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Managed Care Program Annual Report (MCPAR) for Georgia: Georgia Families 360

Due Date	Last edited	Edited By	Status
12/27/2022	12/27/2022	Stephen Fader	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR	
Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A.1	**State name** Auto-populated from your account profile.	Georgia
A.2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Marvis Butler

Number	Indicator	Response
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	mabutler@dch.ga.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Stephen Fader
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	sfader@mslc.com
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/27/2022

Reporting Period

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name** Auto-populated from report dashboard.	Georgia Families 360

Add plans (A.7)

Indicator	Response
Plan name	Amerigroup Community Care

Add BSS entities (A.8)

Indicator	Response
BSS entity name	N/A

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
	Statewide Medicaid enrollment	
B.I.1	Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,513,764
	Statewide Medicaid managed care enrollment	
B.I.2	Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	2196278

Topic III. Encounter Data Report

Number	Indicator	Response
B.III.1	**Data validation entity**	EQRO

Number	Indicator	Response
	Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	Other third-party vendor State Medicaid agency staff

Topic X: Program Integrity

Number	Indicator	Response
B.X.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/ overutilization, and other activities.	None during the fiscal year due to the PHE. However, our contractor, Health Services Advisory Group (HSAG), performed the 2022 External Quality Review for Protocols 1, 2, 3, and 6. Additionally, our contractor, Myers and Stauffer, performed encounter data oversight activities.
B.X.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid	State requires the return of overpayments

Number	Indicator	Response
	system? Select one.	
	Location of contract provision stating overpayment standard	
B.X.3	Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Sections 29.2.1 and 33.1
	Description of overpayment contract standard	
B.X.4	Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The Contractor assumes responsibility for full compliance with all such applicable laws, regulations, and guidelines, and agrees to fully reimburse DCH for any loss of funds or resources or overpayment resulting from non-compliance by Contractor, its staff, agents or subcontractors, as revealed in audits conducted by or on behalf of DCH.
	State overpayment reporting monitoring	
B.X.5	Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on	If requested by the provider, and approved by the Department, to the extent that payments can be returned through the claims payment adjustment process, the claims adjustment process will be followed. Otherwise, providers should send refund checks, made payable to "Georgia Department of Community Health" As a mandatory provision of the settlement agreement, the Department will require an audit of the provider within a 12 month period to assure adherence to the CAP.

Number	Indicator	Response
	various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	
B.X.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	DCH or its Agent is responsible for Enrollment, including Disenrollment for Members, education on enrollment options, and outreach activities. The Contractor shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment for Member functions. Daily enrollment change files are monthly master files are provided to the CMOs.
		Yes
		Changes in provider circumstances: Metrics
		Yes
B.X.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	**Changes in provider circumstances: Describe metric** The Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination was "for cause", the Contractor may terminate, suspend, or withdraw the Provider immediately and shall notify DCH in writing within one (1) Business Day of the termination with the reasons for termination. If a Member is receiving ongoing care, the Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the

Number	Indicator	Response
		suspension, termination, or withdrawal.
	Federal database checks: Excluded person or entities	
B.X.8a	During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
	Website posting of 5 percent or more ownership control	
B.X.9a	Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to B'455.104 and required by 42 CFR 438.602(g)(3).	Yes **Website posting of 5 percent or more ownership control: Link** https://dch.georgia.gov/medicaid-managed-care
B.X.10	**Periodic audits**	https://medicaid.georgia.gov/programs/all-programs/georgia-families/cmo-reviews-and-reports

Number	Indicator	Response
	If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date of the contract between the state and plans participating in the managed care program.	STATE OF GEORGIA CONTRACT BETWEEN THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH AND [CONTRACTOR] FOR PROVISION OF SERVICES TO GEORGIA FAMILIES 360B0 03/03/2014
C1.I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medicaid.georgia.gov/document/publication/georgia-families-360-contract-genericpdf/download
C1.I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1.I.4a	**Special program benefits**	Dental

Number	Indicator	Response
	Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	Behavioral health
	Variation in special benefits	
C1.I.4b	What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
	Program enrollment	
C1.I.5	Enter the total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	31,118
	Changes to enrollment or benefits	
C1.I.6	Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	Disenrollment is paused during the PHE

Topic III: Encounter Data Report

Number	Indicator	Response
C1.III.1	**Uses of**	Rate setting

Number	Indicator	Response
	encounter data	
	For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support Other, specify The Georgia Families 360 program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members.
C1.III.2	**Criteria/ measures to evaluate MCP performance** What types of measures are used by the state to	Overall data accuracy (as determined through data validation) Provider ID field complete Use of correct file formats Timeliness of data corrections Timeliness of initial data submissions

Number	Indicator	Response
	evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of data certifications
C1.III.3	**Encounter data performance criteria contract language** Provide reference(s) to	Section 4.16.3 Encounter Claims Submission Requirements includes the contract requirements for encounter data submissions. 4.16.3.1 The GF 360B: program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely, complete and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set Contractor

Number	Indicator	Response
	the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Capitation Rates, monitor Utilization, follow public health trends and detect potential Fraud. Most importantly, it allows DCH to make recommendations that can lead to the improvement of Health Care outcomes. 4.17.5.3 The Contractor shall generate Encounter data files no less than weekly (or at a frequency defined by DCH) from its Claims management system(s) and/or other sources. The files will contain settled Claims and Claim adjustments and encounters from Providers with whom the Contractor has a capitation arrangement for the most recent month for which all such transactions were completed. The Contractor will provide these files electronically to DCH and/or its designated agent in adherence to the procedure and format indicated in Attachment K, and as updated thereafter.
C1.III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract	4.16.3.11 The Contractor's failure to comply with the defined standard(s) will be subject to a Corrective Action Plan and the Contractor may be liable for Liquidated Damages. Section 25.5 details the liquidated damages.

Number	Indicator	Response
	section references, not page numbers.	
	Incentives for encounter data quality	
C1.III.5	Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
	Barriers to collecting/ validating encounter data	
C1.III.6	Describe any barriers to collecting and/ or validating managed care plan encounter data that the state has experienced	Standards for performance measures are constantly being refined and improved which may cause some delay in aligning data validation and EQR reporting.

Number	Indicator	Response
	during the reporting period.	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
	State's definition of "critical incident," as used for reporting purposes in its MLTSS program	
C1.IV.1	If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	N/A
C1.IV.2	**State definition of "timely" resolution for standard**	Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Care Management Organization (CMO) to act within the

Number	Indicator	Response
	appeals	
	Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR B'438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	timeframes provided in 42 CFR 438.408(b). 4.14.5.8 The Contractor shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3) Working Days or as expeditiously as the Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Contractor shall also
C1.IV.3	**State definition of "timely" resolution for expedited appeals** Provide the state's definition of timely resolution for expedited appeals in the managed care program.	Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the Care Management Organization (CMO) to act within the timeframes provided in 42 CFR 438.408(b). 4.14.5.8 The Contractor shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3) Working Days or as expeditiously as the Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a

Number	Indicator	Response
	Per 42 CFR B'438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Contractor shall also
C1.IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR B'438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP	4.14.3.4 The Contractor shall issue disposition of the Grievance as expeditiously as the Member's health Condition requires but such disposition must be completed within ninety (90) Calendar Days of the filing date.

Number	Indicator	Response
	receives the grievance.	

Topic V. Availability, Accessibility and Network Adequacy

Number	Indicator	Response
C1.V.1	**Gaps/ challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	The most significant challenge faced by the CMOs involves ensuring that members living in Georgia's rural counties have adequate access to all healthcare provider types as measured by the state's time and distance standards. Currently 120 of the state's 159 counties are classified as rural. Network adequacy reports routinely submitted by the CMOs show that both urban and rural members assigned to the health plans have adequate access to a range of Primary Care, Specialty and Ancillary providers. However, historically, members' access to 24-hour pharmacies as well as access to adult and pediatric clinicians practicing in endocrinology, infectious disease, and rheumatology has consistently remained below the state's 90% threshold in many rural counties. Members' access to Psychiatric Residential Treatment Facilities and Narcotic Treatment Programs is also consistently below the state's access threshold for a significant number of counties. The gaps in access are due to the limited availability of providers practicing in these specialties within the county and in surrounding counties.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	In counties where members' access to care falls below the minimum threshold, DCH requires that CMOs submit a corrective action plan (CAP) to address the gaps. Where additional providers who practice in the deficient specialty exist in the area, CMOs are required to identify those providers and make attempts to contract. The CAP must include the name and address of the provider being recruited and the anticipated contract date. Compliance staff monitor the CMOs progress in implementing the corrective actions to ensure that the providers who are successfully contracted are subsequently credentialed and loaded into the CMO system in a timely manner. In addition, to facilitate the CMOs efforts to contract, a data file containing providers who have been successfully enrolled in Medicaid through the credentialing verification organization (CVO) process and are available to contract is transmitted to the CMOs on a daily basis. Where gaps in access exist and there are no providers available to recruit, or where

Number	Indicator	Response
		available providers are unwilling to contract, DCH requires that the CAP include a list of providers located outside the access standard where members can receive care (i.e., covering counties). CMOs must commit to negotiating contracts and single case agreements with willing providers, arrange non-emergency transportation, and/or coordinate telehealth services when necessary to ensure that their assigned members receive care. DCH Compliance staff also review the corrective action plans for these deficiencies to ensure that the CMOs have included a list of covering counties with names of the providers willing to serve their assigned members, where available.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook

C2_Program_State

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.1 General category

Two (2) within eight (8) miles

C2.V.4 Provider

Primary care

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

2 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.1 General category

Two (2) within fifteen (15) miles

C2.V.4 Provider

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.1 General category

Two (2) within eight (8) miles

C2.V.4 Provider

Pediatrician

C2.V.5 Region

Urban

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.1 General category

Two (2) within fifteen (15) miles

C2.V.4 Provider

Pediatrician

C2.V.5 Region

Rural

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to providers

C2.V.1 General category

Two (2) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Obstetric Providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to providers

C2.V.1 General category

Two (2) within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Obstetric Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Specialists

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Specialists

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

General Dental Provider

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

General Dental Provider

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Dental specialty providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Dental specialty providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Hospital

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Hospital

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Behavioral health

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Behavioral health

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

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Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles

C2.V.4 Provider

Pharmacies

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) twenty-four (24) hours a day (or has an afterhours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Pharmacies

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Therapy: Physical/occupational/speech therapists

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

20 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Therapy: Physical/occupational/speech therapists

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

21 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One (1) within thirty (30) minutes or thirty (30) miles

C2.V.4 Provider

Vision providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

22 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

90% of members in county within distance or time to provider

C2.V.1 General category

One within forty-five (45) minutes or forty-five (45) miles

C2.V.4 Provider

Vision Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed fourteen (14) calendar days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

PCPs (routine visits)

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed twenty-four (24) clock hours

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

PCP (adult sick visit)

C2.V.5 Region

state-wide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed twenty-four (24) clock hours

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

PCP (pediatric sick visit)

C2.V.5 Region

state-wide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed fourteen (14) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Maternity Care - First Trimester

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

27 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed seven (7) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Maternity Care - Second Trimester

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

28 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility

standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed three (3) Business Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Maternity Care - Third Trimester

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed thirty (30) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Specialists

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

30 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed thirty (30) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Provider outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed thirty (30) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Vision Providers

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed twenty-one (21) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Dental Providers (routine visits)

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed forty-eight (48) clock hours

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Dental Providers (Urgent Care)

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Thirty (30) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Elective Hospitalizations

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

provider outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Fourteen (14) Calendar Days

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Behavioral health

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Not to exceed twenty-four (24) clock hours

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Urgent Care Providers

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

37 / 37

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

C2.V.2 Measure standard

Appointment Wait Time by Provider Type and/or Service Type - Immediately (twenty-four (24) clock hours a day, seven (7) days a week) and without prior authorization

C2.V.1 General category

Appointment wait time

C2.V.4 Provider

Emergency Providers

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
	BSS website	
C1.IX.1	List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	N/A
	BSS auxiliary aids and services	
C1.IX.2	How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	N/A
	BSS LTSS program data	
C1.IX.3	How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	N/A
	State evaluation of BSS entity performance	
C1.IX.4	What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	N/A

Topic X: Program Integrity

Number	Indicator	Response
	Prohibited affiliation disclosure	
C1.X.3	Did any plans disclose prohibited affiliations? If the state took	No

Number	Indicator	Response
	action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**Amerigroup Community Care** 31,118
D1.I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Amerigroup Community Care** 1.2%
D1.I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Amerigroup Community Care** 1.4%

Topic II. Financial Performance

Number	Indicator	Response
D1.II.1a	**Medical Loss Ratio (MLR)**	**Amerigroup**

Number	Indicator	Response
	What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Community Care** 93.1%
D1.II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Amerigroup Community Care** Program-specific statewide
D1.II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Amerigroup Community Care** Plans must submit separate MLR calculations for LIM+BCC, S-CHIP, Planning for Health Babies, and the Georgia Families 360 Program
D1.II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Amerigroup Community Care** Yes 07/01/2020 06/30/2021

Topic III. Encounter Data

Number	Indicator	Response
D1.III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Amerigroup Community Care** The Contractor shall submit ninety-nine percent (99) of Encounter Data within thirty (30) Calendar Days of Claims payment - both for the original Claim and any adjustment. DCH or its Agent will validate Encounter Data submission according to the Cash Disbursement journal of the Contractor and any of its applicable Subcontractors.
D1.III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting period.	**Amerigroup Community Care** 99.45%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting	**Amerigroup Community Care** 100%

Number	Indicator	Response
	period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
	Appeals resolved (at the plan level)	
D1.IV.1	Enter the total number of appeals resolved as of the first day of the last month of the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Amerigroup Community Care** 215
	Active appeals	
D1.IV.2	Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Amerigroup Community Care** 7
	Appeals filed on behalf of LTSS users	
D1.IV.3	Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter "N/A" if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving	**Amerigroup Community Care** N/A

Number	Indicator	Response
	LTSS at the time that the appeal was filed).	
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	**Amerigroup Community Care** N/A
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR B'438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Amerigroup Community Care** 123

Number	Indicator	Response
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR B'438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Amerigroup Community Care** 75
D1.IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	**Amerigroup Community Care** 215
D1.IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Amerigroup Community Care** 0
D1.IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Amerigroup Community Care** 0
D1.IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined	**Amerigroup Community Care** 0

Number	Indicator	Response
	by the state).	
D1.IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR B'438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Amerigroup Community Care** 17
D1.IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR B'438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Amerigroup Community Care** 0
D1.IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Amerigroup Community Care** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services.	**Amerigroup Community Care** 1

Number	Indicator	Response
	Do not include appeals related to inpatient behavioral health services - those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	
	Resolved appeals related to general outpatient services	
D1.IV.7b	Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services - those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Amerigroup Community Care** 28
	Resolved appeals related to inpatient behavioral health services	
D1.IV.7c	Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	**Amerigroup Community Care** 103
	Resolved appeals related to outpatient behavioral health services	
D1.IV.7d	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Amerigroup Community Care** 45
	Resolved appeals related to covered outpatient prescription drugs	
D1.IV.7e	Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient	**Amerigroup Community Care** 23

Number	Indicator	Response
	prescription drugs, enter "N/A".	
D1.IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Amerigroup Community Care** 0
D1.IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Amerigroup Community Care** N/A
D1.IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Amerigroup Community Care** 14
D1.IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Amerigroup Community Care** 0
D1.IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than	**Amerigroup Community Care** 1

Number	Indicator	Response
	those in items D1.IV.7a-i, enter "N/A".	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**Amerigroup Community Care** 3
D1.IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Amerigroup Community Care** 1
D1.IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Amerigroup Community Care** 0
D1.IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) prior to reaching a decision.	**Amerigroup Community Care** 0
D1.IV.9a	**External Medical Reviews resulting in a favorable decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were	**Amerigroup Community Care** 0

Number	Indicator	Response
	partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR B'438.402(c)(i)(B).	
D1.IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR B'438.402(c)(i)(B).	**Amerigroup Community Care** 0

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Amerigroup Community Care** 30
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**Amerigroup Community Care** 12
D1.IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users.	**Amerigroup Community Care** N/A

Number	Indicator	Response
	An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	
D1.IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS, the state should enter "N/A" in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	**Amerigroup Community Care** N/A
D1.IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely	**Amerigroup Community Care** 30

Number	Indicator	Response
	resolution was provided by plan during the reporting period. See 42 CFR B'438.408(b)(1) for requirements related to the timely resolution of grievances.	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
	Resolved grievances related to general inpatient services	
D1.IV.15a	Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services - those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 0
	Resolved grievances related to general outpatient services	
D1.IV.15b	Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 1
	Resolved grievances related to inpatient behavioral health services	
D1.IV.15c	Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 0

Number	Indicator	Response
	Resolved grievances related to outpatient behavioral health services	
D1.IV.15d	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 0
	Resolved grievances related to coverage of outpatient prescription drugs	
D1.IV.15e	Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 1
	Resolved grievances related to skilled nursing facility (SNF) services	
D1.IV.15f	Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 0
	Resolved grievances related to long-term services and supports (LTSS)	
D1.IV.15g	Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** N/A
	Resolved grievances related to dental services	
D1.IV.15h	Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover	**Amerigroup Community Care** 0

Number	Indicator	Response
	this type of service, enter "N/A".	
D1.IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Community Care** 1
D1.IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Amerigroup Community Care** 1

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Amerigroup Community Care** 1
D1.IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management.	**Amerigroup Community Care** 0

Number	Indicator	Response
	Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	
	Resolved grievances related to access to care/ services from plan or provider	
D1.IV.16c	Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care.	**Amerigroup Community Care**
	Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	0
	Resolved grievances related to quality of care	
D1.IV.16d	Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care.	**Amerigroup Community Care**
	Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	14
	Resolved grievances related to plan communications	
D1.IV.16e	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications.	**Amerigroup Community Care**
	Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	1
D1.IV.16f	**Resolved grievances related to payment or billing**	**Amerigroup**

Number	Indicator	Response
	issues Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**Community Care** 9
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Amerigroup Community Care** 0
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	**Amerigroup Community Care** 0
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Amerigroup Community Care** 0
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal**	**Amerigroup Community Care**

Number	Indicator	Response
	Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR B'438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	0
	Resolved grievances filed for other reasons	**Amerigroup Community Care**
D1.IV.16k	Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	1

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Find in the Excel Workbook

D2_Plan_Measures

1 / 20

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1879

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

58.73%

2 / 20

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Effective Acute Phase Treatment: 46.56%; Effective Continuation Phase Treatment: 25.19%

3 / 20

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

1800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

5-11 Years: 91.53%; 12-18 Years: 78.54%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

7-Day Follow-Up-Total: 54.01%; 30-Day Follow-Up-Total: 74.69%

5 / 20

Complete

D2.VII.1 Measure Name: Follow-Up Care for Children Prescribed ADHD Medication

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

0108

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Initiation Phase: 55.51%; Continuation and Maintenance Phase: 67.47%

6 / 20

Complete

D2.VII.1 Measure Name: Mental Health Utilization Total

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

unknown

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Any Service-Total: 47.14%; Inpatient-Total: 4.16%; Intensive Outpatient or Partial Hospitalization-Total: 0.51%; Outpatient-Total: 42.56%; Emergency Department (ED)-Total: 0.08%; Telehealth-Total: 31.66%

7 / 20

Complete

D2.VII.1 Measure Name: Metabolic Monitoring for Children and Adolescents on Antipsychotics

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2800

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Blood Glucose-1-11 Years: 42.36%; Blood Glucose-12-17 Years: 65.80%; Blood Glucose-Total: 57.74%; Cholesterol-1-11 Years: 32.32%; Cholesterol-12-17 Years: 56.38%; Cholesterol-Total: 48.11%; Blood Glucose and Cholesterol-1-11 Years: 27.39%; Blood Glucose and Cholesterol-12-17 Years: 53.46%; Blood Glucose and Cholesterol-Total: 44.50%

Complete

D2.VII.1 Measure Name: Screening for Depression and Follow Up Plan

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0418

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

CMS

Measure results

Amerigroup Community Care

12-17 Years: 3.59%; 18 Years and Older: 3.03%

9 / 20

Complete

D2.VII.1 Measure Name: Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

2801

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

1-11 Years: 81.42%; 12-17 Years: 82.52%; Total: 82.03%

10 / 20

Complete

D2.VII.1 Measure Name: Use of Multiple Concurrent Antipsychotics in Children and Adolescents

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

unknown

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

1-5 Years NA; 6-11 Years: 1.37%; 12-17 Years: 3.77%; Total: 2.90%

11 / 20

Complete

D2.VII.1 Measure Name: Ambulatory Care: Emergency Department (ED) Visits

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

27.90

12 / 20

Complete

D2.VII.1 Measure Name: Inpatient Utilization - GH/Acute Care - Inpatient Discharges/1000 MM & ALOS

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Total Inpatient-Discharges per 1,000 Member Months-Total: 1.89; Total Inpatient-

Average Length of Stay-Total: 4.49

13 / 20

Complete

D2.VII.1 Measure Name: Child and Adolescent Well-Care Visits

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1516

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

60.99%

14 / 20

Complete

D2.VII.1 Measure Name: Child Immunization Status (Combo 7)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0038

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

67.88%

15 / 20

Complete

D2.VII.1 Measure Name: Chlamydia Screening in Women

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

0033

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

16-20 Years: 66.00%; 21-24 Years: 63.27%

16 / 20

Complete

D2.VII.1 Measure Name: Developmental Screening in the First Three Years of Life

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1448

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

OHSU

Measure results

Amerigroup Community Care

76.64%

17 / 20

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (Combo 2)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

41.12%

18 / 20

Complete

D2.VII.1 Measure Name: Immunizations for Adolescents (Combo 1)

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1407

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

85.40%

19 / 20

Complete

D2.VII.1 Measure Name: Percentage of Eligibles Who received Preventative Dental Services

D2.VII.2 Measure Domain

Dental and oral health services

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

CMCS

Measure results

Amerigroup Community Care

58.55%

20 / 20

Complete

D2.VII.1 Measure Name: Well-Child Visits in the First 30 Months of Life

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

1392

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

07/01/2020 - 06/30/2021

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Well-Child Visits in the First 15 Months-Six or More Well-Child Visits: 56.23%; Well-Child Visits for Age 15 Months-30 Months-Two or More Well-Child Visits: 90.97%

Topic VIII. Sanctions

No plan-level sanctions or corrective actions have been entered for this program report.

Topic X. Program Integrity

Number	Indicator	Response
D1.X.1	**Dedicated program integrity staff**	**Amerigroup Community Care**

Number	Indicator	Response
	Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**Amerigroup Community Care** 82
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Amerigroup Community Care** 0.13:1,000
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past	**Amerigroup Community Care** 32

Number	Indicator	Response
	year?	
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**Amerigroup Community Care** 0.06:1,000
D1.X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Amerigroup Community Care** Makes some referrals to the SMA and others directly to the MFCU **Count of program integrity referrals to the state** 1
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year	**Amerigroup Community Care** 0:1,000

Number	Indicator	Response
	(reported in indicator D1.I.2) as the denominator.	
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**Amerigroup Community Care** This section includes figures for Amerigroup's Georgia Families, Planning for Healthy Babies, and Georgia Families 360 programs. SIU recovery dollars SFY2022 = $104,089.06 SIU PPR Savings SFY2022= $5,011,707.46 MLR Report SFY 2022 Q3 (July - Sept 2021): $22,406.04 Q4 (Oct - Dec 2021): $11,961.60 Q1 (Jan - March 2022): $6,651.86 Q2 (April - June 2022): $15,016.56 Total: $56,036.06* FY 2022 Total Ratio: 0.003% (56,036.06 / 1,731,979,858) *Please note - these figures do not include "pre-payment" savings, only recoupments.
D1.X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the	**Amerigroup Community Care** Monthly

Number	Indicator	Response
	state.	

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Number	Indicator	Response
	BSS entity type	**N/A**
E.IX.1	What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Not Answered
	BSS entity role	**N/A**
E.IX.2	What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	Not Answered