Georgia Department of Community Health

Georgia Families

Choices for a Healthy Life

Georgia Department of Community Health

Quality Strategic Plan

Version 1.0 - June 2007

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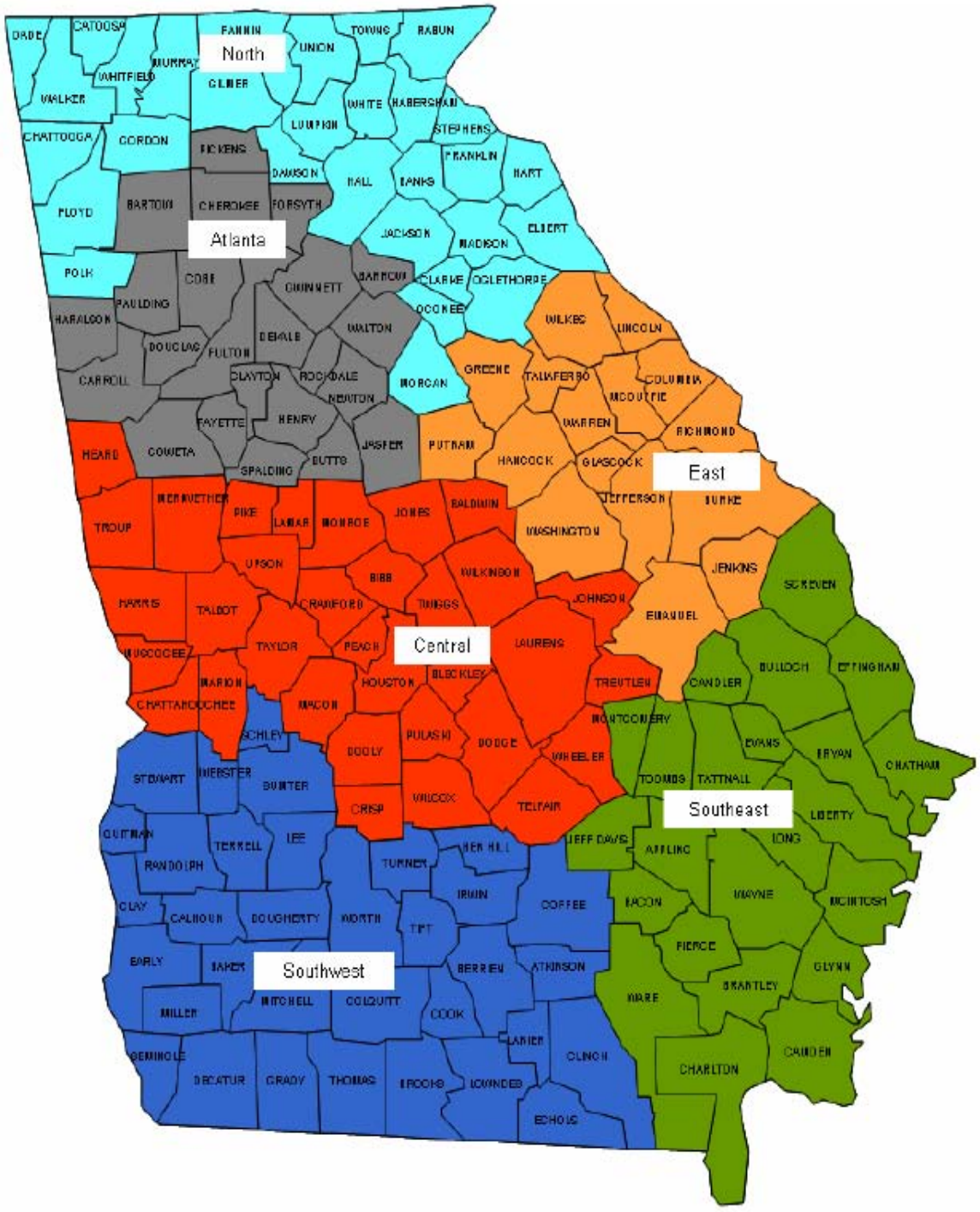
I. Introduction

A. State's Decision to Contract with Managed Care Organization

In 2003, the Georgia Department of Community Health (DCH) identified unsustainable Medicaid growth and projected that without a change to the system, Medicaid would require 50 percent of all new State revenue by 2008. In addition, Medicaid utilization was driving more than 35 percent of total growth each year. For that reason, DCH decided to employ a management of 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. Furthermore, DCH believed that managed care could continuously and incrementally improve the quality of healthcare and services provided to patients and improve efficiency by utilizing both human and material resources more effectively and more efficiently. The DCH Division of Managed Care and Quality submitted a State Plan Amendment in 2004 to implement a full-risk mandatory Medicaid Managed Care program called Georgia Families. Georgia Families is a new program for specific Medicaid eligible members and includes PeachCare for Kids™ enrollees, which is Georgia's State Children's Health Insurance Plan (SCHIP). Georgia Families Medicaid eligibility categories include the following: Low Income Medicaid (LIM), transitional Medicaid, pregnant women in "Right from the Start Medicaid" (RSM), newborns of Medicaid-covered women, refugees, and women with breast and cervical cancer.

Georgia requires mandatory enrollment of specific Medicaid beneficiaries into the managed care entity in accordance with Section 1932(a) (1) (A) of the Social Security Act which is referenced in the State Plan Amendment for Managed Care. The program is a 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). In the state of Georgia, Managed Care Organizations are referred to as Care Management Organizations (CMO). Amerigroup Community Care, Peach State Health Plan and WellCare of Georgia manage the care of approximately 970,000 members under this program as of June 2007. 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.

GEORGIA STATE MAP



The following chart displays the distribution of the membership among the CMOs as of June 1, 2007:

Region	CMO	Membership
Atlanta	AMERIGROUP Peach State WellCare	105,734 167,446 183, 477
	Atlanta Region Total	**456,657**
Central	Peach State WellCare	52,912 72,772
	Central Region Total	**125,684**
North	AMERIGROUP WellCare	54,361 78,821
	North Region Total	**133,182**
East	AMERIGROUP WellCare	28,139 32,921
	East Region Total	**61,060**
Southeast	AMERIGROUP WellCare	34,943 57,551
	Southeast Region Total	**92,494**
Southwest	Peach State WellCare	73,310 31,091
	Southwest Region Total	**104,401**
	Georgia Families Total	973,478

B. Public Comment Process

This plan has been 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 has addressed each comment and amended the plan accordingly. While DCH will address relevant comments on an ongoing basis, the plan will be updated annually.

DCH maintains the ultimate authority for overseeing the Quality Strategic Plan and the management and direction of the Georgia Families program.

C. Performance Driven Objectives

Values and Guiding Principles

- Access – Ensure and support efforts to remove any barriers to healthcare services and resources, including but not limited to language barriers

- 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

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. CMO network providers have the added assistance of the CMOs to educate members about accessing care, referrals to specialists, member benefits, and health and wellness education. Collaboration and partnership between CMOs and network providers affords a more efficient delivery of health care services, better care for members and accountability to taxpayers while at the same time maintaining budget predictability and sustainable growth for DCH.

Goals

It is the goal of DCH to assure that the care provided within managed care is of an acceptable quality, assures accessibility, provides for continuity, and promotes efficiency. Specific goals include:

- 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

- Promotion of acceptable standards of healthcare within managed care programs by monitoring internal/external processes for improvement opportunities

Objectives

- Children's Preventive Health: Over the next five years the state will strive to meet or exceed the Healthcare Effectiveness Data and Information Set (HEDIS) 2006 90th percentile in managed care eligible children with well-child visits during their first 15 months of life (Georgia's Baseline: 47.7 percent of children with six or more visits; HEDIS 90th percentile = 68.6 percent; 75th percentile = 59.2 percent; 50th percentile = 50 percent).
- Children's Preventive Health: In collaboration with Georgia's Immunization program, over the next five years, the Division of Managed Care and Quality will demonstrate an improvement of 5 percentage points in the number of managed care eligible children less than 36 months of age compliant with an immunization 4:3:1:3:3:1* series).(Georgia's Baseline: 76.8 percent)

*(4 DTP [Diphtheria, Tetanus, and Pertussis], 3 Polio, 1 MMR [Measles, Mumps, and Rubella], 3 Hib [Haemophilus Influenza Type B], 3 Hep B [Hepatitis B], and I Varicella)

- Children's Preventive Health: In collaboration with Georgia's Childhood Lead Poisoning Prevention Program (GCLPPP), the Division of Managed Care and Quality will demonstrate an improvement of 10 percentage points in the number of one year old and two year old managed care eligible children receiving a screening for blood lead over the next five years (Georgia's Baseline: Age 9 – 15months- 27.1 percent and Age 21 – 27 months- 21.7 percent).
- Access to Preventive/Ambulatory Health Services: Within the next five years the Division of Managed Care and Quality will demonstrate an improvement of 10 percentage points in the

number of enrolled members age 21 and older who had an ambulatory or preventive care visit. This will bring Georgia to the 90th percentile level for managed Medicaid plans for adults aged 21- 44 years old (based on HEDIS 2006). (Georgia Baseline: 78.9 percent; HEDIS 90th percentile = 87 percent; HEDIS 75th percentile = 83.7 percent; HEDIS 50th percentile = 79 percent)

- Diabetes: Within the next five years, the State will demonstrate an improvement of 20 percentage points in the managed care eligible members with diabetes who had at least one HbA1c test. This will bring Georgia to the 75th percentile level for managed Medicaid plans (based on HEDIS 2006). (Georgia Baseline: 65.3 percent Ages 18 – 75 HEDIS 90th percentile = 88.8 percent; HEDIS 75th percentile = 84.9 percent; HEDIS 50th percentile = 77.4 percent)
- Asthma: Within the next five years the State will demonstrate an improvement of five percentage points in the managed care eligible members with asthma that received appropriate medications. This will bring Georgia to the 90th percentile level for managed Medicaid plans (based on HEDIS 2006). (Georgia Baseline: 88.5 percent. HEDIS 90th percentile = 92.5 percent; 75th percentile = 89.7 percent; 50th percentile = 87.1 percent)
- Maternal and Child Health: Within the next five years the state will demonstrate a 10 percent decrease in the rate of managed care low birth weight babies. This will lead to a reduction in the rate of low birth weight babies from 9.3/1000 to 8.4/1000 live births and ultimately improve Georgia's infant mortality rates.

II. Assessment:

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™.

  Members have the option of identifying themselves as belonging to one of the following race categories: A-Asian, B-Black, H-Hispanic (Used prior to 10/99), M-Mixed, N-Native American, P-

Pacific Islander/Alaskan, U-Unknown (Used prior to 10/99) or W-White.

Members have the option of identifying one of the following ethnicity categories: L = Latino/Hispanic or N= Non Latino/Hispanic.

Furthermore, members have the option of indicating one of the following languages as primary: A – Arabic, C – Creole, E – English, F – French, G – German, H – Hmung, I – Italian, K – Kymer, L – Laotian, O – Portuguese, P – Polish, R – Russian, S – Spanish, V – Vietnamese, X – Other, or Z – Farsi.

This data is sent electronically to each CMO as part of their monthly eligibility file. DCH has requested that each CMO include information as to how they plan to assess and address health care disparities as part of their quality improvement program description. In addition, the Division of Managed Care and Quality will analyze race, language, and ethnicity data to identify apparent health care disparities across its entire population. After analyzing this data, the Division of Managed Care and Quality staff will meet with the CMOs to identify opportunities to address geographic areas and target populations impacted by disparities in healthcare outcomes.

The State requires the CMOs to translate marketing materials for potential enrollees and enrollee materials for established members into all languages that are spoken by 10 percent or more of the population in the plan's service areas. The CMOs are also required to provide oral translation services to all non-English speaking members.

- *External Quality Review*
  Currently the Quality Management Unit of the Division of Managed Care and Quality's is in the process of issuing a Request for Proposal (RFP) for an External Quality Review Organization (EQRO). DCH will contract with an EQRO to conduct annual, external and independent reviews of the quality outcomes, timeliness of service and access to the services covered in this contract. The EQRO will adhere to the requirements specified in the Code of Federal Regulations (CFR) in order to provide:

- Validation of performance improvement projects undertaken by the CMO
- Validation of performance measures produced by a CMO
- A review to determine CMO compliance with federal Medicaid managed care regulations

DCH has set a goal of procuring an EQRO by April 2008.

- *Clinical Standards/Guidelines*
  DCH has established policies for the development and use of practice guidelines (clinical standards/guidelines). CMOs are required to adopt a minimum of three evidence-based clinical practice guidelines such as chronic kidney disease, blood lead screens, and immunization. Practice guidelines must be based on the health needs and opportunities for improvement identified as part of the QAPI (Quality Assessment Performance Improvement) program; CMOs must ensure that practice guidelines are based on valid and reliable clinical evidence or a consensus of health care professionals in a particular field; consider the needs of the member; are adopted in consultation with participating providers; and are reviewed and updated periodically as appropriate.

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

B. Contract Compliance

- *Access to Care*
  The State's contract with the CMOs require 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 Code of Federal Regulations (CFR) chapter IV, subchapter C; Title 45 CFR 95, General Grants Administration Requirements;

CMO access to care contract requirements are summarized in this section.

- *Maintains a Network of Appropriate Providers*
  DCH has implemented processes to monitor and assure that members' access to care is not restricted. The CMO must submit a provider network adequacy and capacity report that demonstrates that the CMO offers an appropriate range of preventive, primary care and specialty services that is 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. By contract, CMOs are required to meet the following geo-access standards.

	Urban	Rural
PCPs	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
Dental 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, seven (7) days a week within thirty (30) minutes or thirty (30) miles

- *Timely Access*
  DCH requires that each CMO have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

Type of Provider	Appointment Wait Time
PCPs (routine visits)	21 Calendar Days
PCP (adult sick visit)	72 hours
PCP (pediatric sick visit)	24 hours
Specialist	30 Calendar Days
Non-emergency hospital stays	30 Calendar Days
Mental health Providers	14 Calendar Days
Urgent Care Providers (including Mental Health)	24 hours
Emergency Providers (including Mental Health)	immediately (24 hours a day, 7 days a week) and without prior authorization

CMOs must provide adequate capacity for initial visits for pregnant women within 14 calendar days and visits for EPSDT (Health Check) eligible children within 90 calendar days of enrollment into the CMO plan and within 24 hours of birth for newborns.

DCH will monitor this function via secret shopper and by random office visits, review of annual Member Survey Reports, and quarterly Provider Survey Reports.

- *Direct Access to Women's Specialist*
  The CMO must allow female members to select a gynecologist or obstetrician-gynecologist (OB-GYN) as their Primary Care Provider (PCP). CMOs must provide female members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive health care services. This is in addition to the member's designated source of Primary Care if that provider is not a women's health specialist. DCH monitors this requirement by review, tracking and trending of reports submitted by the CMOs. Each CMO is required to submit monthly GEO-Access reports to ensure their network is adequately staffed with OB-GYNs. They must also submit a monthly PCP Assignment Report. This report identifies all providers

(including OB-GYNs) that have been selected by members as PCP providers.

- *Out-of-Network Medically Necessary Services*
  If the CMOs network is unable to provide medically necessary covered services to a particular member then the CMO will authorize services for the member to be furnished adequately and timely by an out-of-network provider. The CMO is required to coordinate with the out-of-network providers regarding payment.

  DCH will monitor compliance with this requirement through review of CMO policies and procedures, as well as monitoring complaints regarding accessibility of providers.

- *Second Opinions*
  Each CMO is required to provide for a second opinion in any situation when there is a question concerning a diagnosis or the options for surgery or other treatment of a health condition when requested by any member of the health care team, a member, parent(s) and/or guardian(s), or a social worker exercising a custodial responsibility. The second opinion must be provided by a qualified health care professional within the network, or arrange for the member to obtain one outside the provider network. The second opinion shall be provided at no cost to the member. DCH will monitor compliance with this requirement through review of CMO policies and procedures, as well as monitoring complaints regarding coverage of second opinions.

- *Credentialing*

  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 American Accreditation Healthcare Commission/URAC. At a minimum the contractor shall require that each provider to be credentialed in accordance with state law.

  DCH will conduct monthly reviews of the CMO credentials meeting minutes, documentation of all adverse disciplinary actions recorded on providers along with review of reports with expiration dates for provider licenses, certifications, insurance coverage, and other documents. DCH will use the CMO provider databases to audit expired dates to validate that data has been received and loaded. DCH Provider Services staff confirms that the provider licensure data has been updated in the CMO provider database. DCH will randomly audit the CMOs provider listing to ensure that the following provider credentials are not expired. Malpractice Insurance, Drug Enforcement Administration, Board Certification Documentation, and Delegated Entity lists to include coverage by county, providers' name, providers' specialties.

- *Coordination of Care*
  Pursuant to 42 CFR 428.208(b), the state requires the CMOs to implement procedures to ensure that each enrollee has an ongoing source of primary care appropriate to his or her needs and a person or entity formally designated as primarily responsible for coordinating the health care services furnished to the enrollee.

  The State requires the plans to implement procedures to ensure that in the process of coordinating care, 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.

- *Special Access*
  The State requires that each CMO must have a process in place that ensures members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the member's condition and identified needs.

  The CMOs are also required to inform members with a condition which requires on-going care from a specialist how those members may request a standing referral; and members with a life-threatening condition or disease which requires specialized medical care over a prolonged period of time about how they may request and obtain access to a specialty care center. The CMO Medical Director is responsible for oversight of this process.

  DCH will review CMO policies and procedures to ensure that these provisions are in place and will monitor complaints for evidence of non-compliance.

- *Special Needs Population*
  The State of Georgia defines Special Health Care Needs according to the Bureau of Maternal Child Health's definition as those who have or are at increased risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally. Beginning State Fiscal Year 2009, DCH will implement the Child and Adolescent Health Measurement Initiative (CAHMI) screening tool to identify managed care children with special needs and share with CMOs for coordination and continuity of care.

- *Covered Services*
  Each CMO is required to provide services in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under fee-for-service Medicaid.

  - *Medical Necessity*
    The State requires the CMOs, at a minimum, to provide medically necessary services and benefits pursuant to the Georgia State Medicaid Plan, and the Georgia

Medicaid Policies and Procedures Manual. DCH defines medically necessary services as:

Based upon generally accepted medical practices in light of conditions at the time of treatment, services that are:

- 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 hospital; and
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.
- There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

In addition, the CMO must ensure that coverage is provided for EPSDT eligible members when the provision of that service is necessary to correct or ameliorate a health condition identified during a Health Check screen.

o *Prior Authorization*

The CMOs are permitted to require prior authorization and/or pre-certification for all non-emergent, out-of-network services. The CMOs may not require prior authorization or pre-certification for emergency services, post stabilization services, or urgent care services. Each Plan must require prior authorization and/or pre-certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries. Prior Authorization and/or Pre-Certification for all non-emergent, out-of-network services may be required by the CMOs.

The CMO may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or condition. In accordance with 42 CFR 438.210 (b)(3), any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested, be made by a health care professional who has appropriate clinical experience 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.

- *Grievance System*
  The Grievance System is an internal process that must be exhausted by the member prior to access to an Administrative Law Hearing. DCH requires each CMO to maintain an internal grievance system. DCH requires that each CMO log and track all grievances, proposed actions, appeals and Administrative Law Hearing requests. Written grievance system policies and procedures that detail the operation of the grievance system were submitted to and approved by DCH prior to initial implementation. DCH requires each organization to process each grievance and appeal using applicable state and federal statutory, regulatory, Georgia Families 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.

  - *General Requirements*
    CMOs are required to acknowledge receipt of each filed grievance and appeal in writing within 10 business days of receipt. In compliance with federal statues, the CMOs must maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the grievance, date of the decision, and the disposition.

  - *Grievances*
    A grievance is any dissatisfaction about any matter other than a proposed action. A member or an authorized

representative with the member's consent may file a grievance either orally or in writing. DCH requires that individuals who make decisions on grievances that involve clinical issues are health care professionals who have the appropriate clinical expertise, as determined by DCH, in treating the member's condition or disease and who were not involved in any previous level of review or decision-making. Written notice of the disposition of the grievance must be sent as expeditiously as the member's health condition requires but shall not exceed 90 calendar days of the filing date.

- *Appeal Process*

  An appeal is the request for review of a "Proposed Action." The member or the member's authorized representative with the member's written consent may file an appeal either orally or in writing. Each CMO must ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making; and who are health care professionals who have the appropriate clinical expertise in treating the member's condition or disease if deciding an appeal of a denial that is based on lack of medical necessity; or an appeal that involves clinical issues. Resolution of the appeal and written notice of the appeal resolution must be mailed as expeditiously as the member's health condition requires but shall not exceed 45 calendar days from the date the appeal was received.

- *Administrative Law Hearing*

  The Administrative Law Hearing process shall provide members an opportunity for a hearing before an impartial Administrative Law Judge. The State will maintain 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 et al. A member or authorized representative may request in writing a State Administrative Law Hearing within 30 calendar days of the date the Notice of Adverse Action is mailed by the Plan. The CMOs shall comply with decisions reached as a result

of the Administrative Law Hearing process.

- *Continuation of Benefits*
  Continuation of member's benefits must be granted by the CMO if the member or the representative files the appeal timely and the member requests extension of the benefits. If the final resolution of appeal is adverse to the member, the CMO may recover from the member the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this Section. If the final resolution overturns the Plan decision, the Plan must authorize, provide and pay for disputed services promptly.

- *Special Appeal Rules for SCHIP members*
  Peach Care for Kids™, Georgia's SCHIP program, requires the member to initially request an appeal through the CMOs Grievance System. If resolution is not satisfactory to the member, the member must then file a request for appeal through Peach Care for Kids™. Peach Care for Kids™ is contracted with an independent Physician Review Organization that conducts medical necessity reviews for that program. In addition, the member may elect to present additional information in support of their appeal directly to a DCH appeal panel. The panel will consider information from the CMO, the independent physician review organization, and the member prior to issuing a determination. If the final resolution overturns the Plan decision, the Plan must authorize, provide and pay for disputed services promptly.

- *Subcontractor Relations*
  The CMOs are required to obtain DCH approval prior to hiring or entering into an agreement with any subcontractor. The CMOs should provide an immediate notice to DCH of any changes to any existing subcontractor agreements. The State will request a list of subcontractors quarterly to include dates the contracts were executed.

  DCH requires signed attestation statements from each CMO attesting that the activities of each of their approved subcontractors are being monitored. Each CMO must conduct annual (and as needed) audits of their sub-contractors to ensure all delegated functions are being performed as required.

DCH will review CMO compliance with oversight of subcontractors and all delegated functions by review of all subcontractor related monitoring activities, CMO/subcontractor meeting minutes, and subcontractor monitoring results including CMO analysis, interpretation, and corrective actions.

- *Structure and Operation*
  The CMO must make all of its books, documents, papers, provider records, medical records, financial records, data, surveys and computer databases available for examination and audit by authorized state or federal personnel. Any records requested must be produced immediately for onsite review or sent to the requesting authority by mail within 14 calendar days following a request. All records must be provided at the sole cost and expense of the CMO. DCH must have unlimited rights to use, disclose, and duplicate all information and data in any way relating to this contract in accordance with applicable state and federal laws and regulations. In addition, DCH will conduct periodic audits of operational processes.

- *Utilization Management*
  The CMO must provide assistance to members and providers to ensure the appropriate utilization of resources, using the following program components: prior authorization and pre-certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion, discharge planning and case management. The system should include CMO policies and procedures for evaluating medical necessity, authorizing services, and detecting and addressing the over-utilization and under-utilization of services.

  The CMO must submit a utilization management report on utilization patterns and aggregate trend analysis. These reports should provide to DCH analysis and interpretation of utilization patterns, including but not limited to, high volume services, high risk services, services driving cost increases, including prescription drug utilization; fraud and abuse trends; and quality and disease management. The CMO must provide ad hoc reports pursuant to the requests of DCH.

- *Performance Based Measurement*
  The CMO has to provide for the delivery of quality care with the primary goal of improving the health status of members and

where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. This includes the identification of members at risk of developing conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).

Compliance with contractual requirements for quality improvement will be measured through review of CMO quality minutes and reports, reports of Performance Improvement Projects (PIP), evaluation of member satisfaction surveys, review of CMO annual evaluation of their quality program, and review of standard clinical measures such as:

- Infant deaths per 1,000 live births;
- Low birth weights per 1000 live births;
- Pre-term births per 100 live births;
- Births to women receiving late or no prenatal care;
- Pregnant women with documented substance abuse;
- Percent of members with diabetes with at least one HbA1c test;
- Percent of asthma members receiving appropriate medications;
- Asthma related hospital emergency room visits per 1000 members with asthma;
- Asthma related hospital admissions per 1000 members with asthma;
- Percent of children with six or more well child visits in the first 15 months;
- Percent of children less than 36 months of age that are fully immunized (defined as the 4:3:1:3:3:1 series);
- Percent of one and two-year olds with a blood lead screening;
- Percent of adults aged 21 and older with at least one ambulatory/preventive health visit in the year;
- Percent of members ages 3 through 21 who had at least one dental visit; and
- Percent of members attending outpatient follow-up visit within 7 days of discharge from a psychiatric hospital.

In order to identify the impact of health care disparities, the above indicators will be aggregated by age, gender, and race, ethnicity, primary language, and urban vs. rural residential counties. The Appendix contains a list of all forty- six performance measures that DCH will be reviewing. This list will be updated and revised as necessary.

C. Use of Available and Evolving Health Information Technology

DCH has mechanisms in place to ensure that contracting CMOs maintain health information systems that collect, analyze, integrate, report data, and achieve the objectives of the Georgia Families program. Systems include data on member enrollment spans, provider characteristics, and services rendered. To decrease fragmentation of care, DCH considers mechanisms that make care more member centered and integrated across providers, settings, and conditions. DCH encourages standardization of core measures across integrated delivery systems. 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.

On October 17, 2006, Governor Sonny Perdue issued an executive order creating the Health Information Technology and Transparency (HITT) Advisory Board. DCH goals for HITT in Georgia are to enable the understandable, universal, timely and secure communication of health information across the public and private sectors for the benefit of the health care consumer. The HITT Board advises DCH on the best practices for encouraging the use of electronic health records and establishing a statewide strategy to enable health information to be readily available and transparent. Even with the growth of consumer information on quality, available information is not user-friendly, and few consumers understand it. By adopting and promoting the implementation of user-friendly, secure information technology in the clinical setting DCH encourages improved efficiency in clinical practice, addresses the interconnectivity of clinicians, hospitals and pharmacies, advocates for personalized health care and realizes the potential for improved population health.

Matching funds are being offered to create Health Information Exchange (HIE) pilot programs to demonstrate the use of interoperability of health information. Through the HIE pilot programs, DCH hopes to be able to

share the best practices for creating a framework for statewide interoperable health information systems. The outcomes and how these programs were able to transform health care delivery for the providers and consumers of the State of Georgia would be communicated to stakeholders and private investors to drive this important healthcare strategy throughout Georgia.

By State Fiscal Year 2009, the HITT Web site will be operational and will include national and state standards for quality, outcomes and services.

III. Improvement:

Improving the Quality of Care

The Georgia Families Quality Management Unit is responsible for the oversight of managed care quality improvement initiatives. The CMO must seek input from, and work with members, providers and community resources agencies to actively improve the quality of care provided to members. The CMO must establish a multi-disciplinary quality oversight committee to oversee all quality functions and activities. This committee must meet at least quarterly, but more often if warranted.

The CMO must have an ongoing QAPI (Quality Assessment Performance Improvement) program consistent with 42 CFR 438.240. The CMO's QAPI program must be based on the latest available research in the area of quality assurance. The QAPI program must 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), including those with special health care needs. In addition, CMOs must be accredited by the NCQA, URAC (Health Plan accreditation), Accreditation Association for Ambulatory Health Care (AAAHC), or JCAHO, or must be actively seeking and working towards accreditation within three years.

The Quality Management Unit, working in conjunction with other units within the DCH Division of Managed Care and Quality, will monitor ongoing performance and performance improvement activities of each of the CMOs. Tools available to facilitate improved performance include:

- Public reporting of clinical and quality data
- Preferential auto-assignment of new members to CMOs that demonstrate improved quality of care for their members

- Financial incentives for meeting or exceeding specified performance goals
- Sanctions and liquidated damages for failure of the CMO to meet contractual obligations

After a thorough analysis of the information retrieved from the quality review, strengths and areas for improvement will be identified. Financial incentives occur when CMOs exceed performance expectations. DCH determines the amount of financial performance incentive and allocation methodology. DCH may provide financial incentives for the following areas: EPSDT screenings, lead, dental visits, newborn enrollment notification, and EPSDT tracking and notices for missed appointments and referrals. If CMOs fail to comply with contractual requirements it may result in a corrective action plan (CAP) or the assessment of liquidated damages. A CAP is a detailed written plan requested from the CMOs in cases where the process or indicator reviewed does not reach performance standards. The CAP should include clearly stated objectives and timeframes for completion.

DCH requires CMOs to conduct PIPs that are designed to achieve, thorough 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. PIPs are ongoing for the duration of the Georgia Families contract period. The CMO must perform required clinical performance improvement projects in each of the following areas: EPSDT screens, immunizations, blood lead screens, detection of chronic kidney disease, and emergency room utilization. The CMO must also perform one optional clinical performance improvement project from the following areas: coordination/continuity of care, chronic care management, high volume conditions or high risk conditions. In addition, the CMO must perform two required non-clinical performance improvement projects in the areas of member satisfaction and provider satisfaction, as well as one optional non-clinical performance improvement project from any of the following areas: cultural competence, appeals/grievance/provider complaints, access/service capacity, or appointment availability. The CMO must submit to DCH any and all data necessary to enable DCH to measure the CMOs performance.

Performance improvement projects include some of the following criteria:

- Measure performance using quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time

- Implement interventions designed to achieve quality improvements
- Evaluate the effectiveness of the interventions
- Plan and initiate activities for increasing or sustaining improvement.
- Document the data collection methodology used (including steps taken to assure data is valid and reliable.)

In addition, the CMO must perform a minimum of two focused studies each year, commencing with the second year of operations. One study must focus on preventive care services. The CMO must submit to DCH for approval the areas in which it will conduct focused studies on the first day of the fourth quarter of the first year of operations. CMOs must submit a focused studies report on the first day of the fourth quarter of the first year of operations. The report must include the study design for each of the two required focused studies. The CMO must submit annual reports on the focused studies thereafter which will also include analysis and results.

Intermediate Sanctions

In addition to liquidated damages and in accordance with 42 CFR 438.706, DCH can assess sanctions to the CMOs for not complying with state and/or federal statutory guidelines and Georgia Families contractual provisions. 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 Medicaid managed care program 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
- There is substantial risk to enrollees' health
- The sanction is necessary to ensure the health of the plan's enrollee while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the plan

Unless the duration of a sanction is specified, a sanction shall remain in effect until the state is satisfied that the basis for imposing the sanction has been corrected and is not likely to recur. Before imposing any intermediate sanctions, DCH will give the plan timely notice according to 42 CFR 438.710. In addition, DCH will notify the Centers for Medicare and Medicaid Services (CMS) in writing within 30 days of when a sanction is imposed or lifted.

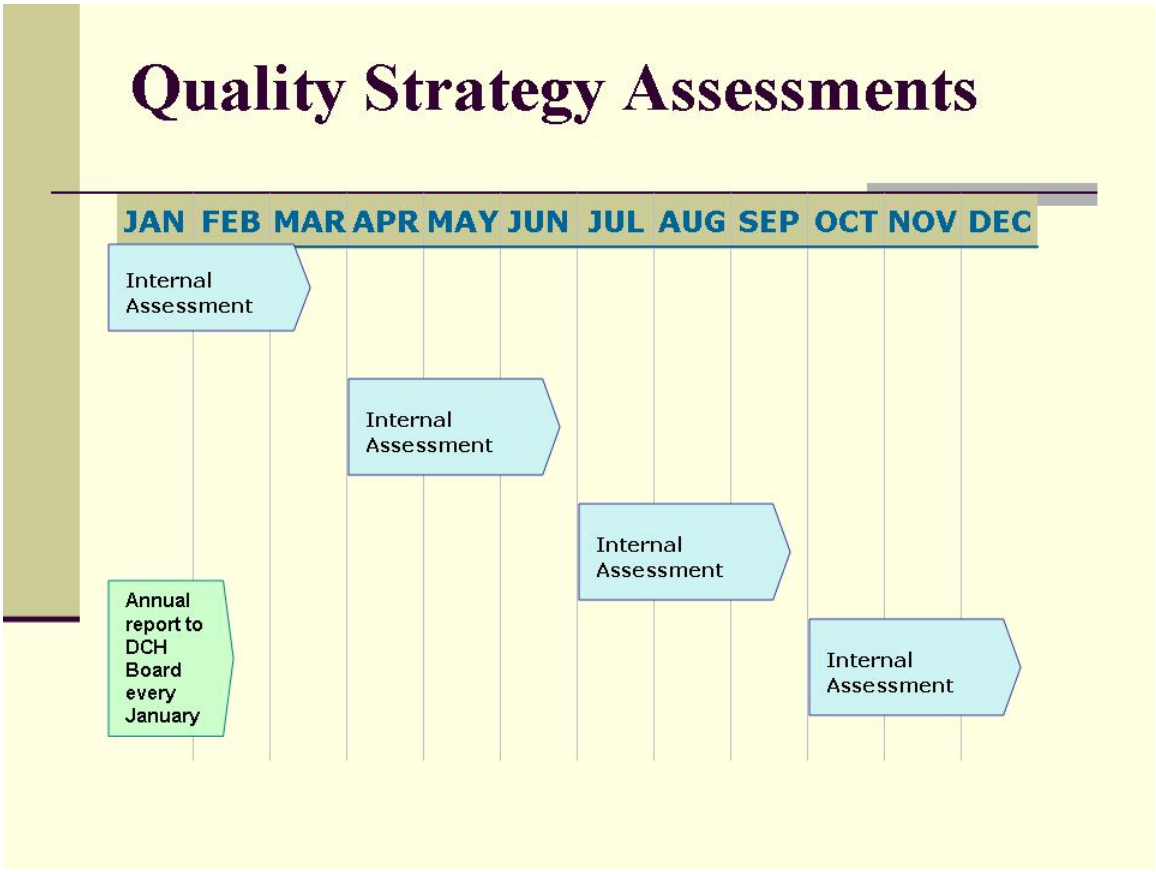
IV. Review of Quality Strategy

The State of Georgia will use a process to develop, review and revise Georgia Medicaid's quality assessment and improvement strategies that includes internal meetings with key decision makers and external meetings with stakeholders. A key component of the State's process is to ensure beneficiaries have access to quality health care in managed care programs by continuously assessing, reviewing and revising the state's quality strategies.

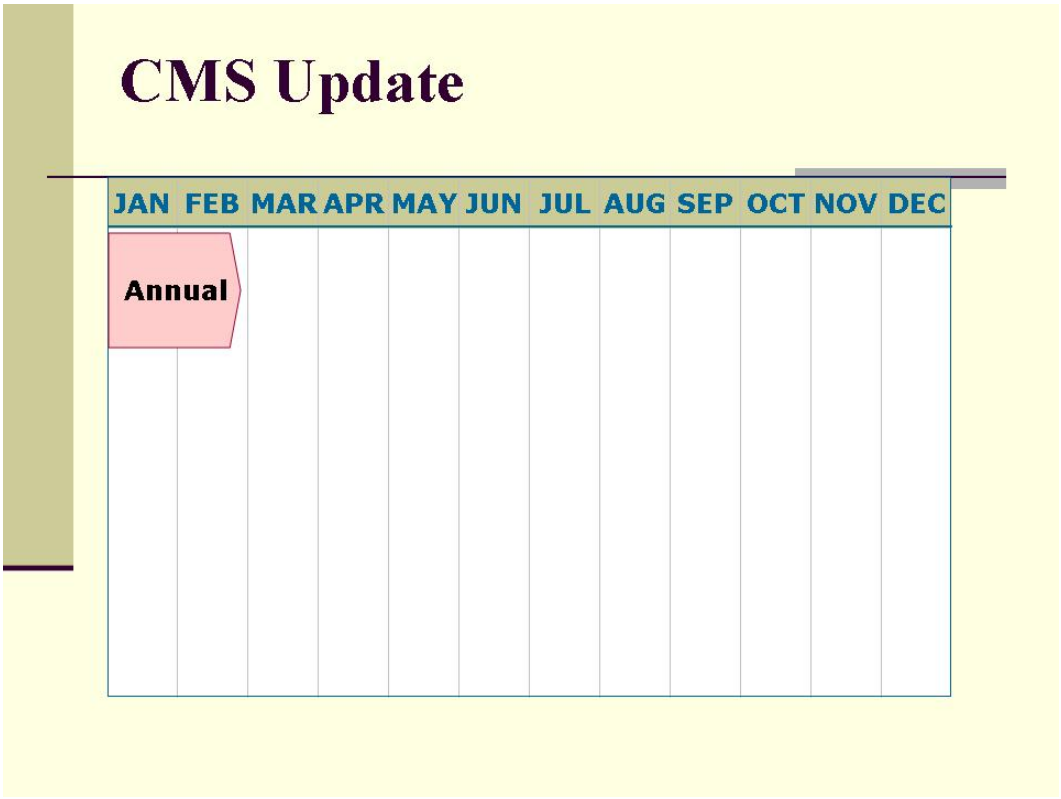
In an effort to maintain a commitment to continuous improvement, the Quality Strategy document will be assessed quarterly and/or when a significant change occurs. The State of Georgia defines a significant change as any change to the Quality Strategic Plan that may reasonably be foreseen to materially affect the delivery or measurement of the quality of health care services.

DCH is responsible for reporting Quality Strategic activities, findings, and actions to members, stakeholders, the DCH Board, and CMS.

A. Timeline for Strategy Assessment



B.Timeline for CMS Update



V. Achievements and Opportunities

Georgia Families successfully transitioned more than 900,000 members from fee-for-service to full risk managed care statewide in 2006. The current membership as of January 2008 is 940,650 individuals. The three CMOs have established provider networks in all regions across the State. As Georgia Families has completed at least one full year since its initial year of operation, DCH will begin to assess the Quality of Care and Service received by Medicaid Managed Care members based on goals and performance driven objectives previously discussed. Georgia Families has identified two areas of opportunities: Capturing of racial, ethnic, and primary language data as well as identifying members with special health care needs. The unique potential to do targeted outreach to at-risk populations and individuals should afford Georgia Families the ability to make significant inroads to addressing health disparities while at the same time improving the health of all Georgians. DCH is aggressively working with their vendors to fulfill this federal requirement and DCH mission.

Appendix

Performance Measures

#	Area	Measure
1	Access to Preventive /Ambulatory Health Services	Percent of enrolled members age 21 and older who had an ambulatory or preventive care visit during the reporting year
2	Access to Preventive /Ambulatory Health Services	Percent of enrolled members ages 12 months and older and under age 21 who had a visit with a primary care practitioner during the reporting year
3	Asthma	Asthma-related Emergency Room Visits per 1,000 Members with Asthma
4	Asthma	Asthma-related Inpatient Admissions per 1,000 Members with Asthma
5	Asthma	Percent of asthma members with at least one dispensed prescription for inhaled corticosteroids, nedocromil, cromolyn sodium, or leukotriene modifiers in the measurement year
6	Asthma	Percent of members receiving treatment for asthma
7	Behavioral Health	Percent of members with behavioral health diagnosis with at least one visit to BH specialist
8	Behavioral Health	Percent of persons with follow-up after hospitalization for mental health within 30 days
9	Behavioral Health	Percent of persons with follow-up after hospitalization for mental health within 7 days
10	Behavioral Health	Percent of unique members with behavioral health diagnosis
11	Children's Preventive Health	Childhood Immunization Status (4:3:1:3:3:1) for children age < 36 months
12	Children's Preventive Health	Percent adolescents with well-care visits: ages 12 through 21
13	Children's Preventive Health	Percent children with well-child visits: 3rd, 4th, 5th, and 6th years
14	Children's Preventive Health	Percent children with well-child visits: first 15 months
15	Children's Preventive Health	Percent of enrolled children under 3 years of age receiving a screening for blood lead test
16	Diabetes	Percent of members with diabetes who completed one fasting lipid panel test in the measurement year
17	Diabetes	Percent of members with diabetes who had a least one HbA1c test in measurement year
18	Diabetes	Percent of members with diabetes who had a least one microalbuminuria test in measurement year

#	Area	Measure
19	Diabetes	Percent of members with diabetes who have a retinal eye exam
20	Diabetes	Percent of members receiving treatment for diabetes
21	Oral Health	Percent of enrolled members ages 3 through 21 who had at least one dental visit
22	Oral Health	Percent of enrolled members ages 3 through 21 who had at least one preventive dental visit
23	Oral Health	Percent of enrolled members ages 3 through 21 who had at least one restorative dental visit
24	Utilization Rates	Audiologist Visits per 1,000 Members
25	Utilization Rates	Emergency Department Visits per 1,000 Members
26	Utilization Rates	Hospital Admissions per 1,000 Members
27	Utilization Rates	Inpatient Days per 1,000 Members
28	Utilization Rates	Inpatient Rehab Visits per 1,000 Members
29	Utilization Rates	Observation Visits per 1,000 Members
30	Utilization Rates	PT/OT/Speech Visits per 1,000 Members
31	Utilization Rates	Readmission rate for Behavioral Health Admits within 30 days
32	Utilization Rates	Readmission rate for Behavioral Health Admits within 7 days
33	Utilization Rates	Readmission rate for non-Behavioral Health Admits within 30 days
34	Utilization Rates	Readmission rate for non-Behavioral Health Admits within 7 days
35	Utilization Rates	Triage Visits per 1,000 Members
36	Utilization Rates	Urgent Care Visits per 1,000 Members
37	Women's Health Care Services	Percent of Cesarean Deliveries (All Ages)
38	Women's Health Care Services	Percent of Deliveries (All Ages)
39	Women's Health Care Services	Percent of Members with Extremely Low Birth weight
40	Women's Health Care Services	Percent of Members with Low Birth weights
41	Women's Health Care Services	Percent of Members receiving Mammograms
42	Women's Health Care Services	Percent of Members receiving Pap Test
43	Women's Health Care Services	Percent of Premature Births
44	Women's Health Care Services	Percent of Stillbirths
45	Women's Health Care Services	Percent of Members with Substance Abuse and Pregnant
46	Women's Health Care Services	Percent of Births to women receiving late or no prenatal care

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