GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

Quality Strategic Plan
For

Georgia Families

Choices for a Healthy Life

And

Georgia Families 360°SM

Better Care, Better Futures.

December 2015

Table of Contents

Section I: Introduction

The Georgia Department of Community Health (DCH), created in 1999 by the Georgia General Assembly through the consolidation of four health agencies, serves as Georgia's lead agency for health care planning, purchasing and oversight. It is the single state agency for Medicaid. In 2003, DCH identified unsustainable Medicaid growth and projected that without a change to the system, the Medicaid program would require 50 percent of all new State revenue by 2008 with Medicaid utilization driving more than 35 percent of the state's annual growth. For those reasons, DCH decided to employ a managed care approach to organize its fragmented system of care, enhance access, achieve budget predictability, explore possible cost containment opportunities and focus on system-wide performance improvements. DCH believed that managed care would continuously improve the quality of healthcare and services provided to eligible members and improve efficiency by utilizing both human and material resources more efficiently and effectively. In 2004, the DCH Division of Managed Care and Quality submitted a State Plan Amendment to implement a full-risk mandatory Managed Care program called Georgia Families for Medicaid and PeachCare for Kids® (the state's standalone CHIP program) members. DCH implemented the Georgia Families program in 2006.

DCH designed the Georgia Families program to serve specific Medicaid eligible and PeachCare for Kids members. The Georgia Families Medicaid eligibility categories include Low Income Medicaid (LIM), transitional Medicaid, pregnant women in "Right from the Start Medicaid" (RSM), newborns of Medicaid-covered women, and women with breast and cervical cancer. Georgia requires mandatory enrollment of these specific Medicaid beneficiaries into the Georgia Families (GF) program in accordance with Section 1932(a) (1) (A) of the Social Security Act which is referenced in Georgia's State Plan Amendment for Managed Care. The program is a partnership between DCH and three full-risk Health Maintenance Organizations (HMOs) licensed by the Georgia Department of Insurance and Safety Fire (DOI). Georgia refers to its Health Maintenance Organizations as Care Management Organizations (CMOs). As of December 2015, Amerigroup, Peach State Health Plan and WellCare of Georgia managed the care of approximately 1.3 million members under the Georgia Families program. The majority of their members are under the age 18 years. The CMOs strive to contain health expenditures, improve access to care and improve quality of care through activities such as utilization management, provider contracting, case and disease management programs, and performance improvement projects.

In August 2010, DCH received CMS approval to allow children under the age of 19 years who were receiving foster care or adoption assistance under title IV-E to enroll in managed care. Beginning in 2011, DCH conducted a very inclusive and transparent process in analyzing Medicaid redesign options and designing a program specific to youth in foster care, juvenile justice and adoption assistance. DCH and its Agent facilitated public input through statewide stakeholder focus groups, two public hearings, an online survey and task forces. DCH also allowed for submission of comments through a "MyOpinion" Mailbox.

In July of 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to the concerns that the Patient Protection and Affordable Care Act, the national recession and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high quality care in a cost effective manner. Subsequent to the delivery of the comprehensive assessment and recommendations in 2012, DCH engaged several stakeholder groups to obtain feedback while considering Medicaid redesign options. The Children and Families Task Force was one such group established in 2012 to study ways to improve care for children in foster care, adoption assistance and certain children in the juvenile justice system. The group met throughout 2013 and into 2014. The Georgia Families 360° (GF 360º) program, a managed care program specifically for the foster care, adoption assistance, and juvenile justice populations, was the result of that collaboration. Seven state child-serving agencies came together to develop a plan to transition these members from a fee for service environment to a managed care environment. They included DCH, the Department of Human Services Division of Family and Children Services, the Department of Behavioral Health and Developmental Disabilities, the Department of Public Health, the Department of Juvenile Justice, the Department of Education, and the Department of Early Care and Learning. Approximately 27,000 children in foster care, adoption assistance, and juvenile justice youth in non-secure community residential placements transitioned to Amerigroup for their health care coverage on March 3, 2014.

The original goal for the Georgia Families Program, as stated in the 2007 Quality Strategic Plan approved by CMS was that care provided by the CMOs would: be of acceptable quality; assure accessibility; provide for continuity; and promote efficiency.

The goals for the Georgia Families 360º Program are to:

1. Enhance the coordination of care and access to services;
2. Improve health outcomes;
3. Develop and utilize meaningful and complete electronic medical records; and
4. Comply fully with regulatory reporting requirements.

The original Georgia Families objectives for each of the three CMOs, with target achievement dates of 2012, were:

1. Meet or exceed the Healthcare Effectiveness Data and Information Set (HEDIS) 2006 90th percentile for well-child visits during the first 15 months of life. Georgia's baseline for this measure was 47.7 percent and the HEDIS 2006 90th percentile was 68.6 percent. The HEDIS 2006 75th percentile was 59.2 percent and the HEDIS 2006 50th percentile was 50 percent. None of the three CMOs achieved the established target for this measure based on their CY 2012 through CY 2014 performance. The CY 2014 rates for this measure ranged from 65% to 66.9%.
2. In collaboration with Georgia's Immunization program, improve by 5 percentage points the number of Georgia Families members under the age of 36 months who are compliant with an immunization 4:3:1:3:3:1 series of vaccines - 4 Diphtheria, Tetanus, and Pertussis, 3 Polio, 1 Measles, Mumps, and Rubella, 3 Haemophilus Influenza Type B, 3 Hepatitis B, and 1 Varicella vaccine. Because Georgia's baseline rate was 76.8 percent and the performance target rate was set at 81.1 percent. WellCare of Georgia was the

only CMO to achieve the targeted performance level in CY 2013 and CY 2014. WellCare's CY 2014 rate for this measure was 84%.

3. In collaboration with Georgia's Childhood Lead Poisoning Prevention Program (GCLPPP), demonstrate an improvement of 10 percentage points in the number of one and two year old Georgia Families' children receiving a screening blood lead level. Georgia's Baseline for children ages 9 – 15 months was 27.1 percent and for ages 21 – 27 months, it was 21.7 percent. Since the establishment of these targets, DCH transitioned to the use of the HEDIS Lead Screening in Children measure that measures the percentage of children two years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. All three CMOs far exceeded the original target blood lead screening rate. Using the HEDIS 2015 specifications for this measure, the CY 2014 results ranged from 78.4% to 81.35%.
4. Demonstrate an improvement of 10 percentage points in the number of enrolled members aged 21 and older who had an ambulatory or preventive care visit during the measurement year. This will bring Georgia to the 2006 HEDIS 90th percentile for managed Medicaid plans for adults aged 21- 44 years old accessing preventive health/primary care services. Georgia's Baseline was 78.9 percent and the HEDIS 2006 90th percentile was 87 percent. The HEDIS 2006 75th percentile was 83.7 percent; and the HEDIS 2006 50th percentile was 79 percent. None of the Georgia Families CMOs met the original target level of performance. Their CY 2014 performance levels for this measure ranged from 79.7% to 81.76%.
5. Demonstrate an improvement of 20 percentage points for the diabetics within their membership who have at least one HbA1c test during the measurement year. This will bring Georgia to the 2006 HEDIS 75th percentile for managed Medicaid plans. Georgia's Baseline was 65.3 percent for ages 18 – 75. The HEDIS 2006 90th percentile was 88.8 percent; the HEDIS 2006 75th percentile was 84.9 percent; and the HEDIS 2006 50th percentile was 77.4 percent. Only one of the Georgia Families CMOs, Amerigroup, met the original target level of performance with a CY 2014 rate of 85.4%. The other two CMOs' CY 2014 performance rates ranged from 83.2% to 83.6%.
6. Demonstrate an improvement of five percentage points for the asthmatics within their membership who receive the appropriate medications. This will bring Georgia to the 2006 HEDIS 90th percentile level for managed Medicaid plans. Georgia's Baseline was 88.5 percent. The HEDIS 2006 90th percentile was 92.5 percent; the HEDIS 2006 75th percentile was 89.7 percent; and the HEDIS 2006 50th percentile was 87.1 percent. Two of the Georgia Families CMOs met or exceeded the original target of a five percentage points over baseline improvement with CY 2014 performance measure rates of 93% and 93.8%. Only WellCare fell short of the target with their CY 2014 performance measure rate of 91.95%.
7. Demonstrate a relative 10 percentage point decrease in the rate of low birth weight (LBW) births to women enrolled in their CMOs. This will lead to a reduction in the rate of low birth weight births for the state of Georgia from 9.3 percent to 8.4 percent of live births and ultimately improve Georgia's infant mortality rates. In 2010, all three CMOs reported LBW rates at or below 7.81%. However, in 2012, the Agency for Healthcare Research and Quality (AHRQ) changed its specifications for the LBW measure and this change resulted in significant increases in the CY 2012 LBW rates reported by the Georgia Families CMOs. The CY 2012 rates ranged from 8.02% to 8.53%. Since that

time, the LBW rates have continued to climb. Amerigroup's LBW rate for CY 2014 was 8.87%. Peach State's LBW rate was 9.04% and WellCare's LBW rate was 9.21% in 2014.

The following value-based purchasing performance targets were established for the first performance year of the GF 360º program.

- Notification of PCP assignment within five days
- Percentage of care plans completed for group three members
- Percentage of youth readmitted to a behavioral health facility or an acute care facility with a behavioral health diagnosis
- Percentage of youth who received contacts according to groups one, two and three requirements
- Percentage of youth who stepped down from F1 to CSI utilization
- Percentage of youth assessed with a diagnosis of ADHD who also had an ADHD prescription within 30, 60 and 90 days
- Percentage of youth assessed with a diagnosis of depression who also had an antidepressant prescription within 30, 60 and 90 days
- Percentage of youth assessed with a diagnosis of psychosis who also had an antipsychotic prescription within 30, 60 and 90 days.
- Percentage of youth assessed with a diagnosis of anxiety who also had an anxiolytic prescription within 30, 60 and 90 days.
- Percentage of youth assessed with a behavioral health diagnosis who also had a psychotropic prescription within 30, 60 and 90 days.

Development and Review of the Quality Strategy

There have been three strategic plan assessments or revisions completed for the Georgia Families program – the original in June 2007 and approved by CMS in February 2008; the second, a revision in February 2010; and the third, a revision in November 2011. Both revisions were submitted to CMS for review and approval and all assessments and revisions followed the CMS 2006 Quality Strategy Toolkit for States. This 2015 Quality Strategic Plan follows the outline contained in the 2012 Quality Strategy Toolkit for States.

As previously mentioned, in July of 2011, DCH awarded a contract for a comprehensive assessment and recommended redesign of Georgia's Medicaid and CHIP programs in response to the concerns that the Patient Protection and Affordable Care Act, the national recession and the fast-growing population would expand Medicaid enrollment in Georgia. It was felt that the Medicaid review and redesign would position Georgia to become a leader in innovative ways to provide high quality care in a cost effective manner. Subsequent to the delivery of the comprehensive assessment and recommendations in 2012, DCH engaged several stakeholder groups to obtain feedback while considering Medicaid redesign options. DCH compiled a table of stakeholder group comments and recommendations which covered such areas as: DCH program administration; provider credentialing; co-payments; claims; reimbursement; prior authorizations; benefits and services; care coordination; data collection; electronic medical records; data sharing; monitoring and oversight; provider networks; access to care; and quality

improvement. Some of the comments and recommendations pertinent to the development of this quality strategy include:

- Provide centralized credentialing
- Provide a medical home for members
- Provide additional medication management
- Provide a dental home for all members
- Ensure timely prior authorization (PA) decisions
- Centralize the PA process
- Provide all screenings in compliance with the EPSDT standards
- Align monitoring, performance improvement projects and focused performance measure targets
- Improve management of psychotropic medications
- Provide care coordination services to meet member needs
- Collect data to monitor success
- Provide members and providers access to Medicaid data
- Provide an outside entity to monitor quality

The original quality strategy for the Georgia Families program was developed by the DCH Managed Care and Quality team and reviewed and commented on by seventeen (17) entities through the Georgia public comment process authorized by the Official Code of Georgia (O.C.G.A) Sec. 49-4-142(a). DCH addressed each original comment and amended the original Quality Strategic Plan accordingly. The original identified strategies focused on:

- Promotion of an organization wide commitment to quality of care and service;
- Improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance;
- Promotion of a system of health care delivery that provides coordinated and improved access to comprehensive healthcare, and enhanced provider and client satisfaction; and
- Promotion of acceptable standards of healthcare within managed care programs by monitoring internal/external processes for improvement opportunities

In 2014, DCH and the CMOs participated in quality improvement training offered by CMS and training led by Georgia's contracted external quality review organization (EQRO) that specifically targeted rapid cycle process improvement. DCH also began working on a request for proposals to re-procure the Georgia Families and Georgia Families 360º managed care contractors. The trainings assisted the DCH Performance, Quality and Outcomes (PQO) Unit in designing the quality-related requirements for the managed care contracts implemented following the re-procurement.

In January of 2015, Georgia's EQRO provided a one-half day of training to DCH staff and the CMOs' medical management, quality and leadership staff on strategic planning and rapid cycle performance improvement. With these new tools in hand DCH's PQO unit, in association with the Aging and Special Populations unit, developed this quality strategy for the Georgia Families and Georgia Families 360º programs. During strategy development sessions, the group utilized

the DCH mission, vision and goals as the anchors for the quality strategy and incorporated input from the task forces previously mentioned into the strategy development. DCH solicited input from the DCH Medical Care Advisory Committee and the Georgia Chapter of the American Academy of Pediatrics. The final draft of the quality strategy was posted for public comment.

The DCH mission is to provide Georgians with access to affordable, quality health care through effective planning, purchasing and oversight. DCH's vision is that the agency will be a lean and responsive state agency that promotes the health and prosperity of its citizens through innovative and effective delivery of quality health care programs.

The DCH Key Goals are to:

- Improve the health status of Georgians by promoting healthy lifestyles, preventive care, disease management and disparity elimination.
- Improve access to quality health care at an affordable price.
- Ensure value in health care contracts.
- Move health plans administered by DCH toward being financially solvent to meet the needs of the members.
- Increase effectiveness and efficiency in the delivery of health care programs.
- Ensure DCH has enough workers with the necessary skills and competencies to meet the current and future demand.

This quality strategic plan combined five of the DCH Key Goals into two focus areas: improving the health status of Georgians and smarter spending of each Medicaid dollar. The resulting objectives, strategies and interventions are listed below. Since the implementation of the new Georgia Families and Georgia Families 360º managed care contracts will not occur until SFY 2017, this quality strategy is designed to extend through the end of CY 2020, allowing DCH to review the performance metric reports based on CY 2019 data in 2020. This timeframe will allow for three full years of operation under the new contract that incorporates elements of the quality strategy.

Georgia Families and Georgia Families 360º Goals, Objectives and Strategies

Goal 1 – Improved Health for Medicaid and PeachCare for Kids (CHIP) Members

Objective 1: Improve access to high quality physical health, behavioral health and oral health care for all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

Strategy: Increase and monitor access to health services for members

Interventions:

1. Enroll local education agencies (LEAs) as telemedicine originating site providers to improve access to telemedicine services
2. Credential FFS providers to ensure the highest quality of providers
3. Assure timeliness and geo-access standards are met by the contracted CMOs' provider networks
4. Encourage co-location of physical health and behavioral health providers
5. Request CMS approval of an extension of the P4HB® Demonstration to make family planning services available to women otherwise not eligible for Medicaid services
6. Collaborate with the Non-Emergency Transportation Unit's staff to identify access to care improvement areas.
7. Review Annual Patient Safety Reports to determine CMOs' strategies to resolve members' complaints regarding access and other issues.
8. Review Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results to identify members' experience with care concerns.

Metrics include: Access to Preventive Health Services, Access to PCPs, Annual Dental Visits, Prenatal and Postpartum Care, Patient Safety Reports, CAHPS Surveys

Objective 2: Increase appropriate utilization of physical and behavioral health services by all Medicaid and PeachCare for Kids members so that select performance metrics will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

Strategy: Increase preventive health and follow up care service utilization

Interventions:

1. Implement preventive health visits and screening services for members aged 21 years and older
2. Ensure the Georgia Families (GF) and the Georgia Families 360° (GF360°) Programs increase EPSDT screening ratios to 80%
3. Collaborate with the GF and GF 360° Programs to increase dental preventive services to 60% utilization
4. Ensure the GF and the GF 360° programs achieve child and adolescent immunization rates at or above the HEDIS 90th percentile
5. Implement payment for smoking cessation counseling codes
6. Collaborate with the GF program, the GF 360° program, the GAAAP and the GAAFP to increase providers' compliance with Bright Futures screening components

7. Collaborate with the GF and the GF 360° programs to increase lead screening rates
8. Ensure DCH policies allow members to have medically necessary access to therapy services in the community and school settings

Metrics include: Frequency of Ongoing Prenatal Care, Well Child Visits (15 months, Ages 3 – 6, Adolescent Visits), Plan All Cause Readmissions, ER Visit Rates, CMS 416 Report metrics, Dental Sealants, Childhood Immunization Rates, Lead Screening Rates, Developmental Screening, Colorectal Cancer Screening, Chlamydia Screening, Breast and Cervical Cancer Screening, Utilization Management Reports

Objective 3: Improve care coordination for all Medicaid and PeachCare for Kids members so that health performance metrics relative to chronic conditions will reflect a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

Strategy: Improve care for chronic conditions

Interventions:

1. Ensure effective case and disease management programs are in place for the GF program
2. Ensure GF 360° members with intensive and complex needs received intensive customized care coordination services
3. Increase access to non-traditional services such as CBAY
4. Address overutilization of psychotropic medications using performance metric tracking
5. Ensure CMOs achieve 90% provider compliance with clinical practice guidelines for asthma, diabetes and ADHD
6. Implement performance improvement projects for the FFS population to address that population's rising re-admission rates
7. Collaborate with Georgia's Medicare QIO to implement care guidelines for hypertension and congestive heart failure
8. Ensure improvements in diabetes control through monitoring of HgA1c levels and the effectiveness of the CMOs' diabetes related performance improvement projects
9. Ensure the GF and GF 360° CMOs' practitioners increase their use of rating scales for members newly identified with ADHD
10. Ensure members with behavioral health conditions are able to access and utilize behavioral health services and monitor these conditions through performance metrics
11. Encourage the establishment of patient-centered medical homes, behavioral health homes, and dental homes
12. Provide access to Hepatitis C drugs

Metrics include: Medication Management for people with Asthma, Use of Multiple Concurrent antipsychotics in Children and Adolescents, Follow up After Hospitalization for Mental Illness, Follow up Care for Children Prescribed ADHD Drugs, Controlling High Blood Pressure, Antidepressant Medication Management, Adherence to Antipsychotics for Individuals with Schizophrenia, Comprehensive Diabetes Care

Objective 4: Decrease the statewide LBW rate to 8.6% by December 2019 as reported in June 2020.

Strategy 1: Improve early access to prenatal care and perinatal case management

Interventions:

1. Identify and reduce barriers to early enrollment for Medicaid eligible pregnant women
2. Implement daily enrollment of eligible pregnant women into the GF program to increase early access to prenatal care
3. Identify and reduce barriers to pregnant women accessing their first prenatal care visit within the first forty-two days of enrollment into Medicaid or the GF or GF 360° programs.
4. Collaborate with centering pregnancy providers to ensure their enrollment as Medicaid program providers
5. Implement a perinatal case management (PCM) program per the CMS approved PCM SPA and track progress through CMO reporting

Metrics include: Low Birth Weight Rate, Weeks of Pregnancy at Time of Enrollment, Prenatal Care, and PCM Reports

Strategy 2: Improve access to family planning and interpregnancy care services

Interventions:

1. Ensure, through policy and collaboration with the GF and GF 360° programs, that family planning services are accessible for all members
2. Collaborate with Georgia's Title X provider, the Georgia Legal Services Program and others to increase awareness about the P4HB program
3. Maintain policy and MMIS system enhancements that allow increased access to long acting reversible contraceptives (LARCs) in the immediate postpartum period
4. Obtain CMS approval for the extension of the P4HB program's Interpregnancy Care and Resource Mother Components for women who previously delivered very low birthweight infants
5. Collaborate with the GF program to increase postpartum visit rates

Metrics include: P4HB Reports – quarterly and annual reports, Adhoc LARC utilization reports, Contraceptive utilization metric, Postpartum Visits

Strategy 3: Decrease non-medically necessary early elective inductions and deliveries and increase utilization of 17-P

Interventions:

1. Maintain policy to prevent Medicaid payment for non-medically necessary early elective inductions and Cesarean sections
2. Continue partnership with the Georgia Hospital Association to reduce early elective deliveries statewide.
3. Collaborate with the GF and GF 360º CMOs to increase their members' utilization of 17-P

Metrics include: Early Elective Deliveries Rate, Antenatal Steroid Use

Objective 5: Require CMOs' use of rapid cycle process improvement/plan-do-study-act principles to achieve a relative 10% increase over CY 2014 rates as reported in June of 2020 based on CY 2019 data.

Strategy 1: Review quarterly utilization, prior authorization, case management, disease management, EPSDT, and P4HB reports to ensure rapid cycle process improvement principles are in use across all program areas and improving care strategies.

Interventions:

1. PQO Unit staff to utilize plan-do-study-act methods to develop and revise report specifications for the CMOs' reporting of utilization, prior authorization, case management, disease management, EPSDT and P4HB quarterly metrics
2. PQO Unit staff to provide feedback to the GF and GF 360° programs' CMOs regarding their quarterly reports
3. PQO Unit staff will engage in face-to-face discussions with the CMOs' staff regarding report follow up during in person Quality Medical Management meetings and CMO specific meetings.

Strategy 2: Continue annual tracking of performance measure rates and comparisons with HEDIS percentiles

Interventions:

1. Collaborate on a weekly basis throughout the calendar year with the DCH MMIS vendor to generate the annual performance measure rates for the GF, GF 360°, FFS and All populations
2. Collaborate with the GF and GF 360° CMOs to generate the CMO specific performance measure rates
3. Participate with the HP designated medical record review vendor to ensure appropriate chart chase logic, medical record retrieval and abstraction of data for the annual hybrid rates
4. Collaborate with the EQRO vendor and HEDIS-certified auditor to ensure annual performance measure rates are validated as accurate and reportable
5. Ensure submission of performance measure rates to CMS through the CMS secure reporting portal

Strategy 3: Participate with CMS in the implementation of a new performance metric monitoring contraceptive utilization.

Strategy 4: Continue annual CAHPS adult and child surveys and the annual CAHPS survey of the PeachCare for Kids (CHIP) members

Interventions:

1. Maintain a contract with a HEDIS-certified CAHPS surveyor
2. Coordinate with the Decision Support Team to obtain the eligibility file for submission to the HEDIS-certified CAHPS surveyor
3. Collaborate with the National CAHPS Data Bank for the submission of the CAHPS survey data for benchmarking purposes

Metrics include: All performance metrics monitored including HEDIS, AHRQ, CMS Adult and Child Core Sets and CAHPS Surveys.

Goal 2 - Smarter Utilization of each Medicaid dollar

Objective 1: Members will be steered to appropriate utilization of services by their PCPs and the CMOs so that improvements will be documented in ER visit rates, utilization management rates and other metrics for the adult and the child populations compared with the CY 2014 rates as reported in June of 2020 based on CY 2019 data.

Strategy 1: Reduce ER visits for ambulatory sensitive conditions

Interventions:

1. The GF and GF 360° CMOs are to ensure each member is assigned to a medical home
2. Educate FFS providers and members about the availability of preventive health services and primary care access for Medicaid adult members
3. Ensure that DCH, the GF and GF 360° CMOs educate their members on the appropriate use of primary care services through the effective implementation of the CMS Living Well Initiative's materials with assistance from the DCH Communications Unit.
4. Maintain an Avoidable ER Use performance improvement project for the GF program
5. Collaborate with the GF and GF 360° CMOs to ensure incentives are in place to encourage the establishment of patient centered medical homes

Metrics include: Ambulatory Care, Avoidable ER Use PIP reports, Utilization Management Reports

Strategy 2: Increase access to urgent care services

Intervention:

1. CMOs to expand the enrollment of urgent care centers in the GF and GF 360° provider networks

Strategy 3: Medical necessity determinations are made using evidence-based criteria

Interventions:

1. Ensure the GF, GF 360°, and the FFS programs have evidence-based criteria in place to determine medical necessity
2. Ensure inter-rater reliability is established for each program
3. Ensure a peer-review process is in place to assist with medical necessity determinations

Metrics include: Prior Authorization Reports

Objective 2: In collaboration with the Georgia Hospital Association's Care Coordination Council, reduce the all cause readmission rate for all Medicaid populations to 9% by the end of CY 2019 as reported in June of 2020.

Strategy 1: Improve the transition of care process

Interventions:

1. Develop a transition of care process for members transitioning from the inpatient setting to other care settings

2. Engage with the Georgia Hospital Association to share the identified process with associated hospitals
3. Engage with Georgia's Medicare Quality Improvement Organization to identify similarities between the Medicaid developed process and the current Medicare transition of care process
4. Engage with the DCH MITA team to create an electronic format through which transition of care information will be transmitted between the inpatient setting and DCH
5. DCH to collaborate with the primary care providers delivering preventive health services to the fee for service population regarding appropriate discharge planning

Metrics include: Transition of care process in place no later than the end of SFY 17, Care Transitions metric

Strategy 2: Ensure effective concurrent review and discharge-planning processes are in place for CMO and FFS members

Interventions:

1. GF and GF 360° CMOs to ensure the discharge planning process from inpatient facilities includes coordination and facilitation of post-discharge appointments and medication reconciliation
2. DCH to collaborate with the primary care providers for the fee for service population to ensure discharge planning for FFS members includes follow up visits and medication reconciliation

Metrics include: Plan All Cause Readmissions metrics

Objective 3: Continue payment denials for identified medically induced negative outcomes and measure effectiveness through claims auditing.

Strategy 1: Ensure hospitals do not receive payments for Hospital Acquired Conditions

Intervention:

1. Implement system edits to deny payments for specified diagnoses that indicate hospital acquired conditions

Metrics include: Hospital-acquired Conditions reports

Strategy 2: Ensure hospitals are not reimbursed for non-medically necessary early elective deliveries

Intervention:

1. Implement policy and system edits to deny payments for early elective inductions and Cesarean sections

Metrics include: Adhoc EED reimbursement reports

Objective 4: Improve access to health care information through collaboration with the Georgia Health Information Technology Extension Center and the Georgia Health Information Network (GaHIN) until 90% of all Georgia's providers are connected to an HIE and to the GaHIN

Strategy 1: Increase provider's use of technology

Interventions:

1. Encourage providers' use of electronic medical records

2. Collaborate with the GaHIN and the GA HITEC to support their activities to educate providers about electronic health records

Metrics include: Counts of Medicaid enrolled providers utilizing EHRs. Counts of Medicaid enrolled providers connected to the GaHIN.

Strategy 2: Encourage members' access to personal health information available through their providers' electronic health records

Section II: Assessment

DCH routinely assesses the quality and appropriateness of care and services delivered to enrollees. CMO contract compliance is monitored continuously and in accordance with federal regulations, the CMOs are subject to annual independent reviews through the External Quality Review process.

Quality and Appropriateness of Care

Each CMO's contract includes a requirement for them to maintain accreditation with their accrediting body and the National Committee for Quality Assurance (NCQA) accredits all three CMOs. As of November 2015, all three CMOs had achieved the NCQA commendable accreditation status. As a requirement for accreditation, each CMO annually submits Healthcare Effectiveness Data and Information Set (HEDIS®) performance measure rates at the specified time to NCQA. Each CMO also submits a set of performance measure rates, as specified by DCH, to the External Quality Review Organization (EQRO) for validation as required by the Code of Federal Regulations (CFR). These rates, trended over time by DCH, identify areas of improvement in health status as well as areas in need of improvement.

In September 2011, HHS Secretary Kathleen Sebelius recognized Georgia in her 2011 Annual Report on the Quality of Care for Children in Medicaid and CHIP as being the state reporting the largest number of CHIPRA Initial Core Set measures for FFY 2010. Georgia reported 18 of the 24 the CHIPRA Initial Core Set measures. The report highlighted Georgia's proactive role in designing its data systems to support quality measurement at the State level. In alignment with CMS's internal goals for quality measurement and improvement, Georgia reported on 20 CHIPRA Initial CORE Set measures for both the CHIP and Medicaid populations in 2012. Georgia will report 54 performance measure rates, included in the CMS Adult and Child Core Sets and using CY 2014 data, to CMS during FY 16 once the new CMS MACPro reporting system is available.

Included in each annual EQRO Technical Report submitted to CMS for the GF and GF 360º programs are details regarding the performance measure rates utilized to assess the quality of care rendered to members. The quality domain of care relates to a CMO's structural and operational characteristics and its ability to increase desired health outcomes for GF and GF 360º members (through the provision of health care services). DCH uses performance measure rates and performance improvement projects (PIPs) to assess care delivered to members by a CMO in areas such as preventive screening and well-care visits, management of chronic disease, and appropriate treatment for acute conditions, all of which are likely to improve health outcomes. In addition, DCH monitors aspects of a CMO's operational structures that promote the delivery of quality care, such as the adoption of practice guidelines, a quality assessment and performance improvement program, and health information systems.

Methods to identify race, ethnicity, and primary language spoken of each Medicaid enrollee

Member data on race, ethnicity and primary language is captured at the time the member enrolls with the Medicaid or PeachCare for Kids® programs. DCH sends the member diversity data electronically to each CMO at least monthly via the 834 eligibility file and daily for members

enrolled in specific eligibility categories. It is important to note, however, that the state does not make the report of this data by members a requirement for enrollment. As a result, demographic information about a significant percentage of the Medicaid and PeachCare for Kids members is not available in our files.

According to the DCH contract, the state is to provide the CMOs with its methodology for identifying the prevalent non-English languages spoken by members. The CMOs are required to notify members of the availability of oral translation/interpretation services and to provide the services as needed. This information, incorporated into the CMOs' written Cultural Competency Plans, describes how they will ensure services rendered to all members are provided in a culturally sensitive manner.

Initiatives to Reduce Disparities

While the 834 eligibility file may not contain a member's demographic information, the CMOs are charged via the specifications for their Quality Assessment and Performance Improvement (QAPI) plan to identify their populations served, including an a race and ethnicity, gender, rural and urban characteristics. Each CMO must also describe the population specific outreach activities implemented during the preceding calendar year to assist in achieving the overall QAPI goals and objectives.

DCH has long been concerned about the rate of low birth weight births in the state. In 2010, a strategic workplan was developed to assist the state in reducing its rising low birthweight rate. Studies show the rate of low birthweight (LBW) among African American mothers continues to be twice that of white women. While several of the strategies were abandoned due to lack of resources to carry them out, many system level interventions were implemented, in partnership with other community agencies, to reduce the state's LBW rate. Despite these efforts, the state's rate has continued to climb. Interventions implemented include:

- The expansion of Centering Pregnancy sites across the state through the efforts of the United Way in partnership with Grady Hospital's Strong Start Grant. Ickovics and others reported, in a 2007 Journal of Obstetrics and Gynecology article, the results of their research on group prenatal care. Eighty percent of their study participants were African American. The women assigned to group care were significantly less likely to have preterm births compared with those in standard care and the effects were strengthened for African American women;
- DCH's partnership with the Georgia Hospital Association's Hospital Engagement Network (HEN) to reduce all early elective deliveries;
- DCH's implementation of a policy to deny reimbursement for non-medically necessary early elective deliveries prior to 39 weeks gestation;
- DCH's partnership with the Georgia Department of Public Health to implement the Perinatal Case Management program as a mechanism to identify, as early as possible, risk factors for poor birth outcomes in women seeking Medicaid presumptive eligibility for pregnancy. Reproductive life planning is also discussed with these women and their assessments and reproductive life plans are shared with their selected CMOs and their OB practitioners;

- DCH's ongoing 1115 Demonstration, Planning for Healthy Babies, that provides access to family planning services for the program's participants along with interpregnancy care services for women who previously delivered a very low birth weight (VLBW) infant so as to prevent a subsequent VLBW birth;
- DCH's implementation of provider reimbursement for immediate postpartum long acting reversible contraceptive (LARC) insertions and the upcoming hospital reimbursement for the purchase of LARCs; and
- DCH's receipt of CMS approval to allow FQHCs and RHCs to purchase and receive reimbursement for LARCs inserted by practitioners within those facilities. Appropriately timed and spaced births reduce the low birth weight (LBW) rate.

The majority of women enrolled in the P4HB program are African American. Initial outreach for this program targeted areas within the state with the highest LBW rates. To reduce the prevalence of LBW babies in the African American community, DCH and the CMOs will revisit the 2010 strategic work plan previously mentioned and implement strategies to halt the increases in the state's LBW rates

African Americans also have a higher incidence of chronic conditions such as diabetes and hypertension. The CMOs case and disease management programs target members identified as high risk to encourage improved health outcomes through a combination of assessment, education, monitoring, measurable outcomes and care coordination.

National Performance Measures

Although CMS has not identified a list of required national performance measures, Georgia continues to report the voluntary adult and child core set measures to CMS on an annual basis. State targets have been set for many of these measures based on HEDIS® audit means and percentiles for performance measure rates. A list of measures and targets to be reported using CY 2015 data is included in Appendix A of this plan

Monitoring and Compliance

On an ongoing basis, several DCH units provide oversight of the GF and the GF 360º programs. The Performance, Quality and Outcomes (PQO) unit monitors the CMOs' compliance relative to coordination and continuity of care; coverage and authorization of services; member grievances; emergency and post-stabilization services; practice guidelines; quality assessment and performance improvement; and health information systems. Unit staff have responsibility for monitoring the GF and GF 360º CMOs' performance across the following areas:

- The EPSDT benefit
- Care coordination activities including case and disease management programs
- Practitioners' compliance with clinical practice guidelines
- Prior authorizations
- Performance measurements
- Performance improvement projects
- Patient safety reports relative to member grievances

- Perinatal case management
- The Planning for Healthy Babies 1115 Demonstration and other non-demonstration family planning services.

The Assistant Chief for Performance, Quality and Outcomes, a physician, leads this unit and is a direct report to the Medicaid Chief. The Contracts Compliance unit monitors the CMOs' compliance relative to the availability of services including compliance with geo-access standards; furnishing of services; cultural competence; selection, credentialing and re-credentialing of providers; relationships with providers and delegation of administrative responsibilities; member rights and protections; the grievance and appeals process; and state administrative law hearings. The Associate Chief for Medicaid Operations, an attorney, leads this unit and is a direct report to the Medicaid Director. The Member Services unit monitors the CMOs' member information and member enrollment and disenrollment requirements and limitations. The Assistant Chief for Member Services is a direct report to the Medicaid Director. The Medical Policy and Provider Services unit monitors the operations of the Georgia Families 360º program and the Assistant Chief for Medical Policy oversees the work of this unit and is a direct report to the Associate Chief for Medicaid Operations. The Medicaid Director is a direct report to the DCH Commissioner who reports directly to the Governor.

DCH hosts collaborative meetings with the CMOs' quality and medical management staff members. These bi-monthly meetings (one is a teleconference and the other is an in-person meeting) cover a wide range of quality improvement and reporting topics. Monthly CMO Operations meetings, conducted by the Assistant Chief for Medicaid Operations, often address the operational components of the quality improvement issues previously discussed with the CMOs' quality and medical management staff members. DCH and the CMOs also participate in monthly calls with the Georgia Chapters of the American Academy of Pediatrics (GAAAP) and the American Academy of Family Physicians (GAAFP). Each quarter, the Chapters devote one meeting to Medicaid and CHIP quality improvement topics relative to children.

The assessment of Georgia's progress towards meeting the objectives outlined in this update is necessary for the continuous, prospective and retrospective monitoring of quality of care and improved outcomes. DCH utilizes several methods to assess whether the objectives were met. These methods include:

- Identifying, collecting and assessing relevant data.
- Reviewing and analyzing periodic reports. Reports and deliverables are used to monitor and evaluate compliance and performance. DCH reviews these reports and provides feedback as appropriate.
- Reviewing and analyzing program-specific Performance Measures. The CMOs annually submit performance measurement reports demonstrating each plan's performance over the prior year. These metrics evaluate the CMOs' compliance in meeting contractual performance standards for specific health care services.

Quarterly and annual reports, submitted by each CMO, assist with the identification of the quality and appropriateness of care best practices and concerns. Quarterly Disease Management reports provide an assessment of the management of members, diagnosed with asthma and

diabetes, who voluntarily enrolled in the program. Quarterly Case Management reports assess the effectiveness of case management services for actively enrolled members who voluntarily enrolled in a case management program. These programs target members who are pregnant; have high emergency room usage; have physical health and behavioral health concerns; or multiple co-morbidities. The quarterly Prior Authorization report captures data for specific service categories (i.e. Dental, Pharmacy, Therapies, Medical Inpatient and Outpatient, etc.) to identify trends with the approval and denial of medically necessary services. The quarterly Utilization Claims Management report assesses the over and under-utilization of high dollar services such as ER visits and NICU admissions.

Presented below in **Table 1** is a list of the CMO required reports and the specific data elements captured in those reports.

Table 1: CMO Quality Reports

Name of Report	Frequency	Data Captured
OB Case Management – OB Initial Assessment Report	Monthly	The OB Perinatal Case Management Report captures the Perinatal Initial Assessment's completion activity, by the Georgia local health departments, for women deemed eligible for presumptive pregnant woman Medicaid. The local health departments send the assessments to the woman's CMO case management team and/or the woman's OB provider once the woman selects them.
P4HB Report	Quarterly	Captures all activity of the P4HB Demonstration for the reporting quarter (i.e. eligibility, enrollment, call volumes, outreach activities, contraception utilization etc.) for all three components of the waiver (FP, IPC & CM).
GF 360º Care Coordination Report	Quarterly	Monitors the effectiveness of the care coordination program by looking at how many members had certain services (i.e. ER visits, inpatient readmissions, PCP visits, transition planning, etc.)
Case Management Report	Quarterly	Three (3) CMO Case Management Program areas submit reports: 1) The OB Case Management report assesses the effectiveness of the High Risk OB Programs (HROB) designed for identified high-risk expectant mothers. These programs should reduce the risk of preterm deliveries that increase the likelihood of low birth weight (LBW) or very low birth weight (VLBW) births. 2) The General Case Management report assesses the effectiveness of the CMOs' complex case management programs for members with co-morbidities, high ER or high inpatient utilization. 3) The Behavioral Health Case Management report assesses the effectiveness of care coordination for members with behavioral health concerns.
Disease Management Report	Quarterly	Two Disease Management programs submit reports: Asthma and Diabetes. The reports assess the effectiveness of the CMOs' interventions to assist members with self-management of their diseases.
Prior Authorization Report	Quarterly	The Prior Authorization reports capture data for GF and GF 360º specific service categories (i.e. Dental, Pharmacy, Therapies, Medical

		Inpatient and Outpatient services, etc.) that identifies trends related to the approval and denial of medically necessary services.
Utilization Claims Management Report	Quarterly	Utilization Claim Management report assesses the over and under-utilization of high dollar services such as ER utilization and NICU admissions.
CMS-416 Reports	Quarterly	DCH utilizes this report to track the GF and GF 360º CMOs' EPSDT Performance on a quarterly basis.
EPSDT Informing Activity Report	Quarterly	The EPSDT Informing Activity report demonstrates whether the GF and GF 360º CMOs comply with Federal and Contractual EPSDT informing activity requirements.
EPSDT Initial Screening Report	Quarterly	The EPSDT Initial Screening report demonstrates whether the GF and GF 360º CMOs comply with Federal and Contractual EPSDT initial visit requirements.
EPSDT Medical Record Review Report	Quarterly	The EPSDT Medical Record Review report assesses whether the GF and GF 360º CMOs providers are following the AAP's Bright Futures guidance when conducting EPSDT preventive health visits.
P4HB Report	Annually	The GF CMOs' P4HB Annual Reports are a summation of activities the CMOs engaged in throughout the year to increase access to and utilization of family planning services. The report also describes the case management activities performed to address the needs of mothers enrolled in the P4HB program's IPC and RM components who previously delivered very low birth weight infants.
EPSDT Program Description (Plan)	Annually	The EPSDT Program Description provides a detailed description of the GF and GF 360º CMOs' delivery of the EPSDT benefit and services.
EPSDT Program Evaluation	Annually	The EPSDT Program Evaluation Report assesses the GF and the GF 360º CMOs' delivery of services and performance under the EPSDT benefit.
Quality Assessment and Performance Improvement (QAPI) Program	Annually	The QAPI report assess the effectiveness of the GF and GF 360º CMOs' QAPI Programs. The reports include a detailed description of all efforts implemented to drive improvements in the quality and appropriateness of care and the effectiveness of those efforts.
Patient Safety Plan and Report	Annually	The GF and GF 360º CMOs' Patient Safety Plans and Reports capture members' complaints regarding the care delivery process.

Clinical Practice Guidelines (CPGs) Audit Reports	Annually	Providers 'utilization of the CPGs for Asthma, Diabetes and ADHD is currently audited annually and reported to DCH by the GF and GF 360º CMOs. The reports evaluate the providers' compliance with the standards of care identified in the CPGs.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

On an annual basis, the CMOs contract with an NCQA certified vendor to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Surveys for their enrolled child and adult populations to assess the members' perspectives about the quality and appropriateness of care they received during the prior year. The data obtained from the surveys informs improvement efforts for those areas that fail to meet the target scores. The CAHPS Adult and the CAHPS Child Surveys results provide information inclusive of that pertaining to members with special health care needs - those children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who require health and related services of a type or amount beyond that required by children generally. In 2014, DataStat, Inc., DCH's NCQA certified CAHPS survey vendor, administered the CAHPS 5.0H Adult and Child Medicaid Health Plan Surveys for the Medicaid Adult, Child and the PeachCare for Kids populations. The surveys consists of the following four global rating measures and five composite measures. In addition, the Adult CAHPS Survey includes three (3) performance measures that DCH tracks: Flu Shot for Adults Ages 18-64; Medical Assistance with Smoking Cessation and; Aspirin Use and Discussion. To evaluate the overall performance of the Georgia Medicaid and PeachCare for Kids programs relative to the CAHPS surveys, the state compares its performance to the National CAHPS Database (NCDB) benchmarks.

CAHPS Global Rating Measures:

- Rating of Health Plan
- Rating of All Health Care
- Rating of Personal Doctor
- Rating of Specialist Seen Most Often

CAHPS Composite Measures:

- Getting Needed Care
- Getting Care Quickly
- How Well Doctors Communicate
- Customer Service
- Shared Decision Making

Value Based Purchasing

Under the new CMO contracts, the GF and the GF 360º CMOs will be required to improve their performance rates to achieve specific performance targets. The DCH defined at-risk performance targets for the new GF and the GF 360º CMOs selected through the re-procurement process are included in **Table 2** below.

Table 2: Value Based Purchasing Performance Measures and Targets

GF 360º Specific Value Based Purchasing Performance Measures and Targets

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2014 Validation Period: SFY 2015 Published: September 2015		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
1	**Care Management** – The percentage of members who received appropriate and timely contacts by their Care Coordinator according to intensity level (e.g. complex care--one face to face per month).			**92% for Complex Care** **92% for Intensive Care** **95% Care Management**		**95% for Complex Care** **95% for Intensive Care** **97% Care Management**		**97% for Complex Care** **97% for Intensive Care** **99% Care Management**	
2	**Operations –** percent of members whose Prior Authorizations for PCP, Dental and Behavioral Health are completed within 5 days of receipt.			**85% completed in 5 days or less**		**87% completed in 5 days or less**		**90% completed in 5 days or less**	
3	**Behavioral Health –** The percent of members readmitted to a behavioral health facility (CSU, PRTF or Inpatient Acute Care Facility) within 30 days of discharge.			**Fewer than 8%**		**Fewer than 6%**		**Fewer than 5%**	
4	**Behavioral Health** – The percentage of enrolled members who experienced reduced behavioral health acute care stays AND increased functional status as determined according to agreed-upon and validated instrument.			**Establish baseline**		**Eligibility for incentive requires that** **1. 75% of members who use BH services have completed functional status determination**		**Eligibility for incentive requires that** **1. 100% of members who use BH services have completed functional status determination**	

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2014 Validation Period: SFY 2015 Published: September 2015		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
						2. reduction in acute BH stays must be a minimum of 50% fewer Average Bed Days		2. reduction in acute BH stays must be a minimum of 70% fewer Average Bed Days	

Value Based Purchasing Metrics and Targets for the GF and the GF 360º Programs

Performance Measures		Baseline Measurement Period		Proposed Targets for Measurement Period: Year 1		Proposed Targets for Measurement Period: Year 2		Proposed Targets for Measurement Period: Year 3	
		Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
1	**Preventive Care for Children: Well-child visits in the First 15 Months of Life – 6 or more visits** – The percentage of members who turned 15 months old during the measurement year and who had six or more well-child visits with a PCP during their first 15 months of life.		68.46		HEDIS 2016 National 50th percentile		HEDIS 2017 National 75th percentile		HEDIS 2018 National 75th percentile
2	**Preventive Care for Children: Childhood Immunization Status – Combo 10** – The percentage of children two years of age who had 4 DTaP; 3 IPV; 1 MMR; 3 HiB; 3 HepB; 1 VZV; 4 PCV; 1 HepA; 2 – 3 RV; and 2 Influenza vaccines by their second birthday.		40.28		HEDIS 2016 National 75th percentile		HEDIS 2017 National 75th percentile		HEDIS 2018 National 90th percentile
3	**Developmental Screening: Developmental Screening in the first three years of life** – The percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12		42.82		70%		Absolute 10% improvement over CY 2017 rate		Absolute 10% improvement over CY 2018 rate

Performance Measures		Baseline Measurement Period Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Proposed Targets for Measurement Period: Year 1 Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Proposed Targets for Measurement Period: Year 2 Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Proposed Targets for Measurement Period: Year 3 Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	months preceding their first, second, or third birthday.								
4	**Preventive Care for Adolescents: Adolescents Well-Care Visits** – The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.		**52.55**		**HEDIS 2016 National 50th percentile**		**HEDIS 2017 National 75th percentile**		**HEDIS 2018 National 75th percentile**
5	**Preventive Dental Services: Total Eligibles Receiving Preventive Dental Services** – The percentage of individuals ages 1-20 who are enrolled for at least 90 continuous days, are eligible for Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, and who received at least one preventive dental service during the reporting period.	**52.65**		**60%**		**10% relative improvement above CY 2017 rate**		**10% relative improvement above CY 2018 rate**	
6	**Obesity Prevention: Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents – BMI Percentile – Total** – The percentage of members 3-17 years of age who had an outpatient visit with a PCP or an OB/GYN and who had evidence of the following during the measurement year: BMI percentile documentation, Counseling for nutrition, and Counseling for physical activity.		**BMI %tile - 51.16; Nutrition Counseling – 61.11 Physical Activity; Counseling – 54.63**		**HEDIS 2016 National 75th percentile**		**HEDIS 2017 National 75th percentile**		**HEDIS 2018 National 90th percentile**
7	**Behavioral Health: Follow–up Care for Children Prescribed ADHD Medication – Initiation Phase** – The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 10-month period, one of which was within 30 days of when the first ADHD medication was dispensed.	**Initiation Phase – 43.12; Continuation Phase – 59.22**		**HEDIS 2016 National 75th percentile**		**HEDIS 2017 National 75th percentile**		**HEDIS 2018 National 90th percentile**	

Performance Measures		Baseline Measurement Period Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Proposed Targets for Measurement Period: Year 1 Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Proposed Targets for Measurement Period: Year 2 Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Proposed Targets for Measurement Period: Year 3 Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
8	**Pregnancy-related Care: Prenatal and Postpartum Care – Postpartum Care** – The percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following: *Postpartum Care* - The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.		**63.24**		**HEDIS 2016 National 75th percentile**		**HEDIS 2017 National 90th percentile**		**HEDIS 2018 National 90th percentile**
9	**Birth Outcomes: Rate of Infants with Low Birth Weight** – The percentage of live births that weighed less than 2,500 grams during the reporting period.	**8.32**		**<= National Vital Statistics LBW rate published Dec of 2016**		**<= National Vital Statistics LBW rate published Dec of 2017**		**<= National Vital Statistics LBW rate published Dec or 2018**	
10	**Diabetes: Comprehensive Diabetes Care (18-75 years old)** –The percentage of members 18-75 years of age with diabetes (type 1 and type 2) who had each of the following: Hemoglobin A1c (HbA1c) testing; HbA1c poor control (>9.0%); HbA1c control (<8.0%); HbA1c control (<7.0%) for a selected population; Eye exam (retinal) performed; Medical attention for nephropathy; and BP control (<140/90 Hg).		**HbA1c testing – 80.5; HbA1c >9 – 52.47; HbA1c <8 – 39.64; HbA1c <7 – 30.08; Eye exam – 57.81; Nephropathy – 74.51; BP control – 56.91**		**HEDIS 2016 National 75th percentile for HbA1c testing; 50th percentile for all other rates**		**HEDIS 2017 National 90th percentile for HbA1c testing; 50th percentile for > 9.0 and 75th percentile for all other rates**		**HEDIS 2018 National 90th percentile for HbA1c testing; 25th percentile for >9.0 and 75th percentile for all other rates**
11	**Cardiovascular Conditions: Controlling High Blood Pressure (18-85)** – The percentage of members 18-85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90) during the measurement year. Use the Hybrid Method for this measure.		**48.36**		**HEDIS 2016 National 50th percentile**		**HEDIS 2017 National 75th percentile**		**HEDIS 2018 National 75th percentile**
12	**Respiratory Conditions: Medication Management for People with Asthma –** The percentage of members 5-64 years of age during the measurement year who were identified as having persistent asthma	**50% compliant - 5 – 11yo – 49.08;**		**HEDIS 2016 National 75th percentile**		**HEDIS 2017 National 75th percentile**		**HEDIS 2018 National 90th percentile**	

Performance Measures		Baseline Measurement Period Calendar Year: 2013 Validation Period: SFY 2014 Published: September 2014		Proposed Targets for Measurement Period: Year 1 Calendar Year: 2017 Validation Period: CY 2018 Published: 10/2018		Proposed Targets for Measurement Period: Year 2 Calendar Year: 2018 Validation Period: CY 2019 Published: 10/2019		Proposed Targets for Measurement Period: Year 3 Calendar Year: 2019 Validation Period: CY 2020 Published: 10/2020	
		Admin	Hybrid	Admin	Hybrid	Admin	Hybrid	Admin	Hybrid
	and were dispensed appropriate medications that they remained on during the treatment period. Two rates are reported: 1) The percentage of members who remained on an asthma controller medication for at least 50% of their treatment period; 2) The percentage of members who remained on an asthma controller medication for at least 75% of their treatment period.	**50% compliant- 12 – 18 yo – 46.26** **75% compliant - 5 – 11yo – 22.88; 75% compliant - 12 – 18 yo – 22.18**							
13	**Experience with Care: CAHPS 5.0H Child Version – Shared Decision Making** – This measure provides information on parents' experience with their child's Medicaid organization. A composite score is calculated for the Shared Decision Making domain of member experience and responses of "Yes" and "A lot" are considered achievements for the Shared Decision Making composite.	**Adult – 53.7% Child – 57.7%**		**Absolute 10% above baseline**		**Relative 10% above CY 2017 rate**		**Relative 10% above CY 2018 rate**	
14.	**Increase in the number of Patient Centered Medical Homes in the Contractor's Network –** The percent increase of Providers enrolled in the Contractor's network that receive NCQA recognition as a Patient Centered Medical Home.	**Establish Baseline**		**Absolute 15% above baseline**		**Relative 15% above CY 2017 total**		**Relative 15% above CY 2018 total**	

Performance Improvement Projects
Each CMO must conduct and report to DCH the results of its DCH specified Performance Improvement Projects (PIPs) designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services. DCH expects these PIPs to have a favorable effect on health outcomes and member satisfaction.

As of January 2016, each GF CMO will conduct eight (8) PIPs. The GF 360º program will conduct three (3) PIPs. All CMOs will use the rapid cycle PIP methodology and follow the guidance provided in the PIP companion guide prepared by the DCH contracted EQRO. The broad topic areas for these PIPs include Member Satisfaction, Provider Satisfaction, Bright Futures Periodicity Schedule, Avoidable ER Use, Appropriate Use of ADHD Medications, Diabetes Care, Postpartum Care and Annual Dental Visit.

External Quality Review (EQR)

Because of the release of a Request for Proposals (RFP) for external quality review services, Health Services Advisory Group was awarded the external quality review organization (EQRO) contract for the state of Georgia in 2008 in compliance with 42 CFR 438.204 . HSAG consistently performs the three required external quality review (EQR) activities as outlined in the Balanced Budget Act (BBA): validation of CMO performance improvement projects; validation of CMO performance measures and; conduct a review within a 3-year period, to determine the CMOs' compliance with standards established by the State to comply with the requirements of 42 CFR 438.204(g).

In addition to the three mandatory EQR activities, HSAG performs optional activities for the state of Georgia. These optional activities include the development and annual maintenance of an auto-assignment algorithm, as specified by DCH, to award members to the GF CMO with the highest quality and cost score and annual validation of DCH generated statewide performance measure rates for the combined managed care and fee for service populations (the ALL rates). DCH reports the ALL population rates to CMS. HSAG conducted an encounter data validation project for Georgia in FY 2010.

DCH plans to re-procure EQR services during the SFY 2016 with scheduled implementation of the new EQR contract during FY 2017.

Section III: State Standards

Access Standards

The State's contract with the CMOs requires them to comply with all applicable federal and state laws, rules and regulations including but not limited to all access to care standards in Title 42 CFR Chapter IV, Subchapter C and Title 45 CFR 95, General Grants Administration Requirements. The CMO contracts require each CMO to establish and maintain a network of appropriate providers that is sufficient to provide adequate access to all services covered for the enrolled population in accordance with section 1932(b)(7) of the Social Security Act (as enacted by section 4704(a) of the BBA of 1997). DCH requires the CMOs to submit provider network adequacy and capacity reports. These reports are reviewed to ensure the CMOs offer an appropriate range of preventive, primary care and specialty services that are adequate for the anticipated number of members for the service area and that its network of providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of members in the service area. A list of the geographic access requirements for the CMOs' networks is shown in **Figure 1** below. The identified goals, objectives and strategies of this quality strategic plan also reference the geographic and timely access to providers.

Figure 1

Provider Type	Urban	Rural
PCPs*	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Pediatricians	Two (2) within eight (8)	Two (2) within fifteen (15)
Obstetric Providers	Two (2) within thirty (30) minutes or (30) miles	Two (2) within forty-five (45) minutes or forty-five (45) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

Provider Type	Urban	Rural
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	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 (3) minutes or thirty (30) miles
Therapy: (Physical Therapists, Occupational Therapists and Speech Therapists)	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Vision Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles

Direct Access to Women's Health Specialist

In compliance with 42 CFR 438.206(b)(2) and to promote improved health care outcomes for enrollees, the state requires the CMOs to provide female members with direct access to women's health specialists for covered care within the network. This is in addition to the member's designated source for primary care if that source is not a women's health specialist. Referrals are not needed for female members to access a women's health specialist within the networks for necessary routine and preventive health covered care including family planning services.

Each CMO is required to submit monthly geographic access reports to ensure its network is adequately staffed with women's health specialists. They must also submit monthly PCP Assignment reports that identify all providers (including women's health specialists) that have been selected by members as their PCPs. DCH monitors this requirement by reviewing, tracking and trending the reports submitted by the CMOs.

Second Opinions

The State requires each CMO to provide and be responsible for payment of a second medical opinion when there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition. Requests for a second medical opinion may be made by a member, a member's appointed representative or any member of the health care team. The CMOs must have a procedure for enrollees to obtain a second medical opinion from a qualified health care professional within the network or arrange for the enrollee to obtain a second medical opinion outside of the network. Each CMO is required to clearly state its procedure for obtaining a second medical opinion in the member handbook. Additionally, the CMO's second opinion procedure is required to be in compliance with section 42 CFR 438.206(3) (b). DCH monitors compliance with this requirement through review of the CMOs' policies and procedures, as well as monitoring complaints regarding coverage of second opinions.

Out of Network

In compliance with 42 CFR 438.206(b)(4) the state requires that if a CMO is unable to provide a member with medically necessary services covered under the contract, the CMO must adequately and timely cover these services outside of the network for as long as the CMO is unable to provide the services. When in-network providers do not furnish the services the member needs because of moral or religious objections, the CMO must furnish these services outside of the network also. The CMO is required to coordinate with the out-of-network providers regarding payment and must ensure that the cost to the member is no greater than it would be if the covered services were furnished within the network.

In addition, the CMOs are responsible for covering care for new enrollees using an out-of-network provider for chronic conditions or an active/ongoing course of treatment. In this circumstance, CMO coverage must continue for up to 30 days while transitioning the member's care to an in-network provider. DCH monitors compliance with out-of-network coverage for unavailable medically necessary services through review of the CMOs' policies and procedures, as well as monitoring complaints regarding accessibility of providers

Credentialing

At a minimum, the CMOs' providers must be credentialed as Medicaid providers in Georgia prior to enrolling as a CMO provider. Beginning in August 2015, DCH implemented the Centralized Credentials Verification Organization that eliminates the need for each CMO to credential their provider network. Beginning in January 2016, all fee for service Medicaid providers will also undergo the credentials verification process by the Centralized Credentials Verification Organization. In addition and due to the specific and sensitive needs of the GF 360º population, including significant behavioral health needs, DCH requires that the GF 360º CMO make certain provider network provisions for Georgia Families 360º members. These provisions include ensuring members have access to:

- Primary care providers and specialist providers who are trained and experienced in trauma-informed care, as well as in treating individuals with special needs.
- Providers who have knowledge and experience in identifying child abuse and neglect.
- Providers who render Core Services, non-specialty community mental health and addictive disease services provided to children and youth meeting the Department of Behavioral Health and Developmental Disabilities (DBHDD) classification and eligibility determination requirements
- Providers who render Intensive Family Intervention (IFI) -- a service which utilizes a team approach and is provided primarily to the youth in his/her living arrangement and within the family system to defuse current behavioral health crisis, ensure linkage to needed community services and resources, and improve the youth's ability to self-recognize and manage behavioral health issues.

Timely Access to Care and Services

Through its contract with the CMOs, DCH requires each CMO to monitor its network provider timeliness and take corrective action if there are compliance issues. CMO's must ensure their providers meet the State's timely access to care and services for appointment wait times, taking

into account the urgency of the need for services. **Figure 2** describes the members' waiting time requirements for appointments with the CMOs' network providers.

Figure 2

Provider Type	Waiting Time
PCPs (routine visits)	Not to exceed fourteen (14) calendar days
PCP (adult sick visit)	Not to exceed twenty-four (24) clock hours
PCP (pediatric sick visit)	Not to exceed twenty-four (24) clock hours
Maternity Care	First Trimester – Not to exceed fourteen (14) Calendar Days Second Trimester – Not exceed seven (7) Calendar Days Third Trimester – Not to exceed three (3) Business Days
Specialists	Not to exceed thirty (30) Calendar Days
Therapy: Physical Therapists, Occupational Therapists, Speech Therapists, Aquatic Therapists	Not to exceed thirty (30) Calendar Days
Vision Providers	Not to exceed thirty (30) Calendar Days
Dental Providers	Not to exceed twenty-one (21) Calendar Days
Dental Providers (Urgent Care)	Not to exceed forty-eight (48) clock hours
Elective Hospitalizations	Thirty (30) Calendar Days
Mental Health Providers	Fourteen (14) Calendar Days
Urgent Care Providers	Not to exceed twenty-four (24) clock hours
Emergency Providers	Immediately (twenty-four (24) clock hours a day, seven (7) days a week) and without prior authorization

The CMOs must also ensure *in office* wait times are within *do not exceed* state established timeframes for enrolled members (see below):

Scheduled Appointments	Wait times shall not exceed 60 minutes. After 30 minutes, the patient must be given an update on the

	wait time with an option of waiting or rescheduling the appointment.
Work-in or Walk-In Appointments	Wait times shall not exceed 90 minutes. After 45 minutes, the patient must be given an update on the wait time with an option of waiting or rescheduling the appointment.

Hours of Operation

The CMOs must ensure their network providers:

- offer hours of operation that are no less than the hours of operation offered to commercial enrollees or are comparable to those of Medicaid fee-for-service providers
- are encouraged to offer after-hours primary care availability during the evenings and on weekends.

Culturally Competent Services

DCH recognizes that racial and ethnic minorities and members with lower socioeconomic status are less likely to get the preventive health care they need, are more likely to suffer from serious illnesses, such as diabetes, heart disease, HIV, or chronic viral hepatitis, and are less likely to have access to quality health care. This may result in poor health outcomes, such as maternal and infant mortality. DCH requires the CMOs to adhere to policies in alignment with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*.

The GF and GF 360º CMOs are required to provide outreach, training, and guidance to providers and members to support equal access to quality and culturally competent care, including language access services for individuals with limited English proficiency, and auxiliary aids and services for individuals with disabilities. In accordance with the National Action Plan to Improve Health Literacy, the CMOs must offer educational materials on disease states prevalent in their population while offering providers strategies for improving the health literacy of their patient populations. Through monitoring and collection of health data by race, ethnicity, sex, primary language, socioeconomic factors, and disability status, DCH ensures the effectiveness of the CMOs efforts in this area.

Assurance of Adequate Capacity and Services

The GF and GF 360º CMOs' contracts require assurances and supporting documentation that demonstrates the CMOs have the capacity to serve their membership in their service areas in accordance with the State's standards for access to care as required by the CFR. Each CMO must submit documentation to the State, in the DCH required format, that demonstrates it complies with the following requirements:

- Offers an appropriate range of preventive, primary care, and specialty services that is adequate for the anticipated number of enrollees for the service area.
- Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of enrollees in the service area.

The documentation must be submitted as required by federal and State standards. After DCH reviews the documentation submitted by the CMOs, DCH must certify to CMS that the CMOs

have complied with the State's requirements for availability of services, as set forth in § 438.206. DCH also makes all of the documentation collected from the CMOs available to CMS upon request.

The Georgia Department of Audits and Accounts (DOAA) conducts reviews of the GeoAccess Reports submitted by the CMOs on a quarterly basis. These reports are reviewed for compliance with the access standards outlined in the CMOs' contracts. They also conduct secret shopper surveys of providers' offices to determine the accuracy of the providers' panel status as well as their compliance with appointment wait times. The DOAA's findings and recommendations for corrective actions are submitted to the DCH. DCH reviews the findings and develops recommendations for corrective action for the CMOs.

Coverage and Authorization of Services

In line with the DCH mission to provide access to affordable, quality health care through effective planning, purchasing and oversight, the GF and GF 360º CMOs must manage service utilization through utilization review, prior authorization and case management.

Covered Services

Pursuant to 42 CFR 438.210(a), each CMO may exceed the service limits but may not provide members with services in an amount, duration, and scope that is less than the amount, duration, and scope for the same services furnished to recipients under the Georgia fee-for-service Medicaid program. For enrollees eligible for Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services, the CMOs must cover all medically necessary services to correct or ameliorate a defect or condition found during a screening even if the services are not covered by the Georgia State Medicaid Plan as long as they are Medicaid covered services as defined in Title XIX of the Social Security Act.

The CMOs are required to offer expanded services to members and to specify which expanded services are covered. The State defines expanded services as those offered by the CMOs and approved by the State that are services more than or not contractually required to be covered by the GF and GF 360º CMOs.

Medical Necessity

Pursuant to 42 CFR section 438.210(a)(4), DCH defines medically necessary services as those services based upon generally accepted medical practices in light of conditions at the time of treatment, and:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition
- Compatible with the standards of acceptable medical practice in the community
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms
- Not provided solely for the convenience of the member or the convenience of the health care provider or facility
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage and

- No other effective and more conservative or substantially less costly treatment, service and/or setting is available.

Services must be sufficient in amount, duration, and scope to reasonably achieve this purpose in accordance with 42 CFR §440.230.

No Arbitrary Denial of Services

The CMOs may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the member's diagnosis, type of illness or condition. In the event of denial of the requested amount, duration or scope of services, the CMOs must notify the requesting provider and give the enrollee and provider written notice of the decision. All decisions to deny service authorization requests, or to authorize a service in the amount, duration or scope that is less than requested, must be made by a health care professional who has appropriate clinical expertise in treating the member's condition or disease. The CMOs must ensure that any compensation to individuals or entities who conduct utilization management activities does not include incentives to deny, limit, or discontinue medically necessary services.

Authorization

DCH necessitates that each CMO require prior authorization and/or pre-certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries. The CMOs are permitted to require prior authorization and/or pre-certification for all non-emergent and/or out-of-network services. The CMOs may not require prior authorization or pre-certification for emergency services, post stabilization services, urgent care services, EPSDT screening services or family planning services.

DCH monitors the CMOs' compliance with the contractually required authorization timeframes as outlined below:

- Standard Service Authorizations (routine): within 14 calendar days from receipt of request
- Expedited Service Authorizations (urgent): within 24 hours from receipt of request
- Retro Authorizations (post service): within 30 calendar days from receipt of request

DCH ensures compliance with this requirement through reviews of the CMOs' prior authorization reports and when necessary, record reviews of prior authorization requests and reviews of complaints/appeals.

Coordination and Continuity of Care

Care coordination and continuity of care facilitate the linkage of members with appropriate services and resources in a synchronized effort to achieve good health. DCH recognizes that coordination and continuity of care is important for member safety, to avoid duplication of services and to improve health care outcomes. DCH requires the GF and GF 360^{o} CMOs to implement care coordination services including: assignment of a PCP to each member, transitions of care, back transfers, court ordered evaluations and screenings, discharge planning, care coordination including coordination with other entities, disease management, case management and the integration of physical and behavioral health services.

Ongoing Source of Primary Care

Pursuant to 42 CFR 438.208(b), the State requires the CMOs to have procedures to ensure each enrollee has an ongoing source of primary care appropriate to his or her needs. The CMOs are required to offer each member a choice of primary care providers (PCPs). The CMOs must inform members of their PCP assignments, their ability to choose a different PCP, the list of providers from which to make a choice and the procedures for making a change.

To improve continuity and coordination of care the CMOs must attempt to perform an initial screening and assessment for all enrollees within 90 days from the date of enrollment to identify pregnancy, chronic conditions, barriers to obtaining health care (such as transportation) and special or significant health care needs. The CMOs must also have procedures to coordinate services to prevent duplication of services. With the implementation of the new GF contracts, the CMOs will be required to ensure every GF and GF 360º member has a designated PCP, who will serve as their medical home, a designated dental home and a behavioral health home if applicable.

The GF 360º CMO will ensure that every GF 360º member has a designated PCP, who will serve as the member's medical home. The medical home is charged with increasing access to care, improving continuity of care, facilitating early identification and treatment of chronic health conditions, and promoting better care coordination. Georgia Families 360º members are also assigned a dental home, which is tasked with the same goals of increasing access to and improving continuity of care, as well as facilitating early identification and treatment of dental health conditions. The GF 360º CMO will ensure that members are assigned a medical home within two business days of receipt of the eligibility file from DCH and dental homes are assigned within five business days of receipt of the eligibility file from DCH. Behavioral Health homes are assigned within 14 days when applicable.

Because the GF 360º population may change placements frequently, special procedures have been put into place to ensure each member has continued access to care. The GF 360º CMO must assess the member's access to the PCP within one business day of receiving notification of a change in member's location. If the PCP no longer meets the geographical access standards, the DFCS case manager, caregiver, foster parent or member must select a new PCP within two business days of the member's relocation or the GF 360º CMO will reassign the PCP within three business days of receipt of notification of the member's relocation. This rule applies to the foster care and juvenile justice members moving between placements.

Ongoing Georgia Families 360º Population Specific Assessments

It is required that GF 360º members receive a medical assessment within ten calendar days of GF 360º CMO's receipt of the eligibility file from DCH or written notice from DFCS/DJJ, whichever comes first. The medical assessment includes all components of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) periodicity schedule, relevant to the member's age, including developmental, vision, hearing and dental assessments. Additionally, all Georgia Families 360º members must receive a health risk screening within thirty days of receipt of the member's eligibility file from DCH.

Trauma assessments are initiated for newly entering or re-entering foster care members within ten (10) calendar days of the GF 360º CMO's receipt of the eligibility file from DCH or written notice from DFCS, whichever comes first. Foster care members who have been in care for twelve months or more and whose Comprehensive Child and Family Assessment (CCFA) is more than twelve months old, as well as Adoption Assistance members for which abuse or neglect has been reported, will have a trauma assessment initiated within ten calendar days of written notification from DFCS.

The Kenny A. Consent Decree states further requirements for foster care members in Fulton and DeKalb counties. Under the terms and conditions of the Kenny A. Consent Decree, the State is to achieve and sustain 31 outcomes as well as maintain certain practice standards for children in the custody of Fulton and DeKalb County DFCS. The practice standards relate to needs assessment, service planning, placement experience, health care, investigation of maltreatment allegations concerning children in foster care, and court reviews and reporting.

The consent decree requires that DFCS refer foster care members in Fulton and DeKalb counties to a CCFA provider within 24 hours after the member's 72-hour hearing. The CCFA is a comprehensive assessment containing a family assessment, trauma assessment, medical assessment, and relative and non-relative home evaluation and reassessments. Additionally, health and dental screenings must be conducted within ten days of placement. The consent decree further requires that foster care members, aged four and older, located in Fulton and DeKalb counties, receive mental health screenings within thirty days of placement. Foster care members in Fulton and DeKalb counties, under the age of four, will receive developmental assessments within thirty days of placement. Under the decree, members are also required to receive EPSDT health screenings within ten days of final discharge from placement.

Identifying Persons with Special Health Care Needs

For Medicaid members enrolled in the GF and GF 360º programs who have special medical needs, the CMOs have implemented mechanisms for identifying, assessing and ensuring the existence of a treatment plan for them. Mechanisms include outreach activities, evaluation of health risk assessments and reviews of historical claims data. The CMOs utilize case and disease management programs to target and improve the health outcomes for these members with special medical needs.

The GF and GF 360º programs recognize that health care outcomes for all members including those with special medical needs are improved when PCP utilization increases. A *medical home* decreases fragmented care, increases early identification and treatment of chronic health conditions and promotes better care coordination. These programs identified that members may not know the importance of PCPs and the positive effects that the use of medical homes has on health status. This barrier is being addressed on an ongoing basis by increasing the members' knowledge of the need for and benefit of declaring a medical home. DCH monitors the CMOs' requirements related to significant health care needs through case and disease management reports.

Special Needs Population

The Managed Care State Plan Amendment (SPA) identifies certain groups of members as those with *special health care needs*. These members are exempt from enrolling in the Georgia Families program and include:

- Medicaid and PeachCare for Kids® members enrolled in the Children's Medical Services Program
- Children receiving services through the Georgia Pediatric Program (GAPP)
- Members residing in hospice or long term care facilities
- Individuals who are institutionalized
- Individuals enrolled in Medicaid who qualify for Medicare and
- Individuals who qualify for Supplemental Security Income (SSI)

The GF program works with the Georgia Department of Human Services Division of Family and Children's Services (DFCS) and Maximus, the Georgia Families enrollment broker, to identify mechanisms to assist with early identification of members with significant health care needs. Methods in use include standardized screening tools such as the Child and Adolescent Health Measurement Initiative (CAHMI) tool and surveys.

Care Coordination for the Georgia Families 360º Population

Each GF 360º member with intensive or complex needs is assigned an interdisciplinary Care Coordination Team (CCT), headed by a Care Coordinator, who leads the team and serves as the primary point of contact. The CCT assists the member in navigating the health care system and coordinates the member's Health Care Service Plan. The professional members of the team are determined based on the member's individual needs. Professionals could include nurses, licensed social workers, behavioral health specialists, substance abuse specialists and developmental disability specialists.

The Health Care Services Plan is an individualized plan developed in collaboration with the Georgia Families 360º member. The plan includes:

- The member's history
- A summary of current medical and social needs and concerns
- Short and long-term needs and goals
- A treatment plan to address the member's physical, psychological, and emotional health care needs
- A list of services, and their frequency, required to address physical, psychological, and emotional health care needs
- A description of who will provide necessary services

Georgia Families 360º members with serious emotional disturbance have a Health Care Service Plan that also includes a safety and contingency crisis plan. The GF 360º CMO, Core Service Providers and/or Intensive Family Interventions (IFI) providers coordinate to develop the Plan. The GF 360º CMO regularly reviews and updates all Georgia Families 360º members' Health Care Service Plans.

In particular, the Foster Care, Adoption Assistance, and Juvenile Justice Members with Special Health Care Needs (MSHCN), identified through the health assessments, are assigned a Nurse Care Manager (NCM). The NCM uses a holistic approach to coordinate clinical care and aid the MSHCN in obtaining medically necessary care and health-related services.

Special Access

DCH requires that each CMO have a process in place that ensures members identified as needing a course of treatment or regular care monitoring have direct access to a specialist appropriate for the member's condition and needs. The CMOs must provide information to members with a condition that requires on-going care from a specialist on how to request a standing referral and how they may request and obtain access to a specialty care center. DCH monitors special access by reviewing the CMOs' policies and procedures to ensure these provisions are in place and by monitoring complaints for evidence of non-compliance.

Structure and Operations Standards

The contracts with the GF and GF 360º CMOs comply with federal and state requirements related to structure and operation. DCH continuously monitors the CMOs to ensure CMO contractual compliance.

Provider Selection

Each CMO must have written policies and procedures for the selection and retention of providers. The CMOs cannot require a physician to participate or accept any plan product unrelated to providing care to members as a condition of contracting with that CMO. The CMOs maintain a formal provider relations function to timely and adequately respond to inquiries, questions and concerns from network providers in addition to a mechanism for provider dispute resolution and execution of a formal system of terminating providers from the network. The CMOs must not enter into any contract agreements with providers that exclude other health care providers from contract agreements for network participation. Health care providers cannot, as a condition of contracting with a CMO, require the CMO to contract with or not contract with another health care provider. The CMOs must not, as a condition of their contract with a provider, require the provider to also participate in any other non-Georgia Medicaid plan. The CMOs must not discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

DCH monitors provider selection through periodic audits of operational processes and review of provider contracts. DCH also monitors the CMOs for compliance through reviews of the CMOs' provider selection policies and provider complaint reports. DCH staff members work closely with the CMOs on all received provider complaints to ensure adequate and timely responses and to track and trend for CMO provider service areas of improvement.

Credentialing

The state of Georgia requires that each CMO comply with the requirements specified in 42 CFR 438.214, which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. Beginning in August 2015, DCH implemented the Centralized Credentials Verification Organization (CVO). All of the GF and GF 360o CMOs

have representation on the CVO's credentialing committee. The CMOs are no longer required to establish and verify credentialing and re-credentialing criteria for all professional providers since this is now the function of the CVO.

Member Information

DCH requires the CMOs to be responsible for educating members on their rights and responsibilities at the time of their enrollment into the CMO and annually. Educational activities and member information is conveyed via mail, by telephone, and/or through face-to-face meetings. The CMOs are responsible for providing members with handbooks and identification cards within 10 calendar days of receiving the member enrollment file from DCH. The CMOs must also have written policies and procedures regarding the rights of members that comply with applicable federal and state laws and regulations.

The CMOs' member handbooks must remain in compliance with requirements set forth in 42 CFR 438.10 and include information on:

- member rights and responsibilities
- the role of PCPs
- how to obtain care
- what to do in an emergency or urgent medical situation
- how to file a grievance
- how to request an appeal or administrative law hearing
- how to report suspected fraud and abuse.

All written materials must be available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The CMOs notify all members and potential members that information is available in alternative formats and how to access those formats. The CMOs make all written information available in English, Spanish and all other prevalent non-English languages as defined by DCH.

DCH monitors the CMOs' compliance with member information requirements through its review of the CMOs' policies and procedures pertaining to enrollment, member handbooks and outreach materials, call-scripts, and other member related materials.

Georgia Families 360º Population Member Information

Within five calendar days of receipt of the eligibility file from DCH, the GF 360º CMO electronically sends the DFCS case manager or juvenile probation and parole specialist the member information packet. Upon request, the packet may be mailed to the foster parent, caregiver, residential placement provider or state agency staff. For Adoption Assistance members, the member information packet is mailed to the Adoption Assistance member or adoptive parent within five calendar days. Some of the information the packet contains includes:

- A welcome letter with the name and contact information for the Georgia Families 360º member's care coordinator
- Information about the roles of the CCT and how to seek help in scheduling appointments and accessing care coordination services
- A Georgia Families 360º member handbook

- A new member ID card
- PCP and dentist change forms
- Explanation of the disenrollment procedures for Adoption Assistance members
- Information on the ombudsman liaison.

The GF 360º member handbook addresses the roles of DFCS and DJJ in consenting to the foster care and juvenile justice member's health care services, how to access the care coordination team, the role of the care coordination team, and continuity of care and transition issues.

Confidentiality
Each member's privacy is protected in accordance with the privacy requirements in 45 CFR Part 160 and 164 Subparts A and E, to the extent that they are applicable. The CMOs must maintain written policies and procedures for compliance with all applicable federal, state and contractual privacy, confidentiality and information security requirements.

Enrollment and Disenrollment
DCH ensures the CMOs comply with the enrollment and disenrollment requirements and limitations set forth in 42 CFR 438.56 including disenrollments requested by the CMOs, disenrollments requested by enrollees and procedures for disenrollment determinations. Enrollment into the GF program is mandatory for members with the following eligibility categories: Low Income Medicaid (LIM); Transitional Medicaid; Right from the Start Medicaid (RSM) for children, pregnant women, and children born to mothers with RSM; eligible women with breast or cervical cancer; refugees; and PeachCare for Kids. Enrollment into the GF 360º program is mandatory for foster children, juvenile justice children in non-secure community residential placements, and children receiving adoption assistance although adoption assistance children may opt out of managed care.

CMO Disenrollment Requests

The CMOs may request member disenrollment for several reasons identified in the contract such as:

- the Member demonstrates a pattern of disruptive or abusive behavior that could be construed as non-compliant and is not caused by a presenting illness
- the Member's utilization of services is fraudulent or abusive
- the Member has moved out of the service region
- the Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for the mentally retarded
- the Member's Medicaid eligibility category changes to a category ineligible for GF or GF 360º, and/or the Member otherwise becomes ineligible to participate in the GF or GF 360º program
- the Member has any other condition as so defined by DCH or
- the Member has died, been incarcerated or moved out of State, thereby making them ineligible for Georgia Medicaid.

Member Requests for CMO Disenrollment

A Member may request disenrollment from a CMO without cause during the ninety (90) calendar days following the date of the Member's initial enrollment with the CMO or the date

DCH sends the Member notice of the enrollment, whichever is later. Members may request disenrollment without cause every twelve (12) months thereafter.

DCH makes final determinations on all disenrollment requests and notifies the CMO via file transfer and the member via surface mail within five (5) calendar days of making the decision.

Georgia Families 360º Member Disenrollment

Adoption Assistance members may elect to disenroll from the CMO *without cause* within the first ninety (90) calendar days following the date of the member's initial enrollment into the CMO or the date DCH sends the member's notice of enrollment, whichever is later. The Adoption Assistance member will return to Fee-for-Service Medicaid.

Adoption Assistance members may also elect to disenroll from the CMO *without cause* during the Adoption Assistance Fee-for-Service selection period and return to Fee-for-Service. If the Adoption Assistance member does not disenroll during this time period, the member must wait until the end of the member's consecutive enrollment period in the CMO.

Adoption Assistance members may disenroll *for cause* at any time if any of the following apply:

- The CMO does not, because of moral or religious objections, provide the covered services the Adoption Assistance member seeks
- The Adoption Assistance member needs related services to be performed at the same time and not all related services are available within the network, and the member's provider or another provider have determined that receiving services separately would subject the Adoption Assistance member to unnecessary risk
- Other reasons, per 42 CFR 438.56(d)(2), including, but not limited to poor quality of care, lack of access to covered services, or lack of providers experienced in dealing with the Adoption Assistance member's health care needs

Adoption assistance members who have disenrolled may request to return to the CMO at any time, subject to eligibility.

In the event that a foster care, Adoption Assistance, or juvenile justice member's eligibility category changes to a category ineligible for the GF 360º CMO, but the member remains eligible for Medicaid, the member will remain enrolled with the CMO, but as a non- GF 360º member until the member's next enrollment period. Members enrolled in Supplemental Security Income (SSI) however, will return to Fee-for-Service. The disenrollment will be processed within three business days of the date the GF 360º eligibility category changes and will not be made retroactive.

Grievance Systems

Each CMO is required to maintain a member grievance system that includes a grievance process, an appeal process and an administrative hearing process. A *grievance* is defined as an expression of dissatisfaction about any matter other than an *action*, for example the quality of services provided and rudeness of a provider. DCH defines an *action* as the denial or limited authorization of a requested service, including the type or level of service, and an *appeal* is a request for review of an *action*. This definition of an *action* complies with 42 CFR 438.400(b).

The CMOs are required to inform members of their rights and general grievance system procedures through adverse determination letters and member handbooks. The grievance process allows the member, or the member's authorized representative to file a grievance or an appeal.

The CMOs must notify the member that he or she has 30 calendar days from the date of an adverse decision to appeal the decision by requesting a fair hearing. The CMOs must provide reasonable assistance in completing the forms for appeals and taking other procedural steps including providing toll-free numbers that have adequate TTY/TTD and interpreter capability. Members must also be informed of their right to continuation of benefits if requested and the appeal is filed timely. Members must be provided with clearly written information explaining that if the final resolution of the appeal is adverse to the member, they may be responsible for the cost of the services furnished and if the final resolution overturns the plan's decision, the plan must authorize, provide and pay for disputed services promptly.

The CMOs are required to acknowledge receipt of each filed grievance and appeal in writing within 10 business days of receipt and make determinations on grievances within 90 calendar days. Final decisions on appeals must be completed within 45 calendar days or as expeditiously as the member's health condition requires. The response must include the decision reached, the reason(s) for the decision, the policies or procedures that provide the basis for the decision, and a clear explanation of any further rights available to the member. Additionally, the CMOs must ensure that the decision-makers for appeals are health care professionals with the appropriate clinical expertise in treating the enrollee's condition or disease.

The Administrative Law Hearing process provides members an opportunity for a hearing before an impartial Administrative Law Judge on all appeals upheld by the CMO. The State maintains an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (O.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 200. A member or authorized representative may request a State Administrative Law Hearing in writing within 30 calendar days of the date the Notice of Adverse Action is mailed by the CMO. The CMOs must adhere to decisions as a result of the Administrative Law Hearing process.

In compliance with federal statues, DCH requires that each CMO log and track all grievances, appeals and Administrative Law Hearing requests and maintain records of whether information was received verbally or in writing. Appeals must include a short, dated summary of the problems, the name of the aggrieved, the date of the appeal, the date of the decision and the disposition.

DCH requires each organization to process each grievance and appeal using applicable state and federal statutory, regulatory and contractual provisions, and internal written policies and procedures. DCH monitors compliance through review of quarterly reports submitted by each CMO, on site record reviews of CMOs and subcontractors, approval of policies and procedures and approvals of member and provider handbooks.

Subcontractor Relationships and Delegation
All subcontracting arrangements entered into by the CMOs must comply with 42 CFR 434.6(b) and (c). Through the contract with the CMOs, DCH requires that all subcontractors that provide care to GF and GF 360º members must have written contracts reviewed by DCH prior to implementation. DCH mandates that each CMO:

- ensures subcontracts fulfill the requirements of the contract and applicable federal and state laws and regulations
- specifies the activities and reporting responsibilities delegated to the subcontractor and
- has provisions for revoking delegation or imposing sanctions in the event that the subcontractor's performance is inadequate.

DCH holds the CMOs accountable for all actions of the subcontractor and its providers.

The CMOs must perform annual and on-going monitoring of all subcontractors, notify the subcontractors of identified deficiencies or areas for improvement and require the subcontractors to take appropriate corrective action when applicable.

DCH requires signed attestation statements from each CMO attesting that the activities of each of their approved subcontractors are being monitored. The State reviews a list of subcontractors quarterly to include dates the contracts were executed and CMO subcontractor audit reports. The CMOs must provide an immediate notice to DCH of any changes to any existing subcontractor agreements and sub-contractual issues that jeopardize access to or quality of the members' care.

Measurement and Improvement Standards

Clinical Practice Guidelines (CPGs)
The CMOs' CPGs are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field. They are adopted in consultation with the CMOs' network providers and their corporate partners. They are reviewed and updated periodically and they must consider the needs of the members. The CMOs disseminate the CPGs via provider handbooks and their web portals to all of their network providers and, upon request, to members and potential members. The CMOs *provider relations* staff members visit providers to promote adherence to the CPGs.

In order to ensure consistent application of the guidelines, the CMOs encourage providers to utilize the CPGs and they monitor the providers' compliance with the guidelines until 90 percent or more of the providers are consistently in compliance. Medical record reviews are conducted annually using a random sample of providers who submit claims for the CMOs' members diagnosed with the following conditions – Asthma, Diabetes, and ADHD. The CMOs may use provider incentive strategies to improve their providers' adherence to the CPGs. Below are the aggregate compliance results for these three CPGs for each CMO based on reviews conducted in 2015 of providers who submitted claims during CY 2014 for the above mentioned conditions.

Provider's Compliance with CPG Monitoring Results for CY 2014

	Amerigroup	Peach State	WellCare
% Compliance with Guidelines	85%	84%	85%
% Providers Scoring 80% or Above	88%	79%	88%
Total Number Records Reviewed 450	450	450	450
Total Number Providers Reviewed	90	123	90

Upon implementation of the newly procured CMO vendors, the CMOs will be required to audit their providers' CPG compliance on a quarterly basis.

Quality Assessment and Performance Improvement (QAPI) Program

DCH requires each CMO to have a QAPI program that meets contractual standards at least as stringent as those requirements specified in 42 CFR 438.236-438.242. The CMOs' ongoing program objectively and systematically monitors and evaluated the quality and appropriateness of care and services rendered, thereby promoting quality of care and quality patient outcomes in service performance to its population.

Each QAPI program should be based on the latest available research in the area of quality assurance and include a method of monitoring, analysis, evaluation and improvement of the delivery, quality and appropriateness of health care furnished to all members (including under and over utilization of services). DCH requires the CMOs to submit annual evaluations of and updates to their QAPI programs. In early 2014, DCH issued a new policy with specifications for the CMOs regarding their QAPI reports. This new guidance established a template for the QAPI reports and specified the components to be included in the QAPI report. They include:

- A brief overview of the QAPI program, the program's goals and objectives for the preceding calendar year and a summary of the goals and objectives met and not met during the year
- An analysis of the demographics of the population served
- The network resources available to the population served and an alignment of those resources with the population
- The effectiveness of the QAPI program and
- Conclusions

DCH reviews all of the CMOs' QAPI report submissions and the QAPI reports continue to improve. One GF CMO, in their 2015 QAPI report re-submission, was able to demonstrate understanding of the populations they were serving and the associated needs of those populations. They correlated their goals, objectives and interventions to drive the necessary improvements in health outcomes of its members going forward.

Performance Improvement Projects (PIPs)

DCH requires the CMOs to conduct PIPs that are designed to achieve, through ongoing measurement and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services. These PIPs are expected to have a favorable effect on health outcomes and member satisfaction. During the fall of 2014, DCH transitioned all of the CMOs PIPs to the rapid cycle process improvement methodology. In order to facilitate this change, DCH and its EQRO met with CMS to discuss a new PIP validation methodology that would align with the rapid cycle process. Following CMS approval of this methodology change, HSAG created a

rapid cycle PIP companion guide that provided the CMOs with systematic instructions in the conduct of rapid cycle PIPs. This guidance was a modified version of the Institute for Healthcare Improvement's (IHI's) Quality Improvement (QI) Model for Improvement. Key concepts include the formation of a team; setting aims; establishing measures; selecting, testing, and implementing interventions; and spreading changes. The core component of the model includes testing changes on a small-scale using Plan-Do-Study-Act (PDSA) cycles and applying rapid-cycle learning and evaluation that informs the project theory during the course of the improvement project.

Once the companion guide was completed, HSAG provided extensive training to the CMOs about the new process that now requires HSAG's review and approval of each step in the process before the CMOs are allowed to advance to the next step. DCH selected the following overarching topic areas for the CMOs' 2015 PIPs and final results of the rapid cycle processes will be reported in January of 2016. CY 2015 has been a learning year and DCH anticipates continued improvement in the conduct of the rapid cycle PIPs going forward under the new CMO contracts. The eight (8) PIP broad topic areas include:

- Bright Futures
- Annual Dental Visits – focusing on the three dental measures in the CMS 416 report
- Postpartum Visits
- Appropriate Use of ADHD Medications
- Diabetes Care
- Avoidable ER Use Collaborative
- Provider Satisfaction
- Member Satisfaction

Annual PIP Validation Reports are published at the following link:
https://dch.georgia.gov/medicaid-quality-reporting

Performance Measurement Data
DCH requires the GF and GF 360º CMOs to generate performance measure rates for a select set of metrics including CMS Adult and Child Core Set measures, AHRQ performance measures, HEDIS measures and CAHPS measures. These metrics align with the quality strategy and inform DCH about the effectiveness of the strategy. Appendix A includes the complete performance measurement list for the CY 2015 reporting. The CMOs must have their performance measure rates independently validated prior to submission to DCH. The CMOs annual performance measurement reports are posted to the DCH website at the following link:
https://dch.georgia.gov/medicaid-quality-reporting

Health Information Systems
DCH requires each CMO to maintain a health information system that is able to collect, analyze, integrate, and report data and the CMOs must collect data on member and provider characteristics and on services furnished to those members.

Complete and Accurate Encounter Data

DCH contracts with the certified public accounting firm of Myers & Stauffer, LLC (M&S) to conduct monthly reconciliations of CMOs' encounter data in the Medicaid Management Information System (MMIS) to the CMOs' cash disbursement journals (amounts paid by the CMOs) to determine the percentage of encounters submitted by the CMOs to DCH. To hold the CMOs accountable for the timely and complete submission of encounter data, DCH established thresholds that the CMOs must meet. The CMOs are required to submit 99% of encounter data based on the reconciliation to CMO cash disbursements.

M&S conducts monthly encounter reconciliations to determine if the submission target is met and any CMO failing to meet the target is subject to sanctions and liquidated damages. As shown in the chart below for the period defined, all three CMOs had a submission rate that exceeded 99%.

Reconciliation Time Period		Submission Rate for Reconciliation Period
Amerigroup	Oct 2013 – Sept 2015	99.20%
Peach State	Oct 2013 – Sept 2015	99.39%
WellCare	Oct 2013 – Sept 2015	99.37%
Combined (all CMOs)		99.33%

In addition to ensuring the volume of encounter data submitted by the CMOs meets DCH's standards, DCH understands that accurate and complete encounter data is critical to the success of any managed care program. DCH relies on the quality of encounter data submissions from the CMOs in order to monitor and improve the quality of care, establish performance measures and generate accurate and reliable reports, and obtain utilization and cost information. The completeness and accuracy of these data are essential for the overall management and oversight of Georgia's Medicaid program.

Section IV: Improvement and Interventions

In Section I of this Plan, DCH identified the objectives, strategies and interventions it has or will implement to achieve its stated goals. Also included were the metrics to be utilized to track progress and target populations in need of additional interventions. Finally, Section I included the target performance levels to be achieved. Throughout this document, DCH has identified the collaborations it has with other agencies and with the CMOs to achieve its performance targets. Additional collaborations may result from future public comments received.

The new CMO contracts contain a value-based purchasing strategy to assist with achievement of the goals identified in this quality strategy. The value based purchasing strategy provides a financial incentive to the CMOs, over and above the auto-assignment strategy, to improve quality and the health outcomes of the CMOs' membership. The value based purchasing metrics and targets have been included in this strategy. DCH and the GF and GF 360º programs will continue to implement, review and modify this strategy using PDSA cycles, to achieve the desired goals.

Intermediate Sanctions

In accordance with 42 CFR 438.706, DCH may use sanctions for CMO non-compliance with state and/or federal statutory guidelines and GF and GF 360º contractual provisions. With the new CMO contracts to be implemented in FY 2017, some of the intermediate sanctions were modified to provide additional clarity, thereby enhancing the ability for enforcement.

DCH maintains sanctions policies that detail the requirements cited in 42 CFR 438, Subpart I for the CMOs. The policies cite the types of sanctions and subsequent monetary penalties or other types of sanctions, should a CMO not adhere to the provisions of the contractual requirements and/or state and federal regulations. Sanctions may include:

- granting members the right to terminate enrollment with the CMO without cause and notifying the affected members of their right to disenroll
- suspension of all new enrollment
- suspension of payment to the CMO
- termination of the contract and/or civil monetary fines in accordance with 42 CFR 438.704

DCH may impose temporary management if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that there is continued egregious behavior by the CMO, including but not limited to behavior that is described in 42 CFR 438.700 or that is contrary to any requirements of sections 1903(m) and 1932 of the Social Security Act. Additionally, DCH may impose intermediate sanctions in accordance with 42 CFR 438.702.

Before imposing any intermediate sanctions, DCH must give the CMO timely notice according to 42 CFR 438.710. Unless the duration of a sanction is specified, a sanction remains in effect until DCH is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur.

Health Information Technology

DCH ensures that contracting CMOs maintain health information systems that collect, analyze, integrate and report data, and achieve the objectives of the GF and the GF 360º programs. The DCH Office of Health Information Technology (HIT) oversees the Electronic Health Record (EHR) Medicaid Incentive Program (MIP).

The MIP offers incentive payments to eligible Medicaid providers to adopt EHRs and meet *meaningful use* criteria that includes significant quality measurements. The adoption of EHRs is expected to improve the overall efficiency and quality of health care. The CMOs' Medicaid providers who meet eligibility requirements are encouraged to participate in the program.

The statewide Georgia Health Information Network (GaHIN) provides a solution for the secure exchange of health information between providers, hospitals, labs, other health care entities, and other health information exchanges (HIEs). The ability to exchange patient health information provides the platform for improved and more efficient health care. Certain groups of Medicaid providers participating in the EHR MIP are now able to use the GaHIN to send and receive secure electronic mail and critical health information such as lab results, continuity of care documents, and prescriptions. These criteria must be met under *meaningful use*.

Information System Initiatives

The DCH MMIS contractor recently contracted with a new NCQA certified software vendor to support the production of performance measure reports that meet HEDIS® specifications. The new software vendor will also conduct the Medical Record Reviews to assist with reporting hybrid performance measure rates. Additionally, the MMIS vendor is collaborating with Georgia's medical management and utilization review vendor to obtain additional administrative data that will support the rate generation process.

DCH will soon transition to a new integrated eligibility system, Georgia Gateway that will serve as a single point of entry for eligibility processing for Georgians seeking public assistance. The system interfaces in batch and real time mode with 41 partners for over 150 file exchanges. Among the features provided through the interfaces is the ability to provide real time verification of customer provided information, such as social security numbers and wages, which improves the eligibility determination process.

The Medicaid Information Technology Architecture (MITA) team is working to develop an electronic process for transmitting the perinatal case management assessments, reproductive life plans and care plans from local public health departments to DCH and the CMOs. The team is also working to develop a mechanism for transmitting transition of care information from the inpatient care setting to DCH and the CMOs.

Section V: Delivery System Reforms

Georgia Families 360º

Children in foster care present unique challenges to Medicaid programs in delivering health care services. Many children in foster care have chronic physical and behavioral health problems as well as psychosocial service needs and providing the necessary services and coordinating care without duplicating services and efforts is challenging.

Another challenge of managing children in foster care is their environmental instability. Care is at times disjointed and sporadic because these children are moved throughout the state, in and out of a variety of custody arrangements. Shifting guardianship from birth parents, foster parents, guardians or adoptive families makes it difficult to coordinate necessary health care services, screenings and follow-ups. There is no central repository for all of their records. Lack of coordination between physical health and behavioral health providers as well as state agencies intensifies these issues.

The decision to transition the foster care, adoption assistance and juvenile justice populations into managed care was considered an opportunity to enhance service to this population through better care coordination. At the time, these populations did not have access to medical management or medical and dental homes. Under managed care, these populations would have access to those services. In order to build critical mass and ensure focus, consistency, and better care coordination, a single CMO was selected to provide Medicaid services to the GF 360º population. Amerigroup was the selected vendor to administer the Georgia Families 360º program.

Value-Based Purchasing was adopted as an incentive to improve the quality of care delivered. Monitoring contracts under a value-based purchasing model shifts the focus from monitoring structures and processes to monitoring outcomes, or measuring the value of the services purchased.

Three PIP topics were selected for the GF 360º program and implemented in early 2015. They include seven-day follow up care after hospitalization for mental illness, follow up care for children prescribed ADHD medication – initiation phase, and adolescent well care visits.

Section VI: Conclusions and Opportunities

DCH has assessed the progress achieved under its original Georgia Families Quality Strategic Plan and identified its accomplishments and opportunities for improvement. DCH also re-evaluated its initiatives and established new goals for the future. These achievements, ongoing challenges and recommendations are listed below.

Achievements

Since the last Quality Strategy update in November 2011, the following have been accomplished:

- Participated in the development of the request for proposal for the re-procurement of the care management organizations
- Submitted a request to extend the P4HB program to CMS although we are still awaiting final approval
- Engaged with the Georgia Hospital Association and the Georgia Department of Public Health to monitor the state's early elective deliveries rate
- Initiated a collaboration with the Georgia Hospital Association's Care Coordination Council to address the Medicaid re-admission rate. As a component of that collaboration, a transition of care form was created that contains fields that meet the requirements for the CMS Adult Core Set's Care Transitions Measure
- Engaged the care management organizations in the CMS QI 301 project with a focus on improving the state's postpartum visit rate and increasing the utilization of long acting reversible contraceptives
- Following the denial of our request to the Designated Standards Maintenance Organization for a modification to the CMS 1500 form in order to calculate gestational age from claims data, we created an alternative approach in collaboration with our MMIS vendor and our medical management and utilization review vendor for generating the gestational age at birth from administrative data. This will inform the calculations for the early elective deliveries, antenatal steroids, and C-sections for Nulliparous Singleton Vertex Adult Core Set measures and assist us with our strategies to reduce the state's low birth weight rate.
- Received approval from CMS for our state plan amendment that allows access to preventive health services for Medicaid adult FFS members. This intervention will link to the CMS Living Well marketing campaign with the goal of improving the establishment of medical homes for FFS members and reducing the state's readmissions rate.
- Initiated system configurations that will allow local school districts to serve as originating sites for telemedicine services, thus improving members' access to providers especially in Georgia's rural counties
- Ongoing participation in the CMS Quality Technical Advisory Group
- Transitioned the CMOs' PIPs to rapid cycle process improvement projects.
- Awarded an Adult Quality Measures grant that allowed for the generation of the CMS Adult Core Set of measures for the Medicaid Adult Only population. The grant also required and funded two PIPs that were conducted by the Georgia Department of Human Services Division of Aging Services. The projects focused on screening for clinical depression and follow-up care, and antidepressant medication management in the Community Care Services Program (CCSP) waiver population. After a six month no cost

extension, the grant period ended on June 20, 2015 and there were several lessons learned from the project.

- Collaborated with CMS and HSAG to develop a new validation process for the rapid-cycle process improvement PIPs. HSAG provided training to the CMOs on the new rapid cycle process during web-based and in-person training in late 2014 and early 2015. All of the CMOs' 2015 performance improvement projects will be validated using the rapid cycle PIP validation process.
- Implemented a policy to deny payment for non-medically necessary labor inductions and Cesarean sections for women less than 39 weeks gestation.
- Received CMS approval of our State plan amendment to collaborate with the Georgia Department of Public Health (DPH) for initial perinatal case management assessments, reproductive life plan discussions, and care plan development for pregnant women. The work is conducted by the local public health agencies across the state and the results are shared with the women's CMOs and/or their obstetrics providers.
- Continued policy and MMIS activities to ensure mandated compliance with the International Classification of Diseases, 10th Edition (ICD-10) code sets within the Medical Assistance Plans Division. The requirement for ICD-10 coding was implemented effective October 1, 2015. The transition to ICD-10 coding has been successful.

Ongoing challenges

DCH continues to work with the quality and medical management staff of the GF and the GF 360º programs to ensure their activities reflect the objectives, strategies and interventions documented in this plan. DCH provides feedback to the CMOs on an ongoing basis about all quality related reports submitted by the CMOs. DCH will be implementing face-to-face reviews of the submitted reports with the CMOs to support the CMOs quality improvement efforts. Report specifications are revised when necessary to better align the reported information with the stated goals and objectives of the work performed. Technical assistance is coordinated with the EQRO for the CMOs' PIPs to ensure they remain on track.

Recommendations

There are no recommendations other than the continued monitoring of the strategies and interventions to determine the overall impact of this strategic plan on the health outcomes of the members served by the GF and GF 360º programs.

Appendix A: GF Performance Measures to be reported in 2016

Measure	HEDIS 2014 Percentiles				Targets
	25	50	75	90	CY2015
MEASURES FOR GF (54 Total; 17 non-HEDIS; 21 Hybrid)					
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE – 6 or more visits (HYBRID)	54.76	62.86	69.75	76.92	variable
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE (HYBRID)	65.97	71.76	77.26	82.69	variable
ADOLESCENT WELL-CARE VISITS (HYBRID)	41.7	48.51	59.21	65.56	variable
CHILDREN AND ADOLESCENT ACCESS TO PRIMARY CARE PRACTITIONERS					
12 to 24 months	85.79	89.94	92.17	94.42	
25 months to 6 years	95.92	96.96	97.86	98.53	
7 to 11 years	86.07	89.08	91.73	93.58	
12 to 19 years	87.78	91.15	93.5	95.19	93.50
ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES – 20 to 44 Years	78.34	83.27	86.21	88.52	88.52
CHILDHOOD IMMUNIZATION STATUS – Combos 3, 6, and 10 (HYBRID)					
Combo 3	66.67	72.33	77.78	80.86	variable
Combo 6	33.33	42.82	50.69	59.37	59.37
Combo 10	25.75	34.18	41.85	49.67	variable
LEAD SCREENING IN CHILDREN (HYBRID)	58.39	70.86	80.83	85.84	variable
WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION & PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS (HYBRID)					
Total BMI	41.85	57.4	73.72	82.46	variable
Total Nutrition	50.00	60.58	69.21	77.47	variable
Total Physical Activity	41.67	51.16	60.82	69.76	variable

ANNUAL DENTAL VISIT					
2 to 3 years	28.35	37.51	43.98	54.20	54.20
4 to 6 years	51.94	59.99	68.85	74.75	
7 to 10 years	55.17	60.95	71.57	78.08	
11 to 14 years	48.56	57.78	65.61	72.11	
15 to 18 years	40.78	51.48	56.52	62.56	
19 to 21 years	26.28	34.04	41.02	45.67	34.04
Total	43.28	52.65	61.13	66.80	
CERVICAL CANCER SCREENING (HYBRID)					76.64*
BREAST CANCER SCREENING	51.21	57.37	65.12	71.35	71.35
PRENATAL AND POSTPARTUM CARE (HYBRID)					
Timeliness of Prenatal Care	77.8	84.3	89.62	93.1	89.62
Postpartum Care	56.18	62.84	69.47	74.03	69.47
FREQUENCY OF ONGOING PRENATAL CARE – 81% or More Expected Visits (HYBRID)	43.73	60.10	71.34	78.37	60.10
CHLAMYDIA SCREENING IN WOMEN - Total	48.86	54.93	62.75	67.19	54.93
IMMUNIZATIONS FOR ADOLESCENTS – Combo 1 (HYBRID)	61.7	71.29	80.9	86.46	variable
APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	58.28	68.53	77.96	83.66	83.66
COMPREHENSIVE DIABETES CARE – All Components (HYBRID)					
HbA1c test	80.18	83.88	87.59	91.73	87.59
HbA1c Poor >9	53.64	44.69	36.52	30.28	44.69
HbA1c Control <8	38.2	46.43	52.89	59.37	46.43
HbA1c control <7	29.31	36.27	40.26	43.55	36.27
Eye exam	46.25	54.14	63.14	68.04	54.14
Attention to nephropathy	75.67	80.05	83.11	86.86	80.05
BP Control <140/90	53.65	61.31	70.07	75.18	61.31
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION					
Initiation	32.61	41.09	46.99	53.03	53.03
Continuation	37.17	49.51	57.55	63.10	63.10

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS					
7 DAY	31.69	42.3	54.45	63.21	63.21
30 DAY	51.39	64.63	74.09	80.34	80.34
AMBULATORY CARE per 1000 Member Months					
ER VISITS	52.31	63.93	73.97	81.24	<52.31
OP VISITS	313.44	352.38	404.51	461.19	
INPATIENT UTILIZATION- GENERAL HOSPITAL/ACUTE CARE					
Total Inpatient ALOS	3.28	3.85	4.22	4.57	
Total Inpatient ALOS for <1 y.o.	21.61	27.93	35.55	48.15	
Medicine ALOS	3.27	3.67	4.09	4.41	
Medicine ALOS for <1 y.o.	8.11	12.3	16.07	23.17	
Surgery ALOS	5.31	6.47	7.29	8.58	
Surgery ALOS for <1 y.o.	5.28	8.4	12.04	18.02	
Maternity ALOS	2.47	2.6	2.74	2.93	
WEEKS OF PREGNANCY AT TIME OF ENROLLMENT					
<0 Weeks					
1-12 Weeks					
13-27 Weeks					
28 or more Weeks					
Unknown					
Total					
RACE/ETHNICITY DIVERSITY OF MEMBERSHIP					
White					
Black					
CESAREAN DELIVERY RATE					28.70
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES – 416 specifications; combined PCK and Medicaid					58.00*
DEVELOPMENTAL SCREENING IN THE FIRST THREE YEARS OF LIFE (HYBRID)					variable

CESAREAN SECTION FOR NULLIPAROUS SINGLETON VERTEX (HYBRID)					18.08*
LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS					8.02*
ANTIDEPRESSANT MEDICATION MANAGEMENT					
Effective Acute Phase Treatment	45.00	49.66	54.31	59.92	54.31
Effective Continuation Phase Treatment	29.90	33.93	38.23	44.08	38.23
DIABETES SHORT-TERM COMPLICATIONS ADMISSION RATE					<62.74
CHRONIC OBSTRUCTIVE PULMONARY DISEASE (COPD) or ASTHMA IN OLDER ADULTS ADMISSION RATE					<559.03
HEART FAILURE ADMISSION RATE					<380.70
ASTHMA IN YOUNGER ADULTS ADMISSION RATE					<63.43
ADULT BMI ASSESSMENT (HYBRID)	71.54	78.81	85.23	90.82	85.23
CONTROLLING HIGH BLOOD PRESSURE (Age 18-85) BP <140/90 (HYBRID)	48.57	56.46	63.76	69.79	56.46
FLU SHOTS FOR ADULTS AGES 18-64 – Captured in CAHPS Survey					34.65*
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT - Total					
Initiation of Treatment	33.5	37.49	43.48	47.06	43.48
Engagement of Treatment	5.35	10.33	14.97	19.14	14.97
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS					
ACE Inhibitors or ARBs	85.72	88.00	89.94	92.01	88.00
Diuretics	85.69	87.90	90.57	92.11	87.90
Total	84.38	86.14	88.25	89.81	88.25
MENTAL HEALTH UTILIZATION					
Any Services	7.64	11.2	15.36	22.75	
Inpatient	0.52	0.94	1.19	2.15	
Intensive Outpatient	0.02	0.14	0.52	1.95	
Outpatient/ED	6.83	10.7	14.75	21.77	

MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION - Captured in CAHPS Survey					
Advising Smokers and Tobacco Users to Quit	73.58	76.8	79.32	81.42	76.80
Discussing Cessation Medications	41.4	45.87	51.68	57.11	45.87
Strategies	37.91	41.57	45.27	50.89	41.57
PLAN ALL-CAUSE READMISSION RATE					
Age 18-44					
Age 45-54					
Age 55-64					
Age 65-74					
Age 75-84					
Age 85 and older					
Total					
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	81.57	86.11	91.21	94.39	86.11
SCREENING FOR CLINICAL DEPRESSION AND FOLLOW-UP PLAN (HYBRID)					
ELECTIVE DELIVERY (HYBRID)					2.00
ANTENATAL STEROIDS (HYBRID)					
ADHERENCE TO ANTIPSYCHOTICS FOR INDIVIDUALS WITH SCHIZOPHRENIA	55.12	61.37	67.13	73.15	61.37
CARE TRANSITION – TIMELY TRANSMISSION OF TRANSITION RECORD (HYBRID)					
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	15.28	19.21	23.62	28.9	23.62
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA – 5 to 64 Years					
Medication Compliance 50% for 5-11 yrs old					
Medication Compliance 50% for 12-18 yrs old					
Medication Compliance 50% for 19-50 yrs old					
Medication Compliance 50% for 51-64 yrs old					
Medication Compliance 50% Total					
Medication Compliance 75% for 5-11 yrs old	20.71	26.63	32.32	39.87	32.32
Medication Compliance 75% for 12-18 yrs old	19.24	24.62	30.58	36.36	
Medication Compliance 75% for 19-50 yrs old	31.53	36	40.36	46.67	

Medication Compliance 75% for 51-64 yrs old	46.32	50.99	56.67	63.83	
Medication Compliance 75% Total	24.55	30.16	34.96	42.79	
MATERNITY CARE-BEHAVIORAL HEALTH RISK ASSESSMENT (HYBRID)					
USE OF MULTIPLE CONCURRENT ANTIPSYCHOTICS IN CHILDREN AND ADOLESCENTS (Baseline measured in CY 2015)					
PREVENTION: DENTAL SEALANTS FOR 6-9 YEAR OLD CHILDREN AT ELEVATED CARIES RISK (Baseline measured in CY 2015)					
PHARMACOTHERAPY MANAGEMENT OF COPD EXACERBATION					
Systemic Corticosteroid	48.27	61.11	74.94	78.20	74.94
Bronchodilator	77.78	83.82	87.61	90.32	83.82
PRESISTENCE OF BETA BLOCKER TREATMENT AFTER A HEART ATTACK	79.72	86.36	91.18	94.74	
COLORECTAL CANCER SCREENING (Baseline measured in CY 2015)					
SURVEY					
CAHPS HEALTH PLAN SURVEY 5.0H, ADULT VERSION					
CAHPS HEALTH PLAN SURVEY 5.0H, CHILD VERSION					

GF 360º Performance Measures to be Reported in 2016

Measure	2015 Amerigroup	2015 State Target
The Child's Access to Care		
Childrens and Adolescents Access to Primary Care Providers - 12-24 Months		95.69%
Childrens and Adolescents Access to Primary Care Providers - 25 Months-6 Years		96.96%
Childrens and Adolescents Access to Primary Care Providers - 7-11 Years		89.08%
Childrens and Adolescents Access to Primary Care Providers - 12-19 Years		93.50%
Childrens and Adolescents Access to Primary Care Providers - Total		82.55%
The Well Child Visit		
Well-Child Visits in the First 15 Months of Life - 6 or More Visits (Hybrid)		67.98% Regional Target
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (Hybrid)		72.80% Regional Target
Lead Screening in Children (Hybrid)		75.34% Regional Target
Childhood Immunization Status - Combo 3, Combo 6, Combo 10 (Hybrid)		Combo 3: 80.30% Regional Target Combo 6: 59.37% Combo 10: 38.94% Regional Target
Adolescent Well-Care Visits (Hybrid)		53.47% Regional Target
Human Papillomavirus Vaccine for Female Adolescents (Hybrid)		23.62%
Immunization for Adolescents - Combo 1 (Hybrid)		71.43% Regional Target
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - BMI Percentile-Total (Hybrid) [Include actual BMI value for hybrid sample]		45.86% Regional Target

Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Nutrition-Total (Hybrid)		60.58% Regional Target
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents - Counseling for Physical Activity-Total (Hybrid)		46.30% Regional Target
Developmental Screening in the First Three Years of Life (Hybrid) (Use Child Core Set Spec)		46.36% Regional Target
The Sick Child Visit		
Appropriate Testing for Children with Pharyngitis		77.96%
Appropriate Treatment for Children with URI - All rates below the 25%tile		86.11%
Follow-Up Care for Children Prescribed ADHD Medication - Initiation Phase		53.03%
Follow-Up Care for Children Prescribed ADHD Medication - Continuation and Maintenance Phase		63.10%
The Child's Dental Visit		
Annual Dental Visit - Ages 2-3 Years		54.20%
Annual Dental Visit - Ages 4-6 Years		82.03%
Annual Dental Visit - Ages 7-10 Years		87.70%
Annual Dental Visit - Ages 11-14 Years		86.55%
Annual Dental Visit - Ages 15-18 Years		82.52%
Annual Dental Visit - Ages 19-21 Years		34.04%
Annual Dental Visit - Total		66.80%
Prevention: Dental Sealants for 6-9 Year Old Children at Elevated Caries Risk (Use Child Core Set)		
Percentage of Total Eligibles That Received Preventive Dental Services (CMS 416 - DPr)		58.00%
Adult Access to Care and Screening		
Adults Access to Preventive/Ambulatory Health Services - 20-44 Years		88.52%
Adult BMI Assessment (Hybrid)		78.81%
Chlamydia Screening for Women - Ages 16-20 Years		51.61%

Chlamydia Screening for Women - Ages 21-24 Years		63.32%
Chlamydia Screening for Women - Total		54.93%
Flu Vaccinations for Adults Ages 18 to 64 (Use Adult Core Set). CAHPS Survey results apply to the AA population only.		34.65%
Medical Assistance with Smoking and Tobacco Use Cessation - Advising Smokers and Tobacco Users to Quit (Use Adult Core Set). CAHPS Survey results apply to the AA population only.		76.80%
Medical Assistance with Smoking and Tobacco Use Cessation- Discussing Cessation Medications (Use Adult Core Set). CAHPS Survey results apply to the AA population only.		45.87%
Medical Assistance with Smoking and Tobacco Use Cessation- Strategies (Use Adult Core Set). CAHPS Survey results apply to the AA population only.		41.57%
Pregnancy and Birth Outcomes		
Weeks of Pregnancy at Time of Enrollment- < 0 Weeks		
Weeks of Pregnancy at Time of Enrollment- 1-12 Weeks		
Weeks of Pregnancy at Time of Enrollment- 13-27 Weeks		
Weeks of Pregnancy at Time of Enrollment- 28 or More Weeks		
Weeks of Pregnancy at Time of Enrollment- Unknown		
Weeks of Pregnancy at Time of Enrollment- Total		
Prenatal and Postpartum Care - Timeliness of Prenatal Care (Hybrid)		89.62%
Prenatal and Postpartum Care - Postpartum Care (Hybrid)		62.84%
Frequency of Ongoing Prenatal Care < 21 % (Hybrid)		
Frequency of Ongoing Prenatal Care - 21-40 % (Hybrid)		
Frequency of Ongoing Prenatal Care - 41-60% (Hybrid)		

Frequency of Ongoing Prenatal Care - 61-80% (Hybrid)		
Frequency of Ongoing Prenatal Care - 81+ % (Hybrid)		71.34%
Live Births Weighing Less than 2,500 Grams ‡ (Lower rate is better) (Use AHRQ Spec)		8.02%
Cesarean Delivery Rate ‡ (Lower rate is better) (Use AHRQ Spec)		28.70%
Cesarean Section for Nulliparous Singleton Vertex (Use Child Core Set) (Hybrid)		18.08%
Elective Delivery (Hybrid) (Use Adult Core Set Spec)		2.00%
Antenatal Steroids (Hybrid) (Use Adult Core Set Spec Addendum)		
Maternity Care- Behavioral Health Risk Assessment (Hybrid) (Use Child Core Set Specs)		
Disease State - Asthma		
Asthma in Younger Adults Admission Rate per 100,000 Member Months - AHRQ PQI 15 ‡ (Use Adult Core Set Spec)		<63.43
Disease State - Diabetes		
Diabetes Short Term Complication Admission Rate per 100,000 Member Months - AHRQ PQI 01 ‡ (Use Adult Core Set Spec)		<62.74
Comprehensive Diabetes Care (18 - 75 Year olds) HbA1c Testing (Hybrid)		87.59%
Comprehensive Diabetes Care - HbA1c Poor Control >9.0 (Lower rate is better) (Hybrid)		44.69%
Comprehensive Diabetes Care - HbA1c Good Control <8.0 (Hybrid)		46.43%
Comprehensive Diabetes Care - HbA1c Good Control <7.0 (Hybrid)		36.27%
Comprehensive Diabetes Care - Eye Exam (Hybrid)		54.14%
Comprehensive Diabetes Care - Medical Attention to Nephropathy (Hybrid)		80.05%
Comprehensive Diabetes Care - Blood Pressure Control <140/90 (Hybrid)		61.31%

Disease State - Cardiovascular Conditions		
Controlling High Blood Pressure (Age 18-85) BP < 140/90 (Hybrid)		56.46%
Heart Failure Admission Rate- AHRQ PQI 08 ‡ (Use Adult Core Set Spec)		<380.70
Behavioral Health		
Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up		63.21%
Follow-Up After Hospitalization for Mental Illness - 30-Day Follow-Up		80.34%
Mental Health Utilization - Any Services		
Mental Health Utilization - Inpatient		
Mental Health Utilization - Intensive OP		
Mental Health Utilization - Outpt/ED		
Screening for Clinical Depression and Follow Up Plan (Hybrid) (Use Adult Core Set Specs)		10.00%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents		
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Initiation of Treatment		43.48%
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - Engagement of Treatment		14.97%
Utilization		
Ambulatory Care - ER Visits per 1000 member months		<52.31
Ambulatory Care - OP Visits per 1000 member months		
Inpatient Utilization (general hospital/acute care) - Total Inpt ALOS		
Inpatient Utilization (general hospital/acute care) - Medicine ALOS		
Inpatient Utilization (general hospital/acute care) - Surgery ALOS		
Inpatient Utilization (general hospital/acute care) - Maternity ALOS		
Plan All Cause Readmission (compare with commercial population) (Use HEDIS Spec but for Medicaid)		
Medication Management		

Antidepressant Medication Management (Age 18+) - Effective Acute Phase Treatment		54.31%
Antidepressant Medication Management (Age 18+) - Effective Continuation Phase Treatment		38.23%
Adherence to Antipsychotics for Individuals with Schizophrenia		61.37%
Note for Medication Management for People with Asthma : Child Core Set requires different age breakdown from HEDIS		
Medication Management for People with Asthma - 50% Compliance for Ages 5-11		85.71%
Medication Management for People with Asthma - 50% Compliance for Ages 12-18		36.00%
Medication Management for People with Asthma - 50% Compliance for Ages 19-50		26.63%
Medication Management for People with Asthma - 50% Compliance for All Ages		75.00%
Medication Management for People with Asthma - 75% Compliance for Ages 5-11		32.32%
Medication Management for People with Asthma - 75% Compliance for Ages 12-18		24.62%
Medication Management for People with Asthma - 75% Compliance for Ages 19-50		36.00%
Medication Management for People with Asthma - 75% Compliance for All Ages		42.79%
Care Transition		
Care Transition- Timely Transmission of Transition Record (Hybrid) (Use Adult Core Set Spec)		
Membership Characteristics		
Race/Ethnicity Diversity of Membership - White		
Race/Ethnicity Diversity of Membership - Black		

®Healthcare Effectiveness Data and Information Set (HEDIS) is a registered trademark of the National Committee for Quality Assurance (NCQA). All measures used HEDIS specifications **unless** otherwise noted.

‡ AHRQ or Other Non-HEDIS Measure; ж CMS Child Core Measure