

Managed Care Program Annual Report (MCPAR) for Georgia: Georgia Pathways

Due date	Last edited	Edited by	Status
12/27/2024	12/27/2024	Stephen Fader	Submitted
Indicator		Response	
Exclusion of CHIP from MCPAR		Not Selected	
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.			

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 Pathways

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 CareSource Georgia Peach State Health Plan

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

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p>Payment risks between the state and plans</p> <p>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.</p>	<p>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.</p>
BX.2	<p>Contract standard for overpayments</p> <p>Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p>State requires the return of overpayments</p>

BX.3	<p>Location of contract provision stating overpayment standard</p> <p>Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).</p>	Sections 29.2.1 and 33.1 The sections referenced are within Amendment 5, which is currently pending CMS approval.
BX.4	<p>Description of overpayment contract standard</p> <p>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.</p>	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	<p>State overpayment reporting monitoring</p> <p>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.</p>	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	<p>Changes in beneficiary circumstances</p> <p>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).</p>	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	<p>Changes in provider circumstances: Monitoring plans</p> <p>Does the state monitor whether plans report provider "for cause" terminations in a</p>	Yes

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
C11.1	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 PROVISION OF SERVICES TO GEORGIA FAMILIES Amendment 8 pending CMS approval
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	06/27/2005
C11.2	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
C11.3	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)
C11.4a	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
C11.4b	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
C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per	2,486

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.

There were no major changes to the population or benefits during the reporting year since this population was new for FY 2024. DCH submitted executed copies of contract Amendment #8 (Pathways) to CMS on 11/26/24. It is now pending CMS review and approval.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	<p>Uses of encounter data</p> <p>For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more.</p> <p>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)).</p>	<p>Rate setting</p> <p>Quality/performance measurement</p> <p>Monitoring and reporting</p> <p>Contract oversight</p> <p>Program integrity</p> <p>Policy making and decision support</p> <p>Other, specify – The Georgia Families program utilizes Encounter data to determine the adequacy of medical services and to evaluate the Quality of care rendered to Members.</p>
C1III.2	<p>Criteria/measures to evaluate MCP performance</p> <p>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.</p> <p>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).</p>	<p>Timeliness of initial data submissions</p> <p>Timeliness of data corrections</p> <p>Timeliness of data certifications</p> <p>Use of correct file formats</p> <p>Provider ID field complete</p> <p>Overall data accuracy (as determined through data validation)</p>
C1III.3	<p>Encounter data performance criteria contract language</p> <p>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.</p>	<p>Section 4.16.3 Encounter Claims Submission Requirements includes the contract requirements for encounter data submissions.</p> <p>4.16.3.1 The GF 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</p>

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	<p>State's definition of “critical incident”, as used for reporting purposes in its MLTSS program</p> <p>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.</p>	N/A
C1IV.2	<p>State definition of “timely” resolution for standard appeals</p> <p>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.</p>	<p>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 time frames provided in 42 CFR 438.408(b). 4.14.5.6 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 make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.</p>
C1IV.3	<p>State definition of “timely” resolution for expedited appeals</p> <p>Provide the state's definition of timely resolution for expedited</p>	<p>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</p>

appeals in the managed care program.
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.

service; the failure to provide services in a timely manner; or the failure of the Care Management Organization (CMO) to act within the time frames provided in 42 CFR 438.408(b).
4.14.5.6 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 make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.

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	<p>Gaps/challenges in network adequacy</p> <p>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.</p>	<p>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.</p>
C1V.2	<p>State response to gaps in network adequacy</p> <p>How does the state work with MCPs to address gaps in network adequacy?</p>	<p>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</p>

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.



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

Primary care

C2.V.5 Region

Urban

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Primary care

C2.V.5 Region

Rural

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Pediatrician

C2.V.5 Region

Urban

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Pediatrician

C2.V.5 Region

Rural

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Obstetric Providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Obstetric Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Specialists

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Specialists

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

General Dental
Provider

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

General Dental
Provider

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Dental specialty
providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

12 / 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

Dental specialty
providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

13 / 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

Hospital

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

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

14 / 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

Hospital

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Behavioral health

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Behavioral health

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Pharmacies

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Pharmacies

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Therapy:
Physical/occupational/speech
therapists

C2.V.5 Region

Urban

C2.V.6 Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Therapy:
Physical/occupational/speech
therapists

C2.V.5 Region

Rural

C2.V.6 Population

Adult and
pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Vision providers

C2.V.5 Region

Urban

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



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

Vision Providers

C2.V.5 Region

Rural

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

PCPs (routine visits)

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

PCP (adult sick visit)

C2.V.5 Region

State-wide

C2.V.6 Population

Adult

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

PCP (pediatric sick visit)

C2.V.5 Region

State-wide

C2.V.6 Population

Pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Maternity Care - First Trimester

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly



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

Maternity Care -
Second Trimester

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Provider Outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Maternity Care -
Third Trimester

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Provider Outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Specialists

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly



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

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

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

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

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

Vision Providers

C2.V.5 Region

State-wide

C2.V.6 Population

State-wide

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

Dental Providers
(routine visits)

C2.V.5 Region

State-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider Outreach

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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
Dental Providers
(Urgent Care)

C2.V.5 Region
state-wide

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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
Elective
Hospitalizations

C2.V.5 Region
state-wide

C2.V.6 Population
Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Urgent Care
Providers

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Provider outreach, Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly



Complete

C2.V.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

Emergency Providers

C2.V.5 Region

state-wide

C2.V.6 Population

Adult and pediatric

C2.V.7 Monitoring Methods

Secret shopper calls, Provider outreach

C2.V.8 Frequency of oversight methods

Quarterly


Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
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)? 42 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	<p>Does this program include MCOs?</p> <p>If “Yes”, please complete the following questions.</p>	Yes
C1XII.5	<p>Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?</p> <p>(i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)</p>	Yes
C1XII.6	<p>Did the State or MCOs complete the analysis(es)?</p>	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	<p>Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?</p> <p>(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)</p>	No
C1XII.8	<p>When was the last parity analysis(es) for this program completed?</p> <p>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).</p>	12/23/2024

C1XII.9	<p>When was the last parity analysis(es) for this program submitted to CMS?</p> <p>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).</p>	12/29/2023
C1XII.10a	<p>In the last analysis(es) conducted, were any deficiencies identified?</p>	No
C1XII.12a	<p>Has the state posted the current parity analysis(es) covering this program on its website?</p> <p>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.</p> <p>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.</p>	Yes
C1XII.12b	<p>Provide the URL link(s).</p> <p>Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.</p>	<p>https://dch.georgia.gov/mental-health-parity-compliance-reports</p>

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment	Amerigroup Community Care
	Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	763
		CareSource Georgia 769
		Peach State Health Plan 955
D1I.2	Plan share of Medicaid	Amerigroup Community Care
	What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment?	0.04%
	<ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1) 	CareSource Georgia 0.04%
		Peach State Health Plan 0.04%
D1I.3	Plan share of any Medicaid managed care	Amerigroup Community Care
	What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?	0.04%
	<ul style="list-style-type: none"> • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2) 	CareSource Georgia 0.04%
		Peach State Health Plan 0.05%

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
		N/A
		CareSource Georgia N/A
		Peach State Health Plan N/A
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
		CareSource Georgia Program-specific statewide
		Peach State Health Plan 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
		CareSource Georgia Plans must submit separate MLR calculations for LIM+BCC, S-CHIP, Planning for Health Babies, Georgia Pathways and the Georgia Families 360 Program
		Peach State Health Plan Plans must submit separate MLR calculations for LIM+BCC, S-CHIP, Planning for Health

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
		CareSource Georgia Yes
		Peach State Health Plan Yes
N/A	Enter the start date.	Amerigroup Community Care 07/01/2022
		CareSource Georgia 07/01/2022
		Peach State Health Plan 07/01/2022
N/A	Enter the end date.	Amerigroup Community Care 06/30/2023
		CareSource Georgia 06/30/2023
		Peach State Health Plan 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.
		CareSource Georgia 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.
		Peach State Health Plan 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	Amerigroup Community Care 98.6%
		CareSource Georgia 99.9%
		Peach State Health Plan 98.6%

from the managed care plan
for the reporting year.

D1III.3	Share of encounter data submissions that were HIPAA compliant	Amerigroup Community Care
		99.8%
	What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance?	CareSource Georgia
	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.	99.9%
		Peach State Health Plan
		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
		7
		CareSource Georgia
		8
		Peach State Health Plan
		4
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
		5
		CareSource Georgia
		4
		Peach State Health Plan
		2
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
		0
		CareSource Georgia
		0
		Peach State Health Plan
		0

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 2 CareSource Georgia 4 Peach State Health Plan 1
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 1 CareSource Georgia 0 Peach State Health Plan 0
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 CareSource Georgia 0 Peach State Health Plan 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	Amerigroup Community Care 0 CareSource Georgia 0 Peach State Health Plan 0

submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".

The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.

To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a	Standard appeals for which timely resolution was provided	Amerigroup Community Care
		6
	Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year.	CareSource Georgia
	See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	8
		Peach State Health Plan
		4

D1IV.5b	<p>Expedited appeals for which timely resolution was provided</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>1</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>
D1IV.6a	<p>Resolved appeals related to denial of authorization or limited authorization of a service</p> <p>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).</p>	<p>Amerigroup Community Care</p> <p>7</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>4</p>
D1IV.6b	<p>Resolved appeals related to reduction, suspension, or termination of a previously authorized service</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>0</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>
D1IV.6c	<p>Resolved appeals related to payment denial</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>0</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>

D1IV.6d	<p>Resolved appeals related to service timeliness</p> <p>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).</p>	<p>Amerigroup Community Care</p> <p>0</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>
D1IV.6e	<p>Resolved appeals related to lack of timely plan response to an appeal or grievance</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>0</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>
D1IV.6f	<p>Resolved appeals related to plan denial of an enrollee's right to request out-of-network care</p> <p>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 services outside the network (only applicable to residents of rural areas with only one MCO).</p>	<p>Amerigroup Community Care</p> <p>0</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>
D1IV.6g	<p>Resolved appeals related to denial of an enrollee's request to dispute financial liability</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>0</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>

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 0
		CareSource Georgia 0
		Peach State Health Plan 0
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 4
		CareSource Georgia 8
		Peach State Health Plan 2
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 0
		CareSource Georgia 0
		Peach State Health Plan 0
D1IV.7d	Resolved appeals related to outpatient behavioral health services Enter the total number of appeals resolved by the plan	Amerigroup Community Care 0
		CareSource Georgia

	during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	0
		Peach State Health Plan
		0
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 3 CareSource Georgia 7 Peach State Health Plan 2
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 CareSource Georgia 0 Peach State Health Plan 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 CareSource Georgia 0 Peach State Health Plan 0
D1IV.7h	Resolved appeals related to dental services Enter the total number of appeals resolved by the plan during the reporting year that	Amerigroup Community Care 0 CareSource Georgia

were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

0

Peach State Health Plan

0

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

CareSource Georgia

0

Peach State Health Plan

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

CareSource Georgia

0

Peach State Health Plan

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
		CareSource Georgia
		0
		Peach State Health Plan
		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
		CareSource Georgia
		0
		Peach State Health Plan
		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
		CareSource Georgia
		0
		Peach State Health Plan
		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
		CareSource Georgia
		0
		Peach State Health Plan
		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 CareSource Georgia 0 Peach State Health Plan 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 CareSource Georgia 0 Peach State Health Plan 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
		13
		CareSource Georgia 1
		Peach State Health Plan 5
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
		0
		CareSource Georgia 0
		Peach State Health Plan 0
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
		CareSource Georgia 0
		Peach State Health Plan 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	Amerigroup Community Care
		0
		CareSource Georgia 0

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 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.

Peach State Health Plan

0

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.

Amerigroup Community Care

13

CareSource Georgia

1

See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

Peach State Health Plan
5

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
		CareSource Georgia 0
		Peach State Health Plan 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
		CareSource Georgia 0
		Peach State Health Plan 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
		CareSource Georgia 0
		Peach State Health Plan 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	Amerigroup Community Care 0
		CareSource Georgia

mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

0

Peach State Health Plan

0

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Amerigroup Community Care

0

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".

CareSource Georgia

0

Peach State Health Plan

1

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Amerigroup Community Care

0

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".

CareSource Georgia

0

Peach State Health Plan

0

D1IV.15g

Resolved grievances related to long-term services and supports (LTSS)

Amerigroup Community Care

0

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".

CareSource Georgia

0

Peach State Health Plan

0

D1IV.15h

Resolved grievances related to dental services

Amerigroup Community Care

0

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

CareSource Georgia

0

not cover this type of service, enter "N/A".

Peach State Health Plan

0

D1IV.15i

Resolved grievances related to non-emergency medical transportation (NEMT)

Amerigroup Community Care

2

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".

CareSource Georgia

0

Peach State Health Plan

0

D1IV.15j

Resolved grievances related to other service types

Amerigroup Community Care

0

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".

CareSource Georgia

0

Peach State Health Plan

4

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	Amerigroup Community Care 0
	Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service.	CareSource Georgia 1
	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.	Peach State Health Plan 2
D1IV.16b	Resolved grievances related to plan or provider care management/case management	Amerigroup Community Care 0
	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.	CareSource Georgia 0
	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.	Peach State Health Plan 0

D1IV.16c	<p>Resolved grievances related to access to care/services from plan or provider</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>4</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>
D1IV.16d	<p>Resolved grievances related to quality of care</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>2</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>1</p>
D1IV.16e	<p>Resolved grievances related to plan communications</p> <p>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.</p>	<p>Amerigroup Community Care</p> <p>1</p> <p>CareSource Georgia</p> <p>0</p> <p>Peach State Health Plan</p> <p>0</p>

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 3 CareSource Georgia 0 Peach State Health Plan 2
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 perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	Amerigroup Community Care 0 CareSource Georgia 0 Peach State Health Plan 0
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 CareSource Georgia 0 Peach State Health Plan 0
D1IV.16i	Resolved grievances related to lack of timely plan response to a service authorization or appeal	Amerigroup Community Care 0 CareSource Georgia

(including requests to expedite or extend appeals)

0

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

Peach State Health Plan

0

D1IV.16j

Resolved grievances related to plan denial of expedited appeal

Amerigroup Community Care

0

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.

CareSource Georgia

0

Peach State Health Plan

0

D1IV.16k

Resolved grievances filed for other reasons

Amerigroup Community Care

1

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.

CareSource Georgia

0

Peach State Health Plan

0

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.



Complete

D2.VII.1 Measure Name: Individuals who applied for Medicaid

1 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants. Measure is not separated by CMO.

Measure results

Amerigroup Community Care

69,876 total for state (not CMO specific)

CareSource Georgia

69,876 total for state (not CMO specific)

Peach State Health Plan

69,876 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Applicants not considered for Pathways and were determined eligible for traditional Medicaid

2 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were not shown the Pathways screens, but were determined to be eligible for traditional Medicaid. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

35,014 total for state (not CMO specific)

CareSource Georgia

35,014 total for state (not CMO specific)

Peach State Health Plan

35,014 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who applied for Medicaid, were potentially ineligible for traditional Medicaid, and were presented the Pathways screens

3 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens. Measures are not separated per CMO.

Measure results

Amerigroup Community Care

3,697 total for state (not CMO specific)

CareSource Georgia

3,697 total for state (not CMO specific)

Peach State Health Plan

3,697 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who applied for Medicaid, were potentially ineligible for traditional Medicaid, and were presented the Pathways screens, cumulative to date

4 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 07/01/2023 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, at any time since the state began processing applications for the demonstration. Measure is not separated per CMO. Measure is Cumulative to date.

Measure results

Amerigroup Community Care

139,799 total for state (not CMO specific)

CareSource Georgia

139,799 total for state (not CMO specific)

Peach State Health Plan

139,799 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who applied for Medicaid, were potentially ineligible for traditional Medicaid, and were presented the Pathways screens, cumulative to date

5 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, but did not elect to be considered for the demonstration at the time of application. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

484 total for state (not CMO specific)

CareSource Georgia

484 total for state (not CMO specific)

Peach State Health Plan

484 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who elected to be considered for Pathways and did not acknowledge they read the requirements of the program

6 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, elected to be considered for the demonstration, but did not sign

the contract acknowledging that they read the requirements of the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

78 total for state (not CMO specific)

CareSource Georgia

78 total for state (not CMO specific)

Peach State Health Plan

78 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who elected to be considered for Pathways and acknowledged that they read the requirements of the program

7 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, elected to be considered for the demonstration, and signed the contract acknowledging that they read the requirements of the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

3,348 total for state (not CMO specific)

CareSource Georgia

3,348 total for state (not CMO specific)

Peach State Health Plan

3,348 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who elected to be considered for Pathways, acknowledged that they read the requirements of the program, and did not report valid qualifying hours and activities or request a reasonable modification 8 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, elected to be considered for the demonstration, signed the contract acknowledging that they read the requirements of the demonstration, but did not report a non-zero number of qualifying hours and activities or request a reasonable modification. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

1,459 total for state (not CMO specific)

CareSource Georgia

1,459 total for state (not CMO specific)

Peach State Health Plan

1,459 total for state (not CMO specific)



D2.VII.1 Measure Name: Individuals who were presented the Pathways screens, did not complete the valid fields to qualify as a Pathways applicant, and were determined eligible for traditional Medicaid 9 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, elected to be considered for the demonstration, signed the contract acknowledging that they read the requirements of the demonstration, did not report a non-zero number of qualifying hours and activities or request a reasonable modification, and were determined eligible for traditional Medicaid. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

329 total for state (not CMO specific)

CareSource Georgia

329 total for state (not CMO specific)

Peach State Health Plan

329 total for state (not CMO specific)



D2.VII.1 Measure Name: Pathways applicants (Individuals who elected to be considered for Pathways, acknowledged they read the requirements of the program, and reported non-zero qualifying activities or requested a reasonable modification) 10 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

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

N/A

Program-specific rate

D2.VII.6 Measure Set

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of new Medicaid applicants who were shown the Pathways screens, elected to be considered for the demonstration, signed the contract acknowledging that they read the requirements of the demonstration and either reported a non-zero number of qualifying hours and activities or requested a reasonable modification, at the time of application. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

1,889 total for state (not CMO specific)

CareSource Georgia

1,889 total for state (not CMO specific)

Peach State Health Plan

1,889 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were determined eligible for traditional Medicaid

11 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were determined eligible for traditional Medicaid, after their application was processed. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

351 total for state (not CMO specific)

CareSource Georgia

351 total for state (not CMO specific)

Peach State Health Plan

351 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were determined ineligible for traditional Medicaid and were not processed for Pathways eligibility due to income, residency, procedural reasons, etc. 12 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were determined ineligible for traditional Medicaid and were not processed for Pathways eligibility due to income, residency, procedural reasons, etc. (These reasons are unrelated to Pathways qualifying hours and activities requirement for minimum hours and verification.) Measure is not separated per CMO.

Measure results

Amerigroup Community Care

517 total for state (not CMO specific)

CareSource Georgia

517 total for state (not CMO specific)

Peach State Health Plan

517 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were determined eligible for the demonstration 13 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were determined eligible for the demonstration, after they were processed for Pathways eligibility. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

286 total for state (not CMO specific)

CareSource Georgia

286 total for state (not CMO specific)

Peach State Health Plan

286 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were denied for Pathways 14 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were denied for Pathways, after they were processed for Pathways eligibility. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

703 total for state (not CMO specific)

CareSource Georgia

703 total for state (not CMO specific)

Peach State Health Plan

703 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were denied for reporting inadequate qualifying hours and activities, no verification was available, and/or available verification did not support 80 hours

15 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were denied for Pathways after they were processed for Pathways eligibility because they reported inadequate qualifying hours and activities, or because no verification was available, and/or their verification did not support 80 hours, at the time of application. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

249 total for state (not CMO specific)

CareSource Georgia

249 total for state (not CMO specific)

Peach State Health Plan

249 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were denied for reporting inadequate hours associated with the qualifying hours and activities requirement

16 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were denied for Pathways after they were processed for Pathways eligibility because they reported an inadequate number of hours associated with the qualifying hours and activities requirement. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

113 total for state (not CMO specific)

CareSource Georgia

113 total for state (not CMO specific)

Peach State Health Plan

113 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who were denied because no verification was available, or available verification did not support 80 hours

17 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were denied for Pathways after they were processed for Pathways eligibility because no verification was available, or available verification did not support 80 hours. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

136 total for state (not CMO specific)

CareSource Georgia

136 total for state (not CMO specific)

Peach State Health Plan

136 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who reported employment and were denied because no verification of employment was available

18 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, whose verification of reported employment activities was not available and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

83 total for state (not CMO specific)

CareSource Georgia

83 total for state (not CMO specific)

Peach State Health Plan

83 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who reported community service, self-employment, on-the-job training, or job readiness activities and were denied because no verification of community service, self-employment, on-the-job training, or job readiness activities was available

19 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, whose verification of reported community service, self-employment, on-the-job training, or job readiness activities was not available and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

49 total for state (not CMO specific)

CareSource Georgia

49 total for state (not CMO specific)

Peach State Health Plan

49 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who reported education or GVRA activities and were denied because no verification of education or GVRA was available 20 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, whose verification of reported education activities or engagement in the GVRA vocational rehabilitation program was not available and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

22 total for state (not CMO specific)

CareSource Georgia

22 total for state (not CMO specific)

Peach State Health Plan

22 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants who reported employment activities and were denied because available verification did not support hours reported for employment

21 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, whose verification of employment activities did not support hours reported and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



D2.VII.1 Measure Name: Pathways applicants who reported community service, self-employment, on-the-job training, or job readiness activities and were denied because available verification did not support hours reported for community service, self-employment, on-the-job training, or job readiness activities

22 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, whose verification of community service, self-employment, on-the-job training, or job readiness activities did not support hours reported and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



D2.VII.1 Measure Name: Pathways applicants who reported education or GVRA activities and were denied because available verification did not support hours reported for education or GVRA

23 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, whose verification of education or engagement in the GVRA vocational rehabilitation program did not support hours reported and whose application were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants denied Pathways due to income, residency, procedural reasons, etc. 24 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, who were denied Pathways due to income, residency, procedural reasons, etc. (These reasons are unrelated to Pathways qualifying hours and activities requirement for minimum hours and verification.) Measure is not separated per CMO.

Measure results

Amerigroup Community Care

454 total for state (not CMO specific)

CareSource Georgia

454 total for state (not CMO specific)

Peach State Health Plan

454 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category

25 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

94,160 total for state (not CMO specific)

CareSource Georgia

94,160 total for state (not CMO specific)

Peach State Health Plan

94,160 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category and were determined eligible for traditional Medicaid

26 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

Program

Access/Eligibility

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, were not shown the Pathways screens, but were determined to be eligible for traditional Medicaid. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

25,221 total for state (not CMO specific)

CareSource Georgia

25,221 total for state (not CMO specific)

Peach State Health Plan

25,221 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category, were potentially ineligible for traditional Medicaid, and were presented the Pathways screens

27 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, and were shown the Pathways screens. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

2,495 total for state (not CMO specific)

CareSource Georgia

2,495 total for state (not CMO specific)

Peach State Health Plan

2,495 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category who did not elect to be considered for Pathways

28 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, were shown the Pathways screens, but did not elect to be considered for the demonstration at the time of renewal or change of circumstance reporting. Measure is separated per CMO.

Measure results

Amerigroup Community Care

76 total for state (not CMO specific)

CareSource Georgia

76 total for state (not CMO specific)

Peach State Health Plan

76 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category, who elected to be considered for Pathways, and did not acknowledge they read the requirements of the program

29 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, were shown the Pathways screens, elected to be considered for the demonstration, but did not sign the contract acknowledging that they read the requirements of the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

175 total for state (not CMO specific)

CareSource Georgia

175 total for state (not CMO specific)

Peach State Health Plan

175 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category, who elected to be considered for Pathways, and acknowledged that they read the requirements of the program

30 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, were shown the Pathways screens, elected to be considered for the demonstration, and signed the contract acknowledging that they read the requirements of the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

2,249 total for state (not CMO specific)

CareSource Georgia

2,249 total for state (not CMO specific)

Peach State Health Plan

2,249 total for state (not CMO specific)

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category, who elected to be considered for Pathways, acknowledged that they read the requirements of the program, and did not report valid qualifying hours and activities or request a reasonable modification

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, were shown the Pathways screens, elected to be considered for the demonstration, signed the contract acknowledging that they read the requirements of the demonstration, but did not report a non-zero number of qualifying hours and activities or request a reasonable modification. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

870 total for state (not CMO specific)

CareSource Georgia

870 total for state (not CMO specific)

Peach State Health Plan

870 total for state (not CMO specific)

D2.VII.1 Measure Name: Individuals who were enrolled in another Medicaid eligibility category, who were presented the Pathways screens, did not complete the valid fields to qualify as a Pathways applicant, and were determined eligible for traditional Medicaid

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, were shown the Pathways screens, elected to be considered for the demonstration, signed the contract acknowledging that they read the requirements of the demonstration, did not report a non-zero number of qualifying hours and activities or request a reasonable modification, and were determined eligible for traditional Medicaid. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

383 total for state (not CMO specific)

CareSource Georgia

383 total for state (not CMO specific)

Peach State Health Plan

383 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees (Individuals who were enrolled in another Medicaid eligibility category, who elected to be considered for Pathways, acknowledged they read the requirements of the program, and reported non-zero qualifying activities or requested a reasonable modification)

33 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were enrolled in another Medicaid eligibility category who were either up for renewal or reported a change in circumstance, who were shown the Pathways screens, elected to be considered for the demonstration, signed the contract acknowledging that they read the requirements of the demonstration and either reported a non-zero number of qualifying hours and activities or requested a reasonable modification, at the time of renewal or change of circumstance reporting. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

1,379 total for state (not CMO specific)

CareSource Georgia

1,379 total for state (not CMO specific)

Peach State Health Plan

1,379 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were determined eligible for traditional Medicaid

34 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were determined eligible for traditional Medicaid, after their renewal or change in circumstance was processed. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

483 total for state (not CMO specific)

CareSource Georgia

483 total for state (not CMO specific)

Peach State Health Plan

483 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were determined ineligible for traditional Medicaid and were not processed for Pathways eligibility due to income, residency, procedural reasons, etc. 35 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were determined ineligible for traditional Medicaid and were not processed for Pathways eligibility due to income, residency, procedural reasons, etc. (These reasons are unrelated to Pathways qualifying hours and activities requirement for minimum hours and verification.) Measure is not separated per CMO.

Measure results

Amerigroup Community Care

246 total for state (not CMO specific)

CareSource Georgia

246 total for state (not CMO specific)

Peach State Health Plan

246 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were determined eligible for the demonstration

36 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were determined eligible for the demonstration, after they were processed for Pathways eligibility. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

140 total for state (not CMO specific)

CareSource Georgia

140 total for state (not CMO specific)

Peach State Health Plan

140 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were denied for Pathways

37 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were denied for Pathways, after they were processed for Pathways eligibility. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

195 total for state (not CMO specific)

CareSource Georgia

195 total for state (not CMO specific)

Peach State Health Plan

195 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were denied for reporting inadequate qualifying hours and activities, no verification was available, and/or available verification did not support 80 hours

38 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were denied for Pathways after they were processed for Pathways eligibility because they reported inadequate qualifying hours and activities, or because no verification was

available, and/or their verification did not support 80 hours, at the time of renewal or change in circumstance reporting during the measurement period. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

54 total for state (not CMO specific)

CareSource Georgia

54 total for state (not CMO specific)

Peach State Health Plan

54 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were denied for reporting inadequate hours associated with the qualifying hours and activities requirement

39 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were denied for Pathways after they were processed for Pathways eligibility because they reported an inadequate number of hours associated with the qualifying hours and activities requirement. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

41 total for state (not CMO specific)

CareSource Georgia

41 total for state (not CMO specific)

Peach State Health Plan

41 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who were denied because no verification was available, or available verification did not support 80 hours

40 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees who were denied for Pathways after they were processed for Pathways eligibility because no verification was available, or available verification did not support 80 hours. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

13 total for state (not CMO specific)

CareSource Georgia

13 total for state (not CMO specific)

Peach State Health Plan

13 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who reported employment and were denied because no verification of employment

41 / 69

was available

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, whose verification of reported employment activities was not available and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

7 total for state (not CMO specific)

CareSource Georgia

7 total for state (not CMO specific)

Peach State Health Plan

7 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who reported community service, self-employment, on-the-job training, or job readiness activities and were denied because no verification of community service, self-employment, on-the-job training, or job readiness activities was available ^{42 / 69}

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, whose verification of community service, self-employment, on-the-job training, or job readiness activities was not available and whose applications were denied. Measure is not separated per CMO.

Measure results**Amerigroup Community Care**

4 total for state (not CMO specific)

CareSource Georgia

4 total for state (not CMO specific)

Peach State Health Plan

4 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who reported education or GVRA activities and were denied because no verification of education or GVRA was available ^{43 / 69}
D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, whose verification of education activities or engagement in the GVRA vocational rehabilitation program was not available and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

6 total for state (not CMO specific)

CareSource Georgia

6 total for state (not CMO specific)

Peach State Health Plan

6 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who reported employment activities and were denied because available verification did not support hours reported for employment 44 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, whose verification of employment activities did not support hours reported and whose applications were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who reported community service, self-employment, on-the-job training, or job readiness activities and were denied because available verification did not support hours reported for community service, self-employment, on-the-job training, or job readiness activities ^{45 / 69}

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, whose verification of community service, self-employment, on-the-job training, or job readiness activities did not support hours reported and who were denied. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees who reported education or GVRA activities and were denied because available ^{46 / 69}

verification did not support hours reported for education or GVRA

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, whose verification of education activities or engagement in the GVRA vocational rehabilitation program did not support hours reported and were denied.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Potential Pathways transferees denied Pathways due to income, residency, procedural reasons, etc.

47 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of potential Pathways transferees, after they were processed for Pathways eligibility, who were denied Pathways due to income, residency, procedural reasons, etc. (These reasons are unrelated to Pathways qualifying hours and activities requirement for minimum hours and verification.) Measure is not separated per CMO.

Measure results

Amerigroup Community Care

141 total for state (not CMO specific)

CareSource Georgia

141 total for state (not CMO specific)

Peach State Health Plan

141 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants (new and transfers) determined eligible for demonstration

48 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants who were determined to be eligible for the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

426 total for state (not CMO specific)

CareSource Georgia

426 total for state (not CMO specific)

Peach State Health Plan

426 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants (new and transfers) who elected to be considered for Pathways and acknowledged that they read the requirements of the program. 49 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who elected to be considered for Pathways and signed the contract acknowledging that they read the requirements of the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

5,597 total for state (not CMO specific)

CareSource Georgia

5,597 total for state (not CMO specific)

Peach State Health Plan

5,597 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants (new and transfers) who were denied for not meeting the qualifying hours and activities requirement (reporting inadequate hours, no verification was available, and/or available verification did not support 80 hours) 50 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were denied for Pathways, after they were processed for Pathways eligibility, because they reported inadequate qualifying hours and activities, or because no verification was available, and/or available verification did not support 80 hours. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

303 total for state (not CMO specific)

CareSource Georgia

303 total for state (not CMO specific)

Peach State Health Plan

303 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways applicants (new and transfers) who were denied Pathways due to income, residency, procedural reasons, etc. 51 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of Pathways applicants, after they were processed for Pathways eligibility, who were denied Pathways due to income, residency, procedural reasons, etc. (These reasons are unrelated to Pathways qualifying hours and activities requirement for minimum hours and verification.) Measure is not separated per CMO.

Measure results

Amerigroup Community Care

595 total for state (not CMO specific)

CareSource Georgia

595 total for state (not CMO specific)

Peach State Health Plan

595 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Total enrollment in the demonstration

52 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

4,231 total for state (not CMO specific)

CareSource Georgia

4,231 total for state (not CMO specific)

Peach State Health Plan

4,231 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: New enrollees in the demonstration

53 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries in the demonstration who began a new enrollment spell during the measurement period and were not enrolled in the demonstration within the prior 3 months. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

425 total for state (not CMO specific)

CareSource Georgia

425 total for state (not CMO specific)

Peach State Health Plan

425 total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries enrolled in the prior month who met the qualifying hours and activities requirement to retain coverage

54 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration in the prior month who retained coverage by meeting the qualifying hours and activities requirement during the measurement period. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries exempt from reporting because they met the qualifying hours and activities requirement for six consecutive months

55 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration who were exempt from reporting qualifying hours and activities because they reported hours to demonstrate that they met the qualifying hours and activities

requirement for six consecutive months. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

32 total for state (not CMO specific)

CareSource Georgia

32 total for state (not CMO specific)

Peach State Health Plan

32 total for state (not CMO specific)



D2.VII.1 Measure Name: Pathways beneficiaries who were subject to an audit for the qualifying hours and activities requirement 56 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration who were subject to an audit completed during the measurement period for the qualifying hours and activities requirement. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries who were subject to an audit for qualifying hours and activities requirement, and were requested to submit verification documents 57 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration who were subject to an audit for qualifying hours and activities and were requested to submit verification documents. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries who were subject to an audit for qualifying hours and activities, were requested to submit verification documents, and were found compliant 58 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration, were subject to an audit for qualifying hours and activities, were requested to submit verification documents, and were found compliant. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries who requested good cause exceptions 59 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration who requested good cause exceptions during the measurement period. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries who were approved for good cause exceptions 60 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries enrolled in the demonstration who met the state criteria for good cause exceptions, such as serious illness, birth or death of a family member, severe weather, family emergencies, or life-changing event. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were presented the Pathways screens and requested reasonable modifications due to disability at application 61 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were shown the Pathways screens and requested a reasonable modification to processes (such as assistance with appeals) or requirements (such as the number of hours) at application due to disability. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who were presented the Pathways screens, requested reasonable modifications due to disability at application, and were eligible for Pathways. 62 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who were shown the Pathways screens, requested a reasonable modification to processes (such as assistance with appeals) or requirements (such as the number of hours) due to disability at application, and were eligible for the demonstration. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries in suspension status for noncompliance 63 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of demonstration beneficiaries in suspension status (i.e., enrolled in the demonstration, but not actively receiving benefits) for noncompliance

with the qualifying hours and activities requirement, including those newly suspended for noncompliance during the measurement period. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries newly suspended for noncompliance 64 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of demonstration beneficiaries newly suspended (i.e., enrolled in the demonstration, but not actively receiving benefits) during the measurement period for noncompliance with the qualifying hours and activities requirement. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries disenrolled from the demonstration for noncompliance 65 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of demonstration beneficiaries newly disenrolled from the demonstration for noncompliance with the qualifying hours and activities requirement and lost Medicaid coverage during the measurement period. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries disenrolled from the demonstration for noncompliance and not reenrolled 66 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of demonstration beneficiaries disenrolled from the demonstration for noncompliance with the qualifying hours and activities requirement during the measurement period or any time during the prior three months and not reenrolled. Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Pathways beneficiaries whose benefits were reinstated after being in suspension status for noncompliance 67 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of beneficiaries whose benefits were reinstated during the measurement period after suspension (i.e., enrolled in the demonstration, but not actively receiving benefits) in a prior month triggered by

noncompliance with the qualifying hours and activities requirement.
Measure is not separated per CMO.

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan

N/A total for state (not CMO specific)



Complete

D2.VII.1 Measure Name: Individuals who reapplied and were presented the Pathways screens after disenrollment for noncompliance 58 / 69

D2.VII.2 Measure Domain

Program Access/Eligibility

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

State-specific

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

No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description

Number of individuals who reapplied and were shown the Pathways screens after being disenrolled from the demonstration for noncompliance.
Measure is not separated per CMO,

Measure results

Amerigroup Community Care

N/A total for state (not CMO specific)

CareSource Georgia

N/A total for state (not CMO specific)

Peach State Health Plan
N/A total for state (not CMO specific)



D2.VII.1 Measure Name: Pathways beneficiaries who reenrolled in the demonstration after disenrollment for noncompliance 69 / 69

D2.VII.2 Measure Domain
Program Access/Eligibility

D2.VII.3 National Quality Forum (NQF) number	D2.VII.4 Measure Reporting and D2.VII.5 Programs
N/A	Program-specific rate

D2.VII.6 Measure Set	D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range
State-specific	No, 06/01/2024 - 06/30/2024

D2.VII.8 Measure Description
Number of beneficiaries reenrolled in the demonstration during the measurement period after disenrollment from the demonstration, including those reenrolling after successful appeal. Measure is not separated per CMO.

Measure results

Amerigroup Community Care
N/A total for state (not CMO specific)

CareSource Georgia
N/A total for state (not CMO specific)

Peach State Health Plan
N/A total for state (not CMO specific)

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.



Complete

D3.VIII.1 Intervention type: Corrective action plan

1 / 4

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

Amerigroup Community Care

D3.VIII.4 Reason for intervention

Georgia Pathways Member Measures were reported incorrectly on the monthly report.

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

12/07/2023

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

Yes, remediated 02/07/2024

D3.VIII.9 Corrective action plan

No



Complete

D3.VIII.1 Intervention type: Corrective action plan

2 / 4

D3.VIII.2 Plan performance issue

Reporting

D3.VIII.3 Plan name

CareSource Georgia

D3.VIII.4 Reason for intervention

Georgia Pathways report contained incorrect data. In reviewing the CareSource report for the January 2024 reporting period (as indicated below) CareSource submitted an incorrect report as it relates to Tabs 1-4. For the December 2023 reporting period, CareSource submitted a report that was also incorrect as it relates to Tabs 1-4.

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

02/16/2024

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

Yes, remediated 03/28/2024

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

3 / 4

D3.VIII.2 Plan performance

issue

Reporting

D3.VIII.3 Plan name

CareSource Georgia

D3.VIII.4 Reason for intervention

Georgia Pathways report contain incorrect data. "As indicated in the email below, for the December 2023 reporting period, Tabs 6-8 for suspended members should reflect 0. Tabs 6-8 are to be filled out with data on outreach to non-compliant members for the January 2024 reporting period with first report due on February 15, 2024. These Tabs should not be filled out for this reporting period.

Sanction details**D3.VIII.5 Instances of non-compliance**

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

03/22/2024

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

Yes, remediated 04/25/2024

D3.VIII.9 Corrective action plan

Yes



Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 4

D3.VIII.2 Plan performance

issue

Reporting

D3.VIII.3 Plan name

Peach State Health Plan

D3.VIII.4 Reason for intervention

Georgia Pathways Member Measures was submitted with incorrect data.

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.7 Date assessed

08/31/2024

D3.VIII.9 Corrective action plan

No

D3.VIII.6 Sanction amount

N/A

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

Yes, remediated 08/31/2024

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
		CareSource Georgia
		6
		Peach State Health Plan
		2
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
		CareSource Georgia
		58
		Peach State Health Plan
		140
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
		CareSource Georgia
		0.17:11,000
		Peach State Health Plan
		0.19:1,000
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
		CareSource Georgia
		39
		Peach State Health Plan
		83

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 CareSource Georgia 0.11:1,000 Peach State Health Plan 0.12:1,000
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 CareSource Georgia Makes referrals to the State Medicaid Agency (SMA) only Peach State Health Plan 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 CareSource Georgia 4 Peach State Health Plan 82
D1X.8	Ratio of program integrity referral to the state What is the ratio of program integrity referrals listed in indicator D1X.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).	Amerigroup Community Care 0.01:1,000 CareSource Georgia 0.01:1,000 Peach State Health Plan 0.11:1,000

Express this as a ratio per 1,000 beneficiaries.

D1X.9a:	Plan overpayment reporting to the state: Start Date	Amerigroup Community Care
	What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	09/01/2024
		CareSource Georgia 06/01/2024 Peach State Health Plan 07/01/2023
D1X.9b:	Plan overpayment reporting to the state: End Date	Amerigroup Community Care
	What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	09/30/2024
		CareSource Georgia 06/30/2024 Peach State Health Plan 06/30/2024
D1X.9c:	Plan overpayment reporting to the state: Dollar amount	Amerigroup Community Care
	From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	\$497,931.56
		CareSource Georgia \$1,155,350 Peach State Health Plan \$0
D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue	Amerigroup Community Care
	What is the total amount of premium revenue for the corresponding reporting period (D1X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	\$1,446,805,734
		CareSource Georgia \$1,047,379,818 Peach State Health Plan \$3,389,799

D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	Amerigroup Community Care
		Monthly
		CareSource Georgia
		Daily
		Peach State Health Plan
		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
		CareSource Georgia No ILOSs were offered by this plan
		Peach State Health Plan No ILOSs were 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.: 0
		CareSource Georgia Not applicable
		Peach State Health Plan Not applicable

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