State of Georgia

Department of Community Health (DCH)

EXTERNAL QUALITY REVIEW OF COMPLIANCE WITH STANDARDS

for

PEACH STATE HEALTH PLAN

November 2015

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. Both programs include fee-for-service and managed care components. The DCH contracts with three privately owned managed care organizations (MCOs), referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State's Medicaid and CHIP programs. The State refers to its managed care program as Georgia Families and to its CHIP program as PeachCare for Kids®. *Georgia Families* refers to all Medicaid and CHIP members enrolled in managed care, approximately 1.3 million beneficiaries.[1-1]

According to federal requirements located within the Code of Federal Regulations (CFR), 42 CFR 438.358, the state, an agent that is not a Medicaid MCO, or its external quality review organization (EQRO) must conduct a review to determine a Medicaid MCO's compliance with standards established by the state related to member rights and protections, access to services, structure and operations, measurement and improvement, and grievance system standards. These standards must be at least as stringent as the federal Medicaid managed care standards described in 42 CFR 438—Managed Care.

To comply with the federal requirements, DCH contracted with Health Services Advisory Group, Inc. (HSAG), as its EQRO to conduct compliance reviews of the Georgia Families CMOs. The DCH uses HSAG to review one-third of the full set of standards each year over a three-year cycle.

Description of the External Quality Review of Compliance With Standards

The DCH requires its CMOs to undergo annual compliance reviews that cover a third of the federal standards each year. This ensures that within a three-year period, a full comprehensive assessment is conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2014–June 30, 2015, and marked the second year of the current three-year cycle of external quality reviews.

HSAG performed a desk review of Peach State Health Plan's (Peach State's) documents and an on-site review that included reviewing additional documents, conducting interviews with key Peach State staff members, and conducting file reviews. HSAG evaluated the degree to which Peach State complied with federal Medicaid managed care regulations and the associated DCH contract requirements in seven performance categories. Six of the seven review areas included requirements associated with federal Medicaid managed care structure and operation standards found at 42 CFR 438.214–438.230, while the seventh area focused specifically on noncompliant standards from the

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 08/2015."

prior review period. The standards HSAG evaluated included requirements that addressed the following areas:

- Provider Selection, Credentialing, and Recredentialing
- Subcontractual Relationships and Delegation
- Member Rights and Protections
- Member Information
- Grievance System
- Disenrollment Requirements and Limitations
- Re-review of all *Not Met* elements from the prior year's review.

Following this overview (Section 1), the report includes:

- Section 2—A summary of HSAG's findings regarding Peach State's performance results, strengths, and areas requiring corrective action.
- Section 3—A description of the process and timeline Peach State followed for submitting to DCH its corrective action plan (CAP) addressing each requirement for which HSAG scored Peach State's performance as noncompliant.
- Appendix A—The completed review tool HSAG used to:
  - Evaluate Peach State's compliance with each of the requirements contained within the standards.
  - Document its findings, the scores it assigned to Peach State's performance, and (when applicable) corrective actions required to bring its performance into compliance with the requirements.
- Appendix B—The completed review tool HSAG used to evaluate Peach State's performance in each of the areas identified as noncompliant from the prior year's review.
- Appendix C—The dates of the on-site review and a list of HSAG reviewers, DCH observers, and all Peach State staff members who participated in the interviews that HSAG conducted.
- Appendix D—A description of the methodology HSAG used to conduct the review and to draft its findings report.
- Appendix E—A template for Peach State to use in documenting its CAP for submission to DCH within 30 days of receiving the draft report.

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

HSAG determined findings for the compliance review from its:

- Desk review of the documents Peach State submitted to HSAG prior to the on-site review.
- On-site review of additional documentation provided by Peach State.
- Interviews of key Peach State administrative and program staff members.
- File review during the on-site review.

HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix D—Review Methodology. If a requirement was not applicable to Peach State during the period covered by the review, HSAG used a *Not Applicable* designation. HSAG then calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards as well as the follow-up review.

Table 2-1 presents a summary of Peach State's performance results.

Table 2-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Provider Selection, Credentialing, and Recredentialing	**10**	**10**	**10**	**0**	**0**	**100.0%**
II	Subcontractual Relationships and Delegation	**7**	**7**	**7**	**0**	**0**	**100.0%**
III	Member Rights and Protections	**6**	**6**	**6**	**0**	**0**	**100.0%**
IV	Member Information	**20**	**20**	**18**	**2**	**0**	**90.0%**
V	Grievance System	**47**	**47**	**43**	**4**	**0**	**91.5%**
VI	Disenrollment Requirements and Limitations	**10**	**10**	**10**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**25**	**25**	**21**	**4**	**0**	**84.0%**
	Total Compliance Score	**125**	**125**	**115**	**10**	**0**	**92.0%**

*** Total # of Elements**: The total number of elements in each standard.

**** Total # of Applicable Elements**: The total number of elements within each standard minus any elements that received a designation of *NA*.

***** Total Compliance Score**: Elements that were *Met* were given full value (1 point).The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

The remainder of this section provides a high-level summary of Peach State's performance noted in each of the areas reviewed. In addition, the summary describes any areas that were not fully compliant with the requirements and the follow-up corrective actions recommended for Peach State.

Standard I—Provider Selection, Credentialing, and Recredentialing

Performance Strengths

Peach State maintained policies and procedures to ensure provider selection, credentialing, and recredentialing activities were performed according to industry and State requirements. The CMO completed all credentialing and recredentialing activities within the required time frames and consistently used primary verification sources to validate providers' licensure, credentials, insurance, and certificates. Peach State monitored providers to ensure the provision of quality care and when quality issues were identified, implemented disciplinary action that could include suspension, restriction, or termination of a practitioner's plan participation status. During the on-site audit, HSAG reviewed 10 credentialing files and 10 recredentialing files. All files reviewed were identified as compliant with all case review elements.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required Peach State to implement corrective actions for this standard.

Standard II—Subcontractual Relationships and Delegation

Performance Strengths

Peach State identified a delegation designee who worked with the corporate delegation designee to review "national delegates" providing services for the CMO. The CMO designee was responsible for providing findings and recommendations to the appropriate staff and committees, as well as monitoring the delegates' performance on an ongoing basis.

HSAG reviewed delegation files for three of the CMO's delegates. All of the delegates reviewed were considered "national delegates" by Peach State, and the delegation activities were completed by the corporate office delegation designee with the support of the CMO designee. All files reviewed consisted of a predelegation evaluation, a written agreement that specified activities to be completed by the delegate, performance standards, monitoring, and reporting expectations. The files also contained documented annual monitoring of delegate performance that outlined findings and any identified deficiencies.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required Peach State to implement corrective actions for this standard.

Standard III—Member Rights and Protections

Performance Strengths

Peach State included its member rights and responsibilities in the member handbook, provider manual, and in its policy and procedure documents. To ensure members were aware of their rights, all members received the member handbook upon enrollment with the CMO, and it was also available on Peach State's website. Member rights were also included in the provider manual as a method to keep providers informed regarding member rights. The CMO staff members were trained on protected health information (PHI) and Health Insurance Portability and Accountability Act of 1996 (HIPAA)-related subjects during the onboarding process and reminded of the importance of confidentiality at least annually via Peach State's annual training.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required Peach State to implement corrective actions for this standard.

Standard IV—Member Information

Performance Strengths

Member handbooks were provided to Peach State's members upon enrollment. The handbook was thorough and described member benefits, rights, responsibilities, both member and provider roles, what to do in case of an emergency, and the CMO's contact information. Member information was available for visually impaired and limited reading proficient members. The member handbook was also available in Spanish. Provider directories were available on Peach State's website and included provider office addresses, office hours, phone numbers, languages spoken, and if the provider was accepting new patients.

Areas Requiring Corrective Action

The Distribution of Member Handbook policy and procedure indicated that Peach State provided a member handbook to newly enrolled members within 10 days after receiving notice from DCH and every year thereafter unless requested sooner by the member. However, Peach State staff indicated that DCH granted approval to not include the handbook in the annual mailing provided that information regarding the handbook was included in the quarterly member newsletter. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request.

In addition, although DCH granted Peach State a waiver from providing a hard copy provider directory to newly enrolled members, the Distribution of Member Handbook policy and procedure

indicated that Peach State provided all new members a provider directory with the new member packet and therefore did not reflect actual practice.

As a result of these findings:

- Peach State must update the Distribution of Member Handbook policy and procedure to include a description of how Peach State notifies existing members (not newly enrolled members) that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy must also reflect how often existing members receive the notice. In addition, the policy must be updated to reflect the CMO's practice regarding informing members of the availability of the provider directory.

Standard V—Grievance System

Performance Strengths

Peach State provided detailed grievance, administrative review, and administrative law hearings policies and procedures. The CMO had designated staff at the local level who demonstrated a comprehensive understanding of the grievance system process. Peach State informed members and providers of the grievance and appeal processes via the member and provider handbooks. During the on-site visit, HSAG reviewed 10 grievance files and 10 appeal files. All cases were compliant with the applicable timeliness requirements.

Areas Requiring Corrective Action

Although Peach State had detailed policies and procedures, in some instances, the CMO's documents contained inaccurate or conflicting information. For example, Peach State's policy indicated that the CMO had 30 calendar days to resolve an appeal; however, the member and provider handbooks differentiate between a pre- and post-service time frame (30 and 45 days, respectively). In addition, the grievance acknowledgment letter contained a statement that Peach State may exceed the 90-day time frame to resolve a grievance.

During the file review for grievance and appeals, it was noted that the appeal resolution letters for upheld denials were not written in a manner that could be easily understood. In some instances the letters contained medical terminology and a direct copy of the clinical reviewer's notes. Two grievance records contained resolution letters that did not address all issues contained in the members' original complaints.

As a result of these findings:

- Peach State must review its policies, procedures, and other documents to correct and ensure consistency in the grievance system information available to members and providers.
- Peach State must ensure that all documents accurately provide members access to the appeal process when Peach State fails to meet required time frames for resolution of grievances and appeals (i.e., constitutes an action).

- Peach State must ensure that appeal resolution letters are written in a manner that is understandable to members.
- Peach State must ensure that grievance resolution letters address all issues identified by the member in his/her complaint.

Standard VI—Disenrollment Requirements and Limitations

Performance Strengths

Peach State accepted all members into the CMO regardless of their religion, gender, race, color, national origin, or health status. Peach State ensured that members could request disenrollment for cause at any time and provided assistance to members to coordinate disenrollment with DCH.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required Peach State to implement corrective actions for this standard.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

Peach State corrected 21 of the 25 elements that were re-reviewed during the on-site review. All elements related to Coordination and Continuity of Care, Coverage and Authorization of Services, and Emergency and Poststabilization Services were *Met* upon reevaluation.

Areas Requiring Corrective Action

The four reevaluated elements (within the Furnishing of Services and Quality Assessment and Performance Improvement standards) that will require continued corrective action are as follows:

- Peach State must address timely access issues to ensure providers return after-hours calls within the appropriate time frames. Urgent calls must be returned within 20 minutes and other calls within one hour.
- Peach State did not meet the minimum geographic access requirements in both rural and urban areas. Specifically, the CMO did not have sufficient provider coverage for primary care physicians (PCPs), specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies.
- Peach State did not meet the DCH-established targets for all performance measures.
- Peach State must continue to evaluate the effectiveness of its quality assessment and performance improvement program.

3. Corrective Action Plan Process

Peach State is required to submit to DCH its CAPs addressing all requirements receiving an HSAG finding of *Not Met*. Peach State must submit its CAPs to DCH within 30 calendar days of receipt of HSAG's draft External Quality Review of Compliance With Standards report. Peach State should identify, for each requirement that requires corrective action, the interventions it plans to implement to achieve compliance with the requirement (including how the CMO will measure the effectiveness of the intervention), the individuals responsible, and the timelines proposed for completing the planned activities.

The DCH, in consultation with HSAG, will review, and when deemed sufficient, approve Peach State's CAPs to ensure they sufficiently address the interventions needed to bring performance into compliance with the requirements.

Appendix A. **Review of the Standards**

Following this page is the completed review tool that HSAG used to evaluate Peach State's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring Peach State's performance into full compliance.

Appendix A. State of Georgia
Department of Community Health (DCH)
External Quality Review of Compliance With Standards
Documentation Request and Evaluation Form
***for* Peach State Health Plan**

Note about the Citations: Unless otherwise specified, the federal Medicaid managed care references for the following requirements are those contained in 42 CFR §438, which describes requirements applicable to Medicaid Managed Care Organizations (MCOs).

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
1. The Contractor does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. *42CFR438.12(a)(1)* and *42CFR438.214(c)*	Peach State does not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification, and does not discriminate against particular providers that serve high-risk populations or specialize in conditions that require costly treatment. PSHP demonstrates this through the following document: ◆ Policy: GACRED01 Credentialing Program Description, Page 11	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State had a Credentialing Program Description and an Initial Credentialing Process policy that outlined the criteria for credentialing. Peach State's policy for initial credentialing indicated that all licensed physicians and other licensed healthcare professionals must complete an application for participation with supporting documentation. Any applicant not meeting the minimum necessary credentialing criteria may be denied participation in the Peach State provider network. The provider data management department provided monitoring to prevent discriminatory practices, and all Credentialing Committee participants signed a nondiscrimination form.		
Required Actions: None.		
2. The Contractor does not employ or contract with providers excluded from participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act (requires a policy and must be in provider subcontracts). The Contractor is responsible for routinely checking the exclusions list and shall immediately terminate any provider found to be excluded and notify the member per the requirements outlined in this contract. *42CFR438.214(d)* *Contract: 4.8.1.4*	Peach State does not employ or contract with providers excluded from participation in federal healthcare programs under either Section 1128 or 1128 A of the Social Security Act. PSHP demonstrates this through the following documents: ◆ Policy: GACRED01 Credentialing Program Description, Pages 6,7 ◆ Policy: GACRED04 Initial Credentialing Process, Pages 2,3,6	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
	◆ Policy: GACRED08 Sanction Information, Pages 1,2 ◆ Policy: GACRED10 Ongoing Monitoring of Sanctions and Complaints, Page 1,2 ◆ Policy: GACONT03 Excluded Provider Review (entire document)	
Findings: During the interview Peach State staff reported that all new hires were screened for exclusion from participation in federal healthcare programs. Additionally, Peach State provided the policy for employee exclusion screening that identified a monthly procedure to be completed by the corporate compliance office staff by the fifth of every month with any findings being reported to the appropriate entities at the corporate and CMO levels. For contracted providers Peach State completed an initial screening during the credentialing process with continued monthly monitoring of the Office of Inspector General (OIG) list of excluded providers, and applicable State Board and/or Medicaid Agency report. The information gathered during the monthly monitoring was shared with the Credentialing Committee members as well as the compliance and quality improvement committees.		
Required Actions: None.		
3. If the Contractor declines to include individuals or groups of providers in its network, the Contractor gives the affected providers written notice of the reason for its decision. *42CFR438.12(a)(1)* *Contract: 4.8.1.7*	If Peach State declines to include individuals or groups of providers in its network, the Contractor gives the affected providers written notice of the reason for its decision. PSHP demonstrates this through the following documents: ◆ Policy: GACRED01 Credentialing Program Description, Page 3,6 ◆ Policy: GACRED04 Initial Credentialing Process, Pages 8,9 ◆ Policy: GACRED09 Recredentialing of Practitioners, Page 6	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided examples of the written notice sent to providers who were denied participation in the Peach State provider network. This notice was sent to the provider within 60 days of the Credentialing Committees decision and included information on the practitioner's right to request reconsideration of the application.		
Required Actions: None.		
4. The Contractor shall maintain written policies and procedures for the credentialing and recredentialing of network providers using standards established by the National Committee for Quality Assurance (NCQA),	Peach State uses standards established by the National Committee for Quality Assurance (NCQA) for the credentialing and recredentialing of network providers.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
The Joint Commission (TJC), or URAC *Contract: 4.8.15.1*	PSHP demonstrates this through the following documents: ◆ Policy: GACRED01 Credentialing Program Description (Entire Document) ◆ Policy: GACRED02 Maintaining Confidentiality Of Credentialing Information (Entire Document) ◆ Policy: ◆ Policy: GACRED0402 Primary Source Verification (Entire Document) ◆ Policy: GACRED06 Provisional Credentialing (Entire Document) ◆ Policy: GACRED07 Practitioner Office Site Review (Entire Document) ◆ Policy: GACRED08 Sanction Information (Entire Document) ◆ Policy: GACRED09 Recredentialing of Practitioners (Entire Document) ◆ Policy: GACRED10 Ongoing Monitoring of Sanctions and Complaints (Entire Document) ◆ Policy: GACRED11 Practitioner Disciplinary Action and Reporting (Entire Document) ◆ Policy: GACRED12 Organizational Providers (entire document)	
Findings: Peach State provided written polices outlining its credentialing and recredentialing procedures that met all aspects of this element. During the on-site review, staff provided the standard operating procedure (SOP) for credentialing review and validation. This crosswalk clearly and concisely outlined the SOP for the CMO's credentialing and recredentialing process.		
Required Actions: None.		

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
5. The Contractor has written policies and procedures for the credentialing and recredentialing of network providers that include:	Peach State has written policies and procedures for the Credentialing and Recredentialing of network providers. PSHP demonstrates this through the following documents: ◆ Policy: GACRED01 Credentialing Program Description (entire document) ◆ Policy: GACRED04 Initial Credentialing Process (entire document)	
(a) The verification of the existence and maintenance of: ◆ Credentials. ◆ Licenses. ◆ Certificates. ◆ Insurance coverage. *Contract: 4.8.15.2*	Peach State re-verifies credentials as part of the re- credentialing review process. PSHP demonstrates this through the following documents: ◆ Policy: GACRED0402 Primary Source Verification (entire document) ◆ Policy: GACRED09 Recredentialing of Practitioners (entire document)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State's Primary Source Verification policy identified the procedure used during the credentialing and recredentialing process. During the interview staff members were able to readily speak to and outline the process for verification of credentials, licenses, certificates, and insurance coverage. HSAG noted that all credentials, licensure, certification, and insurance coverage were verified in all of the case files reviewed.		
Required Actions: None.		
(b) Verification using primary sources. *Contract: 4.8.15.2*	Peach State conducts verifications through various primary sources. PSHP demonstrates this through the following documents: ◆ Policy: GACRED0402 Primary Source Verification (entire document) ◆ Policy: GACRED01 Credentialing Program Description, Pages 5-6 ◆ Policy: GACRED09 Recredentialing of Practitioners (entire document)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard I—Provider Selection, Credentialing, and Recredentialing

Requirements and References	Evidence/Documentation as Submitted by the Care Management Organization (CMO)	Score
Findings: Peach State's Primary Source Verification policy identified the procedure used during the credentialing and recredentialing process. The SOP for credentialing review and validation provided by staff during the on-site visit identified all sites, boards, and/or agencies that were considered primary verification sources. During the file review HSAG noted that Peach State used the OIG's list of excluded providers, and applicable State Board and/or Medicaid Agency reports for primary source verification purposes.		
Required Actions: None.		
(c) The methodology and process for recredentialing providers. *Contract: 4.8.15.2*	Peach State has a methodology and process for credentialing and recredentialing providers. PSHP demonstrates this through the following documents: ◆ Policy: GACRED04 Initial Credentialing Process (entire document) ◆ Policy: GACRED01 Credentialing Program Description, Pages 6,7 ◆ Policy: GACRED09 Recredentialing of Practitioners (entire document)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State's Recredentialing of Practitioners procedure identified the steps taken to initiate and complete the recredentialing process. During the interview staff identified the steps taken to initiate the recredentialing process approximately 180 days prior to the provider's recredentialing period. All case files reviewed during the on-site review were identified as compliant with the recredentialing process.		
Required Actions: None.		
(d) A description of the initial quality assessment of private practitioner offices and other patient care settings. *Contract: 4.8.15.2*	Peach State describes the initial quality assessment of private practitioner offices and other patient care settings. PSHP demonstrates this through the following document: ◆ Policy: GACRED04 Initial Credentialing Process (entire document) ◆ Policy: GACRED01 Credentialing Program Description Pages 6-10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided a Credentialing Program Description that stated, "Unless otherwise required by Peach State's contract with the State, Peach State conducts on-site visits to the provider's/practitioner's office to investigate member complaints related to quality of office site for concerns about physical accessibility and appearance or adequacy of exam room/waiting room space. The site visit is conducted by Provider Solutions." The staff identified two different		

Standard I—Provider Selection, Credentialing, and Recredentialing		
Requirements and References	**Evidence/Documentation as Submitted by the Care Management Organization (CMO)**	**Score**
on-site evaluation tools, one for a practitioner's office and one for a hospital facility. These tools were provided during the on-site review. During on-site interviews, Peach State staff reported that an initial on-site assessment was not completed; however, site visits were completed when there was an identified need.		
Required Actions: None.		
(e) Procedures for disciplinary action, such as reducing, suspending, or terminating provider privileges. *Contract: 4.8.15.2*	Peach State has procedures to address disciplinary action, such as reducing, suspending, or termination provider privileges. PSHP demonstrates this through the following document: ◆ Policy: GACRED11 Practitioner Disciplinary Action and Reporting (Entire Document)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided a Practitioner Disciplinary Action and Reporting policy that outlined the monitoring policy and procedures the CMO used to implement a practitioner disciplinary action. The CMO identified "suspension, restriction or termination of a practitioner's participation status" as the disciplinary actions to be used with providers.		
Required Actions: None.		
6. The Contractor makes credentialing decisions on all completed application packets within 120 calendar days of receipt. *Contract: 4.8.15.1*	Peach State makes credentialing decisions on all completed application packets within 120 calendar days of receipt. PSHP demonstrates this though the following document: Policy: GACRED04 Initial Credentialing Process (entire document)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: All credentialing case files reviewed for Peach State were in compliance with this element.		
Required Actions: None.		

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Documentation Request and Evaluation Form
for Peach State Health Plan

Standard I—Provider Selection, Credentialing, and Recredentialing						
Met	=	10	X	1.00	=	10
Not Met	=	0	X	.00	=	0
Not Applicable	=	0		***NA***		***NA***
Total Applicable	=	10	**Total Score**		=	10
Total Score ÷ Total Applicable					=	100%

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor oversees, and is accountable for any functions and responsibilities that it delegates to any subcontractor. *42CFR438.230(a)(1)* *Contract: 16.1.3*	Peach State Health Plan has policies and procedures that provide Delegated Vendor oversight. In addition, Peach State Health Plan's Delegated Vendors Oversight Committee provides an overview of the Vendors' delegated activities. PSHP demonstrates this through the following documents: ◆ Policy: GA_QI_30 Oversight of Delegated and Non-Delegated Vendors: Section 5, Pages 1-2 ◆ Policy: GA_UM_15 Oversight of Delegated Utilization Management: Paragraph 5, Page 1 ◆ Policy: GA_Cont_13 Use of Subcontractors, Page 1Section 8 ◆ Document: DVOC Visio Chart ◆ Document: DVOC Charter	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings*:* Peach State provided its policies and procedures for monitoring delegates. The Oversight of Delegated and Non-delegated Vendors policy stated that delegate oversight meetings were held no less than twice annually, preferably once per quarter. During the interview staff identified that the delegation function for national delegates was administered at the corporate level. However, Peach State had identified one staff member whose primary roll was oversight of the CMO's national delegates. This staff member participated with the corporate office delegation staff in the delegation reviews for all Peach State delegates. This staff member was then responsible for disseminating the findings to the appropriate CMO staff and committees for oversight, implementation, and completion of any recommendations made based on review findings. During review of the delegate files, HSAG noted meeting minutes from delegate oversight meetings.		
Required Actions: None.		
2. Before any delegation, the Contractor evaluates a prospective subcontractor's ability to perform the activities to be delegated. *42CFR438.230(b)(1)* *Contract: 16.1.3*	Peach State Health Plan performs a pre-delegation audit prior to vendor performing delegation activities to evaluate a prospective subcontractor's ability to perform delegated activities. Peach State Health Plan has had no new contracted delegated subcontractors warranting an evaluation. PSHP demonstrates this though the following documents: ◆ Policy: GA_QI_30 Oversight of Delegated and Non-	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Delegated Vendors: Procedure Section I, Pre-delegation Review, Page 2 ◆ Policy: GA_UM_15 Oversight of Delegated Utilization Management: Procedure Section I, Page 2	
Findings: Peach State's Oversight of Delegated and Non-delegated Vendors policy outlined the process for the CMO's predelegation review. During the on-site interviews CMO staff reported that a predelegation audit was completed with each new company interested in becoming a Peach State delegate. A Peach State designee was responsible for the evaluation, except when the delegate was a national delegate; then, the corporate office (Centene) quality improvement designee completed the predelegation review in collaboration with the CMO's designee or on behalf of the CMO.		
Required Actions: None.		
3. There is a written delegation agreement with each delegate that: ◆ Specifies the activities and reporting responsibilities delegated to the subcontractor. ◆ Provides for revoking delegation or imposing other sanctions if the subcontractor's performance is inadequate. *42CFR438.230(b)(2)* *Contract: 16.1.2*	Peach State Health Plan has written agreements with each delegate. PSHP demonstrates this through the following documents: ◆ Contract: Cenpatico (entire document) ◆ Contract: DentaQuest (Doral) (entire document) ◆ Contract: NIA (entire agreement) ◆ Contract: Nurtur (entire document) ◆ Contract: Opticare (entire agreement) ◆ Contract: Univita (entire agreement) ◆ Contract: US Script (entire agreement)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: During the on-site review, HSAG reviewed delegation files for Nurtur, DentaQuest, and Cenpatico. Delegation agreements were reviewed for each provider and were found to contain the required language for this element.		
Required Actions: None.		
4. The Contractor implements written procedures for monitoring the delegate's performance on an ongoing basis. The Contractor subjects the subcontractor to a formal review according to a periodic schedule established by the State, consistent with industry standards or state CMO laws and regulations. *42CFR438.230(b)(3)* *Contract: 16.1.3*	Peach State Health Plan has policies and procedures, a calendar schedule, and uses NCQA and State Guidelines to evaluate delegates activities. PSHP demonstrates this through the following documents: ◆ Policy:GA_QI_30 Oversight of Delegated and Non-Delegated Vendors, Section 4 Page 4 ◆ Policy: GA_UM_15 Oversight of Delegated	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Utilization Management, Section 4 Page 4 Documentation: Audit Schedule	
Findings: Peach State provided the audit schedule, and policies, and procedures that outlined steps taken to monitor delegates' performance on an ongoing basis. All information reviewed and reported during the interview with HSAG was consistent with State requirements and regulations.		
Required Actions: None.		
5. If the Contractor identifies deficiencies or areas for improvement in the subcontractor's performance the Contractor and the subcontractor take corrective action. *42CFR438.230(b)(4)* *Contract: 16.1.3*	Peach State Health Plan has policies and procedures to address deficiencies or areas for improvement with its delegated vendors. Peach State Health Plan demonstrates this through the following documents: ◆ Policy: GA_QI_30 Oversight of Delegated and Non-Delegated Vendors, Section 5 Pages 4-5 ◆ Policy: GA_UM_15 Oversight of Delegated Utilization Management, Section 5 Page 5 ◆ Example: Corrective Action Plan US Script	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided documentation that clearly outlined its procedure for monitoring delegates' performance and identifying deficiencies or areas for improvement. Staff reported that based on findings from annual reviews, delegates could be placed on either a CAP or a performance improvement plan (PIP). During the delegation file review, HSAG identified an open CAP with Cenpatico. Information reviewed indicated that Cenpatico was placed on a CAP on May 28, 2014, after the audit was completed in April 2014. All information reviewed indicated that the CAP had been open for over a year and was still open at the time of HSAG's on-site review. Staff reported that follow-up reviews had previously been conducted with the delegate and that some of the CAP recommendations had been closed out. Staff also reported and provided documentation that the last CAP element for Cenpatico had been reviewed and was considered closed out as of July 2015.		
Required Actions: None.		
6. The Contractor must provide a listing, including detailed contract information, for all of its subcontractors involved in the execution of the contract, including description of the subcontractor's organization and the responsibilities that are delegated. *Contract:16.1.7*	Peach State Health Plan has a listing, including detailed contract information, for all of its subcontractors involved in the execution of the contract. Peach State Health Plan demonstrates this through the following document: ◆ Example: PSHP Subcontractors Information Report	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard II—Subcontractual Relationships and Delegation

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: Peach State provided a listing of delegates that included detailed contact information, a description of the subcontractor's organization, and delegated responsibilities.		
Required Actions: None.		
7. The Contractor must not contract or permit the performance of any work or services by subcontractors without prior written consent of DCH. *Contract: 16.1.1*	Peach State Health Plan does not contract or permit the performance of any work or services by subcontractors without prior written consent of DCH. Peach State Health Plan demonstrates this through the following document: ◆ Policy: GA_Cont 13 Use of Subcontractors	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State staff reported that an initial notification email was sent or a telephone call was made to DCH when a new subcontractor was being considered for delegation with the CMO. Staff reported that when verbal approval of a delegate was provided by DCH, a follow-up email was sent to gain written approval.		
Required Actions: None.		

Standard II––Subcontractual Relationships and Delegation						
Met	=	7	X	1.00	=	7
Not Met	=	0	X	.00	=	0
Not Applicable	=	0		*NA*		*NA*
Total Applicable	=	7	**Total Score**		=	7
Total Score ÷ Total Applicable					=	100%

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor has written policies regarding member rights. *42CFR438.100(a)(1)* *Contract: 4.3.4.1*	Peach State Health Plan has written policies and procedures regarding member rights and responsibilities. Peach State demonstrates this through the following reference document: ◆ Medicaid/PCFK Member Rights and Responsibilities Policy, GA. MBRS.10 ◆ P4HB Member Rights and Responsibilities Policy, GA. MBRS.18	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided its Member Rights and Responsibilities policy and procedure as evidence of compliance. Member rights were also included in the member handbook.		
Required Actions: None.		
2. The Contractor ensures that its staff and affiliated providers take member rights into account when furnishing services to members. *42CFR438.100(a)(2)*	Peach State Health Plan ensures its staff and affiliated providers take member rights and responsibilities into account when furnishing services to its members. Peach State demonstrates this through the following reference documents: ◆ Medicaid / PCFK Member Rights and Responsibilities Policy, GA. MBRS.10 ◆ P4HB Member Rights and Responsibilities Policy, GA. MBRS.18 ◆ Member Handbook (Medicaid/PCFKs)_Pages 50-53, 117 - 120 ◆ Member Handbook (P4HB)_Pages 30-32, 69 -73 ◆ Customer Service Training Reference Materials_April 2015 ◆ Provider Manual_Pages 109-113	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Rights and Responsibilities policy and procedure indicated that each provider was given the member rights information annually in the provider manual. The policy also indicated that the CMO's customer service representatives (CSRs) were educated on member rights at least annually. Staff		

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
members stated that CSRs were educated on member rights during new hire training and annually thereafter.		
Required Actions: None.		
3. The Contractor ensures that these rights are included in the member handbook and at a minimum specifies the member's right to: ◆ Receive information in accordance with information requirements (42CFR438.10). ◆ Be treated with respect and with due consideration for his or her dignity and privacy. ◆ Have all records and medical and personal information remain confidential. ◆ Receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand. ◆ Participate in decisions regarding his or her healthcare, including the right to refuse treatment. ◆ Be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation. ◆ Request and receive a copy of his or her medical records pursuant to 45CFR160 and 164, subparts A and E, and request that they be amended or corrected as specified in 45CFR164.524 and 164.526. ◆ Be furnished health care services in accordance with requirements for access and quality of services (42CFR438.206 and 42CFR438.210). ◆ Freely exercise his or her rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way the member is treated. ◆ Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the covered services provided to the member for which DCH does not pay the Contractor; not be held liable for covered services provided to the member for which DCH or the CMO plan does not pay the health care provider that furnishes the services; and not be	Peach State Health Plan ensures its members have the right to all of the listed requirements to include 42CFR438.10. Peach State demonstrates this through the following reference documents: ◆ Medicaid/PCFK Member Rights and Responsibilities Policy, GA. MBRS.10 ◆ P4HB Member Rights and Responsibilities Policy, GA. MBRS.18 ◆ Member Handbook (Medicaid/PCFKs)_Pages 50-53, 117 - 119 ◆ Member Handbook (P4HB)_Pages 30-32, 71-74 ◆ Provider Manual_Pages 109-113 ◆ Healthy Moves Newsletter (Spring Edition) ENG and SPAN ◆ Member Web Screen Shot (R&R)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
held liable for payments of covered services furnished under a contract, referral, or other arrangement to the extent that those payments are in excess of the amount the member would owe if the Contractor provided the services directly. ◆ Only be responsible for cost sharing in accordance with 42CFR447.50 through 447.60 and Attachment K of the contract. *42CFR438.100(b)(2) & (3)* *Contract: 4.3.4.1*		
Findings: The member handbook included all of the member rights in this element. Peach State staff indicated that the member handbook was provided to new members upon enrollment, upon request, and was available on Peach State's website.		
Required Actions: None.		
4. The Contractor shall ensure that members are aware of their rights and responsibilities, the role of primary care physicians (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. The Contractor shall convey this information via written materials and via telephone, internet, and face-to-face communications that allow the members to submit questions and receive responses from the Contractor. *Contract: 4.3.1*	Peach State Health Plan ensures that members are aware of their rights and responsibilities, the role of primary care physicians (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. Peach State Health Plan conveys this information via written materials, telephone, internet, and face-to-face communications that allow the members to submit questions and receive responses from the Contractor. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.04 Distribution of Member Materials (entire document) ◆ Member Handbook (Medicaid/PCFKs)_Rights and Responsibilities: 50-53, 117-120, Role of PCP: Page 10, 71-72 , Obtaining Care: Pages 35 & 100,	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Emergency or Urgent Care: Pages 40-41, 106- 107 Grievance & Appeal, Administrative Law Hearing: Pages 42-45 , 109- 115, Suspected Fraud and Abuse: Pages 53-54, 120- 121 ◆ Member Handbook (P4HB) Rights and Responsibilities: Pages 30-33, 71 -75, Role of a Family Planning Provider: Pages 9-10, 49-50, Obtaining Care: Pages 20-21, 60- 61, Emergency or Urgent Care: Pages 21-22 , 62-63 Grievance & Appeal, Administrative Law Hearing: Pages 23-28 , 64 -67 Suspected Fraud and Abuse: Pages 33, 75 ◆ Peach State Member Web Contact Us Screen Shot ◆ Policy: PSHP Administrative Law Hearing_Customer Service ◆ Healthy Moves Newsletter (Spring Edition)ENG and SPAN	
Findings: The information contained in this element was included in the member handbook. The Rights and Responsibilities policy and procedure indicated that members were given the member handbook upon enrollment and that the handbook was also available on Peach State's website.		
Required Actions: None.		
5. Contractor complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45CFR part 91; the Rehabilitation Act of 1973; Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. *42CFR438.100(d)* *Contract: General Program Requirements*	Peach State Health Plan complies with any other federal and State laws that pertain to member rights including Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45CFR part 80; the Age Discrimination Act of 1975 as implemented by regulations at 45CFR part 91, the Rehabilitation Act of 1973, and Titles II and III of the Americans with Disabilities Act; and other laws regarding privacy and confidentiality. Peach State Health Plan demonstrates this through the following documents:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Policy: CC.COMP.04 Confidentiality of PHI (entire policy) ◆ Policy: GA.COMP.PRVC.06 Electronic Transmission of PHI (entire policy) ◆ Policy: GA.COMP.09 Privacy Notice (entire policy) ◆ Policy: GA.COMP.PRVC.13 Obtaining Authorization for the Use or Disclosure of PHI (entire policy) ◆ Policy: GA.COMP.PRVC.17 Individual Rights Regarding Protecting PHI (entire policy) ◆ Policy: GA.COMP.PRVC.21 Individual Rights to PHI Accepting Requests for Amendments to PHI (entire policy) ◆ Policy: GA.COMP.PRVC.23 Individual Rights to PHI Accounting (entire document) ◆ Policy: GA.COMP.PRVC.24 Individual Rights to PHI Requesting Restriction on Uses & Disclosure (entire document) ◆ Policy: GA.COMP.PRVC.25 Individual Rights to PHI Confidential Communications for PHI (entire document) ◆ Policy: GA.COMP.PRVC.52 Protection of PHI Desk Audit (entire document)	
Findings: The member rights section of the member handbook contained the provisions included in the Civil Rights Act, the Age Discrimination Act, and the Rehabilitation Act.		
Required Actions: None.		
6. The Contractor uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts A and E (HIPAA), to the extent that these	Peach State Health Plan uses and discloses individually identifiable health information in accordance with the privacy requirements in 45CFR parts 160 and 164, subparts	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard III—Member Rights and Protections

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
requirements are applicable. *42CFR438.224*	A and E (HIPAA), to the extent that these requirements are applicable. Peach State Health Plan demonstrates this through the following documents: ◆ Policy: CC.COMP.04 Confidentiality of PHI (entire policy) ◆ Policy: GA.COMP.PRVC.06 Electronic Transmission of PHI (entire policy) ◆ Policy: GA.COMP.09 Privacy Notice (entire policy) ◆ Policy: GA.COMP.PRVC.13 Obtaining Authorization for the Use or Disclosure of PHI (entire policy) ◆ Policy: GA.COMP.PRVC.17 Individual Rights Regarding Protecting PHI (entire policy) ◆ Policy: GA.COMP.PRVC.21 Individual Rights to PHI Accepting Requests for Amendments to PHI (entire policy) ◆ Policy: GA.COMP.PRVC.23 Individual Rights to PHI Accounting (entire document) ◆ Policy: GA.COMP.PRVC.24 Individual Rights to PHI Requesting Restriction on Uses & Disclosure (entire document) ◆ Policy: GA.COMP.PRVC.25 Individual Rights to PHI Confidential Communications for PHI (entire document) ◆ Policy: GA.COMP.PRVC.52 Protection of PHI Desk Audit (entire document)	

Standard III—Member Rights and Protections		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: Peach State provided several policies and procedures related to protected health information (PHI) which demonstrated that the CMO was in compliance with this element.		
Required Actions: None.		

Standard III—Member Rights and Protections					
Met	=	6	X 1.00	=	6
Not Met	=	0	X .00	=	0
Not Applicable	=	0	*NA*		*NA*
Total Applicable	=	6	**Total Score**	=	6
Total Score ÷ Total Applicable				=	100%

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor provides all newly enrolled members the member handbook within ten (10) calendar days after receiving notice of the enrollment from DCH or the State's agent and every other year thereafter unless requested sooner by the member. *42CFR438.10(f)(3)* *Contract: 4.3.3.1*	Peach State Health Plan provides all newly enrolled members the member handbook and provider directory within 10 calendar days after receiving notice of the enrollment and at least annually thereafter. DCH granted approval to not include the handbook in the annual mailing. Peach State includes information in the newsletter advising members to contact the plan if they would like a hard copy of the handbook. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.04 Distribution of Member ◆ Materials (entire document) ◆ MMIS Screen Shot ◆ Report: Cenveo Mail Distribution Report ◆ Healthy Moves Newsletter (Spring Edition)ENG and SPAN	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Distribution of Member Handbook policy and procedure indicated that Peach State provided a member handbook to newly enrolled members within 10 days after receiving notice from DCH and every year thereafter unless requested sooner by the member. However, Peach State staff indicated that DCH granted approval to not include the handbook in the annual mailing provided that information regarding the handbook was included in the quarterly member newsletter. Peach State provided a newsletter that included the required information. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request.		
Required Actions: Peach State must update the Distribution of Member Handbook policy and procedure to include a description of how the CMO notifies existing members (not newly enrolled members) that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy and procedure must also reflect how often existing members receive the notice.		
2. The Contractor provides all newly enrolled members the provider directory within ten (10) calendar days of receiving the notice of enrollment from DCH or the State's Agent. *42CFR438.10(f)(3)* *Contract: 4.3.5.1*	DCH granted approval to not include the handbook in the annual mailing. Peach State includes information in the newsletter advising members to contact the plan if they would like a hard copy of the provider directory.	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.04 Distribution of Member Materials (entire document) ◆ MMIS Screen Shot ◆ Report: Cenveo Mail Distribution Report ◆ Healthy Moves Newsletters (ENG and SPAN) – Spring Edition	
Findings: The DCH has granted Peach State a waiver from providing a hard copy provider directory to newly enrolled members. The Peach State member handbook directed members to the CMO's website which contained the provider directory, or to contact member services for assistance with provider selection. The Distribution of Member Handbook policy and procedure indicated that Peach State provided all new members a provider directory with the new member packet and therefore did not reflect actual practice.		
Required Actions: Peach State must update the Distribution of Member Handbook policy and procedure to reflect CMO practice regarding informing members of the availability of the provider directory.		
3. The Contractor makes all written information available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The Contractor notifies all members and potential members that information is available in alternative formats and how to access those formats. *42CFR438.10(d)(1) & (2)* *Contract: 4.3.2.1*	Peach State Health Plan makes all written information available in alternative formats and in a manner that takes into consideration the member's special needs, including those who are visually impaired or have limited reading proficiency. The plan notifies all members and potential members that information is available in alternative formats and how to access those formats. To date, Peach State has not received a member request for written information in an alternative format. Peach State demonstrates this through the following reference documents: ◆ Member Handbooks (Medicaid/PCFKs)_Pages 5- 6, 67-68 ◆ Member Handbooks (P4HB)_Pages 4-5, 44-45	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Policy: GA.MBRS.01 PSHP Submission Guidelines (entire policy) ◆ Healthy Moves Newsletters (ENG and SPAN) – Spring Edition	
Findings: The member handbook included a notice indicating that all written materials were available in alternative formats, including Braille and large print.		
Required Actions: None.		
4. The Contractor makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH. All written materials include a language block, printed in Spanish and all other prevalent non-English languages, that informs the member that the document contains important information and directs the member to call the Contractor to request the document in an alternative language, or to have it orally translated. *42CFR438.10(c)(3)* *Contract: 4.3.2.2 and 4.3.2.3*	Peach State Health Plan makes all written information available in English, Spanish, and all other prevalent non-English languages as defined by DCH. All written materials include a language block, printed in Spanish and all other prevalent non-English languages, that informs the member that the document contains important information and directs the member to call the plan to request the document in an alternative language, or to have it orally translated. To date, Peach State has not received a member request for written information in an alternative format. Peach State demonstrates this through the following reference documents: ◆ PSHP Distribution of Written Information ◆ Policy_GA.MRKT.01 (entire policy) ◆ Healthy Moves Newsletters (ENG and SPAN) – Spring Edition ◆ Member Handbooks (Medicaid/PCFKs)_ Pages 5, 67 ◆ Medicaid Handbook (P4HB)_Pages 4,44 ◆ Peach State Health Plan Member Tip Sheet ◆ PSHP Member Services Policy_GA.MBRS.09	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided a multi-language member handbook which included both English and Spanish versions. When needed, the CMO provided materials in other formats such as Braille or large print. Both versions of the member handbook included a notice that directed the member to call the CMO to		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
obtain information in alternate languages.		
Required Actions: None.		
5. All written materials are worded such that they are understandable to a person who reads at a fifth (5th) grade reading level. The Contractor must use one of the following reference materials to determine the reading level: ◆ Fry Readability Index. ◆ PROSE The Readability Analyst (software developed by Education Activities, Inc.). ◆ Gunning FOG Index. ◆ McLaughlin SMOG Index. ◆ The Flesch-Kincaid Index. ◆ Other word processing software approved by DCH. *42CFR438.10(b)(1)* *Contract: 4.3.2.4*	Peach State Health Plan written materials are worded such that they are understandable to a person who reads at a fifth (5th) grade reading level. The plan uses The Flesch-Kincaid Index to determine the reading level. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MRKT.03 PSHP Determining Literacy Level of Members Policy ◆ Form: Member Materials Attestation Form Member Handbooks (Medicaid/PCFK/P4HB)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Determining Literacy Level of Member Materials policy and procedure indicated that the CMO used the Flesch-Kincaid index to confirm materials were written at the fifth-grade literacy level. Peach State staff also confirmed that the Flesch-Kincaid index was used on all member materials to ensure the reading level was in compliance with the State standard.		
Required Actions: None.		
6. The Contractor makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. *42CFR438.10(c)(4)&(5)* *Contract: 4.3.10.1*	Peach State Health Plan makes oral interpretation services (for all non-English languages) available free of charge and notifies members that oral interpretation is available for any language and how to access those services. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.16 PSHP Interpretive Services ◆ Policy: GA.MBRS.01 PSHP Submission Guidelines ◆ Member Handbook (Medicaid/PCKs)_Page 5, 67 ◆ Member Handbook (P4HB)_Page 4, 44 ◆ Provider Manual _Page 122-123	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Voiance 2014 YTD Report	
Findings: The member handbook provided notice to members regarding oral interpretation services being available free of charge. During the interview, CMO staff indicated that numerous CSRs were bilingual.		
Required Actions: None.		
7. The Contractor has in place a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan. *42CFR438.10(b)(3)*	Peach State Health Plan has a mechanism to help enrollees and potential enrollees understand the requirements and benefits of the plan. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCKs)_Pages 13-16, 75-79 ◆ Member Handbook (P4HB)_Pages 11-14, 51-55 ◆ PSHP Value Add Brochure ◆ Benefits Member Screen Shot	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook contained a summary of requirements and benefits that Peach State offered to its members. During the interview, the member services staff indicated that members and potential members could contact the service center to request a copy of the member handbook.		
Required Actions: None.		
8. The provider directory shall include names, locations, office hours, telephone numbers of, and non-English languages spoken by, current contracted providers. This includes, at a minimum, information on PCPs, specialists, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals. The provider directory also identifies providers that are not accepting new patients. *42CFR438.10(f)(6)* *Contract: 4.3.5.2*	Peach State Health Plan includes names, locations, office hours, telephone numbers of, and non-English languages spoken by, current contracted providers to include at a minimum, information on PCPs, specialists, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse providers, and hospitals. The provider directory also identifies providers that are not accepting new patients. Peach State demonstrates this through the following reference documents: ◆ Provider Directory	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Policy: GA.PDAT.22 Peach State Provider Directory ◆ Example: On-Line Directory Web Screen Print_Page 4 ◆ Policy: GA.MBRS.46 On-Line Directory Assistance	
Findings: The provider directory available on Peach State's website included all of the requirements of this element.		
Required Actions: None.		
9. The member handbook includes a table of contents. *Contract: 4.3.3.2*	Peach State Health Plan member handbook includes a table of contents. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCKs)_Pages 2-4, 64 66 ◆ Member Handbook (P4HB)_Pages 2-3, 42-43	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included a table of contents.		
Required Actions: None.		
10. The member handbook includes information about the roles and responsibilities of the member (this information to be supplied by DCH), and what to do when family size changes. *Contract: 4.3.3.2*	Peach State Health Plan's member handbook includes information about the roles and responsibilities of the member (this information to be supplied by DCH), and what to do when family size changes. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCKs)_Pages 53, 120,89, 70-71 ◆ Member Handbook (P4HB)_ Pages 32-33, 74-75	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included sections on member roles and responsibilities. The member handbook also contained a notice of what to do if a major life change occurred, including a change in family size. The Distribution of Written Information to Providers and Members policy and procedure indicated that member materials were reviewed and approved by DCH.		
Required Actions: None.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
11. The member handbook includes information about the role of the PCP and information about choosing a PCP. *Contract: 4.3.3.2*	Peach State Health Plan member handbook includes information about the role of the PCP and information about choosing a PCP. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCKs)_ Pages 10-11, 72-73	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook contained information about the role of the PCP and information about choosing a PCP.		
Required Actions: None.		
12. The member handbook includes: ◆ Information on benefits and services, including a description of all available Georgia Families (GF) benefits and services. ◆ Information on how to access services, including the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services, non-emergency transportation services (NET), and maternity and family planning services. ◆ An explanation of any service limitations or exclusions from coverage. ◆ A notice stating that the Contractor shall be liable only for those services authorized by the Contractor. ◆ Information on how and where members may access benefits not available from or not covered by the Contractor. ◆ Cost sharing. ◆ The policies and procedures for disenrollment. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Peach State Health Plan's member handbook includes information on benefits and services, access, Health Check (EPSDT), non-emergency transportation services, maternity and family planning services, explanation of any service limitations or exclusions from coverage, notice stating that the plan shall be liable only for those services authorized by the Contractor, how and where members may access benefits not available from or not covered by the Contractor, cost sharing and policies and procedures for disenrollment. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCKs)_Pages 13-17, 35, 28,26,22-24, 54-55,75-79, 92,90,86-88,121-122 ◆ Member Handbook (P4HB)_Pages Pages 11-14, 15,18,34, 51-55, 56, 58-59, 76	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included information about benefits and services, and how to access services including EPSDT, nonemergency transportation, maternity, and family planning services. It also included an explanation of exclusions, how and where members could access benefits not covered by Peach State, information on copays, and policies and procedures for disenrollment.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
13. The member handbook includes: ◆ The medical necessity definition used in determining whether services will be covered. ◆ A description of all pre-certification, prior authorization, or other requirements for treatments and services. ◆ A description of utilization review policies and procedures used by the Contractor. ◆ The policy on referrals for specialty care and for other covered services not furnished by the member's PCP. ◆ Information on how to obtain services when the member is out of the service region. ◆ Geographic boundaries of the service region. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Peach State Health Plan member handbook includes information regarding medical necessity, description of all pre-certification, prior authorization, or other requirements for treatments and services, description of utilization review policies and procedures used by the plan, policy on referrals for specialty care and for other covered services not furnished by the member's PCP, how to obtain services when the member is out of the service region and geographic boundaries of the service region. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCKs)_Pages 18 , 39-40, 41-42, 58, 104-106, 107,125 ◆ Member Handbook (P4HB)_Pages 15-16, 20,22,55-56,60-63	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook contained all of the information described in this element.		
Required Actions: None.		
14. The member handbook includes: ◆ A statement that additional information, including information on the structure and operation of the CMO plan and physician incentive plans, shall be made available on request. ◆ A notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including the Contractor's toll-free telephone line and Web site. *42CFR438.10(f)(2) and 42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Peach State Health Plan member handbook includes a statement that additional information, including information on the structure and operation of the plan and physician incentive plans shall be made available on request and a notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization, including the Contractor's toll-free telephone line and Web-site. Peach State demonstrates this through the following reference documents:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Member Handbook (Medicaid/PCKs)_Pages 54, 6,121,68 ◆ Member Handbook (P4HB)_Pages 30,5, 45 ◆ Customer Service Training Reference Materials_April 2015	
Findings: The member handbook included a statement that information about Peach State's physician incentive plans was available upon request. Appropriate mailing addresses and telephone numbers, including the CMO's toll-free telephone number and website information, were also included in the member handbook. The member services staff indicated that when a call was received with a request for information about Peach State's structure and operations, the call was forwarded to the CMO's compliance department. Calls requesting information regarding provider incentive plans were routed to the provider relations department.		
Required Actions: None.		
15. The member handbook includes a description of member rights and responsibilities as described in Section 4.3.4 of the Contract and 42CFR438.100. *42CFR438.10(f)(6)* *Contract: 4.3.3.2*	Peach State Health Plan member handbook includes a description of member rights and responsibilities as described in Section 4.3.4 of the Contract and 42CFR438.100. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCFKs)_Pages 50-53, 117 – 120 ◆ Member Handbook (P4HB)_Pages 30-33, 71 -75	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member rights and responsibilities were included in the member handbook.		
Required Actions: None.		
16. The member handbook information on advance directives for adult members includes: ◆ The member's right to formulate advance directives. ◆ The member's rights under the State law to make decisions regarding medical care including the right to accept or refuse medical or surgical treatment. ◆ The contractor's policies on respecting the implementation of those rights, including a statement of any limitation regarding the	Peach State includes information in the Member Handbook regarding advance directives, members' rights to make decisions about medical care including the right to accept or refuse treatments and that complaints concerning noncompliance with advance directive requirements may be filed with the Georgia Department of Community Health, Healthcare Facilities Regulations department.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
implementation of the Advance Directives as a matter of conscience. ◆ Information must inform members that complaints may be filed with the State's Survey and Certificate Agency. *42CFR438.10(g)* *Contract: 4.3.3.2, 4.6.12.1.1, 4.6.12.1.2, and 4.6.12.3*	Peach State demonstrates this through the following documents: ◆ Member Handbook (Medicaid and PCFKs)_Pages 55-56, 123 ◆ Member Handbook (P4HB)_Pages 35-36,77-78 ◆ Customer Service Training Reference Materials_April 2015	
Findings: The member handbook included the required advance directive information described in this element.		
Required Actions: None.		
17. The member handbook includes: ◆ The extent to which and how after hours and emergency coverage are provided, including: ▪ What constitutes an emergency medical condition, emergency services, and post-stabilization services with reference to the definitions in 42CFR438.114(a). ▪ The fact that prior-authorization is not required for emergency services. ▪ The process and procedures for obtaining emergency and post-stabilization services, including the use of the 911-telephone system or its local equivalent. ▪ The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services. ▪ The fact that the member has the right to use any hospital or other setting for emergency care. *42CFR438.10(f)(6)* *Contract: 4.3.3.3*	Peach State ensures that members are aware of which and how after hours and emergency coverage are provided. The Medical Management department provides an overview of Care Coordination of Medical Management activities. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCFKs)_Pages 40-41, 106-107 ◆ Member Handbook (P4HB)_Pages 21-22, 62-63	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook included information regarding after-hours and emergency coverage including what constituted an emergency and the definition for poststabilization services. It also included when prior authorization was needed, procedures for emergency services, and that the members could use any hospital in case of an emergency.		

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
18. The member handbook information on the Grievance System includes: ◆ The right to file a grievance or an appeal with the Contractor. ◆ The requirements and timeframes for filing grievances and appeals. ◆ The availability of assistance in filing a grievance or an appeal with the Contractor. ◆ The toll free numbers the member may use to file a grievance or an appeal by phone. ◆ The right to a State Administrative Law hearing, the method to obtain a hearing, and the rules that govern representation at the hearing. *42CFR438.10(g)* *Contract: 4.3.3.4*	Peach State includes information in the Member Handbook regarding the Plan's Grievance System including members' rights to file a grievance or administrative review, the requirements and timeframes for each, the availability of assistance with these if needed and the toll free numbers the member may use to file a grievance or administrative review. Peach State demonstrates this through the following documents: ◆ Member Handbook (Medicaid/PCFKs)_Pages 42-48, 108-114, 109-112 ◆ Member Handbook (P4HB)_Pages 23-29, 64-70	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook contained information on the grievance system including the right to file, the requirements and time frames, availability of assistance when filing, toll-free numbers to file, and the right to a State administrative law hearing.		
Required Actions: None.		
19. The member handbook information on the Grievance System includes: ◆ The fact that, when requested by the member, benefits will continue if the appeal or request for the State Administrative Law hearing is filed within the timeframes specified for filing. ◆ Notice that if the member files an appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member. *42CFR438.10(g)* *Contract: 4.3.3.4*	Peach State's Member Handbook includes information on the Grievance System, benefit continuation if the appeal or request for the State Administrative Law hearing is filed within the timeframes specified for filing, if benefits continue during the appeal of State Administrative Law hearing process, requirements to pay for the cost of services while the appeal is pending and appeal rights. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCFKs)_Pages 49, 116 ◆ Member Handbook (Medicaid/PCFKs); Page 29-30,70-71	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard IV—Member Information

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The appeals process section in the member handbook indicated that when requested by a member, benefits may continue if the appeal or State administrative law hearing was filed within appropriate time frames and that the member may be required to pay the cost of services furnished during the appeals or administrative law hearing process if the final decision was adverse to the member.		
Required Actions: None.		
20. The Contractor gives written notice to DCH of any significant change in information to members at least 30 calendar days before the effective date of the change. *42CFR438.10(f)(4)* *Contract: 4.3.2.5*	Peach State Health Plan provides written notice of any significant change in information to members at least 30 days before the intended effective date of the change. During the review period, there were **no** significant changes requiring notification to members.	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The CMO indicated that no significant changes were made to the information provided to Peach State members during the review period. The CMO staff members indicated that they were aware of the time frame requirements in the element and stated that they would submit the member material to DCH for approval prior to the materials being mailed to the member.		
Required Actions: None.		

Standard IV—Member Information						
Met	=	18	X	1.00	=	18
Not Met	=	2	X	.00	=	0
Not Applicable	=	0		*NA*		*NA*
Total Applicable	=	20	**Total Score**		=	18
Total Score ÷ Total Applicable					=	90%

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor has a system in place that includes a grievance process, an appeal (administrative review) process, and access to the State Administrative Law hearing process. The contractor's appeal process shall include an internal process that must be exhausted by the member prior to accessing and Administrative Law Hearing. *42CFR438.402(a)* *Contract: 4.14.1.1*	Peach State Health Plan (PSHP, Peach State) has a Grievance System in place which includes processes for Grievances, Administrative Reviews and member access to the State Administrative Law Hearing. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, pages 2-9 ◆ Policy: Administrative Reviews, GA.QI.42, pages 1-11 ◆ Policy: Compliance Reporting Program, GA.COMP.33, page 3 ◆ Policy: Administrative Law Hearings / ◆ Binding Arbitration, GA.COMP.34 pages 1-6 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, pages 1-8 ◆ Policy: Adverse Determination (Denial) Notices, GA. UM.07, pages 3-4 ◆ Template Letter: Notice of Proposed Action (English) ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Departmental Procedure: Proposed Actions and Administrative Reviews (entire document). ◆ Step by Step: Medicaid Grievance Step-by-Step Process ◆ Step by Step: Administrative Review ◆ Member Handbook- June 2014, pages 42-49 (English) and 108-116 (Spanish) ◆ Planning for Healthy Babies®-June 2014 (P4HB) Member Handbook, pages ◆ Provider Manual- July 2014, pages 43-4823-29 English, and 64-71 (Spanish).	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: Peach State provided its Member Grievance and Administrative Review and Administrative Law Hearings/Binding Arbitration policies and procedures as evidence that it had a grievance and appeals process, and provided access to the State's administrative law hearing process. The Administrative Reviews policy and procedure indicated that the member may request, in writing, an administrative law hearing once the member exhausted Peach State's appeals process.		
Required Actions: None.		
2. The Contractor has written Grievance System and appeal process policies and procedures that detail the operation of the Grievance System and appeal process. The Contractor's policies and procedures shall be available in the member's primary language. The Grievance System and appeal process policies and procedures shall be submitted to DCH for review and approval as updated. *42CFR438.400(a)(3)* *Contract: 4.14.1.2*	Peach State's policies and procedures detail the components of the Grievance System and are available to members in their primary language at their request. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, pages 2-9, primary language page 4 ◆ Policy: Administrative Review, GA.QI.42, pages 1-11,primary language page 2 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, pages 1-8, language assistance page 2 ◆ Template Letter: Administrative Review ◆ Acknowledgement ; Administrative Review Denied; ◆ Administrative Review Overturned; Extension Letter; ◆ Grievance Acknowledgement; Grievance Resolution; ◆ Notice of Proposed Action; Oral Appeal ◆ Acknowledgement; Plan initiated Extension Letter; ◆ Second Level Grievance Disposition Letter ◆ Departmental procedure: Proposed Actions and Administrative Reviews, (entire document), translation and primary language page 3, 4 ◆ Member Handbook- June 2014, pages 42-49, translation and primary language pages 5-8, 45, 50 (English) and 108-116, translation and primary language pages 67, 112,and 113 (Spanish) ◆ Planning for Healthy Babies-June 2014 (P4HB)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Member Handbook, pages 23-29 and primary language pages 4, 5 (English), 64-71 and 64- 71 and primary language pages 4, 27, 29, 37, Provider Manual, pages 43-46, 122, translation and primary language page 44, 118, 122 primary language page 44, 118, 122 primary language pages 44, 68, 69, 70, 79 (Spanish). ◆ Provider Manual- July 2014, pages 43-48, translation and primary language pages 108, 110, 114, 115.	
Findings: Peach State provided its Member Grievance and Administrative Review and its Administrative Reviews policies and procedures, which summarized the operations of the grievance and appeals processes. The Grievance Process and the Administrative Review policies and procedures indicated that members would be provided interpreter and translation services for materials when needed. Peach State staff indicated that all grievance and appeals policies were submitted to and approved by DCH.		
Required Actions: None.		
3. The Contractor defines action (proposed action) as: ◆ The denial or limited authorization of a requested service, including the type or level of service. ◆ The reduction, suspension, or termination of a previously authorized service. ◆ The denial, in whole, or in part, of payment for a service. ◆ The failure to provide services in a timely manner. ◆ The failure to act within the timeframes for resolution of grievances and appeals specified at 438.408(b). *42CFR438.400(b)* *Contract: 1.4*	Peach State defines proposed action in compliance with the Code of Federal Regulations (CFR) 438.400, the Balanced Budget Act of 1997 (BBA) and the DCH Contract. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, page 9 ◆ Policy: Adverse Determination (Denial) Notices, GA.QI.41 (entire document) ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 9 ◆ Departmental procedure: Proposed Actions and Administrative Reviews, page 1 ◆ Member Handbook- June 2014, pages 42, 44, (English) and 108, 110 (Spanish) ◆ Planning for Healthy Babies Member Handbook (P4HB)-June 2014, pages 23, 25 (English) and 64, 66 (Spanish)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Provider Manual- July 2014, page 43	
Findings: The Member Grievance and Administrative Review policy and procedure included the definition of "action" as described in this element.		
Required Actions: None.		
4. The Contractor defines appeal (administrative review) as a request for review of an action, as action is defined in 42 C.F.R. §438.400. *42CFR438.400(b)* *Contract: 1.4*	Peach State's documents define an administrative review as a request for review of an action. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 1, 11 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 9 ◆ Departmental procedure: Proposed Actions and Administrative Reviews, page 1 ◆ Member Handbook- June 2014, pages 44 (English) and page 110 (Spanish) ◆ Planning for Healthy Babies- June 2014 (P4HB) Member Handbook, page 25 (English) and page 66 (Spanish) ◆ Provider Manual- July 2014, page 44	☐ **Met** ☒ **Not Met** ☐ **NA**
Findings: The Administrative Reviews and the Member Grievance and Administrative Review policies and procedures defined an "administrative review" as a request for review of an action. However, the Administrative Reviews policy and the Step by Step: Administrative Review procedure both stated: "If it is recognized that Peach State Health Plan has failed to act within the required timeframe for resolution of an appeal, a Notice of Proposed Action letter will be sent explaining the handling of this case and **allowing 30 days to file a grievance**. The member will be offered **grievance rights for late resolution** by inserting the following verbiage in the letter's rationale: 'If you are unhappy with the processing of this appeal in any way, you may file a grievance by calling member services at 1-800-704-1484.' " As defined in Requirement 3 above, the failure to process a grievance or an appeal in a timely manner was an "action," and therefore required issuance of a notice of action and access to the appeal process, not the grievance process.		
Required Actions: Peach State must ensure that its policies, processes, and communications to members are accurate and consistent and provide members access to the correct process (appeal) when Peach State fails to meet required timelines for resolution of grievances and appeals (an action).		
5. The Contract defines grievance as an expression of dissatisfaction about any matter other than an action. ◆ Possible subjects for grievances include but are not limited to, the quality of care or services provided or aspects of interpersonal	Peach State defines grievances as expressions of dissatisfaction about any matter other than an action. PSHP demonstrates this through the following documents:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
relationship such as rudeness of a provider or employee, or failure to respect the member's rights. *42CFR438.400(b)* *Contract: 1.4*	◆ Policy: Member Grievance Process, GA.QI.08, page(s) 2 and 9 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 2, 9-10 ◆ Member Handbook, page 42 (English) and 108(Spanish) ◆ P4HB Member Handbook, page 23 (English) and 64(Spanish) ◆ Provider Manual, page 113	
Findings: The Member Grievance Process, Member Grievance and Administrative Review, the member handbook, and the provider manual all defined a "grievance" as an expression of dissatisfaction about any matter other than an action. The policy and procedure documents also listed the possible subjects summarized in this element.		
Required Actions: None.		
6. The Contractor has provisions for who may file a grievance: ◆ A member or member's authorized representative may file a grievance, either orally or in writing. ◆ A Grievance may be filed about any matter other than a proposed action. ◆ A provider cannot file a grievance on behalf of the member. *42CFR438.402(b)(1) and 42CFR438.402(b)(3)* *Contract: 4.14.2.1,*	The Plan has provisions for a member or a member's authorized representative to file a grievance. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, page 2 ◆ Policy: Administrative Review, GA.QI.42 , page(s) 1, 8 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 2 ◆ Step by Step: Grievances ◆ Member Handbook, pages 42-43 (English) and113 (Spanish) ◆ Provider Manual, pages 39-40	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance and Administrative Review policy and procedure indicated that a member or member's authorized representative may file a grievance, either orally or in writing, that it may be filed about any matter other than a proposed action, and that a provider cannot file a grievance on behalf of the member.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
7. The contractor shall ensure that the individuals who make decisions on grievances that involve clinical issues are health care professional 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. *Contract: 4.14.2.2*	The Plan ensures that individuals who make decisions on grievances or administrative reviews are individuals who were not involved in any previous level of review or decision-making and have the appropriate clinical expertise in treating the member's condition in the cases of administrative review based on lack of medical necessity, grievances regarding denial of expedited administrative review or grievances involving clinical issues. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, page 1 ◆ Policy: Administrative Review, GA.QI.42, page (s) 2, 4 ◆ Template Letter: Administrative Review Denial, page 1 ◆ Departmental Procedure: Proposed Actions and Administrative Reviews, page 7 ◆ Member Handbook, page 43 (English) and 114 (Spanish) ◆ P4HB Member Handbook, page 24 (English) and 65 (Spanish)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance Process policy and procedure indicated that the grievance decision would be made by a healthcare professional with clinical expertise in treating the member's condition/disease and who was not involved in any previous level of review or decision making.		
Required Actions: None.		
8. Contractor shall provide written notice of the disposition of the grievance as expeditiously as the member's health condition requires but must be completed within 90 days but not to exceed 90 calendar days of the filing date. *Contract: 4.14.2.3*	Peach State issues the disposition letter for all grievances and all administrative reviews as expeditiously as the member's health condition requires and not more than 90 calendar days from receipt by the Plan. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, pages 4, 6	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Policy: Member Grievance and ◆ Administrative Review, GA.MBRS.11, page 3 ◆ Template Letter: Grievance Acknowledgment Letter page 1 ◆ Step by Step: Grievances, page(s) 1,2 ◆ SOP: Grievances, page 9 ◆ Member Handbook, page 43 (English) and 109 (Spanish) ◆ P4HB Member Handbook, page 24 (English) and 65 (Spanish) ◆ Provider Manual, page 113	

Findings: The Grievance Process policy and procedure indicated that Peach State would provide written notice to the member, in his/her primary language, of the disposition of the grievance no longer than 90 calendar days after the filing date. However, the grievance acknowledgment letter stated, "You will receive written notice of our findings no later than 90 calendar days from the date we received your grievance. **However, <u>if we need additional time</u>, you will be notified when to expect a resolution.**"

In addition, although the grievance disposition letters for the 10 grievance files reviewed were sent to the member within 90 calendar days, two of the letters did not address all of the member issues identified in the initial complaint.

Required Actions: Peach State must ensure that it processes all grievances and issues disposition letters within 90 calendar days with no extensions. Peach State must also remove language from the member acknowledgment letter indicating that the CMO may take additional time. Peach State must also address each member issue identified in the grievance in the disposition resolution letter.

9. The member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent may file an appeal (administrative review) of a proposed action either orally or in writing within 30 calendar days from the date of the notice of "proposed action." A written request must be provided when an oral request has been made, unless the request is for expedited resolution. *42CFR438.402(b)(3)* *Contract: 4.14.4.1 and 4.14.4.2*	Peach State's documents and processes allow for a member to file an appeal orally or in writing and informs the member if the appeal is filed orally, it must be requested in writing (except in the case of expedited requests.) PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 3 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, pages 4-5 ◆ Template Letter: Notice of Proposed Action (English)	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	page 1 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Oral Administrative Review Acknowledgment Letter page 1 ◆ Member Handbook, page 45 (English) and 111-112 (Spanish) ◆ P4HB Member Handbook, page 26 (English) and 67 (Spanish) ◆ Provider Manual, page(s) 43-44	
Findings: The Administrative Reviews policy and procedure indicated that a member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent may file an appeal (administrative review) of a proposed action via mail, email, fax, or in person within 30 calendar days from the date of the notice of proposed action. The policy also indicated that if the appeal was requested orally, it must be followed by a written request, unless the request was for an expedited appeal.		
Required Actions: None.		
10. An appeal (administrative review) shall be filed directly with the contractor or its delegated representatives. The Contractor may delegate this authority to an administrative review committee, but the delegation must be in writing. *Contract: 4.14.4.3*	An administrative review shall be filed directly with the contractor of its delegated representatives. The Contractor may delegate this authority to an administrative review committee, but the delegation must be in writing. PSHP demonstrates this through the following documents: ◆ Policy: GA.QI.41 Adverse Determination (Denial) ◆ Notices page 11 (NPA letter template) ◆ Policy: GA.MBRS.11 Member Grievance and Administrative Review page 1 ◆ Policy: GA.QI.42 Administrative Review, pages 3 ◆ Template Letter: Notice of Proposed Action (English) page 2	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Grievance and Administrative Review policy and procedure summarized that Peach State's CSR would document the necessary information for the appeal. Reviews involving medical necessity decisions would be reviewed by a same or similar healthcare professional who had appropriate training and expertise in the field of medicine involved in the medical judgement. The CMO had not delegated this activity.		
Required Actions: None.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
11. For termination, suspension, or reduction of previously authorized services, timely filing is defined as the later of the following: ◆ Within ten (10) days of the Contractor mailing the notice of action, or ◆ The intended effective date of the proposed action. For all other actions, 30 calendar days from the date of the notice of proposed action. *42CFR438.402(b)(2) and 438.420(a)* *Contract: 4.14.4.2 and 4.14.7.1*	Peach State's documents and processes reflect that administrative reviews may be filed within ten days of the mailing of the notice of proposed action or the intended effective date of the action if for termination, suspension or reduction of previously authorized services and within 30 calendar days for all other actions. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page(s) 1-3, 9 ◆ Template Letter: Notice of Proposed Action (English) ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Administrative Review Acknowledgment Letter ◆ Step by Step: Administrative Reviews ◆ Departmental Procedure: Denials and Administrative Reviews ◆ Member Handbook, page(s) 44, 45 (English) and 110, 111 (Spanish) ◆ P4HB Member Handbook, pages 25, 26 (English) and 66, 67 (Spanish) ◆ Provider Manual, pages 43- 45	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that when Peach State terminated, suspended, or reduced previously authorized services, timely filing of a request for an administrative review would be the latter of the following: within 10 days of the CMO's mailing of the notice of adverse action or the intended effective date of the proposed action. For all other administrative reviews, the request must be filed within 30 calendar days of the date of the notice of proposed action.		
Required Actions: None.		
12. The individuals who make the decisions on the administrative reviews are individuals who were not involved in any previous level of review or decision-making and will have the appropriate clinical expertise in treating the member's condition or disease when deciding the following:	Peach State has processes in place to ensure that all proposed action determinations are made by a physician or other peer review consultant who has appropriate clinical expertise in treating the member's condition.	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ An administrative review of a denial that is based on lack of medical necessity. ◆ An administrative review that involves clinical issues. *Contract: 4.14.4.4*	PSHP demonstrates this through the following documents: ◆ Policy: Adverse Determination (Denial) ◆ Notices, GA.QI.41, page 1 ◆ Policy: Administrative Review, GA.QI.42, page(s) 2, 4 ◆ Policy: Member Grievance and ◆ Administrative Review, GA.MBRS.11, page 1 ◆ Template Letter: Admin Review Denial, page 1	
Findings: The Administrative Reviews policy and procedure indicated that the decision would be made by a healthcare professional who was not involved in any level of previous review or decision. The policy also stated that a physician or other appropriate clinical peer would evaluate medical necessity decisions for adverse administrative review decisions. All 10 administrative review (appeal) files reviewed complied with this element.		
Required Actions: None.		
13. A member must exhaust the Contractor's appeal (administrative review) process before requesting a State Administrative Law hearing. The member may request the State Administrative Law hearing 30 days from the date of the notice of appeal resolution (notice of adverse action). *42CFR438.402(b)(3)* *Contract: 4.14.3.3 and 4.14.6.3*	Members are informed by Peach State that they must exhaust the Plan's administrative review process before requesting a State Administrative Law hearing and that when that has occurred, the State Administrative Law hearing must be requested within 30 days of the date of the notice of appeal resolution. PSHP demonstrates this through the following documents: ◆ Policy: Adverse Determination (Denial) Notices, GA.QI.41, pages 3 ◆ Policy: Administrative Review, GA.QI.42, page 7-8 ◆ Policy: Administrative Law Hearing / ◆ Binding Arbitration, GA.COMP.34, page 1, 3 ◆ Policy: Member Grievance and ◆ Administrative Review, GA.MBRS.11, page 6 ◆ Template Letter: Notice of Proposed Action (English) page 1 ◆ Template Letter: Notice of Proposed Action (Spanish) page 1	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Departmental Procedure: Proposed Action and Administrative Review Process, pages 1, 2, 6,7 ◆ Member Handbook, pages 47 (English) and 113-114 (Spanish) ◆ P4HB Member Handbook, pages 28 (English) and 69, 70 (Spanish) ◆ Provider Manual, pages 46	
Findings: The Adverse Determination (Denial) Notices policy and procedure indicated that the member must exhaust Peach State's appeal process before a State administrative law hearing can be requested. The Administrative Reviews policy and procedure indicated that the member had 30 days from the date of an administrative review notice of adverse action to request the hearing.		
Required Actions: None.		
14. Notices of proposed action must be in writing and meet the language and format requirements of 42CFR438.10 and Contract Section 4.3.2 to ensure ease of understanding and be sent in accordance with the timeframes described in Section 4.14.3.4. *42CFR438.404(a)* *Contract: 4.14.3.2*	The Plan's notices of proposed action meet the language and formatting requirements of 42 CFR 438.10 and Contract Section 4.3.2 PSHP demonstrates this through the following documents: ◆ Policy: Adverse Determination (Denial) Notices, GA.QI.41, pages 1, 3, 4, 10 (NPA letter template) ◆ Policy: Administrative Review, GA.QI.42, pages 7 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 2 ◆ Template Letter: Notice of Proposed Action (English) page 2 ◆ Template Letter: Notice of Proposed Action, page 2 (Spanish) ◆ Departmental Procedure: Proposed Action and Administrative Reviews, page 3	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determination (Denial) Notices policy and procedure indicated that the notice of proposed action would be easily understandable, include specific reasons for the determination, and that Peach State would meet the required time frames.		
Required Actions: None.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
15. All proposed actions are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member's condition or disease. *Contract: 4.14.3.1*	Peach State has processes in place to ensure that all proposed action determinations are made by a physician or other peer review consultant who has appropriate clinical expertise in treating the member's condition. PSHP demonstrates this through the following documents: ◆ Policy: Adverse Determination (Denial) ◆ Notices, GA.QI.41, page 1 ◆ Policy: Administrative Review, GA.QI.42, page 2, 4 ◆ Policy: Member Grievance and ◆ Administrative Review, GA.MBRS.11, page 1 ◆ Template Letter: Admin Review Denial page 1	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determination (Denial) Notices policy and procedure indicated that "all proposed actions will be made by a physician or other peer review consultant who has appropriate clinical expertise in treating the member's condition or disease."		
Required Actions: None.		
16. Notices of proposed action must contain: ◆ The action the Contractor has taken or intends to take, including the service or procedure that is subject to the action. ◆ Additional information, if, any that could alter the decision. ◆ The specific reason used as basis for the action (the reasons must have a factual basis and a legal/policy basis). ◆ The member's right to file an appeal (administrative review) through the Contractor's internal Grievance System and how to do so. ◆ The provider's right to file a provider complaint under the Contractor's provider complaint system. ◆ The requirement that a member exhaust the Contractor's internal administrative review process. ◆ The circumstances under which expedited review is available and how to request it. ◆ The member's right to have benefits continue pending resolution of the appeal (administrative review) and how to request that benefits be	Peach State's notices of proposed action contain all the required components detailed in 42 CFR 438.404(b) and DCH Contract §4.14.3.3. PSHP demonstrates this through the following documents: ◆ Policy: GA.QI.41 Adverse Determination (Denial) ◆ Notices pages 3-5 ◆ Template Letter: Notice of Proposed Action (English), entire document ◆ Template Letter: Notice of Proposed Action (Spanish), entire document ◆ Example: Notice of Proposed Action letter redacted, pages 1, 2	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
continued. ◆ The circumstances under which the member may have to pay for the costs of services if benefits are continued during the administrative review process. *42CFR438.404(b)* *Contract: 4.14.3.3*		
Findings: The Adverse Determination (Denial) Notices policy and procedure indicated that the adverse determination letter would include the items in this element.		
Required Actions: None.		
17. The contractor shall mail the Notice of Proposed Action within the following timeframes: *Contract: 4.14.3.4*	Peach State's Notices of Proposed Action is mailed within appropriate timeframes.	
(a) For termination, suspension, or reduction of previously authorized Medicaid-covered services the Notice of Proposed Action must be mailed at least 10 calendar days before the date of the proposed action except in the event of one of the following exceptions: ◆ The Contractor has factual information confirming the death of a member. ◆ The Contractor receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates he or she understands that this must be the result of supplying that information. ◆ The member's whereabouts are unknown and the post office returns the Contractor's mail directed to the member indicating no forwarding address. ◆ A change in the level of medical care is prescribed by the member's physician. *42CFR438.404(c)* *Contract: 4.14.3.4.1*	Peach State's documents and processes reflect that notices of proposed action for termination, suspension or reduction of previously authorized services are mailed at least 10 calendar days before the effective date of the proposed action unless one of the exception requirements of 42 CFR 438.404(c), 42 CFR 438.211, 438.214 and DCH Contract §4.14.3.4.1 is met. PSHP demonstrates this through the following documents: ◆ Policy: Adverse Determination (Denial) Notices, GA.QI.41, page(s) 4-5 ◆ Departmental Procedure: Proposed Actions and Administrative Reviews page(s)3-4 (42CFR 438.213)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determination (Denial) Notices policy and procedure indicated that, for proposed actions to terminate, suspend, or reduce previously authorized covered services, Peach State faxed or mailed the notice of proposed action 10 calendar days before the date of the proposed action or not later than the		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
date of the proposed action in the event of the exceptions listed in the element.		
Required Actions: None.		
(b) The Contractor may shorten the period of advance notice to five (5) calendar days before the date of the proposed action if the Contractor has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources. *Contract: 4.14.3.4.3*	Peach State's documents and processes reflect that the Contractor may shorten the period of advance notice to five (5) calendar days before the date of the proposed action if the Contractor has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources. PSHP demonstrates this through the following documents: ◆ Departmental Procedure: Proposed Actions and Administrative Reviews, page 3	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: Peach State provided its Proposed Actions and Administrative Review procedure and indicated that it may shorten the notice period to five calendar days if Peach State had facts indicating that action should be taken because of probable member fraud and that facts had been verified though secondary sources.		
Required Actions: None.		
(c) For denial of payment, at the time of any proposed action affecting the claim. *42CFR438.404(c)(2)* *Contract: 4.14.3.4.5,*	◆ Example: Explanation of Payment	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Adverse Determination (Denial) Notices policy and procedure indicated that Peach State would mail or fax a notice of action when payment for services were denied for noncovered, unauthorized, or denied service.		
Required Actions: None.		
(d) For standard service authorization decisions that deny or limit service, within 14 calendar days of the receipt of the request for service. *42CFR438.404 (c)(3)* *Contract: 4.11.2.5.1 and 4.14.3.4.6*	◆ Policy: Timeliness of UM Decision, GA.UM.05, page 2 ◆ Member Handbook, pages 18 (English) and 81-82 (Spanish) ◆ P4HB Member Handbook, pages 16 (English) and 44 (Spanish) ◆ Provider Manual, pages 38-39	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook indicated that Peach State would mail the notice of proposed action for standard service authorization decisions that deny or limit service within 14 calendar days of the receipt of the request for service.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
(e) For expedited service authorization decisions, within 24 hours. *42CFR438.404 (c)(6)* *Contract: 4.11.2.5.2*	◆ Policy: Timeliness of UM Decision, GA.UM.05, page 3 ◆ Member Handbook, pages 18 (English) and 81-82 (Spanish) ◆ P4HB Member Handbook, pages 16 (English) and 44 (Spanish) ◆ Provider Manual, pages 38-39	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook indicated that Peach State would mail the notice of proposed action for expedited service authorization decisions within 24 hours.		
Required Actions: None.		
(f) For authorization decisions not reached within the timeframes required in Section 4.11.2.5, on the date the timeframes expire, as this constitutes a denial and is thus a proposed action. *42CFR438.404 (c)(5)* *Contract: 4.14.3.4.8*	◆ Policy: Timeliness of UM Decision, GA.UM.05, page 7	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Timeliness of UM [Utilization Management] Decisions and Notifications policy and procedure indicated that Peach State would mail the notice of proposed action for authorization decisions not reached within the time frames on the date the time frame expired and that this constituted a denial and was thus a proposed action.		
Required Actions: None.		
18. If the Contractor extends the timeframe for authorization decisions and issuance of the notice of proposed action according to Section 411.2.5, it provides the member: ◆ Written notice of the reason for the decision to extend the timeframe. ◆ The right to file a grievance if the member disagrees with the decision. ◆ Issuance of its decision (and carries out the decision) as expeditiously as the member's health condition requires and no later than the date the extension expires. *Contract: 4.14.3.4.7*	Peach State provides written notice to the member if the timeframe for an authorization decision is extended and notifies the member of the reason and their right to file a grievance regarding the extension. The Plan issues and carries out the decision as expeditiously as the member's health condition requires and no later than the date that the extension expires. PSHP demonstrates this through the following documents: ◆ Policy: Timeliness of UM Decisions and Notifications, GA.UM.05, page(s) 2-4 ◆ Template Letter: Plan Initiated Extension Letter, page 1	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Findings: The Timeliness of UM Decisions and Notifications policy and procedure indicated that if Peach State extended time frames for authorization decisions, it issued the notice of proposed action and provided the member the reason for the extension and the right to file a grievance. The policy also stated that Peach State would follow the time frame as outlined in this element.		
Required Actions: None.		
19. In handling grievances and appeals (administrative reviews), the Contractor must give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability. *42CFR438.406(a)(1)* *Contract: 4.14.1.4*	Peach State offers and provides assistance to members in completing forms and any other procedural step in the grievance or administrative review process. In addition to extended assistance in English, the Plan provides access to interpreter services at no charge to the member and TTY/TTD lines which also have interpreter capability. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, page 1 ◆ Policy: Administrative Review, GA.QI.42, page 2 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page(s) 2, 6 ◆ Template Letter: Notice of Proposed Action (English), page 2 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Extension Letter, page 1 ◆ Template Letter: Administrative Review Acknowledgment Letter page 1 ◆ Member Handbook, page 42- 46 (English) and 108-112 (Spanish) ◆ P4HB Member Handbook, page 23-28 (English) and 64-66 (Spanish) ◆ Provider Manual, page 44	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Grievance Process and the Administrative Reviews policies and procedures indicated that Peach State would provide the member reasonable assistance in completing grievance and appeals forms and provide interpreter services and toll-free numbers for interpreter services if needed.		
Required Actions: None.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
20. The Contractor acknowledges each grievance and administrative review in writing within ten (10) working days of receipt in the member's primary language. *42CFR438.406(a)(2)* *Contract: 4.14.1.5*	Peach State acknowledges each grievance and administrative review within 10 business days of receipt. PSHP demonstrates this through the following documents and SharePoint database log screen shots: ◆ Policy: GA.QI.08 Member Grievance Process page(s) 3, 5 ◆ Policy: GA.QI.42 Administrative Review page 3 ◆ Policy: GA.MBRS.11 Member Grievance and Administrative Review pages 2, 3, 5 ◆ Screen shot: Grievance SharePoint Database ◆ Screen shot: Administrative Review SharePoint Database ◆ Member Handbook, page 43, 45 (English) and 109, 113 (Spanish) ◆ P4HB Member Handbook, pages 24, 26 (English) and 65, 68 (Spanish) ◆ Provider Manual, page(s) 44, 113	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Grievance Process and the Administrative Reviews policies and procedures indicated that Peach State would send written acknowledgement to the member within 10 business days of receipt and the acknowledgement would be written in the member's primary language. All of the grievance and administrative (appeal) files reviewed complied with this element.		
Required Actions: None.		
21. The Contractor must resolve each administrative review and provide written notice of the disposition as expeditiously as the member's health condition requires, not to exceed: ◆ For standard resolution of appeals, 45 calendar days from the day the Contractor receives the appeal. ◆ For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal. *42CFR438.408(b)* *Contract: 4.14.4.8*	Peach State issues the disposition letter for all grievances and all administrative reviews as expeditiously as the member's health condition requires and not more than 90 calendar days from receipt by the Plan. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, pages 1, 5, 6,	☐ **Met** ☒ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 3 ◆ Template Letter: Grievance Acknowledgment Letter, page 1 ◆ Medicaid Grievance Step-by-Step Process: page 1 ◆ SOP: Medicaid Member Grievance, page 9 ◆ Member Handbook- June 2014, page 43 (English) and 109, 112 (Spanish) ◆ Planning for Healthy Babies(P4HB) Member Handbook- June 2014, pages 24, 26 (English) and pages 65, 67 (Spanish) ◆ Provider Manual- July 2014, page 113	
Findings: The Administrative Reviews policy and procedure indicated that Peach State would resolve each request for a review and provide written notice of the resolution as expeditiously as the member's health condition required. The documentation indicated that the process would not exceed 30 calendar days from receipt of the appeal request and for expedited resolution of an appeal, it would not exceed three business days from receipt of the appeal. While 30 days is a stricter standard than (and therefore complies with) DCH's required time frame of 45 days, other Peach State documents (e.g., member and provider handbooks) indicated the time frames as 30 calendar days for pre-service and 45 calendar days for post-service appeal decisions. All of the administrative review (appeal) files reviewed during the on-site audit complied with the timeliness requirements described in this element.		
Required Actions: Peach State must ensure that its documents (i.e., policies, procedures, manuals, and training materials) that communicate appeal decision time frames to members, providers, and its own staff are consistent and accurate.		
22. The Contractor's appeal (administrative review) process must provide:	Peach State's administrative review process includes all the requirements of 42 CFR 438.406(b) and Contract §4.14.4.1 and §4.14.4.5-4.14.4.7. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, pages 1, 3 ◆ Template Letter: Notice of Proposed Action (English) pages 1, 2, 3 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Oral Administrative Review	

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Acknowledgment Letter page 1 ◆ Template Letter: Administrative Review Acknowledgment Letter page 1 ◆ Departmental Procedure: Denials and Administrative Reviews pages 1, 3, 5, 7 ◆ SOP: Denials and Administrative Reviews pages 4, 5, 6 ◆ Member Handbook, pages 44, 45, 46 (English) and 111-113 (Spanish) ◆ P4HB Member Handbook, page 21, 22, 23 (English) and 63-65 (Spanish) ◆ Provider Manual, pages 43, 44	
(a) Oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date) and must be confirmed in writing, unless the member or the provider requests expedited resolution. *42CFR438.406(b)(1)*	◆ Policy: Administrative Review, GA.QI.42, pages 3 ◆ Template Letter: Notice of Proposed Action (English) pages 1 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Oral Administrative Review Acknowledgment Letter, page 1 ◆ Template Letter: Administrative Review Acknowledgment Letter, page 1 ◆ Departmental Procedure: Denials and Administrative Reviews, pages 3, 5, 7 ◆ SOP: Denials and Administrative Reviews page 4, 6 ◆ Member Handbook-June 2014, pages 44, 45 (English) and 111-113 (Spanish) ◆ P4HB Member Handbook, page 21, 22, 23 (English) and 63-65 (Spanish) ◆ Provider Manual, pages 43, 44	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that Peach State's oral appeals process must be followed by a member's written confirmation unless the member or provider requested an expedited process.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
(b) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's consent, must be given a reasonable opportunity to present evidence and allegations of fact or law, in person as well as in writing. (The Contractor must inform the member of the limited time available for this in the case of expedited resolution.) *42CFR438.406(b)(2)* *Contract: 4.14.4.5*	◆ Policy: Administrative Review, GA.QI.42, pages 1, 3 ◆ Template Letter: Notice of Proposed Action (English) pages 1, 2 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Oral Administrative Review Acknowledgment Letter page 1 ◆ Template Letter: Administrative Review Acknowledgment Letter page 1 ◆ Departmental Procedure: Denials and Administrative Reviews page 1 ◆ SOP: Denials and Administrative Reviews page 5 ◆ Member Handbook-June 2014, pages 45 (English) and 111-113 (Spanish) ◆ P4HB Member Handbook, page 21, 22, 23 (English) and 63-65 (Spanish) ◆ Provider Manual, pages 43, 44	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure and the administrative review acknowledgment letter indicated that Peach State members/their representatives may present supporting evidence and documentation. These documents included the time frames required for timely document submission.		
Required Actions: None.		
(c) The member, the member's authorized representative, or the provider acting on behalf of the member with the member's written consent, must be given an opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the administrative review process. *42CFR438.406(b)(3)* *Contract: 4.14.4.6*	◆ Policy: Administrative Review, GA.QI.42, page 3 ◆ Template Letter: Notice of Proposed Action (English) page 2 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Oral Administrative Review Acknowledgment Letter page 1 ◆ Template Letter: Administrative Review Acknowledgment Letter page 1 ◆ Departmental Procedure: Denials and Administrative ◆ Reviews page 4	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ SOP: Denials and Administrative Reviews page 5 ◆ Member Handbook-June 2014, pages 46 (English) and 111-113 (Spanish) ◆ P4HB Member Handbook, page 21, 22, 23 (English) and 63-65 (Spanish) ◆ Provider Manual, pages 43, 44	
Findings: The Administrative Reviews policy and procedure and the administrative review acknowledgment letter indicated that Peach State members were given the opportunity to review the member's case file, including medical records, and other documentation and records during the appeals process.		
Required Actions: None.		
(d) Included, as parties to the appeal: ◆ The member and his or her representative. ◆ The provider, acting on behalf of the member with the member's written consent. ◆ The legal representative of a deceased member's estate. *42CFR438.406(b)(4)* *Contract: 4.14.4.7*	◆ Policy: Administrative Review, GA.QI.42, page 3 ◆ Template Letter: Notice of Proposed Action (English) pages 1, 3 ◆ Template Letter: Notice of Proposed Action (Spanish) ◆ Template Letter: Oral Administrative Review Acknowledgment Letter, page 1 ◆ Template Letter: Administrative Review Acknowledgment Letter, page 1 ◆ Departmental Procedure: Denials and Administrative Reviews, page 1 ◆ Member Handbook-June 2014, page 44 (English) and 111-113 (Spanish) ◆ P4HB Member Handbook, page 21, 22, 23 (English) and 63-65 (Spanish) ◆ Provider Manual, pages 43, 44	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that the member, his or her representative, the provider acting on behalf of the member with written consent, or a legal representative may appeal adverse determinations and were included as parties to the appeal.		
Required Actions: None.		
23. The Contractor has an expedited review process for appeals, when the Contractor determines, or the provider indicates that taking the time for a standard resolution could seriously jeopardize the member's life or health or	Peach State's expedited review process includes the stipulation that no punitive action will be taken against a practitioner who requests expedited review or supports a	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
ability to regain maximum function. The Contractor's expedited review process includes: ◆ The Contractor ensures that punitive action is not taken against a provider who requests an expedited resolution or supports a member's appeal. ◆ If the Contractor denies a request for expedited resolution of an appeal, it must: ▪ Transfer the appeal to the timeframe for standard resolution, and ▪ Make reasonable efforts to give the member prompt oral notice of the denial and follow-up within two (2) calendar days with a written notice. ◆ For notice of an expedited resolution of an appeal, the Contractor must also make reasonable efforts to provide oral notice of resolution. *42CFR438.410* *Contract: 4.14.4.8*	member's request for same, that a denied request for expedited review is automatically transferred to the standard timeframe and member and practitioner verbal notification is conducted promptly (on the day the decision is made) and followed with written notice within two calendar days if the request is denied. If expedited resolution is approved, verbal notification is conducted promptly on the day the decision is made. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page(s) 1, 5 ◆ Departmental Procedure: Proposed Actions and Administrative Reviews page(s) 7, 8 ◆ SOP: Denials and Administrative Reviews page 4, 9-10 ◆ Step by Step: Administrative Reviews, page 2 ◆ Member Handbook, pages 45 (English) and 111 (Spanish) ◆ P4HB Member Handbook, page 26 (English) and 67 (Spanish) ◆ Provider Manual, page 45	
Findings: The Administrative Reviews policy and procedure, Denials and Appeals work process, and the Proposed Action and Administrative Review Process collectively contained the requirements in this element.		
Required Actions: None.		
24. The Contractor may extend the timeframes for resolution of the appeal (administrative review) (both expedited and standard) by up to 14 calendar days if: ◆ The member, member's authorized representative, or the provider acting on behalf of the member requests the extension, or ◆ The Contractor shows (to the satisfaction of DCH, upon its request) that	Peach State has processes in place to facilitate extension of administrative review timeframes by up to 14 calendar days if requested by the member, the member's authorized representative or the practitioner acting on behalf of the member. Peach State only requests an extension with documentation of the need for additional information and	☒ **Met** ☐ **Not Met** ☐ **NA**

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
there is need for additional information and how the delay is in the member's interest. *42CFR438.408(c)* *Contract: 4.14.4.9*	that the outcome will be in the member's best interest. PSHP demonstrates this through the following documents: ◆ Departmental procedure: Denials and Administrative Reviews, page 5 ◆ Policy: Administrative Review, GA.QI.42, page(s) 5,6 ◆ SOP: Denials and Administrative Reviews, page 1 ◆ Step by Step: Administrative Reviews, pages 2-3 ◆ Member Handbook, pages 45, 46 (English) and 111, 112 (Spanish) ◆ P4HB Member Handbook, pages 26, 27 (English) and 67, 68 (Spanish) ◆ Provider Manual, pages 45-46	
Findings: The Denials and Appeals Work Process indicated that Peach State may extend the time frames for resolution of appeals, both expedited and standard, by up to 14 calendar days if the member, authorized representative, or provider acting on behalf of the member requested the extension or if there was a need for additional information and the delay was in the member's best interest.		
Required Actions: None.		
25. If the Contractor extends the timeframes, it must—for any extension not requested by the member—give the member written notice of the reason for the delay. *42CFR438.408(c)* *Contract: 4.14.4.9*	Peach State notifies the member if an extension is applied that was not requested by the member including the specific reason for the need for extension. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 6 ◆ Template Letter: Plan Initiated Extension Letter, page 1 ◆ Departmental procedure: Denials and Administrative Reviews, page 5 ◆ SOP: Denials and Administrative Reviews, page 1 ◆ Step by Step: Administrative Reviews, page 2	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Denials and Appeals Work Process indicated that when Peach State initiated a time frame extension, it must give the member written notice of the reason for the delay.		

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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
26. If the Contractor upholds the proposed action in response to an administrative review filed by the member, the contractor shall issue a notice of adverse action within the timeframes described in Section 4.14.4.8 and 4.14.4.9. *Contract: 4.14.5.1*	Peach State's written notice of an administrative review that upholds the initial proposed action meets all language and format requirements of 42 CFR 438.408(d) and Contract §4.14.5.1. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, pages 5, 7 ◆ Template Letter: Administrative Review Denial, page 2 ◆ Departmental procedure: Denials and Administrative Reviews, page 6 ◆ SOP: Denials and Administrative Reviews, page(s) 5, 8	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that when Peach State upheld, in whole or part, the proposed action decision, Peach State would issue a notice of adverse action in accordance with Sections 4.14.4.8 and 4.14.4.9.		
Required Actions: None.		
27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes: ◆ The results and date of the adverse action including the service or procedure that is subject to the action. ◆ Additional information, if any, that could alter the decision. ◆ The specific reason used as the basis of the action. ◆ The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing date is stamped. ◆ The right to continue to receive benefits pending a State Administrative Law hearing. ◆ How to request continuation of benefits. ◆ Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State	The Plan's written notice of administrative review resolution includes all the requirements of 42 CFR 438.408(3) and Contract §4.14.5.2. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 7, 8 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, pages 2-3 ◆ Template Letter: Administrative Review Denial pages, 1, 2 ◆ Departmental procedure: Denials and Administrative Reviews, page 6 ◆ SOP: Denials and Administrative Reviews pages 7, 8 ◆ Step by Step: Administrative Reviews, page 3	☐ **Met** ☒ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Administrative Law hearing. ◆ Circumstances under which expedited resolution is available and how to request it. *42CFR438.408(e)* *Contract: 4.14.5.2*		
Findings: The Administrative Reviews policy and procedure indicated that the written notice of adverse action would be translated into the member's primary language, and be produced in large print or alternative format as needed by the member. The Denials and Appeals Work Process specified what the written notice of adverse action must contain. The 10 administrative review (appeal) resolution letters reviewed included the required information; however, in some cases these letters did not meet the fifth-grade reading/understandability level. In three cases the rationale provided for upholding a denial was copied directly from the clinician reviewer notes.		
Required Actions: Peach State must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters.		
28. The Contractor continues the member benefits if:	Peach State has processes in place to continue member benefits during the processing of an administrative review when each of the provisions of 42 CFR 438.420(b) and Contract §4.14.7.1 and 4.14.7.2 are met. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, pages 9-10 ◆ Template Letter: Administrative Review Denial, page 2 Departmental procedure: Denials and Administrative Reviews, page 8 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 4 ◆ SOP: Denials and Administrative Reviews, page 10 ◆ Member Handbook, pages 49 (English) and 116 (Spanish) ◆ P4HB Member Handbook, pages 29 (English) and 70, 71 (Spanish) ◆ Provider Manual, pages 47-48	

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
(a) The member, member's authorized representative, or the provider files a timely appeal—defined as on or before the later of the following: ◆ Within ten (10) days of the Contractor mailing the notice of action. ◆ The intended effective date of the proposed action. *42CFR438.420(b)(1)* *Contract: 4.14.7.1*	◆ Policy: Administrative Review, GA.QI.42, page 9 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 4 ◆ Template Letter: Administrative Review Denial, page 2 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews, page 10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that if the member, authorized representative, or provider filed a timely appeal, and the action involved termination, suspension, or reduction of previously authorized services, the member could request that benefits be continued, and that the request must be filed on or before the latter of either 10 calendar days of the notice of action mailing or the intended effective date of the proposed action.		
Required Actions: None.		
(b) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment. *42CFR438.420(b)(2)* *Contract: 4.14.7.2*	◆ Policy: Administrative Review, GA.QI.42, page 9 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 4 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews, page 10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that benefits could continue if the appeal involved "the termination, suspension or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits."		
Required Actions: None.		
(c) The services were ordered by an authorized provider. *42CFR438.420(b)(3)* *Contract: 4.14.7.2*	◆ Policy: Administrative Review, GA.QI.42, page 9 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 4 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews, page 10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that benefits could continue if the appeal involved "the termination, suspension or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
expired; and the member requests extension of the benefits."		
Required Actions: None.		
(d) The original period covered by the original authorization has not expired. *42CFR438.420(b)(4)* *Contract: 4.14.7.2*	◆ Policy: Administrative Review, GA.QI.42, page 10 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 4 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews, page 10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that benefits could continue if the appeal involved "the termination, suspension or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits."		
Required Actions: None.		
(e) The member requests an extension of benefits. *42CFR438.420(b)(5)* *Contract: 4.14.7.2*	◆ Policy: Administrative Review, GA.QI.42, page10 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 4 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews, page 10	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that benefits could continue if the appeal involved "the termination, suspension or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits."		
Required Actions: None.		
29. If the Contractor continues or reinstates the benefits while the appeal is pending, the benefits must be continued until one of the following occurs: ◆ The member withdraws the appeal. ◆ Ten (10) calendar days pass after the Contractor mails the notice of action providing the resolution of the appeal against the member, unless the member (within the 10-day timeframe) has requested a State Administrative Law hearing with continuation of benefits until a State Administrative Law hearing decision is reached.	Peach State's policies and processes support continuing benefits while an appeal is in process upon request until the member withdraws the administrative review, ten days after the resolution of the administrative review is mailed, the State Administrative Law hearing office issues a determination adverse to the member or the time period or service limits previously authorized have been met. PSHP demonstrates this through the following documents:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
◆ A State Administrative Law hearing office issues a hearing decision adverse to the member. ◆ The time period or service limits of a previously authorized service has been met. *42CFR438.420(c)* *Contract: 4.14.7.3*	◆ Policy: Administrative Review, GA.QI.42, page(s) 9, 10 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, pages 4-5 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews page 11 ◆ Member Handbook, pages 46 (English) and 116 (Spanish) ◆ P4HB Member Handbook, pages 29 (English) and 70, 71 (Spanish) ◆ Provider Manual, page 47, 48	
Findings: The Administrative Reviews policy and procedure included all of the required information as contained in this element. Specifically, the policy indicated that if Peach State continued or reinstated benefits while the appeal was pending, the benefits must be continued until one of the following occurred**:** the member withdrew the appeal, 10 calendar days passed after Peach State mailed the notice of adverse action (unless the member [within the 10-day time frame] had requested a State administrative law hearing with continuation of benefits until a State administrative law hearing decision was reached), a State administrative law hearing office issued a hearing decision adverse to the member, or the time period/service limits of a previously authorized service had been met.		
Required Actions: None.		
30. If the final resolution of the appeal is adverse to the member, that is, upholds the Contractor's action, the Contractor may recover 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 (contract section 4.14.7). *42CFR438.420(d)* *Contract: 4.14.7.4*	Peach State has processes in place to recover the cost of services furnished to the member while the administrative review was pending if the outcome of the review is adverse to the member and notifies the member of this. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 10 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 5 ◆ Template Letter: Administrative Review Denial page 2 ◆ Departmental procedure: Denials and Administrative Reviews, page 8	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ SOP: Denials and Administrative Reviews, page 11 ◆ Member Handbook, pages 49 (English) and 116 (Spanish) ◆ P4HB Member Handbook, page(s) 29,30 (English) and 71 (Spanish) ◆ Provider Manual, page 48	
Findings: The Administrative Reviews policy and procedure indicated that if the final resolution of the appeal was adverse to the member, Peach State may recover "the cost of the services furnished to the member while the administrative law hearing is pending, to the extent that they were furnished solely because of the Continuation of Benefits requirement."		
Required Actions: None.		
31. If the Contractor or the State Administrative Law judge reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending: ◆ The Contractor must authorize or provide the disputed services promptly, and as expeditiously as the member's health condition requires. ◆ The Contractor must pay for those services. *42CFR438.424* *Contract: 4.14.7.5and 4.14.7.6*	Peach State authorizes or provides the disputed services promptly and as expeditiously as the member's health condition requires if the State Administrative Law judge reverses a decision to deny, limit or delay services that were not provided while the administrative review was pending. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 10 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 5 ◆ Departmental procedure: Denials and Administrative Reviews, page 8 ◆ SOP: Denials and Administrative Reviews, page 11 ◆ Member Handbook, pages 49 (English) and 116 (Spanish) ◆ P4HB Member Handbook, pages 29, 30 (English) and 71 (Spanish) ◆ Provider Manual, page 48	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews and the Administrative Law Hearings/Binding Arbitration policies and procedures indicated that if Peach State or the State Administrative Law judge reversed a decision to deny, limit, or delay services that were not furnished while the appeal or administrative law hearing was pending,		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Peach State must authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires. The policies and procedures also indicated that Peach State must pay for those services.		
Required Actions: None.		
32. The Contractor logs and tracks all grievances, proposed actions, appeals, and Administrative Law hearing requests as described in Section 4.18.4.5. *42CFR438.416* *Contract: 4.14.8.1*	Peach State has systems in place to log and track all grievances, proposed actions, appeals and Administrative Law hearing requests as described in Section 4.18.4.5 of the contract. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, page 8 ◆ Policy: Administrative Review, GA.QI.42, page 9 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 7 ◆ Policy: Administrative Law Hearing /Binding Arbitration, GA.COMP.34, page 1 ◆ Departmental procedure: Denials and Administrative Reviews, page(s) 8, 9 ◆ Screen Shot: Grievance SharePoint Database ◆ Screen Shot: Administrative Review SharePoint Database ◆ Screen Shot: TRUCARE ◆ Screen Shot: Administrative Law Hearing Tracking system	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Grievance Process policy and procedure indicated that Peach State recorded all grievances and maintained a record of each grievance review and any actions taken related to the grievance. The policy stated that Peach State included, at minimum, member demographic information, the nature of the complaint, and its resolution. The Administrative Reviews policy stated that Peach State logged and tracked all proposed actions, administrative reviews, and administrative law hearing requests and maintained records of administrative reviews that included a short summary of the issues, name of the appellant, date of the appeal, date of the decision, and the resolution. Peach State used a SharePoint database to document and track grievances, proposed actions, appeals, and administrative law hearing requests.		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		
33. The Contractor shall 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. *Contract: 4.14.8.2*	Peach State has systems in place to maintain records for grievances, whether received verbally or in writing that include a short, dated summary of the issues, the member's name, the date received, the date of the decision and the resolution of each case. PSHP demonstrates this through the following documents: ◆ Policy: Member Grievance Process, GA.QI.08, page 8 ◆ Policy: Member Grievance and ◆ Administrative Review, GA.MBRS.11, page 7 ◆ Screen Shot: Grievance SharePoint Database	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Grievance Process policy and procedure indicated that Peach State maintained records of grievances, both oral and written, and included a dated summary of the problem, member information, date of the grievance, date of the decision, and the disposition. Peach State also provided evidence of tracking via its Grievance SharePoint Database.		
Required Actions: None.		
34. The Contractor shall maintain records of appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. *Contract: 4.14.8.3*	Peach State has systems in place to maintain records of appeals, whether received verbally or in writing that include a short, dated summary of the issues, the member's name, the date received, the date of the decision and the resolution of each case. PSHP demonstrates this through the following documents: ◆ Policy: Administrative Review, GA.QI.42, page 9 ◆ Policy: Member Grievance and Administrative Review, GA.MBRS.11, page 7 ◆ Departmental procedure: Denials and Administrative Reviews, page(s) 8, 9 ◆ Screen Shot: TRUCARE ◆ Screen Shot: Administrative Review SharePoint	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Administrative Reviews policy and procedure indicated that Peach State logged and tracked all proposed actions, administrative reviews, and administrative law hearing requests to include a short summary, name of the appellant, date of the appeal, date of the decision, and the resolution. Peach State also		

Standard V—Grievance System

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
provided evidence that it maintained records in its TruCare tracking system.		
Required Actions: None.		
35. The Contractor must provide the information about the member Grievance System specified in 42CFR438.10(g)(1) to all providers and subcontractors at the time they enter into a contract. *42CFR438.414*	The Plan provides information to all practitioners, providers and subcontractors at the time of entering into a contract on member rights to file grievances, administrative reviews and State Administrative Law hearings, the requirements and timeframes for filing grievances and administrative reviews, the method for a member to request a State Administrative Law hearing and the rules that govern representation at the hearing. PSHP demonstrates this through the following document: ◆ Provider Manual, page(s) 43, 113 (grievances), 43-45 (appeals), 46-47 [Administrative Law hearing (ALH)], 42 (rules for representation at ALH), 48 (member assistance and toll free numbers), 47-48 (continuation of benefits), 48 (member may be required to pay), 93-96 (claim appeal rights to providers)	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The provider manual contained the member grievance and appeals processes, filing time frames, information on how to file, and administrative law hearing information. The provider manual was given to providers when they contracted with Peach State.		
Required Actions: None.		

Standard V—Grievance System					
Met	=	43	X 1.00	=	43
Not Met	=	4	X .00	=	0
Not Applicable	=	0	***NA***		***NA***
Total Applicable	=	47	**Total Score**	=	43
Total Score ÷ Total Applicable				=	**91.5%**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
1. The Contractor shall accept all individuals for enrollment without restrictions. The Contractor shall not discriminate based on: ◆ Religion ◆ Gender ◆ Race ◆ Color ◆ National origin Contractor will not use any policy or practices that have the effect of discriminating on the above basis or on the basis of health, health status, pre-existing condition or need for health care services. *Contract: 4.1.1.4*	Peach State Health Plan shall accept all individuals for enrollment without restrictions and shall not discriminate based on religion, gender, race, color and national origin. Peach State will not use any policy or practices that have the effect of discriminating on the above basis or on the basis of health, health status, pre-existing condition or need for health care services. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCFKs); Page 50, 117 ◆ Member Handbook (P4HB); Page 30, 71-74 ◆ Medicaid/PCFK Member Rights and Responsibilities Policy, GA. MBRS.10 ◆ P4HB Member Rights and Responsibilities Policy, GA. MBRS.18	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The member handbook indicated that Peach State accepted all individuals for enrollment without restriction and did not discriminate based on religion, gender, race, color, and national origin. The member handbook also contained information that the CMO would not discriminate on the basis of health status or pre-existing conditions.		
Required Actions: None.		
2. A member may request disenrollment from a CMO for the following reasons: ◆ For cause at any time. ◆ Without cause: ▪ During 90 calendar days following the date of their initial enrollment or the day DCH or its agent sends the member notice of enrollment—whichever is later. ▪ Every 12 months thereafter. ▪ Upon automatic enrollment. *42CFR438.56(c)(i-iii)*	Peach State Health Plan members may request disenrollment for cause at any time and without cause during the 90 days following the date of the member's initial enrollment with Peach State, or the date the State sends the member notice of enrollments, whichever is later and at least once every 12 months thereafter. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.28 Peach State Health Plan	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Contract: 4.2.1.1	Member Initiated Disenrollment Policy ◆ Member Handbook (Medicaid/PCFKs); Page 54, 122 ◆ Member Handbook (P4HB); Page 34,76 ◆ DCH Member Initiated Disenrollment Example	
Findings: The Member Initiated Disenrollment policy and procedure indicated that the member could request disenrollment for cause at any time. The member could request disenrollment without cause during the 90 calendar days following the date of initial enrollment or the day DCH sent the member notice of enrollment, whichever is later, every 12 months thereafter, and upon the member's automatic enrollment.		
Required Actions: None.		
3. The following constitutes cause for disenrollment requested by the member: ◆ The member moves out of the service area. ◆ The Contractor does not, because of moral or religious objections, provide the covered service the member seeks. ◆ The member needs related services performed at the same time and not all the related services are available within the network. A provider has determined that providing the services separately would subject the member to unnecessary risk. ◆ The member requests to be assigned to the same Contractor as family members. ◆ The member's Medicaid eligibility category changes to ineligible for GF. ◆ Other reasons include but are not limited to poor quality of care, lack of access to services covered under the Contract, or lack of providers experienced in dealing with the member's mental health care needs. *42CFR438.56(d)(2)(i-iv)* *Contract: 4.2.1.2*	The following constitutes cause for disenrollment requested by the member ◆ The member moves out of the service area ◆ The Contractor does not because of moral or religious objections, provide the covered service the member seeks ◆ The member needs related services performed at the same time and not all the related services are available within the network. A provider has determined that providing the services separately would subject the member to unnecessary risk ◆ The member requests to be assigned to the same ◆ Contractor as family members ◆ The member's Medicaid eligibility category changes to ineligible for GF ◆ Other reasons include but are not limited to poor ◆ quality of care, lack of access to services covered under the Contract, or lack of providers experienced in dealing with the member's mental health care needs Peach State demonstrates this through the following reference documents:	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Policy: GA.MBRS.28 Peach State Health Plan Member ◆ Initiated Disenrollment Policy ◆ Member Handbook (Medicaid/PCFKs); Page 54,122 ◆ Member Handbook (P4HB); Page 34, 76 ◆ DCH Member Disenrollment Example	
Findings: The Member Initiated Disenrollment policy and procedure indicated what constituted cause for disenrollment requested by the member. All of the causes for disenrollment listed in the element were included in the policy.		
Required Actions: None.		
4. The Contractor provides assistance to members seeking to disenroll. Assistance consists of providing forms to the member and referring the member to DCH or its agent who makes disenrollment determinations. *Contract: 4.2.1.3*	Peach State Health Plan provides assistance to members seeking to disenroll, assistance consists of referring the member to DCH or its agent for the forms and who makes disenrollment determinations. Peach State refers members to DCH for assistance with completing the forms. Peach State demonstrates this through the following reference documents: ◆ Member Handbook (Medicaid/PCFKs); Page 52, 123- 124 ◆ Policy: GA.MBRS.28 Peach State Health Plan Member Initiated Disenrollment Policy	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Member Initiated Disenrollment policy and procedure indicated that Peach State would assist members seeking disenrollment by referring them to DCH. The DCH completed the forms and made the disenrollment determinations. Member services staff confirmed the process that was outlined in the policy.		
Required Actions: None.		
5. For disenrollment initiated by the Contractor, the Contractor notifies DCH or its agent upon identification of a member who it knows or believes meets the criteria for disenrollment, as defined in Contract Section 4.2.3. and completes all disenrollment paperwork for members it is seeking to disenroll. *Contract: 4.2.2.1 and 4.2.2.2*	Peach State Contractor notifies DCH or its agent upon identification of a member who it knows or believes meets the criteria for disenrollment, as defined in Contract Section 4.2.3. and completes all disenrollment paperwork for members it is seeking to disenroll.	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.29 Peach State Health Plan Initiated Disenrollment Policy_GA.MBRS. 29 ◆ Peach State Health Plan Disenrollment Example	
Findings: The Member Initiated Disenrollment policy and procedure indicated that Peach State would adhere to this requirement by completing a Peach State Disenrollment Request Form (which included the disenrollment reason). The documentation was forwarded to DCH for determination.		
Required Actions: None.		
6. The Contractor may request disenrollment if: ◆ 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. *Contract: 4.2.3*	Peach State may request disenrollment of a member if: ◆ 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. Peach State demonstrates this through the following reference document: ◆ Policy: GA.MBRS.29 Peach State Health Plan Initiated Disenrollment Policy ◆ Member Handbook (Medicaid/PCFKs); Page 54-55,122	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	◆ Member Handbook (P4HB); Page 34, 76	
Findings: The Peach State Initiated Disenrollment policy and procedure indicated the disenrollment reasons identified in the element. The CMO staff indicated that no instances of member fraud had occurred since 2010.		
Required Actions: None.		
7. Prior to requesting Disenrollment of a member, the Contractor shall document: ◆ At least three (3) interventions over a period of ninety (90) calendar days that occurred through treatment, case management, and care coordination to resolve any difficulty leading to the request. ◆ Provide at least one (1) written warning to the member, certified return receipt requested, regarding implications of his or her actions. The DCH recommends that this notice be delivered within ten (10) business days of the member's action. *Contract: 4.2.2.3*	Prior to requesting disenrollment of a member, Peach State Health Plan shall document at least three (3) interventions over a period of ninety (90) calendar days that occurred through treatment, case management, and care coordination to resolve any difficulty leading to the request. Peach State shall provide at least one (1) written warning to the member, certified return receipt requested, regarding implications of his or her actions. DCH recommends that this notice be delivered within ten (10) business days of the member's action, if the member has demonstrated abusive or threatening behavior as defined by DCH, only one (1) written attempt to resolve the difficulty is required. Peach State did not initiate any disenrollment requests during this review period. When applicable, Peach State will comply with the requirements for plan initiated disenrollments. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.29 Peach State Health Plan Initiated Disenrollment Policy ◆ Peach State Health Plan Disenrollment Example	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Peach State Initiated Disenrollment policy and procedure indicated that the CMO would document three interventions over a period of 90 calendar days in attempts to resolve issues. Further, the CMO would provide a written warning to the member, certified return receipt requested, in order to inform the member of the implications of his or her actions.		
Required Actions: None.		

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
8. The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for disenrollment outlined in Section 4.2.3 before requesting disenrollment of the member. *Contract: 4.2.2.4*	Peach State Health Plan shall cite to DCH or its Agent at least one (1) acceptable reason for disenrollment outlined in Section 4.2.3 before requesting disenrollment of the member. Peach State demonstrates this through the following reference documents: ◆ Policy: GA.MBRS.29 Peach State Health Plan Initiated Disenrollment Policy ◆ Peach State Disenrollment Example ◆ Member Handbook (Medicaid/PCFKs); Page 54-55,122 ◆ Member Handbook (P4HB); Page 34, 76	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Peach State Initiated Disenrollment policy and procedure indicated that the CMO would cite at least one acceptable reason for disenrollment.		
Required Actions: None.		
9. The Contractor may not request disenrollment of a member for discriminating reasons, including: ◆ Adverse changes in a member's health status; ◆ Missed appointments; ◆ Utilization of medical services; ◆ Diminished mental capacity; ◆ Pre-existing medical condition; ◆ Uncooperative or disruptive behavior resulting from his or her special needs; or ◆ Lack of compliance with the treating physician's plan of care. ◆ Member attempts to exercise his/her rights under the Grievance System. *Contract: 4.2.4.1 and 4.2.4.2*	Peach State may not request disenrollment of a member for discriminating reasons, including: ◆ Adverse changes in a member's health status ◆ Missed appointments ◆ Utilization of medical services ◆ Diminished mental capacity ◆ Pre-existing medical condition ◆ Uncooperative or disruptive behavior resulting from his or her special needs; or ◆ Lack of compliance with the treating physician's plan of care Peach State demonstrates this through the following reference document: ◆ Policy: GA.MBRS.29 Peach State Health Plan	☒ **Met** ☐ **Not Met** ☐ **NA**

Standard VI—Disenrollment Requirements and Limitations

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Initiated Disenrollment Policy	
Findings: The Peach State Initiated Disenrollment policy and procedure indicated that the CMO would not request disenrollment of a member for any of the reasons listed in the element.		
Required Actions: None.		
10. The request of one PCP to have a member assigned to another provider is not sufficient cause for the Contractor to request the member be disenrolled from the plan. The Contractor shall utilize its PCP assignment process to assign the member a new PCP. *Contract: 4.2.4.3*	A Peach State PCP request to have a member assigned to another provider is not sufficient cause for the Contractor to request the member be disenrolled from the plan. The Contractor shall utilize its PCP assignment process to assign the member a new PCP. Peach State demonstrates this through the following reference document: ◆ Policy: GA.MBRS.29 Peach State Health Plan Initiated Disenrollment Policy ◆ Peach State PCP Selection Change Policy_GA.MBRS.39	☒ **Met** ☐ **Not Met** ☐ **NA**
Findings: The Peach State Initiated Disenrollment policy and procedure indicated that the request from one PCP to have a member assigned to a different provider was not sufficient cause for Peach State to request that the member be disenrolled from the CMO. The policy also indicated that Peach State used its PCP assignment process to assign a member to a different and available PCP.		
Required Actions: None.		

Standard VI—Disenrollment Requirements and Limitations						
Met	=	10	X	1.00	=	10
Not Met	=	0	X	.00	=	0
Not Applicable	=	0		*NA*		*NA*
Total Applicable	=	10	**Total Score**		=	10
Total Score ÷ Total Applicable					=	100%

Appendix B. **Follow-Up Review Tool**

Following this page is the completed follow-up review tool that HSAG used to evaluate Peach State's performance and to document its findings; the scores it assigned associated with the findings; and, when applicable, corrective actions required to bring Peach State's performance into full compliance.

Appendix B. State of Georgia
Department of Community Health (DCH)
Follow-Up On Reviews From Previous Noncompliant Review Findings
for Peach State Health Plan

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(b) **Provider Appointments—Office Wait Times:** *Contract 4.8.14.3*

The CMO informs providers and has processes to ensure that wait times for appointments do not exceed the following:

- Scheduled Appointments—Sixty (60) minutes. After 30 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.
- Work-in or Walk-in Appointments—Ninety (90) minutes. After 45 minutes, the patient must be given an update on waiting time with an option of waiting or rescheduling the appointment.

Findings: The provider manual indicated that wait times for scheduled appointments must not exceed 60 minutes and after 30 minutes, the patient must be updated on expected wait times and offered options to wait or to reschedule. Similarly, the provider manual indicated that work-in and walk-in appointment wait times must not exceed 90 minutes and after 45 minutes, the patient must be updated on the wait time and provided the option to wait or reschedule the appointment. Evidence of adequate monitoring of this element was not apparent at the time of the on-site visit.

Required Actions: The CMO must develop a monitoring practice to ensure wait times do not exceed the requirements in this element.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure member wait times do not exceed the requirements set forth in 42 CFR 438.206(c)(1) and Contract Section 4.8.14.3, Peach State Health Plan will implement the following initiatives: 1. Providers are educated continuously on the appointment wait time standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Implemented January, 2015/Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60 provider visits per month each, and we currently have sixteen Provider Relations Representatives in the field statewide.		◆ Provider Relations Representatives	
2. In addition to our educational activities, beginning January 1, 2015, we have outsourced our audit to The Myers Group, who will conduct statewide quarterly provider surveys to identify providers who are non-compliant with the office wait times access requirement. The Myers Group will survey providers and ask them to self-report their wait times and communication with their patients. Of note, members are surveyed through the CAHPS Survey.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Implemented January 2015
◆ Providers whose office wait times exceed the requirement will be re-educated by their assigned Provider Relations Representative on the timely access requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback on the barriers to maintaining compliant wait times and interventions will be proposed. These providers will be re-surveyed the following quarter to ensure		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	◆ Ongoing ▪ Re-education to occur 14 calendar days after receipt of the audit results ▪ Re-surveying of providers will occur during the Quarter after a provider's failure to meet the access standard

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
they have become complaint with the wait time standards. ◆ Providers failing to demonstrate compliance with the office wait times requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented within the provider's practice to ensure they are able to meet the appointment access requirements. The non-compliant letters will be mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) business days of receipt of our letter. CAPs will be monitored for compliance through the use of secret shopper call(s) that will be made to the office by a Provider Relations Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for any applicable recommendations and/or action plans. 3. During the First Quarter of 2015, Peach State Health Plan will work to identify participating		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives ◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director,	◆ Ongoing ▪ Corrective Action Plans will be mailed out fourteen (14) days after receipt of the audit results ▪ Providers must submit their CAP within seven (7) days of receipt ▪ Secret shopper calls will be conducted sixty (60) calendar days after the implementation of the provider's CAP ◆ 3/31/2015

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
provider groups with Practice Management Systems that allow them to capture patient wait times who are willing to share their internal average wait time reports with the Plan to 1) identify trends in wait time patterns i.e. longer wait times on certain days of the week, 2) to better understand the reasons for the non-compliant wait times and 3) develop interventions that address the underlying issues resulting in office wait times exceeding the standard. Once we have identified groups with the ability to run patient wait time reports, we will request that they submit their wait time reports to us within 30 calendar days. Within 14 calendar days of receipt of the wait time reports, we will analyze the data to determine if there are any trends in the non-compliant wait times. Once we have completed our analysis, Provider Relations will schedule a meeting with the group to review findings and discuss possible reasons for the trends, to ask the provider for feedback on challenges with meeting wait time standards and to discuss possible interventions that will reduce patient wait times. Once we have agreed on interventions, Provider Relations will submit the interventions to the Provider in writing within seven (7) calendar days. The provider will then implement interventions and monitor wait times for 30		◆ Provider Relations, Peach State Health Plan ◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives ◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Assigned Provider Relations Staff	◆ 4/30/2015 ◆ Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
calendar days. The provider will then submit a new report of patient wait times for the previous 30 days to determine if interventions were successful in reducing wait times. If the interventions were successful, Provider Relations will develop a plan to implement similar interventions with network providers statewide within the following quarter.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Ongoing
4. Member education will be conducted to ensure members understand the provider appointment office wait time standards.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Ongoing
5. Member CAHPS quality surveys currently capture member input regarding appointment wait times to include quarterly monitoring of member feedback related to the appointment wait time standards. Additionally, member feedback related to appointment wait times is captured through our member grievance process, and non-compliant providers identified through this process are educated via face-to-face visit and monitored as described above.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Ongoing
Other Evidence/Documentation:			

Standard II—Furnishing of Services
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
PSHP_Appoint Avail and Wait Time_Scripts.xlsx Wait Time Survey_Q1 2015.xlsx Wait Time Survey_Q2 2015.xlsx
July 2015 Re-review Findings: Peach State contracted with the Meyers Group to survey members and report on provider appointment office wait times. Peach State provided two quarterly reports for review, and the CMO had a monitoring program in place to ensure providers met the wait times established in the element.
July 2015 Required Actions: None.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(c) **Appointment Wait Times:** *Contract 4.8.142.3*

The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:

(i) (PCPs (Routine Visits)—14 calendar days

Findings: The provider manual indicated that PCP appointment availability for routine care must not exceed 14 calendar days, but the Timely Access Report indicated that only 84 percent of providers met this goal during quarter three of CY 2013.

Required Actions: The CMO did not meet the required 90 percent goal for each quarter during the review period and must obtain that goal in order to receive a Met status on this element.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure the Plan meets and requires its providers to meet DCH standards for timely access to care and services, Peach State Health Plan will continue the following initiatives described below: Providers are educated continuously on the appointment timely access standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60 provider visits per month each, and we currently have sixteen		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	◆ Implemented January, 2015/Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Provider Relations Representatives in the field statewide. The Myers Group will conduct quarterly statewide provider surveys to identify providers who are non-compliant with one or more of the appointment timely access requirements.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Implemented January 2015
Providers whose appointment access exceeds any requirement will be re-educated via a face-to-face visit by their assigned Provider Relations Representative on the timely access requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliant timely access for appointments and interventions will be proposed. The provider will be instructed to implement the proposed interventions within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become compliant with the timely access standards.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	◆ Ongoing ▪ Re-education to occur 14 calendar days after receipt of the audit results ▪ Re-surveying of providers will occur during the Quarter after a provider's failure to meet the access standard
Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach	◆ Ongoing ▪ Corrective Action Plans will be mailed out fourteen (14) days after receipt of the audit

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Corrective Action Plan (CAP) that outlines the steps and processes the provider intends to implement to ensure compliance with the appointment access requirements. The non-compliant letters will be mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) calendar days of receipt of our letter. CAPs will be monitored for compliance through the use of a secret shopper call(s) that will be made to the office by a Provider Relations Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for any applicable recommendations and/or action plans. Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meeting appointment timely access standards during the meeting. Additionally, the feedback received during these meetings will be used to create new/improved interventions that can be implemented throughout the network.		State Health Plan ◆ Provider Relations Representatives ◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Tracy Smith, Director, Provider Relations, Peach	results ▪ Providers must submit their CAP within seven (7) days of receipt ▪ Secret shopper calls will be conducted sixty (60) calendar days after the implementation of the provider's CAP ◆ 3/31/2015 ◆ 4/30/2015

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access requirements as specified in the provider contract.		State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	
Other Evidence/Documentation: PSHP_Appoint Avail and Wait Time_Scripts.xlsx Consolidated Timely Access Results.xlsx			
July 2015 Re-review Findings: Peach State provided its consolidated timely access report, and it indicated compliance with the timeliness standard in the element.			
July 2015 Required Actions: None.			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(c) **Appointment Wait Times:** *Contract 4.8.142.3*

The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:

(ii) PCP (Adult Sick Visit)—24 hours

Findings: The provider manual indicated that PCP appointment availability for adult sick visits must not exceed 24 hours, but the Timely Access Report indicated that only 89 percent of providers met this goal during quarter three of CY 2013. The CMO did not meet the required 90 percent goal for each quarter during the review period.

Required Actions: The CMO must ensure that 90 percent of its PCPs meet the requirement for providing an adult sick visit appointment within 24 hours.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure the Plan meets and requires its providers to meet DCH standards for timely access to care and services, Peach State Health Plan will continue the following initiatives described below: Providers are educated continuously on the appointment timely access standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	◆ Implemented January, 2015/Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
provider visits per month each, and we currently have 16 Provider Relations Representatives in the field statewide. The Myers Group will conduct quarterly provider surveys to identify providers who are non-compliant with one or more of the appointment timely access requirements.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Implemented January 2015
Providers whose appointment access exceeds any requirement will be re-educated via face-to-face visit by their assigned Provider Relations Representative on the timely access requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliant timely access for appointments, and interventions will be proposed. The provider will be instructed to implement proposed interventions within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become compliant with the timely access standards.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	◆ Ongoing ▪ Re-education to occur 14 calendar days after receipt of the audit results ▪ Re-surveying of providers will occur during the Quarter after a provider's failure to meet the access standard
Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director,	◆ Ongoing ▪ Corrective Action Plans will be mailed out fourteen (14) days after

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented within the provider's practice to ensure they are able to meet the appointment access requirements. The non-compliant letters will be mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) calendar days of receipt of our letter. CAPs will be monitored by for compliance through the use of a secret shopper call(s) that will be made to the office by a Provider Relations Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for recommendation and action plan.		Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	receipt of the audit results ▪ Providers must submit their CAP within seven (7) days of receipt ▪ Secret shopper calls will be conducted sixty (60) calendar days after the implementation of the provider's CAP
Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meeting appointment timely access standards during the meeting.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan	◆ Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Additionally, the feedback received during these meetings will be used to create new/improved interventions that can be implemented throughout the network. Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access requirements as specified in the provider contract.		◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Representatives	◆ Ongoing
Other Evidence/Documentation: PSHP_Appoint Avail and Wait Time_Scripts.xlsx Consolidated Timely Access Results.xlsx			
July 2015 Re-review Findings: Peach State provided its consolidated timely access report, and it indicated compliance with the timeliness standard in the element.			
July 2015 Required Actions: None.			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(c) **Appointment Wait Times:** *Contract 4.8.142.3*

The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:

(vi) Non-emergency Hospital Stays—30 calendar days

Findings: The provider manual indicated that non-emergency hospital stays should be provided within 30 calendar days, but the Timely Access Report indicated that only 83 percent of providers met this goal during quarter three of CY 2013 and 86 percent during quarter four of CY 2013. The CMO did not meet the required 90 percent goal for each quarter during the review period.

Required Actions: The CMO must ensure that 90 percent of its non-emergency hospital stays are under the 30 calendar day goal.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
In an effort to ensure that 90 percent of the Plan's non-emergency hospital stays are provided within 30 calendar days, Peach State Health Plan will implement the following initiatives: 1. The Utilization Management Director and Prior Authorization Manager will partner with the Plan's Provider Network Director to outreach to providers identified as scheduling non-emergent hospital admissions beyond 30 calendar days to re-educate the providers on the standard by 3/27/15.		◆ Tomeika Horne, Director, Utilization Management Peach State Health Plan to collaborate with Provider Network ◆ Tracy Smith, Director, Provider Network to collaborate with Utilization Management	◆ The collaboration and outreach will begin by 3/27/15

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
2. Monitor monthly trends by provider type and provide a monthly report of providers who schedule non-emergent hospital stays beyond the 30 day contractual requirement to the Director of Provider Network. 3. Within 7 days of notification of providers whose appointment access exceeds the contractual requirement, face to face provider network representative will provide re-education and assess for barriers regarding maintaining the requirement. The provider will be instructed to implement proposed interventions within seven (7) calendar days and will be re-surveyed the following quarter to ensure they have become compliant with the timely access standards. Providers failing to demonstrate compliance will receive a letter of non-compliance and will be required to submit a Corrective Action Plan (CAP). Continued non-compliance will result in review by the Peer Review Committee for recommendation.		◆ Andrea Afolabi, Manager, Prior Authorization to complete monthly review and submit to Provider Network ◆ Tracy Smith, Director, Provider Network to oversee provider reeducation ◆ Provider Network Representatives to complete provider reeducation	◆ The PA manager will initiate the monthly reports by 3/27/15 ◆ Provider Network Representatives will begin outreach and education following notification by 3/27/15
Other Evidence/Documentation: PSHP_Appoint Avail and Wait Time_Scripts.xlsx Consolidated Timely Access Results.xlsx			
July 2015 Re-review Findings: Peach State provided its consolidated timely access report, and it indicated compliance with the timeliness standard in the element.			
July 2015 Required Actions: None.			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(c) **Appointment Wait Times:** *Contract 4.8.142.3*

The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:

(vii) Mental Health Providers—14 calendar days

Findings: The provider manual indicated that mental health provider appointment availability must be provided within 14 calendar days, but the Timely Access Report indicated that only 88 percent of providers met this goal during quarter four of CY 2013. The CMO did not meet the required 90 percent goal for each quarter during the review period.

Required Actions: The CMO must ensure that 90 percent of its mental health providers provide access for an appointment within 14 calendar days.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure the Plan meets and requires its providers to meet DCH standards for timely access to care and services, Peach State Health Plan will continue the following initiatives described below: Providers are educated continuously on the appointment timely access standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60 provider visits per month each, and we currently have 16 Provider		◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Vendor Provider Relations staff	◆ Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Relations Representatives in the field statewide. The Myers Group will conduct quarterly provider surveys to identify providers who are non-compliant with one or more of the appointment timely access requirements. Providers whose appointment access exceeds any requirement will be re-educated via face-to-face visit by their assigned Provider Relations Representative on the timely access requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliant timely access for appointments, and interventions will be proposed. The provider will be instructed to implement proposed interventions within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become compliant with the timely access standards. Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented within the provider's practice to ensure they are able to meet the appointment access requirements. The non-compliant letters will be			◆ Ongoing education & training. ◆ Ongoing education & training.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) calendar days of receipt of our letter. CAPs will be monitored by for compliance through the use of a secret shopper call(s) that will be made to the office by a Provider Relations Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for recommendation and action plan. Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meeting appointment timely access standards during the meeting. Additionally, the feedback received during these meetings will be used to create new/improved interventions that can be implemented throughout the network. Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access requirements as specified in the provider contract.			◆ Ongoing education & training. ◆ Ongoing education & training.
Other Evidence/Documentation: Consolidated Timely Access Results.xlsx			

Standard II—Furnishing of Services
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
July 2015 Re-review Findings: Peach State provided its consolidated timely access report, and it indicated compliance with the timeliness standard in the element.
July 2015 Required Actions: None.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(d) **Timelines–Visits for Pregnant Women:** *Contract 4.8.142.5*

The CMO provides adequate capacity for initial visits for pregnant women within 14 calendar days of enrollment into the CMO plan.

Findings: The provider manual indicated that initial pregnancy visit appointments must be provided within 14 days of the request, but the Timely Access Report indicated that only 84 percent of members met this goal during quarter three of CY 2013. The CMO did not meet the required 90 percent goal for each quarter during the review period and must obtain that goal in order to receive a Met status on this element.

Required Actions: The CMO must ensure that 90 percent of its providers have availability of visits within 14 days for newly enrolled pregnant women.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure the Plan meets and requires its providers to meet DCH standards for timely access to care and services, Peach State Health Plan will continue the following initiatives described below: Providers are educated continuously on the appointment timely access standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60 provider visits per month each, and we currently have 16 Provider Relations Representatives in the field statewide.		◆ Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan ◆ Tracy Smith, Director, Provider Relations, Peach State Health Plan ◆ Provider Relations Staff	◆ Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
The Myers Group will conduct quarterly provider surveys to identify providers who are non-compliant with one or more of the appointment timely access requirements. Providers whose appointment access exceeds any requirement will be re-educated via face-to-face visit by their assigned Provider Relations Representative on the timely access requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliant timely access for appointments, and interventions will be proposed. The provider will be instructed to implement proposed interventions within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become complaint with the timely access standards. Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented within the provider's practice to ensure they are able to meet the appointment access requirements. The non-compliant letters will be			◆ Ongoing education & training. ◆ Ongoing education & training.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) calendar days of receipt of our letter. CAPs will be monitored by for compliance through the use of a secret shopper call(s) that will be made to the office by a Provider Relations Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for recommendation and action plan. Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meeting appointment timely access standards during the meeting. Additionally, the feedback received during these meetings will be used to create new/improved interventions that can be implemented throughout the network. Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access requirements as specified in the provider contract.			◆ Ongoing education & training.
Other Evidence/Documentation: Consolidated Timely Access Results.xlsx			

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
July 2015 Re-review Findings: Peach State provided its consolidated timely access report, and it indicated compliance with the timeliness standard in the element.
July 2015 Required Actions: None.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. Timely Access: *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(f) **Timelines–Returning Calls After-Hours:** *Contract 4.8.14.4*

The CMO ensures that provider response times for returning calls after-hours do not exceed the following:

- Urgent Calls—Twenty minutes
- Other Calls—One hour

Findings: The provider manual indicated that urgent after-hours calls from providers should occur within 20 minutes and other calls within an hour. Evidence of adequate monitoring of this element was not apparent at the time of the on-site visit.

Required Actions: The CMO must develop a monitoring practice to ensure that providers return urgent calls within 20 minutes and other calls within one hour.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure providers return urgent/non-urgent calls within the timeframes set forth in 42 CFR 438.206(c)(1) and Contract Section 4.8.14.3, Peach State Health Plan will implement the following initiatives: Providers are educated continuously on the after-hours return call standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60 provider visits per month each, and we currently have 16 Provider Relations Representatives in the field statewide.		• Tracy Smith, Director, Provider Relations, Peach State Health • Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan • Provider Relations Staff	• As of January 1, 2015, the provider relations staff began face to face visits with the deficient providers.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
The Myers Group will conduct quarterly provider after-hours surveys to identify providers who are non-compliant with one or more of the after-hours return call requirements. Providers whose after-hours calls time frame exceeds any requirement will be re-educated via face-to-face visit by their assigned Provider Relations Representative on the after-hours return call requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliance with the after-hours call requirements, and interventions will be proposed. The provider will be instructed to implement proposed interventions that will bring them into compliance within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become compliant with the after-hours return calls standard. Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented within the provider's practice to ensure they are able to meet the after-hours return call			• Within ninety (90) calendar days of receiving approval from DCH. • Ongoing • Ongoing • Ongoing

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
requirements. The non-compliant letters will be mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) calendar days of receipt of our letter. CAPs will be monitored by for compliance through the use of a secret shopper call(s) that will be made after-hours to the office by a Provider Relations Representative or Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for recommendation and action plan. Peach State's Provider Relations Staff, who regularly visit provider offices, conduct focused training during these visits related to after-hours return call requirements. Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access and after-hours return call requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meet appointment timely access and after-hours standards during the meeting. Additionally, the feedback received during these meetings will be used to create new/improved interventions that can be			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
implemented throughout the network. Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access and after-hours return call requirements. Member education will be conducted to ensure members understand that urgent after-hours calls from providers should occur within 20 minutes and other calls within an hour. Member CAHPS quality surveys currently capture member input regarding the amount of time it takes for a provider to return their call after-hours, to include quarterly monitoring of member feedback related to the after-hours return call time standards. Additionally, member feedback related to after-hours return calls is captured through our member grievance process, and non-compliant providers identified through this process are educated via face-to-face visit and monitored as described above.			
Other Evidence/Documentation: Q1 2015_AfterHoursSurvey_Final.xlsx Q2 2015_AfterHoursSurvey_Final.xlsx			
July 2015 Re-review Findings: Peach State monitored the after-hours provider call back times and met DCH's goal for returning urgent calls within 20 minutes. During quarter 2, 2015, providers achieved a routine call back rate of 89 percent, one percentage point below the 90 percent goal.			
July 2015 Required Actions: The CMO must continue implementing interventions with providers until the goal of returning routine calls within one hour is achieved at least 90 percent of the time.			

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

5. **Geographic Access:** *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

Findings: The CMO monitors the appropriate geographic access standards, but Peach State does not meet all of the standards. Peach State submits a deficiency report to the State as a result of its analysis. The CMO did not meet the requirement to have at least 90 percent of members with access to providers within the time/distance analysis in the element. It was noted the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCPs
- Specialists
- General dental providers
- Dental subspecialty providers
- Mental health providers
- Pharmacies

Required Actions: The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To meet the geographic access standards for PCPs in the urban area, PSHP will: **To meet the geographic access standards for PCPs in the rural setting, PSHP will:** Peach State will partner with key IPA/PHO providers in each of the six regions to assist with the recruitment of previously opt-out practitioners to opt-in to Peach State's network to fill service gaps. In addition, collaboration with our par rural hospitals to assist with adding all new RHCs which will help to provide coverage in densely populated areas. Also, Peach State will contract with newly Georgia Medicaid enrolled providers that offer an opportunity to meet access standards. Finally, our provider relations team will assist in recruitment of non-Medicaid enrolled providers to get them to become eligible as a Medicaid provider. **To meet the geographic access standards for specialists in the urban setting, PSHP will:** To meet the geographic access standards for specialists in the rural setting, Peach State has expand our collaboration with the Georgia Partnership for Telehealth, local health departments and other venues that have access to telehealth equipment to ensure specialty access within the county. As a result, Peach State has partnered with Albany Area Primary Health		◆ Clyde White, Vice President, Contracting Peach State Health Plan	◆ All coordination efforts for the delivery of specialty services in the rural areas of telehealth originating sites and provider recruitment are ongoing. ◆ December 2015

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Care, Inc., South Central Primary Care Center, Inc., and Bleckly Memorial Hospital. Peach State will provide transportation for members to and from these locations as needed. Member Services team will assist members with scheduling appointments and transportation needs. Peach State will continue to utilize single case agreements in our current deficient counties to provide access to care. In addition, transportation will be provided and arrange through Peach State's Member Services and transportation vendor.			

Other Evidence/Documentation:
ATL Region_Q1 2015_Deficiency Report.xls
Central_Q1 2015_Deficiency Report.xlsx
EAST Region_Q1 2015_Deficiency Report 042715 (2).xlsx
NORTH Region_Q1 2015_Deficiency Report.xls
SE Region_Q1 2015_Deficiency Report.xls
SW Region_Q1 2015_Deficiency Report.xlsx

July 2015 Re-review Findings: Upon re-review, Peach State did not meet all of the standards. Peach State submitted a deficiency report to the State as a result of its analysis. The CMO did not meet the requirement to have at least 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCPs
- Specialists
- General dental providers
- Dental subspecialty providers
- Mental health providers
- Pharmacies

July 2015 Required Actions: The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies. Peach State must continue its efforts to close its network adequacy gaps and keep DCH informed of its progress.

Standard IV—Coordination and Continuity of Care

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

3. Ongoing Source of Primary Care: *42 CFR 438.208(b)(1); Contract 4.1.2; 4.8.2.1; 4.8.2.3; 4.8.2.5*

The CMO:

- Has written PCP selection policies and procedures describing how members select their PCP.
- Ensures that each member 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.

Findings: After reviewing all documents provided by Peach State and interviewing CMO staff during the on-site audit, no areas of concern were noted for this element. However, the policy for changing a PCP and the actual reported procedure were not congruent. The policy stated that the member can switch PCPs every 30 days within the first 90 days and every 6 months after. However, staff reported that the member was allowed to change PCPs at any time.

Required Actions: The CMO needs to align its policies, procedures, and process for changing a PCP, and ensure that CMO staff members are educated about how members select their PCP.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
In an effort to ensure the Plan's PCP selection policy is followed, the following initiative will be implemented: ◆ Peach State Health Plan staff who are capable of performing PCP assignment changes will be re-trained on the PCP selection policy which specifically states that members can switch PCPs every 30 days within the first 90 days and every 6 months thereafter. Of note, the Plan's policies are reviewed bi-annually with all call-center and utilization management staff to ensure continuous and ongoing awareness of the Plan's policy. ◆ Peach State Health Plan's staff that are capable of performing PCP assignment	Peach State will conduct a quarterly sample of PCP assignments to ensure that all PCP assignments are granted within the required timeframe. Staff members who fail to meet the requirement are subject to re-education and potential performance improvement plans.	Chevron Cardenas, Senior Director, Member Relations, Peach State Health Plan	Within thirty (30) calendar days of receiving approval from DCH.

Standard IV—Coordination and Continuity of Care			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
changes will be audited on a monthly basis to ensure compliance with this requirement as a part of our ongoing quality monitoring. Specifically, random audits of PCP changes per staff member will be reviewed against the Plan's PCP selection policy. Staff members who fail to meet the requirement are subject to re-education and potential performance improvement plans.			

Other Evidence/Documentation:

Policy and procedure GA.MBRS.39 PCP Selection and Change: While members will be assigned to the same PCP for six (6) months and encouraged to receive services from the assigned PCP, the member may elect to receive services from any Peach State participating Primary Care Provider at any time regardless of assignment.

Call Center Work Process and Script: PCP Changes

- A new member will choose a PCP when they select to participate with the Peach State Health Plan. The member may elect to receive services from any Peach State participating Primary Care Provider at any time regardless of assignment.
- If the member does not choose a PCP he will be auto-assigned (assigned by the plan) to a provider
  - PCP selection can be made
    - Through Incoming call from the Member
    - Mail (Member Data Change Form)
    - Fax (Member Data Change Form)
    - Secure Web Portal
      - Member Data Change Form can be found on the PSHP website.
- Members are allowed to change PCP's **without a reason** for the *first* 90 days they are signed up with the Peach State Health Plan.
- After 90 days, the member can change PCP every 6 months **without a reason.**
- Members are allowed to change PCP at *anytime* for the following reasons:
  - Your PCP is no longer in your area.
  - Because of religious or moral reasons the PCP does not provide the services you seek.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

- You want the same PCP as other family members.

- Member PCP changes made between the 1st and 23rd of the month are effective the 1st day of the current month. Changes requested on or after the 24th until the last day of the month are effective for the first of the following month.
  - Example: Change requests made on 12/23 will be effective12/01, change requests made on 12/24 will be effective 1/01.

You must document in your notes that you advised the member about the 6 month lock-in rule. See example below:

Call Type PCP/PMP Change
Adam Smith -
Male
Speaks English Wesley Physician Services
4891 Highway 589 Sumrall MS 39482
6017584606 Prov #/Aff #:
P100004833220002
Program: GP
Accept Code:
Open in Panel: 2455
LOCK IN RULE ADVISED 6 MONTHS ADDR VERIFIED EFF DATE 5/1/13 NEW ID CARD IN 10 CALENDAR DAYS, TEMP ID CARD ON PSHP.COM
PCP changes take 24-48 hours to show in CRM and on the Secure Web Portal

July 2015 Re-review Findings: Peach State aligned its policies, procedures, and process for changing a PCP, and provided training to staff members who were capable of changing the member's PCP assignment. Prior to re-review of the element during the July 2015 comprehensive review, Peach State completed two quarterly audits of PCP assignments and identified a combined passing score of 97.10 percent.

July 2015 Required Actions: None.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

7. Protects Member Privacy: *45 CFR 160 and 164, subparts A and E; Contract 4.8.17.6*

The CMO implements procedures to ensure that in the process of coordinating care, each Member's privacy is protected consistent with the confidentiality requirements.

Findings: Peach State staff reported that members are asked to verbalize consent for the case manager to speak with family/caregivers during the initial telephone call. Then, staff will send out a release of information form for the member to sign. This release of information form was then uploaded into TruCare and was visible to staff working with this member. During staff interviews HSAG questioned if the case manager speaks directly to pregnant minors. Staff indicated they would not speak to pregnant minors without parent/guardian consent.

Required Actions: Peach State needs to revise its policy to ensure the ability of a pregnant minor to speak on her own behalf and consent to all health care services related to pregnancy without notifying a parent/guardian, unless she chooses to do so. This is noted in Georgia Code O.C.G.A.31-9-2 (2010) Persons authorized to consent to surgical or medical treatment: Any female, regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. The Consent Standard Operating Procedure (SOP) was revised on 9/14/2014 that specifically addresses the privacy requirements for pregnant minors. 2. Case managers will be re-trained on the specific SOP by March 27th 2015. The training will include a review of the contractual requirement for consent related to pregnancy and will include the EQRO findings, detailed review of the SOP, documentation expectations. 3. Revise the audit tool to incorporate review of the authorized consent for pregnancy	Conduct a monthly audit. The manager will randomly select cases from the TruCare system for each CM. The audit will evaluate the effectiveness of the training and to ensure compliance. Case managers who fail to meet the requirement are subject to re-education and potential performance improvement plans	Latonya Jones, Supervisor, Care Coordination; revised the SOP Asia Beene, Senior Trainer, Medical Management; will provide the training Tonya Hendley, Manager of Case Management will revise the audit tool Tonya Hendley, Manager of Case management will conduct monthly audits	The revised SOP will be implemented immediately after training Training on the new SOP will be completed by March 27, 2015. The audit tool will be revised by March 27, 2015 The revised audit will be utilized immediately following the training

Other Evidence/Documentation:
DOCUMENT NAME: HIPAA Verification & Authorized Consent EFFECTIVE DATE: 9/24/14:

Standard IV—Coordination and Continuity of Care

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

SCOPE: Peach State Health Plan (PSHP) Medical Management applicable to the process of verifying HIPAA and obtaining proper consent when speaking to members.

PURPOSE: To implement a consistent work process that provides instructions on how Medical Management staff verifies HIPAA and obtains authorized consent.

WORK PROCESS:

1. MM staff must obtain authorized consent from members for one of the following:
   - A. The state requires individuals to be ≥18 years of age in order to consent to medical treatment or enter into a contract (with the exception of "G" as defined below) [Reference: Georgia Code O.C.G.A.31-9-2 (2010)]
   - B. Any adult, for himself or herself, whether by living will, advance directive for health care, or otherwise;
   - C. Any person authorized to give such consent for the adult under an advance directive for health care or durable power of attorney for health care;
   - D. In the absence or unavailability of a person authorized pursuant, any married person for his or her spouse;
   - E. In the absence or unavailability of a living spouse, any parent, whether an adult or a minor, for his or her minor child;
   - F. Any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his or her care; and any guardian, for his or her ward;
   - G. Any female, regardless of age or marital status, for herself when given in connection with pregnancy, or the prevention thereof, or childbirth;

July 2015 Re-review Findings: Peach State developed a new policy, HIPAA [Health Insurance Portability and Accountability Act of 1996] Verification & Authorized Consent, which was approved and went into effect on 9/24/2014. The policy identified specific instances where CMO staff must obtain authorized consent from members with an identifiable element that ensured the ability of a pregnant minor to speak on her own behalf and consent to all healthcare services related to pregnancy without notifying a parent/guardian.
The Consent Standard Operating Procedure and HIPAA Verification & Authorized Consent form demonstrated that Peach State was in compliance with this element. In addition, the CMO provided evidence of staff training regarding this requirement.

July 2015 Required Actions: None.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

8. Care Coordination Functions: *Contract 4.11.8.1*

In addition to the above requirements, the CMO's care coordination system includes the following related and additional functions:

- Case Management
- Disease Management
- Transition of Care
- Discharge Planning

Findings: Discharge planning from an inpatient setting was limited to information gathered from the member or the member's guardian after the member was about to be or had already been discharged. The case file review process found this process to be inadequate for transition of care and discharge planning.

Required Actions: The CMO must ensure that there is a discharge process in place for members transitioning between care settings.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Revise the Discharge Planning Standard Operating Procedure (SOP) to clearly demonstrate the documentation expectations of the discharge process for the transition points. 2. Training will be provided on the revisions regarding the specific SOP by March 27th 2015. The training will include a review of the contractual requirement for the transition of care/discharge planning and will include the EQRO findings, review of the actual changes in the SOP, documentation expectations.	Conduct monthly audits. The managers will randomly select cases from the TruCare system for each UM nurse. The audit will evaluate the effectiveness of the training and to ensure compliance. The UM nurse (s) who fail to meet the requirement are subject to re-education and potential performance improvement plans	Lisa Schottroff, Director, Case Management and Tomeika Horne, Director, Utilization Management will revise the SOP Asia Beene, Senior Trainer, Medical Management will provide the training Mevelta Hill-Sims and Tonya Hendley, Managers of Case Management will conduct monthly audits Mary David and Majorie Augustin, Managers of Utilization Management will conduct monthly audits	The SOP will be revised by March 27, 2015. Training on the revised SOP will be completed by March 27, 2015. Audits specific to the revisions will be conducted monthly immediately following the training Audits specific to the revisions will be conducted monthly immediately following the training

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

Other Evidence/Documentation: Discharge Planning Policy NU-007:

1. **Discharge Planning Note (Admission).** The CM will collaborate with the provider to begin discharge planning of the member at the time of the initial review. Collaborative efforts between the provider and health plan CM should focus on the member's health needs and identify any services and supplies required to facilitate a timely and appropriate discharge to an alternate / lower level of care. The Inpatient Case Manager will document a discharge planning note upon admission in the clinical Review Notes along with initial clinical information.
    a. The information will include the member and/or guardians name, relationship (if applicable), contact information, social status (DFACS or CBH involvement), and any known discharge planning needs.
    b. Documentation in Clinical Review notes
    Examples: DCP: Collaboration with Hospital CM, request for d/c plan from hospital CM when available, No DME, HH needs identified at this time or ABC home health or member to go home with wound vac, collaboration with health plan case manager to follow up with member
2. **Discharge Planning Note (Concurrent).** Upon the concurrent review, the Case Manager will assess discharge planning needs to complete a timely and safe discharge. The Inpatient Case Manager will document a discharge planning note in the clinical Review Notes along with the updated clinical information.
    a. Documentation in Clinical Review notes
    Examples: Updated contact and social information, identified support persons, continued collaboration with hospital CM request, for d/c plan from hospital CM when available ,any known discharge planning needs i.e. home health, medications, DME, and potential barriers, collaboration with health plan case manager
    b. Discharge planning Notes guidelines for NICU Admission:
        i. Once every 30 days when 32 weeks gestation or less (if applicable)
        ii. Every 5-7 business days when 33 weeks and older (if applicable)
    c. Any time d/c planning is conducted please document***

Members Active in CM

1. UM nurse with notify assigned CM of inpatient admission via task
    a. Assigned to: Assigned CM
    b. Task activity: Inpatient Notification
    c. Priority: High
    d. Start Date: Default
    e. End Date: Same day by 5:00 PM (or next business day by 5:00 PM)
2. If discharge needs are identified, the UM nurse will initiate discharge planning with facility (collaboration with hospital CM, request for d/c plan, etc.)
    a. Members with current inpatient services-remain under UM concurrent management.
    b. Once UM has initiated discharge planning to the assigned CM with the facility, the PSHP UM and CM nurse will coordinate the remaining discharge planning.
    c. The UM nurse will document the following in the clinical review notes:

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- **Example**: DCP: Collaboration with Hospital CM, request for d/c plan from hospital CM when available, No DME, HH needs identified at this time or ABC home health or member to go home with wound vac, collaboration with health plan case manager to follow up with member,, No DME, HH needs identified at this time or ABC home health, member to go home with wound vac, collaboration with health plan case manager to follow up with member.

d. The UM nurse will document in the Discharge Note screen the final discharge plans and communication with assigned CM.
e. UM nurse will notify assigned CM of Discharge dates for members:
   - Assigned to: Assigned CM
   - Task Activity: Discharge Date
   - Priority: High
   - Start Date: Default
   - End Date: Same day by 5:00 PM (or next business day by 5:00 PM)

Members who are NOT ACTIVELY engaged in CM, but meet CM criteria

1. If discharge needs are identified, the UM nurse will initiate discharge planning with facility (providing HHC/DME contact information to facility, etc.).
2. The UM nurse will notify Care Coordination Unit of the care coordination that is needed via task CM Region 1.
3. Care Coordination will perform care coordination activities (conduct f/u to vendor to ensure services will be timely post discharge, confirm start of services, etc.)
4. Once member is discharged, Care Coordination will conduct the post hospitalization call to the member to ensure services have been initiated & offer CM services.
5. If member is agreeable to CM services, Care Coordination will warm transfer the call to the Case Manager for enrollment.
6. If the member is agreeable to CM services, yet does not want to be transferred to Case Management at the time of the call, Care Coordination will send a referral to the CM department.

Members who do not meet CM criteria but have discharge needs

Follow the same process for Members who are NOT ACTIVELY engaged in CM, but meet CM criteria.

July 2015 Re-review Findings: Peach State updated the discharge policy and SOP to reflect procedures to be used with all members who were being discharged/ transitioned from an inpatient setting back into the community. The policy identified the concurrent review nurse as responsible for the facilitation of all inpatient discharges and was meant to provide a streamlined process for monitoring and managing discharges. Peach State completed training with all identified staff on 3/31/2015, monitoring was conducted in the next quarter following the training, and the audit results identified that 98 percent of care management staff were compliant with discharge procedures.

July 2015 Required Actions: None.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

9. Case Management—Components: *Contract 4.11.9.1-2*

The CMO's case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:
(c.) Development of a care plan

Findings: The member's care plan addressed the member's physical, social, and behavioral health issues that were identified during the assessment. The goals were member-centered, measurable, and achievable; however, for adults, the level of provider, caregiver, or guardian involvement in the development of the care plan was lacking.

Required Actions: The CMO should incorporate provider, family, caregiver, or guardian input into the development of the care plan.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Revise the current SOP to clearly document the requirements for input into the development of the care plan. The SOP revision will be completed by February 27, 2015. 2. Revise the audit tool to incorporate provider, family, caregiver and/or guardian input related to the development of the care plan and will be completed by February 27, 2015 3. Case managers will receive training on the revisions regarding the specific SOP by March 27th 2015. The training will include a review of the contractual requirement for the development of a care plan and will include the EQRO findings, review of the actual changes in the SOP, documentation expectations and the audit tool revisions.	Conduct a monthly audit. The managers will randomly select cases from the TruCare system for each CM. The audit will evaluate the effectiveness of the training and to ensure compliance. Case managers who fail to meet the requirement are subject to re-education and potential performance improvement plans	Lisa Schottroff, Director, Case Management Lisa Schottroff, Director, Case Management will revise the audit tool Asia Beene, Senior Trainer, Medical Management will provide the training Melveta Hill-Sims and Tonya Hendley, Managers of Case Management will conduct the monthly audits	The SOP will be revised by March 27, 2015. The audit tool will be revised by March 27, 2015 Training on the revised SOP will be completed by March 27, 2015. The revised audit tool will be utilized beginning April 1, 2015

Other Evidence/Documentation:
CM-002 Case Management Outreach and Enrollment: The CM must ask the member if he/she would like the family/caregiver/guardian involved in the development/ongoing management of the care plan. This needs to be clearly documented and if the member wishes the family/caregiver/guardian involvement;

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this should be incorporated into the care plan. **Training Information for Documentation in the Assessment:** Caregiver Resources: *(target next-of-kin or someone member approved CM to speak with. Obtain name and valid phone number; or document: see personal contacts section*) Must ask the member if he/she would like the family/caregiver/guardian involved in the development/ongoing management of the care plan. This needs to be clearly documented and if the member wishes the family/caregiver/guardian involvement; this should be incorporated into the care plan.
July 2015 Re-review Findings: Peach State updated its policy and procedure to reflect a change in SOP that included the documentation of information gathered by the case manager which reflected the member's desire to have his/her family or caregiver participate in the management and development of the care plan. This information was then documented in the care plan. Peach State also provided documentation of staff training.
July 2015 Required Actions: None.

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9. Case Management—Components: *Contract 4.11.9.1-2*
The CMO's case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:
(f) Monitoring

Findings: Peach State provided documentation that showed a formalized monitoring process. The case file review showed that the contract frequency with the member was at an interval appropriate for the member's needs. During the case management file review, it was noted that there was a lack of medication reconciliation by the case managers. No medication reconciliation was identified for any of the cases reviewed.

Required Actions: Case managers need to complete medication reconciliation with all members in case management. This includes creating the most accurate list possible of all medications a member is taking—including drug name, dosage, frequency, and route—and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Revise the Standard Operating Procedure (SOP) for Case Management follow up to clearly define how medication reconciliation should be performed for all transition of care points. The SOP revision will be completed by March 27, 2015. 2. Incorporate medication reconciliation into the Plan's audit tool by March 27, 2015. 3. Case managers will receive training on the revisions regarding the specific SOP by March 27th 2015. The training will include a review of the contractual requirement for monitoring and will include the EQRO findings, review of the actual changes in the SOP, documentation expectations and the audit tool revisions.	Conduct a monthly audit. The managers will randomly select cases from the TruCare system for each CM. The audit will evaluate the effectiveness of the training and to ensure compliance. Case managers who fail to meet the requirement are subject to re-education and potential performance improvement plans	Lisa Schottroff, Director, Case Management will revise the SOP Lisa Schottroff, Director, Case Management will revise the audit tool Asia Beene, Senior Trainer, Medical Management will provide the training Melveta Hill-Sims and Tonya Hendley, Managers of Case Management will conduct monthly audits	The SOP will be revised by March 27, 2015. The audit tool will be revised by March 27, 2015 Training on the revised SOP will be completed by March 27, 2015. The revised audit tool will be utilized beginning April 1, 2015

Other Evidence/Documentation:
DOCUMENT NAME: Case Management Outreach and Enrollment. The Nurse will make 2 attempts to discuss HEDIS care gaps, care plan and obtain the plan of care from the Provider office within 5 days of enrollment using the note type Case Management/Care Coordination structured note for documentation. The

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provider involvement in the development and ongoing management will be included in the care plan. Use the below template with each successful contact with the Provider office:

Medication Reconciliation (review of member reported meds):
Physician Plan of Care:
Specialists/Referrals: (if applicable)
SDS-UI/ Care Gaps Reviewed: (if applicable)
If the care gap is a SDS-UI HEDIS care gap, request the provider fax the clinical information to 866.595.8134 & send task to Major Cole
Are there any issues that the provider request CM assistance with at this time? Y/N
If yes, list and insert into the care plan for follow-up

CM discussed care planning problems, goals, and interventions with provider. Provider agrees with the care plan. Provider agrees to contact CM if there are any questions/concerns. CM's contact name and # provided.

Documentation for Follow-Up Note and Post-Partum HROB Outline Template Instructions

1. Pharmacy: See Medication Summary for details (*review US Scripts adherent or non-adherent to medication*) (document: review of pharmacy system, note if member compliant or non-compliant and if the member is not taking any medications; document "mbr not taking any medications" if no medication is taken; (If the member is in the hospital upon referrals and/or recently discharged; you must complete a medication reconciliation.) *If the member is not taking any medications, document "mbr not taking any medications")*

July 2015 Re-review Findings: Peach State provided the policy for case management outreach that outlined the care manager's responsibility for completing outreach to the member's provider to gather information and input for the member's assessment and care plan. The CMO also provided an SOP that outlined when to complete medication reconciliation and what documentation was needed in the member's case file. Peach State also provided documentation of staff training.

July 2015 Required Actions: None.

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9. Case Management—Components: *Contract 4.11.9.1-2*
The CMO's case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:
(h) Follow-up

Findings: Peach State provided documentation that showed a formalized process for monitoring and following up with providers, members, and/or caregivers/guardians. During the case management file review, it was noted that there was fragmentation of follow-up between physical health and behavioral health. With physical health, HSAG saw evidence of active follow-up of the member's progress and needs. For behavioral health (BH), HSAG identified that referrals for BH services were being given, but there was no follow-up with the provider, member, or caregiver/guardian concerning the member's utilization of services, diagnosis, medications, and/or progress.

Required Actions: Case managers need to monitor both the member's physical health and behavioral health progress. This will include behavioral health service utilization, diagnosis, medication reconciliation, and treatment progress.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Revise the Standard Operating Procedure (SOP) for Case Management follow up to clearly define how case managers should follow-up on behavioral health referrals regarding the provider, member, or caregiver/guardian utilization of services, diagnosis, medications and progress. The revised SOP will be completed by March 27, 2015. 2. Incorporate behavioral health referrals/follow up in the Plan's audit tool. 3. Case managers will receive training on the revisions regarding the specific SOP by March 27th 2015. The training will include a review of the contractual requirement for follow up and will include the EQRO findings, review of the actual changes in the SOP, documentation expectations and the audit tool revisions.	Conduct monthly audits. The managers will randomly select cases from the TruCare system for each CM. The audit will evaluate the effectiveness of the training and to ensure compliance. Case managers who fail to meet the requirement are subject to re-education and potential performance improvement plans	Lisa Schottroff, Director, Case Management Lisa Schottroff, Director, Case Management will revise the audit tool Asia Beene, Senior Trainer, Medical Management will provide training Melveta Hill-Sims and Tonya Hendley, Managers of Case Management will conduct the monthly audits	The SOP will be revised by March 27, 2015 The audit tool will be revised by March 27, 2015 Training on the revised SOP will be completed by March 27, 2015. The revised audit tool will be utilized beginning April 1, 2015

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Other Evidence/Documentation:
SOP CM-003 Case Management Follow up & OBCM-003

3. Care Plan Documentation
   - C. All behavioral health diagnosis will be included in the care plan (admission, medication reconciliation and treatment progress)
   - H. There will be documented follow-up on all referrals made to behavioral health, Nurtur or external agencies

7. Integrated Rounds
   - All members with referrals and/or behavioral health diagnosis to behavioral health will be presented in rounds to integrate the management of these members.

July 2015 Re-review Findings: Peach State provided documentation of care management training that focused on the integration of a member's behavioral health diagnosis into the care plan and documentation of follow-up for all referrals made for the member. Peach State also provided documentation of staff training.

July 2015 Required Actions: None.

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10. Case Management—Identify Members With the Greatest Need: *42 CFR 438.208(c); Contract 4.11.9.3*

The CMO makes a special effort to identify members who have the greatest need for case management, including those who have catastrophic or other high-cost or high-risk conditions, including pregnant women under 21, high risk pregnancies, and infants and toddlers with established risk for developmental delay.

Findings: During the case management file review, it was noted that members identified for case management were typically pulled from a trigger list. The case file review did not show evidence of cases being identified through Impact Pro despite some members with serious conditions.

Required Actions: The CMO should review its predictive modeling algorithm to determine if members with special health care needs are being identified as early as possible and being referred for care management services.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Revise the Standard Operating Procedure (SOP) to reflect the new corporate enhancement of the predicative modeling system. This enhancement occurred late in the 4th quarter 2014. The new health categories are now utilized for early identification of high risk or special health care members. 2. Provided training to the triage nurse who is accountable for obtaining the report and case assignment. The training occurred on January 5th, 2015.	Monitor the referral summary report on a monthly basis to ensure compliance with identifying members for case management. If the triage case manager fails to meet the requirement is subject to re-education and potential performance improvement plans	Lisa Schottroff, Director, Case Management will revise the SOP Melveta Hill-Sims, Manager of Case Management provided the training Melveta Hill-Sims, Manager of Case Management will monitor the referral summary report	The revised SOP was completed on December 15, 2014. The training occurred on January 5, 2015 The monitoring of the referral summary report began on February 2, 2015

Other Evidence/Documentation:
DOCUMENT NAME: CASE MANAGEMENT REFERRALS
PURPOSE:
To provide a consistent process for the referral of appropriate cases to the Case Management Department.
WORK PROCESS:
1. For appropriate Case Management (CM) referrals, refer to the CM Trigger List (See Attachment A).

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2. CM referrals will be received from various sources in the following manner:
   Via "CM Referral" by all UM, internal departments, and Delegated Vendors (Nurtur, Nursewise, Cenpatico) having access to TruCare
   External Vendors who do not have access to TruCare will submit referrals to CM via the
   PSHP CM-DM REFERRALS@CENTENE.COM email box. (Dentaquest, Univita, NIA, US Script, Opticare)
   - Via phone queue as a warm transfer (i.e., Member services or from a member self- referral at 1-800-504-8573)
   - The Start Smart and Case Management Queues in CRM (Member Services)
3. CM referrals will be sent in the following manner for those with access to TruCare:
   a. Click "Referral Summary" under the "Care Management" tab
   b. Click "Create new referral request"
   c. **Source**: see table 1.1 below
   d. **Description**: see table 1.1 below
   e. **Date**: automatically defaults to current date/time
   f. **Last Name/First Name**: Name of the person submitting the referral (MANDATORY FIELD- except Alere)
   g. **Phone Number/Ext**: Phone ext of person submitting the referral (MANDATORY FIELD-except Alere)
   h. **Reason for Referral**: see table 1.1 below
   i. **Additional Referral Comments**: Please provide a brief explanation of reason for the referral-MANDATORY FIELD
   j. **Action:** Document Referral Decision Now? Choose: No
   k. Assign to the following queue:
      i. For pregnant members referred from PC/Alere: ***CM Triage*** queue
      ii. For pregnant members referred from UM/PA/MedDir/CM Liaison: *CM* ***OB Referral*** queue
      iii. For Complex (Adult, Peds, NICU, Sickle Cell) members: ***CM Referral*** queue
   l. Click "submit" to send the referral

July 2015 Re-review Findings: Peach State provided a case management referral policy that outlined the process for making referrals to case management. This policy identified the sources which provided the cases and how the cases were uploaded into the CMO's TruCare system. Peach State also provided documentation of staff training.

July 2015 Required Actions: None.

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12. Discharge Planning: *Contract 4.11.11*
The CMO maintains and operates a formalized discharge-planning program that includes a comprehensive evaluation of the member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

Findings: While Peach State provided documentation that showed a formalized discharge planning process, during the case management file review it was noted that no active discharge planning was being completed for members who were hospitalized while receiving case management services. There was no evidence of coordination between utilization management and the care management team or involvement by the case manager in the discharge planning process.

Required Actions: The CMO must ensure process implementation for discharge planning for members who are transitioning between care settings.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
1. Revise the Discharge Planning Standard Operating Procedure (SOP) and the CM follow-up SOP to clearly demonstrate the documentation expectations of the discharge process for the transition points. The SOP revisions will be completed by February 27, 2015. 2. Case managers will receive training on the revisions regarding the specific SOP by March 27th 2015. The training will include a review of the contractual requirement for the transition of care/discharge planning and will include the EQRO findings, review of the actual changes in the SOP, documentation expectations.	Monitor the weekly integration rounds presentations to ensure compliance with the SOP. The case manager (s) and/or um nurse (s) who fail to meet the requirement are subject to re-education and potential performance improvement plans	Lisa Schottroff, Director, Case Management and Tomeika Horne, Director, Utilization Management will revise the SOP Asia Beene, Senior Trainer, Medical Management will provide training Mevelta Hill-Sims and Tonya Hendley, Managers of Case Management and Mary David and Majorie Augustin, Managers of Utilization Management will monitor the weekly integration rounds	The SOP will be revised and submitted for approval by February 27, 2015. Training on the revised SOP will be completed by March 27, 2015. Monitoring will begin immediately after training

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Other Evidence/Documentation: Discharge Planning Policy NU-007:

3. **Discharge Planning Note (Admission).** The CM will collaborate with the provider to begin discharge planning of the member at the time of the initial review. Collaborative efforts between the provider and health plan CM should focus on the member's health needs and identify any services and supplies required to facilitate a timely and appropriate discharge to an alternate / lower level of care. The Inpatient Case Manager will document a discharge planning note upon admission in the clinical Review Notes along with initial clinical information.
    a. The information will include the member and/or guardians name, relationship (if applicable), contact information, social status (DFACS or CBH involvement), and any known discharge planning needs.
    b. Documentation in Clinical Review notes
    Examples: DCP: Collaboration with Hospital CM, request for d/c plan from hospital CM when available, No DME, HH needs identified at this time or ABC home health or member to go home with wound vac, collaboration with health plan case manager to follow up with member
4. **Discharge Planning Note (Concurrent).** Upon the concurrent review, the Case Manager will assess discharge planning needs to complete a timely and safe discharge. The Inpatient Case Manager will document a discharge planning note in the clinical Review Notes along with the updated clinical information.
    a. Documentation in Clinical Review notes
    Examples: Updated contact and social information, identified support persons, continued collaboration with hospital CM request, for d/c plan from hospital CM when available ,any known discharge planning needs i.e. home health, medications, DME, and potential barriers, collaboration with health plan case manager
    b. Discharge planning Notes guidelines for NICU Admission:
        i. Once every 30 days when 32 weeks gestation or less (if applicable)
        ii. Every 5-7 business days when 33 weeks and older (if applicable)
    c. Any time d/c planning is conducted please document***

Members Active in CM

3. UM nurse with notify assigned CM of inpatient admission via task
    a. Assigned to: Assigned CM
    b. Task activity: Inpatient Notification
    c. Priority: High
    d. Start Date: Default
    e. End Date: Same day by 5:00 PM (or next business day by 5:00 PM)
4. If discharge needs are identified, the UM nurse will initiate discharge planning with facility (collaboration with hospital CM, request for d/c plan, etc.)
    a. Members with current inpatient services-remain under UM concurrent management.
    b. Once UM has initiated discharge planning to the assigned CM with the facility, the PSHP UM and CM nurse will coordinate the remaining discharge planning.
    c. The UM nurse will document the following in the clinical review notes:

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- **Example**: DCP: Collaboration with Hospital CM, request for d/c plan from hospital CM when available, No DME, HH needs identified at this time or ABC home health or member to go home with wound vac, collaboration with health plan case manager to follow up with member,, No DME, HH needs identified at this time or ABC home health, member to go home with wound vac, collaboration with health plan case manager to follow up with member.

d. The UM nurse will document in the Discharge Note screen the final discharge plans and communication with assigned CM.
e. UM nurse will notify assigned CM of Discharge dates for members:
   - Assigned to: Assigned CM
   - Task Activity: Discharge Date
   - Priority: High
   - Start Date: Default
   - End Date: Same day by 5:00 PM (or next business day by 5:00 PM)

Members who are NOT ACTIVELY engaged in CM, but meet CM criteria

7. If discharge needs are identified, the UM nurse will initiate discharge planning with facility (providing HHC/DME contact information to facility, etc.).
8. The UM nurse will notify Care Coordination Unit of the care coordination that is needed via task CM Region 1.
9. Care Coordination will perform care coordination activities (conduct f/u to vendor to ensure services will be timely post discharge, confirm start of services, etc.)
10. Once member is discharged, Care Coordination will conduct the post hospitalization call to the member to ensure services have been initiated & offer CM services.
11. If member is agreeable to CM services, Care Coordination will warm transfer the call to the Case Manager for enrollment.
12. If the member is agreeable to CM services, yet does not want to be transferred to Case Management at the time of the call, Care Coordination will send a referral to the CM department.

Members who do not meet CM criteria but have discharge needs

Follow the same process for Members who are NOT ACTIVELY engaged in CM, but meet CM criteria.

July 2015 Re-review Findings: Peach State updated the discharge policy and SOP to reflect procedures to be used with all members who were being discharged/ transitioned from an inpatient setting back into the community. The policy identified the concurrent review nurse as responsible for the facilitation of all inpatient discharge and was meant to provide a streamlined process for monitoring and managing discharges. Peach State completed training with all identified staff on 3/31/2015, monitoring was conducted during the quarter following the training, and the audit results identified that 98 percent of care management staff were compliant with discharge procedures.

July 2015 Required Actions: None.

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2. Sufficiency of Services: *42 CFR 438.210(a)(3)(i); Contract 4.5.4.1*

The CMO has and follows processes to ensure that the services provided to each member are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are provided.

Findings: The Covered Benefits and Services Policy was compliant with defining the overall covered benefits and services. The UM Program Description outlined the process for making determinations as do the Clinical Decision Criteria. Additional clarification was obtained during the interview process regarding the following statement in the UM Program Description: "Authorizations may be granted outside of the benefit plan with the medical director's approval." This practice was not exclusive to EPSDT requirements as those persons 21 years of age and over may also be afforded a medical necessity review.

Required Actions: The CMO should re-visit this practice to establish guidelines related to benefit limitations versus need for medical necessity review for persons 21 years of age and older.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
In an effort to clearly establish guidelines related to benefit limitations versus the need for a medical necessity review for persons 21 years of age and older, Peach State Health Plan will implement the following initiatives: 1. Revise GA.UM.02 Clinical Decision Criteria policy to clarify the Plan's process for authorizations granted outside of the benefit plan with medical director approval to include persons 21 years of age and over. 2. Staff training on the revised Clinical Decision Criteria Policy by March 27th 2015. The training will include a review the EQRO findings, detailed review of the policy and guidelines expectations.	Conduct monthly audits by randomly selecting cases to evaluate the effectiveness of the training and to ensure compliance. Case managers who fail to meet the requirement are subject to re-education and potential performance improvement plans.	Tomeika Horne, Director, Utilization Management, Peach State Health Plan will revise the Clinical Decision Criteria Policy Asia Beene, Senior Trainer, Medical Management will complete training Andrea Afolabi, Manager, Prior Authorization will complete monthly audits Mary David, Manager, Inpatient will complete monthly audits	Clinical Decision Criteria Policy will be revised by 3/27/15 The training on the revised Clinical Decision Criteria Policy will be completed by 3/27/15 The audits will be completed monthly following the completion of the training by 3/27/15

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		Marjorie Augustin, Manager, NICU will complete monthly audits	

Other Evidence/Documentation:
DOCUMENT NAME: CLINICAL DECISION CRITERIA AND APPLICATION
PURPOSE:
To ensure that clinical decisions are made and documented using all relevant clinical information and are based on written, nationally recognized clinical decision support criteria.
POLICY:
Peach State and delegated vendors (as applicable) will use clinical support criteria to evaluate medical necessity, level of care and/or clinical appropriateness of select services including inpatient hospitalization and outpatient referrals and they will work collaboratively to ensure that members have timely access to high quality healthcare and appropriate healthcare resources. The UM criteria and the procedures for applying them will be reviewed annually **[UM-2, A5]** and updated as appropriate.

Medical Necessity review may be granted outside of the benefit plan with the medical director's approval not limited to members under the age of 21 years old.
Evidenced based, nationally recognized clinical support tools: [UM-2, A1]

For children under 21, Peach State provides medically necessary services to correct or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT (Health Check) screening, regardless whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act.

July 2015 Re-review Findings: Peach State updated its Clinical Decision Criteria and Application policy on 2/24/2015 to reflect the established guidelines related to benefit limitations versus the need for medical necessity review for persons 21 years of age and older. Peach State also provided documentation of staff training

July 2015 Required Actions: None.

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14. Timelines—Expedited Authorizations Decisions and Notifications: *42 CFR 438.210(d)(2)(i); Contract 4.11.2.5.2*

If the provider indicates, or the CMO determines, that following the standard timeframes could seriously jeopardize the member's life or health, the CMO makes an expedited authorization determination and provides notice within 24 hours.

Findings: The CMO reported that requests were frequently marked as "urgent" or "stat" but noted that these were usually related to the provider's delay in submission of the request, impacting the need for a quick response to the request. Marking all requests "urgent" also may represent standard practice by a given provider. The CMO's initial reviewer may contact the provider to discuss the need for an urgent request and then process it as a standard request if the provider agrees. The denial file review revealed an urgent request that was delayed/pended while waiting for clinical documentation. The HSAG reviewer appreciated the need for the clinical documentation to determine medical necessity; however, there was opportunity to request an extension or to deny an expedited review if it failed to meet criteria and process as a standard request.

Additionally, the CMO would not issue a written notice to the member if a request for an expedited review was denied; only the provider would be notified.

Required Actions: The CMO needs to operationalize the process for expedited reviews and extensions as outlined in the Timeliness of UM Decisions and Notifications policy, paragraph B. 2. Providers who are inappropriately marking "urgent" on all requests (or are marking requests "urgent" due to delay in submissions) would benefit from education related to the definition of an urgent/expedited request. The CMO needs to develop a notice of action (NOA) for members, to address denial of a request for an expedited review.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
In an effort to operationalize the process for expedited reviews and extensions as outlined in the Timeliness of UM Decisions and Notifications policy, paragraph B, Peach State Health Plan will implement the following initiatives: 1. Provide retraining on the process for expedited reviews and extensions as outlined in the Timeliness of UM Decisions and Notifications policy by March 27th 2015. The training will include a review the EQRO	Conduct monthly audits by randomly selecting cases to evaluate the effectiveness of the training and to ensure compliance. Case Managers that fail this requirement will be reeducated on this standard and are subject to potential performance improvement plans.	Asia Beene, Senior Trainer, Medical Management will complete training Andrea Afolabi, Manager, Prior Authorization will complete monthly audits Tracy Smith, Director, Provider Network to oversee provider	The training on the Timeliness of UM Decision and Notification policy will be completed by 3/27/15 The audits will be completed monthly following the completion of the training by 3/27/15 The provider reeducation

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findings, detailed review of the policy and staff expectations to operationalize the process for expedited reviews and extensions as outlined in the Timeliness of UM Decisions and Notifications. 2. Provider Network will be notified by a monthly report of providers who continuously request inappropriate urgent requests. Within 7 days of notification of providers who inappropriately submit urgent requests, face to face provider network representative will provide re-education and assess for barriers regarding the correct and appropriate request type. 3. Develop a notice of action (NOA) for members, to address denial of a request for an expedited review.		reeducation Provider Network Representatives to complete provider reeducation Tomeika Horne, Director, Utilization Management will develop NOA for members	will be completed following the monthly report by 3/27/15 The NOA will be developed by 3/27/15

Other Evidence/Documentation:
DOCUMENT NAME: Timeliness of UM Decisions and Notifications

PURPOSE:

To ensure that utilization management decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

POLICY:

Peach State has timelines in place for providers to notify the plan of a service request and for Peach State to make Utilization Management (UM) decisions and notifications to the member and provider.

1. **Non-urgent, pre-service decisions (Standard Service Prior Authorization)**
    a. Prior Authorization decisions for non-urgent services shall be made within fourteen (14) Calendar Days of receipt of the request for services. **[DCH Contract 4.11.2.5.1]** Peach State will make every effort to gather all pertinent clinical information to support the authorization request within the allotted 14 calendar days. If the clinical information is not received and/or gathered within the 14 calendar days, a written notification to member and provider will be generated.
    b. Time of receipt is when the request is made to the plan according to the plan's filing procedures, regardless of whether the plan has all the

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information necessary to make the decision. The date/time of receipt is documented for all requests.

c. An extension may be granted for an additional 14 days if the Member or the Provider requests an extension, or if Peach State justifies to DCH a need for additional information and the extension is in the Member's interest. [**DCH Contract 4.11.2.5.1**]When the extension is granted, both the provider and member will be notified. The Member will receive written notice of the reasons for the decision to extend the timeframe and the right to file a Grievance if he or she disagrees with that decision. The determination will be carried out expeditiously as the Member's health requires and no later than the date the extension expires. [**DCH Contract 4.14.3.4.7**]

d. If the request for authorization is approved**,** the Case Manager or designee will notify the requesting provider of the approval by telephone, fax, or email within one business day after the decision is made, not to exceed the original authorization period. When notifying by telephone, the Case Manager will notify and document the date and time of the notification in the authorization system and recite the following disclaimer.

   - *Following is the disclaimer: "Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records and patient's eligibility on the date the service is rendered."*

e. If the request for authorization is denied, or a limited authorization of a requested service, including the type and level of service, is proposed, the Medical Director or designee will notify the provider orally within one business day after the decision is made, and will notify the Member and Provider, in writing, within 2 business days of the verbal notification, not to exceed the original 14 day determination period. Notice of Action for standard Service Authorization decisions that deny or limit services, are completed within the fourteen (14) Calendar Days of receipt of the request for services. [**DCH Contract 4.14.3.4.6**]

f. After providing oral notification and the written Notice of Proposed Action, the Case Manager or designee will document the Proposed Action including date and time of notification in the clinical documentation system.

2. **Expedited / Urgent Pre-Service Service Authorization Decisions**

a. In the event a Provider indicates, or Peach State determines, that following the standard authorization timeline above could seriously jeopardize the Member's life and health, Peach State shall make an expedited authorization determinations within 24 hours of receipts of the request. **[DCH Contract 4.11.2.5.2]**

b. Time of receipt is when the request is made to the plan according to the plan's filing procedures, regardless of whether the plan has all the information necessary to make the decision. The date/time of receipt is documented for all requests.
Peach State may extend the twenty- four hour (24) period for up to five (5) Business Days if the member or the Provider requests an extension, or if Peach State justifies to DCH a need for additional information and the extension is in the Member's interest. [**DCH Contract 4.11.2.5.2]**
If the extension is granted, both the member and the provider will be notified. The Member will receive written notice of the reasons for the decision to extend the timeframe and the right to file a Grievance if he or she disagrees with that decision. The determination will be carried out expeditiously as the Member's health requires and no later than the date the extension expires. [**DCH Contract 4.14.3.4.7**]
If the request for authorization is approved, the Case Manager or designee will notify the requesting provider of the approval by telephone, fax, or email within 24-hours [**DCH Contract 4.11.2.5.2**.], not to exceed the original authorization period or subsequent extension. When notifying

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by telephone, the Case Manager will notify and document the date and time of the notification in the authorization system and recite the following disclaimer.
Following is the disclaimer: "Authorization is not a guarantee of benefits or payment. Payment of benefits is subject to any subsequent review of medical information or records and patient's eligibility on the date the service is rendered."

If the request for expedited authorization is denied, or a limited authorization of a requested service, including the type and level of service, is proposed, the Medical Director or designee will notify the requesting provider of the review decision by telephone, fax, or email within 24-hours **[DCH Contract 4.11.2.5.2]** not to exceed the original authorization period or subsequent extension.
After providing oral notification and the written Notice of Proposed Action, the Case Manager or designee will document the Proposed Action including date and time of notification in the clinical documentation system.

Urgent Concurrent Review Decisions

Determination for urgent concurrent, expedited continued stay review is completed within 24 hours of receipt of the request for services. **[UM5, A1]**
The request to approve additional days for urgent concurrent care is related to care not previously approved.
Time of receipt is when the request is made to the plan according to the plan's filing procedures, regardless of whether the plan has all the information
necessary to make the decision. The date/time of receipt is documented for all requests.
If within the initial 24 hours after the request for additional days was received, but without clinical information, and at least one attempt was made by
the UM staff to obtain the information, the Medical Director or designee may extend the review period for up to 72 hours to make the review
determination.

Service or additional days request made while a member is in the process of receiving care is considered to be an urgent concurrent request if the care requested meets the definition of urgent, even if the earlier care was not previously approved by the Plan. If the request does not meet the definition of urgent care, the request may be handled as a new request and decided within the timeframe appropriate for the type of decision (i.e. preservice and postservice).

July 2015 Re-review Findings: Peach State provided the Timeliness of UM Decisions and Notification policy that outlined the process for making timely UM decisions. Peach State shared the development and provision of training to staff to ensure the expedited reviews and extensions procedures were being appropriately operationalized. Peach State provided audit results that indicated 100 percent compliance from staff making UM decisions after receiving training on the process.

July 2015 Required Actions: None.

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24. Notice of Action—Decisions Not Reached Within the Required Timeframes: *42 CFR 438.404(c)(5) and (6); Contract 4.14.3.4.8*

For both standard and expedited authorization decisions not reached within the required timeframes according to 4.11.2.5, the CMO mails the notice of action on the date the timeframe expires, as this constitutes a denial and is thus an adverse action**.**

Findings: While the CMO's written policy outlined the current process for decisions not reached within the requirement time frames, during staff interviews it was indicated that the practice was to approve, not deny, for decisions not reached within the required time frame. The CMO explained that expiration of the time frame would be of no fault to the member, who would not be penalized by issuing a denial.

Required Actions: The CMO needs to operationalize the process outlined in paragraph B.6. of Peach State's Timeliness of UM Decisions and Notifications policy.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
In an effort to operationalize the process for expedited reviews and extensions as outlined in the Timeliness of UM Decisions and Notifications policy, paragraph B6, Peach State Health Plan will implement the following initiatives: 1. Staff retraining on the process for decisions not reached within the required timeframe as outlined in the Timeliness of UM Decisions and Notifications policy by March 27th 2015. The training will include a review the EQRO findings, detailed review of the policy and staff expectations to operationalize the process for decisions not reached within the timeframe as outlined in the Timeliness of UM Decisions and Notifications.	Conduct monthly audits by randomly selecting cases to evaluate the effectiveness of the training and to ensure compliance. Case Managers that fail this requirement will be reeducated on this standard and are subject to potential performance improvement plans.	Asia Beene, Senior Trainer, Medical Management will complete training Andrea Afolabi, Manager, Prior Authorization will complete monthly audits Mary David, Manager, Inpatient will complete monthly audits Marjorie Augustin, Manager, NICU will complete monthly audits	The training on the Timeliness of UM Decision and Notification policy will be completed by 3/27/15 The audits will be completed monthly following the completion of the training by 3/27/15

Other Evidence/Documentation:

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
July 2015 Re-review Findings: Peach State provided documentation that retraining was completed by March 27, 2015, on the process for decisions not reached within the required time frame as outlined in the Timeliness of UM Decisions and Notifications policy. Peach State provided audit results that indicated 100 percent staff compliance with the UM decision making time frame after receiving training.
July 2015 Required Actions: None.

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5. Coverage Decisions—Prudent Layperson Standard: *42 CFR 438.114(a); Contract 4.6.1.2; 4.6.1.4*

The CMO bases its coverage decisions for emergency services on the severity of the symptoms at the time of presentation and covers emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson.

Findings: The CMO had contractual arrangements with facilities regarding emergency services payment. Facilities that received a triage payment were afforded the opportunity to submit medical records for evidence of comprehensive emergency care to support higher payment. Medical records were reviewed by a claims representative, not a clinician, for this reconsideration. After the claims higher payment reconsideration, the facility was afforded appeal rights if higher payment was not provided. This information was included in the explanation of payment to the facility.

Required Actions: Medical record submissions need to be reviewed by appropriate clinical staff as outlined in the provider manual (p. 83)—either a medical director or designee will review the information.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure Peach State Health Plan's prudent layperson policy and ED claim appeal payment policy reiterate the Plan's current process for use and application of a prudent layperson review versus a clinical staff review, the ED PLP Review Process policy will be revised to state the following: **ED PLP Review Process (CC.MRU.12.03)** To provide a consistent and standardized process for the review of emergency room visits through the use of the "Prudent Lay Person" definition of an emergency as defined by the Federal Government through the Balanced Budget Act of 1997 and individual State Administrative Codes (PLP Definition). **Overview:** Prudent Layperson (PLP) review of emergency		Yolanda Spivey, Senior Director, Provider Data	Within thirty (30) calendar days of receiving approval from DCH.

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
department (ED) claims is performed by the Medical Record Unit (MRU) staff. The responsibilities of the MRU for PLP review of ED claims include: ◆ Review of the submitted ED record ◆ Application of the PLP Definition of Emergency ◆ Making a determination of whether the PLP Definition of Emergency has been met ◆ Communication of PLP determination to the Claims department ◆ Issuance of letters associated with the PLP determination In the event a facility disagrees with the prudent layperson's determination, an appeal level review will be conducted by either a medical director or his/her designee as stated in the ED PLP Appeal Process policy (CC.MRU.12.05).			

Other Evidence/Documentation:
DOCUMENT NAME: EMERGENCY SERVICES (***REFERENCE NUMBER:*** *GA.UM.12)*
PROCEDURE:
Accessing Emergency Medical Services

1. Peach State utilizes the prudent layperson (PLP) definition of an emergency medical condition (see 'Definitions') as determined by the Balanced Budget Act (BBA) of 1997 and the Georgia Families Contract with Peach State. The Plan will cover all emergency services to screen and stabilize a member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed. **[UM-12, A1]**.
2. Prior Authorization is not required for Emergency Medical Services and post stabilization services.

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3. If members are unsure as to the urgency or emergency of the situation, they are encouraged to contact their PCP and/or the 24 hr Nurse Triage Line (Nurse Wise) for assistance.
July 2015 Re-review Findings: Peach State provided the Emergency Services Policy that was revised on 4/28/2015. This policy reflects the use of a "prudent layperson" definition of an emergency medical condition. Peach State also reported DCH-approved changes to the ED PLP Review Process (CC.MRU.12.03). Peach State's Emergency Services policy and procedure was updated to reflect the change in making claims decisions for emergency services. The policy stated, "Peach State utilizes the prudent layperson (PLP) definition of an emergency medical condition (see 'Definitions') as determined by the Balanced Budget Act (BBA) of 1997 and the Georgia Families Contract with Peach State. The Plan will cover all emergency services to screen and stabilize a member without prior approval where a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed."
July 2015 Required Actions: None.

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17. Financial Responsibility—Services to Maintain Stabilization: *42 CFR 422.113(c)(2)(ii); 42 CFR 438.114(c); Contract 4.6.2.3*

The CMO is financially responsible for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are administered to maintain the member's stabilized condition for one hour while awaiting response on a pre-certification or prior authorization request.

Findings: The CMO required notification of observation and inpatient stays, and payment was based on the notification and clinical review for medical necessity, regardless of network status, and would allow for retrospective review. The policies and other written documentation did not clearly identify the payment process for the one-hour window while awaiting response. The staff could not articulate how this would be covered and paid, such as if a member was moved to observation status for poststabilization, or how they would identify if there were poststabilization services provided outside of the emergency charge.

Required Actions: The CMO needs to develop clarity in policy and practice related to this one-hour poststabilization requirement to ensure compliance with this element.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure clarity in policy and practice related to the one-hour poststabilization requirement, Peach State Health Plan will revise its GA.UM.12 policy to state the following: *Peach State Health Plan is financially responsible for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are administered to maintain the member's stabilized condition for one hour while awaiting response on a pre-certification or prior authorization request.* 1. Revise GA.UM.12 Emergency Service to clarify the process and clearly state the CMO is financially responsible for poststabilization services obtained from any provider, regardless	Conduct monthly audits by randomly selecting cases to evaluate the effectiveness of the training and to ensure compliance. Case Managers that fail this requirement will be reeducated on this standard and are subject to potential performance improvement plans.	Tomeika Horne, Director, Utilization Management, Peach State Health Plan will revise the Emergency Service UM Policy Asia Beene, Senior Trainer, Medical Management will complete training Andrea Afolabi, Manager, Prior Authorization will complete monthly audits Mary David, Manager, Inpatient will complete	The Emergency Services GA.UM Policy will be revised by 3/27/15 The training on the Emergency Services UM Policy will be completed by 3/27/15 Monthly audits will be performed following the training by 3/27/15

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of whether they are within or outside the CMO's provider network, that are administered to maintain the member's stabilized condition for one hour while awaiting response on a pre-certification or prior authorization request. 2. Staff retraining on the policy that clarifies the CMO is financially responsible for poststabilization services by March 27th 2015. The training will include a review the EQRO findings, detailed review of the policy and staff expectations. 3. Revise Emergency Services Payment Policy to clarify the process and clearly state the contractual requirement in which CMO is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative per the contractual requirement.		monthly audits Marjorie Augustin, Manager, NICU will complete monthly audits Yolanda Spivey, Senior Director, Provider Data to revise Emergency Services payment policy	

Other Evidence/Documentation:
DOCUMENT NAME: EMERGENCY SERVICES

1. Peach State adheres to the Georgia Families 4.6.2.4 contractual requirement below by maintaining financial responsibility for post stabilization services and waiving the prior authorization requirement for post stabilization of services. Peach State is financially responsible for post stabilization services

   obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if:

   a. The CMO does not respond to the provider's request for precertification or prior authorization within one (1) hour.
   b. The CMO cannot be contacted.
   c. The CMO's representative and the attending physician cannot reach an agreement concerning the member's care and a CMO plan physician is

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not available for consultation. In this situation the CMO shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a CMO plan physician is reached or one of the criteria in Contract 4.6.2.5 are met. **[Georgia Families 4.6.2.4].**
July 2015 Re-review Findings: Peach State provided the revised Emergency Services policy which reflected that the CMO was financially responsible for poststabilization services. The CMO clarified the policy and procedure related to this one-hour poststabilization requirement to ensure compliance with this element and provided training to staff members to update them on the new policy.
July 2015 Required Actions: None.

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18. Financial Responsibility—Services Not Prior Authorized: *CFR 422.113(c)(2)(iii)(A–C); 42 CFR 438.114(c); Contract 4.6.2.4.1-3; 4.6.2.4*

The CMO is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if:

- The CMO does not respond to the provider's request for precertification or prior authorization within one (1) hour.
- The CMO cannot be contacted.
- The CMO's representative and the attending physician cannot reach an agreement concerning the member's care and a CMO plan physician is not available for consultation. In this situation the CMO shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a CMO plan physician is reached or one of the criteria in Contract 4.6.2.5 are met.

Findings: The CMO required notification of observation and inpatient stays, and payment was based on the notification and clinical review for medical necessity, regardless of network status, and would allow for retrospective review. The policies and other written documentation did not clearly define the payment process for the specified conditions noted in the element; the staff could not articulate how this would be covered and paid.

Required Actions: The CMO needs to clarify its policy and practice related to these poststabilization requirements to ensure compliance with this element.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure clarity in policy and practice related to poststabilization financial requirements, Peach State Health Plan will revise its GA.UM.12 policy to state the following: Peach State Health Plan is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the Plan's provider network, that are not prior authorized by a Plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if: ◆ Peach State does not respond to the		Tomeika Horne, Director, Utilization Management, Peach State Health Plan will revise the Emergency Service UM Policy Asia Beene, Senior Trainer, Medical Management will complete training. Yolanda Spivey, Senior Director, Provider Data to revise Emergency Services	The Emergency Services UM Policy will be revised by 3/27/15 The training on the Emergency Services UM Policy will be completed by 3/27/15 The Emergency Services Payment Policy will be revised by 3/27/15

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provider's request for precertification or prior authorization within one (1) hour. ◆ Peach State's representative and the attending physician cannot reach an agreement concerning the member's care and a Peach State plan physician is not available for consultation. In this situation Peach State shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a Peach State physician is reached or one of the criteria in Contract 4.6.2.5 are met. 1. Revise GA.UM.12 Emergency Service to clarify the process and clearly state the contractual requirement in which CMO is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative per the contractual requirement. 2. Staff retraining on the policy that clarifies the CMO is financially responsible for /pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative per the contractual requirement by March 27th 2015. The training will include a review the EQRO findings,		payment policy	

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detailed review of the policy and staff expectations. 3. Revise Emergency Services Payment Policy to clarify the process and clearly state the contractual requirement in which CMO is financially responsible/pays for poststabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative per the contractual requirement.			

Other Evidence/Documentation:
DOCUMENT NAME: Emergency Services

1. Peach State adheres to the Georgia Families 4.6.2.4 contractual requirement below by maintaining financial responsibility for post stabilization services and waiving the prior authorization requirement for post stabilization of services. Peach State is financially responsible for post stabilization services obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if:
    a. The CMO does not respond to the provider's request for precertification or prior authorization within one (1) hour.
    b. The CMO cannot be contacted.
    c. The CMO's representative and the attending physician cannot reach an agreement concerning the member's care and a CMO plan physician is not available for consultation. In this situation the CMO shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a CMO plan physician is reached or one of the criteria in Contract 4.6.2.5 are met. **[Georgia Families 4.6.2.4].**

July 2015 Re-review Findings: Peach State provided the revised Emergency Services policy which reflected that the CMO was financially responsible for the poststabilization services obtained from any provider in or out of the CMO's network. The CMO's updated policy clarified its current practice related to these poststabilization requirements, and training based on the policy change was completed by March 27, 2015. Staff also reported that monthly audits began the month following the training to ensure new procedures were being followed.

July 2015 Required Actions: None.

Standard VI—Emergency and Poststabilization Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

19. End of Financial Responsibility: *42 CFR 422.113(c)(3); 42 CFR 438.114(c); Contract 4.6.2.5*

The CMO retains financial responsibility for poststabilization services it has not approved until one of the following occurs:

- An in-network provider with privileges at the treating hospital assumes responsibility for the member's care;
- An in-network provider assumes responsibility for the member's care through transfer;
- The CMO's representative and the treating physician reach an agreement concerning the member's care; or
- The member is discharged.

Findings: The CMO required notification of observation and inpatient stays, and payment was based on the notification and clinical review for medical necessity, regardless of network status, and would allow for retrospective review. The policies and other written documentation did not clearly define the payment process for the specified conditions noted in the element; the staff could not articulate how this would be covered and paid.

Required Actions: The CMO needs to clarify its policy and practice related to these poststabilization requirements to ensure compliance with this element.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure clarity in policy and practice related to poststabilization financial requirements, Peach State Health Plan will revise its GA.UM.12 policy to state the following: Peach State Health Plan retains financial responsibility for poststabilization services it has not approved until one of the following occurs: ◆ An in-network provider with privileges at the treating hospital assumes responsibility for the member's care; ◆ An in-network provider assumes responsibility for the member's care through transfer; ◆ The Plan's representative and the		Tomeika Horne, Director, Utilization Management, Peach State Health Plan will revise the Emergency Service UM Policy Asia Beene, Senior Trainer, Medical Management will complete training Yolanda Spivey, Senior Director, Provider Data to revise Emergency Services payment policy	The Emergency Services UM Policy will be revised by 3/27/15 The training on the Emergency Services UM Policy will be completed by 3/27/15 The Emergency Services Payment Policy will be revised by 3/27/15

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
treating physician reach an agreement concerning the member's care; or ◆ The member is discharged. 1. Revise GA.UM.12 Emergency Service to clarify the process and clearly state the contractual requirement in which the CMO retains financial responsibility for poststabilization services it has not approved until one of the following occurs: ◆ An in-network provider with privileges at the treating hospital assumes responsibility for the member's care; ◆ An in-network provider assumes responsibility for the member's care through transfer; ◆ The CMO's representative and the treating physician reach an agreement concerning the member's care; or the member is discharged 2. Staff retraining on when the CMO will retain financial responsibility for members by March 27th 2015. The training will include a review the EQRO findings, detailed review of the policy and staff expectations. 3. Revise Emergency Services Payment Policy to clarify the process and clearly state the contractual requirement in which the CMO retains financial responsibility for poststabilization services it has not approved until one of the following occurs: ◆ An in-network provider with privileges			

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at the treating hospital assumes responsibility for the member's care; ◆ An in-network provider assumes responsibility for the member's care through transfer; ◆ The CMO's representative and the treating physician reach an agreement concerning the member's care; or the member is discharged			

Other Evidence/Documentation:
DOCUMENT NAME: EMERGENCY SERVICES

1. Peach State adheres to the Georgia Families 4.6.2.4 contractual requirement below by maintaining financial responsibility for post stabilization services and waiving the prior authorization requirement for post stabilization of services. Peach State is financially responsible for post stabilization services

   obtained from any provider, regardless of whether they are within or outside the CMO's provider network, that are not prior authorized by a CMO plan provider or organization representative but are administered to maintain, improve, or resolve the member's stabilized condition if:

   a. The CMO does not respond to the provider's request for precertification or prior authorization within one (1) hour.
   b. The CMO cannot be contacted.

The CMO's representative and the attending physician cannot reach an agreement concerning the member's care and a CMO plan physician is not available for consultation. In this situation the CMO shall give the treating physician the opportunity to consult with an in-network physician and the treating physician may continue with care of the member until a CMO plan physician is reached or one of the criteria in Contract 4.6.2.5 are met. **[Georgia Families 4.6.2.4].**

July 2015 Re-review Findings: Peach State provided the revised Emergency Services policy which reflected that the CMO was financially responsible for the poststabilization services obtained from any provider in or out of the CMO's network. CMO staff reported that training was completed by March 27, 2015, and monthly audits started the month following the training.

July 2015 Required Actions: None.

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

6. The CMO achieved DCH-established performance targets.

State-specified element

Findings: Peach State did not meet all DCH-established performance targets for CY 2013. The following deficiencies were noted:

Measure	Targets CY 2013	Peach State CY 2013 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE – 6 OR MORE VISITS (HYBRID)	70.70	57.64
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (HYBRID)	72.26	69.44
ADOLESCENT WELL-CARE VISITS (HYBRID)	49.65	45.14
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.59	88.51
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.52	83.56
CHILDHOOD IMMUNIZATION STATUS—Combos 3	82.48	79.17
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	76.85
ANNUAL DENTAL VISIT	69.07	68.13
CERVICAL CANCER SCREENING (HYBRID)	78.51	73.84
PRENATAL AND POSTPARTUM CARE (HYBRID)		
TIMELINESS OF PRENATAL CARE	90.39	82.64
POSTPARTUM CARE	71.05	61.81
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	72.99	57.64
CHLAMYDIA SCREENING IN WOMEN	58.40	57.69
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 (HYBRID)	80.91	78.01
APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	76.37	76.33
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HBA1C TEST	87.01	79.51
HBA1C CONTROL <8%	48.72	32.64
HBA1C CONTROL <7%	36.72	24.07
LDL SCREEN	76.16	68.92
LDL CONTROL	35.86	23.44
ATTENTION TO NEPHROPATHY	78.71	70.83
BP CONTROL <140/80 MM HG	39.10	29.34
BP CONTROL <140/90 MM HG	63.50	53.65
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	52.48	43.04
Continuation	63.11	57.73

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	69.57	60.18
30 DAY	84.28	75.48
AMBULATORY CARE per 1000 Member Months		
OP VISITS	388.71	332.51
CESAREAN DELIVERY RATE	28.70	29.59
PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	50.06
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	8.10	8.73
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	52.74	39.64
Effective Continuation Phase Treatment	37.31	24.86
ANTIBIOTIC UTILIZATION-% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	41.51	39.98
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	57.52	44.15
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT		
Initiation of Treatment	43.62	38.06
Engagement of Treatment	18.56	7.08
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS—Total	88.55	86.42
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	81.26
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.53
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years		
Medication Compliance 50% Total	52.31	44.22
Medication Compliance 75% Total	29.14	19.00

Required Actions: Peach State must meet all DCH-established performance targets before this element will be given a Met status.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE – 6 OR MORE VISITS (HYBRID)	70.70	57.64
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (HYBRID)	72.26	69.44
ADOLESCENT WELL-CARE VISITS (HYBRID)	49.65	45.14
CHILDHOOD	82.48	79.17

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

IMMUNIZATION STATUS—Combos 3		
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	76.85
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 (HYBRID)	80.91	78.01

Implemented multidisciplinary collaborative workgroups that meet bi-monthly. These workgroups uses data and causal/barrier analysis tools to identify barriers and implement interventions to improve and all BFG (EPSDT/HEDIS) related measures.

Identified non pay-for-performance high volume providers and conducted in-person education sessions with provider and/or office manager and billing staff to educate on EPSDT and HEDIS related performance measures, review medical records, provide and explain CareGap reports and Peach State Health Plan web portal**.** As of June 30, 2014, over 30 providers received this on-site training. Going forward, Large and Small Group meetings with providers will continue to be scheduled in order to educate providers enrolled in pay-for -performance and non-pay for performance programs. The education will be focused on EPSDT and compliance with EPSDT standards which are more stringent than the HEDIS specifications (e.g., lead screenings).

PSHP offers a Pay-For-Performance Incentive program to its high-volume providers. Twenty-five providers are participating in the program representing approximately 175,000 members. The 10 measures that are addressed are:

2014 Provider Incentive Measures.x

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
Healthy Start Newborn and Women Program Expansion: The Healthy Start Newborn and Women Program is a collaboration with participating hospital facilities with the highest number of deliveries. Peach State Health Plan staff is on-site at specific hospitals to provide face-to-face education on benefits, educate on the importance of EPSDT screening visits and assist with hospital discharge appointment scheduling for new mothers and their newborns. Peach State Health Plan expanded the Program to include Emory Midtown Hospital as this hospital has become a high delivery facility. As a part of the Healthy Start Process, follow-up is conducted with the PCP and OBGYN to verify that a member has kept the appointment. This is done via telephonic outreach or by sending a fax confirmation sheet. If a member has missed an appointment, the member is contacted to assist with rescheduling the appointment, or, if necessary, conduct home visit, especially if the member is unable to be contacted Implemented a Non-Health Benefit Ratio (HBR) Pay-for Performance Program: This program allows for providers not enrolled in other Pay-for Performance programs the			Face-to-face visits were (and continue to be) conducted with these providers groups to review the periodicity schedule, review medical records/EMR for opportunities, provide billing/coding education, review non-compliant reports, and provide quarterly results. Of the twenty-five providers who are participating, fourteen are currently exceeding the incentive program goals for three or more of the measures. 04/2014 05/2014

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
opportunity to receive incentives for improving EPSDT related care and services. Providers must improve their scores for EPSDT screenings (well visits) to be eligible to receive any incentive. Requiring improvements in well visits scores should assist in achieving improved outcomes for EPSDT eligible members. Contact Method Test – In collaboration with five providers, Peach State Health Plan staff mailed 500 non-compliant members postcards to inform them of the need to obtain past due EPSDT screening visits. One hundred non-compliant members assigned to each of the five providers were randomly selected. Half of the non-compliant members were mailed greeting card style postcards with Peach State Health Plan's address stamped on the outside. The remaining non-compliant members were mailed a 5X7 post card with the providers stamped address on the outside. The general information in both postcards was identical. This small "test" was done to determine if postcards sent from the provider office or the Health Plan would prompt members to schedule/keep appointments. Auto-dialer vs. Live Call Test – Peach State Health Plan auto-dialed non-compliant members (parent/guardians) ages 3- 12- years old as of 12/31/2014 in all counties in Georgia except Chatham County. Non-compliant members			07/2014 09/2014

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
(parents/guardians) ages 3- 12- years old as of 12/31/2014 in Chatham County received live calls from a Peach State Health Plan staff member. The information provided during both the auto-dialer and live call included general information on the importance of scheduling and keeping past due EPSDT screening visits. The call method varied to determine which method is most effective. Afterhours Clinic – Peach State Health Plan collaborated with a local Federally Qualified Health Center (FQHC) in a high volume low compliant area of Atlanta to provide an after-hours clinic for adolescents. The FQHC provided adolescent well visits after school/work hours for member (parent/guardian) convenience Wednesday through Friday from 5pm – 8pm November 10-21, 2014. PSHP called and scheduled non-adherent members between the ages of 12-18 affiliated with the FQHC and past due EPSDT screening visit. These calls included assistance with scheduling transportation when needed and an offer of a gift card for those who kept their appointment.			10/2014
ANNUAL DENTAL VISIT 69.07 68.13 **PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES –** Use 416 specifications; run combined PCK and Medicaid 58.00 50.06			11/2014

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
Implemented multidisciplinary Dental Workgroup collaborative workgroups that meet bi-monthly. These workgroups uses data and causal/barrier analysis tools to identify barriers and implement interventions to improve preventive dental care rates to include sealant rates and all HEDIS related measures. Dental Improvement Workgroup - Implemented a rapid cycle improvement pilot to determine if educating three high volume low performing providers about sealants in addition to providing reports to more easily identify members who have not had a sealant placed will increase the sealant application rate for the targeted provider's 6-9 year old members. Further updates on this intervention, its effectiveness and modifications will be made quarterly. Provider outreach regarding sealant use on members 6-9 years of age including: Letters of explanation accompanied by rosters of Peach State members 6-9 years of age who receive services from the practitioners but have not had sealants applied, sent on two occasions three months apart **Member and Provider Preventive Dental Improvement Outreach -** Peach State Health Plan and DentaQuest continued efforts to increase the use of dental services, particularly preventive services, as well as sealant	Member and Provider Preventive Dental Improvement Outreach	Member and Provider Preventive Dental Improvement Outreach	05/2014 07/2014 Dentaquest disseminated a letter explaining the importance of sealant placement and a report listing the members the providers have treated and need sealants in July 2014. The sealant rate for Medicaid and PeachCare for Kids EPSDT members showed a quarter-over-quarter increase in the first three quarters of FFY 2014.  Cover Letter regarding Dental Seal

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
application. ◆ Quarter 3 - Member outreach campaign ▪ Auto phone calls to members in need of a preventive dental visit, with postcards to all members not successfully contacted by phone ▪ Auto phone calls to members 6-9 years of age in need of sealants, with postcards to all members not successfully contacted by phone ◆ Quarter 4 - Follow up member outreach campaign ▪ Auto calls and postcards to all remaining members in need of a preventive dental visit			 Dental Sealant Rate Analysis.docx Q3/2014 Q4/2014 Member and Provider Preventive Dental Improvement Outreach
Other Evidence/Documentation:			
July 2015 Re-review Findings: At the time of the on-site visit, Peach State's performance measures were being validated and final rates were not available for review. Post-audit review of the finalized rates indicated Peach State did not achieve all of the DCH targets.			
July 2015 Required Actions: Peach State must meet all DCH-established performance targets to obtain a *Met* status for this element.			

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

16. The CMO has a process for evaluating the impact and effectiveness of the QAPI Program.

42CFR438.240(b)(3)
Contract: 4.12.5.2

Findings: Peach State continues to adjust its QAPI Program to ensure it evaluates the impact and effectiveness of its quality programs.

Required Actions: Peach State must incorporate DCH's suggested revisions into its QAPI report to ensure all quality elements are addressed and integrated into the overall quality program.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
WOMEN'S HEALTH	**WOMEN'S HEALTH**	**WOMEN'S HEALTH**	**WOMEN'S HEALTH**
Breast Cancer Screening a) Automated Call Campaign to Members	**Breast Cancer Screening** a) i) Stand II QAPI Att 10 - RE Breast Cancer and	**Breast Cancer Screening**	**Breast Cancer Screening** a) 7/25/2014; 10/17/2014;

CERVICAL CANCER SCREENING (HYBRID)	78.51	73.84
PRENATAL AND POSTPARTUM CARE (HYBRID) TIMELINESS OF PRENATAL CARE POSTPARTUM CARE	90.39 71.05	82.64 61.81
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	72.99	57.64
CHLAMYDIA SCREENING IN WOMEN	58.40	57.69
CESAREAN DELIVERY RATE	28.70	29.59
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	8.10	8.73
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.53

Ron Purisima

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

b) Live Calls to Members c) Member Incentive Offered	High Blood Pressure POM scheduled for 724 ii) Stand II QAPI Att 10b – BCS POM_all dates.xls b) Stand II QAPI Att 11+12 - BCS - Live calls and Gift Cards c) Stand II QAPI Att 11+12 - BCS - Live calls and Gift Cards Evaluation Methodology: Monitor HEDIS monthly rates for the BCS - Breast Cancer Screening measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Intervention / Baseline / RM 1 / RM 2 Auto-calls 63.13% 62.96% 64.14% ↑ Live Calls 64.14% 65.58% 67.55% ↑ Incentive 64.14% 65.58% 67.55% ↑		11/19/2014; 12/18/2014 b) 9/2014 to 12/2014 c) 9/2014 to 12/2014
Chlamydia Screening in Women a) Letter to provider requesting medical record evidence if member had chlamydia screening b) Non-compliant list of members sent to provider c) Health Department Data Exchange – Peach State sends list of non-compliant members to Department of Public Health (DPH) and	**Chlamydia Screening in Women** a) i) Stand II QAPI Att 13+14a - RE Print Samples for Job# 55514 2nd request ii) Stand II QAPI Att 13+14b - CHL Provider Letter and Non-compliant list b) Stand II QAPI Att 13+14 - CHL Provider Letter and Non-compliant list c) Stand II QAPI Att 15 - RE PHIP Data Request 7864	**Chlamydia Screening in Women**	**Chlamydia Screening in Women** a) 9/4/2014 b) 9/4/2014 c) 9/30/2014

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

DPH returns chlamydia screening data for members	Evaluation Methodology: Monitor HEDIS monthly rates for the CHL - Chlamydia Screening in Women measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Intervention / Baseline / RM 1 / RM 2 Prov Letter / 46.89% / 48.84% / 51.73% ↑ Gap Report / 46.89% / 48.84% / 51.73% ↑ DPH Data / 46.89% / 48.84% / 51.73% ↑		
Cervical Cancer Screening a) Automated Call Campaign to members to get screened	**Cervical Cancer Screening** a) i) Stand II QAPI Att 16 - RE Cervical Cancer POM ii) Stand II QAPI Att 16b – CCS POM_all dates.xls Evaluation Methodology: Monitor HEDIS monthly rates for the CCS - Cervical Cancer Screening measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline.	**Cervical Cancer Screening**	**Cervical Cancer Screening** a) 8/21/2014; 10/24/2014; 11/17/2014; 12/19/2014

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

Prenatal/Postpartum Care

a) Provider letter explaining postpartum visit timing of 21 to 56 days postpartum
b) Medical record review to assess provider documentation of postpartum visit
c) Meeting with Altegra (HEDIS medical record review vendor) to discuss concerns regarding obtaining medical records from providers

PROVIDER BEHAVIOR DEPENDENT

APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	76.37	76.33
APPROPRIATE TREATMENT	85.34	81.26

Results:

Intervention	Baseline	RM 1	RM 2	
Auto Calls	62.48%	64.05%	65.18%	↑

Prenatal/Postpartum Care

a) Stand II QAPI Att 17 - Postpartum Provider Letter
b) Stand II QAPI Att 18 - Medical Record Documentation Review
c) Stand II QAPI Att 19 - Altegra-Peach State Health Plan Meeting

Evaluation Methodology:
Monitor HEDIS annual rates for Postpartum Care submeasure of the PPC - Prenatal and Postpartum Care measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline.

Results:

Baseline	RM 1	
61.81%	70.30%	↑

PROVIDER BEHAVIOR DEPENDENT

Prenatal/Postpartum Care

PROVIDER BEHAVIOR DEPENDENT

Ron Purisima

Prenatal/Postpartum Care

a) 10/1/2014
b) 9/26/2014
c) 11/11/2014

PROVIDER BEHAVIOR DEPENDENT

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

FOR CHILDREN WITH URI		
ANTIBIOTIC UTILIZATION-% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	41.51	39.98

Provider Education Letters
a) URI and CWP
b) Use of antibiotics

Provider Education Letters
a) i) Stand II QAPI Att 20 - HEDIS QUICK TIP CWP+URI
ii) Stand II QAPI Att 20+21 - FW MDC Print Request- Provider Driven Mail Out
b) i) Stand II QAPI Att 21 - HEDIS QUICK TIP AAB
ii) Stand II QAPI Att 20+21 - FW MDC Print Request- Provider Driven Mail Out

Evaluation Methodology:
Monitor HEDIS monthly rates for the URI - Appropriate Treatment for Children with Upper Respiratory Infection, the CWP - Appropriate Testing for Children with Pharyngitis, and the AAB - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measures. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline.

Results:

Intervention	Baseline	RM 1	RM 2	
URI Provider Letter	84.03%	83.99%	83.89%	→

Provider Education Letters

Provider Education Letters
a) 9/26/2014
b) 9/26/2014

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

CWP Provider Letter	79.43%	79.41%	79.40%	➔
AAB Provider Letter	22.83%	22.59%	22.86%	➔

BEHAVIORAL HEALTH

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION Initiation Continuation	52.48 63.11	43.04 57.73
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS 7 DAY 30 DAY	69.57 84.28	60.18 75.48
ANTIDEPRESSANT MEDICATION MANAGEMENT Effective Acute Phase Treatment Effective Continuation Phase Treatment	52.74 37.31	39.64 24.86
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT Initiation of Treatment Engagement of Treatment	43.62 18.56	38.06 7.08

ADHD

a) Monthly ADHD Gap Analysis
b) Target Member Report
c) Weekly Clinical Outreach Report (surveillance program)

BEHAVIORAL HEALTH

ADHD

a) Stand II QAPI Att 22+29+32 - GAP Analysis & Predictive Modeling FUH, AMM, ADD
b) Stand II QAPI Att 23+24 - Weekly Outreach Report ADD
c) Stand II QAPI Att 23+24 - Weekly Outreach

BEHAVIORAL HEALTH

Ron Purisima

ADHD

BEHAVIORAL HEALTH

ADHD

a) On going
b) On going
c) On going

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)			
	Report ADD Evaluation Methodology: Monitor HEDIS annual rates for the Initiation Phase and the Continuation and Maintenance Phase submeasures of the Follow-up Care for Children Prescribed ADHD Medication measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Submeasure / Baseline / RM 1 / ↑ Acute / 43.04% / 43.58% / ↑ Continuation / 57.73% / 58.19% / ↑		
FUH a) Provide Technical Assistance to Providers to Encourage accurate and timely billing of FUH codes b) Contact the Facilities with claims for IP MH Stay with no FUH claim. Provide technical assistance for timely billing of Rev Code UB 510. c) Participate in facility discharge plan meetings and member staffing d) Conduct Telephonic Outreach to all eligible members discharged from an inpatient setting to engage in follow up services e) Complete Predictive Target Report for	**FUH** a) Stand II QAPI Att 25 - Training Notification 4.3.14 b) Stand II QAPI Att 26+30+31 - UB and 510 Revenue Codes c) Stand II QAPI Att 27 - DCP staffings d) Stand II QAPI Att 28 - FUH Telephone Outreach e) Stand II QAPI Att 22+29+32 - GAP Analysis & Predictive Modeling FUH, AMM, ADD f) Stand II QAPI Att 26+30+31 - UB and 510 Revenue Codes g) Stand II QAPI Att 26+30+31 - UB and 510 Revenue Codes	**FUH**	**FUH** a) On going b) On going c) On going d) On going e) On going f) On going g) On going

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

PSHP FUH f) Ensure accurate configuration for bundled and individually billed UB codes g) Pay all 510 Revenue Codes inaccurately denied due to system configuration errors **Depression** a) Monthly Depression Gap Analysis b) Weekly Clinical Outreach Report	Evaluation Methodology: Monitor HEDIS annual rates for the 30-Day Follow-up and the 7-Day Follow-up submeasures of the Follow-up After Hospitalization for Mental Illness measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Submeasure / Baseline / RM 1 /  30-Day F/U / 75.48% / 72.79% /  7-Day F/U / 60.18% / 56.78% / **Depression** a) Stand II QAPI Att 22+29+32 - GAP Analysis & Predictive Modeling FUH, AMM, ADD b) Stand II QAPI Att 33 - AMM Telephone Outreach Evaluation Methodology: Monitor HEDIS annual rates for the Effective Acute Phase Treatment and the Effective Continuation Phase Treatment submeasures of the Antidepressant Medication Management measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results:	**Depression**	**Depression** a) 12/31/2014 b) 12/31/2014

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

CHRONIC CONDITIONS

COMPREHENSIVE DIABETES CARE—All Components	87.01	79.51
(HYBRID)	48.72	32.64
HbA1c test	36.72	24.07
HbA1c Control <8%	76.16	68.92
HbA1c control <7%	35.86	23.44
LDL Screen	78.71	70.83
LDL Control	39.10	29.34
Attention to nephropathy	63.50	53.65
BP Control <140/80 mm Hg		
BP Control <140/90 mm Hg		
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	57.52	44.15
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years	52.31	44.22
Medication Compliance 50% Total	29.14	19.00
Medication Compliance 75% Total		
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS—Total	88.55	86.42

Diabetes

a) Opticare (member outreach to provide diabetic eye screening)
b) Nurtur (disease management program)
c) Member mailer (Corporate)

Submeasure	Baseline	RM 1	
Acute	39.64%	39.57%	↓
Continuation	24.86%	24.86%	→

CHRONIC CONDITIONS

Diabetes

a) Stand II QAPI Att 34 - Opticare JOC Sept 22 2014 Mtg Minutes
b) Stand II QAPI Att 35 - Nurtur_OPS_Minutes 10_24_2014
c) Stand II QAPI Att 36+37 - RE Diabetes

CHRONIC CONDITIONS

Ron Purisima

Diabetes

CHRONIC CONDITIONS

Diabetes

a) 8/31/2014
b) 12/31/2014
c) 9/17/2014

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Member and Provider Mailer

Evaluation Methodology:
Monitor HEDIS annual rates for submeasures of the CDC – Comprehensive Diabetes Care measure. Baseline is the final rate for the year prior to the implementation of the interventions with Remeasurement (RM) 1 as the final rate for the year following the baseline.

Results:

Opticare

Measure	Baseline	RM 1	
Eye Exam	57.81%	58.63%	↑

Nurtur

Measure	Baseline	RM 1	
HbA1c test	79.51%	83.63%	↑
HbA1c >9%	63.19%	53.17%	↑
HbA1c <8%	32.64%	37.32%	↑
HbA1c <7%	24.07%	27.73%	↑
Nephropathy	70.83%	77.82%	↑
BP <140/90	53.65%	53.17%	→

Evaluation Methodology:
Monitor HEDIS monthly rates for the submeasures of the CDC – Comprehensive Diabetes Care measure. Baseline is the rate for the month prior to the implementation of the interventions and Remeasurement (RM) 1 and 2 are the months

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	following the baseline. Results: Corporate Mailer Measure / Baseline / RM 1 / RM 2 HbA1c test: 65.11% / 68.87% / 71.99% ↑ Eye Exam: 30.12% / 34.12% / 43.81% ↑ Nephropathy: 58.88% / 61.76% / 63.77% ↑		
CBP a) Postcard to member to follow up with PCP and to adhere to blood pressure medication regimen b) Automated call campaign to member to follow up with PCP and to adhere to blood pressure medication regimen	**CBP** a) i) Stand II QAPI Att 38 - CBP Postcards ii) Stand II QAPI Att 38b - High Blood Pressure Member Postcard Mailing b) Stand II QAPI Att 39 - CBP POM Campaign Results 2014 Evaluation Methodology: Monitor HEDIS annual rates for the CBP – Controlling High Blood Pressure measure. Baseline is the final rate for the year prior to the implementation of the interventions with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Baseline / RM 1 44.15% / 36.64% ↓	**CBP** **Pharmacy Related**	**CBP** a) 10/7/2014 b) 7/2/2014; 10/18/2014 **Pharmacy Related** a) 3/31/2014;

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Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

Pharmacy Related a) Med adherence Letters	**Pharmacy Related** a) Stand II QAPI Att 40 - PSHP-Respiratory Adherence Member Letter Evaluation Methodology: Monitor HEDIS monthly rates for the ASM – Use of Appropriate Medications for People with Asthma measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Intervention | Baseline | RM 1 | RM 2 Mem Letters | 88.25% | 91.15% | 89.71% ↑ Mem Letters | 89.71% | 89.10% | 89.39% → Mem Letters | 89.65% | 90.19% | 90.78% ↑		6/30/2014; 9/30/2014; 12/31/2014

Other Evidence/Documentation:

July 2015 Re-review Findings: Peach State continues to work with DCH in the formulation of its Quality Assessment and Performance Improvement plan. While some initiatives were showing improvement (e.g., breast cancer screening, chlamydia screening in women, cervical cancer screening, prenatal/postpartum care, attention deficit hyperactivity disorder [ADHD], and diabetes), others remained unaffected by interventions.

July 2015 Required Actions: Peach State should continue to incorporate DCH's suggested revisions and continue to evaluate the overall effectiveness of the QAPI plan on the quality of healthcare provided to its members.

Appendix C. **On-Site Review Participants**

The document following this page includes the dates of HSAG's on-site review, the names/titles of the HSAG reviewers, and the names/titles of other individuals who participated in or observed some or all of the on-site review activities, including Peach State's key staff members who participated in the interviews that HSAG conducted.

Review Dates

The following table shows the dates of HSAG's on-site visit to Peach State.

Table C-1—Review Dates	
Date of On-Site Review	July 21–22, 2015

Participants

The following table lists the participants in HSAG's on-site review for Peach State.

Table C-2—HSAG Reviewers and Peach State Health Plan/Other Participants		
HSAG Review Team		Title
Team Leader	Elizabeth Stackfleth, MPA	Director, State & Corporate Services
Reviewer	Rachel Costello, PhD, MS, PCC-S	Senior Project Manager, State & Corporate Services
Reviewer	Steve Kuszmaul, MBA	Project Manager, State & Corporate Services
Peach State Health Plan Participants		Title
Dean Geeson, MD, MBA		Chief Medical Officer
Idalia M. Gonzalez, MD		Medical Director
Leslie Naamon		Chief Operating Officer
Robyn Lorys, PharmD		Vice President (VP), Quality Improvement
Chevron Cardenas		Senior Director, Customer Service
Lakeisha Moore		Manager, Customer Service
Mark Reed		Director, Customer Service
Tia McCann		Compliance Coordinator
Scott Johnson		Compliance, Project Manager
Linda McGarity		Manager, Compliance
Deborah Johnson		Senior Director, Compliance
Tonnette Tucker		Manager, Provider Data Management and Credentialing
Detra Friley-Clark		Director, Provider Data Management and Credentialing
Tracy D. Smith		Provider Relations
Yolanda Spivey		Senior Director, Data Analysis
Bruce Walters, RN		Clinical Quality Liaison
Claudette Bazile		VP, Compliance
LaShon Hodge		Title not provided
Tracy Saafir		Senior Director of Medical Management
Tomeika Horne		UM Director
Lisa Schottroff		Director, Case Management

Table C-2—HSAG Reviewers and Peach State Health Plan/Other Participants	
Shay Hawkins	QI Manager
Ronald Purisima	Director, QI
Laquanda Brooks	VP, Medical Management
Lamar Watson	Manager, Grievance and Appeals
Marcia Dobbins	Manager, Accreditation
LaDona Tookes	Title not provided
I. Jarvis	Project Manager
S. Dziabis	Chief Medical Director
Department of Community Health Participants	**Title**
Janice Carson, MD, MSA	Assistant Chief
Ericka Lawrence, MS	Quality and Outcomes Program Specialist
Tiffany Griffin, BSN	Quality Program Specialist II
Woody Dahmer	Title not provided

Appendix D. **Review Methodology**

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR 438.358—the external quality review of compliance with standards for the DCH Georgia Families CMOs addresses HSAG's:

- Objective for conducting the reviews.
- Activities in conducting the reviews.
- Technical methods of collecting the data, including a description of the data obtained.
- Data aggregation and analysis processes.
- Processes for preparing the draft and final reports of findings.

HSAG followed standardized processes in conducting the review of each CMO's performance.

Objective of Conducting the Review of Compliance With Standards

The primary objective of HSAG's review was to provide meaningful information to DCH and the CMOs. HSAG assembled a team to:

- Collaborate with DCH to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, on-site review activities schedules, and on-site review agenda.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective, and based on the results of collaborative planning with DCH, HSAG developed and used a data collection tool to assess and document the CMOs' compliance with certain federal Medicaid managed care regulations, State rules, and the associated DCH contractual requirements. The review tool included requirements that addressed the following performance areas:

- Standard I—Provider Selection, Credentialing, and Recredentialing
- Standard II—Subcontractual Relationships and Delegation
- Standard III—Member Rights and Protections
- Standard IV—Member Information
- Standard V—Grievance System
- Standard VI—Disenrollment Requirements and Limitations
- Follow-up on areas of noncompliance from the prior year's review

The DCH and the CMOs will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

The review was the second year of the current three-year cycle of CMO compliance reviews.

HSAG's Compliance Review Activities and Technical Methods of Data Collection

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DCH and the CMOs, as they related to the scope of the review. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012[D-1] for the following activities:

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the CMOs a customized desk review form and instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site reviews.
- Developing the agenda for the two-day on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMOs to facilitate their preparation for HSAG's review.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DCH, and of documents the CMOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMOs' operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of sample cases plus an oversample for grievances, appeals, credentialing, and recredentialing cases for the on-site CMO audit from the list submitted to HSAG from the CMO.

On-site review activities: HSAG reviewers conducted an on-site review for each CMO, which included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's two-day review activities.

[D-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Quality-of-Care/Quality-of-Care-External-Quality-Review.html. Accessed on: February 19, 2013.

- A review of the documents and files HSAG requested that the CMOs have available on-site.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring the CMOs' performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Description of Data Obtained

To assess the CMOs' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CMOs, including, but not limited to, the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- The provider manual and other CMO communication to providers/subcontractors
- The member handbook and other written informational materials
- Narrative and/or data reports across a broad range of performance and content areas

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the CMOs' key staff members.

Table D-1 lists the major data sources HSAG used in determining the CMOs' performance in complying with requirements and the time period to which the data applied.

Table D-1—Description of the CMOs' Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	July 1, 2014–June 30, 2015
Information obtained through interviews	July 30, 2015—the last day of each CMO's on-site review
Information obtained from a review of a sample of the CMOs' records for file reviews	July 1, 2014–June 30, 2015

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the CMOs' performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a CMO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. The protocol describes the scoring as follows:

Met indicates full compliance defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as *either* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point), *Not Met* (0 points), and *Not Applicable* (0 points) and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

To draw conclusions about the quality and timeliness of, and access to, care and services the CMOs provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the CMOs' performance in complying with each of the requirements.
- Scores assigned to the CMOs' performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to DCH and to the CMOs for their review and comment prior to issuing final reports.

Appendix E. **Corrective Action Plan**

Following this page is a document HSAG prepared for Peach State to use in preparing its corrective action plan (CAP). The template includes each of the requirements for which HSAG assigned a performance score of *Not Met*, and for each of the requirements, HSAG's findings and the actions required to bring the organization's performance into full compliance with the requirement.

Instructions for completing and submitting the CAP are included on the first page of the CAP document that follows.

Criteria that will be used in evaluating the sufficiency of the CAP are:

- The completeness of the CAP document in addressing each required action and assigning a responsible individual, a timeline/completion date, and specific actions/interventions that the organization will take.
- The degree to which the planned activities/interventions meet the intent of the requirement.
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement.
- The appropriateness of the timeline for correcting the deficiency.

Corrective action plans that do not meet the above criteria will require resubmission of the CAP by the organization until it is approved by DCH. Implementation of the CAP may begin once approval is received.

Appendix E. State of Georgia
Department of Community Health (DCH)
Corrective Action Plan
for Peach State Health Plan

Instructions: For each of the requirements listed below that HSAG scored as *Not Met*, identify the following:

- Intervention(s) planned by your organization to achieve compliance with the requirement, including how the CMO will measure the effectiveness of the intervention
- Individual(s) responsible for ensuring that the planned interventions are completed
- Proposed timeline for completing each planned intervention

This plan is due to DCH no later than 30 calendar days following receipt of this draft External Quality Review of Compliance With Standards report. The DCH, in consultation with HSAG, will review and approve the CAPs to ensure that they sufficiently address the interventions needed to bring performance into compliance with the requirements. Approval of the CAPs will be communicated in writing. Once approved, CAP activities and interventions may begin. Follow-up monitoring will occur to ensure that all planned activities and interventions were completed.

Standard IV—Member Information

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. The Contractor provides all newly enrolled members the member handbook within ten (10) calendar days after receiving notice of the enrollment from DCH or the State's agent and every other year thereafter unless requested sooner by the member.

42CFR438.10(f)(3)
Contract: 4.3.3.1

Findings: The Distribution of Member Handbook policy and procedure indicated that Peach State provided a member handbook to newly enrolled members within 10 days after receiving notice from DCH and every year thereafter unless requested sooner by the member. However, Peach State staff indicated that DCH granted approval to not include the handbook in the annual mailing provided that information regarding the handbook was included in the quarterly member newsletter. Peach State provided a newsletter that included the required information. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request.

Required Actions: Peach State must update the Distribution of Member Handbook policy and procedure to include a description of how the CMO notifies existing members (not newly enrolled members) that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy and procedure must also reflect how often existing members receive the notice.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard IV—Member Information
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
2. The Contractor provides all newly enrolled members the provider directory within ten (10) calendar days of receiving the notice of enrollment from DCH or the State's Agent. *42CFR438.10(f)(3)* *Contract: 4.3.5.1*
Findings: The DCH has granted Peach State a waiver from providing a hard copy provider directory to newly enrolled members. The Peach State member handbook directed members to the CMO's website, which contained the provider directory, or to contact member services for assistance with provider selection. The Distribution of Member Handbook policy and procedure indicated that Peach State provided all new members a provider directory with the new member packet and therefore did not reflect actual practice.
Required Actions: Peach State must update the Distribution of Member Handbook policy and procedure to reflect CMO practice regarding informing members of the availability of the provider directory.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard V—Grievance System

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

4. The Contractor defines appeal (administrative review) as a request for review of an action, as action is defined in 42 C.F.R. §438.400.

42CFR438.400(b)
Contract: 1.4

Findings: The Administrative Reviews and the Member Grievance and Administrative Review policies and procedures defined an "administrative review" as a request for review of an action. However, the Administrative Reviews policy and the Step by Step: Administrative Review procedure both stated: "If it is recognized that Peach State Health Plan has failed to act within the required timeframe for resolution of an appeal, a Notice of Proposed Action letter will be sent explaining the handling of this case and **allowing 30 days to file a grievance**. The member will be offered **grievance rights for late resolution** by inserting the following verbiage in the letter's rationale: 'If you are unhappy with the processing of this appeal in any way, you may file a grievance by calling member services at 1-800-704-1484.' " As defined in Requirement 3 above, the failure to process a grievance or an appeal in a timely manner was an "action," and therefore required issuance of a notice of action and access to the appeal process, not the grievance process.

Required Actions: Peach State must ensure that its policies, processes, and communications to members are accurate and consistent and provide members access to the correct process (appeal) when Peach State fails to meet required timelines for resolution of grievances and appeals (an action).

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)
8. Contractor shall provide written notice of the disposition of the grievance as expeditiously as the member's health condition requires but must be completed within 90 days but not to exceed 90 calendar days of the filing date. *Contract: 4.14.2.3*
Findings: The Grievance Process policy and procedure indicated Peach State would provide written notice to the member, in his/her primary language, of the disposition of the grievance no longer than 90 calendar days after the filing date. However, the grievance acknowledgment letter stated, "You will receive written notice of our findings no later than 90 calendar days from the date we received your grievance. **However, <u>if we need additional time</u>, you will be notified when to expect a resolution."** In addition, although the grievance disposition letters for the 10 grievance files reviewed were sent to the member within 90 calendar days, two of the letters did not address all of the member issues identified in the initial complaint.
Required Actions: Peach State must ensure that it processes all grievances and issues disposition letters within 90 calendar days with no extensions. Peach State must also remove language from the member acknowledgment letter indicating that the CMO may take additional time. Peach State must also address each member issue identified in the grievance in the disposition resolution letter.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard V—Grievance System

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

21. The Contractor must resolve each administrative review and provide written notice of the disposition as expeditiously as the member's health condition requires, not to exceed:
    - For standard resolution of appeals, 45 calendar days from the day the Contractor receives the appeal.
    - For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal.

42CFR438.408(b)

Contract: 4.14.4.8

Findings: The Administrative Reviews policy and procedure indicated that Peach State would resolve each request for a review and provide written notice of the resolution as expeditiously as the member's health condition required. The documentation indicated that the process would not exceed 30 calendar days from receipt of the appeal request and for expedited resolution of an appeal, it would not exceed three business days from receipt of the appeal. While 30 days is a stricter standard than (and therefore complies with) DCH's required time frame of 45 days, other Peach State documents (e.g., member and provider handbooks) indicated the time frames as 30 calendar days for pre-service and 45 calendar days for post-service appeal decisions.

All of the administrative review (appeal) files reviewed during the on-site audit complied with the timeliness requirements described in this element.

Required Actions: Peach State must ensure that its documents (i.e., policies, procedures, manuals, and training materials) that communicate appeal decision time frames to members, providers, and its own staff are consistent and accurate.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard V—Grievance System

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes:

- The results and date of the adverse action including the service or procedure that is subject to the action.
- Additional information, if any, that could alter the decision.
- The specific reason used as the basis of the action.
- The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing date is stamped.
- The right to continue to receive benefits pending a State Administrative Law hearing.
- How to request continuation of benefits.
- Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State Administrative Law hearing.
- Circumstances under which expedited resolution is available and how to request it.

42CFR438.408(e)

Contract: 4.14.5.2

Findings: The Administrative Reviews policy and procedure indicated that the written notice of adverse action would be translated into the member's primary language, and be produced in large print or alternative format as needed by the member. The Denials and Appeals Work Process specified what the written notice of adverse action must contain. The 10 administrative review (appeal) resolution letters reviewed included the required information; however, in some cases these letters did not meet the fifth-grade reading/understandability level. In three cases the rationale provided for upholding a denial was copied directly from the clinician reviewer notes.

Required Actions: Peach State must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

1. **Timely Access:** *42 CFR 438.206(c)(1)*

The CMO meets and requires its providers to meet DCH standards for timely access to care and services, taking into account the urgency of need for services according to the following standards:

(f) **Timelines–Returning Calls After-Hours:** *Contract 4.8.14.4*

The CMO ensures that provider response times for returning calls after-hours do not exceed the following:

- Urgent Calls—Twenty minutes
- Other Calls—One hour

Findings: The provider manual indicated that urgent after-hours calls from providers should occur within 20 minutes and other calls within an hour. Evidence of adequate monitoring of this element was not apparent at the time of the on-site visit.

Required Actions: The CMO must develop a monitoring practice to ensure that providers return urgent calls within 20 minutes and other calls within one hour.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
To ensure providers return urgent/non-urgent calls within the timeframes set forth in 42 CFR 438.206(c)(1) and Contract Section 4.8.14.3, Peach State Health Plan will implement the following initiatives: Providers are educated continuously on the after-hours return call standards. These standards are included in all monthly provider education packets and are discussed in all provider meetings. These standards are a required element within our New Provider Orientations, and are listed in our Provider Manual. Education is ongoing and targets all providers. Provider Relations Representatives perform an average of 60 provider visits per month each, and we currently have 16 Provider Relations Representatives in the field statewide.		• Tracy Smith, Director, Provider Relations, Peach State Health • Marty Fallon, Sr. Director, Provider Relations, Peach State Health Plan • Provider Relations Staff	• As of January 1, 2015, the provider relations staff began face to face visits with the deficient providers.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
The Myers Group will conduct quarterly provider after-hours surveys to identify providers who are non-compliant with one or more of the after-hours return call requirements. Providers whose after-hours calls time frame exceeds any requirement will be re-educated via face-to-face visit by their assigned Provider Relations Representative on the after-hours return call requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliance with the after-hours call requirements, and interventions will be proposed. The provider will be instructed to implement proposed interventions that will bring them into compliance within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become compliant with the after-hours return calls standard. Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented			◆ Within ninety (90) calendar days of receiving approval from DCH. ◆ Ongoing ◆ Ongoing ◆ Ongoing

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
within the provider's practice to ensure they are able to meet the after-hours return call requirements. The non-compliant letters will be mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7) calendar days of receipt of our letter. CAPs will be monitored by for compliance through the use of a secret shopper call(s) that will be made after-hours to the office by a Provider Relations Representative or Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for recommendation and action plan. Peach State's Provider Relations Staff, who regularly visit provider offices, conduct focused training during these visits related to after-hours return call requirements. Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access and after-hours return call requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meet appointment timely access and after-hours standards during			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
the meeting. Additionally, the feedback received during these meetings will be used to create new/improved interventions that can be implemented throughout the network. Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access and after-hours return call requirements. Member education will be conducted to ensure members understand that urgent after-hours calls from providers should occur within 20 minutes and other calls within an hour. Member CAHPS quality surveys currently capture member input regarding the amount of time it takes for a provider to return their call after-hours, to include quarterly monitoring of member feedback related to the after-hours return call time standards. Additionally, member feedback related to after-hours return calls is captured through our member grievance process, and non-compliant providers identified through this process are educated via face-to-face visit and monitored as described above.			
Other Evidence/Documentation: Q1 2015_AfterHoursSurvey_Final.xlsx Q2 2015_AfterHoursSurvey_Final.xlsx			
July 2015 Re-review Findings: Peach State monitored the after-hours provider call back times and met the DCH goal for returning urgent calls within 20 minutes.			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
During quarter 2, 2015, providers achieved a routine call back rate of 89 percent, one percentage point below the 90 percent goal.			
July 2015 Required Actions: The CMO must continue implementing interventions with providers until the goal of returning routine calls within one hour is achieved at least 90 percent of the time.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)

5. **Geographic Access:** *Contract 4.8.13.1*

The CMO meets the following geographic access standards for all members:

	Urban	Rural
PCPs	Two within eight miles	Two within 15 miles
Specialists	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
General Dental Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Dental Subspecialty Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Hospitals	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Mental Health Providers	One within 30 minutes or 30 miles	One within 45 minutes or 45 miles
Pharmacies	One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles	One 24/7 hours a day (or has an after-hours emergency phone number and pharmacist on call) seven days a week within 30 minutes or 30 miles

Findings: The CMO monitors the appropriate geographic access standards, but Peach State does not meet all of the standards. Peach State submits a deficiency report to the State as a result of its analysis. The CMO did not meet the requirement to have at least 90 percent of members with access to providers within the time/distance analysis in the element. It was noted the CMO did not meet the requirements in both urban and rural areas in the following provider categories:

- PCPs
- Specialists
- General dental providers
- Dental subspecialty providers
- Mental health providers
- Pharmacies

Required Actions: The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
To meet the geographic access standards for PCPs in the urban area, PSHP will: **To meet the geographic access standards for PCPs in the rural setting, PSHP will:** Peach State will partner with key IPA/PHO providers in each of the six regions to assist with the recruitment of previously opt-out practitioners to opt-in to Peach State's network to fill service gaps. In addition, collaboration with our par rural hospitals to assist with adding all new RHCs which will help to provide coverage in densely populated areas. Also, Peach State will contract with newly Georgia Medicaid enrolled providers that offer an opportunity to meet access standards. Finally, our provider relations team will assist in recruitment of non-Medicaid enrolled providers to get them to become eligible as a Medicaid provider. **To meet the geographic access standards for specialists in the urban setting, PSHP will:** To meet the geographic access standards for specialists in the rural setting, Peach State has expand our collaboration with the Georgia Partnership for Telehealth, local health departments and other venues that have access to telehealth equipment to ensure specialty		◆ Clyde White, Vice President, Contracting Peach State Health Plan	◆ All coordination efforts for the delivery of specialty services in the rural areas of telehealth originating sites and provider recruitment are ongoing. ◆ December 2015

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
access within the county. As a result, Peach State has partnered with Albany Area Primary Health Care, Inc., South Central Primary Care Center, Inc., and Bleckly Memorial Hospital. Peach State will provide transportation for members to and from these locations as needed. Member Services team will assist members with scheduling appointments and transportation needs. Peach State will continue to utilize single case agreements in our current deficient counties to provide access to care. In addition, transportation will be provided and arrange through Peach State's Member Services and transportation vendor.			
Other Evidence/Documentation: ATL Region_Q1 2015_Deficiency Report.xls Central_Q1 2015_Deficiency Report.xlsx EAST Region_Q1 2015_Deficiency Report 042715 (2).xlsx NORTH Region_Q1 2015_Deficiency Report.xls SE Region_Q1 2015_Deficiency Report.xls SW Region_Q1 2015_Deficiency Report.xlsx			
July 2015 Re-review Findings: Upon re-review, Peach State did not meet all of the standards. Peach State submitted a deficiency report to the State as a result of its analysis. The CMO did not meet the requirement to have at least 90 percent of members with access to providers within the time/distance analysis in the element. HSAG noted that the CMO did not meet the requirements in both urban and rural areas in the following provider categories: ◆ PCPs ◆ Specialists ◆ General dental providers ◆ Dental subspecialty providers ◆ Mental health providers			

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2014–June 30, 2015)			
◆ Pharmacies **July 2015 Required Actions:** The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies. Peach State must continue its efforts to close its network adequacy gaps and keep DCH informed of its progress.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

6. The CMO achieved DCH-established performance targets.

State-specified element

Findings: Peach State did not meet all DCH-established performance targets for CY 2013. The following deficiencies were noted:

Measure	Targets CY 2013	Peach State CY 2013 Rate
WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE – 6 OR MORE VISITS (HYBRID)	70.70	57.64
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (HYBRID)	72.26	69.44
ADOLESCENT WELL-CARE VISITS (HYBRID)	49.65	45.14
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.59	88.51
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.52	83.56
CHILDHOOD IMMUNIZATION STATUS—Combos 3	82.48	79.17
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	76.85
ANNUAL DENTAL VISIT	69.07	68.13
CERVICAL CANCER SCREENING (HYBRID)	78.51	73.84
PRENATAL AND POSTPARTUM CARE (HYBRID)		
TIMELINESS OF PRENATAL CARE	90.39	82.64
POSTPARTUM CARE	71.05	61.81
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	72.99	57.64
CHLAMYDIA SCREENING IN WOMEN	58.40	57.69
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 (HYBRID)	80.91	78.01
APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	76.37	76.33
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HBA1C TEST	87.01	79.51
HBA1C CONTROL <8%	48.72	32.64
HBA1C CONTROL <7%	36.72	24.07
LDL SCREEN	76.16	68.92
LDL CONTROL	35.86	23.44
ATTENTION TO NEPHROPATHY	78.71	70.83
BP CONTROL <140/80 MM HG	39.10	29.34
BP CONTROL <140/90 MM HG	63.50	53.65
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	52.48	43.04
Continuation	63.11	57.73

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FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	69.57	60.18
30 DAY	84.28	75.48
AMBULATORY CARE per 1000 Member Months		
OP VISITS	388.71	332.51
CESAREAN DELIVERY RATE	28.70	29.59
PERCENTAGE OF ELIGIBLES THAT RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	50.06
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	8.10	8.73
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	52.74	39.64
Effective Continuation Phase Treatment	37.31	24.86
ANTIBIOTIC UTILIZATION-% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	41.51	39.98
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	57.52	44.15
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT		
Initiation of Treatment	43.62	38.06
Engagement of Treatment	18.56	7.08
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS—Total	88.55	86.42
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	81.26
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.53
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years		
Medication Compliance 50% Total	52.31	44.22
Medication Compliance 75% Total	29.14	19.00

Required Actions: Peach State must meet all DCH-established performance targets before this element will be given a Met status.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

WELL-CHILD VISITS IN THE FIRST 15 MONTHS OF LIFE – 6 OR MORE VISITS (HYBRID)	70.70	57.64
WELL-CHILD VISITS IN THE THIRD, FOURTH, FIFTH, AND SIXTH YEARS OF LIFE (HYBRID)	72.26	69.44
ADOLESCENT WELL-CARE VISITS (HYBRID)	49.65	45.14

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CHILDHOOD IMMUNIZATION STATUS—Combos 3	82.48	79.17
LEAD SCREENING IN CHILDREN (HYBRID)	81.86	76.85
IMMUNIZATIONS FOR ADOLESCENTS—Combo 1 (HYBRID)	80.91	78.01

Implemented multidisciplinary collaborative workgroups that meet bi-monthly. These workgroups uses data and causal/barrier analysis tools to identify barriers and implement interventions to improve and all BFG (EPSDT/HEDIS) related measures.

Identified non pay-for-performance high volume providers and conducted in-person education sessions with provider and/or office manager and billing staff to educate on EPSDT and HEDIS related performance measures, review medical records, provide and explain CareGap reports and Peach State Health Plan web portal**.** As of June 30, 2014, over 30 providers received this on-site training. Going forward, Large and Small Group meetings with providers will continue to be scheduled in order to educate providers enrolled in pay-for -performance and non-pay for performance programs. The education will be focused on EPSDT and compliance with EPSDT standards which are more stringent than the HEDIS specifications

PSHP offers a Pay-For-Performance Incentive program to its high-volume providers. Twenty-five providers are participating in the program representing approximately 175,000 members. The 10 measures that are addressed are:

2014 Provider Incentive Measures.x

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(e.g., lead screenings). Healthy Start Newborn and Women Program Expansion: The Healthy Start Newborn and Women Program is a collaboration with participating hospital facilities with the highest number of deliveries. Peach State Health Plan staff is on-site at specific hospitals to provide face-to-face education on benefits, educate on the importance of EPSDT screening visits and assist with hospital discharge appointment scheduling for new mothers and their newborns. Peach State Health Plan expanded the Program to include Emory Midtown Hospital as this hospital has become a high delivery facility. As a part of the Healthy Start Process, follow-up is conducted with the PCP and OBGYN to verify that a member has kept the appointment. This is done via telephonic outreach or by sending a fax confirmation sheet. If a member has missed an appointment, the member is contacted to assist with rescheduling the appointment, or, if necessary, conduct home visit, especially if the member is unable to be contacted Implemented a Non-Health Benefit Ratio (HBR) Pay-for Performance Program: This program allows for providers not enrolled in			Face-to-face visits were (and continue to be) conducted with these providers groups to review the periodicity schedule, review medical records/EMR for opportunities, provide billing/coding education, review non-compliant reports, and provide quarterly results. Of the twenty-five providers who are participating, fourteen are currently exceeding the incentive program goals for three or more of the measures. 04/2014 05/2014

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other Pay-for Performance programs the opportunity to receive incentives for improving EPSDT related care and services. Providers must improve their scores for EPSDT screenings (well visits) to be eligible to receive any incentive. Requiring improvements in well visits scores should assist in achieving improved outcomes for EPSDT eligible members. Contact Method Test – In collaboration with five providers, Peach State Health Plan staff mailed 500 non-compliant members postcards to inform them of the need to obtain past due EPSDT screening visits. One hundred non-compliant members assigned to each of the five providers were randomly selected. Half of the non-compliant members were mailed greeting card style postcards with Peach State Health Plan's address stamped on the outside. The remaining non-compliant members were mailed a 5X7 post card with the providers stamped address on the outside. The general information in both postcards was identical. This small "test" was done to determine if postcards sent from the provider office or the Health Plan would prompt members to schedule/keep appointments. Auto-dialer vs. Live Call Test – Peach State Health Plan auto-dialed non-compliant members (parent/guardians) ages 3- 12- years old as of			07/2014 09/2014

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12/31/2014 in all counties in Georgia except Chatham County. Non-compliant members (parents/guardians) ages 3- 12- years old as of 12/31/2014 in Chatham County received live calls from a Peach State Health Plan staff member. The information provided during both the auto-dialer and live call included general information on the importance of scheduling and keeping past due EPSDT screening visits. The call method varied to determine which method is most effective. Afterhours Clinic – Peach State Health Plan collaborated with a local Federally Qualified Health Center (FQHC) in a high volume low compliant area of Atlanta to provide an after-hours clinic for adolescents. The FQHC provided adolescent well visits after school/work hours for member (parent/guardian) convenience Wednesday through Friday from 5pm – 8pm November 10-21, 2014. PSHP called and scheduled non-adherent members between the ages of 12-18 affiliated with the FQHC and past due EPSDT screening visit. These calls included assistance with scheduling transportation when needed and an offer of a gift card for those who kept their appointment. **ANNUAL DENTAL VISIT** 69.07 68.13 **PERCENTAGE OF ELIGIBLES THAT RECEIVED** 58.00 50.06			10/2014

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PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid				11/2014
Implemented multidisciplinary Dental Workgroup collaborative workgroups that meet bi-monthly. These workgroups uses data and causal/barrier analysis tools to identify barriers and implement interventions to improve preventive dental care rates to include sealant rates and all HEDIS related measures.				05/2014
Dental Improvement Workgroup - Implemented a rapid cycle improvement pilot to determine if educating three high volume low performing providers about sealants in addition to providing reports to more easily identify members who have not had a sealant placed will increase the sealant application rate for the targeted provider's 6-9 year old members. Further updates on this intervention, its effectiveness and modifications will be made quarterly. Provider outreach regarding sealant use on members 6-9 years of age including: Letters of explanation accompanied by rosters of Peach State members 6-9 years of age who receive services from the practitioners but have not had sealants applied, sent on two occasions three months apart				07/2014 Dentaquest disseminated a letter explaining the importance of sealant placement and a report listing the members the providers have treated and need sealants in July 2014. The sealant rate for Medicaid and PeachCare for Kids EPSDT members showed a quarter-over-quarter increase in the first three quarters of FFY 2014.

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Member and Provider Preventive Dental Improvement Outreach - Peach State Health Plan and DentaQuest continued efforts to increase the use of dental services, particularly preventive services, as well as sealant application. ◆ Quarter 3 - Member outreach campaign ▪ Auto phone calls to members in need of a preventive dental visit, with postcards to all members not successfully contacted by phone ▪ Auto phone calls to members 6-9 years of age in need of sealants, with postcards to all members not successfully contacted by phone ◆ Quarter 4 - Follow up member outreach campaign ▪ Auto calls and postcards to all remaining members in need of a preventive dental visit	Member and Provider Preventive Dental Improvement Outreach	Member and Provider Preventive Dental Improvement Outreach	Cover Letter regarding Dental Seal Dental Sealant Rate Analysis.docx Q3/2014 Q4/2014 Member and Provider Preventive Dental Improvement Outreach

Other Evidence/Documentation:

July 2015 Re-review Findings: At the time of the on-site visit, Peach State's performance measures were being validated and final rates were not available for review. After the on-site visit, Peach State's performance measure rates were finalized with the following audited and final rates falling below the DCH target.

Measure	CY2014 Targets	Peach State CY2014 Rate
CHILDREN AND ADOLESCENTS' ACCESS TO PRIMARY CARE PRACTITIONERS—12 to 19 Years	91.85	88.63
ADULTS' ACCESS TO PREVENTIVE/AMBULATORY HEALTH SERVICES—20 to 44 Years	88.32	81.17
ANNUAL DENTAL VISIT		

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2 TO 3 YEARS	55.78	45.07
TOTAL	69.92	67.67
CERVICAL CANCER SCREENING (HYBRID)	76.64	68.53
PRENATAL AND POSTPARTUM CARE (HYBRID)		
TIMELINESS OF PRENATAL CARE	89.72	82.13
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	73.97	57.77
CHLAMYDIA SCREENING IN WOMEN	57.25	56.71
COMPREHENSIVE DIABETES CARE—All Components (HYBRID)		
HBA1C TEST	87.32	83.63
HBA1C POOR >9	43.02	53.17
HBA1C CONTROL <8%	48.57	37.32
HBA1C CONTROL <7%	34.76	27.73
ATTENTION TO NEPHROPATHY	79.28	77.82
BP CONTROL <140/90 MM HG	60.93	53.17
FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION		
Initiation	51.86	43.58
Continuation	63.75	58.19
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS		
7 DAY	68.79	56.78
30 DAY	81.98	72.79
AMBULATORY CARE per 1000 Member Months		
ER VISITS	<53.98	54.10
CESAREAN DELIVERY RATE	28.70	29.84
PERCENTAGE OF ELIGIBLES WHO RECEIVED PREVENTIVE DENTAL SERVICES – Use 416 specifications; run combined PCK and Medicaid	58.00	52.17
PERCENTAGE OF ELIGIBLES WHO RECEIVED DENTAL TREATMENT SERVICES – Use 416 specifications; run combined PCK and Medicaid	31.50	24.53
CESAREAN SECTION FOR NULLIPAROUS SINGLETON VERTEX (HYBRID)	15.23	0.00
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	7.99	9.04
ANTIDEPRESSANT MEDICATION MANAGEMENT		
Effective Acute Phase Treatment	56.17	39.57
Effective Continuation Phase Treatment	40.17	24.86
ANTIBIOTIC UTILIZATION-% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	39.06	38.49
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	56.20	36.64
FLU SHOTS FOR ADULTS AGES 18–64	34.65	26.70
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE		

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TREATMENT		
Initiation of Treatment	43.43	39.65
Engagement of Treatment	16.17	8.24
MEDICAL ASSISTANCE WITH SMOKING AND TOBACCO USE CESSATION		
Advising Smokers and Tobacco Users to Quit	73.70	70.50
Discussing Cessation Medications	34.00	31.90
Strategies	31.40	31.30
APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.86	83.50
ADHERENCE TO ANTIPSYCHOTICS FOR INDIVIDUALS WITH SCHIZOPHRENIA	61.34	33.33
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years		
Medication Compliance 75% for 5–11 yrs old	29.46	18.82
MATERNITY CARE-BEHAVIORAL HEALTH RISK ASSESSMENT (HYBRID)	10.42	0.00

July 2015 Required Actions: Peach State must meet all DCH-established performance targets to obtain a Met status for this element.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date

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16. The CMO has a process for evaluating the impact and effectiveness of the QAPI Program.

42CFR438.240(b)(3)
Contract: 4.12.5.2

Findings: Peach State continues to adjust its QAPI Program to ensure it evaluates the impact and effectiveness of its quality programs.

Required Actions: Peach State must incorporate DCH's suggested revisions into its QAPI report to ensure all quality elements are addressed and integrated into the overall quality program.

Evidence/Documentation Submitted by the CMO

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date
WOMEN'S HEALTH	**WOMEN'S HEALTH**	**WOMEN'S HEALTH**	**WOMEN'S HEALTH**

CERVICAL CANCER SCREENING (HYBRID)	78.51	73.84
PRENATAL AND POSTPARTUM CARE (HYBRID) TIMELINESS OF PRENATAL CARE POSTPARTUM CARE	90.39 71.05	82.64 61.81
FREQUENCY OF ONGOING PRENATAL CARE—81% or More Expected Visits (HYBRID)	72.99	57.64
CHLAMYDIA SCREENING IN WOMEN	58.40	57.69
CESAREAN DELIVERY RATE	28.70	29.59
PERCENTAGE OF LIVE BIRTHS WEIGHING LESS THAN 2,500 GRAMS	8.10	8.73
HUMAN PAPILLOMAVIRUS VACCINE FOR FEMALE ADOLESCENTS (HYBRID)	22.27	21.53

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Breast Cancer Screening d) Automated Call Campaign to Members e) Live Calls to Members f) Member Incentive Offered	**Breast Cancer Screening** d) i) Stand II QAPI Att 10 - RE Breast Cancer and High Blood Pressure POM scheduled for 724 ii) Stand II QAPI Att 10b – BCS POM_all dates.xls e) Stand II QAPI Att 11+12 - BCS - Live calls and Gift Cards f) Stand II QAPI Att 11+12 - BCS - Live calls and Gift Cards Evaluation Methodology: Monitor HEDIS monthly rates for the BCS - Breast Cancer Screening measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Intervention / Baseline / RM 1 / RM 2 Auto-calls 63.13% 62.96% 64.14% ↑ Live Calls 64.14% 65.58% 67.55% ↑ Incentive 64.14% 65.58% 67.55% ↑	**Breast Cancer Screening**	**Breast Cancer Screening** d) 7/25/2014; 10/17/2014; 11/19/2014; 12/18/2014 e) 9/2014 to 12/2014 f) 9/2014 to 12/2014
Chlamydia Screening in Women d) Letter to provider requesting medical record evidence if member had chlamydia screening e) Non-compliant list of members sent to provider	**Chlamydia Screening in Women** d) i) Stand II QAPI Att 13+14a - RE Print Samples for Job# 55514 2nd request ii) Stand II QAPI Att 13+14b - CHL Provider Letter and Non-compliant list e) Stand II QAPI Att 13+14 - CHL Provider Letter and Non-compliant list	**Chlamydia Screening in Women**	**Chlamydia Screening in Women** d) 9/4/2014 e) 9/4/2014 f) 9/30/2014

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f) Health Department Data Exchange – Peach State sends list of non-compliant members to Department of Public Health (DPH) and DPH returns chlamydia screening data for members **Cervical Cancer Screening** b) Automated Call Campaign to members to get screened	f) Stand II QAPI Att 15 - RE PHIP Data Request 7864 Evaluation Methodology: Monitor HEDIS monthly rates for the CHL - Chlamydia Screening in Women measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Intervention / Baseline / RM 1 / RM 2 Prov Letter 46.89% 48.84% 51.73% ↑ Gap Report 46.89% 48.84% 51.73% ↑ DPH Data 46.89% 48.84% 51.73% ↑ **Cervical Cancer Screening** b) i) Stand II QAPI Att 16 - RE Cervical Cancer POM ii) Stand II QAPI Att 16b – CCS POM_all dates.xls Evaluation Methodology: Monitor HEDIS monthly rates for the CCS - Cervical Cancer Screening measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline.	**Cervical Cancer Screening**	**Cervical Cancer Screening** b) 8/21/2014; 10/24/2014; 11/17/2014; 12/19/2014

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Prenatal/Postpartum Care d) Provider letter explaining postpartum visit timing of 21 to 56 days postpartum e) Medical record review to assess provider documentation of postpartum visit f) Meeting with Altegra (HEDIS medical record review vendor) to discuss concerns regarding obtaining medical records from providers **PROVIDER BEHAVIOR DEPENDENT**	Results: Intervention | Baseline | RM 1 | RM 2 | Auto Calls | 62.48% | 64.05% | 65.18% | ↑ **Prenatal/Postpartum Care** d) Stand II QAPI Att 17 - Postpartum Provider Letter e) Stand II QAPI Att 18 - Medical Record Documentation Review f) Stand II QAPI Att 19 - Altegra-Peach State Health Plan Meeting Evaluation Methodology: Monitor HEDIS annual rates for Postpartum Care submeasure of the PPC - Prenatal and Postpartum Care measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Baseline | RM 1 | 61.81% | 70.30% | ↑ **PROVIDER BEHAVIOR DEPENDENT**	**Prenatal/Postpartum Care** **PROVIDER BEHAVIOR DEPENDENT**	**Prenatal/Postpartum Care** d) 10/1/2014 e) 9/26/2014 f) 11/11/2014 **PROVIDER BEHAVIOR DEPENDENT**

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	APPROPRIATE TESTING FOR CHILDREN WITH PHARYNGITIS	76.37	76.33		
	APPROPRIATE TREATMENT FOR CHILDREN WITH URI	85.34	81.26		
	ANTIBIOTIC UTILIZATION-% OF ANTIBIOTICS OF CONCERN OF ALL ANTIBIOTIC SCRIPTS—Total	41.51	39.98		
Provider Education Letters c) URI and CWP d) Use of antibiotics				**Provider Education Letters** c) i) Stand II QAPI Att 20 - HEDIS QUICK TIP CWP+URI ii) Stand II QAPI Att 20+21 - FW MDC Print Request- Provider Driven Mail Out d) i) Stand II QAPI Att 21 - HEDIS QUICK TIP AAB ii) Stand II QAPI Att 20+21 - FW MDC Print Request- Provider Driven Mail Out Evaluation Methodology: Monitor HEDIS monthly rates for the URI - Appropriate Treatment for Children with Upper Respiratory Infection, the CWP - Appropriate Testing for Children with Pharyngitis, and the AAB - Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis measures. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline.	Ron Purisima **Provider Education Letters**	**Provider Education Letters** c) 9/26/2014 d) 9/26/2014

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BEHAVIORAL HEALTH

FOLLOW-UP CARE FOR CHILDREN PRESCRIBED ADHD MEDICATION Initiation Continuation	52.48 63.11	43.04 57.73
FOLLOW-UP AFTER HOSPITALIZATION FOR MENTAL ILLNESS 7 DAY 30 DAY	69.57 84.28	60.18 75.48
ANTIDEPRESSANT MEDICATION MANAGEMENT Effective Acute Phase Treatment Effective Continuation Phase Treatment	52.74 37.31	39.64 24.86
INITIATION AND ENGAGEMENT OF ALCOHOL AND OTHER DRUG DEPENDENCE TREATMENT Initiation of Treatment Engagement of Treatment	43.62 18.56	38.06 7.08

Results:

Intervention	Baseline	RM 1	RM 2	
URI Provider Letter	84.03%	83.99%	83.89%	➔
CWP Provider Letter	79.43%	79.41%	79.40%	➔
AAB Provider Letter	22.83%	22.59%	22.86%	➔

BEHAVIORAL HEALTH

BEHAVIORAL HEALTH

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BEHAVIORAL HEALTH

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ADHD d) Monthly ADHD Gap Analysis e) Target Member Report f) Weekly Clinical Outreach Report (surveillance program)	**ADHD** d) Stand II QAPI Att 22+29+32 - GAP Analysis & Predictive Modeling FUH, AMM, ADD e) Stand II QAPI Att 23+24 - Weekly Outreach Report ADD f) Stand II QAPI Att 23+24 - Weekly Outreach Report ADD Evaluation Methodology: Monitor HEDIS annual rates for the Initiation Phase and the Continuation and Maintenance Phase submeasures of the Follow-up Care for Children Prescribed ADHD Medication measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Submeasure / Baseline / RM 1 / Acute / 43.04% / 43.58% / ↑ Continuation / 57.73% / 58.19% / ↑	**ADHD**	**ADHD** d) On going e) On going f) On going
FUH h) Provide Technical Assistance to Providers to Encourage accurate and timely billing of FUH codes i) Contact the Facilities with claims for IP MH Stay with no FUH claim. Provide technical assistance for timely billing of Rev Code	**FUH** h) Stand II QAPI Att 25 - Training Notification 4.3.14 i) Stand II QAPI Att 26+30+31 - UB and 510 Revenue Codes j) Stand II QAPI Att 27 - DCP staffings k) Stand II QAPI Att 28 - FUH Telephone	**FUH**	**FUH** h) On going i) On going j) On going k) On going l) On going m) On going n) On going

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UB 510. j) Participate in facility discharge plan meetings and member staffing k) Conduct Telephonic Outreach to all eligible members discharged from an inpatient setting to engage in follow up services l) Complete Predictive Target Report for PSHP FUH m) Ensure accurate configuration for bundled and individually billed UB codes n) Pay all 510 Revenue Codes inaccurately denied due to system configuration errors **Depression** c) Monthly Depression Gap Analysis d) Weekly Clinical Outreach Report	Outreach l) Stand II QAPI Att 22+29+32 - GAP Analysis & Predictive Modeling FUH, AMM, ADD m) Stand II QAPI Att 26+30+31 - UB and 510 Revenue Codes n) Stand II QAPI Att 26+30+31 - UB and 510 Revenue Codes Evaluation Methodology: Monitor HEDIS annual rates for the 30-Day Follow-up and the 7-Day Follow-up submeasures of the Follow-up After Hospitalization for Mental Illness measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Submeasure / Baseline / RM 1 30-Day F/U 75.48% 72.79% ↓ 7-Day F/U 60.18% 56.78% ↓ **Depression** c) Stand II QAPI Att 22+29+32 - GAP Analysis & Predictive Modeling FUH, AMM, ADD d) Stand II QAPI Att 33 - AMM Telephone Outreach Evaluation Methodology: Monitor HEDIS annual rates for the Effective Acute	**Depression**	**Depression** c) 12/31/2014 d) 12/31/2014

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CHRONIC CONDITIONS

COMPREHENSIVE DIABETES CARE—All Components (HYBRID)	87.01 48.72	79.51 32.64
HbA1c test	36.72	24.07
HbA1c Control <8%	76.16	68.92
HbA1c control <7%	35.86	23.44
LDL Screen	78.71	70.83
LDL Control	39.10	29.34
Attention to nephropathy	63.50	53.65
BP Control <140/80 mm Hg		
BP Control <140/90 mm Hg		
CONTROLLING HIGH BLOOD PRESSURE (HYBRID)	57.52	44.15
MEDICATION MANAGEMENT FOR PEOPLE WITH ASTHMA—5 to 64 Years	52.31 29.14	44.22 19.00
Medication Compliance 50% Total		
Medication Compliance 75% Total		
ANNUAL MONITORING FOR PATIENTS ON PERSISTENT MEDICATIONS—Total	88.55	86.42

Phase Treatment and the Effective Continuation Phase Treatment submeasures of the Antidepressant Medication Management measure. Baseline is the final rate for the year prior to the implementation of the intervention with Remeasurement (RM) 1 as the final rate for the year following the baseline.

Results:

Submeasure	Baseline	RM 1	
Acute	39.64%	39.57%	↓
Continuation	24.86%	24.86%	→

CHRONIC CONDITIONS

CHRONIC CONDITIONS

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CHRONIC CONDITIONS

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Diabetes d) Opticare (member outreach to provide diabetic eye screening) e) Nurtur (disease management program) f) Member mailer (Corporate)	**Diabetes** d) Stand II QAPI Att 34 - Opticare JOC Sept 22 2014 Mtg Minutes e) Stand II QAPI Att 35 - Nurtur_OPS_Minutes 10_24_2014 f) Stand II QAPI Att 36+37 - RE Diabetes Member and Provider Mailer Evaluation Methodology: Monitor HEDIS annual rates for submeasures of the CDC – Comprehensive Diabetes Care measure. Baseline is the final rate for the year prior to the implementation of the interventions with Remeasurement (RM) 1 as the final rate for the year following the baseline. Results: Opticare Nurtur	**Diabetes**	**Diabetes** d) 8/31/2014 e) 12/31/2014 f) 9/17/2014

Opticare

Measure	Baseline	RM 1	
Eye Exam	57.81%	58.63%	↑

Nurtur

Measure	Baseline	RM 1	
HbA1c test	79.51%	83.63%	↑
HbA1c >9%	63.19%	53.17%	↑
HbA1c <8%	32.64%	37.32%	↑
HbA1c <7%	24.07%	27.73%	↑
Nephropathy	70.83%	77.82%	↑
BP <140/90	53.65%	53.17%	→

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

CBP c) Postcard to member to follow up with PCP and to adhere to blood pressure medication regimen d) Automated call campaign to member to follow up with PCP and to adhere to blood pressure medication regimen	Evaluation Methodology: Monitor HEDIS monthly rates for the submeasures of the CDC – Comprehensive Diabetes Care measure. Baseline is the rate for the month prior to the implementation of the interventions and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Corporate Mailer **Measure** / **Baseline** / **RM 1** / **RM 2** HbA1c test: 65.11% / 68.87% / 71.99% ↑ Eye Exam: 30.12% / 34.12% / 43.81% ↑ Nephropathy: 58.88% / 61.76% / 63.77% ↑ **CBP** c) i) Stand II QAPI Att 38 - CBP Postcards ii) Stand II QAPI Att 38b - High Blood Pressure Member Postcard Mailing d) Stand II QAPI Att 39 - CBP POM Campaign Results 2014 Evaluation Methodology: Monitor HEDIS annual rates for the CBP – Controlling High Blood Pressure measure. Baseline is the final rate for the year prior to the implementation of the interventions with Remeasurement (RM) 1 as the final rate for the year following the baseline.	**CBP**	**CBP** c) 10/7/2014 d) 7/2/2014; 10/18/2014

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2013–June 30, 2014)

Pharmacy Related b) Med adherence Letters	Results: Baseline: 44.15% ↓ (RM 1: 36.64%) **Pharmacy Related** b) Stand II QAPI Att 40 - PSHP-Respiratory Adherence Member Letter Evaluation Methodology: Monitor HEDIS monthly rates for the ASM – Use of Appropriate Medications for People with Asthma measure. Baseline is the rate for the month prior to the implementation of the intervention and Remeasurement (RM) 1 and 2 are the months following the baseline. Results: Mem Letters: 88.25% (RM 1: 91.15%, RM 2: 89.71%) ↑ Mem Letters: 89.71% (RM 1: 89.10%, RM 2: 89.39%) → Mem Letters: 89.65% (RM 1: 90.19%, RM 2: 90.78%) ↑	**Pharmacy Related**	**Pharmacy Related** b) 3/31/2014; 6/30/2014; 9/30/2014; 12/31/2014

Other Evidence/Documentation:

July 2015 Re-review Findings: Peach State continues to work with DCH in the formulation of its Quality Assessment and Performance Improvement plan. While some initiatives were showing improvement (e.g., breast cancer screening, chlamydia screening in women, cervical cancer screening, prenatal/postpartum care, attention deficit hyperactivity disorder [ADHD], and diabetes), others remained unaffected by interventions.

July 2015 Required Actions: Peach State should continue to incorporate DCH's suggested revisions and continue to evaluate the overall effectiveness of the QAPI plan on the quality of healthcare provided to its members.

Interventions Planned	Intervention Evaluation Method	Individual(s) Responsible	Proposed Completion Date