



GEORGIA DEPARTMENT OF  
COMMUNITY HEALTH



# Georgia Families

*Choices for a Healthy Life*



**QUALITY STRATEGIC PLAN –UPDATE**

**JANUARY 2010**

## DCH Quality Focus

The Department of Community Health (DCH) created the Quality Strategic Plan in June 2007 and obtained Centers for Medicare and Medicaid Services (CMS) approval for the plan in 2008. Since that time, DCH has continuously assessed the Plan and its effectiveness toward achieving the defined goals and objectives. Achievements to date have been recorded in the Plan's updates. Since the last update, significant changes have taken place within DCH to strengthen its quality direction and focus. One of the most significant of those changes was the re-alignment of managed care and fee-for-service staff and programs to create a synergistic quality effect. Because the Medicaid providers serve both the fee-for-service and managed care populations, the staff members focused on quality initiatives from both program areas were brought together in one unit. This coming together enhanced the unit's ability to educate each other about their unique quality initiatives and where appropriate, combine like initiatives. It also allowed DCH to communicate a common message to all providers about the quality of care to be delivered to all Medicaid and PeachCare for Kids™ recipients.

The DCH continues its strong commitment to the process of quality strategic planning and assessment. Each annual update will identify plans for the forthcoming year; acknowledge accomplishments of the prior year; identify opportunities for improvement, and review and revise goals. By doing this, DCH ensures its ongoing focus on quality care, optimal service and improved outcomes. This current update will provide details about Georgia's efforts to ensure the highest quality of health care delivery to all Medicaid and PeachCare for Kids™ members.

## Mission

To provide access to affordable, quality health care in our communities; encourage responsible health planning and use of health care resources; and promote healthy behaviors and improved health outcomes.

### Guiding Principles

*Access:* Ensure and support efforts to remove any barriers to healthcare services and resources.

*Beneficiary Satisfaction:* Listen to, understand, and address the needs of beneficiaries and stakeholders in a prompt, respectful, and responsive manner

*Cultural and Linguistic Competence:* Ensure that members have access to appropriate services that are responsive and accessible to a diverse population

*Accountability:* Demonstrate responsibility to stakeholders

*Integrity:* Perform responsibilities with honesty, sincerity, courtesy and the highest quality of ethical and professional conduct

*Communication:* Promote an open transparent exchange of information and ideas with a commitment to listen and respond accurately, reliably, and in a timely manner to beneficiaries and stakeholders

### **DCH Health Policy Priorities for 2010:**

- Medicaid Transformation
- Health Care Consumerism
- Financial & Program Integrity
- Health Improvement
- Workforce Development
- Emergency Preparedness
- Customer Service

### **DCH Organizational Changes**

The Georgia Department of Community Health (DCH) was created in 1999 to serve as the lead agency for health care planning and purchasing issues in Georgia. The General Assembly created DCH by consolidating four agencies involved in purchasing, planning and regulating health care. In 2009, the General Assembly passed legislation to transition the Georgia Division of Public Health and the Office of Healthcare Facility Regulation to DCH from the Department of Human Services. The Public Health Emergency Preparedness Section became a separate unit under DCH. DCH is also designated as the single state agency for Medicaid. Currently, the Divisions associated with DCH are:

- Emergency Preparedness and Response
- Financial Management
- The Office of General Counsel
- Healthcare Facility Regulation
- Information Technology
- The Office of Inspector General
- Public Health
- State Health Benefit Plan
- Medicaid
- Operations

## **Assessment**

DCH has taken time to assess the progress achieved under its original Georgia Families Quality Strategic Plan and has identified its accomplishments and opportunities for improvement. DCH has also re-evaluated its initiatives and established goals and will identify revisions to both in this Plan update.

Some of our major accomplishments during this assessment period include:

- Procured an External Quality Review Organization which performed its initial year of contracted work to DCH's satisfaction
- Worked with consumer groups and the communications department to educate members on the availability and use of the HITT website
- Redefined performance measures to align with standardized and nationally accepted metrics
- Defined performance targets for reported metrics
- Facilitated the Strategic Quality Council and the Improving Birth Outcomes Workgroup that brought together DCH business units with community stakeholders in an effort to collectively improve the health outcomes for all Georgia citizens

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# I. Introduction

## ***A. States Decision to Contract with Managed Care Organization***

Georgia Families (GF) continues its partnership between DCH and private Managed Care Organizations (MCO) which are full-risk Health Maintenance Organizations (HMO) licensed by the Department of Georgia Insurance and Safety Fire (DOI). Georgia's Managed Care Organizations are referred to as Care Management Organizations (CMO). Amerigroup Community Care, Peach State Health Plan and WellCare of Georgia are the three CMOs that have managed the care of members enrolled in this program since its inception.

Georgia requires mandatory managed care enrollment for PeachCare for Kids™, Georgia's Children's Health Insurance Program (CHIP), and specific Medicaid eligible members. The Georgia Families Medicaid eligibility categories include Low Income Medicaid (LIM), transitional Medicaid, pregnant women and children in "Right from the Start Medicaid" (RSM), newborns of Medicaid-covered women, refugees, and women with breast and cervical cancer.

The Georgia Families program strives to promote appropriate utilization of services and quality of care through activities such as utilization management, provider contracting, case and disease management programs, and performance improvement projects. The State, in collaboration with the Care Management Organizations (CMOs), the State of Georgia, the Georgia Families enrollment broker (Maximus), advocacy groups, and beneficiaries work as strategic partners for quality improvement.

The Georgia Families program is currently in its fourth year of implementation and has transitioned from a start-up program to a mature program. It is redesigning its processes, policies, procedures, operations, and organization to perform effectively as it moves into a higher phase of growth and development. This Plan is a part of that redesign effort.

Georgia Families will continue, at a minimum and as applicable, to be in compliance with all Federal and state laws and regulations including quality assessment and improvement requirements in Title XIX of the Social Security Act; Title 42 Code of Federal Regulations (CFR) 438. The Plan's goals and objectives create the framework that will guide the program to improve the health care outcomes of our members.

## Membership Update

The following chart displays the distribution of the membership among the CMOs as of December 1, 2009:

Region	CMO	Membership
<b>Atlanta</b>	AMERIGROUP	130,042
	Peach State	177,098
	WellCare	220,606
	<b>Atlanta Region Total</b>	<b>527,746</b>
<b>Central</b>	Peach State	51,610
	WellCare	83,664
	<b>Central Region Total</b>	<b>135,274</b>
<b>North</b>	AMERIGROUP	28,265
	WellCare	36,942
	<b>North Region Total</b>	<b>65,207</b>
<b>East</b>	AMERIGROUP	55,305
	WellCare	99,987
	<b>East Region Total</b>	<b>155,292</b>
<b>Southeast</b>	AMERIGROUP	35,171
	WellCare	65,326
	<b>Southeast Region Total</b>	<b>100,497</b>
<b>Southwest</b>	Peach State	79,010
	WellCare	37,782
	<b>Southwest Region Total</b>	<b>116,792</b>
	<b>Georgia Families Total</b>	<b>1,100,808</b>

Source: Georgia Families monthly process results summary report – December 2009

## B. Comment Process

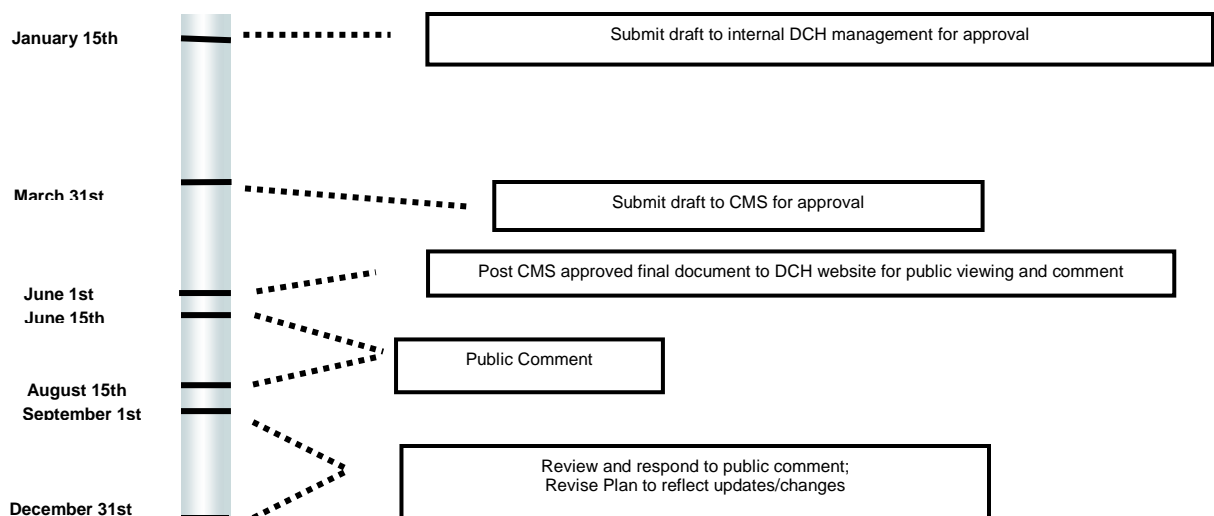
The Medicaid Managed Care Final Rule 42 CFR §438.202(a) requires that state Medicaid programs have a written Quality Assessment and Performance Improvement (QAPI) strategy for their managed care programs. 42 CFR §438.202(d) requires that state Medicaid programs "periodically" review the effectiveness of their managed care quality assessment and performance improvement (QAPI) strategies. Also, 42 CFR §438.202(e)(1) requires that state Medicaid programs submit to the Centers for Medicaid and Medicare Services (CMS) "regular" reports on the effectiveness and implementation of the QAPI strategy.

Two strategic plan assessments have been conducted for the Georgia Families program - one in June 2007(submitted to CMS in February 2008) and the second in May 2008 (submitted to CMS in March 2009). CMS evaluated and approved Georgia’s QAPI strategy after finding it to be in compliance with all applicable federal requirements.

Georgia conducts strategic plan assessments every year. Where indicated, changes to the strategy are made and the results of the assessment are reported to CMS. DCH maintains the ultimate authority for oversight of the Quality Strategic Plan and the management and direction of the Georgia Families program. The final approved Quality Strategic Plan will be posted at the below site:

[http://dch.georgia.gov/00/channel\\_title/0,2094,31446711\\_96559860,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html),

DCH will accept and address comments on the Quality Strategic Plan from stakeholders, advocacy groups, consumer groups, and others that review the document on an ongoing basis; however, the plan will be updated annually. Comments are encouraged and should be submitted to [managedcarequality@dch.ga.gov](mailto:managedcarequality@dch.ga.gov). Public comments will be accepted from June 15th to August 15th of each year and updates/changes reflected in the subsequent revision of the Plan.





## **C. Goals and Performance Driven Objectives:**

The goals set by Georgia Families reflect the State's priorities and areas of concern for the population covered by the CMOs. Quantifiable performance driven objectives have been established to demonstrate success or identify challenges in meeting intended outcomes.

1. Promotion of an organization wide commitment to quality of care and service
  - 1.1. Design, develop and implement (DDI) Georgia's new Medicaid Management Information System (MMIS)
  - 1.2. Develop and implement mechanisms to increase collaboration for quality
  - 1.3. Utilize care management and care coordination programs and processes to promote member self-care and wellness, prevention of disease complications, and cost-effective service delivery
  
2. Improvement and enhancement of the quality of patient care provided through ongoing, objective, and systematic measurement, analysis, and improvement of performance
  - 2.1. Increased Children's Preventive Health Screenings
  - 2.2. Increased Access to Preventive/Ambulatory Health Services
  - 2.3. Increased Prevention and Screening for Cervical and Breast Cancer
  - 2.4. Improved Access to Oral Health Services
  - 2.5. Improvements in Birth Outcomes
  - 2.6. Improvements in Respiratory Conditions and Asthma Care
  - 2.7. Improvements in Diabetes Care and Outcomes
  - 2.8. Assurance that Individuals with Behavioral Health concerns are properly cared for
  - 2.9. Appropriate Drug utilization
  
3. Promotion of a system of health care delivery that provides coordinated and improved access to comprehensive healthcare and enhanced provider and client satisfaction.
  - 3.1. Reducing Low Birth Weight Rates Project
  - 3.2. Promotion of the Patient-Centered Medical Home concept
  - 3.3. Improvements in member and provider satisfaction
  - 3.4. Enhanced Benefits - CMOs are to provide members with health education and prevention programs as well as expanded access to services and providers thereby giving them the tools needed to live healthier lives.
  
4. Promotion of acceptable standards of healthcare within managed care programs by monitoring internal/external processes for improvement opportunities
  - 4.1. Maintaining fiscally sound contracts, policies and procedures that adequately address quality issues and requirements
  - 4.2. Performance Improvement Projects
  - 4.3. Reviews of CMO Clinical Practice Guidelines
  - 4.4. EQRO activities

## II. Assessment

DCH routinely assesses the quality and appropriateness of care and services delivered to enrollees. The level of CMO contract compliance is monitored continually and in accordance with federal regulations, CMOs are subject to annual independent review through the EQR process.

### ***A. Quality and Appropriateness of Care***

#### Race, Ethnicity, and Primary Language

Member data on race, ethnicity and primary language is captured at the time the member enrolls with Medicaid or PeachCare for Kids™. The member diversity data is then sent electronically to each CMO as part of their monthly eligibility file. Additionally, in FY 2010 the CMOs will monitor and report on several HEDIS diversity metrics. This information will be utilized by the CMOs to ensure the following:

- Adequate number of PCPs and specialist per member population
- Adequate number of PCPs and specialist with language capability for the population per county
- Adequate written materials and translation services available in the prevalent languages of potential enrollees and enrollee materials for established members translated into all languages that are spoken by 5 percent or more of the population in the plan's service areas
- Identification of areas within the state with best practices and opportunities for improvement
- Development of CMO cultural competency plan

#### External Quality Review

The Performance, Quality and Outcomes (PQO) unit of the Medicaid Division competitively procured Health Services Advisory Group (HSAG) to work as the State's external quality review organization (EQRO) in compliance with CFR 438.204. HSAG is contracted with DCH to perform 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
- A review, conducted within a 3-year period, to determine the CMO compliance with standards established by the State to comply with the requirements of 438.204(g).

In addition, HSAG is conducting an encounter data validation audit as an optional activity and provided assistance with the development of an auto-assignment algorithm based on quality and cost of care.

### Clinical Standards/Guidelines

DCH requires the CMOs to institute Clinical Practice Guidelines (CPGs) in the following three areas: chronic kidney disease, blood lead screening and immunizations. Along with these required Clinical Practice Guidelines, the CMOs have adopted additional evidence-based clinical practice guidelines and disseminated them to providers via their provider handbooks and web portals. CMO provider relations' staff visits to providers promote adherence to the CPGs. Each of the three CMOs has adopted the same clinical practice guideline to address Child and Adolescent Obesity and all three are working in collaboration with DCH to approve and adopt a standardized hypertension practice guideline.

CPGs must be disseminated to all network providers and, upon request, to members and potential members. In order to ensure consistent application of the guidelines, the CMOs encourage providers to utilize the CPGs and monitor compliance with the guidelines until 90 percent or more of the providers are consistently in compliance. The CMOs may use provider incentive strategies to improve providers' adherence to the CPGs.

Each CMO trends their providers' adherence to the CPGs by medical record reviews (MRR) and performance measure outcomes. Currently, CMOs submit bi-annual performance measure outcome updates and quarterly medical record review data to DCH. DCH will transition the MRR to ad-hoc reporting with implementation of the next amendment to the CMO contract.

## **B. Contract Compliance**

DCH recognizes that monitoring access is the initial step to ensure members have access to appropriate providers conveniently located; thus reducing access as barriers to care. Information on participating providers is critical to: assisting enrollees in selecting a health plan that will provide seamless continuity of care at the time of enrollment; improving health care outcomes; and improving quality of care delivered.

### **Access to Care**

The State’s contract with the CMOs requires the entities 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; Title 45 CFR 95, General Grants Administration Requirements. Accesses to care contract requirements are detailed in this section.

#### *Maintains and Monitors a Network of Appropriate Providers*

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 CMO offers 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. Geographic access requirements for CMO networks are listed below (see below):

	<b>Urban</b>	<b>Rural</b>
PCPs (primary care providers)	Two (2) within eight (8) miles	Two (2) within fifteen (15) 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
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 after hours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles

\* This requirement will be effective with the approval and implementation of the 2010 amendment to the CMO contract as drafted.

*Timely Access*

Through its contract with the CMOs, DCH requires each CMO to monitor their network provider timeliness and take corrective action if there are compliance issues. 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;
- meet the state’s timely access to care and services for appointment wait times, taking into account the urgency of the need for services (see below)

PCPs (routine visits)	Not to exceed 14 calendar days
PCP (adult sick visit)	Not to exceed 24 hours
PCP (pediatric sick visit)	Not to exceed 24 hours
Specialists	Not to exceed 30 Calendar Days
*Dental Providers (routine visits)	Not to exceed 21 Calendar Days
*Dental Providers (urgent care)	Not to exceed 48 hours
Non-emergency hospital stays	30 Calendar Days
Mental health Providers	14 Calendar Days
Urgent Care Providers	Not to exceed 24 hours
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization

\* This requirement will be effective with the approval and implementation of the 2010 amendment of the CMO contract as drafted.

Additionally, the CMOs must ensure provider response times for returning calls after-hours are within the contractual standard (see below):

*Urgent Calls	Shall not exceed 20 minutes
*Other Calls	Shall not exceed one hour

\* This requirement will be effective with the approval and implementation of the 2010 amendment to the CMO contract as drafted.

CMOs must also ensure “in office” wait times are within “do not exceed” state established time frames 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

\* This requirement will be effective with the approval and implementation of the 2010 amendment to the CMO contract as drafted.

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’ contract. 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. Their findings and recommendations for corrective actions are submitted

to the Department. The Department reviews the findings and develops recommendations for corrective action to the Plans.

#### *Direct Access to Women's 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 within the network for covered care. This is in addition to the member's designated source of primary care if that source is not a women's health specialist. No referrals are 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 their network is adequately staffed with women's health specialists. They must also submit a monthly PCP Assignment Report which identifies all providers (including women's health specialists) that have been selected by members as their PCP. DCH monitors this requirement by reviewing, tracking and trending the reports submitted by the CMOs.

#### *Second Opinion*

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. 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 plan is required to clearly state its procedure for obtaining a second medical opinion in the member handbook. Additionally, the plan'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 CMO 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, CMOs are responsible for covering care for new enrollees utilizing 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 continues to monitor compliance with out-of-network coverage for unavailable medically necessary services through review of CMO policies and procedures, as well as monitoring complaints regarding accessibility of providers.

### *Credentialing*

The State requires that each CMO complies with the requirements specified in 42 CFR 438.214 which include selection and retention of providers, credentialing and re-credentialing requirements, and nondiscrimination. DCH requires the CMOs to establish and verify credentialing and re-credentialing criteria for all professional providers. At a minimum the plan's providers must be credentialed as Medicaid providers in the State prior to enrolling as a CMO provider. Each CMO is required to credential network providers in accordance with the standards of the National Committee for Quality Assurance (NCQA), Joint Commission on Accreditation Healthcare Organization (JCAHO), or Utilization Review Accreditation Commission (URAC). The CMOs are required to:

- have a system for verification and examination of the credentials of each of its providers;
- have written policies and procedures for credentialing providers to ensure compliance with all applicable federal and state regulations;
- have written policies/procedures for taking appropriate action whenever, as determined under the quality assurance program, inappropriate or substandard services have been provided or services which should have been furnished have not been provided;
- have a written plan for conducting reviews of physicians and other licensed medical providers which includes ongoing review within the organization; and
- exercise reasonable care in assuring that delivered health care services are performed by appropriately licensed providers.

DCH conducts reviews of the CMO credentialing meeting minutes; documentation of all adverse disciplinary actions recorded on the providers; and reports with expiration dates for provider licenses, certifications, insurance coverage, and other documents. DCH also randomly audits the CMOs' provider listings to ensure the following provider credentials are not expired: Malpractice Insurance, Drug Enforcement Administration Registration, Board Certification Documentation, and Delegated Entity lists to include coverage by county, providers' name and specialties.

## **Coordination and Continuity of Care**

Care coordination and continuity of care facilitate the linkage of members with appropriate services and resources in a coordinated 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.

### *Ongoing Source of Primary Care*

Pursuant to 42 CFR 428.208(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 provider (PCP). The plan must inform members of: their PCP assignment; 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.

### *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. These members include:

- Medicaid members 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;
- People who are institutionalized;
- Children eighteen (18) years of age or younger who are in foster care or another out-of-home placement;
- Children (18) years of age or younger who are getting foster care or adoption assistance under Title IV-E of the Social Security Administration;
- People in Medicaid who qualify for Medicare; and
- People who qualify for Supplemental Security Income (SSI)

Georgia Families is aggressively working 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 being explored include utilization of standardized screening tools such as the Child and Adolescent Health Measurement Initiative (CAHMI) tool and surveys.

The CMOs have implemented mechanisms for identifying, assessing and ensuring the existence of a treatment plan for individuals with special health care needs. Mechanisms include: outreach activities; evaluation of health risk assessments; and



review of historical claims data. The CMOs utilize case and disease management programs to target and improve the health outcomes for members identified as having special health care needs.

Georgia Families recognizes that health care outcomes for all members including those with special health care 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. Georgia Families 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 by increasing member knowledge of the need for and benefit of declaring a medical home. In the interim, DCH will monitor CMO requirements related to significant health care needs through case and disease management reports to be implemented with the approved contract amendment.

#### *Special Access*

The State 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 CMO policies and procedures to ensure these provisions are in place and by monitoring complaints for evidence of non-compliance.

#### **Coverage and authorization of services**

In line with the DCH mission to improve access to affordable, quality health care; encourage healthy behaviors to achieve improved health outcomes; and assure responsible health planning and use of health care resources, the 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 Periodic Screening, Diagnostic and Treatment (EPSDT) services, the Plan 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.

Plans are required to offer expanded services to members and to specify which expanded services are covered by the Plan. The State defines expanded services as

those offered by the plan and approved by the State that are services more than or not contractually required to be covered by the CMO.

### *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
- there must be no other effective and more conservative or substantially less costly treatment, service and setting available.

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

### *Authorization*

The state requires that each Plan 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. Plans 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 CMO compliance with contractually required authorization timeframes 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

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 services, 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 enrollee's condition or disease.

DCH ensures compliance with this requirement through CMO record reviews of prior authorization requests as well as on site audits, and reviews of complaints/appeals.

### **Structure and Operation**

The contract with the CMOs complies with federal and state requirements related to structure and operation. DCH continues to monitor to ensure CMO contractual compliance.

#### *Provider Selection*

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. CMOs are not allowed to enter into any exclusive 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 cannot, as a condition of their contract with a provider, require the provider to also participate in any other non-Georgia Medicaid plan. CMOs cannot discriminate against providers serving high-risk populations or those that specialize in conditions requiring costly treatments.

DCH monitors this through periodic audits of operational processes and review of provider contracts. DCH monitors the CMOs for compliance through reviewing provider selection policy 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.

#### *Member Information*

The State requires the CMOs to be responsible for educating members on their rights and responsibilities at the time of their enrollment into the plan and annually. Educational activities and member information may be 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 Plans' member handbooks are 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 request a Grievance, Appeal, or Administrative Law Hearings, and
- 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. CMOs notify all members and potential members that information is available in alternative formats and how to access those formats. The CMO makes all written information available in English, Spanish and all other prevalent non-English languages as defined by DCH.

DCH monitors compliance with member information requirements through review of: policies and procedures pertaining to enrollment; member handbooks and outreach material; call-scripts; and other member related materials.

#### *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 CMO; disenrollments requested by the enrollee; and procedures for disenrollment determinations. Enrollment into Georgia Families (GF) 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™.

#### *CMO Disenrollment Requests*

The CMO 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, and/or the Member otherwise becomes ineligible to participate in GF.
- 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 Medicaid.

#### *Member Requests for CMO Disenrollment*

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

#### *Subcontractor Delegation*

All subcontracting arrangements entered into by the CMO 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 Georgia Families 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 CMO accountable for all actions of the subcontractor and its providers. CMOs must: perform annual and on-going monitoring of all subcontractors; notify the subcontractor of identified deficiencies or areas for improvement; and require the subcontractor 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 requests and 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 member care.

#### *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. CMOs must maintain written policies and procedures for compliance with all applicable federal, state, and contractual privacy, confidentiality, and information security requirements.

#### *Internal Grievance System*

Each CMO is required to maintain a member grievance system that includes a grievance process, an appeal process and an administrative hearing process. In compliance with 42 CFR 438.400(b) 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. A grievance is defined as an expression of dissatisfaction about any matter other than an action such as the quality of services provided and rudeness of a Provider.

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 enrollee, or the enrollee’s authorized representative to file a grievance or appeal.

CMOs must notify the enrollee that he or she has 30 calendar days from the date of an adverse decision to appeal the decision by requesting a fair hearing. Plans must provide reasonable assistance in completing 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.

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 done within 45 calendar days or as expeditiously as the enrollee’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 enrollee. Additionally, the plan must ensure that the decision-makers for grievances/appeals are health care professionals with the appropriate clinical expertise in treating the enrollee’s condition or disease when the reason for the grievance involves clinical issues or relates to the denial of expedited resolution of an appeal.

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 Plan. CMOs must adhere to decisions as a result of the Administrative Law Hearing process.

In compliance with federal statutes, DCH requires that each CMO log and track all grievances, appeals and Administrative Law Hearing requests and maintain records of whether received verbally or in writing. Grievances must include a short, dated summary of the problems, the name of the grievant, the date of the grievance/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, and approval of policies and procedures and member and provider handbooks.

### Quality Measurement and Improvement

The CMO contracts require each CMO to maintain National Committee for Quality Assurance (NCQA) certification. As of April 2009, each of the three plans had received new health plan accreditation and two of those plans submitted Healthcare Effectiveness Data and Information Set (HEDIS) performance data to NCQA.

Georgia Families is utilizing HEDIS and Agency for Healthcare Research and Quality (AHRQ) performance measures including both administrative and hybrid reporting that will be monitored and changed as necessary to assess improvements in quality of care. These performance measures are formally reported to DCH by each CMO at least annually based on calendar year per HEDIS and AHRQ metric specifications. Performance measure targets have been established and will be modified as needed. The FY 2010 amendment to the CMO contract contains language allowing the CMOs to develop performance incentives for their network providers to drive achievement of the performance targets. This contract addendum also contains liquidated damages that may be levied should a CMO fail to achieve the established performance targets.

DCH is soliciting a Medical Record Review (MRR) Organization for validation of hybrid performance measures (through the MMIS vendor). DCH is also negotiating with our EQRO vendor to modify the contract to allow for EQRO validation of performance measures.

## **C. Use of Available and Evolving 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 Georgia Families program. In addition, DCH strives to create an interoperable system that allows providers to access multiple systems (i.e. immunization registry, lead, Medicaid Management Information System (MMIS), etc.) simultaneously.

The Georgia Health Information Technology Transparency (HITT) website (<http://georgiahealthinfo.com>) became fully functional in May 2009. The launch of the site was done in two phases.

- Phase I went live in December 2008 and included:
  - ❖ Implementation of the technical architecture by IBM,
  - ❖ MayoClinic.com health education content (prevention, wellness, and disease management information), and
  - ❖ Basic provider profiles including cost and quality comparison data.
- Phase II was launched in May 2009 and included
  - ❖ Expansion of provider profile information
  - ❖ Addition of a long-term care decision support content tool featuring the Centers for Medicare and Medicaid Services' five-star quality rating system, facility inspection reports and extensive information on the average cost of care for nursing home and in-home health care. Consumers can also download checklists to evaluate over 3,600 facilities and look-up information on over 20,000 physicians.

Some of the communications and marketing initiatives for the Georgia HITT site included: DCH Communications office in conjunction with the Office of HITT held a press conference announcing the launch of Phase II of the web site; brochures, flyers and other web site literature were distributed in the local DFCS offices to promote the use of the web site to Medicaid members; DCH participated in health fairs throughout the state to disseminate web site literature; and, Twitter™ and Facebook™ were utilized allowing for the public to follow the latest updates through social networking media.

The “Compare Health Plans” section of the website is designed to assist consumers with selecting the right health insurance plan for themselves and their family. This section also displays selected HEDIS measures that are indicators of the quality of care for children, women and the diabetic population. DCH and other stakeholders continue to collaborate to design information that will be available on the website such as selected measures from validated Member Satisfaction survey results, and network data. Additionally, the HITT team, as part of the Strategic Quality Council workgroup is assisting in making Georgians aware of the Council's initiatives to educate citizens about hypertension in an effort to prevent and reduce cardiovascular deaths in Georgia.

### **III. Improvement**

Quality Improvement is a formal approach to the analysis of performance and systematic efforts to improve it. Based on the results of the assessment activities, Georgia Families will strive to improve the quality of care delivered.

#### ***A.Improvement through Interventions and Sanctions***

DCH, in collaboration with the CMOs, has implemented several interventions to improve the quality of care delivered to GF members. Interventions that are in place include:

- Quality Assessment and Improvement Programs;
- Cross-State Agency Collaborative/Initiative;



- Performance Improvement Project(s);
- Pay-for-Performance incentives;
- Information System or Electronic Health Record initiatives;
- Implementation of optional EQRO Activities; and
- Assurance of complete and accurate encounter data

#### Quality Assessment and Performance Improvement Programs (QAPI)

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 CMO's ongoing program objectively and systematically monitors and evaluates 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 is based on the latest available research in the area of quality assurance and includes 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). The state requires the plans to submit annual evaluations of and updates to their QAPI program.

#### Cross-State Agency Collaborative/Initiative

Within the DCH Division of Medicaid, the Performance, Quality and Outcomes (PQO) Unit has responsibility for oversight of quality initiatives, health care utilization and medical management in the managed care program. This unit interacts internally with the DCH Medical Policy, Provider Services, Member Services and Contract Services Units to assure we meet and exceed our goal of quality health care. As barriers are identified, effective solutions are sought after and implemented with involvement of internal and external stakeholders.

DCH and CMO leadership have taken a lead role in reaching out to Georgia's child health providers on an individual basis and through the Georgia Chapters of the American Academy of Pediatrics and the American Academy of Family Physicians. Partnerships have also been forged with the Division of Public Health on issues related to lead exposure, childhood obesity, asthma, and low birth weight rates; with the Georgia Division of Family and Children Services to discuss issues related to eligibility and children in state custody; with the Department of Behavioral Health and Developmental Disabilities to discuss issues related to mental health; and with the Georgia Department of Education on issues related to health care services provided in the school settings. In each of these collaborations, the aim is to improve the quality of children's health care with documented improvements in performance metrics.

In July 2009, the Improving Birth Outcomes Work Group was formed with the goal of reducing Georgia's low birth weight rate from 9.5% to 8.6% by 2015. The Work Group includes representatives from: the Georgia Medicaid program staff; the

Georgia OB GYN Society; leadership from the three Medicaid CMOs; the Georgia State Health Benefit Plan program staff and insurers; Commercial Insurers; Private Practitioners; the Georgia Family Connections Partnership; the Hispanic Health Coalition; the Georgia State Health Policy Center; the United Way of Metro Atlanta, the Georgia Office of Health Improvement; and the Voices for Georgia's Children. The Work Group identified objectives and strategies to achieve the goal. Achieving these objectives aligns with DCH's mission and is critical to Georgia's success in reaching this goal.

In June 2009, DCH spearheaded the Strategic Quality Council. With representation from DCH business units including HITT, the Office of Health Improvement, Public Health and the State Health Benefit Plan and in partnership with the CMOs, the Council decided its strategic direction was to prevent cardiovascular deaths and reduce Georgia's cardiovascular death rate. In 2008 the United Healthcare Foundation ranked Georgia's cardiovascular death rate as 40<sup>th</sup> in the nation. The group identified six factors that contribute to cardiovascular deaths in Georgia: cardiovascular disease, hypertension, diabetes, hypercholesterolemia, obesity and smoking. Hypertension was found to have the highest prevalence based on the business units' claims data. To improve Georgia's ranking, group members decided to support and implement initiatives to prevent, detect and appropriately manage hypertension. Progress will be monitored using performance metric results generated by the department's MMIS system.

The Council is organizing a statewide initiative "May 2010 Blood Pressure Awareness Campaign" to encourage Georgians to get their blood pressure checked ("Know your numbers") and learn about the dangers of untreated hypertension.

DCH will continue collaborations with internal and external stakeholders to improve both quality of and access to care.

#### Performance Improvement Projects (PIPs)

DCH requires CMOs to conduct PIPs that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical and non-clinical care and services that are expected to have a favorable effect on health outcomes and member satisfaction.

As a result of the evaluation of the effectiveness of the PIPS, DCH will modify the required PIPs with the implementation of an amendment to the CMO contract to include:

- Well-child visits during the first fifteen (15) months of life; blood lead screening; childhood immunization rates; access to care for members aged 20 – 44; emergency room utilization; member satisfaction and provider satisfaction; we will no longer require the chronic kidney PIP. Previously our contract required two focused studies (dental and childhood obesity); these focused studies will be transitioned to required PIPs. DCH will work

with the CMOs to identify and implement a focus study in any area that needs to be addressed based on data and stakeholder input. The EQRO annual report describes each CMO's performance in detail and is available each year at

[http://dch.georgia.gov/00/channel\\_title/0,2094,31446711\\_96559860,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html)

- EQRO validated performance improvement projects (PIP) addressing: well-child visits; blood lead screening; childhood immunization rates; and access to care for members aged 20 – 44. It was identified by our EQRO that the study questions for the CMO PIPs were not consistent across the three CMOs, making it impossible to compare results across the CMOs. As a result of the EQRO's finding, the CMOs agreed to the same study questions for their PIPs going forward. This action moved each of the PIPs back to their baseline performance year.

Additionally, the well-child visits during the first 15 months of life PIP has been identified as an area for collaborative improvement by all three CMOs. DCH enlisted the assistance of its EQRO to coordinate a collaborative performance improvement project focused on improving the number of eligible members who kept their appointments with their primary care provider for six or more well child visits during the first fifteen months of life. This collaborative PIP in addition to the other required PIPs will continue to be submitted annually.

#### Pay-for-Performance Incentives

DCH contracted with its EQRO to develop an auto-assignment algorithm for members who were otherwise not assigned to a CMO within thirty (30) days of enrollment. The algorithm was developed with 70% of the weight assigned to quality measures and 30% of the weight assigned to cost. The quality component utilizes the HEDIS quality measures validated by the EQRO. The algorithm was submitted to CMS for review and was incorporated into a Managed Care State Plan Amendment (SPA). This updated SPA was submitted to CMS for review and upon CMS approval, the new auto-assignment algorithm will be implemented.

The CMOs offer incentives to their contracted providers who meet certain quality and performance standards, targets or goals. The CMO provider pay-for-performance incentives encourage and reward providers for surpassing these standards, targets or goals.

#### Information System Initiatives

In July 2010, DCH will transition to a new Medicaid Management Information System (MMIS). In preparation for this transition, DCH staff members have been engaged with the new MMIS vendor to assure that quality metric reporting will be easily obtainable from the new system. This new system will have the capacity to

generate reports for both the managed care and fee for service populations based on the DCH selected HEDIS and AHRQ performance measures.

DCH is also implementing an Electronic Health Record (EHR) through the new MMIS. The focus of the MMIS-EHR is to automate the point-of-care documentation within the physician's practice and allow interoperability between the physician's practice and other caregivers and stakeholders across the continuum of care. The MMIS-EHR will allow beneficiaries to take responsibility for their well being through healthy behaviors and access to primary care physicians.

DCH has proposed that the new MMIS system be NCQA certified, thus guaranteeing reports that meet HEDIS specifications. The MMIS vendor will also contract with a Medical Record Review Organization to assist with reporting hybrid measures. DCH will modify the contract with its EQRO vendor to allow EQRO validation of the MMIS generated HEDIS performance measures. This will allow comparisons between the MMIS generated performance metric reports for the Georgia Families program, the FFS program and the individual CMO generated and EQRO validated performance measure reports. This MMIS initiative supports improvements in access to and quality of care as improvements can only be driven by accurate, validated, useful and reliable data. More importantly, for quality to improve across the health care continuum, data must be monitored at all levels.

#### Implementation of Optional EQRO Activities

HSAG is conducting an Encounter Data Validation (EDV) project, which is an Optional EQRO Activity, during the 2009 contract year. This year's EDV project focuses on validating CMO EPSDT visits. In particular the study's purpose is to evaluate the extent to which administrative encounters for EPSDT visits are accurate and complete. This study will be complete in the first quarter of 2010 and preliminary results will be available in the HSAG Annual Report.

#### Complete and Accurate Encounter Data

In 2009, DCH focused efforts on reducing a significant backlog of CMO encounter data. The backlogged volume affected the completeness of encounter data available for analysis, reporting and oversight. DCH contracted with the certified public accounting firm of Myers & Stauffer, LLC (M & S) to conduct monthly reconciliations of encounter data in MMIS to the CMOs' case disbursement journals (amounts paid by the CMOs) to determine the percentage of encounters submitted by the CMOs. To hold the CMOs accountable for the timely and complete submission of encounter data, DCH established thresholds that the CMOs must meet. Currently, the CMOs are required to submit 97% to 98% 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. Over the past year, DCH has worked with ACS and the three CMOs to resolve issues that would affect the timely submission of encounter data. As a result, the CMOs have significantly improved encounter submission rates. For the most recent

reconciliation time period of October 2007 through August 2009, the CMOs have the following submission rates:

<b>CMO</b>	<b>Submission Rate for Reconciliation Period</b>
<b>Amerigroup</b>	99.24%
<b>Peach State</b>	99.19%
<b>WellCare</b>	94.80%
<b>Combined (all CMOs)</b>	<b>96.96%</b>

In addition to ensuring the volume of encounter data submitted by the CMOs meets DCH's standards, DCH knows 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.

### Sanctions

In accordance with 42 CFR 438.706, DCH may use sanctions for CMO non-compliance with state and/or federal statutory guidelines and Georgia Families Contractual provisions. With the addendum to the CMO contract, liquidated damages may also be levied if a CMO fails to achieve established performance targets.

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
- The State may impose temporary management only if it finds (through onsite survey, enrollee complaints, financial audits, or any other means) that there is continued egregious behavior by the plan, 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, the State may impose intermediate sanctions in accordance with 42 CFR 438.702.

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

## **B. Assessing Progress**

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 will assess whether or not the objectives have been met utilizing several methods:

- Identifying, collecting and assessing relevant data.
- Review and analysis of periodic reports: reports and deliverables are used to monitor and evaluate compliance and performance. DCH reviews these reports and provides feedback as appropriate.
- Review and analysis of program-specific Performance Measures: CMOs submit performance measurement reports which measure each plan's performance and evaluates its compliance in meeting contractual performance standards for specific health care services. Under their amended contract, CMOs are required to improve their performance rates to achieve specific performance targets.

In addition, GF will work to improve the quality of care provided by the CMOs by reviewing each CMO's QAPI evaluation, CAHPS and HSAG annual report findings over time.

As required, the process intended to embark on quality improvement was addressed in the initial Quality Strategy approved by CMS March 2008 and available at the below link:  
[http://dch.georgia.gov/00/channel\\_title/0,2094,31446711\\_96559860,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html)

## **IV. Review**

As with this submission, new projects and/or strategies evolve with data collection, assessment of data, implementation of interventions and evaluation of the effectiveness of the GF Quality Strategy.

### ***A. Frequency of Assessment***

Assessment and review of the components of the Quality Strategy are ongoing processes. DCH is responsible for reporting Quality Strategic activities, findings, and actions to members, providers, stakeholders, the DCH Board, and CMS.

## **B. Frequency of Updates**

The Quality Strategy will also be revised when a significant change occurs. DCH defines a significant change as any change to the Quality Strategic Plan that may affect the delivery or measurement of the quality of health care. CMS approval on all revisions/updates will be attained by the State prior to posting on the DCH website.

## **C. Interim Updates**

As the Quality Strategy evolves, DCH will document challenges and successes that result in changes to the Strategy, including interim performance results, as available, for each strategy objective. After internal review and approval, results of interim performance measures will be available on the DCH website below:

[http://dch.georgia.gov/00/channel\\_title/0,2094,31446711\\_96559860,00.html](http://dch.georgia.gov/00/channel_title/0,2094,31446711_96559860,00.html)

## **V. Achievements and Opportunities**

This section describes various quality improvement achievements and opportunities identified by DCH.

### Achievements

DCH transitioned from using six “HEDIS-like” performance measures to employing over thirty standardized measures to assess the quality of care provided to GF members.

The procurement and pending implementation of the Georgia MMIS system which supports standardized performance measures is a major DCH achievement. This process will make the generation of performance measurement reports easier and may reduce DCH’s reliance on an outside vendor to generate DCH specific reports.

DCH continues to work to address EPSDT program areas of concern identified through collaboration and data review. Our efforts include aggressively working with Georgia provider organizations and societies to educate providers on the five required components of the EPSDT visit - Comprehensive Health and Developmental History; Comprehensive Unclothed Physical Exam; Laboratory Tests; Immunizations; and Health Education/ Anticipatory Guidance. DCH has been successful in ensuring consistent utilization of the American Academy of Pediatrics/Bright Futures 2008 periodicity schedule.

### Opportunities

DCH continues to develop a definition for “special health care needs” that is specific to Georgia. We are currently reviewing the federal Maternal and Child Health Bureau’s definition of Children with special healthcare needs (CSHCN). Ideas such as using ICD-9-CM codes for children younger than 21 years and

CSHCN screening tools such as the CAMHI tool are being investigated. Once defined, screening tools will be developed through a collaborative stakeholder process and utilized by GF.

Ensuring reliable and complete encounter data within the DCH MMIS system to accurately reflect performance is an ongoing opportunity for improvement. DCH worked with external consultants and the CMOs to improve the encounter data submission rates. Subsequent encounter data submission rates have complied with DCH requirements.

DCH is also working to improve coordinated care and comprehensive EPSDT visits by promoting the “medical home” for all preventive services for EPSDT eligible members. We have learned that provider education and member outreach efforts are necessary to further awareness and knowledge about the availability and expectations of EPSDT services with the goal of increasing member utilization of EPSDT services.

To ensure providers are performing all required EPSDT visit components during each periodic visit, DCH discussed the mandatory EPSDT visit components with CMS staff members and provided details of that discussion to the CMOs. DCH also prepared and posted a banner message for Medicaid providers to inform them of the mandatory EPSDT visit components. The CMOs then prepared and distributed blast faxes and made modifications to their member and provider handbooks to educate members and providers about the components of a complete and comprehensive EPSDT visit. Ongoing education about the EPSDT visit will continue.

DCH staff members regularly meet with representatives from the Georgia Chapters of the American Academies of Pediatrics and Family Physicians to discuss “on the ground” issues related to the EPSDT (Health Check) program. Additionally, DCH will update its EPSDT – Health Check Manual in July 2010 and align the periodicity schedule for the fee-for-service program with that of the managed care program.



## VI. APPENDICES

### Appendix A: Updated Performance Measures List

This list of performance measures and targets will be reviewed and updated at least annually to reflect current standards and progress

#	Area	Measure	Targets for SFY 10 Contract year in <b>Red</b>			
			25	50	75	90
1.	Children's Preventive Health	<b>WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE:</b> Percentage of members who turned 15 months old during the measurement year and who had the following number of well-child visits with a PCP during their first 15 months of life: <ol style="list-style-type: none"> <li>1. No well-child visits</li> <li>2. One well-child visit</li> <li>3. Two well-child visits</li> <li>4. Three well-child visits</li> <li>5. Four well-child visits</li> <li>6. Five well-child visits</li> <li>7. <b>Six or more well-child visits</b></li> </ol>	1.0 1.0 2.2 3.9 7.2 13.6 44.5	1.9 1.9 3.1 5.8 10.6 17.8 57.5	3.1 3.3 5.1 8.1 13.6 20.8 <b>65.4</b>	6.8 6.4 7.5 9.9 16.1 23.4 73.7
2.	Children's Preventive Health	<b>WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH AND SIXTH YEARS OF LIFE:</b> Percentage of members 3 – 6 years of age who received one or more well-child visits with a PCP during the measurement year.	1.6	2.2	2.5	2.9
3.	Children's Preventive Health	<b>ADOLESCENT WELL-CARE VISITS:</b> The percentage of enrolled members 12-21 years of age who had at least one comprehensive well-care visit with a PCP or OB/GYN practitioner during the measurement year.	35.9	42.1	51.4	56.7
4.	Access to Preventive /Ambulatory Health Services	<b>CHILDREN AND ADOLESCENTS ACCESS TO PRIMARY CARE PRACTITIONERS:</b> Percentage of members 12 months – 19 years of age who had a visit with a primary care practitioner.	78.1	84.5	90.0	91.9
5.	Access to Preventive /Ambulatory Health Services	<b>ADULTS ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES:</b> Percentage of members <b>20 – 44 yrs</b> and older who had an ambulatory or preventive care visit.	71.6	79.6	<b>84.8</b>	87.6
6.	Children's Preventive Health	<b>CHILDHOOD IMMUNIZATION STATUS- COMBO 2:</b> Percentage of children two years of age who had four diphtheria, tetanus and acellular pertussis (DTaP), three polio (IPV), one measles, mumps and rubella (MMR), two H influenza type B (Hib), three hepatitis B, one chicken pox (VZV) by their second birthday. The measure calculates a rate for each vaccine and two separate combination rates.	63	<b>72</b>	79	83
7.	Children's Preventive Health	<b>LEAD SCREENING IN CHILDREN:</b> Percentage of children two years of age who had one or more capillary or venous lead blood tests for lead poisoning by their second birthday	49.3	<b>65.9</b>	76.5	84.0
8.	Children's Preventive Health	<b>WEIGHT ASSESSMENT AND COUNSELING FOR NUTRITION AND PHYSICAL ACTIVITY FOR CHILDREN/ADOLESCENTS:</b> Percentage of members 2-17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of BMI percentile documentation, counseling for nutrition and counseling for physical activity during the measurement year.  Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.				
9.	Oral Health	<b>ANNUAL DENTAL VISIT:</b> The percentage of members 2 – 21 years of age who had at least one dental visit during the measurement year.	36.4	45.1	51.3	61.3
10.	Prevention and Screening	<b>CERVICAL CANCER SCREENING:</b> The percentage of women 21-64 years of age who received one or more Pap tests to screen for cervical cancer.	59	65	74	79
11.	Prevention and Screening	<b>BREAST CANCER SCREENING:</b> The percentage of women 40-69 years of age who had a mammogram to screen for breast cancer.	47	54	59	65

#	Area	Measure	Targets for SFY 10 Contract year in <b>Red</b>			
			25	50	75	90
12.	Access/Availability of Care	<p><b>PRENATAL AND POSTPARTUM CARE*</b>: 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 facets of prenatal and postpartum care:</p> <ul style="list-style-type: none"> <li>a. Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.</li> <li>b. Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery.</li> </ul>	77	84	89	92
13.	Utilization Rates	<p><b>FREQUENCY OF ONGOING PRENATAL CARE*</b>: The percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:</p> <ul style="list-style-type: none"> <li>c. &lt; 21 percent of expected visits</li> <li>d. 21 percent – 40 percent of expected visits</li> <li>e. 41 percent – 60 percent of expected visits</li> <li>f. 61 percent – 80 percent of expected visits</li> <li>g. ≥ 81 percent of expected visits</li> </ul>	3.4	7.7	15.1	24.4
14.	Women’s Health Care Services	<b>CESAREAN DELIVERY RATE</b> : This measure is used to assess the number of provider-level Cesarean deliveries per 100 deliveries	26.56			
15.	Utilization	<b>RATE OF INFANTS WITH LOW BIRTH WEIGHT</b> : This measure is used to assess the number of low birth weight infants per 100 births	6.26			
16.	Women’s Health Care Services	<p><b>WEEKS OF PREGNANCY AT TIME OF ENROLLMENT*</b>: The percentage of women who delivered a live birth during the measurement year by the weeks of pregnancy at the time of their enrollment in the organization, according to the following time periods:</p> <ul style="list-style-type: none"> <li>• Prior to pregnancy (280 days or more prior to delivery)</li> <li>• The first 12 weeks of pregnancy, including the end of the 12<sup>th</sup> week (279 – 196 days prior to delivery)</li> <li>• The beginning of the 13<sup>th</sup> week through the end of the 27<sup>th</sup> week of pregnancy (195 – 91 days prior to delivery)</li> <li>• The beginning of the 28<sup>th</sup> week of pregnancy or after (90 days or fewer prior to delivery)</li> <li>• Unknown</li> </ul>				
17.	Respiratory Condition	<b>APPROPRIATE TREATMENT FOR CHILDREN WITH UPPER RESPIRATORY INFECTION</b> : The percentage of children 3 months – 18 years of age who were given a diagnosis of upper respiratory infection (URI) and were not dispensed an antibiotic prescription.	78	84	89	93
18.	Asthma	<p><b>USE OF APPROPRIATE MEDICATIONS FOR PEOPLE WITH ASTHMA</b>: Percentage of members 5 – 56 years of age during the measurement year who were identified as having persistent asthma and who were appropriately prescribed medication during the measurement year.</p> <p>5-9 Years 10-17 Years 18-56 Years <b>TOTAL</b></p>	88.7 86.1 81.4 84	91.8 89.5 85.8 87	94.5 91.5 88.9 90	96.1 93.3 90.7 <b>93</b>
19.	Asthma	<b>PERCENT OF MEMBERS WHO HAVE HAD A VISIT TO AN EMERGENCY DEPARTMENT (ED)/URGENT CARE OFFICE FOR ASTHMA IN THE PAST SIX MONTHS</b> : This measure is used to assess the percent of patients who have had a visit to an Emergency Department (ED)/Urgent Care office for asthma in the past six months.	COULD NOT FIND			
20.	Asthma	<b>ASTHMA ADMISSION RATE- RATE PER 100,000 POPULATION</b> : This measure is used to assess the number of patients admitted for asthma per 100,000 population (Population ages 2 to 17 years).	180.895			

#	Area	Measure	Targets for SFY 10 Contract year in <b>Red</b>			
			25	50	75	90
21.	Diabetes	<p><b>COMPREHENSIVE DIABETES CARE:</b> The percentage of members 18 – 75 years of age with diabetes (type 1 and type 2) who each of the following:</p> <ul style="list-style-type: none"> <li>a. <b>Hemoglobin A1c (HbA1c) testing</b></li> <li>b. HbA1c poor control (&gt;9.0%)</li> <li>c. HbA1c good control (&lt;7.0%)</li> <li>d. Eye exam (retinal) performed</li> <li>e. LDL-C screening</li> <li>f. LDL-C control (&lt;100 mg/dL)</li> <li>g. Medical attention for nephropathy</li> <li>h. Blood pressure control (&lt;130/80 mm Hg)</li> <li>i. Blood pressure control (&lt;140/90 mm Hg)</li> </ul>	70 58 27.7 39.7 67 25.1 69 25.8 49.6	<b>79</b> 48 32.8 53.8 73 33.1 77 29.7 58.2	84 38 38.9 62.5 78 37.9 82 36.5 65.7	89 31 42.5 67.6 81 42.6 86 41.2 71.3
22.	Utilization Rates	<p><b>DIABETES SHORT TERM COMPLICATIONS ADMISSION RATE- RATE PER 100,000 POPULATION:</b> This measure is used to assess the number of patients admitted for diabetes short-term complications (ketoacidosis, hyperosmolarity, coma) per 100,000 population (All non-maternal discharges ages 6 to 17 years with ICD-9-CM principal diagnosis code for short term complications)</p>	29.019			
23.	Behavioral Health	<p><b>FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION:</b> Percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who have at least three follow-up care visits within a 10-month period, one of which is within 30 days of when the first ADHD medication was dispensed.</p> <ul style="list-style-type: none"> <li>• <b>Initiation Phase.</b> The percentage of members 6-12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who had one follow-up visit with practitioner with prescribing authority during the 30-day Initiation Phase.</li> <li>• <b>Continuation and Maintenance (C&amp;M) Phase.</b> The percentage of members 6-12 years of age as of the Index Prescription Episode Start Date with an ambulatory prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the Initiation Phase, had at least two follow-up visits with a practitioner with 270 days (9 months) after the Initiation Phase ended.</li> </ul>	23.8  27.4	32.6  38.6	40.6  47.9	47.3  58.3
24.	Behavioral Health	<p><b>FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS:</b> Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an outpatient visit, an intensive outpatient encounter or partial hospitalization with a mental health practitioner.</p> <ol style="list-style-type: none"> <li>1. The percentage of members who received follow-up within 7 days of discharge</li> <li>2. The percentage of members who received follow-up within 30 days of discharge</li> </ol>	51.4 26	65.9 38	75.0 58	80.3 66
25.	Utilization Rates	<p><b>MENTAL HEALTH UTILIZATION:</b> The number and percentage of members receiving the following mental health services during the measurement year:</p> <ul style="list-style-type: none"> <li>• Any Services</li> <li>• Inpatient</li> <li>• Intensive outpatient or partial hospitalization</li> <li>• Outpatient or ED</li> </ul>				
26.	Utilization Rates	<p><b>INPATIENT UTILIZATION- GENERAL HOSPITAL/ACUTE CARE:</b> This measure summarizes utilization of acute inpatient care and services in the following categories:</p> <ul style="list-style-type: none"> <li>• Total Inpatient</li> <li>• Medicine</li> <li>• Surgery</li> <li>• Maternity</li> </ul>				
27.	Access/Availability of Care	<p><b>CALL ABANDONMENT:</b> The percentage of calls received by the organization's Member Services call centers (during operating hours) during the measurement year that were abandoned by the caller before being answered by a live voice. Lower rates represent better performance.</p>				

#	Area	Measure	Targets for SFY 10 Contract year in <b>Red</b>			
			25	50	75	90
28.	Satisfaction With the Experience of Care	<p><b>CAHPS HEALTH PLAN SURVEY 4.0H, CHILD VERSION:</b> This measure provides information on parents' experience with their child's Medicaid organization. Results summarize member experience through ratings, composites and individual question summary rates. Four global rating questions reflect overall satisfaction:</p> <ul style="list-style-type: none"> <li>• Rating of All Health Care</li> <li>• Rating of Health Plan</li> <li>• Rating of Personal Doctor</li> <li>• Rating of Specialist Seen Most Often</li> </ul> <p>Five composite scores summarize responses in key areas:</p> <ul style="list-style-type: none"> <li>• Customer Service</li> <li>• Getting Care Quickly</li> <li>• Getting Needed Care</li> <li>• How Well Doctors Communicate</li> <li>• Shared Decision Making</li> </ul> <p>Item-specific question summary rates are reported for the rating questions and each composite question. Question Summary Rates are also reported individually for two items summarizing the following concepts:</p> <ul style="list-style-type: none"> <li>• Health Promotion and Education</li> <li>• Coordination of Care</li> </ul>				
29.	Utilization Rates	<p><b>ANTIBIOTIC UTILIZATION:</b> This measure summarizes the following data on outpatient utilization of antibiotic prescriptions during the measurement year, stratified by age and gender:</p> <ul style="list-style-type: none"> <li>• Total number of antibiotic prescriptions</li> <li>• Average number of antibiotic prescriptions per member per year (PMPY)</li> <li>• Total days supplied for all antibiotic prescriptions</li> <li>• Average days supplied per antibiotic prescription</li> <li>• Total number of prescriptions for antibiotics of concern</li> <li>• Average number of prescriptions PMPY for antibiotics of concern</li> <li>• Percentage of antibiotics of concern for all antibiotic prescriptions</li> <li>• Average number of antibiotics PMPY reported by drug class: <ul style="list-style-type: none"> <li>• For selected "antibiotics of concern"</li> <li>• For all other antibiotics</li> </ul> </li> </ul>				
30.	Utilization Rates	<p><b>OUTPATIENT DRUG UTILIZATION:</b> This measure summarizes data on outpatient utilization of drug prescriptions, stratified by age, during measurement year. The following data are reported:</p> <ul style="list-style-type: none"> <li>• Total cost of prescriptions</li> <li>• Average cost of prescriptions PMPM</li> <li>• Total number of prescriptions</li> <li>• Average number of prescriptions PMPY</li> </ul>				
31.	Health Plan Descriptive Information	<p><b>RACE/ETHNICITY DIVERSITY OF MEMBERSHIP:</b> An unduplicated count and percentage of members enrolled any time during the measurement year by race and ethnicity</p>				
32.	Health Plan Descriptive Information	<p><b>LANGUAGE DIVERSITY OF MEMBERSHIP:</b> An unduplicated count and percentage of Medicaid members enrolled at any time during the measurement year by demand for language interpreter services and spoken language.</p>				

**Appendix B: Individual CMO PIP Performance\***

<b>CMO</b>	<b>PIP</b>	<b>Validation Status</b>
Amerigroup Community Care	Well Child Visit 15 Months	MET
	Childhood Immunization Rates	MET
	Blood Lead Screening	MET
	Access to Care for Members 20-44yrs	MET
	Member Satisfaction	MET
	Provider Satisfaction	MET
Peach State Health Plan	Well Child Visit 15 Months	MET
	Childhood Immunization Rates	MET
	Blood Lead Screening	MET
	Access to Care for Members 20-44yrs	MET
	Member Satisfaction	MET
	Provider Satisfaction	MET
WellCare Georgia	Well Child Visit 15 Months	MET
	Childhood Immunization Rates	MET
	Blood Lead Screening	MET
	Access to Care for Members 20-44yrs	MET
	Member Satisfaction	MET
	Provider Satisfaction	MET

\*Validation Status reflects the EQR findings for CMO data submitted to the EQRO in June 2009.

## Appendix C: Individual CMO Performance Measure Results

A Georgia Families “roll up” will be submitted to CMS with the next update to the Quality Strategic Plan

Measure	Amerigroup Community Care <sup>1</sup>			Peach State Health Plan <sup>2</sup>			WellCare of Georgia <sup>1</sup>			SFY 2010 Targets
	Numerator	Denominator	CMO Rate	Numerator	Denominator	CMO Rate	Numerator	Denominator	CMO Rate	
Well Child Visits in the first 15 months of life with 6 or more visits (WCV-15)	282	453	62.25% Hybrid	212	411	51.58% Hybrid	236	411	57.42% Hybrid	65.40%
Childhood Immunization <sup>4</sup> Combo 2 (CIS)	1,323	4,433	29.84% <sup>3</sup>	258	411	62.77% Hybrid	312	411	75.91% Hybrid	72%
Lead Screening in Children	309	453	68.21% Hybrid	235	411	57.18% Hybrid	271	411	65.94% Hybrid	65.90%
Adult Access to Preventive/Ambulatory Health Services (20 - 44 years)	5,529	6,809	81.20%	8,398	10,646	78.88%	14,602	18,569	78.64%	84.80%
Member with Diabetes who had a HbgA1c test performed during measurement period	336	451	74.5% Hybrid	264	411	64.23% Hybrid	297	411	72.26% Hybrid	79%
Use of Appropriate Medication for People with Asthma	2,196	2,391	91.84%	1,540	1,690	91.12%	3,239	3,576	90.58%	94.50%

Note: CMO rates reflect the EQR validated findings for CMO data submitted to the EQRO in June 2009.

<sup>1</sup>AMERIGROUP Community Care and WellCare-Georgia rates include both PeachCare for Kids™ and Medicaid for all measures

<sup>2</sup>Peach State Health Plan rates include Medicaid only for the all measures

<sup>3</sup>AMERIGROUP reported its CIS rate using administrative data only

<sup>4</sup>No Georgia Registry of Immunizations, Transactions and Services (GRITS) data was used for reporting the CIS measure