

Managed Care Program Annual Report (MCPAR) for Georgia: Planning 4 Healthy Babies (P4HB)

Due date	Last edited	Edited by	Status
12/27/2025	12/23/2025	Stephen Fader	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under each plan.	Plan to submit on 12/27/2025

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.	Shanique Horne
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	shanique.horne@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.	12/23/2025

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	07/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	06/30/2025
A6	Program name Auto-populated from report dashboard.	Planning 4 Healthy Babies (P4HB)

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.	2,125,663
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.	1,748,992

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	<p data-bbox="310 100 716 142">Data validation entity</p> <p data-bbox="310 153 716 321">Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs.</p> <p data-bbox="310 321 716 699">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.</p>	<p data-bbox="760 100 1114 142">State Medicaid agency staff</p> <p data-bbox="760 174 834 216">EQRO</p> <p data-bbox="760 247 1081 285">Other third-party vendor</p>

Topic X: Program Integrity

Number	Indicator	Response
BX.1	<p data-bbox="313 107 695 180">Payment risks between the state and plans</p> <p data-bbox="313 201 727 863">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 data-bbox="760 107 1369 1052">DCH-OIG Program Integrity collaborated with MSLC and DCH Executive Leadership to facilitate a review of FFS Payments for CMO Beneficiaries that overlapped with Capitation Payments for (COS 010). o Methodology: This review focused on Fee-for-Service (FFS) payments for inpatient claims submitted for Medicaid beneficiaries enrolled in Care Management Organizations (CMOs). Claims were identified that overlapped with CMO capitation payments to determine potential overpayments. o Findings: This review identified inpatient hospital claims improperly paid FFS while CMOs was concurrently receiving capitation payments for the same members and covered services for claims submitted between 2020 and 2024. o Results: Initial Findings and Overpayment Notices were sent to three (3) CMOs to facilitate recoupment of approximately \$3,152,820 from the CMOs. These overpayments are pending review and/or appeal, if necessary, with the CMOs as of 12/9/2025. POC: John Lott and Johnny R. Brooks.</p>
BX.2	<p data-bbox="313 1108 618 1182">Contract standard for overpayments</p> <p data-bbox="313 1203 727 1360">Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.</p>	<p data-bbox="760 1108 1308 1138">State requires the return of overpayments</p>
BX.3	<p data-bbox="313 1413 634 1528">Location of contract provision stating overpayment standard</p> <p data-bbox="313 1549 727 1703">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>	<p data-bbox="760 1413 1081 1442">Sections 29.2.1 and 33.1.</p>
BX.4	<p data-bbox="313 1755 704 1829">Description of overpayment contract standard</p> <p data-bbox="313 1850 727 1944">Briefly describe the overpayment standard selected in indicator B.X.2.</p>	<p data-bbox="760 1755 1377 2070">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.</p>

<p>BX.5</p>	<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?</p> <p>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>	<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.</p>
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<p>BX.6</p>	<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>	<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.</p>
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<p>BX.7a</p>	<p>Changes in provider circumstances: Monitoring plans</p> <p>Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.</p>	<p>Yes</p>
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<p>BX.7b</p>	<p>Changes in provider circumstances: Metrics</p> <p>Does the state use a metric or indicator to assess plan reporting performance? Select one.</p>	<p>Yes</p>
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<p>BX.7c</p>	<p>Changes in provider circumstances: Describe metric</p> <p>Describe the metric or indicator that the state uses.</p>	<p>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</p>
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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	No
<p>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.</p>		
BX.9a	Website posting of 5 percent or more ownership control	Yes
<p>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 42 CFR 438.602(g)(3) and 455.104.</p>		
BX.9b	Website posting of 5 percent or more ownership control: Link	https://dch.georgia.gov/medicaid-managed-care
<p>What is the link to the website? Refer to 42 CFR 602(g)(3).</p>		

BX.10

Periodic audits

<https://dch.georgia.gov/medicaid-managed-care>

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.

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Yes
BXIII.1a	<p>Timeframes for standard prior authorization decisions</p> <p>Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and within state-established timeframes. For rating periods that start before January 1, 2026, a state's time frame may not exceed 14 calendar days after receiving the request. For rating periods that start on or after January 1, 2026, a state's time frame may not exceed 7 calendar days after receiving the request. Does the state set timeframes shorter than these maximum timeframes for standard prior authorization requests?</p>	Yes
BXIII.1b	<p>State's timeframe for standard prior authorization decisions</p> <p>Indicate the state's maximum timeframe, as number of days, for plans to provide notice of their decisions on standard prior authorization requests.</p>	3
BXIII.2a	<p>Timeframes for expedited prior authorization decisions</p> <p>Plans must provide notice of their decisions on prior authorization requests as expeditiously as the enrollee's condition requires and no later than 72 hours after receipt of the request for service. Does the state set timeframes shorter than the maximum timeframe for expedited prior authorization requests?</p>	No

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	<p>Program contract</p> <p>Enter the title of the contract between the state and plans participating in the managed care program.</p>	<p>STATE OF GEORGIA CONTRACT BETWEEN THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH AND [CONTRACTOR] FOR PROVISION OF SERVICES TO GEORGIA FAMILIES (1115(a) Waiver)</p>
N/A	<p>Enter the date of the contract between the state and plans participating in the managed care program.</p>	01/01/2011
C11.2	<p>Contract URL</p> <p>Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.</p>	<p>https://medicaid.georgia.gov/document/document/georgia-families-amended-and-restated-contract-generic-0/download</p>
C11.3	<p>Program type</p> <p>What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.</p>	Managed Care Organization (MCO)
C11.4a	<p>Special program benefits</p> <p>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.</p> <p>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.</p>	None of the above – Limited Benefit for Family Planning
C11.4b	<p>Variation in special benefits</p> <p>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.</p>	<p>Women who are enrolled in the P4HB program are granted a 30 day period to select a CMO of their choice. Furthermore, effective January 1, 2015, once a woman selects a CMO, she transitions to her selected CMO the day following her CMO selection. If the woman does not select a CMO within the 30 day choice period, she is auto-assigned to a CMO, in order to receive P4HB services , based on DCH's auto-assignment algorithm.</p>

C11.5	Program enrollment	54,145
	Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	
C11.6	Changes to enrollment or benefits	There were no major changes to the population or benefits during the reporting year.
	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.	

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 Department 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.

4.16.3.3 If the Contractor fails to comply with the encounter data reporting requirements of this Contract, DCH will impose sanctions pursuant to the Sanctions or Liquidated Damages of this contract. 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). 4.14.5.9 For standard resolution of an appeal, Contractor has thirty (30) Calendar days from the date of receipt of the Appeal to issue a decision or sooner if the Member’s physical or mental health condition warrants a faster resolution.</p>
C1IV.3	<p>State definition of “timely” resolution for expedited appeals</p> <p>Provide the state’s definition of timely resolution for expedited 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.</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). 4.14.5.10 For expedited resolution of an appeal, Contractor has seventy-two (72) hours from the date of receipt of the Appeal to issue a decision. If Contractor denies the request for an expedited Appeal, Contractor must utilize the timeframe for a standard resolution. In this instance, Contractor must provide prompt notice to the Member that the request for an expedited Appeal has been denied.</p>

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.

4.14.2.4 The Contractor shall issue written disposition of the Grievance as expeditiously as the Member’s health Condition requires but such disposition must be completed within ninety (90) Calendar Days from the date the Contractor receives the grievance.

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 2025, 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.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	<p data-bbox="313 107 480 136">BSS website</p> <p data-bbox="313 161 721 317">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.</p>	<p data-bbox="760 107 1380 296">https://www.georgia-families.com, https://gateway.ga.gov/access/, https://www.mmis.georgia.gov/portal/PubAccess.Member%20Information/tabId/11/Default.aspx</p>
C1IX.2	<p data-bbox="313 369 618 441">BSS auxiliary aids and services</p> <p data-bbox="313 466 708 873">How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.</p>	<p data-bbox="760 369 1370 483">Telephone, email, and websites. Members with disabilities would use the Georgia Relay line for telephonic assistance, if needed.</p>
C1IX.3	<p data-bbox="313 926 630 955">BSS LTSS program data</p> <p data-bbox="313 980 721 1234">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).</p>	N/A
C1IX.4	<p data-bbox="313 1287 721 1358">State evaluation of BSS entity performance</p> <p data-bbox="313 1383 721 1507">What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?</p>	<p data-bbox="760 1287 1365 1476">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.</p>

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

Number	Indicator	Response
C1XII.4	<p data-bbox="324 107 690 178">Does this program include MCOs?</p> <p data-bbox="324 199 690 262">If "Yes", please complete the following questions.</p>	Yes
C1XII.5	<p data-bbox="324 317 738 430">Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system?</p> <p data-bbox="324 451 738 598">(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>	No
C1XII.6	<p data-bbox="324 653 690 766">Did the State or MCOs complete the most recent parity analysis(es)?</p>	<p data-bbox="771 653 1372 850">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).</p>
C1XII.7a	<p data-bbox="324 936 714 1092">Have there been any events in the reporting period that necessitated an update to the parity analysis(es)?</p> <p data-bbox="324 1113 714 1396">(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 data-bbox="324 1451 738 1564">When was the last parity analysis(es) for this program completed?</p> <p data-bbox="324 1585 738 2026">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>	12/23/2025

C1XII.9	When was the last parity analysis(es) for this program submitted to CMS?	12/23/2025
	<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>	
C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website?	Yes
	<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. 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>	
C1XII.12b	Provide the URL link(s).	https://dch.georgia.gov/mental-health-parity-compliance-reports
	<p>Response must be a valid hyperlink/URL beginning with "http:///" or "https://". Separate links with commas.</p>	

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D11.1	<p>Plan enrollment</p> <p>Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).</p>	<p>Amerigroup Community Care 19,087</p> <p>CareSource Georgia 12,932</p> <p>Peach State Health Plan 22,126</p>
D11.2	<p>Plan share of Medicaid</p> <p>What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)</p>	<p>Amerigroup Community Care 0.9%</p> <p>CareSource Georgia 0.6%</p> <p>Peach State Health Plan 1%</p>
D11.3	<p>Plan share of any Medicaid managed care</p> <p>What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)</p>	<p>Amerigroup Community Care 1.1%</p> <p>CareSource Georgia 0.7%</p> <p>Peach State Health Plan 1.3%</p>
D11.4: Parent	<p>Organization: The name of the parent entity that controls the Medicaid Managed Care Plan.</p> <p>If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.</p>	<p>Amerigroup Community Care Elevance Health</p> <p>CareSource Georgia CareSource Management Group Co. and Humana Inc</p> <p>Peach State Health Plan Centene Corporation</p>

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	<p>Medical Loss Ratio (MLR)</p> <p>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.</p>	<p>Amerigroup Community Care 47.8%</p> <p>CareSource Georgia 57.8%</p> <p>Peach State Health Plan 313.6%</p>
D1II.1b	<p>Level of aggregation</p> <p>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.</p>	<p>Amerigroup Community Care Program-specific statewide</p> <p>CareSource Georgia Program-specific statewide</p> <p>Peach State Health Plan Program-specific statewide</p>
D1II.2	<p>Population specific MLR description</p> <p>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.</p>	<p>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. MLR is regional specific and has been aggregated for the whole state.</p> <p>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. MLR is regional specific and has been aggregated for the whole state.</p> <p>Peach State Health Plan</p>

Plans must submit separate MLR calculations for LIM+BCC, S-CHIP, Planning for Health Babies, Georgia Pathways, and the Georgia Families 360 Program. MLR is regional specific and has been aggregated for the whole state.

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

07/01/2023

CareSource Georgia

07/01/2023

Peach State Health Plan

07/01/2023

N/A

Enter the end date.

Amerigroup Community Care

06/30/2024

CareSource Georgia

06/30/2024

Peach State Health Plan

06/30/2024

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	<p data-bbox="313 107 708 176">Definition of timely encounter data submissions</p> <p data-bbox="313 201 708 453">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.</p>	<p data-bbox="813 138 1377 657">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. P4HB encounter submissions are not separately validated from the rest of the Georgia Families encounter submissions.</p> <p data-bbox="813 699 1377 1218">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. P4HB encounter submissions are not separately validated from the rest of the Georgia Families encounter submissions.</p> <p data-bbox="813 1260 1377 1780">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. P4HB encounter submissions are not separately validated from the rest of the Georgia Families encounter submissions.</p>
D1III.2	<p data-bbox="313 1839 727 1992">Share of encounter data submissions that met state’s timely submission requirements</p> <p data-bbox="313 2013 727 2074">What percent of the plan’s encounter data file submissions</p>	<p data-bbox="813 1871 1219 1948">Amerigroup Community Care 99.18%</p> <p data-bbox="813 1990 1219 2074">CareSource Georgia 99.92%</p>

(submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.

Peach State Health Plan

99.99%

D1III.3

Share of encounter data submissions that were HIPAA compliant

What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.

Amerigroup Community Care

99.9%

CareSource Georgia

99.9%

Peach State Health Plan

98.3%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	<p data-bbox="313 107 727 180">Appeals resolved (at the plan level)</p> <p data-bbox="313 201 727 642">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.</p>	<p data-bbox="813 136 1219 222">Amerigroup Community Care 70</p> <p data-bbox="813 264 1089 350">CareSource Georgia 5</p> <p data-bbox="813 392 1146 478">Peach State Health Plan 7</p>
D1IV.1a	<p data-bbox="313 695 526 724">Appeals denied</p> <p data-bbox="313 745 704 905">Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.</p>	<p data-bbox="813 724 1219 810">Amerigroup Community Care 52</p> <p data-bbox="813 852 1089 938">CareSource Georgia 2</p> <p data-bbox="813 980 1146 1066">Peach State Health Plan 6</p>
D1IV.1b	<p data-bbox="313 1115 683 1188">Appeals resolved in partial favor of enrollee</p> <p data-bbox="313 1209 704 1335">Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.</p>	<p data-bbox="813 1144 1219 1230">Amerigroup Community Care 3</p> <p data-bbox="813 1272 1089 1358">CareSource Georgia 1</p> <p data-bbox="813 1400 1146 1486">Peach State Health Plan 0</p>
D1IV.1c	<p data-bbox="313 1535 704 1608">Appeals resolved in favor of enrollee</p> <p data-bbox="313 1629 704 1755">Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.</p>	<p data-bbox="813 1564 1219 1650">Amerigroup Community Care 15</p> <p data-bbox="813 1692 1089 1778">CareSource Georgia 1</p> <p data-bbox="813 1820 1146 1906">Peach State Health Plan 1</p>
D1IV.2	<p data-bbox="313 1955 516 1984">Active appeals</p> <p data-bbox="313 2005 646 2070">Enter the total number of appeals still pending or in</p>	<p data-bbox="813 1984 1219 2070">Amerigroup Community Care 1</p>

process (not yet resolved) as of the end of the reporting year.

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

N/A

CareSource Georgia

N/A

Peach State Health Plan

N/A

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A". The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this

Amerigroup Community Care

N/A

CareSource Georgia

N/A

Peach State Health Plan

N/A

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 Enter the total number of standard appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	Amerigroup Community Care 69 CareSource Georgia 5 Peach State Health Plan 7
D1IV.5b	Expedited appeals for which timely resolution was provided Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	Amerigroup Community Care 1 CareSource Georgia 0 Peach State Health Plan 0
D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	Amerigroup Community Care 70 CareSource Georgia 4 Peach State Health Plan 7
D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service Enter the total number of appeals resolved by the plan	Amerigroup Community Care 0 CareSource Georgia 0

	during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	Peach State Health Plan 0
D1IV.6c	Resolved appeals related to payment denial Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	Amerigroup Community Care 0 CareSource Georgia 1 Peach State Health Plan 0
D1IV.6d	Resolved appeals related to service timeliness Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	Amerigroup Community Care 0 CareSource Georgia 0 Peach State Health Plan 0
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	Amerigroup Community Care 0 CareSource Georgia 0 Peach State Health Plan 0
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	Amerigroup Community Care 0 CareSource Georgia 0 Peach State Health Plan 0

D1IV.6g Resolved appeals related to denial of an enrollee's request to dispute financial liability

Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.

Amerigroup Community Care

0

CareSource Georgia

0

Peach State Health Plan

0

Appeals by Service

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

Number	Indicator	Response
D1IV.7a	<p>Resolved appeals related to general inpatient services</p> <p>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”.</p>	<p>Amerigroup Community Care 21</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
D1IV.7b	<p>Resolved appeals related to general outpatient services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). 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”.</p>	<p>Amerigroup Community Care 12</p> <p>CareSource Georgia 4</p> <p>Peach State Health Plan 1</p>
D1IV.7c	<p>Resolved appeals related to inpatient behavioral health services</p> <p>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”.</p>	<p>Amerigroup Community Care 4</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
D1IV.7d	<p>Resolved appeals related to outpatient behavioral health services</p> <p>Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or</p>	<p>Amerigroup Community Care 1</p> <p>CareSource Georgia 0</p>

substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

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

14

CareSource Georgia

1

Peach State Health Plan

6

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". (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).

Amerigroup Community Care

N/A

CareSource Georgia

N/A

Peach State Health Plan

N/A

D1IV.7h

Resolved appeals related to dental services

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

Amerigroup Community Care

11

CareSource Georgia

0

Peach State Health Plan

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.7k:	Resolved appeals related to durable medical equipment (DME) & supplies Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. 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.7l:	Resolved appeals related to home health / hospice Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. 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.7m:	Resolved appeals related to emergency services / emergency department Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. 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.7n:	Resolved appeals related to therapies	Amerigroup Community Care 7

Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy 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.7o

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-n 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	<p data-bbox="313 107 691 134">State Fair Hearing requests</p> <p data-bbox="313 161 721 317">Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.</p>	<p data-bbox="813 138 1219 165">Amerigroup Community Care</p> <p data-bbox="813 193 829 220">2</p> <p data-bbox="813 262 1084 289">CareSource Georgia</p> <p data-bbox="813 317 829 344">0</p> <p data-bbox="813 386 1146 413">Peach State Health Plan</p> <p data-bbox="813 441 829 468">0</p>
D1IV.8b	<p data-bbox="313 527 711 638">State Fair Hearings resulting in a favorable decision for the enrollee</p> <p data-bbox="313 665 721 821">Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.</p>	<p data-bbox="813 558 1219 585">Amerigroup Community Care</p> <p data-bbox="813 613 829 640">0</p> <p data-bbox="813 682 1084 709">CareSource Georgia</p> <p data-bbox="813 737 829 764">0</p> <p data-bbox="813 806 1146 833">Peach State Health Plan</p> <p data-bbox="813 861 829 888">0</p>
D1IV.8c	<p data-bbox="313 947 721 1058">State Fair Hearings resulting in an adverse decision for the enrollee</p> <p data-bbox="313 1085 721 1209">Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.</p>	<p data-bbox="813 978 1219 1005">Amerigroup Community Care</p> <p data-bbox="813 1033 829 1060">0</p> <p data-bbox="813 1102 1084 1129">CareSource Georgia</p> <p data-bbox="813 1157 829 1184">0</p> <p data-bbox="813 1226 1146 1253">Peach State Health Plan</p> <p data-bbox="813 1281 829 1308">0</p>
D1IV.8d	<p data-bbox="313 1367 721 1444">State Fair Hearings retracted prior to reaching a decision</p> <p data-bbox="313 1472 721 1713">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.</p>	<p data-bbox="813 1398 1219 1425">Amerigroup Community Care</p> <p data-bbox="813 1453 829 1480">1</p> <p data-bbox="813 1522 1084 1549">CareSource Georgia</p> <p data-bbox="813 1577 829 1604">0</p> <p data-bbox="813 1646 1146 1673">Peach State Health Plan</p> <p data-bbox="813 1701 829 1728">0</p>
D1IV.9a	<p data-bbox="313 1787 667 1898">External Medical Reviews resulting in a favorable decision for the enrollee</p> <p data-bbox="313 1925 721 2083">If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the</p>	<p data-bbox="813 1818 1219 1845">Amerigroup Community Care</p> <p data-bbox="813 1873 829 1900">0</p> <p data-bbox="813 1942 1084 1969">CareSource Georgia</p> <p data-bbox="813 1997 829 2024">0</p>

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).

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	<p>Grievances resolved</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.</p>	<p>Amerigroup Community Care 337</p> <p>CareSource Georgia 18</p> <p>Peach State Health Plan 11</p>
D1IV.11	<p>Active grievances</p> <p>Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.</p>	<p>Amerigroup Community Care 11</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
D1IV.12	<p>Grievances filed on behalf of LTSS users</p> <p>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.</p>	<p>Amerigroup Community Care N/A</p> <p>CareSource Georgia N/A</p> <p>Peach State Health Plan N/A</p>
D1IV.13	<p>Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance</p> <p>For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the</p>	<p>Amerigroup Community Care N/A</p> <p>CareSource Georgia N/A</p> <p>Peach State Health Plan N/A</p>

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.

D1IV.14	Number of grievances for which timely resolution was provided	Amerigroup Community Care
	Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	337
		CareSource Georgia
		18
		Peach State Health Plan
		11

Grievances by Service

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

Number	Indicator	Response
D1IV.15a	<p>Resolved grievances related to general inpatient services</p> <p>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”.</p>	<p>Amerigroup Community Care 22</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
D1IV.15b	<p>Resolved grievances related to general outpatient services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). 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”.</p>	<p>Amerigroup Community Care 208</p> <p>CareSource Georgia 1</p> <p>Peach State Health Plan 6</p>
D1IV.15c	<p>Resolved grievances related to inpatient behavioral health services</p> <p>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”.</p>	<p>Amerigroup Community Care 1</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
D1IV.15d	<p>Resolved grievances related to outpatient behavioral health services</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that</p>	<p>Amerigroup Community Care 3</p> <p>CareSource Georgia</p>

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

0

Peach State Health Plan

0

D1IV.15e

Resolved grievances related to coverage of outpatient prescription drugs

Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".

Amerigroup Community Care

3

CareSource Georgia

0

Peach State Health Plan

1

D1IV.15f

Resolved grievances related to skilled nursing facility (SNF) services

Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".

Amerigroup Community Care

0

CareSource Georgia

0

Peach State Health Plan

0

D1IV.15g

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

Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".

Amerigroup Community Care

N/A

CareSource Georgia

N/A

Peach State Health Plan

N/A

D1IV.15h

Resolved grievances related to dental services

Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".

Amerigroup Community Care

20

CareSource Georgia

0

Peach State Health Plan

0

D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT)	Amerigroup Community Care
	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".	5
		CareSource Georgia
		0
		Peach State Health Plan
		0
<hr/>		
D1IV.15k	Resolved grievances related to durable medical equipment (DME) & supplies	Amerigroup Community Care
	Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	7
		CareSource Georgia
		0
		Peach State Health Plan
		0
<hr/>		
D1IV.15l	Resolved grievances related to home health / hospice	Amerigroup Community Care
	Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	0
		CareSource Georgia
		0
		Peach State Health Plan
		0
<hr/>		
D1IV.15m	Resolved grievances related to emergency services / emergency department	Amerigroup Community Care
	Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	6
		CareSource Georgia
		0
		Peach State Health Plan
		0
<hr/>		
D1IV.15n	Resolved grievances related to therapies	Amerigroup Community Care
	Enter the total number of grievances resolved by the plan during the reporting year that	7
		CareSource Georgia

were related to speech language pathology services or occupational, physical, or respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

0

Peach State Health Plan

0

D1IV.15o

Resolved grievances related to other service types

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".

Amerigroup Community Care

55

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	<p>Resolved grievances related to plan or provider customer service</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.</p>	<p>Amerigroup Community Care 9</p> <p>CareSource Georgia 3</p> <p>Peach State Health Plan 1</p>
D1IV.16b	<p>Resolved grievances related to plan or provider care management/case management</p> <p>Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.</p>	<p>Amerigroup Community Care 22</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
D1IV.16c	<p>Resolved grievances related to network adequacy or 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 113</p> <p>CareSource Georgia 2</p> <p>Peach State Health Plan 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 1</p> <p>CareSource Georgia 1</p> <p>Peach State Health Plan 0</p>
D1IV.16e	<p>Resolved grievances related to plan communications</p> <p>Enter the total number of grievances resolved by the plan during the</p>	<p>Amerigroup Community Care 8</p>

	<p>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>CareSource Georgia 1</p> <p>Peach State Health Plan 0</p>
<p>D1IV.16f</p>	<p>Resolved grievances related to payment or billing issues</p> <p>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.</p>	<p>Amerigroup Community Care 141</p> <p>CareSource Georgia 11</p> <p>Peach State Health Plan 7</p>
<p>D1IV.16g</p>	<p>Resolved grievances related to suspected fraud</p> <p>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.</p>	<p>Amerigroup Community Care 0</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
<p>D1IV.16h</p>	<p>Resolved grievances related to abuse, neglect or exploitation</p> <p>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.</p>	<p>Amerigroup Community Care 0</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan 0</p>
<p>D1IV.16i</p>	<p>Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)</p> <p>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</p>	<p>Amerigroup Community Care 6</p> <p>CareSource Georgia 0</p> <p>Peach State Health Plan</p>

service authorization or appeal request (including requests to expedite or extend appeals). 0

D1IV.16j	Resolved grievances related to plan denial of expedited appeal	Amerigroup Community Care
	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.	1
		CareSource Georgia
		0
		Peach State Health Plan
		0

D1IV.16k	Resolved grievances filed for other reasons	Amerigroup Community Care
	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.	36
		CareSource Georgia
		0
		Peach State Health Plan
		3

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: Enrollment of P4HB Population Eligible in the Community 1 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Percentage of members enrolled in the program based on the number of members eligible. Measure is reported at a State level and not by plan.

Measure results

Amerigroup Community Care

35.3%

CareSource Georgia

35.3%

Peach State Health Plan

35.3%



Complete

D2.VII.1 Measure Name: Growth in Enrollment 2 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Percentage of growth of enrollment in the calendar year.

Measure results

Amerigroup Community Care

-0.6%

CareSource Georgia

2.3%

Peach State Health Plan

-5.9%



Complete

D2.VII.1 Measure Name: Use of Family Planning Services within Six Months of Enrollment

3 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Percentage of enrollees using Family Planning Services within Six Months of Enrollment. Measure is reported at a State level and not by plan.

Measure results

Amerigroup Community Care

Any Family Planning Visit in First 6 Months 11.4%; Any Visit /Service for Contraceptive Method in First 6 Months 6.3%

CareSource Georgia

Any Family Planning Visit in First 6 Months 11.4%; Any Visit /Service for Contraceptive Method in First 6 Months 6.3%

Peach State Health Plan

Any Family Planning Visit in First 6 Months 11.4%; Any Visit /Service for Contraceptive Method in First 6 Months 6.3%



Complete

D2.VII.1 Measure Name: Acceptance of Case Management Services

4 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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, 01/01/2022 - 09/30/2022

D2.VII.8 Measure Description

Rate of member accepting case management services

Measure results

Amerigroup Community Care

47.6%

CareSource Georgia

11.9%

Peach State Health Plan

85.0%



Complete

D2.VII.1 Measure Name: Adverse Delivery Outcome for Repeat Delivery with 18 Months

5 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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

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

Program-specific rate

N/A

D2.VII.6 Measure Set

State-specific

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

No, 01/01/2011 - 12/31/2020

D2.VII.8 Measure Description

Percentage of Adverse Delivery Outcomes within 18 months of previous delivery. Measure is reported at a State level and not by plan.

Measure results

Amerigroup Community Care

IPC 4.2% RSM 7.8%

CareSource Georgia

IPC 4.2% RSM 7.8%

Peach State Health Plan

IPC 4.2% RSM 7.8%



Complete

D2.VII.1 Measure Name: Assignment of Resource Mother

6 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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, 10/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Rate at which resource mothers were accepted.

Measure results

Amerigroup Community Care

23.0%

CareSource Georgia

10.1%

Peach State Health Plan

39.8%



Complete

D2.VII.1 Measure Name: Any Face-to-face or Telephone Visit with Resource Mother Among Interpregnancy Care or Resource Mother Only Enrollees for Q1-Q3 2022 and for Q4 2022, by Medicaid Care Management Organization

7 / 7

D2.VII.2 Measure Domain

Maternal and perinatal health

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

Rates of telephone visits with Resource Mothers.

Measure results

Amerigroup Community Care

Q1 - Q3: 144/613 (23.5%) Q4: 16/74 (21.6%)

CareSource Georgia

Q1 - Q3: 855/1081 (79.1%) Q4: 30/374 (8.0%)

Peach State Health Plan

Q1 - Q3: 433/1038 (41.7%) Q4: 6/334 (2%)

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. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

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

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	<p data-bbox="313 107 711 178">Dedicated program integrity staff</p> <p data-bbox="313 199 711 388">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).</p>	<p data-bbox="813 136 1219 220">Amerigroup Community Care 21</p> <p data-bbox="813 262 1089 346">CareSource Georgia 4</p> <p data-bbox="813 388 1146 472">Peach State Health Plan 2</p>
D1X.2	<p data-bbox="313 527 711 598">Count of opened program integrity investigations</p> <p data-bbox="313 619 711 745">How many program integrity investigations were opened by the plan during the reporting year?</p>	<p data-bbox="813 556 1219 640">Amerigroup Community Care 239</p> <p data-bbox="813 682 1089 766">CareSource Georgia 57</p> <p data-bbox="813 808 1146 892">Peach State Health Plan 53</p>
D1X.4	<p data-bbox="313 947 711 1018">Count of resolved program integrity investigations</p> <p data-bbox="313 1039 711 1165">How many program integrity investigations were resolved by the plan during the reporting year?</p>	<p data-bbox="813 976 1219 1060">Amerigroup Community Care 192</p> <p data-bbox="813 1102 1089 1186">CareSource Georgia 39</p> <p data-bbox="813 1228 1146 1312">Peach State Health Plan 66</p>
D1X.6	<p data-bbox="313 1367 711 1480">Referral path for program integrity referrals to the state</p> <p data-bbox="313 1501 711 1627">What is the referral path that the plan uses to make program integrity referrals to the state? Select one.</p>	<p data-bbox="813 1396 1300 1522">Amerigroup Community Care Makes referrals to the State Medicaid Agency (SMA) only</p> <p data-bbox="813 1585 1300 1711">CareSource Georgia Makes referrals to the State Medicaid Agency (SMA) only</p> <p data-bbox="813 1795 1300 1921">Peach State Health Plan Makes some referrals to the SMA and others directly to the MFCU</p>
D1X.7	<p data-bbox="313 1997 711 2068">Count of program integrity referrals to the state</p>	<p data-bbox="813 2026 1219 2068">Amerigroup Community Care</p>

Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of referrals made.

13

CareSource Georgia

3

Peach State Health Plan

Not applicable

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 to the SMA and the MFCU in aggregate.

Amerigroup Community Care

Not applicable

CareSource Georgia

Not applicable

Peach State Health Plan

111

D1X.9a:

Plan overpayment reporting to the state: Start Date

What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Amerigroup Community Care

08/01/2025

CareSource Georgia

07/01/2024

Peach State Health Plan

07/01/2024

D1X.9b:

Plan overpayment reporting to the state: End Date

What is the end date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?

Amerigroup Community Care

08/30/2025

CareSource Georgia

03/31/2025

Peach State Health Plan

06/30/2025

D1X.9c:

Plan overpayment reporting to the state: Dollar amount

From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?

Amerigroup Community Care

\$415,709.85

CareSource Georgia

\$617,624

Peach State Health Plan

\$889,357

D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	Amerigroup Community Care \$4,461,699.99 CareSource Georgia \$955,222,338 Peach State Health Plan \$5,152,038
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:
		CareSource Georgia Not applicable
		Peach State Health Plan Not applicable

Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select "Not reporting data".

Number	Indicator	Response
N/A	<p>Are you reporting data prior to June 2026?</p> <p>If “Yes”, please complete the following questions under each plan.</p>	Yes

Topic XIV. Patient Access API Usage

⚠ Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	<p>Are you reporting data prior to June 2026?</p> <p>If “Yes”, please complete the following questions under each plan.</p>	Not reporting data

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

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to "Review & submit."

Number	Indicator	Response
F1	Notes (optional)	Not answered