 <= X < 12 clock hours cumulative: up to $250/ 30min 12 <= X < 24 clock hours cumulative: up to $500/ 30min

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
	24 <= X clock hours cumulative: up to $1,000/ 30min up to a maximum of $50,000 per occurrence
The CMO shall report address changes, other TPL resource and PCP assignments for their members in the daily 834 inbound files within 24 hours or within the next 834 inbound file submission to DCH.	$500 for each Calendar Day, or part thereof, that CMO fails to submit an inbound 834 timely and/or accurately
The CMO shall transmit daily to DCH, in the formats and methods specified in the HIPAA Implementation and DCH Companion Guides or as otherwise specified by DCH: member address changes, telephone number changes, third party liability and PCP	$500 per calendar day, or part thereof, that such transmissions are late or inaccurate.
Vendors will be subject to adhering to the data quality standards defined by the Department. Data quality standards will be applied to data submissions to the GA claims vendor as well as the DCH data warehouse. As data quality standards are meant to improve over time, data elements and thresholds may shift based on priorities and overall performance of vendors. Vendors will be provided three months' notice of any data quality changes. Standards will include completion, validity, and accuracy metrics. Upon receipt of data and baseline, each vendor will be provided a goal based on their individual submission which will not be lower than the average performance of vendors.	Each percentage point to the tenth of a percentage under the vendor's specified threshold is $5,000 per data element per submission
Marketing and Member Outreach	
The CMO must issue written notice to affected members' upon provider's notice of termination in the CMO's plan in accordance with contract deadlines.	$5,000 per day or any part thereof
The CMO must submit acceptable member and provider directed materials or documents in a timely manner, (i.e., member, handbooks, policies and procedures).	$5,000 per day or any part thereof.
The CMO must not misrepresent information or make false statements furnished to a member, potential member, or health care provider.	$75,000 per violation
The CMO must not distribute directly, or indirectly, through any agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information.	$75,000 per violation
Material Subcontractors	
The CMO must not violate a subcontracting requirement in the contract,	$50,000 per violation

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
including but not limited to engaging a subcontractor without prior written consent of DCH.	
Provider Networks	
The CMO must conduct quarterly validation of provider demographic data and provide DCH with current and accurate data for all contracted providers and submit a report to DCH within thirty (30) days after the end of each reporting quarter.	$5,000 per day or any part thereof.
The CMO must submit attestations for each provider network report in the established DCH format with all required data elements	$5,000 per day or any part thereof.
The CMO must provide an adequate network of providers and must be in full compliance with geographic access standards specified in the contract and appointment wait time standards specified in the contract. The CMO must submit electronic provider network reporting demonstrating its full compliance with the provider network requirements within ten (10) calendar days of the member file received on the first of each month.	0.25% of the monthly total capitation payment for provider types not meeting the geographic access standards per service area until the deficiency is fully corrected
The CMO must ensure that all executed provider contracts are processed and loaded into all systems including but not limited to the CMO's claims processing system, within thirty (30) calendar days of receipt of notification of credentialing and enrollment from the provider or DCH or its designated fiscal agent.	$1,000 per application per day or any part thereof for each day beyond 30 days
The CMO shall ensure that all provider network data files are tested and validated for accuracy prior to CMO deliverable submissions, which shall include the use of access and availability audits.	$5,000 per day or any part thereof
HIPPA Compliance; Privacy/Security	
CMO must comply with the HIPPA privacy and security rules and the Business Associate Agreement ("BAA"). The CMO must ensure member confidentiality in accordance with 45 CFR Part 160 and 45 CFR Part 164; an incident of noncompliance will be assessed as per member and/or per HIPAA regulatory violation.	$25,000 per member per violation (unless otherwise specified in BAA). $300 per day or any part thereof for not complying with any deadlines set forth in BAA (unless otherwise specified in BAA).
The vendor shall adhere to all cybersecurity requirements specified in this agreement, including security assessments, policy adherence, and patch management.	$50,000 per violation
Quality Performance	
The CMO must achieve the performance measure targets for each quality	$100,000 per violation

Performance Guarantee Description	Liquidated Damage(s) (Assessed Per Day | Per Violation | etc. for which Contractor is in breach of designated Performance Guarantee)
performance measure.	
The CMO must deliver effective P4HB Demonstration services as evidenced by achievement of annual targeted LBW and VLBW reduction targets.	$100,000 per violation
The CMO must achieve annual targeted reductions in the pregnancy rate.	$100,000 per violation
The CMO must comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.211 and the contract, including the requirement that these compensation arrangements do not directly or indirectly have the effect of reducing or limiting the services provided to any plan enrollee.	$25,000 per violation
Data and IT Requirements	
Completion metric: Upon receipt of data and baseline, each vendor will be provided a goal based on their individual submission which will not be lower than the average performance of vendors.	$5,000 per violation
Validity metric: Upon receipt of data and baseline, each vendor will be provided a goal based on their individual submission which will not be lower than the average performance of vendors	$5,000 per violation
Accuracy metric: Upon receipt of data and baseline, each vendor will be provided a goal based on their individual submission which will not be lower than the average performance of vendors.	$5,000 per violation
The CMO must provide 95% or greater of the mandatory data elements per eRFP Attachment N as prescribed below: 80% of data elements available at ninety (90) days or less prior to operational start date (OSD); 90% of data elements available at sixty (60) days or less prior to OSD; 95% of data elements available at thirty (30) days or less prior to OSD; 100% of data elements available at operational start date (OSD) The CMO must additionally have seventy (70) percent of the conditional data elements, as identified in contract Attachment L, available by the operational start date.	$5,000 per deviation per day or any part thereof

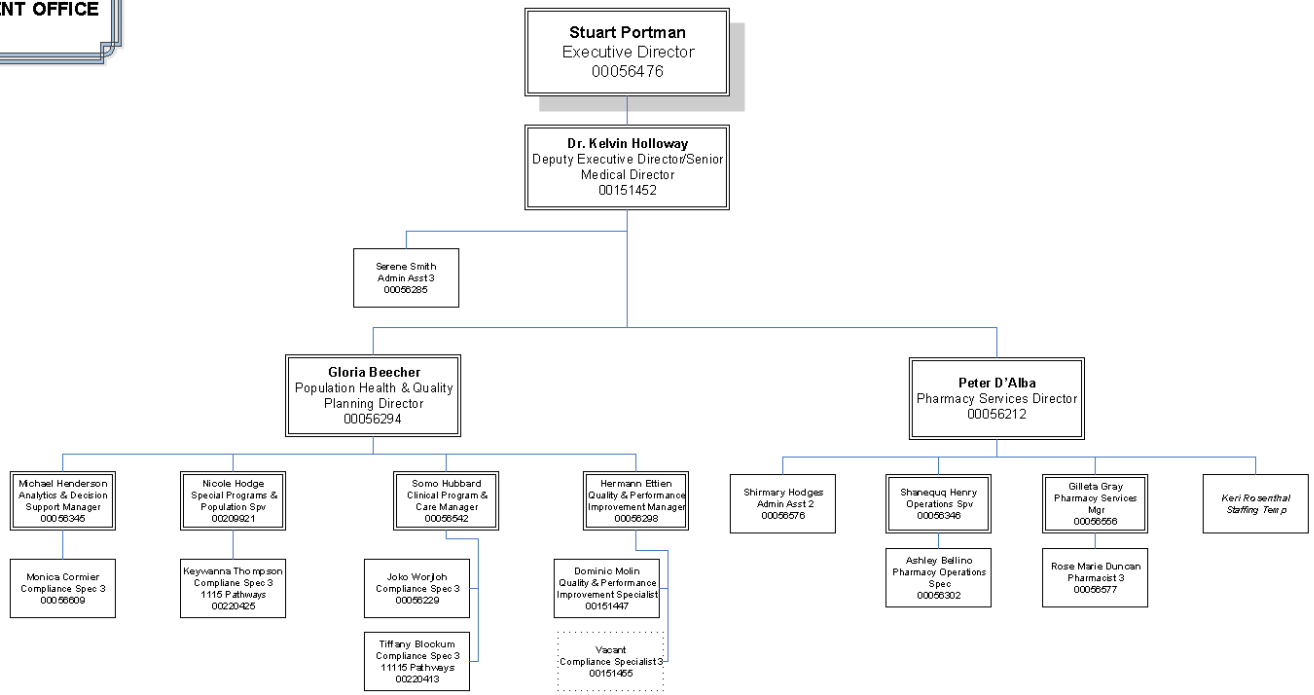
Appendix H. DCH Organizational Charts



As of 2/1/24

2024
MEDICAL ASSISTANCE PLANS
PERFORMANCE & CARE MANAGEMENT OFFICE

Dotted Line Boxes = Vacant Position
Double Line Boxes = Managerial Position
Italic Font = Contract Staff



As of 2/1/24