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

Due date	Last edited	Edited by	Status
12/27/2024	12/27/2024	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
A1	**State name** Auto-populated from your account profile.	Georgia
A2a	**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
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	mabutler@dch.ga.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Stephen Fader
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	sfader@mslc.com
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/27/2024

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2023
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2024
A6	**Program name** Auto-populated from report dashboard.	Georgia Families 360

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

	Indicator	Response
	Plan name	Amerigroup Community Care

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

	Indicator	Response
	BSS entity name	Gainwell

Add In Lieu of Services and Settings (A.9)

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** Guidance on In Lieu of Services on Medicaid.gov.

	Indicator	Response
	ILOS name	Institution for Mental Disease Stays longer than 15 days in a month

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	2,133,117
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	1,796,088

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** 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.	State Medicaid agency staff EQRO Other third-party vendor

Topic X: Program Integrity

Number	Indicator	Response
BX.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. If no PI activities were performed, enter 'No PI activities were performed during the reporting period' as your response. 'N/A' is not an acceptable response.	The Program Integrity Unit conducted a review of improper payments made after a member's Date of Death to determine if Managed Care Plans (MCP) were following Part I Policies and Procedures for Medicaid/Peach Care for Kids, Section 202.6 which states, "The submission of claims with dates of service after a member's date of death are prohibited and will be denied." The methodology for this review included the following: • Review of MCP business processes involving improper payment for claims paid after member's date of death. • MCP review of GAMMIS claims data to determine if claims should be recouped. • Virtual Meeting with each MCP to facilitate overview of business processes for improper payments. Findings from the review revealed the following for MCPs: • Inaccurate information regarding Date of Death. The Date of Death in GAMMIS did not always match the information on file with the MCPs. • Issues with MCPs reviewing daily 834-file. MCPs were not recouping Date of Death claims included in the 834-file received from GAMMIS. • Failure to recoup Date of Death claims. MCPs failed to notify providers of recoupment within 18 months of the last date of service in accordance with O.C.G.A. 33-20A-62 (a)(3). As a result, the Program Integrity Unit implemented procedures to require the MCPs to conduct a quarterly review of GAMMIS claims data to ensure improper payments made after a member's date of death are recouped in accordance with O.C.G.A. 33-20A-62 (a)(3). This additional requirement serves as a come behind to the 834-file to ensure Date of Death claims are recouped in a timely manner. Additionally, CSR 1816 is currently in UAT2 testing to: Add Date/Time Field to Store Last Change to Death Date.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State requires the return of overpayments

BX.3	**Location of contract provision stating overpayment standard** 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 The sections referenced are within Amendment 5, which is currently pending CMS approval.
BX.4	**Description of overpayment contract standard** 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.
BX.5	**State overpayment reporting monitoring** 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 various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	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.
BX.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.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a	Yes

	timely manner under 42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	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 suspension, termination, or withdrawal.
BX.8a	**Federal database checks: Excluded person or entities** 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

BX.9a	**Website posting of 5 percent or more ownership control** 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 §455.104 and required by 42 CFR 438.602(g)(3).	Yes
BX.9b	**Website posting of 5 percent or more ownership control: Link** What is the link to the website? Refer to 42 CFR 602(g)(3).	https://dch.georgia.gov/medicaid-managed-care
BX.10	**Periodic audits** 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, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter 'No such audits were conducted during the reporting year' as your response. 'N/A' is not an acceptable response.	https://dch.georgia.gov/medicaid-managed-care

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title 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 PROVISSERVICES TO GEORGIA FAMILIES 360°
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	03/03/2014
C1I.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/sites/medicaid.georgia.gov/files/related_files/site_page/GF%20Contract%20-%20Generic%20%28002%29.pdf
C1I.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)
C1I.4a	**Special program benefits** 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 Dental
C1I.4b	**Variation in special benefits** 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
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per	31,323

	month during the reporting year (i.e., average member months).	
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter 'There were no major changes to the population or benefits during the reporting year' as your response. 'N/A' is not an acceptable response.	Medicaid eligibility redeterminations resumed following the end of the PHE.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of 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)).	Rate setting 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.
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to 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 initial data submissions Timeliness of data corrections Timeliness of data certifications Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation)
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to 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.	Section 4.16.3 Encounter Claims Submission Requirements includes the contract requirements for encounter data submissions. 4.16.3.1 The GF 360º 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 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.
C1III.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 section references, not page numbers.	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.
C1III.5	**Incentives for encounter data quality** 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
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter 'The state did not experience any barriers to collecting or validating encounter data during the reporting year' as your response. 'N/A' is not an acceptable response.	Standards for performance measures are constantly being refined and improved which may cause some delay in aligning data validation and EQR reporting.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident", as used for reporting purposes in its MLTSS program** 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
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §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.	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 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
C1IV.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. Per 42 CFR §438.408(b)(3),	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

	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.	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 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
C1IV.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 §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 receives the grievance.	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.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter 'No challenges were encountered' as your response. 'N/A' is not an acceptable response.	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. Over the course of SFY 2024, however, members' access to 24-hour pharmacies and Psychiatric Residential Treatment Facilities was consistently below the state's 90% access standard. The gaps in access were due to the limited availability of providers practicing in these specialties within the county and in surrounding counties. In addition, the prevalence of rural hospital closings in Georgia has resulted in the closure of the labor and delivery units in these areas, which has led to Ob/Gyn providers relocating to major metropolitan areas for better opportunities leaving fewer providers available to provide Ob/Gyn care to Georgia Families members. As a result, the Plans are having difficulties meeting the state's wait time requirements for Ob/Gyn appointments and members must travel farther to receive care. The Plans are continuing their recruitment efforts to address the gaps in access overall, and where feasible, make telehealth services available to members to ensure access.
C1V.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 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. DCH engages with the CMOs and the provider community to identify specific issues that could potentially be creating barriers to access, and we revisit our policies.

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.

Access measure total count: 37

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 37

C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.3 Standard type

Two (2) within eight (8) miles

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Urban	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 37

C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.3 Standard type

Two (2) within fifteen (15) miles

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.3 Standard type

Two (2) within eight (8) miles

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pediatrician	Urban	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

90% of members in county within distance to providers

C2.V.3 Standard type

Two (2) within fifteen (15) miles

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pediatrician	Rural	Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetric Providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Obstetric Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialists	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialists	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dental Provider	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
General Dental Provider	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental specialty providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental specialty providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

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C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

15 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

16 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

17 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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	C2.V.5 Region	C2.V.6 Population
Pharmacies	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

18 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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	C2.V.5 Region	C2.V.6 Population
Pharmacies	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

19 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Therapy: Physical/occupational/speech therapists	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

20 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Therapy: Physical/occupational/speech therapists	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

21 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Vision providers	Urban	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

22 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

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

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Vision Providers	Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

23 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
PCPs (routine visits)	State-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

24 / 37

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.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
PCP (adult sick visit)	state-wide	Adult

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

25 / 37

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.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
PCP (pediatric sick visit)	state-wide	Pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

26 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Maternity Care - First Trimester	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

27 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Maternity Care - Second Trimester	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

28 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Maternity Care - Third Trimester	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

29 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialists	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

30 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Provider outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

31 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Vision Providers	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

32 / 37

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.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Providers (routine visits)	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

33 / 37

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.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Dental Providers (Urgent Care)	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

34 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Elective Hospitalizations	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

provider outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

35 / 37

C2.V.2 Measure standard

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

C2.V.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Behavioral health	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

36 / 37

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.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Urgent Care Providers	state-wide	Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

37 / 37

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.3 Standard type

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Emergency Providers	state-wide	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
C1IX.1	**BSS website** List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://www.georgia-families.com, https://gateway.ga.gov/access/, https://www.mmis.georgia.gov/portal/PubAccess.Member%20Information/tabId/11/Default.aspx
C1IX.2	**BSS auxiliary aids and services** 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.	Telephone, email, and websites. Members with disabilities would use the Georgia Relay line for telephonic assistance, if needed.
C1IX.3	**BSS LTSS program data** 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
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Monitoring of activities performed by the BSS and regular meetings. Monthly monitoring of a sampling of customer service calls to the BSS for customer service levels and veracity of information.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took 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).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Beginning December 2024, this section must be completed for programs that include MCOs

Number	Indicator	Response
C1XII.4	**Does this program include MCOs?** If "Yes", please complete the following questions.	Yes
C1XII.5	**Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?** (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	**Did the State or MCOs complete the analysis(es)?**	Other, specify – Other (The MCOs reported on each specific mental health parity criteria (e.g., financial limitations, NQTLs) and reviewed in coordination with the Department's contractor Myers and Stauffer).
C1XII.7a	**Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?** (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	**When was the last parity analysis(es) for this program completed?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	12/23/2024

C1XII.9	**When was the last parity analysis(es) for this program submitted to CMS?** States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).	12/29/2023
C1XII.10a	**In the last analysis(es) conducted, were any deficiencies identified?**	No
C1XII.12a	**Has the state posted the current parity analysis(es) covering this program on its website?** The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A “Yes” response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	**Provide the URL link(s).** Response must be a valid hyperlink/URL beginning with “http://” or “https://”. Separate links with commas.	https://dch.georgia.gov/mental-health-parity-compliance-reports

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Amerigroup Community Care** 31,323
D1I.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** 1.5%
D1I.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** 1.7%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** 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. Write MLR as a percentage: for example, write 92% rather than 0.92.	**Amerigroup Community Care** 96.7%
D1II.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
D1II.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, Georgia Pathways, and the Georgia Families 360 Program
D1II.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

N/A	Enter the start date.	**Amerigroup Community Care** 07/01/2022
N/A	Enter the end date.	**Amerigroup Community Care** 06/30/2023

Topic III. Encounter Data

Number	Indicator	Response
D1III.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.
D1III.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 year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year 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 year.	**Amerigroup Community Care** 97.7%
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting year) 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 year.	**Amerigroup Community Care** 99.8%

Topic IV. Appeals, State Fair Hearings & Grievances

Beginning June 2025, Indicators D1.IV.1a-c must be completed. Submission of this data before June 2025 is optional; if you choose not to respond prior to June 2025, enter “N/A”.

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during 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** 670
D1IV.1a	**Appeals denied** Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Amerigroup Community Care** 616
D1IV.1b	**Appeals resolved in partial favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Amerigroup Community Care** 8
D1IV.1c	**Appeals resolved in favor of enrollee** Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee. If you choose not to respond prior to June 2025, enter “N/A”.	**Amerigroup Community Care** 46
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Amerigroup Community Care** 39

D1IV.3	**Appeals filed on behalf of LTSS users** 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 LTSS at the time that the appeal was filed).	**Amerigroup Community Care** 0
D1IV.4	**Number of critical incidents filed during the reporting year 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 year 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	**Amerigroup Community Care** 0

	enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Amerigroup Community Care** 525
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Amerigroup Community Care** 140
D1IV.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** 670

D1IV.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
D1IV.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
D1IV.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 by the state).	**Amerigroup Community Care** 0
D1IV.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 §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**Amerigroup Community Care** 0
D1IV.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 §438.52(b)(2)(ii), to obtain	**Amerigroup Community Care** 1

	services outside the network (only applicable to residents of rural areas with only one MCO).	
D1IV.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

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.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. 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”.	**Amerigroup Community Care** 8
D1IV.7b	**Resolved appeals related to general outpatient services** 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** 32
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** 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** 228
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that	**Amerigroup Community Care** 269

	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”.	
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** 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 prescription drugs, enter “N/A”.	**Amerigroup Community Care** 38
D1IV.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
D1IV.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** 0
D1IV.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** 94

D1IV.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
D1IV.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 those in items D1.IV.7a-i paid primarily by Medicaid, enter “N/A”.	**Amerigroup Community Care** 0

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Amerigroup Community Care** 0
D1IV.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** 0
D1IV.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
D1IV.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) during the reporting year prior to reaching a decision.	**Amerigroup Community Care** 0
D1IV.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 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 §438.402(c)(i)(B).	**Amerigroup Community Care** 0

D1IV.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 §438.402(c)(i)(B).	**Amerigroup Community Care** 0

Grievances Overview

Number	Indicator	Response
D1IV.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** 178
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Amerigroup Community Care** 8
D1IV.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. 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.	**Amerigroup Community Care** 0
D1IV.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 year 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	**Amerigroup Community Care** 0

	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.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Amerigroup Community Care** 178

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** 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
D1IV.15b	**Resolved grievances related to general outpatient services** 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** 0
D1IV.15c	**Resolved grievances related to inpatient behavioral health services** 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
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or	**Amerigroup Community Care** 0

	substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** 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** 0
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services** 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
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** 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** 0
D1IV.15h	**Resolved grievances related to dental services** 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 this type of service, enter “N/A”.	**Amerigroup Community Care** 0

D1IV.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** 0
D1IV.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 paid primarily by Medicaid, enter “N/A”.	**Amerigroup Community Care** 0

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.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
D1IV.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. 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.	**Amerigroup Community Care** 0

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Amerigroup Community Care** 7
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of 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.	**Amerigroup Community Care** 12
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. 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.	**Amerigroup Community Care** 6

D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Amerigroup Community Care** 146
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan 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** 2
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan 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
D1IV.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 by the plan during the reporting year that were filed due to a lack of	**Amerigroup Community Care** 0

	timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §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.	**Amerigroup Community Care** 0
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Amerigroup Community Care** 4

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.

Quality & performance measure total count: 29

Complete

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

1 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Ages: 16-20- 63.55% 21-24- 63.49%

Complete

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

2 / 29

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

Yes

D2.VII.8 Measure Description

OSHU

Measure results

Amerigroup Community Care

68.13%

Complete

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

3 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Combination 2 (Meningococcal, Tdap, HPV): 41.36%

Complete

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

4 / 29

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

No, 07/01/2022 - 06/30/2023

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 70.53% Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits 89.25%

Complete

D2.VII.1 Measure Name: Sealant Receipt on Permanent First Molars

5 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

ADA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio

6 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

5–11 Years 90.80% 12–18 Years 77.16%

Complete

D2.VII.1 Measure Name: Oral Evaluation, Dental Services

D2.VII.2 Measure Domain

Dental and oral health services

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

2517

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

CMS

Measure results

Amerigroup Community Care

Age <1 0.42% Ages 1–2 37.44% Ages 3–5 56.84% Ages 6–7 59.09% NC Ages 8–9 59.71% NC Ages 10–11 58.01% NC Ages 12–14 56.13% NC Ages 15–18 46.98% NC Ages 19–20 14.78% NC

Complete

D2.VII.1 Measure Name: Topical Fluoride for Children

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

CMS

Measure results

Amerigroup Community Care

Rate 1—Dental or Oral Health Services—Ages 1-2 23.86% NC Rate 1—Dental or Oral Health Services—Ages 3-5 40.74% NC Rate 1—Dental or Oral Health Services—Ages 6-7 39.81% NC Rate 1—Dental or Oral Health Services—Ages 8-9 38.75% NC Rate 1—Dental or Oral Health Services—Ages 10-11 36.97% NC Rate 1—Dental or Oral Health Services—Ages 12-14 27.82% NC Rate 1—Dental or Oral Health Services—Ages 15-18 4.47% NC Rate 1—Dental or Oral Health Services—Ages 19-20 0.57% NC Rate 2—Dental Services—Ages 1-2 9.70% NC Rate 2—Dental Services—Ages 3-5 27.91% NC Rate 2—Dental Services—Ages 6-7 29.27% NC Rate 2—Dental Services—Ages 8-9 28.97% NC Rate 2—Dental Services—Ages 10-11 28.67% NC Rate 2—Dental Services—Ages 12-14 21.52% NC Rate 2—Dental Services—Ages 15-18 3.77% NC Rate 2—Dental Services—Ages 19-20 0.39% NC Rate 2—Dental Services—Total 17.62% NC Rate 3—Oral Health Services—Ages 1-2 11.44% NC Rate 3—Oral Health Services—Ages 3-5 8.69% NC Rate 3—Oral Health Services—Ages 6-7 7.22% NC Rate 3—Oral Health Services—Ages 8-9 6.93% NC Rate 3—Oral Health Services—Ages 10-11 5.27% NC Rate 3—Oral Health Services—Ages 12-14 4.25% NC Rate 3—Oral Health Services—Ages 15-18 0.38% NC Rate 3—Oral Health Services—Ages 19-20 0.09% NC Rate 3—Oral Health Services—Total 4.51% NC

Complete

D2.VII.1 Measure Name: Follow-up after Emergency Department Visit for Mental Illness: 18 and older

D2.VII.2 Measure Domain

Primary care access and preventative 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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Follow-up After ED Visit for Alcohol & Other Drug Abuse/dependence:>=18 y-o

10 / 29

D2.VII.2 Measure Domain

Primary care access and preventative care

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

3488

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment

11 / 29

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0004

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Medical Assistance with Smoking and Tobacco Use Cessation

D2.VII.2 Measure Domain

Primary care access and preventative care

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

0027

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Advising Smokers and Tobacco Users to Quit : 64.29% Discussing Cessation Medications: 29.27 Discussing Cessation Strategies: 28.82%

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management

D2.VII.2 Measure Domain

Primary care access and preventative care

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

5–11 Years 90.80% 12–18 Years 77.16%

Complete

D2.VII.1 Measure Name: Follow-up After Hospitalization for Mental Illness:18 and older

14 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Diabetes Screening for People with Schizophrenia or Bipolar Disorder who are Using Antipsychotic Medications

15 / 29

D2.VII.2 Measure Domain

Behavioral health care

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

1932

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Diabetes Care for People with Serious Mental Illness: HbA1c poor control (>9)

16 / 29

D2.VII.2 Measure Domain

Behavioral health care

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

2607

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Use of Opioids at High Dosage in Persons Without Cancer

17 / 29

D2.VII.2 Measure Domain

Substance Abuse Disorder

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

2940

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

PQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Concurrent Use of Opioids and Benzodiazepines

18 / 29

D2.VII.2 Measure Domain

Substance Abuse Disorder

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

3389

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

PQA

Measure results

Amerigroup Community Care

N/A

Complete

D2.VII.1 Measure Name: Use of Pharmacotherapy for Opioid Use Disorder

19 / 29

D2.VII.2 Measure Domain

Substance Abuse Disorder

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

3400

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

CMS

Measure results

Amerigroup Community Care

N/A

Complete

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

20 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

52.75%

Complete

D2.VII.1 Measure Name: Percentage of youth readmitted to a behavioral health facility or an acute care facility with a behavioral health -related primary diagnosis within 30 days of discharge*

21 / 29

D2.VII.2 Measure Domain

Behavioral health care

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

Custom

Measure results

Amerigroup Community Care

R1: 13.97% R2: 14.35%

Complete

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

22 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

CMS

Measure results

Amerigroup Community Care

12–17 Years GR 2.69% NC 18–64 Years GR 2.36% NC

Complete

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

23 / 29

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

State-specific

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

1–11 Years 78.40% 12–17 Years 79.05%

Complete

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

24 / 29

D2.VII.2 Measure Domain

Behavioral health care

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

Custom

Measure results

Amerigroup Community Care

Ages 1–5 NA NC Ages 6–11 2.73% NC Ages 12–17 2.56% NC Total 2.60% NC

Complete

D2.VII.1 Measure Name: Rate your health plan (Child)

25 / 29

D2.VII.2 Measure Domain

Health plan enrollee experience of care

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

0006

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

61.43%

Complete

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

26 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

447.5

Complete

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

27 / 29

D2.VII.2 Measure Domain

Primary care access and preventative care

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

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

Program-specific rate

N/A

D2.VII.6 Measure Set

HEDIS

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Total Inpatient—Discharges per 1,000 Member Years—Total 30.93
NC Total Inpatient—Average Length of Stay—Total 4.48 NC

Complete

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

28 / 29

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

57.91%

Complete

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

29 / 29

D2.VII.2 Measure Domain

Primary care access and preventative care

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

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

Program-specific rate

0033

D2.VII.6 Measure Set

HEDIS

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

No, 07/01/2022 - 06/30/2023

D2.VII.8 Measure Description

NCQA

Measure results

Amerigroup Community Care

Combination 7: 66.67%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 1

Complete

D3.VIII.1 Intervention type: Corrective action plan 1 / 1

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Amerigroup Community Care

D3.VIII.4 Reason for intervention

GF360 Encounter completion percentage is below the contractual requirement of 99 percent.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/03/2024

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

No

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** 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).	**Amerigroup Community Care** 21
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Amerigroup Community Care** 110
D1X.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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Amerigroup Community Care** 0.25:1,000
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Amerigroup Community Care** 109
D1X.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 to the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months)? Express this as a ratio per 1,000 beneficiaries.	**Amerigroup Community Care** 0.25:1,000

D1X.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 referrals to the State Medicaid Agency (SMA) only
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.	**Amerigroup Community Care** 5
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referrals listed in indicator D1.X.7 made to the state during the reporting year to the number of enrollees? For number of enrollees, use the average number of individuals enrolled in the plan per month during the reporting year (reported in indicator D1.I.1). Express this as a ratio per 1,000 beneficiaries.	**Amerigroup Community Care** 0.01:1,000
D1X.9a:	**Plan overpayment reporting to the state: Start Date** What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Amerigroup Community Care** 09/01/2024
D1X.9b:	**Plan overpayment reporting to the state: End Date** What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	**Amerigroup Community Care** 09/30/2024
D1X.9c:	**Plan overpayment reporting to the state: Dollar amount** From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	**Amerigroup Community Care** $497,931.56

D1X.9d:	**Plan overpayment reporting to the state: Corresponding premium revenue** What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	**Amerigroup Community Care** $1,446,805,734
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Amerigroup Community Care** Monthly

Topic XI: ILOS

> ⚠ **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if “Yes”, which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter “0” for utilization.

Number	Indicator	Response
D4XI.1	**ILOSs offered by plan** Indicate whether this plan offered any ILOS to their enrollees.	**Amerigroup Community Care** Yes, at least 1 ILOS is offered by this plan
D4XI.2a	**ILOSs utilization by plan** Select all ILOSs offered by this plan during the contract rating period. For each ILOS offered by the plan, enter the deduplicated number of enrollees that utilized this ILOS during the contract rating period. If the plan offered this ILOS during the contract rating period but there was no utilization, enter “0”.	**Amerigroup Community Care** Institution for Mental Disease Stays longer than 15 days in a month: 10

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Gainwell** Subcontractor
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Gainwell** Enrollment Broker/Choice Counseling Beneficiary Outreach