

State of Georgia



Department of Community Health (DCH)

**EXTERNAL QUALITY REVIEW
OF COMPLIANCE WITH STANDARDS**
for
PEACH STATE HEALTH PLAN

December 2014



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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, referred to by the State as care management organizations (CMOs), to deliver services to members who are enrolled in the State’s Medicaid managed care and CHIP programs. The State refers to its Medicaid managed care program as Georgia Families and to its CHIP program as PeachCare for Kids[®]. For the purposes of this report, 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 CMO, or its external quality review organization (EQRO) must conduct a review to determine a Medicaid CMO’s compliance with standards established by the state related to enrollee 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

DCH requires its CMOs to undergo an annual compliance review that covers 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, 2013–June 30, 2014, and marked the first 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, file reviews, case reviews, and a management information system demonstration. 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 measurement and improvement standards found at 42 CFR §438.236–§438.240, and §438.242, while

¹⁻¹ Georgia Department of Community Health. “Georgia Families Monthly Adjustment Summary Report, Report Period: 09/2014.”

the seventh area focused specifically on noncompliant standards from the prior review period. The standards HSAG evaluated included requirements that addressed the following areas:

- ◆ Availability of Services
- ◆ Furnishing of Services
- ◆ Cultural Competence
- ◆ Coordination and Continuity of Care
- ◆ Coverage and Authorization of Services
- ◆ Emergency and Poststabilization Services
- ◆ Re-review of all *Partially Met* and *Not Met* elements from the prior year's review.

Additionally, HSAG performed a focused, case-specific file review of a sample of Peach State's members in the case management program between January 1, 2014, and May 30, 2014. HSAG also reviewed a sample of members enrolled in the disease management program between January 1, 2014, and May 30, 2014. Furthermore, HSAG reviewed a sample of cases involving members whose covered services/authorizations were denied between July 1, 2013, and June 30, 2014.

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 final report.
- ◆ Appendix F—The completed review tools HSAG used to evaluate Peach State's case management cases.
- ◆ Appendix G—The completed review tools HSAG used to evaluate Peach State's disease management cases.

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.
- ◆ Systems demonstrations during the on-site review.
- ◆ 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	Availability of Services	17	17	17	0	0	100.0%
II	Furnishing of Services	22	22	14	8	0	63.6%
III	Cultural Competence	14	14	14	0	0	100.0%
IV	Coordination and Continuity of Care	21	21	13	8	0	61.9%
V	Coverage and Authorization of Services	25	25	22	3	0	88.0%
VI	Emergency and Poststabilization Services	20	20	16	4	0	80.0%
NA	Follow-up Reviews From Previous Noncompliant Review Findings	4	4	2	2	0	50.0%
Total Compliance Score		123	123	98	25	0	79.7%
* 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 <i>NA</i> .							
*** Total Compliance Score: Elements that were <i>Met</i> 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—Availability of Services

Performance Strengths

Peach State monitored its provider network to ensure all services were available to Georgia Families members. The CMO conducted an analysis each quarter to test for variations in travel times and distances between members and providers. It maintained a mix of provider types such that most if not all services were available within the network in order to minimize the need for members to obtain services outside the network. Peach State monitored providers to ensure they were accepting new patients and ensured continuity of care was maintained if and when a member obtained services from other providers. When out-of-network providers were needed, the CMO coordinated payment such that the member was not balance-billed and attempted to contract with those providers in order to make the provider network more robust.

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—Furnishing of Services

Performance Strengths

Peach State monitored aspects of network access to ensure members were able to obtain timely services. The CMO ensured that its contracted providers offered access to services for Georgia Families members consistent with Georgia Medicaid fee-for-service or commercial members. When an issue arose and a provider needed to be reminded about service goals, the CMO had a corrective action process to communicate needed improvement.

Areas Requiring Corrective Action

The State established a goal that 90 percent of providers must meet appointment wait time requirements. Peach State monitored these wait times for compliance with the State standard. Peach State's network providers did not meet the 90 percent goal for the following appointment wait time targets:

- ◆ Primary care provider (PCP) (Routine Visits)—not to exceed 14 calendar days
- ◆ PCP (Adult Sick Visit)—not to exceed 24 hours
- ◆ Non-emergency Hospital Stays—not to exceed 30 calendar days
- ◆ Mental Health Providers—not to exceed 14 calendar days
- ◆ Timeliness—Visits for Pregnant Women—Within 14 days of enrollment

In addition, Peach State did not have adequate monitoring mechanisms in place to oversee provider office wait times or when a provider returned calls to Georgia Families' members. The monitoring activities in the following areas were not sufficient to ensure the requirements were met:

- ◆ Scheduled in-office appointment wait times of not more than 60 minutes.
- ◆ In-office work-in or walk-in appointment wait times of no more than 90 minutes.
- ◆ After-hours urgent calls returned within 20 minutes and other calls within one hour.

Also, Peach State was required to meet certain time and distance geographic access standards in both urban and rural areas. The CMO did not meet the following geographic access standards:

- ◆ PCPs
 - Urban areas: Two within eight miles.
 - Rural areas: Two within 15 miles.
- ◆ Specialists
 - Urban areas: One within 30 minutes or 30 miles.
 - Rural areas: One within 45 minutes or 45 miles.
- ◆ General dental providers
 - Urban areas: One within 30 minutes or 30 miles.
 - Rural areas: One within 45 minutes or 45 miles.
- ◆ Dental subspecialty providers
 - Urban areas: One within 30 minutes or 30 miles.
 - Rural areas: One within 45 minutes or 45 miles.
- ◆ Mental health providers
 - Urban areas: One within 30 minutes or 30 miles.
 - Rural areas: One within 45 minutes or 45 miles.
- ◆ Pharmacies
 - Urban areas: One 24 hours a day, seven days a week within 15 minutes or 15 miles.
 - Rural areas: One 24 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.

Standard III—Cultural Competence

Performance Strengths

Peach State served its members in a culturally competent manner by educating staff and providers on expected conduct. Its cultural competency plan was available on Peach State's Web site and was accessible to providers. Member materials were produced in English and Spanish, and members were able to call member services if materials were not easily understood. The CMO offered free linguistic services to members and providers as needed.

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—Coordination and Continuity of Care

Performance Strengths

Peach State's monitoring and follow-up of members in case management was focused and specific to the member's needs. The frequency of contact with members and providers was robust in the outpatient setting. Peach State had a pharmacy lock-in program that provided an added layer of services to ensure that members were appropriately accessing medications.

Areas Requiring Corrective Action

HSAG identified the following areas for improvement:

The CMO was responsible for ensuring the following: members had an ongoing source of primary care and the ability to choose a PCP, and the CMO's policy and procedures described how a member was to select a PCP. Peach State's policy for changing a PCP and its actual reported procedure were not congruent. The policy stated that members were able to switch PCPs every 30 days within the first 90 days of enrollment and every 6 months thereafter. However, staff reported that the member was allowed to change PCPs at any time.

Peach State was responsible for ensuring that the member's privacy was protected, consistent with the confidentiality requirement. During the interview Peach State staff reported that case managers asked verbal permission to speak with the member's family/guardian/caregiver except in the case of a pregnant minor. Staff indicated that case managers would not speak to the pregnant minor without the consent of the minor's parent/guardian. This was inconsistent with O.C.G.A. 31-9-2 (5) (2010) as any female, regardless of age or marital status, could consent for treatment herself when given in connection with pregnancy, or the prevention thereof, or childbirth.

Peach State provided policies and procedures that outlined the provision of case management, disease management, transition of care, and discharge planning. However, during the file review, staff members were unable to demonstrate documented instances of case managers either completing or receiving the discharge plan for members who were being discharged from an inpatient facility.

Peach State was unable to identify how case managers included the member, the member's provider, and/or the caregiver/family member/guardian in care plan development. HSAG identified that care plans were completed using the initial assessment without input from other entities.

Peach State staff provided documentation of continued monitoring of a member's progress with care plan goals. Staff members were unable to identify a formal process that would be used to identify any care gaps in the member's utilization of services.

Peach State provided documentation that outlined the formalized process of monitoring and follow-up concerning care for physical illness. HSAG noted that behavioral health (BH) services were being completed. However, there was no documentation of follow-up with the provider, member, or caregiver/guardian concerning the member's utilization of BH services, diagnosis, medications, and/or progress. Once a referral for BH services was completed, the case manager did not complete any other care coordination for this service area.

Peach State provided a policy and procedure that outlined a formal process for identifying members who have the greatest need for case management using Impact Pro, the CMO's predictive modeling software. However, HSAG noted that members reviewed in the case management file review were typically referred based on diagnoses and conditions identified on a trigger list rather than being identified using Impact Pro.

Standard V—Coverage and Authorization of Services

Performance Strengths

Peach State demonstrated adequate management and oversight of policies and procedures. The Utilization Management staff members were knowledgeable and demonstrated a collaborative process with the medical directors through noted interactions and case rounds.

Areas Requiring Corrective Action

While Peach State had oversight and processes for monitoring the *aging of service* requests to ensure adherence to required turnaround times, the policy and practice for untimely service requests were in conflict. Decisions not reached within the required time frames constituted a denial, as was noted in policy, but in practice CMO staff members stated they would provide an approval.

Peach State staff noted that providers frequently indicated that a request was urgent; however, the request may have failed to meet the criteria for an expedited review. Provider education was needed to ensure understanding of the definition of an urgent/expedited review. Additionally, if an expedited request was denied for not meeting criteria, the member must be notified of this action; staff indicated that only the provider would be notified.

Denial File Review Summary

Peach State's internal denial review process, as well as the denial review processes of its external delegates, demonstrated overall compliance. Standard requests were reviewed promptly, and notifications were appropriate and timely. Medical director review and decision rationale were well documented.

Standard VI—Emergency and Poststabilization Services

Performance Strengths

Peach State ensured that members were able to access emergency services 24 hours a day, seven days a week to treat emergency medical conditions. The CMO did not deny payment for any emergency services regardless of network status and ensured payment for all triage/screening services.

Areas Requiring Corrective Action

Peach State accepted medical records to support requests for higher levels of reimbursement for triage/screening claims. The provider manual noted that either a medical director or designee would review the information, but the practice was for nonclinical staff to conduct the review. Peach State needs to ensure appropriate clinical staff members are reviewing the medical records.

Peach State had difficulty articulating assurance of coverage and payment for poststabilization services. While written policy supported coverage of poststabilization services, staff could not define the process in practice. It was noted that all observation stays required prior authorization.

Case and Disease Management Focused Review

Case Management

HSAG performed case-specific file reviews that focused on members in case management. The reviews focused on the assessment of the member's needs, the development of the care plans, case management monitoring and follow-up, multidisciplinary team approach, and transitions of care and discharge planning. The review looked for gaps in the assessment, the care plan, monitoring and follow-up, presentation of the member in a multidisciplinary setting, and the process for handling transitions of care including discharge planning.

Methodology

HSAG developed a case management evaluation guide in collaboration with DCH, which HSAG used to conduct the review at the individual case level. The case management evaluation guide covered the following areas:

- ◆ Identification
- ◆ Assessment
- ◆ Care Plan Development
- ◆ Monitoring and Follow-up
- ◆ Transition of Care and Discharge Planning

HSAG selected eight member sample cases, plus an oversample of three cases to review. The sample cases were pulled from a file provided by the CMO and contained members with open enrollment in the case management program between January 1, 2014, and May 30, 2014. HSAG provided the CMO with the selected sample cases HSAG would review on-site by uploading the information to the HSAG file transfer protocol (FTP) site on June 30, 2014. The CMO was responsible for assuring the identified sample cases were available for the reviewers during the on-site review.

An HSAG audit team composed of clinicians with care management experience reviewed case documentation from the selected cases of members enrolled in case management. The manager from each Peach State case management program was included in the case review process, to present the case to the HSAG audit team, navigate through the CMO's care management system, and respond to any questions.

Identification

HSAG reviewed the CMO's process for identifying members who could benefit from case management services.

Observations:

During the case file review it was noted that members identified for case management were referred by another internal CMO department via a “trigger list” that was typically based on inpatient admissions. Staff reported that members were also able to self-refer to case management or be referred by their provider. HSAG did not see evidence that members were identified for case management using the CMO’s predictive modeling software, Impact Pro.

Recommendations:

- ◆ Explore options for greater utilization of predictive modeling to identify members who could benefit from case management.

Assessment

HSAG reviewed the CMO’s process for assessing members’ needs and the inclusion of family and/or caregivers and providers’ input into the assessment process.

Observations:

During the case file review it was noted that timely assessments were completed and included an assessment of the member’s current physical/behavioral issues and concerns, social needs, support system, and linguistic and cultural needs and barriers. For child cases, caregiver and guardian involvement in the assessment was clearly understood. However, HSAG did not find evidence of the CMO involving the member’s family and/or caregiver in the assessment process for adult members. In addition, HSAG identified limited or no inclusion of the adult member’s provider and inconsistent contact and input from infant/child/adolescent providers during the assessment process.

Recommendations:

- ◆ Increase family/caregiver involvement in the assessment process for all members.
- ◆ Increase provider involvement in the assessment process for all members.

Care Plan Development

HSAG reviewed the CMO’s process for care plan development to determine if the care plan addressed needs identified in the assessment and included input from family and/or caregivers and providers.

Observations:

During the file review it was noted that the care plan addressed the member’s physical, social, and behavioral health issues identified during the assessment. The goals were member-centered, measurable, and achievable. However, for adult cases, the level of provider and family/caregiver involvement in care plan development was lacking.

Recommendations:

- ◆ Increase provider and family/caregiver involvement in care plan development.

Monitoring and Follow-up

HSAG reviewed the CMO's process for monitoring and follow-up of members enrolled in case management.

Observations:

The intensity and frequency of monitoring and follow-up was tailored to the member's individual identified needs. There was communication between case management staff and the member concerning any changes in the contact frequency, with buy in from the member.

The CMO had a pharmacy lock-in program to identify members who were using multiple controlled substances and used criteria to determine whether the member might benefit from coordination of medications by one pharmacy. HSAG identified this as a strength; however, while members who met the criteria for this program were notified of their enrollment, the CMO indicated that it no longer sent notification to the providers due to a high volume of returned mail for providers. CMO staff reported the reason for returned mail was incorrect provider mailing addresses.

During the case file review HSAG identified the following areas of concern:

- ◆ Lack of medication reconciliation by the case managers, with the exception of the pharmacy review, which was specific to controlled substances.
- ◆ Fragmentation between physical health and behavioral health. For physical health, HSAG noted active monitoring of the member's progress and needs; however, for behavioral health, HSAG identified that a referral for behavioral health services was often given but there was no monitoring or follow-up with the member or provider concerning the member's utilization of services, diagnosis, medications, or progress.
- ◆ A formal care gap analysis was not conducted to determine needed care versus provided care.

During the file review HSAG noted inconsistency with use of a multidisciplinary team. Two of the eight cases reviewed were brought to the Integrated Care Model (ICM) rounds; however, the case notes lacked documentation of feedback from ICM rounds regarding member care or possible care options.

Recommendations:

- ◆ Implement a process to ensure that providers are notified of members enrolled in the pharmacy lock-in program to improve coordination of care.
- ◆ Explore ways to decrease fragmentation between Peach State's physical health and behavioral health programs.
- ◆ Train case managers on medication reconciliation and incorporate a process to ensure medication reconciliation is conducted for members in case management.
- ◆ Increase utilization of a multidisciplinary team approach for case consultation.

- ◆ Ensure documentation of the case presentation covers feedback from team members, inclusion of outside participants (e.g., family/caregivers, providers, and/or specialists and their feedback), treatment recommendations, and follow-up.

Transitions of Care and Discharge Planning

Observations:

During the file review staff reported that discharge planning was completed for all members who had an inpatient stay. However, it was noted that discharge planning from an inpatient setting was limited to information gathered from the member or the member's guardian after the member had already been discharged or was about to be discharged. Gathering information from the member after the member had already been discharged was inadequate. HSAG noted that there was communication fragmentation between the utilization management and case management departments as it related to discharge planning and follow-up. Peach State indicated that discharge planning was a function of utilization management; however, HSAG was unable to identify formal discharge planning being conducted or communicated from the utilization management department to the case manager.

Recommendations:

- ◆ Ensure coordination of discharge planning between utilization management and case management for members enrolled in case management.
- ◆ Obtain a copy of the discharge plan and/or document the discharge plan for all members transitioning between care settings that are enrolled in case management in the case management system.

Disease Management

HSAG performed case-specific file reviews that focused on members in disease management. The review focused on the identification for disease management, assessment, education, monitoring, and measureable outcomes.

Methodology

HSAG conducted on-site disease management record reviews at Peach State. Eight records were randomly selected with an oversample of three records. Each record file was reviewed with Peach State staff and discussed during the review process.

The review sample consisted of asthma and diabetes disease management cases.

Findings

Peach State delegated its disease management functions to the Nurtur TeleCare Management Program for members with asthma, diabetes, chronic obstructive pulmonary disease (COPD), congestive heart failure, and coronary artery disease.

The telephonic disease management coaching program included disease-specific management by registered nurses, respiratory technicians, and community health workers.

Program Type and Identification

Observations:

Peach State had an effective referral process for identifying members who could benefit from disease management. The target population consisted of individuals with a qualifying condition, evidence of poor control, or frequent utilization of care that could be more appropriately managed in a different setting. Members were referred to the program by CMO case managers and providers, or through a claims stratification process. Peach State also identified members through claims review of emergency department utilization.

Despite the identification and referral process, the CMO had difficulty engaging members in the disease management program.

Recommendations:

- ◆ Develop methods to improve initial engagement of members referred to disease management.

Assessment and Guidelines

Observations:

Peach State and its delegated disease management partner, Nurtur, adopted disease management guidelines developed by national organizations. Peach State had well-developed assessment and disease management care plans. For several of the cases reviewed, the disease case managers lost contact with the member after the first or second contact for disease management.

Recommendations:

- ◆ Peach State should develop additional methods to improve the continued engagement of members after the baseline assessment is completed.

Education

Observations:

Members who agreed to be enrolled in disease management programs received enrollment education packets concerning their disease process. The packets had been developed to include both pediatric and adult content. Members referred to disease management, either through claims or referrals, but who had not agreed to be enrolled in disease management did not receive any educational materials about their disease process from Peach State or Nurtur.

Recommendations:

- ◆ Consider developing information that could be sent to members identified for disease management as a mechanism to engage members. The educational materials could summarize the information currently included in disease management enrollment packets.

Monitoring

Observations:

The case manager received communication about the member from Nurtur and the disease manager via an interface built between Nurtur and TruCare software systems. The telephonic disease management coaching program included disease-specific management by registered nurses, respiratory technicians, and community health workers. Once enrolled in the program, members received written educational materials, clinical review, coaching calls, and case manager follow-up regarding validated high alerts. In addition, the case manager provided fax/telephonic follow-up with providers.

Coaching calls occurred at least every 30 days and often were more frequent based on the member's needs. The program's goal was to educate the member on his or her disease and how to control/manage it.

Some cases reviewed showed that the disease case manager was not able to contact the member again and the case was closed.

Recommendations:

- ◆ When follow-up has not been accomplished, at-risk members, particularly children, should be evaluated for a potential referral to case management or discussed in integrated care management rounds.

Measureable Outcomes

Observations:

Peach State did not measure member outcomes using disease management data.

Recommendations:

- ◆ Peach State should monitor disease management members for health outcomes improvement.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

Peach State corrected two of the four elements requiring corrective action. The CMO changed policies and practices to ensure at least 450 records were reviewed, which was a sufficient amount to verify if the CMO's providers were compliant with clinical practice guidelines. The CMO also provided its CPG evaluation (due July 2014), which met the CPG provider compliance goals.

Areas Requiring Corrective Action

Two areas still require corrective action. The CMO did not meet all DCH-established performance goals; therefore, this item will remain on the corrective action list until these goals are met. Peach State must continue to improve its Quality Assessment and Performance Improvement (QAPI) Program to ensure all quality elements are addressed and that they are integrated in terms of overall program impact.

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 final 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, 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—Availability of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>1. Availability of Services—Establishing and Maintaining an Adequate Network of Providers: 42 CFR 438.206(b); Contract 4.8.1.2; 4.8.1.6</p> <p>The care management organization (CMO) has written provider selection and retention policies and procedures and maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract. In establishing and maintaining the network, the CMO considers:</p>	<p>Peach State has written policies and procedures to ensure that our network of Providers is adequate to meet the care and services needed for our members via contracted providers or single-case agreements. Contracts are executed with all network providers. Peach State monitors availability through Contract required reports, member grievances and satisfaction surveys. PSHP also monitors availability by conducting telephonic surveys of provider appointment availability, conducting provider office visits, utilization patterns to detect any unusual practice, and feedback from case management/care coordination staff. In addition, Peach State maintains an adequate number and geographic distribution of PCP’s, specialists and pharmacies in accordance with DCH requirements. In the event of closed panels, the Peach State Provider Services Department staff contacts the provider to inquire about the reason for closing the panel; if unable to resolve the providers panel closure, the Plan ensures other providers in the area with open panels can absorb the affected members.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Practitioner and Telephone Accessibility Analysis 2011-2013 (entire document) • Policy: GA.CONT. 10 Evaluation of Provider Availability (entire document) • Contract: GA SCP Contract, GA HOSP Contract, GA PCP Contract, Single Case Agreements (entire document) • Report: 2014 Population Assessment 	
<p>(a) The anticipated Medicaid/Georgia Families (GF) enrollment.</p>	<p>Peach State documents how it considers anticipated enrollment through the following document:</p> <ul style="list-style-type: none"> • Policy: GA.CONT. 10 - Evaluation of Provider Availability, Page 2 • Report: 2014 Population Assessment 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A

Findings: Peach State provided its Annual Population Assessment document, which indicated the CMO considers anticipated enrollment by analyzing product line



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<p>population variations, languages spoken, and race/ethnicity.</p> <p>Required Actions: None.</p>		
<p>(b) The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the CMO.</p>	<p>Peach State documents how it considers the expected utilization of services through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT. 10 - Evaluation of Provider Availability (entire document) • Report: 2014 Population Assessment <p>In addition, Peach State conducts an annual analysis of Practitioner Availability which takes into account member cultural needs and preferences, languages, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey results, grievance trend analysis and geographic location for PCPs and select high volume specialty types. Peach State demonstrates this through the following document:</p> <ul style="list-style-type: none"> • Practitioner and Telephone Accessibility Analysis 2011-2013 (entire document) • Report: Spring Provider Report, Page 3 • Report: 2014 Population Assessment 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State provided its Annual Population Assessment document, which indicated the CMO considers anticipated enrollment by analyzing product line population variations, languages spoken, and race/ethnicity. This document also summarized the likelihood an individual or population will incur health care risks, thereby ensuring the CMO analyzes projected case management utilization.</p> <p>Required Actions: None.</p>		
<p>(c) The numbers and types (in terms of training, experience, and specialization) of providers required to furnish the contracted Medicaid services.</p>	<p>Peach State documents how it considers the number and types of providers required to furnish services through the following document:</p> <ul style="list-style-type: none"> • Policy: GA.CONT. 10 - Evaluation of Provider Availability (entire document) • Policy: GA.CRED.12 – Organizational Providers (entire document) <p>In addition, Peach State conducts an annual analysis of Practitioner Availability which takes into account member cultural needs and preferences, languages,</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>CAHPS[®] survey results, grievance trend analysis and geographic location for PCPs and select high volume specialty types. Peach State demonstrates this through the following document:</p> <ul style="list-style-type: none"> • Practitioner and Telephone Accessibility Analysis 2011-2013 (entire document) <p>Moreover, Peach State ensures members that have complex, catastrophic or other high risk conditions receive adequate health care services that are deemed medically necessary. The Plan’s Medical Management Department, consisting of both Case Management and Utilization Management, seeks to meet the needs of these authorized services within the provider network or by initiating a written single case agreement (SCA) according to the Network Development & Contracting Department SCA policy: GA.CONT.02.</p> <p>Peach State demonstrates this through the following document:</p> <ul style="list-style-type: none"> • Contract: Single Case Agreement (SCA) (entire document) 	
<p>Findings: Peach State provided its GeoAccess reports, and they indicated the CMO monitors the number and types of providers included in its network. The CMO also considers various credentialing bodies that were summarized in the Organizational Providers policy when considering the inclusion of providers into the CMO’s network. The Evaluation of Provider Availability policy included evidence that the CMO considers the provider’s specialty when evaluating the need for inclusion in the CMO’s network.</p>		
<p>Required Actions: None.</p>		
<p>(d) The number of network providers who are not accepting new Medicaid patients.</p>	<p>Peach State documents how it monitors the number providers accepting new patients through the following document:</p> <ul style="list-style-type: none"> • Policy- GA.CONT. 10 - Evaluation of Provider Availability, Page 3, 4 • Report: GeoAccess Q1 2014 Provider Listing (Accepting new patients column AB, Tab one) <p>Moreover, Peach State conducts an annual analysis of Practitioner Availability which includes open practice data for primary care physicians. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Page 22 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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	<ul style="list-style-type: none"> • Practitioner and Telephone Accessibility Analysis 2011-2013 (entire document) 	
<p>Findings: Peach State provided its Q1 2014 GeoReport–Provider Listing document, and it showed that the CMO monitors the number of providers not accepting new patients.</p>		
<p>Required Actions: None.</p>		
<p>(e) The geographic location of providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.</p>	<p>Peach State documents how it considers geographic locations and physical accessibility of members through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT. 10 Evaluation of Provider Availability, (entire document) • Policy: GA.CRED.07 Practitioner Office Site Review, (entire document) • Practitioner Office Site Evaluation Tool <p>In addition, Peach State conducts an annual analysis of Practitioner Availability which takes into account geographic location for PCPs and select high volume specialty types. The Plan also monitors grievances regarding office sites, which includes whether the location provides adequate physical access for members with disabilities, and reports these grievances to the Credentialing Committee on a monthly and biennial basis. The biennial report summarizes six months of grievance data. Offices that receive grievances regarding the office site have an office site inspection by a Provider Solutions Representative. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Practitioner and Telephone Accessibility Analysis 2011-2013 (entire document) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State conducts its GeoAccess analysis quarterly, and the CMO considers the geographic distance between providers and members along with the travel times between providers and members.</p>		
<p>Required Actions: None.</p>		



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<p>2. Availability of Services—Direct Access to Women’s Health Specialist: <i>42 CFR 438.206(b)(2); Contract 4.8.3.1</i></p> <p>The CMO provides female members with direct in-network access to a women’s health specialist for covered care necessary to provide a woman’s routine and preventive health care services. This is in addition to the member’s designated source of primary care if that source is not a women’s health specialist.</p>	<p>Peach State provides female members with direct in-network access to a women’s health specialist for covered care necessary to provide a woman’s routine and preventative health care services. PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Page 18 • Member Handbook, Page(s) 7, 20, 22, 31-33 (accessible at www.pshpgeorgia.com) • Prior Authorization List • Prior Authorization Guide • P4HB Member Handbook (entire document) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Both the provider manual and the member handbook indicated that obstetric/gynecological services can be obtained on a self-referral basis.</p> <p>Required Actions: None.</p>		
<p>3. Availability of Services—Direct Access to Specialists: <i>42 CFR 438.208(c)(4); Contract 4.8.3.2</i></p> <p>The CMO has a process in place that ensures that (i) members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the member’s condition and identified needs, and (ii) the CMO Medical Director oversees this process.</p>	<p>Peach State members who are determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the member’s condition and identified needs. Peach State’s Medical Director is responsible for oversight of this process. Direct access means that neither a PCP referral nor a Peach State prior authorization is required. PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Page 42 • Member Handbook, Page(s) 23-28, 47-49, 53 • Prior Authorization List • Prior Authorization Guide • Policy: GA.UM.20 Prior Authorization, Pre-certification and Notification, (entire document) • 2011 PSHP UM Program Description • Policy: GA.CM.08 Case Management Care Coordination Policy, Page 17 • Policy: GA.UM.02.01 Medical Necessity Review Work Process, Page 3 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Care Coordination/Case Management Services Policy indicated that the case manager would coordinate access to a specialist and process needed</p>		



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<p>referrals. Peach State staff members verified this process during staff interviews. Members are also encouraged to contact their PCP for a referral to an in-network provider, but this is not mandatory. A member may self-refer to a specialist without seeing his or her PCP first.</p> <p>Required Actions: None.</p>		
<p>4. Availability of Services—Direct Access/Treatment Plans: <i>42 CFR 438.208(c)(3)(i-iii); Contract 4.8.3.3</i></p> <p>The CMO ensures that members who are determined to need a course of treatment or regular care monitoring have a treatment plan and that the treatment plan is: (i) developed by the member’s PCP with member participation, and in consultation with any specialists caring for the member; and (ii) approved in a timely manner by the CMO Medical Director and in accord with any applicable State quality assurance and utilization review standards.</p>	<p>Peach State’s treatment plans are developed and approved timely with the member, PCP and applicable specialist participation for those members who need a course of treatment or regular care monitoring. Peach State ensures members who are determined to need a course of treatment or regular care have a treatment plan.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Page(s) 7, 26, 28, 31, 42-43, 45, 105 • Contract, GA PCP Contract • Policy: GA.CM 08 Case Management Care Coordination Policy, Page 11 • Policy: GA.UM. 20 Prior Authorization, Pre-certification and Notification, Page 2 • 2011 CM Program Description, Page 17 • Sample: Breast Care Plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Care Coordination/Case Management Services Policy indicated that the case manager would coordinate access to a specialist and process needed referrals. Peach State staff members verified this process during staff interviews. Members are also encouraged to contact their PCP for a referral to an in-network provider, but this was not mandatory. A member may self-refer to a specialist without seeing his or her PCP first.</p> <p>Required Actions: None.</p>		
<p>5. Availability of Services—Second Opinion: <i>42 CFR 438.206(b)(3); Contract 4.11.7.1-3</i></p> <p>The CMO provides for a second opinion from a qualified health care professional within the network, or arranges for the member to obtain one outside the network, at no cost to the member.</p>	<p>PSHP provides second opinions from health care professionals within the network or arranges for members to obtain a second opinion from an out-of-network provider with no cost to the member.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy, GA.UM.21 Second Opinion (entire document) • Provider Manual, Page(s) 41, 104 • Member Handbook, Page(s) 35, 48 • 2011 UM Program Description, Page 15 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The member handbook informed the member that a second opinion was available in the network. It also stated that if a provider for the second opinion</p>		



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<p>was not available within the network, the member could see an out-of-network provider at no cost.</p> <p>Required Actions: None.</p>		
<p>6. Availability of Services—Coverage Out of Network: <i>42 CFR 438.206(b)(4); Contract 4.8.19.1</i></p> <p>If the CMO’s network is unable to provide necessary services, covered under the contract, to a particular member, the CMO:</p> <ul style="list-style-type: none"> ◆ Adequately and in a timely manner covers these services out of network for the member, for as long as the CMO is unable to provide them. ◆ Informs the out-of-network provider that the member cannot be balance billed. 	<p>Peach State ensures that members receive necessary and timely services. If the Plan is unable to provide the services in-network, Peach State would authorize and pay for service provided by an out-of-network and/or out-of-state non-contracted provider through a single-case agreement (SCA) at no cost to the member. PSHP also informs out-of-network and/or out of state non-contracted providers that the member cannot be balance billed via the single case agreement.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT.02 Single Case Agreement (SCA), pages 1, 3 • Sample: Single Case Agreement, page 1, section C • Policy: GA.CONT.01 Provision of Services by Out of Network/Out of State Non Contracted Providers (Entire document) • 2014 UM Program Description, Page 15 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State staff summarized the single case agreement process used when services were not available within the network. The Single Case Agreement indicates that the provider should only look to the CMO for compensation and that providers cannot expect and attempt to obtain compensation from the member.</p> <p>Required Actions: None.</p>		
<p>7. Availability of Services—Out-of-Network Provider Payment and Cost to Member: <i>42 CFR 438.206(b)(5); Contract 4.8.19.2</i></p> <p>The CMO, consistent with the scope of contracted services, requires out-of-network providers to coordinate with the CMO with respect to payment.</p>	<p>PSHP requires out-of-network providers to coordinate with the Plan via a single-case agreement (SCA) for payment of services. The out-of-network provider is also advised via the single case agreement that the member cannot be balanced billed.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT.01 Provision of Services by Out of Network/Out of State Non Contracted Providers, pages 3, 4 • Policy: GA.CONT.02 Single Case Agreement (SCA) (Entire document) • Member Handbook, Page(s) 37, 47 • Sample: Single Case Agreement, page 1, section C 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State staff summarized the single case agreement process used when services are not available within the network. The Single Case Agreement</p>		



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<p>indicated that the provider should only look to the CMO for compensation and that providers cannot expect and attempt to obtain compensation from the member.</p> <p>Required Actions: None.</p>		
<p>8. Availability of Services—Out-of-Network Provider Payment and Cost to Member: <i>Contract 4.8.19.2</i></p> <p>The CMO coordinates with out-of-network providers regarding payment according to the following DCH contract provisions:</p>		
<p>(a) If the CMO offers the service through an in-network provider(s), and the member chooses to access the service (i.e., it is not an emergency) from an out-of-network provider, the CMO is not responsible for payment.</p>	<p>Peach State is not responsible for payment with regards to unauthorized, non-emergency services provided by an out-of-network provider.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT.01 Provision of Services by Out of Network/Out of State Non Contracted Providers, pages 1, 2 • Member Handbook, Page(s) 12, 47 • Provider Manual, Page 20, 34, 105 • Policy: GA.UM.21, Second Opinions, Page 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The member handbook summarized that services provided by non-participating providers were not a covered benefit and the member would be responsible for the cost of those services.</p> <p>Required Actions: None.</p>		
<p>(b) If the service is not available from an in-network provider, but the CMO has three (3) documented attempts to contract with the provider, the CMO is not required to pay more than Medicaid fee for service (FFS) rates for the applicable service, less ten percent (10%).</p>	<p>In cases where a patient is scheduled to receive care, receiving care, or has received care at a non-participating provider location and SCA negotiation is attempted with a Provider but contact with a negotiator at the Provider location is unsuccessful after three (3) attempts, the Peach State Contract Negotiator will direct an email to the Peach State Medical Management Representative and indicate that reimbursement shall be at the Peach State Non-Par/GA Medicaid FFS Fee Schedule and/or according to DCH provisions as outlined in the Agreement between Peach State and DCH.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT.02 Single Case Agreement (SCA), Page 5 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>Findings: Peach State provided its Provider Recruitment Committee policy, and it described the attempts to contact providers in order to execute a contract. The policy also described the contacting attempts log as the tracking mechanism the CMO uses to record all attempts. The single case agreement also summarized the contracting attempts and reimbursement rates.</p>		
<p>Required Actions: None.</p>		
<p>(c) If the service is available from an in-network provider, but the service meets the emergency medical condition standard, and the CMO has three (3) documented attempts to contract with the provider, the CMO is not required to pay more than the Medicaid FFS rates for the applicable service, less ten percent (10%).</p> <p><i>(Note: When paying out-of-state providers in an emergency situation, the CMO does not allow members to be held accountable for payment under these circumstances.)</i></p>	<p>In the event services rendered to a member meet the emergency medical condition standard, Peach State’s Contract Negotiator will attempt to complete negotiations with the provider via a single-case agreement (SCA) within 24 hours. However, if the SCA negotiation is attempted with a provider but contact with a negotiator at the provider location is unsuccessful after three (3) attempts, the Peach State Contract Negotiator will direct an email to the Peach State Medical Management Representative and indicate that reimbursement shall be at the Peach State Non-Par/GA Medicaid FFS Fee Schedule and/or according to DCH provisions as outlined in the Agreement between Peach State and DCH.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT.07 Provider Recruitment, Page 3 • Policy: GA.CONT.02 Single Case Agreement (SCA), Page 5 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State provided its Provider Recruitment Committee policy, and it described the attempts to contact providers in order to execute a contract. The policy also described the contracting attempts log as the tracking mechanism the CMO uses to record all attempts. The single case agreement also summarized the contracting attempts and reimbursement rates.</p>		
<p>Required Actions: None.</p>		
<p>(d) If the service is not available from an in-network provider and the member requires the service and is referred for treatment to an out-of-network provider, the payment amount is a matter between the CMO and the out-of-network provider.</p>	<p>It is the policy of Peach State to contract and provide for In Network services to cover all medically necessary covered services to Peach State members. Should Peach State not have a contracted in network provider of the specialty required to provide the medically necessary covered services, the Medical Management Department would authorize such services to an Out of Network/Out of State Non Contracted Provider based on the individuals need.</p> <p>All Out of Network/Out of State Non Contracted Services would require prior</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>authorization by the Peach State Medical Management department prior to the provision of the services (except in an emergency) in order to be eligible for payment. A single–case agreement (SCA) would be negotiated between the Plan and the provider as the payment amount is a matter between the provider and Peach State.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CONT.01 Provision of Services by Out of Network/Out of State Non Contracted Providers, Page 2 • Policy: GA.CONT.02 Single Case Agreement (SCA), Page 2 • Sample: Single Case Agreement 	
<p>Findings: Peach State staff summarized the single case agreement process used when services are not available within the network. The Single Case Agreement indicated that the provider should only look to the CMO for compensation and that providers cannot expect and attempt to obtain compensation from the member.</p>		
<p>Required Actions: None.</p>		
<p>9. Services Not Available In-Network—Cost to Member: <i>42 CFR 438.206(b)(5); Contract 4.8.19.3</i></p> <p>In the event that needed services are not available from an in-network provider and the member must receive services from an out-of-network provider, the CMO ensures that the member is not charged more than it would have if the services were furnished within the network.</p>	<p>PSHP ensures that members are not charged more for out-of-network services when in-network services are not available.</p> <p>Grievances regarding the practitioner balance billing the member are forwarded by Peach State’s Quality Department to its Provider Solutions Department to intervene on the member’s behalf and educate the practitioner.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Member Handbook, Page(s) 47 • Policy: GA.CONT.02 Single Case Agreements (SCA), page 2 • Sample: Single Case Agreement, page 1, section C • Policy: GA.QI.08 Grievance Process, Page 3 	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>
<p>Findings: The member handbook indicated that the member should not receive a bill from providers for medically needed and prior-authorized services. It further instructs members to call member services if they receive a bill and that the CMO would address the bill with the provider.</p>		
<p>Required Actions: None.</p>		



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<p>10. Credentialing: <i>42 CFR 438.206(b)(6); 42 CFR 438.214(b)2; Contract 4.8.1.2; 4.8.15.1</i></p> <p>The CMO ensures that all providers are appropriately credentialed and maintain current licenses by following a documented process and having written policies and procedures for credentialing and recredentialing its in-network providers using standards established by the National Committee for Quality Assurance (NCQA), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or American Accreditation Healthcare Commission/URAC.</p>	<p>Peach State ensures that all providers are appropriately credentialed and maintain current licenses by following a documented process and having written policies and procedures for credentialing and recredentialing its in-network providers using standards established by the National Committee for Quality Assurance (NCQA), Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), or American Accreditation Healthcare Commission (URAC). The Plan also maintains an oversight process for delegates credentialing and recredentialing standards.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.PDAT.05 IPA/PHO Provider Adds/Terminations/Changes, Page(s) 1.A, E • Policy: GA.CRED.03 Credentialing Committee (entire document) • Policy: GA.CRED.01 Credentialing Program Description (entire document) • Policy: GA.CRED.04.02 Primary Source Verification (entire document) • Policy: GA.CRED.07 Practitioner Office Site Review (entire document) • Policy: GA.CRED.12 Organizational Providers (entire document) • Policy: GA.CRED.10 Ongoing Monitoring of Sanctions and Complaints (entire document) • Policy: GA.CRED.11 Practitioner Disciplinary Action and Reporting (entire document) • Policy : GA.CRED.11.02 Appeal Right and Hearing Process (entire document) • Policy: GA.CRED.02 Maintaining Confidentiality of Credentialing Information (entire document) • Policy: GA.CRED.06 Provisional Credentialing (entire document) • Policy: GA.CRED.09 Recredentialing of Practitioners (entire document) 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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	<ul style="list-style-type: none"> • Policy: GA.CRED.05 Practitioners Right to Review and Correct Information (entire document) • Attachment A1 : GA.CRED.05 Right to Review Information(entire document) • Oversight of Delegated Credentialing • Credentialing Committee Member Roster 	
<p>Findings: Peach State staff members described the credentialing and recredentialing process. They further indicated that staff members regularly monitor certification boards for changes in provider status.</p>		
<p>Required Actions: None.</p>		

Standard I—Availability of Services Results						
Met	=	17	X	1.00	=	17.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0		N/A		N/A
Total Applicable	=	17	Total Score	=		100.0%



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Standard II—Furnishing of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>1. Timely Access: <i>42 CFR 438.206(c)(1)</i></p> <p>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:</p>		
<p>(a) Provider Office Hours—Comparable for Medicaid Members: <i>42 CFR 438.206(c)(1)(ii); Contract 4.8.14.1</i></p> <p>The CMO requires that all its network providers offer hours of operation that are no less than the hours of operation offered to commercial and FFS patients and encourages the providers to offer after-hours office care in the evenings and on weekends.</p>	<p>Peach State requires providers to meet Contract standards for timely access to care and services and maintain the same office hours offered to commercial and FFS patients. In addition, the Plan regularly monitors, measures, and analyzes access to the provider network. Peach State also encourages after-hours office care by allowing the provider to use a special add-on CPT code for services provided after normal business hours.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Pages 16, 96, 98 • Contract: PCP Agreement, Attachment A, Section III, EE, Page 26 • Policy: GA.QI.03 Accessibility of Services, (entire document) • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) <p>In addition, Peach State conducts an annual Practitioner and Telephone Access Analysis which includes analysis of data on appointment accessibility, results from an after hours care</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	survey, CAHPS [®] survey results, grievance data and Health Plan telephone access statistics to assess member’s access to practitioners and the Plan. This analysis includes After Hours information. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Practitioner and Telephone Access Analysis, (entire document) 	

Findings: The provider manual indicated that hours of operation offered to Medicaid members must be no less than the hours offered to commercial members.

Required Actions: None.

<p>(b) Provider Appointments—Office Wait Times: <i>Contract 4.8.14.3</i></p> <p>The CMO informs providers and has processes to ensure that wait times for appointments do not exceed the following:</p> <ul style="list-style-type: none"> ◆ 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. 	<p>Peach State monitors appointment access against standards and initiates actions as needed to improve. In addition, PSHP added questions to the annual Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) surveys regarding office wait times. The results are then analyzed and discussed with an internal multidisciplinary team.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Page 17 • Practitioner and Telephone Access Analysis, (entire document) • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
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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



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<p>appointment. Evidence of adequate monitoring of this element was not apparent at the time of the on-site visit.</p> <p>Required Actions: The CMO must develop a monitoring practice to ensure wait times do not exceed the requirements in this element.</p>		
<p>(c) Appointment Wait Times: <i>Contract 4.8.14.2</i></p> <p>The CMO has in its network the capacity to ensure that waiting times for appointments do not exceed the following:</p>	<p>Peach State maintains an adequate network of providers to ensure its members (adult and pediatric) receive timely access to providers for the following services: routine visits, sick visits, specialist visits, dental care, non-emergency hospital stay, mental health services, urgent and emergency care.</p> <p>Peach State also utilizes member grievances files to determine if a member experienced unreasonable wait times in conjunction with conducting quarterly survey calls to provider offices to verify if appointment availability is within the terms of the contract. Moreover, Peach State conducts an annual Practitioner and Telephone Access Analysis which includes analysis of data on appointment accessibility audited against the DCH Standards for PCP Routine, PCP Adult Sick, and Pediatric Sick visit timeliness.</p>	
<p>(i) PCPs (Routine Visits)—14 calendar days</p>	<p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QL.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	
<p>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.</p> <p>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.</p>		
<p>(ii) PCP (Adult Sick Visit)—24 hours</p>	<p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 Provider Manual, Page 17 Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 Report: Timely Access Report Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>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.</p> <p>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.</p>		



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(iii) PCP (Pediatric Sick Visit)—24 hours	Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The provider manual indicated that PCP appointment availability for pediatric sick visits must not exceed 24 hours. The Timely Access Report indicated the CMO met the 90 percent goal for each quarter.		
Required Actions: None.		
(iv) Specialist—30 calendar days	Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf <ul style="list-style-type: none"> • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	
<p>Findings: The provider manual indicated that specialist appointment availability must not exceed 30 calendar days. The Timely Access Report indicated the CMO met the 90 percent goal for each quarter.</p> <p>Required Actions: None.</p>		
(v) Dental Providers (Routine-21 calendar days; Urgent-48 hours)	Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The provider manual indicated that dental appointment availability must not exceed 21 calendar days for routine appointments and 48 hours for urgent appointments. The Timely Access Report indicated the CMO met the 90 percent goal for each quarter.</p> <p>Required Actions: None.</p>		
(vi) Non-emergency Hospital Stays—30 calendar days	Peach State demonstrates this through the following documents as well as monitors/tracks and trends member and provider complaints related to non-emergency hospital stays:	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	
<p>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.</p>		
<p>Required Actions: The CMO must ensure that 90 percent of its non-emergency hospital stays occur within the 30 calendar day goal.</p>		
<p>(vii) Mental Health Providers—14 calendar days</p>	<p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at <a checkbox"="" href="http://www.pshpgeorgia.com/files/2011/12/Peach- </td> <td> <input type="> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A 	



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	State-Fall-Provider-Report-2013.pdf <ul style="list-style-type: none"> • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	
<p>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.</p>		
<p>Required Actions: The CMO must ensure that 90 percent of its mental health providers provide access for an appointment within 14 calendar days.</p>		
(viii) Urgent Care Providers—24 hours	Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The provider manual indicated that urgent care provider appointment availability must not exceed 24 hours. The Timely Access Report showed that the CMO met the 90 percent goal for each quarter of the review period.</p>		
<p>Required Actions: None.</p>		
(ix) Emergency Providers—Immediately (24 hours a day, 7 days a week) and without prior authorization	PSHP maintains an adequate network of providers to ensure its members (adult and pediatric) receive timely access to providers for the following services: routine visits, sick visits,	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	specialist visits, dental care, non-emergency hospital stay, mental health services, urgent and emergency care. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section FF (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 • Policy: GA.QI.03 Evaluation of Access, VI Practitioner and Telephone Access Analysis, Page(s) 2 • Report: Timely Access Report • Document: Fall Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Peach-State-Fall-Provider-Report-2013.pdf) • Document: Spring Newsletter (can be accessed at http://www.pshpgeorgia.com/files/2011/12/Spring-Provider-Report-2014.pdf) 	
Findings: The provider manual indicated that emergency provider services must be rendered immediately and be available 24 hours a day, seven days a week. The Timely Access Report showed that the CMO met the 90 percent goal for each quarter of the review period.		
Required Actions: None.		
<p>(d) Timelines—Visits for Pregnant Women: <i>Contract 4.8.14.5</i></p> <p>The CMO provides adequate capacity for initial visits for pregnant women within 14 calendar days of enrollment into the CMO plan.</p>	<p>Peach State requires participating physicians provide an initial visit for all pregnant Members within fourteen (14) calendar days.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section GG (Compliance with State Medicaid Requirements), Page 23 • Provider Manual, Page 17 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> • Policy: GA.QI.03, Evaluation of the Accessibility of Services, Page 2 • Member Handbook, Page 8 • Report: Timely Access Report Q12011 	
<p>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.</p>		
<p>Required Actions: The CMO must ensure that 90 percent of its providers have availability of visits within 14 days for newly enrolled pregnant women.</p>		
<p>(e) Timelines—Visits for Children Eligible for Health Checks: <i>Contract 4.8.14.5</i></p> <p>The CMO provides adequate capacity to provide initial visits for children eligible for health checks within ninety (90) calendar days of enrollment into the CMO plan.</p>	<p>Peach State requires participating physicians must provide an initial visit for all pregnant Members within fourteen (14) calendar days.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, Section GG (Compliance with State Medicaid Requirements) • Provider Manual, Page 17 • Policy: GA.QI.03, Evaluation of the Accessibility of Services, Page 2 • Member Handbook, Page 23 • Report: Timely Access Report Q12011 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The provider manual indicated that health check visit appointments must occur within 90 calendar days. The Timely Access Report showed that the CMO met the 90 percent goal for each quarter of the review period.</p>		
<p>Required Actions: None.</p>		
<p>(f) Timelines—Returning Calls After-Hours: <i>Contract 4.8.14.4</i></p> <p>The CMO ensures that provider response times for returning calls after-hours do not exceed the following:</p> <ul style="list-style-type: none"> ◆ Urgent Calls—Twenty minutes 	<p>Peach State has written policies to ensure members after-hours calls are returned timely.</p> <p>In addition, Peach State monitors provider telephone response times through the use of custom questions on the annual Adult and Child Consumer Assessment of Healthcare Providers and</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>◆ Other Calls—One hour</p>	<p>Systems (CAHPS[®]) surveys.</p> <p>PSHP demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Page 17 • Policy: GA.QI.03, Evaluation of the Accessibility of Services, Page 2 • Practitioner and Telephone Access Analysis, Page 3 	
<p>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.</p>		
<p>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.</p>		
<p>2. Services Available Twenty-Four/Seven: <i>42 CFR 438.206(c)(1)(iii); Contract 4.6.1.1; 4.6.2.1; 4.9.5.5</i></p> <p>The CMO makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary.</p>	<p>Peach State conducts an annual Practitioner and Telephone Access Analysis. One of the goals referenced for both appointment timeliness and after hours survey is to ensure members have access to medical care 24 hours a day, 7 days a week.</p> <p>Peach State also monitors provider telephone availability through the use of custom questions on the annual Adult and Child Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) surveys. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Practitioner and Telephone Access Analysis, Page(s) 1, 2 <p>Moreover, Peach State has a network that ensures the member will have available medically necessary service 24 hours a day, 7 days a week.</p> <p>Peach State demonstrates this through the following documents:</p>	<p><input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A</p>



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	<ul style="list-style-type: none"> Contract: GA Hospital Contract, Article III, Section 3.1, Page 3 Contract: GA PCP Contract, Article III, Section 3.1, Page 3 Policy: GA.CONT.10, Evaluation of Provider Availability, Page 2 Policy: GA.QI.03, Evaluation of the Accessibility of Services, Page 2 Provider Manual, Pages 22, 31 Member Handbook, Pages 1, 2, 8, 13, 14, 20, 23, 36 	
<p>Findings: Both the provider manual and the member handbook indicated that services were available 24 hours a day, seven days a week when medically necessary.</p> <p>Required Actions: None.</p>		
<p>3. Ensures Compliance: 42 CFR 438.206(c)(1)(iv-v); Contract 4.8.1.11</p> <p>The CMO has mechanisms to monitor and ensure the CMO and its providers comply with the access and timeliness requirements and that members have timely access to quality care.</p>	<p>Peach State monitors timely access of its provider network via quarterly survey calls. The Plan also has in place processes to assist providers who do not meet the requirements.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Report: Timely Access Reports Provider Manual, Page 16 Policy: GA.QI.03, Evaluation of the Accessibility of Services, Page 2 Practitioner and Telephone Access Analysis, (entire document) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO provided its Timely Access Report as evidence that it monitors access and timeliness requirements such that members have timely access to quality care.</p> <p>Required Actions: None.</p>		
<p>4. Takes Corrective Action: 42 CFR 438.206(c)(1)(vi); Contract 4.8.14.6</p>	<p>Peach State conducts on-going Practitioner and Telephone Access Analysis and has put processes in place to audit the</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met



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<p>The CMO takes corrective action if there is a failure to perform in compliance with the timely access requirements.</p>	<p>Plan’s provider network with regards to timely access in an effort to ensure that corrective action plans are carried out by practitioners who fail to meet the access and timeliness requirements.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Practitioner and Telephone Access Analysis, Page(s) 6-9 • Policy: GA.QI.03, Evaluation of the Accessibility of Services, Page(s) 2-3 • Template: Provider Corrective Action Plan Letter • Step-by-Step: Timely Access Requirements 	<p><input type="checkbox"/> N/A</p>
<p>Findings: Peach State staff explained the corrective action process and provided the corrective action plan letter it would send to providers needing corrective action for timely access requirements.</p>		
<p>Required Actions: None.</p>		

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<p>5. Geographic Access: Contract 4.8.13.1</p> <p>The CMO meets the following geographic access standards for all members:</p> <table border="1"> <thead> <tr> <th></th> <th align="center">Urban</th> <th align="center">Rural</th> </tr> </thead> <tbody> <tr> <td align="center">PCPs</td> <td align="center">Two within eight miles</td> <td align="center">Two within 15 miles</td> </tr> <tr> <td align="center">Specialists</td> <td align="center">One within 30 minutes or 30 miles</td> <td align="center">One within 45 minutes or 45 miles</td> </tr> <tr> <td align="center">General Dental Providers</td> <td align="center">One within 30 minutes or 30 miles</td> <td align="center">One within 45 minutes or 45 miles</td> </tr> <tr> <td align="center">Dental Subspecialty Providers</td> <td align="center">One within 30 minutes or 30 miles</td> <td align="center">One within 45 minutes or 45 miles</td> </tr> <tr> <td align="center">Hospitals</td> <td align="center">One within 30 minutes or 30 miles</td> <td align="center">One within 45 minutes or 45 miles</td> </tr> <tr> <td align="center">Mental Health Providers</td> <td align="center">One within 30 minutes or 30 miles</td> <td align="center">One within 45 minutes or 45 miles</td> </tr> <tr> <td align="center">Pharmacies</td> <td align="center">One 24/7 hours a day, seven (7) days a week within 15 minutes or 15 miles</td> <td align="center">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</td> </tr> </tbody> </table>		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	<p>Peach State maintains a network of Providers to adequately meet the care and services needed for our members and ensures that Peach State members have geographical access to providers. The Plan measures this requirement on a quarterly basis by region and provider type. The Plan’s findings based on our measurements are submitted to the Department of Community Health (DCH). In areas where provider types do not exist, Peach State will provide transportation services that allow members to receive care in a neighboring county. Peach State responds to all identified deficiencies via a Corrective Action Preventive Action (CAPA).</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Contract: GA PCP Contract, Attachment A, section IV • Contract: GA SCP Contract, Attachment A, section IV • Policy: GA.CONT.10, Evaluation of Provider Availability, Page 2 • Contract: Single Case Agreement • Report: GeoAccess Report 1st Qtr. 2014 • Report: Q1 2014 GeoAccess CAP Deficiency Reports <p>In addition, Peach State conducts an annual analysis of Practitioner Availability which takes into account geographic location for PCPs and select high volume specialty types.</p> <p>Peach State demonstrates this through the following document:</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
	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																								



Appendix A. State of Georgia
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Standard II—Furnishing of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> Practitioner Availability 2011-2013 (entire document) 	
<p>Findings: The CMO monitored the appropriate geographic access standards, but 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. It was noted the CMO did not meet the requirements in both urban and rural areas in the following provider categories:</p> <ul style="list-style-type: none"> ◆ PCPs ◆ Specialists ◆ General dental providers ◆ Dental subspecialty providers ◆ Mental health providers ◆ Pharmacies 		
<p>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.</p>		
<p>6. Assurances of Adequate Capacity and Services: <i>42 CFR 438.207(a)</i></p> <p>The CMO assures DCH and provides supporting documentation that demonstrates that it has the capacity to serve the expected enrollment in its service area in accordance with DCH's standards for access to care and in accordance with the following requirements:</p>	<p>Peach State monitors and evaluates member access to Primary, Specialty, Behavioral Health Care Practitioners, Hospitals, and telephone access to Member Services.</p>	
<p>(a) Nature of Supporting Documentation: <i>42 CFR 438.207(b)(1-2); Contract; 4.18.6.1; 5.7-8</i></p> <p>The CMO submits documentation to DCH in a format specified by the State to demonstrate that it complies with the following requirements:</p>	<p>Peach State documents are submitted to DCH in a State approved format. The documentation validates our ability to maintain a network of providers to adequately service the needs of the anticipated number of members in the service area.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Report: GeoAccess Report(s) – 1st Qtr. 2014 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State conducted a GeoAccess analysis to verify its geographic access requirements, and the resulting reports were produced in a format acceptable to the State.</p>		
<p>Required Actions: None.</p>		



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Standard II—Furnishing of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
(i) Offers an appropriate range of preventive, primary care, and specialty services that are adequate for the anticipated number of enrollees for the service area.	Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Policy: GA.CONT.10, Evaluation of Provider Availability, Page 2 • Report: GeoAccess Report(s) – 1st Qtr. 2014 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: Peach State’s GeoAccess report provided evidence that the CMO offers an appropriate range of preventive, primary care, and specialty services that were adequate for anticipated membership.		
Required Actions: None.		
(ii) Maintains a network of providers that is sufficient in number, mix, and geographic distribution to meet the needs of the anticipated number of members in the service area.	Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Policy: GA.CONT.10, Evaluation of Provider Availability, Page 2 • Report: GeoAccess Report(s) – 1st Qtr. 2014 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: Peach State’s GeoAccess report provided evidence that the CMO maintains a network of providers sufficient in number, mix, and geographic distribution to meet the needs of the anticipated membership.		
Required Actions: None.		
(b) Timing of Documentation: <i>42 CFR 438.207(c)(1-2); Contract 5.7-8</i> The CMO submits the DCH-required documentation according to the DCH contract requirements, but no less frequently than at any time that there has been either of the following: <ul style="list-style-type: none"> ◆ A significant change (as defined by DCH) in the CMO’s operations that would affect adequate capacity and services including changes in the CMO’s services, benefits, geographic service area, or payments ◆ Enrollment of a new population 	Peach State ensures that DCH required documents are submitted in compliance with contractual, regulatory, and accreditation requirements. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Policy: GA.CONT.10, Evaluation of Provider Availability, Page 2 • Report: GeoAccess Report(s) – 1st Qtr. 2014 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: Peach State’s GeoAccess report provided evidence that the CMO maintains a network of providers sufficient to meet the needs of the anticipated membership.		



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Standard II—Furnishing of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
Required Actions: None.		

Standard II—Furnishing of Services Results						
Met	=	14	X	1.00	=	14.0
Not Met	=	8	X	.00	=	0.0
Not Applicable	=	0	N/A	N/A	=	N/A
Total Applicable	=	22	Total Score	=	=	63.6%



**Appendix A. State of Georgia
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Standard III—Cultural Competence

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>Furnishing of Services—Cultural Considerations: <i>42 CFR 438.206(c)(2)</i></p> <p>The CMO participates in the State’s efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds as demonstrated by the following:</p>		
<p>1. Comprehensive Written Plan: <i>Contract 4.3.9.1</i></p> <p>The CMO has a comprehensive written cultural competency plan that describes how the CMO ensures that services are provided in a culturally competent manner to all members, including those with limited English proficiency.</p>	<p>Peach State Health Plan (“Peach State”) has a comprehensive written Cultural Competency Plan (CCP) that ensures services are provided in a culturally competent manner to all members including those with limited English.</p> <p>Peach State demonstrates this through the following document(s):</p> <ul style="list-style-type: none"> • Cultural Competency 2013 Strategic Plan • Cultural Competency 2014 Strategic Plan – pending DCH approval 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO provided its Cultural Competency 2013 and 2014 Strategic Plans for review. These plans were comprehensive and described how the CMO ensured services were provided in a culturally competent manner. During the staff interview, staff members discussed a provider office that was seeing a high volume of Burmese and Nepalese members, and the CMO staff worked with the interpreter vendor to provide on-site interpreter services on a regular basis.</p>		
<p>Required Actions: None.</p>		
<p>2. Comprehensive Written Plan—Content: <i>Contract 4.3.9.1</i></p> <p>The CMO’s cultural competency plan describes how providers, individuals, and systems within the CMO plan will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes values, affirms and respects the worth of the individual members, and protects and preserves the dignity of each.</p>	<p>Peach State Health Plan (“Peach State”) has developed and maintained a comprehensive Cultural Competency Plan (CCP) that meets the needs of the members and providers we service and that complies with the requirements as outlined in our contract with the Department of Community Health. The Strategic CCP includes goals based on CLAS guidelines, objectives for each goal, measurable actions and activities that can be tracked and monitored via performance indicators, outcomes, and business areas responsible for completing the objectives. The CCP evaluation is based on performance</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	indicators and outcomes. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Cultural Competency 2013 Strategic Plan, Pages 6-28 • Cultural Competency Plan 2013 Evaluation 	
Findings: The Cultural Competency Strategic Plan 2013 indicated that people of all cultures, races, ethnic backgrounds, and religions would be provided services in a culturally competent manner.		
Required Actions: None.		
3. Plan Submitted to DCH: <i>Contract 4.3.9.2</i> The CMO submits its cultural competency plan to DCH for review and approval as updated.	Peach State submits its CCP to DCH for review and approval as updated. Peach State demonstrates this in the following E-Mail: <ul style="list-style-type: none"> • Cultural Competency 2014 Strategic Plan – pending DCH approval 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The CMO provided a copy of an e-mail that included both submission of the Cultural Competency Strategic Plan 2013 to DCH and the approval of the plan from DCH.		
Required Actions: None.		
4. Provides Plan Summary to Providers: <i>Contract 4.3.9.3</i> The CMO provides a summary of its cultural competency plan to its in-network providers, which includes information on how the providers (i) may access the full plan on the CMO’s Web site and (ii) can request a hard copy from the CMO at no charge to the provider.	Peach State provides a summary of the cultural competency plan (CCP) to its in-network providers, which includes information on how the providers may access the full plan and can request a hard copy at no charge to the provider. The information on cultural competency is located in the Provider Manual which is accessible and available to in-network providers on the Plan’s Web site. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Provider Manual – Page(s) 26-27 - Accessible @ www.pshpgeorgia.com • Screen Print of Web site - Information in Provider 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<p>Manual – Page(s) 26-27</p> <ul style="list-style-type: none"> • Cultural Competency Plan accessible at the following link: http://www.pshpgeorgia.com/careers/diversity/cultural-competency/ 	
<p>Findings: The full Cultural Competency plan was available on the Peach State Web site and available to both providers and members.</p>		
<p>Required Actions: None.</p>		
<p>5. Provides Oral Interpretation: <i>42 CFR 438.10(c)(4); Contract 4.3.10.1</i></p> <p>The CMO provides oral translation services of information to any member who speaks any non-English language regardless of whether a member speaks a language that meets the threshold for “prevalent non-English” language.</p>	<p>Peach State provides oral translation services of information to members who speak a non-English language regardless of whether a member speaks a language that meets the threshold for “prevalent non-English” language.</p> <p>Peach State Member Services staff will assist all members in obtaining an interpreter for non-English language regardless of whether a member speaks a language that meets the threshold of a prevalent non-English language.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Description of the Language Services Associates (LSA) program (entire document) • Policy: GA.MBRS.16 – Hearing Impaired/Language Specific Interpreter Services • Policy: GA.MBRS.17 – Telecommunications Device for the Deaf (TDD) Services (entire document) • Language interpretation utilization record • Voiance Usage Guide • LAS – Communication Tool • Voiance YTD Utilization Report • Voiance Program Description 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>Findings: Oral translation services were provided simply by calling a member services representative, who would arrange the services free of charge.</p> <p>Required Actions: None.</p>		
<p>6. Notifies Members—Oral Interpretation: 42 CFR 438.10(c)(5); Contract 4.3.10.1</p> <p>The CMO notifies members of the availability of oral interpretation services and informs them of how to access the services.</p>	<p>Peach State notifies its members of the availability of oral interpretation services through the Plan’s Member Handbook and informs them of how to access the services through the Plan’s Member Services Representative Call Center Script. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Member Service Call Script • Member Handbook is accessible @ the following link: http://www.pshpgeorgia.com/for-members • Member Handbook, Pages 1-2, 59-60 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Information about interpreter and translation services was available on page 1 of the member handbook.</p> <p>Required Actions: None.</p>		
<p>7. Oral Interpretation—Free to Members: 42 CFR 438.10(c)(4); Contract 4.3.10.1</p> <p>The CMO does not charge members for translation services.</p>	<p>Peach State does not charge its members or providers for translation services. Peach State demonstrates this through the following document(s):</p> <ul style="list-style-type: none"> • Member Handbook, Pages- 1-2, 59-60 • Provider Manual, Page 101 • Policy: GA.MBRS.16 Hearing Impaired/Language Specific Interpreter Services (entire document) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Information about interpreter and translation services was available on page 1 of the member handbook. The information included a notice that services are “free of charge.”</p> <p>Required Actions: None.</p>		
<p>8. Written Materials—Alternative Formats: 42 CFR 438.10(d)(1)(ii); Contract 4.3.2.1</p> <p>The CMO makes all written member materials available in alternative formats and in a manner that takes into consideration the member’s</p>	<p>Peach State makes all written member materials 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. Peach State demonstrates this through the following</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
special needs, including those who are visually impaired or have limited reading proficiency.	documents: <ul style="list-style-type: none"> • Member Handbook, Pages – 1-2, 59-60 • Provider Manual, Page 107 • Policy: GA.MBRS.16 Hearing Impaired/Language Specific Interpreter Services (entire document) • Policy: GA.MBRS.17 Telecommunications Device for the Deaf (TDD) Services (entire document) • Policy: GA.QI.42 Administrative Reviews (page 7) 	
Findings: The member handbook indicated that written materials were available in alternate formats taking into consideration any special needs. Required Actions: None.		
9. Informs Members—Alternative Formats: 42 CFR 438.10(d)(2); Contract 4.3.2.1 The CMO notifies all members and potential members that information is available in alternative formats and how to access those formats.	Peach State notifies all members and potential members that information is available in alternative formats and how to access those formats in the Member Handbook and via the website. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Member Handbook, Pages 1-2, 59-60 • Website screen shot – Informing members of alternative formats • Policy: GA.MBRS.16 Hearing Impaired/Language Specific Interpreter Services (entire document) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: The member handbook indicated that members could obtain materials in alternate formats as needed and how to obtain them. Required Actions: None.		
10. Written Materials—Available Languages: 42 CFR 438.10(c)(3); Contract 4.3.2.2 The CMO makes all written information available in English, Spanish, and all other prevalent non-English languages, as defined by DCH (i.e., a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State).	Peach State makes all written member material available in English and Spanish. The Plan’s Spanish translation of the Member Handbook begins on page 60. The current prevalent non-English language spoken is Spanish Peach State demonstrates this in the following documents: <ul style="list-style-type: none"> • Member Handbook, Pages 56-118 • Policy: GA.MRKT.01 Distribution of Written 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	Information to Providers and Members (entire document) <ul style="list-style-type: none"> Report: Voiance YTD Utilization Report 	
Findings: Peach State provides written materials in English and Spanish. No other prevalent non-English languages are spoken; however, materials would be made available in whatever non-English language as needed.		
Required Actions: None.		
11. Written Materials—Language Block: <i>Contract 4.3.2.3</i> All written materials the CMO distributes to members 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 CMO to request the document in an alternative language or to have it orally translated.	Peach State prints all member material in English and Spanish as well as uses the language block on any member materials printed only in English to inform the member that the document contains important information and directs the member to call Peach State to request the document in an alternative language or to have it orally translated. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> Member Handbook, Page 1& 2 Policy: GA.QI.42 Administrative Reviews (page 7) Example: EPSDT Brochure - English Example: EPSDT Brochure - Spanish 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
Findings: Peach State provided its member handbook for review. Pages 1–63 are in English and pages 64–131 are in Spanish. The CMO also provided Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) brochures in both English and Spanish.		
Required Actions: None.		
12. Written Materials—Understandable: <i>42 CFR 438.10(b)(i); Contract 4.3.2.4</i> The CMO has and follows processes to ensure that its written member materials are worded such that they are understandable to a person who reads at the fifth (5th) grade level.	Peach State’s policies ensure that its written member materials are worded such that they are understandable to a person who reads at the fifth (5th) grade level. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> Policy: GA.MRKT.03 Determining Literacy Level of Member Materials (entire document) Policy: GA.MRKT.01 Distribution of Written Information to Providers and Members 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> Example: Sample: 5th Grade Letter - New Seventh Grade 	
<p>Findings: Peach State uses the Flesch-Kinkaid test to verify the fifth-grade readability level of its written member materials.</p> <p>Required Actions: None.</p>		
<p>13. Medicaid Members Not Segregated: <i>Contract 4.8.16.1</i></p> <p>The CMO ensures that all in-network providers (i) accept members for treatment, unless they have a full panel and are accepting no new GF or commercial patients and (ii) do not intentionally segregate members in any way from other persons receiving services.</p>	<p>Peach State prohibits its in-network providers from intentionally segregating members from the treatment and covered services provided to other non-Medicaid members and prohibits them from refusing to treat members as long as the physician has not reached their requested panel size.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Provider Manual, Page 21 Contract: Primary Care Physician Provider Agreement Article III, 3.6, Attachment A, BB 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The provider manual indicated that Peach State prohibits all providers from intentionally segregating members from fair treatment and covered services provided to other non-Medicaid members. The CMO monitors this through its grievance process and confirmed they receive very few segregation-related grievances.</p> <p>Required Actions: None.</p>		
<p>14. Nondiscrimination: <i>42 CFR 438.6(d)(iv); 42 CFR 438.100(d); Contract 4.8.16.2</i></p> <p>The CMO ensures that members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.</p>	<p>Peach State ensures that members are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability. Its provider-written agreements for both PCPs and specialists include a provision stating that providers cannot:</p> <ul style="list-style-type: none"> Discriminate in the rendering of covered services under the agreement against individuals on the basis of race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, physical or mental disability, type of HMO or payer, or need 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>for health care services.</p> <ul style="list-style-type: none"> • Use any policy or practice that has the effect of discriminating based on the above member characteristics. <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Contract: Primary Care Physician Provider Agreement Article III, 3.13, Attachment A, AA and BB • Provider Manual, Page 21 • Member Handbook, Page 42 	
<p>Findings: The provider manual indicated that services must be provided without regard to race, color, national origin, sex, age, disability, political beliefs, religion, sexual preference, health status, marital status, or income. The CMO monitors this through its grievance process.</p>		
<p>Required Actions: None.</p>		

Standard III—Cultural Competence Results						
Met	=	14	X	1.00	=	14.0
Not Met	=	0	X	.00	=	0.0
Not Applicable	=	0		N/A		N/A
Total Applicable	=	14	Total Score	=	100.0%	



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Standard IV—Coordination and Continuity of Care

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>1. CMO Responsibilities: <i>42 CFR 438.208(b); Contract 4.11.8.1–2</i></p> <p>The CMO assumes responsibility for care coordination that is designed to ensure and promote timely access to care/services, continuity of care, and coordination/integration of care.</p>	<p>Peach State assumes responsibility for care coordination that is designed to ensure and promote timely access to care/services, continuity of care, and coordination/integration of care. Peach State focuses on early identification of members with a complex severe illness which require intensive management and extensive amounts of resources in order to regain optimal health or improved functionality.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, Pages 9, 14,17 • Policy: GA.CM.08 Care Coordination / Case Management Services, Pages 1 • Provider Manual, Pages 42-43 • Policy: Transition of Care-Entire document • 2014 UM Program Description, Page 23 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State used clinical and non-clinical staff members to conduct care coordination activities to promote timely access to care and services, continuity of care, and coordination/integration of care.</p>		
<p>Required Actions: None.</p>		
<p>2. Policies and Procedures: <i>42 CFR 438.208(b); Contract 4.11.8.3</i></p> <p>The CMO has policies and procedures designed to accommodate the specific cultural and linguistic needs of its members and include, at a minimum:</p> <ul style="list-style-type: none"> ◆ Provision of an individual needs assessment and diagnostic assessment; development of an individual treatment plan, as necessary, based on the needs assessment; establishment of treatment objectives; monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary. 	<p>Peach State has policies and procedures to accommodate the specific cultural and linguistic needs of its members. Peach State ensures an individual needs assessment and diagnostic assessment is completed for its members. Based on the results of the assessment a treatment plan is developed and outcomes are monitored to ensure the treatment plan is revised as necessary. Peach State also takes steps to ensure that all members and/or authorized family members or guardians are involved in the treatment process. Peach State has</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<ul style="list-style-type: none"> ◆ A strategy to ensure that all members and/or authorized family members or guardians are involved in treatment planning. ◆ Procedures and criteria for making referrals to specialists and sub-specialists. ◆ Procedures and criteria for maintaining care plans and referral services when the member changes PCPs. ◆ Capacity to implement, when indicated, case management functions such as individual needs assessments, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of the treatment plans. 	<p>procedures for specialist/sub-specialist referrals, maintaining care plans and establishing treatment plans.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, Pages 11-12, 14-17 • Policy: GA.CM.08 Care Coordination / Case Management Services Pages 1-2, 9-19 • Sample Assessment Tool • Sample Care Plan Tool • Provider Manual, Page 42-45 	
<p>Findings: Peach State presented a comprehensive assessment process that addresses members’ physical and behavioral health, psychosocial, cultural, and linguistic needs. The assessment process included the member, family/caregivers, and the member’s provider(s) and was used to develop individual treatment plan goals and objectives that are measurable, realistic, and obtainable for the member.</p>		
<p>Required Actions: None.</p>		
<p>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</p> <p>The CMO:</p> <ul style="list-style-type: none"> ◆ 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. 	<p>Peach State has written policies and procedures on how a member selects a PCP. Peach State ensures the member has ongoing source of primary care appropriate to his/her needs.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.MBRS 38 PCP Selection and Change-P4HB (entire document) • Policy: GA.MBRS 38 PCP Selection and Change-Medicaid (entire document) • Policy: GA.CM 08 Case Management Care Coordination Policy, Page 1 • Member Handbook, Pages 6-7 • Provider Manual, Pages 6 	<p> <input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>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 are not congruent. The policy states that the member can switch PCPs every 30 days within the first 90 days of enrollment and every 6 months thereafter. However, staff reported that the member was allowed to change PCPs at any time.</p> <p>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.</p>		
<p>4. PCP Responsibility for Coordinating Care: <i>42 CFR 438.208(b)(1); Contract 4.8.2.5</i></p> <p>The CMO ensures that the primary care providers fulfill their responsibilities for:</p> <ul style="list-style-type: none"> ◆ Supervising, coordinating, and providing all primary care to each assigned member. ◆ Coordinating and/or initiating referrals for specialty care (both in and out of network). ◆ Maintaining continuity of care. ◆ Maintaining member medical records, which includes documenting all services provided by the PCP as well as the specialty services. 	<p>Peach State ensures the PCP is informed of their responsibilities for supervising, coordinating and providing primary care, referring members for specialty care, maintaining continuity of care and documenting all services provided by the PCP as well as the specialty services.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.CM 08 Case Management Care Coordination Policy, Pages 2, 11, 17- • Policy: GA.CONT.02 Single Case Agreement (SCA(entire document)) • Sample: Single Case Agreement • Provider Manual, Pages 6-7, 29-30 • Member Handbook, Page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>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. Peach State provides education and monitoring of providers through monthly site visits by the provider relations department, the provision of the provider manual, and the welcome packet sent to new providers.</p> <p>Required Actions: None.</p>		
<p>5. Coordination and Transition Across Providers/Settings, Including Other CMOs, PIHPs, PAHPs: <i>42 CFR 438.208(b)(2); Contract 4.8.17.1; 4.11.4.1</i></p> <p>The CMO's care coordination system includes:</p>		



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<p>(a) Advocating for and linking or transitioning members to services as necessary across providers and settings, including, as applicable, other CMOs, PIHPs, PAHPs, and Fee-for-Service providers.</p>	<p>Peach State has processes in place to advocate for and link or transition members to services as necessary across providers and settings. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.16 Transition of Care (entire document) • Policy: GA.CM 08 Case Management Care Coordination Policy, Pages 11, 15, 17 • Policy: GA.CONT.02 Single Case Agreement (SCA) (entire document) • Sample of SCA • Provider Manual, Pages 6, 19, 21-22 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State provided information during the on-site audit outlining review procedures that ensure members have the coverage necessary for care. Case managers work with members to address all physical, mental health, and psychosocial needs. Members are linked, as needed, to other services (e.g., completing a Supplemental Security Income [SSI] application, the Georgia Pediatric Program (GAPP), as well as reviewing members who have transitioned into foster care).</p>		
<p>Required Actions: None.</p>		
<p>(b) Coordinating the member care with these other entities.</p>	<p>Peach State ensures the member’s care is coordinated with other entities. Peach State demonstrates this through the following document:</p> <ul style="list-style-type: none"> • Policy: GA.UM.16 Transition of Care (entire document) • Policy: GA.CM 08 Case Management Care Coordination, Pages 11, 15, 17 • Provider Manual, Pages 6, 19, 21-22 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State provided documentation of and reported during the on-site interviews standard procedures for coordinating member care. Case managers work with the member’s PCP and community organizations to facilitate referrals and follow up to ensure receipt of referrals.</p>		
<p>Required Actions: None.</p>		



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<p>6. Coordinates and Shares Information With Other Organizations Serving the Member (e.g., CMOs, PIHPs, and PAHPS, Education, etc.): <i>42 CFR 438.208(b)(3); Contract 4.8.17.1–5</i></p> <p>The CMO coordinates and shares information with:</p> <ul style="list-style-type: none"> ◆ All divisions within DCH, as well as with other State agencies, and with other health plans operating within the same service region. ◆ Local education agencies in the referral and provision of children’s intervention services provided through the school to ensure medical necessity and prevent duplication of services. ◆ The services furnished to its members with the service the member receives outside the CMO plan, including services received through any other managed care entity. ◆ Non-Emergency Transportation (NET) Providers. ◆ Ideally, with CMO-contracted providers of essential community services who would normally contract with the State as well as other public agencies and with non-profit organizations that have maintained a historical base in the community. 	<p>Peach State coordinates and shares information with all divisions within DCH, state agencies, other CMOs, local education agencies, NET providers, and community organizations to ensure members receive adequate services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, Page 6 • Policy: GA.CM 08 Case Management Care Coordination Policy, Pages 12-13 • Policy: GA.UM.16 Transition of Care (entire document) • Sample: Foster Care Transition of Care Form • Provider Manual, Pages 26, 60-61 • Member Manual, Page 21-22 • 2014 UM Program Description, Page 6 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The communication with outside agencies was fairly robust. Peach State used a network of children’s intervention services providers and had a process in place to ensure there was no duplication of services.</p>		
<p>Required Actions: None.</p>		
<p>7. Protects Member Privacy: <i>45 CFR 160 and 164, subparts A and E; Contract 4.8.17.6</i></p> <p>The CMO implements procedures to ensure that in the process of coordinating care, each Member’s privacy is protected consistent with the confidentiality requirements.</p>	<p>Peach State ensures the member’s privacy is protected consistent with the confidentiality requirements when coordinating the member’s care. All Peach State staff is required to complete a mandatory confidentiality training at least annually. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, Pages 6-7 • Policy: GA.CM.08 Care Coordination / Case Management Services, Page 2 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> • Member Handbook, Pages 55-56 • Provider Manual, Pages 29, 22-23, 30 	
<p>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 it was questioned if the case manager speaks directly to pregnant minors. Staff indicated they would not speak to pregnant minors without parent/guardian consent.</p>		
<p>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.</p>		
<p>8. Care Coordination Functions: <i>Contract 4.11.8.1</i></p> <p>In addition to the above requirements, the CMO’s care coordination system includes the following related and additional functions:</p> <ul style="list-style-type: none"> ◆ Case Management ◆ Disease Management ◆ Transition of Care ◆ Discharge Planning 	<p>Peach State has policies and procedures for its care coordination system to include, case management, disease management, transition of care and discharge planning. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, Page 12 • Policy: GA.CM.08 Care Coordination / Case Management Services, Pages 1-2 • Policy: GA.UM.16 Transition of Care (entire document) • Policy: GA.UM.32 Continued Stay and Discharge Planning, Page 1 • Provider Manual, Pages 42-47 • GA DM 06 Sickle Cell Disease (entire document) • Asthma Program Description (entire document) • Diabetes Program Description (entire document) 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>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.</p> <p>Required Actions: The CMO must ensure that there is a discharge process in place for members transitioning between care settings.</p>		
<p>9. Case Management—Components: <i>Contract 4.11.9.1-2</i></p> <p>The CMO’s case management system emphasizes prevention, continuity of care, and coordination of care and includes the following:</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description (entire document) • Policy: GA.CM.08 Care Coordination / Case Management Services (entire document) • Sample: Complex Assessment Form • Sample: HROB Assessment Form • Sample: Care Plan 	
<p>(a) Early identification of members who have or may have special needs.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> Document: Health Risk Assessment Document: HROB Assessment Form Example: Care Plan 	
<p>Findings: Peach State demonstrated compliance through the CMO’s use of predictive modeling (Impact Pro) to identify members with special needs and the use of the health risk assessment (HRA). Case selection and assignment was prioritized by members assigned a PCP and identified with a risk score above 4.65.</p> <p>Required Actions: None.</p>		
<p>(b) Assessment of member’s risk factors.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Document: Health Risk Assessment Document: HROB Assessment Form Example: Care Plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State staff reported during the on-site interview that the HRA was available for all members to complete, and that members are encouraged to complete the HRA, but completing it was not mandatory. The case management team will also reach out telephonically to the members identified for case management to complete a general screening to determine the member’s needs.</p> <p>Required Actions: None.</p>		
<p>(c) Development of a care plan.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<p>documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Document: Health Risk Assessment • Document: HROB Assessment Form • Example: Care Plan 	
<p>Findings: A member’s care plan addresses the member’s physical, social, and behavioral health issues that have been 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.</p>		
<p>Required Actions: The CMO should incorporate provider, family, caregiver, or guardian input into the development of the care plan.</p>		
<p>(d) Referrals and assistance to ensure timely access to providers.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Document: Health Risk Assessment • Document: HROB Assessment Form • Example: Care Plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State reported during the on-site audit that members do not need prior authorization for in-network providers, but they do for out-of-network providers. Members are also encouraged to contact their PCP for a referral to an in-network provider, but this was not mandatory. A member may self-refer to a specialist without seeing his or her PCP first.</p>		
<p>Required Actions: None.</p>		
<p>(e) Coordination of care actively linking the member to providers, medical services, residential, social and other support services where needed.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Document: Health Risk Assessment • Document: HROB Assessment Form • Example: Care Plan 	
<p>Findings: Peach State reported during the on-site audit that case managers are responsible for making clinical referrals to ensure timely access, and non-clinical staff can arrange for referrals to community resources. Team members facilitate timely coordination of services though pre-certification of services if necessary, and follow up to ensure services were both provided and effective.</p> <p>Required Actions: None.</p>		
(f) Monitoring.	Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Document: Health Risk Assessment • Document: HROB Assessment Form • Example: Care Plan 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State provided documentation that showed a formalized monitoring process. The case file review showed that the contact 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.</p> <p>Required Actions: Case managers need to complete medication reconciliation with all members in case management. This includes creating the most accurate</p>		



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<p>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.</p>		
<p>(g) Continuity of care.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Document: Health Risk Assessment • Document: HROB Assessment Form • Example: Care Plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State reported during the on-site audit that the CMO ensures member continuity of care despite a practitioner’s discontinuation of its contract with the CMO. For members who are actively receiving a course of treatment for an acute episode of chronic illness or acute behavioral health conditions, the CMO will continue treatment with the provider for up to 90 days, or through the postpartum period for members in the second or third trimester of pregnancy.</p>		
<p>Required Actions: None.</p>		
<p>(h) Follow-up.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Document: Health Risk Assessment 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> • Document: HROB Assessment Form • Example: Care Plan 	
<p>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.</p>		
<p>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.</p>		
<p>(i) Documentation.</p>	<p>Peach State has policies and procedures in place to ensure case managers provide early identification of members who have or may have special needs, perform necessary assessments of member’s risk factors, develop treatment plans, develop care plans, facilitate referrals, and provide care coordination with providers and other organizations to include monitoring, follow up and documentation.</p> <p>Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Document: Health Risk Assessment • Document: HROB Assessment Form • Example: Care Plan 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: Peach State provided examples of documentation completed in the clinical documentation system. During the case management file review, it was noted that this documentation provides a concise demonstration of interventions, education, and referrals being completed for members. The documentation also provided demonstration of provider outreach for continuity of care purposes.</p>		
<p>Required Actions: None.</p>		
<p>10. Case Management—Identify Members With the Greatest Need: 42 CFR 438.208(c); Contract 4.11.9.3</p>	<p>Peach State focuses on early identification of members with a complex severe illness which require intensive management and extensive amounts of resources in order to regain optimal health or improved functionality.</p>	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>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.</p>	<p>Peach State ensures high risk, catastrophic, pregnant women under 21, high risk pregnancy, and infants and toddlers are identified early. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, (entire document) • Policy: GA.CM.08 Care Coordination / Case Management Services, Pages 3-6, 24-25 • Reference: GA.CM.8 Automatic Referral List, Attachment A (entire document) • Policy: GA.CM.07 Start Smart for Your Baby (entire document) • Member Handbook, Pages 19-27 • Provider Handbook, Pages 38-43 	
<p>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.</p>		
<p>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.</p>		
<p>11. Disease Management: <i>Contract 4.11.10.1-3</i></p> <p>The CMO has disease management programs for individuals with chronic conditions that include, at a minimum:</p> <ul style="list-style-type: none"> ◆ Programs for members with diabetes and members with asthma ◆ Two additional programs from among the following: perinatal case management, obesity, hypertension, sickle-cell disease, or HIV/AIDS. 	<p>Peach State has disease management programs to help manage members with asthma, HIV/AIDS, diabetes, and sickle cell. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • GA DM 06 Sickle Cell Disease (entire document) • Asthma Program Description (entire document) • Diabetes Program Description (entire document) • Policy: GA.CM.08 Care Coordination / Case Management Services, Pages 23-24 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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	<ul style="list-style-type: none"> • Policy: GA_CM 07_Start Smart Perinatal Mgmt. Program Overview (entire document) • Member Handbook, Pages 19-27 • Provider Handbook, Pages 38-43 	

Findings: Peach State had a disease management program with an effective referral method. Peach State had disease management programs for diabetes and asthma as well as additional programs to meet DCH contract requirements.

Required Actions: None.

<p>12. Discharge Planning: Contract 4.11.11</p> <p>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.</p>	<p>Peach State ensures a member has a formalized discharge planning program that includes a comprehensive evaluation of the member’s health needs and identification of services to facilitate an appropriate discharge from an institutional clinical setting. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 CM Program Description, page 9 • 2014 UM Program Description, Pages 4, 22-23 • Policy: GA.UM.32 Continued Stay and Discharge Planning, Page 1 • Policy: GA.UM.08 Care Coordination Policy 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
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Findings: While Peach State provided documentation that showed a formalized discharge planning process, during the case management file review it was noted that no discharge plans were completed, communicated to the case manager, or documented by the case manager. 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 for members enrolled in case management.

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



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Met	=	13	X	1.00	= 13.0
Not Met	=	8	X	.00	= 0.0
Not Applicable	=	0		N/A	N/A
Total Applicable	=	21	Total Score	=	61.9%



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Standard V—Coverage and Authorization of Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>1. Comparable Coverage: 42 CFR 438.210(a)(2); 42 CFR 440.230; Contract 4.5.1.1</p> <p>The CMO provides to members DCH-contracted medically necessary services in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services to beneficiaries under fee-for-service Medicaid.</p>	<p>Peach State provides medically necessary services to its members in an amount, duration, and scope that are no less than the amount, duration, and scope for the same services to beneficiaries under fee-for-service Medicaid. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.18 Covered Benefits and Services, Page 1 • Member Handbook- Pages 9-11, 13, 72-75, 77 • Provider Manual, Pages 56-58 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The provided documentation demonstrated written compliance with the provision of medically necessary services equal to or above the fee-for-service benefits. Interview with staff was consistent with the documentation.</p> <p>Required Actions: None.</p>		
<p>2. Sufficiency of Services: 42 CFR 438.210(a)(3)(i); Contract 4.5.4.1</p> <p>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.</p>	<p>Peach State 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. Peach State utilizes Interqual criteria and medically necessary criteria to make authorization decisions. Interdisciplinary team rounds are held two times a week with a physician to ensure that members receive the appropriate amount, duration, and scope of services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.18 Covered Benefits and Services, Page 1-4 • Member Handbook, Pages 9-11, 13, 72-75, 77 • 2014 UM Program Description, Pages 15-17 • 2014 CM Program Description, Page 9 • GA.UM.02 Clinical Decision Criteria Page 1, 3-4 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
	<ul style="list-style-type: none"> Interdisciplinary Rounds Sign-In Sheet 	
<p>Findings: The Covered Benefits and Services Policy was compliant with defining the overall covered benefits and services. The UM Program Description outlines 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.</p> <p>Required Actions: The CMO should re-visit this practice to establish guidelines related to benefit limitations versus the need for medical necessity review for persons 21 years of age and older.</p>		
<p>3. Prohibited Reasons for CMO Decisions: <i>42 CFR 438.210(a)(3)(ii); Contract 4.5.1.1</i></p> <p>The CMO does not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the member.</p>	<p>Peach State does not deny or reduce services based on diagnosis, type of illness, or condition. Peach State utilizes Interqual criteria and medically necessary criteria to make authorization decisions. Only Medical Directors can deny services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Policy: GA.UM.18 Covered Benefits and Services, Page 1 2014 UM Program Description, Pages 15-17 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The Covered Benefits and Services Policy and UM Program Description provided written documentation of compliance with the element. During an interview with the medical director and UM staff, there was confirmation of this practice.</p> <p>Required Actions: None.</p>		
<p>4. Decisions Based on Medical Necessity: <i>42 CFR 438.210(a)(3)(i-iii); Contract 1.4; 4.5.1.1; 4.5.4.1-3; 4.11.1.1</i></p> <p>The CMO provides all medically necessary services that meet the criteria as defined by DCH in its definition of “medical necessity” included in its contract with the CMO.</p>	<p>Peach State and its delegated vendors (as applicable) use clinical support criteria to evaluate medical necessity. Peach State provides medically necessary services prescribed based on generally accepted medical practices and in accordance with the DCH contract requirements. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> 2014 UM Program Description, Page 15-16 Policy: GA.UM.02 Clinical Decision Criteria, Pages 1-4 Provider Manual, Pages 30-31 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> Member Handbook, Pages 13 Policy: UM.15 Oversight of Delegated Vendor (entire document) Delegated Vendor Audit Tool Interdisciplinary Rounds Sign-In Sheet 	
<p>Findings: The provided documents demonstrated written compliance with the element. Review of the denial files supported the appropriate medical necessity review in practice.</p>		
<p>Required Actions: None.</p>		
<p>5. Written Policies and Procedures: <i>42 CFR 438.210(b)(1); Contract 4.11.1.1</i></p> <p>The CMO has and follows written utilization management policies and procedures that include protocols and criteria for evaluating medical necessity and authorizing initial and continuing services.</p>	<p>Peach State follows written utilization management policies and procedures for evaluating medical necessity and authorizing initial and continuing services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Policy: GA.UM.18 Covered Benefits and Services (entire document) Policy: GA.UM.04 Appropriate UM Professionals (entire document) Policy: GA.UM.02 Clinical Decision Criteria, (entire document) Policy: GA.UM.20 Prior Authorization, Pre Certification and Notification, (entire document) Policy: GA.UM.32 Continued Stay and Discharge Planning, (entire document) Report: 2013 IRR Results, (entire document) Policy: GA.UM.06 Clinical Information and Documentation (entire document) Provider Manual, Pages 35-37 Affirmation Statement, Staff Sign-in Sheet, Staff Meeting Minutes 3-28-14 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>Findings: The documentation provided for written confirmation of compliance with the elements and outlined the criteria used for medical necessity determinations. The denial file review evidenced criteria citations in the decision-making process for determination of medical necessity.</p> <p>Required Actions: None.</p>		
<p>6. Written Policies and Procedures—Authorizations and Reviews: <i>42 CFR 438.210(b)(1); Contract 4.11.1.1</i></p> <p>The CMO’s written policies and procedures address which services require prior authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective, or prospective review.</p>	<p>Peach State has written policies and procedures for which services require prior authorization and how requests for initial and continuing services are provided in addition to which services will be subject to concurrent, retrospective, or prospective review. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 UM Program Description, Pages 8, 12, 21-24 • Policy: GA.UM.20 Prior Authorization, Pre-Certification and Notification, (entire document) • Policy: GA.UM.06 Clinical Information and Documentation (entire document) • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications (entire document) • Prior Authorization Prescreen Tool accessible at http://www.pshpgeorgia.com/for-providers/pre-auth-needed/medicaid-pre-auth-needed/ • Peach State Prior Authorization Guide accessible at http://www.pshpgeorgia.com/files/2009/09/PS_HP-GA_MedicaidPriorAuthorization_20130702.pdf • Provider Manual, Pages 32-34 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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<p>Findings: The written documentation and staff interviews demonstrated compliance with the element. The denial file review did not demonstrate prior authorization requirements that were more stringent or in conflict with the outlined prior authorization expectations.</p> <p>Required Actions: None.</p>		
<p>7. Authorization of Services—Consistent Application of Review Criteria: <i>42 CFR 438.210(b)(2)(i); Contract 4.11.1.1</i></p> <p>The CMO has mechanisms to ensure consistent application of review criteria.</p>	<p>Peach State utilizes a consistent application of review criteria. All staff that performs medical necessity reviews is required to pass an annual Interrater Reliability test to evaluate consistency in review criteria. Weekly audits are conducted to ensure staff is consistent with the review criteria. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.02 Clinical Decision Criteria (Entire Document) • Report: 2013 IRR Results • Department Procedure: Audit of UM Nurses • Medical Review Criteria Training June 2013 • Provider Manual, Page 37 • Member Handbook, Pages 13, 77 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation demonstrated compliance with the measurement of interrater reliability for all necessary staff, inclusive of the medical director’s team. After recent training had been accomplished, there was evidence that management had completed additional nurse staff audits to ensure staff understood any new criteria.</p> <p>Required Actions: None.</p>		
<p>8. Authorization of Services—Consults With Requesting Physician: <i>42 CFR 438.210(b)(2)(ii); Contract 4.11.2.6</i></p> <p>The CMO’s policies and procedures include consulting with the requesting physician when appropriate.</p>	<p>Peach State’s policies and procedures include consulting with the requesting physician when appropriate to facilitate authorization of services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.QI.41 Adverse Determination (Denial) Notices, Pages 2-3, 10-11 • Policy: GA.UM.02 Clinical Decision Criteria Page 2,4 • Provider Manual, Page 37 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>Findings: The written documentation demonstrated compliance with this element. During the file review and in discussion with the medical director, there was evidence of peer-to-peer discussion. A case decision was not rendered until the medical director had discussion with the requesting provider to ensure understanding of the need. Additionally, peer-to-peer discussion was evident post decision on another case reviewed. Peer-to-peer discussion was afforded for five days post the decision for reconsideration of a denial.</p>		
<p>Required Actions: None.</p>		
<p>9. Required Clinical Expertise: <i>42 CFR 438.210(b)(3); Contract 4.11.2.4; 4.14.3.1</i></p> <p>The CMO ensures that:</p> <ul style="list-style-type: none"> ◆ Prior authorization and pre-certification is conducted by a currently licensed, registered, or certified health care professional who is appropriately trained in the principles, procedures, and standards of utilization review. ◆ All proposed actions (i.e., any decision to deny a service authorization request or to authorize a service in an amount, duration, or scope that is less than requested) are made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the member’s condition or disease. 	<p>Prior authorization and precertification is conducted by licensed health professionals. Peach State ensures that a currently licensed physician, dentist, or other peer review consultant with appropriate training and clinical expertise in treating the condition reviews the request and determines proposed actions. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> ● 2014 UM Program Description, Pages 9-12 ● Policy: GA.UM.04 Appropriate UM Professionals, (entire document) ● Policy: GA.UM.02 Clinical Decision Criteria Page 3 -4 ● Provider Manual, Page 37 ● Medical Review Criteria Training June 2013 ● Job Description: Licensed Staff (Medical Director & Case Manager) ● Board Certified Consultant List 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The denial file reviews evidenced appropriate health care professionals rendering denial decisions. Specialists appropriately reviewed and rendered decisions for services such as dental, pharmacy, complex radiology, and behavioral health requests.</p>		
<p>Required Actions: None.</p>		
<p>10. Utilization Management (UM) Committee: <i>Contract 4.11.1.3</i></p> <p>The CMO has a utilization management committee comprised of network providers within each service area (which could be one committee if each</p>	<p>Peach State’s Utilization Management Committee includes Peach State Staff and network providers within each service area. The UM Committee is chaired by the Medical Director and the committee reports up through the Quality Improvement Council (QIC) and ultimately</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>service area is represented on the committee) that is accountable to the Medical Director and governing body of the CMO.</p>	<p>to the Peach State Board of Directors. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 UM Program Description, Pages 6-8 • UMC Charter • 2013 QI Committee Org Chart • UMC Minutes 11-13-13 • UMC Minutes 9-18-13 • Document: UM Committee Members by Region 	
<p>Findings: The written documents demonstrated compliance with the element. There was evidence of robust minutes for the committee meetings with the medical director presiding. In addition the QIC minutes were reviewed to ensure appropriate upward reporting and oversight.</p>		
<p>Required Actions: None.</p>		
<p>11. UM Committee Meetings and Records: <i>Contract 4.11.1.3</i></p> <p>The CMO’s UM committee(s) meets on a regular basis and maintains records of activities, findings, recommendations, and actions.</p>	<p>Peach State maintains evidence for the Utilization Management Committee through meeting minutes. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 UM Program Description, Page 6-8 • 2013 UMC Calendar • UMC Minutes 11-13-13 • UMC Minutes 9-18-13 • Quality Improvement Council Meeting – Medicaid: April 2, 2014 • Quality Improvement Council Meeting - Medicaid: June 4, 2014 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>
<p>Findings: The written documentation demonstrated compliance with the element. Additional meeting agendas and minutes were reviewed to ensure meetings were continued on a regular basis throughout the review period, including Quality Improvement Council meeting minutes from April and June 2014.</p>		
<p>Required Actions: None.</p>		



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<p>12. Timelines—Standard Authorization Decisions and Notifications: <i>42 CFR 438.210(d)(1); Contract 4.11.2.5.1; 4.14.3.4.5</i></p> <p>The CMO makes prior authorization decisions and provides notice to the provider and member for non-urgent services as expeditiously as the member’s health care condition requires and within 14 calendar days of receipt of the request for service.</p>	<p>Peach State makes prior authorization decisions and sends notification to the provider and member within fourteen (14) calendar days following the receipt of the requests and/or as expeditiously as the member’s health condition requires. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 2 • 2014 UM Program Description, Page 21 • Provider Manual, Pages 32 • Member Handbook, Pages 13, 77 • Report: Q1 2014 Turn Around Time Report • Prior Auth Aging Log Sample • Denial Case File #6 Time Stamp 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation demonstrated compliance with the element. The denial file reviews were compliant with the required standard turnaround time of 14 days. A sample of the Prior Auth Aging Log was reviewed during the on-site visit, to ensure ongoing monitoring and oversight for timely review of service requests. Additionally, the time stamp for the denial file review of case #6 was provided to ensure timeliness of the 24-hour pharmacy turnaround time requirement.</p>		
<p>Required Actions: None.</p>		
<p>13. Timelines—Extension for Standard Authorization Decisions and Notifications: <i>42 CFR 438.210(d)(1)(i-ii); Contract 4.11.2.5.1</i></p> <p>The CMO may extend the timeline for up to an additional 14 calendar days if:</p> <ul style="list-style-type: none"> ◆ The member or the provider requests an extension of the timeline, or ◆ The CMO justifies to DCH a need for additional information and how the extension is in the member’s interest. 	<p>For standard authorizations, the provider, the member, the member’s representative or the Health Plan may request an extension up to an additional 14 calendar days. If the extension is initiated by Peach State, the member is given written notice of the reasons for the extension and is informed of their right to file a grievance. Peach State will demonstrate to the satisfaction of the State that there was a need for additional information and how the delay was in the best interest of the member. Peach State demonstrates this through the following documents:</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 2 2014 UM Program Description, Page 22 Extension Letter Provider Manual, Pages 32 Member Handbook, Pages 13, 77 	
<p>Findings: The written documentation demonstrated compliance with the element. During staff interviews it was indicated that extensions had not been requested by the member, provider, or the CMO.</p>		
<p>Required Actions: None.</p>		
<p>14. Timelines—Expedited Authorizations Decisions and Notifications: 42 <i>CFR 438.210(d)(2)(i); Contract 4.11.2.5.2</i></p> <p>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.</p>	<p>Decision and notification regarding expedited authorizations must be made within 24 hours following the receipt of the requests and/or as expeditiously as the member’s health condition requires. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 3 2014 UM Program Description, Page 21 Provider Manual, Pages 32 Policy: GA.UM.15 Oversight Delegation of UM (entire document) Delegated Vendor Audit Tool Report: Q1 2014 TAT Report Prior Auth Aging Log Sample 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO reported that requests are frequently marked as “urgent” or “stat” but noted that these are 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.</p>		



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<p>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.</p>		
<p>15. Timelines—Extension for Expedited Authorizations Decisions and Notifications: <i>42 CFR 438.210(d)(2)(ii); Contract 4.11.2.5.2</i></p> <p>The CMO may extend the 24 hour timeframe for up to five business days if:</p> <ul style="list-style-type: none"> ◆ The member or the provider requests an extension, or ◆ The CMO justifies to DCH a need for additional information and the extension is in the member’s interest. 	<p>For expedited authorizations, the provider, the member, the member’s representative or the Health Plan may request an extension up to an additional 5 business days. If the extension is initiated by Peach State, the member is given written notice of the reasons for the extension and informed of their right to file a grievance. Peach State will demonstrate to the satisfaction of the State that there was a need for additional information and how the delay was in the best interest of the member. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 3 • 2014 UM Program Description, Page 21-22 • Extension Letter • Provider Manual, Pages 32 • Member Handbook Page 13, 77 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation demonstrated compliance with the element. During staff interviews it was indicated that extensions had not been requested by the member, provider, or the CMO.</p>		
<p>Required Actions: None.</p>		
<p>16. Authorization for Services Delivered: <i>Contract 4.11.2.5.3</i></p> <p>The CMO makes authorization determinations involving health care services that have been delivered within 30 calendar days of receipt of the necessary information.</p>	<p>Peach State makes authorization determinations involving health care services delivered within 30 calendar days of receipt. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 6 • 2014 UM Program Description, Page 22 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> Provider Manual, Page 36 	
<p>Findings: The written documentation and the staff interviews demonstrated compliance with the element. Retrospective files were not included as part of the denial files review.</p> <p>Required Actions: None.</p>		
<p>17. Notice of Adverse Action: <i>42 CFR 438.210(c); Contract 4.14.3.2</i></p> <p>The CMO notifies the requesting provider in writing and gives the member written notice of any CMO proposed decision to deny a service authorization request, or to authorize a service in an amount, duration, or scope that is less than requested.</p>	<p>Peach State notifies the requesting provider and the member of any proposed decision to deny a request or authorize a service in an amount, duration or scope that is less than requested. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Pages 2-3 Policy: GA.QI.41 Adverse Determination (Denial) Notices, Pages 3, 10-11 Provider Manual, Page 32 Member Handbook Page 40 Sample: Notice of Proposed Action 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The 10 denial files reviewed during the on-site visit were compliant with written documentation of the CMO decision to deny a service request. A written notification was provided to the member and provider.</p> <p>Required Actions: None.</p>		
<p>18. Notice of Proposed Adverse Action—Language and Format: <i>42 CFR 438,404(a); Contract 4.14.3.2</i></p> <p>As applicable, the CMO’s written notice of adverse action to the member meets the language and format requirements of 42 CFR 438(10)(c) and (d) and Contract 4.3.2.</p>	<p>Peach State makes all member written notices of adverse action available in alternative formats and in a manner that takes into consideration the members special needs, including those who are visually impaired or have limited reading proficiency. The written notice includes a language block printed in Spanish that informs the member that the document contains important information and directs the member to call the Health Plan to request the document in an alternative language or to have it orally translated if needed. The written notice is worded such that they are understandable to a</p>	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	person who reads at the fifth grade level. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Policy: GA.UM.07 Adverse Determinations (Denial) Notices, Pages 3-4, 10-11 • Policy: GA.MRKT.01 Distribution of Written Information to Providers and Members, Page 1-2 • Member Handbook, Pages 1- 2 • Sample: Notice of Proposed Action 	
Findings: The denial file reviews included review of the NOA to members. The template language was in compliance with the element. The narrative of the denial rationale was understandable and was written at the fifth-grade reading level, with consideration that medical terminology can raise the reading level.		
Required Actions: None.		
19. Content of Notice of Proposed Adverse Action: 42 CFR 438,404(b)(1-7); Contract 4.14.3.3 The CMO’s notice of adverse action contains the following: <ul style="list-style-type: none"> ◆ 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 the basis for the action which must have a factual basis and legal/policy basis). ◆ The member’s right to file an administrative review through the CMO’s internal grievance system as described in Contract 4.14. ◆ The provider’s right to file a provider complaint as described in Contract 4.9.7. ◆ The requirement that the member exhaust the CMO’s internal administrative review process. ◆ The circumstances under which expedited review is available and how to 	The Peach State Notice of Proposed Adverse Action letter provides the information required according to 42CFR 438.404 (b)(1-7) and Contract 4.14.3.3.1-7. Peach State demonstrates this through the following documents: <ul style="list-style-type: none"> • Policy: GA.QI.41 Adverse Determination (Denial) Notices, Pages 3-4, 10-11 • Sample: Notice of Proposed Action • Member Handbook Page 38-42 • Provider Manual, Page 32-40 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>request it.</p> <ul style="list-style-type: none"> The member’s right to have benefits continue pending resolution of the administrative review with the CMO, member instructions on how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services. 		
<p>Findings: The denial file reviews included review of the NOA. There was evidence of the required language in the notice template and narrative summary to members and providers. While the NOA contained language to address continuation of benefits, the letter does not specify that the continuation of benefits refers only to those previously approved services that have been terminated, reduced, or suspended. Continuation of the benefit does not apply if the denial refers to a new request for services, such as for ongoing therapy or home health services. The reviewer did not assess appeals to determine if the language was impactful to the appeal process. However, the CMO indicated that this was model language directed by the State.</p>		
<p>Required Actions: None.</p>		
<p>20. Notice of Proposed Action Timeframe—Termination, Suspension, or Reduction of Previously Authorized Covered Services: <i>42 CFR 438 404(c)(1); Contract 4.14.3.4.1–4</i></p> <p>For proposed actions to terminate, suspend, or reduce previously authorized covered services, the CMO mails the notice of proposed action at least 10 calendar days before the date of the proposed action or not later than the date of the proposed action in the event of one of the following exceptions:</p> <ul style="list-style-type: none"> The CMO has factual information confirming the death of a member. The CMO 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 that 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 CMO mail directed to the member indicating no forwarding address. The member’s provider prescribes a change in the level of medical care. The date of action will occur in less than 10 calendar days in accordance with 42 CFR 483.12(a)(5)(ii). 	<p>Peach State has policies and processes in place to mail the Notice of Proposed Action 10 calendar days before the date of the proposed action; or, if one of the allowed exceptions occurs, no later than the date of the proposed action. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> Policy: GA.QI.41 Adverse Determination (Denial) Notices, Pages 4, 5 Provider Manual, Page 32-40 Sample: Notice of Proposed Action 	<p> <input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A </p>



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<ul style="list-style-type: none"> ◆ The CMO may shorten the period of advance notice to five calendar days before the date of action if the CMO has facts indicating that action should be taken because of probable member fraud and the facts have been verified, if possible, through secondary sources. 		
<p>Findings: The written documentation demonstrated compliance with the element. During staff interviews it was indicated that the CMO does not terminate, suspend, or reduce services once authorized.</p> <p>Required Actions: None.</p>		
<p>21. Notice of Proposed Action Timeframe—Denial of Payment: <i>42 CFR 438 404(c)(2); Contract 4.14.3.4.5</i></p> <p>The CMO provides notice of action at the time of any action/proposed action affecting the claim.</p>	<p>Peach State has a policy and process in place to provide notice of action at the time of any action/proposed action affecting the claim. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.COMP.33 Provider Complaints, (entire document) 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation, GA.COMP.33 Provider Complaints, and staff interviews demonstrated compliance with this element. Claims denials were not included in the denial files review sampling.</p> <p>Required Actions: None</p>		
<p>22. Written Notice of Reasons—Decisions to Extend Timeframes: <i>42 CFR 438.404(c)(4)(i); Contract 4.14.3.4.7</i></p> <p>If the CMO extends the timeframe for decision and sending the notice of action/proposed action according to Section 4.11.2.5, the CMO gives the member written notice of the reasons for the decision to extend the timeframe and informs the member of the right to file a grievance if he or she disagrees with the decision.</p>	<p>Peach State sends the member written notice of the Plan’s reason(s) for extending the timeframe and informs the member of their right to file a grievance regarding Peach State’s decision. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 2 • Member Handbook, Pages 13 • Provider Manual Page 32 • Extension Letter 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation demonstrated compliance with the element. During staff interviews it was indicated that the CMO does not terminate, suspend, or reduce services once authorized.</p> <p>Required Actions: None.</p>		



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Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>23. Extensions of Timelines—CMO Responsibility: <i>42 CFR 438.404(c)(4)(ii); Contract 4.14.3.4.7</i></p> <p>If the CMO extends the timeframe for decision and sending the notice of action/proposed action, the CMO carries out its determination as expeditiously as the member’s health condition requires and no later than the date the extension expires.</p>	<p>When a timeframe is extended, Peach State makes decisions as expeditiously as the member’s health condition requires and no later than the date the extension expires. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 2 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation demonstrated compliance with the element. During staff interviews it was indicated that the CMO does not terminate, suspend, or reduce services once authorized.</p> <p>Required Actions: None.</p>		
<p>24. Notice of Action—Decisions Not Reached Within the Required Timeframes: <i>42 CFR 438.404(c)(5) and (6); Contract 4.14.3.4.8</i></p> <p>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.</p>	<p>For decisions not reached within the standard or expedited timeframes required, a Notice of Proposed Action letter shall be mailed on the date the timeframe expires. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Pages 6-7 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: While the CMO’s written policy outlined the current process for decisions not reached within the requirement timeframes, 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.</p> <p>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.</p>		
<p>25. Compensation for Utilization Management Activities: <i>42 CFR 438.210(e); Contract 4.11.1.4</i></p> <p>The CMO does not structure compensation to individuals or entities that conduct utilization management activities so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary</p>	<p>Peach State does not structure compensation to employees or vendors involved in utilization management activities to provide incentives to deny, limit or discontinue medically necessary services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • 2014 UM Program Description, Page 9 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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services to any member (i.e., the CMO, and any delegated utilization review agent), and does not permit or provide compensation or anything of value to its employees, agents, or contractors based on: <ul style="list-style-type: none"> ◆ Either a percentage of the amount by which a claim is reduced for payment or the number of claims or the cost of services for which the person has denied authorization or payment, or ◆ Any other method that encourages the rendering of a proposed action. 	<ul style="list-style-type: none"> • Policy GA.UM.04 Appropriate UM Professionals, Page 5 • 2013 Affirmative Statement Meeting Minutes and Sign-in Sheet • Provider Manual, Page 31 • Member Handbook, Page 53, 124 • Peach State Website- http://www.pshpgeorgia.com/for-members/benefit-information/lang_enaffirmative-statementlang_enlang_esdeclaracion-afirmativelang_es/ • March 2014 Employee Email & 2014 Affirmative Statement 	

Findings: The CMO demonstrated compliance both in written documentation and staff interviews. The Affirmative Statement written acknowledgement by staff was well managed and tracked for all reviewers.

Required Actions: None.

Standard V—Coverage and Authorization of Services Results

Met =	22	X	1.00	=	22.0
Not Met =	3	X	.00	=	0.0
Not Applicable =	0		N/A		N/A
Total Applicable =	25		Total Score	=	88.0%



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<p>1. Availability of Emergency Services: <i>42 CFR 438.206(c)(1)(iii); Contract 4.6.1.1</i></p> <p>The CMO has emergency services available 24 hours a day, seven days a week to treat an emergency medical condition.</p>	<p>Peach State has emergency services available 24 hours a day, seven days a week. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1 • 2014 UM Program Description, Page 26 • Member Handbook Page 8 • Provider Manual, Page 1 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO provides for emergency services through any accessible emergency provider regardless of participating or non-participating network status, 24 hours a day, seven days a week. There are no prior authorization requirements.</p> <p>Required Actions: None.</p>		
<p>2. Definition of Emergency Medical Services and Condition: <i>42 CFR 438.114(a)(1-3); Contract 1.4; 4.6.1.2</i></p> <p>The CMO defines emergency services and an emergency medical condition consistent with the DCH contractually required definition.</p>	<p>Peach State’s definition of emergency services and conditions is consistent with the DCH contract definition. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 3,5 • 2014 UM Program Description, Page 26 • Member Handbook, Page 35 • Provider Manual, Pages 49 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The policy and all documentation are consistent with the contractually required definition. The member handbook provides appropriate direction related to emergency services.</p> <p>Required Actions: None.</p>		
<p>3. Does Not Limit/Define Emergency Medical Condition: <i>42 CFR 438.114(d)(i); Contract 4.6.1.2</i></p> <p>The CMO does not limit or define what constitutes an emergency medical condition based on a list of diagnoses or symptoms.</p>	<p>Peach State does not limit or define what constitutes an emergency condition based on diagnosis or symptoms. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, (entire document) • 2014 UM Program Description, Page 26 • Provider Manual, Pages 49 • Member Handbook Page 35 • ER Monitoring Report 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>Findings: The CMO used a list of diagnoses to establish a fast payment practice for those conditions deemed as emergent. For those diagnosis codes not on the list, a triage payment was made. The facility had up to 90 days to provide medical records for reconsideration to support the additional emergency services payment. The payment methodology for emergency facilities was outlined in each contract. This list only impacted facility payment; professional services were not subject to this payment logic. A sample of the monthly ER Monitoring Report was reviewed on-site to evaluate triage payment, emergency services payment, and any issuance of denials. It was noted that denials could be issued based on lack of member eligibility at the time of service.</p>		
<p>Required Actions: None.</p>		
<p>4. Prior Authorization Not Required: <i>Contract 4.6.1.3; 4.6.3</i></p> <p>The CMO does not require prior authorization or pre-certification for emergency or urgent care services.</p>	<p>Peach State does not require prior authorization or pre-certification for emergency or urgent care services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1 • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 1 • 2014 UM Program Description, Page 14 • Member Handbook, Pages 35-36 • Provider Manual, Page 50 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation and staff interviews confirmed that the CMO does not require prior authorization for emergency or urgent care services. Payment was based on place of service and revenue codes; there were no edits to pend or deny emergency or urgent services.</p>		
<p>Required Actions: None.</p>		
<p>5. Coverage Decisions—Prudent Layperson Standard: <i>42 CFR 438.114(a); Contract 4.6.1.2; 4.6.1.4</i></p> <p>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.</p>	<p>Peach State bases emergency services on the severity of the symptoms at the time of presentation. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Pages 1-2 • 2014 UM Program Description, Pages 26 • Provider Manual, Pages 49 • ER Monitoring Report 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO had contractual arrangements with facilities regarding emergency services payment. Facilities that receive a triage payment are afforded the opportunity to submit medical records for evidence of comprehensive emergency care to support higher payment. Medical records are 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.</p>		



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<p>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.</p>		
<p>6. Coverage and Payment—Providers: <i>42 CFR 438.114(c)(i); Contract 4.6.1.3</i></p> <p>The CMO covers and pays for emergency services when furnished by a qualified provider, regardless of whether that provider is in the CMO’s network.</p>	<p>Peach State covers and pays for emergency services when furnished by a qualified in or out of- network provider. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 3 • 2014 UM Program Description, Page 26 • Member Handbook, Pages 36 • Provider Manual, Page 51 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO covered and paid for emergency services based on place of service and revenue codes, regardless of participating or non-participating network status. Claims processing did not vary by network status; only the contracted rate was variable.</p>		
<p>Required Actions: None.</p>		
<p>7. Coverage and Payment—Screening Examination: <i>42 CFR 438.114(d)(2); Contract 4.6.1.3</i></p> <p>The CMO pays for any screening examination services conducted to determine whether an emergency medical condition exists.</p>	<p>Peach State covers any screening exam conducted to determine an emergent condition. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 4 • 2014 UM Program Description, Page 26 • Provider Manual, Page 50 • ER Monitoring Report 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO covered screening payments inclusive to the comprehensive emergency service payment or as a separate triage payment. The payment determination was based on the facility contract or the out-of-network status.</p>		
<p>Required Actions: None</p>		
<p>8. Coverage and Payment—Duration: <i>42 CFR 438.114(d)(3); Contract 4.6.1.3</i></p> <p>The CMO pays for all emergency services that are medically necessary until the member is stabilized.</p>	<p>Peach State pays for all emergency services until the member is stabilized. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 3 • 2014 UM Program Description, Pages 26 • Member Handbook, Page 36 • Provider Manual, Pages 49 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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<p>Findings: The documentation and staff interviews demonstrated compliance with the element. The CMO paid for all emergency services based on place of service, revenue codes, and contractual agreements.</p> <p>Required Actions: None</p>		
<p>9. Determining Status of Members' Conditions: <i>42 CFR 438.114(d)(3); Contract 4.6.1.5</i></p> <p>The attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the CMO.</p> <p><i>(Note: The CMO, however, may send one of its physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the member, provided that such arrangements do not delay the provision of emergency service.)</i></p>	<p>Peach State ensures the attending emergency room physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 3 • Provider Manual, Page 50 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The documentation and staff interviews demonstrated compliance with the element. The CMO did not send one of its physicians to assume care responsibilities. The CMO required notification of an observation stay or inpatient admit.</p> <p>Required Actions: None.</p>		
<p>10. Retroactive Claim Denial Prohibited: <i>42 CFR 438.114(c)(1)(ii)(A); Contract 4.6.1.6</i></p> <p>The CMO does not retroactively deny a claim for an emergency screening examination because the condition, which appeared to be an emergency medical condition under the prudent layperson standard, turned out to be non-emergency in nature.</p>	<p>Peach State does not retroactively deny a claim for an emergency screening examination conducted to determine whether an emergency medical condition exists. Peach state does not deny for emergency room services if the condition was determined not to be an emergency, but appeared to be using the prudent layperson standard. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Pages 1,5 • Provider Manual, Page 50 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation and staff interviews demonstrated compliance with this element. Staff indicated that there were no claims payment take backs for screening/triage services.</p> <p>Required Actions: None</p>		



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<p>11. Determining Factor for Payment Liability: <i>42 CFR 438.114(c)(1)(ii)(A); Contract 4.6.1.6</i></p> <p>If an emergency screening examination leads to a clinical determination by the examining physician that an actual emergency medical condition does not exist, the determining factor for the CMO payment liability is whether the member had acute symptoms of sufficient severity at the time of presentation, in which case the CMO pays for all screening and care services provided.</p>	<p>Peach State pays for all screening services provided to determine an emergent condition. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Provider Manual, Pages 50 • Policy: GA.UM.12 Emergency Services, Pages 3-4 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation and staff interviews demonstrated compliance with the element. The CMO paid by place of service and revenue code; all screening services were paid.</p>		
<p>Required Actions: None.</p>		
<p>12. May Not Deny Coverage/Payment—Member Instructed to Seek Emergency Services: <i>42 CFR 438.114(c)(1)(ii)(B); Contract 4.6.1.8</i></p> <p>The CMO does not deny coverage/payment of services if a representative of the CMO instructs the member to seek emergency services and is responsible for payment for the medical screening examination and for other medically necessary emergency services without regard to whether the member’s condition meets the prudent layperson standard.</p>	<p>Peach State does not deny coverage/payment of services if a Peach State representative instructs the member to seek emergency services and is responsible for payment for the associated medical screening examination and for other medically necessary emergency services without regard to whether the member’s condition meets the prudent layperson standard. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1,4 • 2011 UM Program Description, Page 26 • PSHP Daily NurseWise Call Detail for 6/11/2014 • NurseWise Disposition Case 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO did not deny payment of services if a representative instructed the member to seek emergency services. However, depending on the contractual arrangement with the facility, the service could be paid at the triage level, which would cover the screening examination. The facility would then need to submit medical records for reconsideration of higher reimbursement.</p>		
<p>Required Actions: None.</p>		



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<p>13. May Not Deny Coverage/Payment—Provider Failure to Notify CMO: 42 CFR 438.114(d)(1)(ii); Contract 4.6.1.7</p> <p>While the CMO may establish guidelines and timelines for submittal of notification regarding provision of emergency services, the CMO does not refuse to cover an emergency service based on the emergency room provider, hospital, or fiscal agent’s failure to notify the member’s PCP, CMO plan representative, or DCH of the member’s screening and treatment within those guidelines/timelines.</p>	<p>Peach State does not refuse to cover an emergency service based on the emergency room provider or hospital provider. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1 • 2014 UM Program Description, Page 26 • Member Handbook, Page 36 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation and staff interviews demonstrated compliance with the element. The CMO did not require any notification for emergency services.</p>		
<p>Required Actions: None.</p>		
<p>14. Member Not Liable: 42 CFR 438.114(d)(2); Contract 4.6.1.9</p> <p>The CMO ensures that members who have an emergency medical condition are not liable for payment of subsequent screening and treatment needed to diagnose the specific condition or to stabilize the member.</p>	<p>Peach State ensures that members who have an emergency medical condition are not liable for payment. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1 • 2014 UM Program Description, Page 26 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation, the member handbook (p. 47), and staff interviews demonstrated compliance with the element. Staff described the grievance process steps if a member was billed and engagement of the Provider Network staff to assist with resolution, if needed.</p>		
<p>Required Actions: None.</p>		
<p>15. Poststabilization Services—Availability: 42 CFR 422.113(c); 42 CFR 438.114(c); Contract 4.6.2.1</p> <p>The CMO provides poststabilization care services 24 hours a day, seven days a week, both inpatient and outpatient, related to an emergency medical condition, that are provided after a member is stabilized in order to maintain the stabilized condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the member’s condition.</p>	<p>Peach State provides post stabilization care services 24 hours a day, seven days a week for both inpatient and outpatient related emergencies. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1 • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Pages 5, 8 • Member Handbook, Page 40,41 • Provider Manual, Page 49-50 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A



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	<ul style="list-style-type: none"> • 2014 UM Program Description, Page 26 	
<p>Findings: The written documentation and staff interviews demonstrated compliance with the element. The CMO provided poststabilization services 24 hours a day, seven days a week, but did require notification of any observation or inpatient stays.</p>		
<p>Required Actions: None.</p>		
<p>16. Financial Responsibility—Prior Authorized Services: <i>42 CFR 422.113(c)(2)(i); 438.114(c); Contract 4.6.2.2</i></p> <p>The CMO is responsible/pays for poststabilization services that are prior authorized or pre-certified by an in-network provider or organization representative, regardless of whether they are provided within or outside the CMO’s network of providers.</p>	<p>Peach State pays for post stabilization services that are prior authorized with both in and out of network providers. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Page 1,2,3 • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Page 5 • Member Handbook, Page 36 • Provider Manual, Page 51 • 2014 UM Program Description, Page 26 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO did not require prior authorization or notification of any emergency services. Claims payment was based on place of service and revenue codes regardless of network participation.</p>		
<p>Required Actions: None</p>		
<p>17. Financial Responsibility—Services to Maintain Stabilization: <i>42 CFR 422.113(c)(2)(ii); 42 CFR 438.114(c); Contract 4.6.2.3</i></p> <p>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.</p>	<p>Peach State is responsible for poststabilization services obtained from any provider, regardless of whether the provider is a non-participating or participating provider within the Plan’s network that are administered to maintain the member’s stabilized condition. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA. UM.12 Emergency Services, Page 2-3 • Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Pages 3 • Member Handbook, Page 36 • Provider Manual, Page 50 • 2014 UM Program Description, Page 26 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The CMO required notification of observation and inpatient stays, and payment was based on the notification and clinical review for medical necessity,</p>		



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<p>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.</p> <p>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.</p>		
<p>18. Financial Responsibility—Services Not Prior Authorized: <i>CFR 422.113(c)(2)(iii)(A–C); 42 CFR 438.114(c); Contract 4.6.2.4.1-3; 4.6.2.4</i></p> <p>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:</p> <ul style="list-style-type: none"> ◆ 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. 	<p>Peach State is financially responsible for post stabilization services for in and out of network providers regardless of prior authorization. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> ● Policy: GA.UM.12 Emergency Services, Pages 1,2,3 ● Policy: GA.UM.05 Timeliness of UM Decisions and Notifications, Pages 5 ● 2014 UM Program Description, Page 26 ● Member Handbook, Page 36 ● Provider Manual, Page 51 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>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.</p> <p>Required Actions: The CMO needs to clarify its policy and practice related to these poststabilization requirements to ensure compliance with this element.</p>		



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Standard VI—Emergency and Poststabilization Services

Requirements and References	Evidence/Documentation as Submitted by the CMO	Score
<p>19. End of Financial Responsibility: 42 CFR 422.113(c)(3); 42 CFR 438.114(c); Contract 4.6.2.5</p> <p>The CMO retains financial responsibility for poststabilization services it has not approved until one of the following occurs:</p> <ul style="list-style-type: none"> ◆ 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. 	<p>Peach State is responsible for post stabilization services until the member is admitted or discharged regardless of whether the provider is an in or out of network provider. Post stabilization services are considered complete when a Plan physician with treating privileges at that hospital assumes responsibility for the member’s care, a Plan physician assumes responsibility for the member’s care through transfer or the member is discharged. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Pages 1,3 • Policy: GA.UM.05 Timeliness of UM , Pages 5-6 • Provider Manual, Pages 50 	<input type="checkbox"/> Met <input checked="" type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>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 will 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.</p>		
<p>Required Actions: The CMO needs to clarify its policy and practice related to these poststabilization requirements to ensure compliance with this element.</p>		
<p>20. Limit on Charges for the Member: 42 CFR 422.113(c)(2)(iv); 42 CFR 438.114(c); Contract 4.6.2.6</p> <p>In the event the member receives poststabilization services from a provider outside the CMO’s network, the CMO does not charge the member more than he or she would be charged if he or she had obtained the services through an in-network provider.</p>	<p>Peach State does not charge the member more than he or she would be charged by an in network provider if he or she obtained services from an out of network provider for post stabilization services. Peach State demonstrates this through the following documents:</p> <ul style="list-style-type: none"> • Policy: GA.UM.12 Emergency Services, Pages 1 • 2014 UM Program Description, Page 26 	<input checked="" type="checkbox"/> Met <input type="checkbox"/> Not Met <input type="checkbox"/> N/A
<p>Findings: The written documentation and staff interviews demonstrated compliance with this element.</p>		
<p>Required Actions: None.</p>		



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

Standard VI—Emergency and Poststabilization Services Results						
Met	=	16	X	1.00	=	16.0
Not Met	=	4	X	.00	=	0.0
Not Applicable	=	0		N/A		N/A
Total Applicable	=	20	Total Score	=		80.0%

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
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Standard I—Clinical Practice Guidelines

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

3. The practice guidelines include a methodology for measuring and assessing compliance.

Contract: 4.12.7.2

Findings: Peach State provided its CPG Compliance spreadsheet, which included the scores for compliance on each of the three CPGs. The CMO also submitted its Methodology for CPG Reviews documentation, which summarized the calculation process. The CMO had a methodology for measuring and assessing compliance; however, it did not review enough records to ensure a proper random sample.

Required Actions: Peach State must change its monitoring process to ensure at least 450 charts are reviewed in order to calculate CPG compliance correctly.

Evidence/Documentation Submitted by the CMO

To ensure at least 450 charts are reviewed to calculate CPG compliance, Peach State Health Plan implemented the following interventions:

- ◆ Increase Plan’s oversample size from 10% to 33% per CPG to ensure that a total of 450 charts are reviewed and audited annually, as noted in the following policy:
 - Policy: GA.QI.06 – Preventive Health and Clinical Practice Guidelines
- ◆ Conduct quarterly CPG compliance audits to ensure the Plan meets the CPG compliance audit requirements. This intervention will assist the Plan in ensuring early identification of barriers and development of effective interventions.
- ◆ Development of a database that will:
 - Allow vendor entry of audit results and easy transfer of audit results from the vendor to the health plan.
 - Facilitate validation, tracking and monitoring of the required chart quantities.

Peach State Health Plan demonstrates this through the following document:

- ◆ **Screenshot: CPG Database**
- ◆ **Policy: GA.QI.06 Preventive Health and Clinical Practice Guidelines**

Findings: Peach State provided its Preventive Health and Clinical Practice Guidelines policy, which indicated how the CMO would ensure at least 450 charts would be reviewed in order to calculate and confirm CPG compliance. The CMO displayed its CPG compliance analysis accomplished for July 2014 reporting, and the auditor verified at least 450 charts were reviewed.

Required Actions: None.

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5. In order to ensure consistent application of the guidelines, the CMO encourages providers to utilize the guidelines and measures compliance with the guidelines until 90 percent or more of the providers are consistently in compliance.

Contract: 4.12.7.5

Findings: Peach State provided its CPG Compliance spreadsheet, which included the compliance scores for each of the three CPGs; however, the CMO did not review enough charts to ensure compliance across the provider population.

Required Actions: Peach State must improve provider compliance with CPGs until 90 percent of providers adhere to the CMO’s CPGs. The CMO must change its policies and processes to ensure at least 450 charts are reviewed in order to calculate CPG compliance correctly.

Evidence/Documentation Submitted by the CMO

- ◆ Peach State Health Plan (Peach State) determined that increasing the number of reviews by moving from an annual review process to a quarterly review process will allow better and quicker assessment of practitioner compliance with the three (3) Clinical Practice Guidelines (CPGs): Clinical Guidelines for Asthma, Clinical Guidelines for Diabetes Mellitus and Clinical Guidelines for Attention Deficit Hyperactivity Disorder (ADHD). This process was evidenced by the following policy:
- ◆ Policy: GA.QI.06 – Preventive Health and Clinical Practice Guidelines (attached) in the Performance Measurement section on page 5, item e. includes the interventions for the increase in oversample and the process for Corrective Action Plans (CAPs) for practitioners who score < 80% on specific elements of the audit.
- ◆ All practitioners who score less than 80% on the CPG audit are placed on a Corrective Action Plan (CAP) and are required to submit the CAP to the Plan within fourteen business days of receipt of the deficiency letter notifying them of what element(s) showed deficiencies. The Medical Record Review Nurses deliver the notification letter containing the deficiencies on the same day that the medical record review was completed. The template deficiency letter and policy GA.QI.06 – Preventive Health and Clinical Practice Guidelines are attached for review. The template contains a blank area that allows the auditing nurse to write in specific information about the deficiencies. During the exit meeting, the nurses review the letter with the practitioner and his/her staff and provide assistance with understanding what was needed for the impending CAP and may provide resources that will assist the provider with meeting the CAP requirements (such as the Asthma Action Plan). The auditing nurse also educates the practitioner on elements missed during the onsite visit and specific remedies for the deficient audit element. This process was evidenced by the following policy:
Policy: GA.QI.06 – Preventive Health and Clinical Practice Guidelines (attached) in the Performance Measurement section on page 5, item e.
- ◆ Peach State analyzed the results of each audit to address the specific deficiencies within each CPG’s compliance and had developed these interventions aimed at moving the overall compliance rates to at or above 90%. Targeting the specific areas of deficiency will increase the Plan’s overall CPG compliance to meet the 90% compliance threshold.
- ◆ Diabetes CPG: Influenza Vaccine – the addition of a care gap notification to providers through the provider portal notifying each provider of members who



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have not received an influenza vaccine. Measurement: increase rate to 90% on quarterly audit review.

- ◆ Diabetes CPG: Eye Exam – develop a process with Peach State’s eye vendor, OptiCare, to ensure that providers performing eye exams for diabetic patients in eye specialist’s offices are documented and forwarded to the PCP of record for inclusion in the chart. Measurement: increase rate to 90% on quarterly audit review.
- ◆ Asthma CPG: Documented Asthma Action Plan – Plan will distribute an example of an Asthma Action Plan to Provider Relations (PR) Representatives to distribute to practitioners and post on the provider web portal. Medical Record Review nurses will also provide a copy of the Asthma Action Plan immediately following the audit if the practitioner scored less than 80% on that element. Review nurses and the PR Representatives will also educate practitioners on how to access the Asthma Action Plan on the web portal for future reference. Measurement: increase rate to 90% on quarterly audit review.
- ◆ ADHD CPG: Rating Scale - Educate practitioners on the recommendation of the use of Conners Comprehensive Behavioral Rating Scales or any equivalent scale for the initial and follow-up assessments of children with ADHD, provide website information where the Conners Scales or its equivalent can be located, and encourage providers to purchase the tool. Measurement: increase rate to 90% on quarterly audit review.

To ensure at least 450 charts are reviewed to calculate CPG compliance, Peach State Health Plan will implement the following interventions:

- ◆ Increase Peach State’s oversample size from 10% to 33% per CPG to ensure that a total of 450 charts are reviewed and audited annually, as noted in the following policy:
- ◆ Policy: GA.QI.06 – Preventive Health and Clinical Practice Guidelines (attached)
- ◆ Conduct quarterly CPG compliance audits to ensure that Peach State meets the CPG compliance audit requirements. This intervention will assist Peach State in ensuring early identification of barriers and development of effective interventions.
- ◆ Development of a database that will:
 - Allow live entry of audit results and easy transfer of audit results from Peach State to the vendor.
 - Facilitate validation, tracking and monitoring of the required chart quantities.
- ◆ Review quarterly audit results during the Plan’s QIC Committee meetings to elicit cross-departmental feedback while determining:
 - effectiveness of Peach State’s existing interventions
 - any potential barriers possible recommendations to meet or exceed established targets



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Peach State Health Plan demonstrates this through the following documents:

- ◆ **Screenshot: CPG Database**
- ◆ **Policy: GA.QI.06 Preventive Health and Clinical Practice Guidelines**

Findings: Peach State’s CPG reporting will occur in July 2014, so the final CPG analysis for that reporting was underway but not finalized at the time of this review. HSAG reviewed the preliminary CPG analysis, which suggests Peach State will comply with the element.

Required Actions: None.



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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 supplied its Performance Improvement Projects and Performance Measures Policy and Procedure. The CMO also provided its Interactive Data Submission System performance measure reporting table, and Peach State monitors each measure required by the State. Although Peach State monitors the required measures, the CMO did not achieve the DCH-established performance targets.

Required Actions: Peach State must meet DCH-established performance targets in order to comply with this element.

Evidence/Documentation Submitted by the CMO

Peach State Health Plan was diligently working to meet and/or exceed the DCH established performance targets noted below.

Performance Measures:

Rapid cycle improvement programs are underway in 2014 to increase HEDIS rates. The Plan will monitor the leading indicators below to assess these for small tests of change.

Childhood and Adolescent:

Measure	HEDIS RY2013	DCH 2012 Target
Childhood Immunizations – Combo 3	76.74%	82.00%
Lead Screening	74.19%	81.00%
Well Child Visits – 15 months	55.32%	69.70%
Well Child Visits – 3-6 year olds	67.59%	71.80%
Adolescent Well Care – 12-21 year olds	43.98%	46.80%
Weight Assessment, etc. - Nutritional	56.02%	58%
Child/Adol Access to Primary Care	87.97%	91.80%
CHIPRA 416 –Dental Preventive	48.06%	80%
CHIPRA 416 –Dental Treatment	23.14%	N/A

- ◆ Target the top five (5) provider groups with a significant percentage of membership and offer each provider group an Incentive Program aimed at ensuring provider involvement in increasing the ten (10) related performance measures. The Incentive Program will be managed by the Plan’s Medical Director, Provider Relations and Quality Improvement teams to include face to face visits with providers to review periodicity schedule, review medical records/EMR for opportunities, provide billing/coding education, review non-compliant reports and provide quarterly results. Quarterly measurement of effectiveness of intervention: An increase in three (3) of the ten (10) targeted performance measure rates across the five (5) provider groups. Of note, an



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increase in a minimum of three (3) performance measure rates was required to obtain the incentive.

- ◆ Enhanced involvement and collaboration of vendors to increase rates to include the following:
- ◆ Dentaquest: implement programs to increase annual preventive dental visits using the rapid cycle concept. Dentist will receive a report that provides listing of enrolled children, ages 1-9, who have not received any preventative services
- ◆ A letter and report will be sent to the providers of enrolled children, ages 6-9. The letter will explain the importance of sealant placement along with a report that lists the members the provider treats who need to be seen for sealant applications on first and second permanent molars. Quarterly measurement of effectiveness of interventions: increase in quarterly sealant and dental visit rates on CMS 416 report.
- ◆ Dental Home: Implementing dental home concept to all new members by providing a list of nearby dentists and education on dental benefits and services needed. Measurement: of those members who received the letter, a claim run will be conducted 60 – 90 days after the distribution of the letter to determine the effectiveness of the intervention.

Women’s Health:

Measure	HEDIS RY2013	DCH 2012 Target
Breast Cancer Screening	56.46%	59.60%
Cervical Cancer Screening	73.54%	78.90%
Frequency of Prenatal Care	65.03%	73.70%
Timeliness of Prenatal Care	86.71%	90.00%

- ◆ Target ten high volume and high noncompliant providers statewide for whom we would provide a gap report. In addition, these noncompliant members will receive outreach and incentives to obtain mammograms and cervical cancer screenings. Quarterly measurement of effectiveness of interventions: number of incentives paid and appointments kept with resultant increase in rates.
- ◆ Enhance collaboration and partnership with the Public Health Departments and Public Health Labs with scheduled meetings and data exchange. Quarterly measurement of effectiveness of interventions: Scheduled meetings result in successful claims data submission to PSHP and produce an increase in claims for screenings.

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Chronic Conditions- Diabetes

Measure	HEDIS RY2013	DCH 2012 Target
HbA1C Test	79.83%	86.40%
HbA1C Poor >9	55.48%	43.20%
HbA1C Control <8	39.13%	46.60%
HbA1C Control <7	27.61%	35.50%
LDL Screen	67.83%	75.40%
LDL Control	20.35%	33.60%
Attention to Nephropathy	73.39%	77.70%
BP Control <140/90	53.74%	61.60%

- ◆ Member outreach to 25 members in Atlanta region with uncontrolled diabetes (HbA1C Poor >9) to educate them on the disease and the importance of keeping appointments and obtaining additional screening. In addition, we will perform telephonic calls to providers to discuss members with HbA1C Poor >9 and schedule appointments for these members. We will follow these members throughout the year to determine if member becomes controlled. These members will be referred to the disease management program if not already enrolled. Quarterly measurement of effectiveness of intervention: 20% of members contacted (5 members) will have HbA1C < 9; 100% of those not already in disease management will be referred.
- ◆ Add a web portal eye exam reminder for providers with diabetic members informing them of the member’s need for an annual exam. Quarterly measurement of effectiveness of intervention: 100% of providers will be educated on the new portal based care gap via Provider Relations face-to-face visits and educational mailers. Additionally, the eye exam element will increase in the CPG compliance audit by 10%.

Behavioral Health

Measure	HEDIS RY2013	DCH 2012 Target
F/U Care for ADHD – Initiation Phase	43.73%	48.10%
F/U After MH Hospital - F/U within 30 Days	70.79%	83.60%



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F/U After MH Hospital – F/U within 7 Days	52.52%	64.30%
Antidepressant Meds Mgmt - Acute Phase	43.92%	N/A
Antidepressant Meds Mgmt - Cont Phase	28.13%	N/A

- ◆ A focus study conducted showed that providers throughout the state are not aware of the need to schedule appointments within seven (7) days of a member’s behavioral health hospitalization and/or within 30 days of a member being diagnosed with ADHD. Educational materials are being developed and will include the recommendation to schedule appointments within the required days. The Plan’s educational materials will be distributed to the Plan’s top ten (10) high volume providers by Cenpatico Behavioral Health’s Provider Relations department. Quarterly measurement of effectiveness of intervention: 10% increase in visit rates within the required days.
- ◆ Obtain live prescription fill data from the Plan’s Pharmacy Benefit Manager (PBM) which will allow Cenpatico Behavioral Health the ability to perform weekly member and provider outreach to all newly diagnosed ADHD members who have been prescribed ADHD medication. Outreach includes informing the member of the need for a follow up visit within 30 days of the prescription fill. This includes scheduling assistance as needed. Quarterly measurement of effectiveness of intervention: 20% of members receiving outreach will have an appointment within 30 days.

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



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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
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 PAPILOMAVIRUS 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



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



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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’s Quality Improvement Program Evaluation demonstrated that the CMO evaluates the impact and the effectiveness of the Quality Program.

Required Actions: Peach State should revise the format of its annual assessment of its quality program to ensure all quality elements are addressed and that they are integrated in terms of overall program impact.

Evidence/Documentation Submitted by the CMO

Peach State Health Plan revised the format of its Quality Assessment Performance Improvement Program Evaluation to comply with the newly revised DCH QAPI Program report specifications. In addition, PSHP will convene a multidisciplinary Performance Outcomes Steering Committee to review the QAPI requirements and monitor the synthesis of quality outcomes evaluations by provider relations, medical management, quality improvement, medical affairs, pharmacy, and member services. This approach will ensure that all quality projects are integrated into Peach State’s evaluation to determine the effectiveness of the overall quality strategy in improving member outcomes. We agree that this multidisciplinary holistic approach to incorporate the revised report specifications will better ‘tell the story’ of Peach State’s quality improvement program.

Peach State Health Plan demonstrates this through the following document:

- ◆ **Document: 2014 QI Workplan**

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.

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 15–16, 2014

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	Jennifer Lenz , MPH, CHCA	Executive Director, State & Corporate Services
Reviewer	Rachel Costello, PhD, MS, PCC-S	Senior Project Manager
Reviewer	Terry Huysman, RN, BSN, CHC	Director, State & Corporate Services
Reviewer	Pat Minnick, RN, MBA	Director of Quality Improvement
Reviewer	Steve Kuszmaul, MBA	Project Manager, State & Corporate Services
Peach State Health Plan Participants		Title
Dr. Dean Greeson		Chief Medical Officer
Dr. Idalia Gonzales		Medical Director
Tanya Hendley		Manager, Case Management
Melveta Hill-Sims		Manager, Complex Case Management
Lisa Schottroff		Director, Case Management
Laquanda Brooks		VP, Medical Management
Tracy Saafir		Sr. Director, Medical Management
Tomeika Arnold		Director, Utilization Management
Mary David		Manager, Utilization Management
Tracy Smith		Director, Public Relations
Joyce McElwain		Director, Quality Improvement
Daniel Scott		Pharmacy Provider Liaison
Debra Peterson-Smith		Sr. VP, Operations
Andrea Stuckey-Hundley		Manager, Compliance
Donna Mariney		Manager, Medical Management
Andrea Afolabi		Manager, Prior Authorization
Marjorie Augustin		Manager, Utilization Management
Ron Crowley		Director, Medical Management Intake
Linda Philpot		Project Manager
Chevron Cardenas		Sr. Director, Member and Provider Services

Table C-2—HSAG Reviewers and Peach State Health Plan/Other Participants	
Rhonda Lee-Hines	Supervisor, Member and Provider Services
Dietrick Williams	VP, Implementation
LaShon Hodge	Director, Contracting
Detra Friley-Clark	Director, Provider Data & Credentialing
Tonnette Tucker	Manager, Provider Data & Credentialing
Ronald Purisima	Manager, Quality Improvement
Claudette Bazile	VP, Compliance
Greg Gertz	Corporate Director, Ethics and Compliance
Marcia Dobbins	Manager, Accreditation Medical Management
Leslie Naamon	Chief Operating Officer
Yolanda Spivey	Sr. Director, Claims Operations
Khris Baker	Director, Client Services, Nurtur
Department of Community Health Participants	Title
Kimberly Foster, RN, BSN, MBA	Director 1, Managed Care Quality
Terri Portis, MPA	Project Director
Tiffany Simmons, BSN	Compliance Auditor
Patricia Garcia	Program Auditor

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 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—Availability of Services
- ◆ Standard II—Furnishing of Services
- ◆ Standard III—Cultural Competence
- ◆ Standard IV—Coordination and Continuity of Care
- ◆ Standard V—Coverage and Authorization of Services
- ◆ Standard VI—Emergency and Poststabilization Services
- ◆ Case and Disease Management Focused Review
- ◆ Follow-up on areas of partial compliance or non-compliance 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 first 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 case management, disease management, and service denial cases for the on-site CMO audit from the list of such members submitted to HSAG from the CMO.

^{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.

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.
- ◆ A review of the documents HSAG requested that the CMOs have available on-site.
- ◆ A review of the member cases HSAG requested from the CMO.
- ◆ 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, 2013–June 30, 2014
Information obtained through interviews	July 1, 2013—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, 2013–June 30, 2014

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 six standards and the follow-up standards and an overall percentage-of-compliance score across the reviewed 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 draft reports to DCH and to the CMOs for their review and comment prior to issuing final reports.

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 CMO until it is approved by DCH. Implementation of the CAP may begin once approval is received.



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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
- ◆ 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 final 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.



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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.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date



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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.

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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.

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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.

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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.

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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.

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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.

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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



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subspecialty providers, mental health providers, and pharmacies.

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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.

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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.

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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.

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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:

(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.

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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.

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Standard IV—Coordination and Continuity of Care

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:

(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.

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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.

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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.

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Standard V—Coverage and Authorization of Services

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

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.

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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.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date



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Department of Community Health (DCH)
Corrective Action Plan
for Peach State Health Plan

Standard V—Coverage and Authorization of Services

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

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.

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**Appendix E. State of Georgia
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Standard VI—Emergency and Poststabilization Services

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

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.

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Standard VI—Emergency and Poststabilization Services

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

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.

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Standard VI—Emergency and Poststabilization Services

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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.

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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.

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**Appendix E. State of Georgia
Department of Community Health (DCH)
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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 PAPILOMAVIRUS 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.

Interventions Planned	Individual(s) Responsible	Proposed Completion Date



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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.

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Appendix F. Case Management File Review Tools

Following this page are the Case Management File Review Tools HSAG used to evaluate Peach State's cases.



Appendix F. State of Georgia
Department of Community Health (DCH)
Case Management File Review Tool
for Peach State Health Plan

Case Management File Review Tools—Peach State

Case Identifier: Case 1
Diagnosis: Pre-term labor
Synopsis: 27-year-old female referred to case management at 32 weeks gestation for symptoms of pre-term labor.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was identified for high-risk case management at 32 weeks gestation due to pre-term labor. Member was referred to case management by the prior authorization case manager who identified some observation stays for the member. Member referred to care management on 1/3/2014.

Recommendations:

- ◆ None.

2. In what level of case management or program type is the member enrolled?

Observations:

- ◆ High-risk pregnancy

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ 1/17/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)

Case Management Evaluation Guide

- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

Observations:

- ◆ High-risk pregnancy.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member undergo a comprehensive assessment that included documentation of the member’s physical, behavioral, social, and psychological needs; risk factors; and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ Comprehensive assessment completed on 1/17/2014.
- ◆ Member lives with her three children, ages 10, 6, and 3.
- ◆ Father is involved.
- ◆ Member indicates that she is not planning to breastfeed due to pain.
- ◆ Member has had three episodes of pre-term labor.
- ◆ Member on bed rest.
- ◆ Member has had three urinary tract infections during this pregnancy. Symptoms of morning sickness.
- ◆ No social needs identified.
- ◆ No other health conditions noted.

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member’s cultural and/or linguistic needs?

Observations:

- ◆ A note that accompanied the comprehensive assessment dated 1/17/2014 included assessment for cultural and linguistic needs. No needs were identified.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member’s over-/underutilization of resources?

Observations:

- ◆ Case management notes indicated a review of utilization. The case manager contacted the provider on 1/15/2014 to obtain information on services

Case Management Evaluation Guide

provided and noted that the member was receiving home health services although a review of claims did not show claims were submitted to the CMO for these services.

Recommendations:

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member’s family or caregivers?

Observations:

- ◆ For obstetrics members, the CMO reported that it rarely involves family or caregivers.
- ◆ No involvement noted in this case.

Recommendations:

- ◆ The case manager should solicit input from family or caregivers as part of the comprehensive assessment.

9. Does the comprehensive assessment process include discussion(s) with the member’s providers?

Observations:

- ◆ Case notes showed attempts to involve the obstetrician and home health agency.
- ◆ 1/17/2014 – Contact with obstetrician who reported that the member had an abnormal Down syndrome screening (subsequent screening negative) and was given a prescription for nausea.

Recommendations:

- ◆ None.

III. Care Plan Development

10. Does the care plan reflect the member’s problems and needs (identified during the assessment) wherein the member could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc., observed in the record.)

Observations:

- ◆ The care plan was developed on 1/17/2014.
- ◆ Member indicated that she wants tubal ligation.
- ◆ Care plan includes goals for prenatal vitamins, pre-term labor knowledge deficit, education on postpartum visit and postpartum care, tubal ligation.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member’s caregiver/family
- ◆ Providers and/or specialists

Observations:

Case Management Evaluation Guide

- ◆ Care plan reflects member input.
- ◆ Care plan does not reflect input from the member’s family.
- ◆ Care plan does not reflect input from the member’s OBGYN.

Recommendations:

- ◆ The case manager should reflect input from the member’s family and treating providers into the care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ Care gap analysis was not reflected in the care plan.

Recommendations:

- ◆ The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Did the case manager document activities to monitor the member’s ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ No contact noted with member after enrollment into case management until notation of delivery.
- ◆ 3/5/2014 – case manager checked for utilization and noted admission for delivery.
- ◆ 3/12/2014 – outreach to member to conduct postpartum assessment.
- ◆ 4/25/2014 – outreach to provider as member could not be contacted. Provider confirmed member attended the postpartum care visit and confirmed contraceptive method.
- ◆ The care plan noted the member’s request for tubal ligation; however, action on this request was not documented.

Recommendations:

- ◆ The CMO should ensure that members enrolled in case management have an active care plan.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ The care plan was not communicated to the member’s provider.

Recommendations:

- ◆ The CMO should incorporate a process for communicating the care plan with the member’s provider.

Case Management Evaluation Guide

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

- ◆ The care plan did not include involvement of the member’s caregiver and/or family.

Recommendations:

- ◆ The case manager should include the member’s caregiver and/or family in the care plan and ongoing communication as appropriate.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ No referrals were indicated.

Recommendations:

- ◆ None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member’s individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ A multidisciplinary team was not used to manage this member.

Recommendations:

- ◆ The CMO should use a multidisciplinary team in the management of members in case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnoses, and other relevant information.

Observations:

- ◆ There were no hospitalizations, ER visits, or urgent care visits after enrollment into care management and prior to delivery.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member’s discharge plan and evaluate and identify the member’s needs?

Observations:



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Case Management Evaluation Guide

- ◆ A discharge plan was not obtained for the delivery. The CMO reported that case managers are only alerted if there are member needs identified during delivery.

Recommendations:

- ◆ The CMO should ensure there is a process to obtain the discharge plan for all hospitalizations.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ No discharge plan or transition of care needs was obtained.

Recommendations:

- ◆ The CMO should note that an assessment of coordination of care and/or transition of care needs was conducted, even if needs were not identified.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies were in place?

Observations:

- ◆ The case manager attempted to reach the member post-discharge. The case manager was unable to contact the member and followed up directly with the obstetrician to verify that the member had scheduled a postpartum visit.

Recommendations:

- ◆ None.



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Case Management File Review Tool
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Case Identifier: Case 2

Diagnosis: Asthma, diabetes, hypertension, gastroesophageal reflux disease (GERD), COPD, bipolar, fibromyalgia, seizure disorder, eczema.

Synopsis: 39-year-old female, self-referral for case management services for seizures.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was identified for case management through self-referral. Member called for “caretaker” for seizures. Member was identified for case management on 1/13/2014.

Recommendations:

- ◆ None.

2. In what level of case management or program type is the member enrolled?

Observations:

- ◆ Moderate.

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO’s case management program?

Observations:

- ◆ Member was enrolled in case management on 1/22/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age

Case Management Evaluation Guide

- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

Observations:

- ◆ Chronic condition.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member undergo a comprehensive assessment that included documentation of the member’s physical, behavioral, social, and psychological needs; risk factors; and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ A health risk assessment was completed on 1/22/2014. Score of 237 – moderate.
- ◆ Member identified issues with coping.
- ◆ Receiving assistance from son.
- ◆ Member goal for “getting support/assessment for seizure diagnosis.” No life goals identified by member.
- ◆ No advance directive.
- ◆ Member not currently working.
- ◆ Member connected with primary care provider. Pending neurology appointment.
- ◆ Member describes her overall health as poor.
- ◆ Member reported diagnoses: Asthma, diabetes (2011), hypertension (2011), eczema, seizure disorder (last 6 months), bipolar, GERD, fibromyalgia, ovarian cysts.
- ◆ Gall bladder removal (10/2013).
- ◆ No current home health services.
- ◆ Uses glucometer, no supplies needed.
- ◆ No tobacco.
- ◆ Member indicates her health has worsened over the last 6 months from uncontrolled seizures. Has been inpatient 2 times in the past 30 days.
- ◆ Has visited the emergency room in the past 6 months.
- ◆ Member indicates that she has bipolar, feeling depressed. Requested that someone from Cenpatco Behavioral Health contact her. Member is not taking medication for her behavioral health issues. Has seen a therapist in the past but no behavioral health provider currently.
- ◆ Denies alcohol or drug use.
- ◆ Receives assistance with food stamps and Section 8 housing.
- ◆ Member does not feel she has help when needed. Member lives with her son, and 16- and 5-year-old daughters. Member requests a caregiver.

Case Management Evaluation Guide

- ◆ Member indicates she needs assistance with community resources – support group/educational services. Member is not on SSI.
- ◆ Member indicates that she does not take her medications as prescribed.

Recommendations:

- ◆ The CMO should consider assessing for information about chronic disease that is consistent with its clinical practice guidelines, such as an asthma action plan, and completion of services, such as an annual flu shot and eye exam for members with diabetes.

6. Does the assessment include documentation of the member’s cultural and/or linguistic needs?

Observations:

- ◆ The member did not identify any cultural or linguistic needs.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member’s over-/underutilization of resources?

Observations:

- ◆ Utilization of services was conducted on 1/22/2014. The case manager identified additional diagnoses for chronic obstructive pulmonary disease and a gastric ulcer.

Recommendations:

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member’s family or caregivers?

Observations:

- ◆ Not applicable. The member lives with her children all under the age of 18 and no other family supports or caregivers were identified.

Recommendations:

- ◆ None.

9. Does the comprehensive assessment process include discussion(s) with the member’s providers?

Observations:

- ◆ The case manager attempted to reach the primary care provider on 1/22/2014.
- ◆ The case manager had contact with Emory and identified that the member was receiving services outpatient.

Recommendations:

- ◆ None.

III. Care Plan Development

10. Does the care plan reflect the member’s problems and needs (identified during the assessment) wherein the member could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc., observed in the record.)

Observations:

Case Management Evaluation Guide

- ◆ The care plan was developed on 1/22/2014.
- ◆ The care plan included the following goals:
 - Support for psychosocial issues
 - Make referral to Cenpatico Behavioral Health.
 - Decrease readmission by assisting member with scheduling physician visits and filling medications.
 - Assess compliance with physician appointments, medication refills, and support system to present additional admissions.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member's caregiver/family
- ◆ Providers and/or specialists

Observations:

- ◆ The member provided input to the care plan.
- ◆ The member did not identify adult family members or a caregiver to participate in the care plan development.
- ◆ The member's provider was contacted on 1/22/2014.

Recommendations:

- ◆ None.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ No care gap analysis was documented.

Recommendations:

- ◆ The case manager should ensure that a care gap analysis is conducted.

IV. Monitoring and Follow-up

13. Did the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ The case management notes show much activity with this member; however the care plan was not frequently updated to reflect the activity.
- ◆ The neurologist indicated that seizures were due to stress.
- ◆ Member indicated that she applied for SSI but was denied and is in the appeal process.

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- ◆ Member had many needs that could benefit from ongoing case management, but the case was closed.
- ◆ **Recommendations:** The case manager should reassess the needs of the member to determine if the member may benefit from ongoing case management services. This member had many issues that could benefit from ongoing case management services.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ The case manager attempted to make contact with the primary care provider early in the process on 1/22/2014.
- ◆ Member was referred to Nurtur for diabetes. Per Nurtur note on 1/22/2014 – member’s blood pressure was noted as extremely high; Nurtur contacted the primary care physician’s office and the member was directed to the emergency room but refused. The member refused contact with 911. The member did follow up with the PCP.

Recommendations:

- ◆ None.

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

- ◆ Not applicable.

Recommendations:

- ◆ None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ Member was referred to Cenpatico Behavioral Health services on 1/13/2014. Outreach by social work on 1/13/2013.
- ◆ Member referred to social worker on 1/14/2014 to assist with in-home care resources. Note by social worker on 2/2/2014 identified that there were no resources for someone to help the member in her home with her children.
- ◆ Member referred to the epilepsy foundation.

Recommendations:

- ◆ None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member’s individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing

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- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ No documentation noted for multidisciplinary team approach for the management of the member. The member was referred to behavioral health; notes were entered by Nurture and the social worker, but no communication was documented between the various team members.

Recommendations:

- ◆ The CMO should promote the use of a multidisciplinary team for managing individuals with case management.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnoses, and other relevant information.

Observations:

- ◆ Member was admitted to Emory from 1/14/2014–1/16/2014 for seizures.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member’s discharge plan and evaluate and identify the member’s needs?

Observations:

- ◆ The discharge plan was not obtained. The case manager noted that the member was discharged home on 1/16/2014 with no discharge needs.

Recommendations:

- ◆ The CMO should implement a process to obtain a discharge plan for all hospitalizations.

20. Does the care plan address the member’s coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ The case manager did not obtain the discharge plan but indicated that the member had no discharge needs.

Recommendations:

- ◆ The CMO should obtain the discharge plan for each member before determining that a member has no discharge needs.

21. Did the case manager follow up with the member and monitor the member’s ongoing needs to ensure care, services, and supplies were in place?

Observations:

- ◆ The case manager did not document a post-discharge note.

Recommendations:

- ◆ The CMO should ensure that all members are contacted post-discharge.



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Case Identifier: Case 3
Diagnosis: Stage III Breast Cancer
Synopsis: Member with a recent diagnosis of Stage III breast cancer, history of Type I diabetes mellitus.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was referred to case management via the CMO trigger list and referred by internal staff from utilization management. Member was inpatient for vomiting post chemotherapy treatment for Stage III breast cancer. Member was identified for case management on 5/11/2014.

Recommendations:

- ◆ None.

2. In what level of case management or program type is the member enrolled?

Observations:

- ◆ Complex Case Management. Scoring in the low range.

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ Member enrolled into case management on 5/28/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

Observations:

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- ◆ Chronic condition, high-cost condition.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member undergo a comprehensive assessment that included documentation of the member’s physical, behavioral, social, and psychological needs; risk factors; and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ The member had a comprehensive assessment completed on 5/28/2014.
- ◆ Member reported having some visual impairment since starting chemotherapy treatment.
- ◆ Husband was identified as support along with church. Husband is employed.
- ◆ Member’s health care goal – remission from breast cancer.
- ◆ Member has a primary care physician and oncologist.
- ◆ Rates overall health as fair.
- ◆ Wants life planning information.
- ◆ New diagnosis of breast cancer, as of February 2014.
- ◆ Diabetes mellitus since age 16 and hypertension diagnoses.
- ◆ Currently undergoing chemotherapy every 2 weeks.
- ◆ Member allergic to Zithromax.
- ◆ Member identified a glucometer as medical equipment.
- ◆ Member has had two inpatient admissions in the last 12 months, post chemotherapy for dehydration and elevated glucose.
- ◆ Has past outpatient treatment history for anxiety and depression.
- ◆ No activities of daily living (ADL) assistance required.
- ◆ No social referrals needed.

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member’s cultural and/or linguistic needs?

Observations:

- ◆ The member had no cultural or linguistic needs.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member’s over-/underutilization of resources?

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Observations:

- ◆ Case management notes demonstrated a review of Impact Pro for utilization of resources.

Recommendations:

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member’s family or caregivers?

Observations:

- ◆ The assessment did not include a discussion with the member’s family.

Recommendations:

- ◆ The CMO should attempt to include the member’s family in the assessment process.

9. Does the comprehensive assessment process include discussion(s) with the member’s providers?

Observations:

- ◆ The CMO did not include a discussion with the member’s provider during the assessment process.

Recommendations:

- ◆ The CMO should include provider input into the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member’s problems and needs (identified during the assessment) wherein the member could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc., observed in the record.)

Observations:

- ◆ The care plan was completed on 5/28/2014. The care plan demonstrated goal priorities that were associated with the problems identified in the assessment, based on member input, and prioritized.
- ◆ Log of blood sugars.
- ◆ Facilitate clinical reevaluation. (PCP input of Hba1c 15.4).
- ◆ Pap smear.
- ◆ Readmission risk – decreased readmission by physician appointments and filling prescriptions.
- ◆ Verbalize barriers.
- ◆ Community resources – SSI and social supports
- ◆ Maintain healthy blood pressure. Obtain home blood pressure monitor.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member

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- ◆ The member’s caregiver/family
- ◆ Providers and/or specialists

Observations:

- ◆ 5/29/2014 – call to oncologist.
- ◆ 6/1/2015 – communication with PCP and oncologist.

Recommendations:

- ◆ None.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ Care gap analysis was conducted as part of the assessment. The case manager identified that the member had hypertension but did not have a blood pressure monitor.

Recommendations:

- ◆ None.

IV. Monitoring and Follow-up

13. Did the case manager document activities to monitor the member’s ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ Changes to the care plan were reflected.

Recommendations:

- ◆ None.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ Communication with both the PCP and oncologist was demonstrated.

Recommendations:

- ◆ None.

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

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(Insert case manager contact with caregiver/family.)

Observations:

- ◆ There was no documentation of discussion with the member’s family related to the care plan.

Recommendations:

- ◆ The case manager should include discussion with the member’s family related to the care plan.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ The case manager provided the member with referrals to SSI and social supports.

Recommendations:

- ◆ None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member’s individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ There was no evidence of a multidisciplinary team approach used to manage the member.

Recommendations:

- ◆ The case manager should use a multidisciplinary team to manage the member’s care.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnoses, and other relevant information.

Observations:

- ◆ There were no hospitalizations or ER visits noted after enrollment into case management.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member’s discharge plan and evaluate and identify the member’s needs?

Observations:

- ◆ N/A.

Recommendations:



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- ◆ None.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ N/A.

Recommendations:

- ◆ None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies were in place?

Observations:

- ◆ N/A.

Recommendations:

- ◆ None.



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Case Identifier: Case 4
Diagnosis: Cerebral palsy, blind, deaf, asthma, epilepsy, respiratory illness, osteopenia, multiple sclerosis
Synopsis: 16-year old male with severe disabilities and multiple needs as new member to the CMO.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was referred to case management by the member's guardian on 5/2/2014.

Recommendations:

- ◆ None.

2. In what level of case management or program type is the member enrolled?

Observations:

- ◆ Complex Case Management – High stratification

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ Member was enrolled into case management on 5/5/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

Observations:

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- ◆ High-cost condition
- ◆ High-risk condition
- ◆ Chronic conditions

Recommendations:

- ◆ None.

II. Assessment

5. Did the member undergo a comprehensive assessment that included documentation of the member’s physical, behavioral, social, and psychological needs; risk factors; and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ A comprehensive assessment was completed on 5/5/2014 with the member’s guardian.
- ◆ Blind, deaf, nonverbal, multiple severe disabilities.
- ◆ Member has a guardian, who is a former special education teacher.
- ◆ Member has a primary care provider.
- ◆ Health identified as poor.
- ◆ Member has cerebral palsy and has been blind, deaf, and nonverbal since birth. Diagnosis of multiple sclerosis, epilepsy, and paralysis.
- ◆ Developmental problems.
- ◆ Multiple medications.
- ◆ Uses a nebulizer, feeding tube, diapers.
- ◆ Overall health – worsened, weight improved.
- ◆ Requires assistance with ADLs - bathing, dressing, eating, walking, stairs, bathroom.
- ◆ Caregiver (guardian) – does not feel she has help when needed.
- ◆ Unsure of immunizations.
- ◆ Member is new to the CMO.
- ◆ Needs help with community resources, assistance with SSI.
- ◆ Severe disabilities with multiple needs.

Assessment note - Mother deceased, father not involved. SSI – denied due to death benefits and child support from father.

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member’s cultural and/or linguistic needs?

Observations:

- ◆ No cultural or linguistic needs were identified.

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Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member's over-/underutilization of resources?

Observations:

- ◆ Member new to the CMO.

Recommendations:

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- ◆ Member is a child and assessment included the guardian.

Recommendations:

- ◆ None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- ◆ The member's provider was contacted on 5/5/2014 and was provided with information on the contact for durable medical equipment (DME).

Recommendations:

- ◆ None.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs (identified during the assessment) wherein the member could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc., observed in the record.)

Observations:

- ◆ The member's care plan was developed on 5/5/2014.
- ◆ Goals included the caregiver to be able to navigate the system to ensure needs are met.
- ◆ Referral to the Georgia Pediatric Program (GAPP) for private duty nursing.
- ◆ Connection with Univita home health DME vendor to obtain needed supplies and services.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member's caregiver/family
- ◆ Providers and/or specialists



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Observations:

- ◆ The care plan reflects participation from the member's guardian as the member is a child.

Recommendations:

- ◆ None.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ A care gap analysis was not documented.

Recommendations:

- ◆ The case manager should incorporate a care gap analysis.

IV. Monitoring and Follow-up

13. Did the case manager document activities to monitor the member's ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ The care plan was updated based on progress toward goals. The case manager demonstrated follow-up on nutritional supplementation not received and resolved the issue to resolution.

Recommendations:

- ◆ None.

14. Did the case manager communicate the member's care plan to providers and document collaboration efforts with the member's providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ The care plan was not communicated to the member's provider; however, collaboration with the provider's office to provide DME vendor contact was done.

Recommendations:

- ◆ None.

15. Did the case manager document discussion of the member's care plan and any ongoing communication efforts with the member's caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

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- ◆ The case manager communicated with the member’s guardian.

Recommendations:

- ◆ None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ The member’s caregiver was referred to GAPP for private duty nursing, which was approved for 8 hours a week.
- ◆ The member’s caregiver was referred to Chamberlain Edwards to assist with SSI and the appeals process.

Recommendations:

- ◆ None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member’s individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ The member was presented at the integrated case management rounds with a summary of the case discussion.

Recommendations:

- ◆ None.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnoses, and other relevant information.

Observations:

- ◆ The member did not have any hospitalizations or ER visits within the last six months. The member was new to the CMO in May 2014.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member’s discharge plan and evaluate and identify the member’s needs?

Observations:

- ◆ N/A.

Recommendations:

- ◆ None.



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20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ N/A.

Recommendations:

- ◆ None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies were in place?

Observations:

- ◆ N/A.

Recommendations:

- ◆ None.



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Case Identifier: Case 5

Diagnosis: Complex Case Management

Synopsis: 18-year-old referred by UM for case management after major accident and hospitalization that resulted in the member's left leg being amputated.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Through UM process/trigger list after hospitalization for severe injury to left leg due to all-terrain vehicle (ATV) accident that resulted in his left leg being amputated.

Recommendations:

- ◆ None.

2. What level of case management or program type is the member enrolled in?

Observations:

- ◆ Complex Case Management

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ 4/28/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy

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- ◆ Infant/toddler with risk for developmental delays

Observations:

- ◆ Member's current condition, status post left leg amputation due to traumatic injury.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ The initial assessment for this member was comprehensive and covered all physical, behavioral, social, and psychological needs.
- ◆ Member reported that he has a PCP and describes himself as in good health.
- ◆ Member has no history of major medical issues and no reported behavioral or psychological issues prior to the accident.
- ◆ Member reported alcohol use in the past and currently lives with his aunt and uncle due to his poor relationship with his mother. The member was referred for case management after an ATV accident that severely damaged his left leg, which was later amputated.
- ◆ Member goal is to get his wound site healed and fit with a prosthesis.
- ◆ Member reported that he currently uses crutches to get around and stated that his health has worsened and he has had 2 hospitalizations, one for the ATV accident and one for appendicitis.
- ◆ Member also reported some feelings of hopelessness since the accident and requested the telephone number for behavioral health services. At the time of the assessment the member reported that he needed help with some ADLs, meals, food, and housing.

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- ◆ The assessment identified no cultural or linguistic needs for the member.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- ◆ Impact Pro identified that the member had not had a well visit since 4/28/2014.

Recommendations:

Case Management Evaluation Guide

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Observations:

- ◆ The member identified his aunt as his point of contact and the aunt reported that the member was living with her husband and her and this is the best place for the member due to his relationship with his mother. The aunt also reported that the member had issues with alcohol and would sneak cigarettes.

Recommendations:

- ◆ None.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- ◆ The assessment contained no documented interaction with the member's provider.

Recommendations:

- ◆ Inclusion of a member's provider during the assessment process to provide feedback and insight into member's medical and treatment history.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- ◆ Care plan identified the member's potential for withdrawal and depression due to injury.
- ◆ Decrease risk for readmission.
- ◆ Identify barriers to compliance.
- ◆ Discharged on 7/3/2014 to home with IV antibiotics; home health approved for IV antibiotics due to wound infection on left leg.
- ◆ Switch from pediatrician to PCP.
- ◆ Evaluation for BH.
- ◆ Care gaps: flu shot, well check, hepatitis C screening.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member's caregiver/family
- ◆ Providers and specialists

Observations:

- ◆ The care plan reflected member and caregiver input to goals, but the care plan did not reflect any input from the member's provider.

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Recommendations:

- ◆ Inclusions of the member’s provider in the development of the care plan to ensure all member needs are met.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ The care gaps identified as goals in the care plan for completion by the member were flu shot, well check, and hepatitis C screening. This information was collected from Impact Pro but does not reflect a formalized review of multiple data sources to identify the members care gaps.

Recommendations:

- ◆ The CMO should incorporate a process for assessing care gaps.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member’s ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ Case notes reflected the case manager’s contact with and attempts to contact the member, the aunt, and the member’s providers. Examples of contact attempted and made are as follows: on May 15, 2014, the case manager attempted to contact provider with no success, left voicemail with orthopedist office for return call; again on May 15 the case manager called the aunt with referral information for PCP. On July 3, 2014, the case manager made contact with the member’s aunt and identified that the member was in the hospital for infection in his wound site on the left leg. The aunt reported to the case manager that the member would need to be sent home with IV antibiotics to be administered via his peripherally inserted central catheter (PICC) line. The aunt expressed a need to secure home health care nursing prior to the member being discharged from the hospital. The case manager then contacted the referral agency to support the member in obtaining the services needed to complete the administration of IV antibiotics.

Recommendations:

- ◆ None.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ The case notes identified contact made with the member’s provider(s). It was clearly documented in the notes that the case manager would review the member’s care plan with the provider or the provider’s nurse.

Recommendations:

Case Management Evaluation Guide

- ◆ None.

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

- ◆ Development of the care plan and the discussion the case manager had with the member and caregivers was documented in the assessment note. The case manager clearly documented all ongoing contact with the aunt on multiple occasions.

Recommendations:

- ◆ None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ The case manager supported the member in getting home health care and documented in the care plan that the case manager provided the member with the contact number for behavioral health care. The case management notes identified the contact that the case manager had with the home health agency to support the linkage of the member for prescribed services. There were no case notes presented that identified follow-up with the home health agency to determine member progress with the services being provided. For the behavioral health component of the care plan, the case manager documented in the care plan that the member was experiencing a reduction in reported symptoms of hopelessness. There was no documentation provided during the interview that identified any communication between the case manager and the behavioral health provider.

Recommendations:

- ◆ Ensure monitoring of the behavioral health component in the care plan.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member’s individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ There was no documentation presented during the interview that identified this member’s case as having been presented during any team meetings, case conferencing, grand rounds, member rounds, or multidisciplinary work groups.

Recommendations:

- ◆ The case manager should use a multidisciplinary team to manage the member’s care.

Case Management Evaluation Guide

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- ◆ Member had two hospitalizations prior to identification for case management. The first was for the ATV accident and subsequent amputation of the lower part of his left leg. The second hospitalization was for acute appendicitis that resulted in surgery to remove the member's appendix. Member was hospitalized for infection at the wound site on his left leg member, had wound surgically debrided, and was released to home July 3, 2014, with PICC line in place for continued IV antibiotic treatments.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- ◆ No discharge planning noted for member's July 2014 hospital stay. Case manager did have contact with the member's aunt who identified the member's need for home health care for administration of IV antibiotics.

Recommendations:

- ◆ Obtain member discharge plan from hospital stay; complete medication reconciliation; and review for any needed referrals, linkage, or support.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ The care plan was updated by the case manager to address member's need for home health care after release from hospital to administer IV antibiotics based on the information provided by the aunt.

Recommendations:

- ◆ Seek provider/hospital staff input for changes to care plan to address post hospitalization needs.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:

- ◆ Case manager documented continued contact with the member's aunt and providers concerning the member's progress and needs, and the case manager documented support with linkage to home health agency for administration of IV antibiotics in the home. No follow-up/monitoring noted after the initial contact with the home health agency or aunt to determine the outcome of the services provided.

Recommendations:

- ◆ Ensure continued monitoring of progress post discharge from facility.



Appendix F. State of Georgia
Department of Community Health (DCH)
Case Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 6

Diagnosis: Pregnancy Induced Hypertension (PIH)

Synopsis: 32-year-old female referred 3/3/2014 for case management after hospitalization for PIH.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was referred for case management on 3/3/2014 by Alere after hospitalization for PIH – client was identified through trigger list.

Recommendations:

- ◆ None.

2. What level of case management or program type is the member enrolled in?

Observations:

- ◆ High risk OB.

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ 4/4/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

Observations:

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- ◆ High risk pregnancy.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ 32 y/o female, pregnant, referred for case management after hospitalization for pregnancy induced hypertension (PIH).
- ◆ Member identified the father of the baby as a point of contact. Member reported that she lives with her boyfriend and their three children (11 y/o son, 9 y/o and 3 y/o daughters).
- ◆ Member identified her OB provider is Sharon Joyce Bailey, but member has not identified a primary provider (pediatrician) for the unborn child. Member reported no previous history of complicated pregnancy or pre-term delivery, member reported that she is to deliver at Gwinnett Medical Center.
- ◆ Member reported that her prescribed prenatal vitamins (PNVs) caused increased nausea and vomiting, and she is currently taking over-the-counter (OTC) PNVs.
- ◆ Member reported no other medical issues or hypertension (HTN) prior to pregnancy, reported to assessor that she does smoke and did drink alcohol, but she will quit smoking and not drink alcohol while she is pregnant.
- ◆ Member denied any issues with completion of ADLs, cultural or linguistic needs, and any social needs. Member reported that she has the support of her family and boyfriend, she is currently receiving WIC and she has already signed the consent for a bilateral tubal ligation (BTL).

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- ◆ Both the assessment and the assessment note address the member's cultural and linguistic needs.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- ◆ No issues with over or underutilization of resource noted.

Recommendations:

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Case Management Evaluation Guide

Observations:

- ◆ There was no identified discussion with the member's boyfriend (father of the baby) or family in either the assessment or the assessment note.

Recommendations:

- ◆ Inclusion of the member's support system in the assessment process.

9. Does the comprehensive assessment process include discussion(s) with the member's providers?

Observations:

- ◆ There was no identified communication with the member's OB provider in either the assessment or the assessment note.

Recommendations:

- ◆ Inclusion of the member's provider during the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member's problems and needs identified during the assessment that could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- ◆ Care plan: manage PIH effectively, obtain dental care, and select a pediatrician for the baby. Member agrees with care plan follow-up.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member's caregiver/family
- ◆ Providers and specialists

Observations:

- ◆ The care plan reflected the member's participation but did not reflect any participation by the member's family/support system or her provider.

Recommendations:

- ◆ Inclusion of the member's family/support system and provider(s).

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ Care gaps identified were member's noncompliance with her prescribed PNVs, and Impact Pro identified member's lack of a flu shot as a care gap. This information was collected from Impact Pro but does not reflect a formalized review of multiple data sources to identify the member's care gaps.

Recommendations:

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- ◆ The CMO should incorporate a process for assessing care gaps

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member’s ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ Case manager called the provider and received information (4/7/2014) concerning member’s need to have a second glucose test; no follow-up was indicated for this identified need, and the care plan was not updated to reflect the change.

Recommendations:

- ◆ Ensure follow-up for all identified member needs and update care plan as needed to address these needs.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ 4/4/2014: attempted to contact the OB provider, left message; 4/7/2014: contacted provider, discussed care plan; provider reported that member had experienced PIH with all pregnancies and would need an updated glucose test.

Recommendations:

- ◆ None.

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

- ◆ No communication with the family concerning the care plan, were noted during the review of the care management file.

Recommendations:

- ◆ Communication and outreach to family concerning members care plan and ongoing needs.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ No referral needs identified for the member.

Recommendations:

- ◆ None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member’s individual needs by making use of any of the following?

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- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ There was no documentation presented during the interview that identified this member’s case as having been presented during any team meetings, case conferencing, grand rounds, member rounds, or multidisciplinary work groups.

Recommendations:

- ◆ The case manager should use a multidisciplinary team to manage the member’s care.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- ◆ Member admitted to hospital on 6/15/2014, and release on 6/17/2014, after delivery.
- ◆ Member returned to the hospital and was admitted on 6/23/2014, and was released 6/25/2014 for essential hypertension.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member’s discharge plan and evaluate and identify the member’s needs?

Observations:

- ◆ Peach State did receive notification of the member’s delivery on 6/15/2014. Staff reported that when there is a “normal” birth, there is typically no discharge plan.
- ◆ There was no identified discharge plan for the member’s 6/23/2014 to 6/25/2014 hospital stay.

Recommendations:

- ◆ Obtain member discharge plan from hospital stay, complete medication reconciliation, and review for any needed referrals, linkage, or support.

20. Does the care plan address the member’s coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ No update to the care plan was identified due to hospitalization.

Recommendations:

- ◆ Identify member needs and update care plan.

21. Did the case manager follow up with the member and monitor the member’s ongoing needs to ensure care, services, and supplies are in place?

Observations:

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- ◆ Healthy Start contacted the member on 6/16/2014, and the member reported that she was going to switch the baby to WellCare because that is the only CMO with which Cooper Pediatrics is contracted. The member's postpartum appointment is 8/5/2014. Healthy Start followed up with member on 7/8/2014 after well-baby appointment missed, member reported that she had not taken her baby to the well-baby appointment because of her desire to get the baby linked with Cooper Pediatrics.
- ◆ This case is still open and ongoing; the member's postpartum visit is scheduled for 8/5/2014; case manager will attempt to contact member at that time.

Recommendations:

- ◆ None.



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for Peach State Health Plan

Case Identifier: Case 7

Diagnosis: Laryngeal cleft and subglottic stenosis

Synopsis: 11-day-old infant admitted to hospital after aspirating breast milk while nursing.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was referred for case management after social worker identified member need from trigger list on April 8, 2014, during visit with member in the hospital.

Recommendations:

- ◆ None.

2. What level of case management or program type is the member enrolled in?

Observations:

- ◆ Enrolled 4/16/2014.

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ Complex Pediatric Case Management

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

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Observations:

- ◆ High-risk and high-cost condition.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ Member is an 11-day-old infant female who presented to the ED after aspirating breast milk while feeding. The member's mother is her primary care giver and the member's parent's primary language is Nepali. While the father speaks English he is not available during the day due to employment obligations. Teleconferencing services were utilized in a three-way call to support the linguistic needs of the family.
- ◆ The member's mother reported that the member's current medical issues were not diagnosed until the child was 5 days old and due to physical issues, the child uses a feeding tube and was experiencing apnea.
- ◆ The member's mother reported that the child's pediatrician is Dr. Homer and that the child also has an ear, nose, and throat (ENT) specialist that she sees for the laryngeal cleft and subglottic stenosis. DME is an apnea monitor.
- ◆ Member's mother reported that the child has a follow-up appointment with the pediatrician on 5/20/2014 and is scheduled for ENT surgery on 6/25/2014. The current goal is to get the child's weight up to 11 pounds before the 6/25/2014 surgery date and to complete the surgery so the member can eat normally.

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- ◆ Primary language is Nepali – Voiance utilized during all contacts with the member's mother.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- ◆ No under- or overutilization of services identified during the assessment.

Recommendations:

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member's family or caregivers?

Case Management Evaluation Guide

Observations:

- ◆ The assessment was completed by the child’s mother.

Recommendations:

- ◆ None.

9. Does the comprehensive assessment process include discussion(s) with the member’s providers?

Observations:

- ◆ Communication with the member’s provider was not identified in the assessment.

Recommendations:

- ◆ Communication with member’s provider during the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member’s problems and needs identified during the assessment that could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- ◆ Care plan was completed on 4/17/2014, and the following goals were identified: understand use of medical equipment, refer to case management, and reduce readmission risk; self-management, access to follow-up and resources to evaluate eating need.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member’s caregiver/family
- ◆ Providers and specialists

Observations:

- ◆ The care plan reflects the participation of the member’s caregiver; at this time the member is unable to participate due to age. The care plan does not reflect any provider or specialist input.

Recommendations:

- ◆ Seek provider and specialist input for care plan.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

- ◆ Impact Pro identified the member’s lack of an Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) visit as the care gap. This information

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was collected from Impact Pro but does not reflect a formalized review of multiple data sources to identify the members care gaps.

Recommendations:

- ◆ The CMO should incorporate a process for assessing care gaps

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member’s ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ 5/1/2014: case manager attempted to contact member’s mother, left message.
- ◆ 5/15/2014: case manager contacted the mother who reported that the child was having no issues with feeding.
- ◆ 5/28/2014: case manager attempted to contact member’s mother, sent letter.
- ◆ 6/3/2014: case manager attempted to contact member’s mother, unable to leave message.

Recommendations:

- ◆ None.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ On April 17, case manager attempted to contact the member’s pediatrician to discuss member’s treatment plan, left message. On the same day, case manager received message from the pediatrician’s office, was told by office staff that the provider would be unable to provide the case manager with any information concerning the member because they did not have a release of information.
- ◆ There was no attempt to follow up with the pediatrician after this first attempt, and there was no attempt to contact the member’s ENT provider.

Recommendations:

- ◆ Continued outreach to providers to ensure continuity of care and support of member needs.

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

Observations:

- ◆ The care plan was completed with the member’s mother.

Recommendations:

- ◆ None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the

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member actually received those services?

Observations:

- ◆ No referral needs were identified during the assessment.

Recommendations:

- ◆ None.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ There was no documentation presented during the interview that identified this member's case as having been presented during any team meetings, case conferencing, grand rounds, member rounds, or multidisciplinary work groups.

Recommendations:

- ◆ The case manager should use a multidisciplinary team to manage the member's care.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant information.

Observations:

- ◆ Member was identified for case management while in the hospital after the original diagnosis and then on 5/7/2014, member was seen and treated in the ER for conjunctivitis.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member's discharge plan and evaluate and identify the member's needs?

Observations:

- ◆ No discharge plan identified for the member's hospitalization.

Recommendations:

- ◆ Obtain member discharge plan from hospital stay, complete medication reconciliation, and review for any needed referrals, linkage, or support.

20. Does the care plan address the member's coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ No needs identified from ER visit.

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Recommendations:

- ◆ None.

21. Did the case manager follow up with the member and monitor the member's ongoing needs to ensure care, services, and supplies are in place?

Observations:

- ◆ Case manager continued to make follow-up calls with the member's mother. It was reported that the surgery was moved from 6/25/2014 to 8/4/2014. The case manager identified that the member was doing better physically and calls reduced from biweekly to monthly. This case is still open.

Recommendations:

- ◆ None.



Appendix F. State of Georgia
Department of Community Health (DCH)
Case Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 8

Diagnosis: Biliary Cholestasis

Synopsis: 5-month-old male child, diagnosed at 2 months old with biliary cholestasis. Member is currently waiting for a liver transplant.

Case Management Evaluation Guide

I. Identification

1. How was the member identified or referred for case management services?

Observations:

- ◆ Member was referred for case management by the corporate team on 5/21/2014 after child was placed on liver transplant list – member was identified with trigger list.

Recommendations:

- ◆ None.

2. What level of case management or program type is the member enrolled in?

Observations:

- ◆ Complex Pediatric Case Management.

Recommendations:

- ◆ None.

3. When was the member enrolled in the CMO's case management program?

Observations:

- ◆ 5/21/2014.

Recommendations:

- ◆ None.

4. Was the member identified as having any of the following special needs?

- ◆ Chronic condition(s)
- ◆ High-cost condition(s)
- ◆ High-risk condition(s)
- ◆ Pregnant woman under 21 years of age
- ◆ High-risk pregnancy
- ◆ Infant/toddler with risk for developmental delays

Case Management Evaluation Guide

Observations:

- ◆ High-cost, high-risk chronic condition.

Recommendations:

- ◆ None.

II. Assessment

5. Did the member have a comprehensive assessment that included documentation of the physical, behavioral, social, and psychological needs of the member, as well as any risk factors and past medical/psychiatric treatment history?

(Insert assessment findings observed in the record [* indicates areas from the assessment that should be addressed in the care plan].)

Observations:

- ◆ Assessment done 5/28/2014 with members mother (Kelsie), member's Impact Pro score was low and minimal needs were identified; however, due to member's placement on the liver transplant list, this member will remain in case management.
- ◆ Mother reported that the member does have a PCP (Dr. Lachazc) and a gastrointestinal specialist (Dr. Dubta), reported the member's health as fair due to need for liver transplant.
- ◆ Member is taking medications and is diagnosed with biliary cholestasis; his next follow-up appointment with his PCP is 6/12/2014. At this time, the liver transplant approved pending a donor.
- ◆ The member is currently fed through a nasogastric (NG) tube via feeding pump.
- ◆ Member is living with his mother and father and 2 siblings, mother reported support from family and friends.
- ◆ Member's mother reported that there were no issues with completing the member's ADLs, and there are no current financial or social concerns. However, the member's mother reported that while she is working currently, she is not sure that she will be able to continue working after the member receives his transplant.

Recommendations:

- ◆ None.

6. Does the assessment include documentation of the member's cultural and/or linguistic needs?

Observations:

- ◆ No cultural or linguistic needs identified during the assessment.

Recommendations:

- ◆ None.

7. Does the assessment include documentation of a review of the member's over-/under-utilization of resources?

Observations:

- ◆ Member has not had his immunizations; this is due to the pediatrician recommending to the parents to not get the child immunized due to current condition.

Recommendations:

Case Management Evaluation Guide

- ◆ None.

8. Does the comprehensive assessment process include discussion(s) with the member’s family or caregivers?

Observations:

- ◆ Member’s mother actively participated in the assessment process as member is 5 months old.

Recommendations:

- ◆ None.

9. Does the comprehensive assessment process include discussion(s) with the member’s providers?

Observations:

- ◆ No communication with provider noted during the assessment.

Recommendations:

- ◆ Inclusion of member’s PCP and specialist during the assessment process.

III. Care Plan Development

10. Does the care plan reflect the member’s problems and needs identified during the assessment that could benefit from case management interventions?

(Insert care plan goals, interventions, outcomes, barriers, etc. observed in the record.)

Observations:

- ◆ Care plan was completed on 5/28/2014; goals identified are EPSDT exam for immunization and to keep the mother informed about transplant.

Recommendations:

- ◆ None.

11. Does the care plan reflect participation of any of the following?

- ◆ The member
- ◆ The member’s caregiver/family
- ◆ Providers and specialists

Observations:

- ◆ The member’s mother actively participated in the development of the care plan as the member is only 5 months old. There was no documented contact with the member’s provider.

Recommendations:

- ◆ Ensure that the member’s provider is part of the care planning process.

12. Does the care plan reflect care gap analysis, identification, and interventions?

(Care gap analysis refers to the process of analyzing, identifying, and documenting any gaps between the care recommended to the member by providers, specialists, or CMO staff members and the care the member actually receives.)

Observations:

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- ◆ Care gap identified – Member behind on immunizations.

Recommendations:

- ◆ None.

IV. Monitoring and Follow-up

13. Does the case manager document activities to monitor the member’s ongoing and changing needs and make changes in the care plan to reflect those needs?

(Insert case manager monitoring activities and changes to the care plan as observed in the record.)

Observations:

- ◆ 5/22/2014: case manager attempted to contact member’s parent, was unable to leave message.
- ◆ 6/17/2014: case manager attempted to contact member’s parent, was unable to leave message.
- ◆ 6/24/2014: case manager attempted to contact member’s parent, left voice message.
- ◆ 7/7/2014: case manager attempted to contact member’s parent, left voice message.
- ◆ 7/16/2014: case manager attempted to contact member’s parent, left voice message.
- ◆ 7/16/2014: case manager attempted to contact member’s parent. Mom’s telephone is disconnected per note, case management trying to get a number for the grandmother to outreach to the member’s mother.

Recommendations:

- ◆ None.

14. Did the case manager communicate the member’s care plan to providers and document collaboration efforts with the member’s providers and/or specialists?

(Insert case manager contact with providers.)

Observations:

- ◆ 5/29/2014: case manager called and spoke to the hematologist nurse to discuss the member’s treatment plan. It was reported to the case manager that the member had a follow-up appointment on 6/26/2014 and the member would be placed on the transplant list on 5/30/2014.
- ◆ 7/5/2014: case manager called and spoke with the transplant nurse. It was identified that the member had an Aflac appointment on 7/2/2014. Case manager requested that notes from that appointment be faxed over to her after completion.
- ◆ 7/7/2014: case manager contacted the transplant nurse after receiving the documentation from most recent doctor’s visit to follow-up due to doctor’s note stating the member had received his liver. The transplant nurse reported that the member had not received a liver transplant.

Recommendations:

- ◆ None.

15. Did the case manager document discussion of the member’s care plan and any ongoing communication efforts with the member’s caregiver(s) and/or family?

(Insert case manager contact with caregiver/family.)

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Observations:

- ◆ 5/22/2014: case manager attempted to contact member's parent, was unable to leave message.
- ◆ 6/10/2014: case manager contacted member's mother to discuss SSI referral and linkage.
- ◆ 6/17/2014: case manager attempted to contact member's parent, was unable to leave message.
- ◆ 6/24/2014: case manager attempted to contact member's parent, left voice message.
- ◆ 7/7/2014: case manager attempted to contact member's parent, left voice message.
- ◆ 7/16/2014: case manager attempted to contact member's parent, left voice message.
- ◆ 7/16/2014: case manager attempted to contact member's parent. Mom's telephone is disconnected per note, case management trying to get a number for the grandmother to outreach to the member's mother.

Recommendations:

- ◆ None.

16. Did the case manager make referrals (medical, psychiatric, community resource, etc.) for the member and document follow-up efforts to ensure the member actually received those services?

Observations:

- ◆ Case manager made referral for support with SSI application. No identified follow up to verify receipt of application.

Recommendations:

- ◆ Case manager needs to ensure follow up to verify referral linkage and completion.

17. Did the CMO use a multidisciplinary team approach to holistically manage each member's individual needs by making use of any of the following?

- ◆ Grand rounds
- ◆ Care team meetings
- ◆ Case conferencing
- ◆ Member rounds
- ◆ Multidisciplinary work pods/groups

Observations:

- ◆ 6/2014: case manager communicated with corporate case management team to discuss member's case.
- ◆ 6/10/2014: case manager presented member's case during ICM rounds. The need for an SSI referral was identified during the rounds.
- ◆ 7/7/2014: case manager communicated with corporate case management team to discuss member's case.
- ◆ 7/15/2014: case manager presented member's case during ICM rounds for follow-up on SSI application.

Recommendations:

- ◆ None.

V. Transition of Care and Discharge Planning

18. If the member had hospitalizations, ER visits, and/or urgent care visits within the last six months, list admission dates, diagnosis, and other relevant

Case Management Evaluation Guide

information.

Observations:

- ◆ Member has had multiple hospitalizations for jaundice since he was diagnosed with liver issues at 2 months old. Member was also hospitalized from 5/25/2014–5/26/2014.

Recommendations:

- ◆ None.

19. Did the case manager obtain the member’s discharge plan and evaluate and identify the member’s needs?

Observations:

- ◆ No discharge plan was identified during the file review.

Recommendations:

- ◆ Obtain member discharge plan from hospital stay; complete medication reconciliation; and review for any needed referrals, linkage, or support.

20. Does the care plan address the member’s coordination of care and/or transitions of care needs with specific interventions targeting those needs?

Observations:

- ◆ No update to the care plan needed due to hospital discharge.

Recommendations:

- ◆ None.

21. Did the case manager follow up with the member and monitor the member’s ongoing needs to ensure care, services, and supplies are in place?

Observations:

- ◆ Case manager continues to monitor this case and is currently trying to obtain contact information for the mother of the member to discuss the member’s current progress.

Recommendations:

- ◆ None.

Appendix G. Disease Management File Review

Following this page are the completed Disease Management File Review Tools HSAG used to evaluate Peach State's cases.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Disease Management File Review Tools—Peach State

Case Identifier: Case 1
Diagnosis: Asthma
Synopsis: 6-year-old male asthmatic

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Asthma.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was identified through claims data; member had two ED visits for asthma.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ Disease manager completed an assessment call with parent. This was followed up by a home visit by the disease manager. Parent gave a return demonstration on how to give a treatment, and on care and use of a nebulizer. During the home visit, parent informed disease manager member was not on any medication. Disease manager contacted PCP office and informed PCP. PCP renewed prescription for medication.

Recommendations:

- ◆ The disease case manager should assess for a completed asthma action plan.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Disease Management

Observations:

- ◆ A care plan was created and sent to the PCP. PCP renewed medications.

Recommendations:

None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- ◆ National appropriate disease management guidelines were used.

Recommendations:

◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ Member has had two calls with disease manager and one home visit. Disease manager would like to schedule another home visit but parent reluctant.

Recommendations:

◆ None.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ Asthma toolkit was sent to the member upon enrollment and discussed during the home visit.

Recommendations:

◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ There was documentation the parent verbalized complete understanding of the condition, triggers, use of medication, and actions required.

Recommendations:

◆ None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Disease Management

Observations:

- ◆ The disease manager helped the parent create a care plan for self-management and reiterated the need for medication to be available as needed for the member's condition.

Recommendations:

- ◆ The disease case manager should obtain the care plan and align it with the asthma action plan.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ The parent has become reluctant to re-engage with the disease manager. Disease manager referred the member to case manager for follow-up.

Recommendations:

- ◆ None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- ◆ The disease manager collaborated with the parent and the member's PCP to coordinate appropriate care.

Recommendations:

- ◆ None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ The member did not deteriorate.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member health outcomes that related to disease management interventions.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 2
Diagnosis: Diabetes and Asthma
Synopsis: Adult female with both asthma and diabetes

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Asthma.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was identified for both asthma and diabetes disease management. The asthma claims history was more significant, so the CMO decided to focus on asthma disease management first.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ An assessment was completed, but the member would not take any additional calls. The disease manager tried additional numbers, leaving messages each time. The multiple calls were left at different times, on different days and at different times of the month.

Recommendations:

- ◆ None.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ No, the member would not participate in the development of a care plan.

Recommendations:

- ◆ None.

Disease Management

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- ◆ No, the member would not participate in the development of a care plan.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ The member would not participate in the development of a care plan.

Recommendations:

- ◆ None.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ The member was mailed a disease management enrollment kit for asthma.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ No, the member would not participate.

Recommendations:

- ◆ None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- ◆ No, the member would not participate.

Recommendations:

- ◆ None.

Disease Management

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ Not being monitored, the member would not participate.

Recommendations:

- ◆ None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- ◆ No, the member would not participate.

Recommendations:

- ◆ None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ No, the member would not participate.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member health outcomes that could be related to disease management interventions.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 3
Diagnosis: Asthma
Synopsis: 9-year-old male

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Asthma.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was identified by a case manager referral; the member had been in the ED.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ A baseline assessment was completed; the disease case manager spoke about triggers for an asthma attack, what causes an asthma attack, and that there is a smoker in the house.
- ◆ The disease manager asked the father about any additional conditions.
- ◆ Calls to the father were scheduled for every 30 days.

Recommendations:

- ◆ The disease case manager should assess for a personalized asthma action plan.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ A care plan was sent to member's PCP, with set goals for member and caregiver.

Disease Management

Recommendations:

- ◆ None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- ◆ National guidelines have been approved and are in use for asthma.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ An asthma education packet was sent to member and parent.

Recommendations:

- ◆ None.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ An asthma education packet was sent to member and parent.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ Father verbalized an understanding of his son’s disease process, including triggers, medications, and actions needed.

Recommendations:

- ◆ None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- ◆ The disease manager and the father developed a self-care plan for the son to assist in the control of asthma flare-ups.

Disease Management

Recommendations:

- ◆ The disease case manager should obtain the care plan and align it with the asthma action plan.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ Unable to determine how the member is being monitored. The member moved, and the CMO is unable to locate.

Recommendations:

- ◆ Once the member became unable to locate, a referral should have been made to case management because the member is a child.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- ◆ This was not demonstrated.

Recommendations:

- ◆ Document any collaboration and care coordination with providers, community agencies, or the member's family or caregivers.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ The member was not transitioned from disease management to case management. It is unknown if the member deteriorated due to lost contact.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member health outcomes that could be related to disease management interventions.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 4
Diagnosis: Diabetes
Synopsis: 33-year-old female diabetic

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Diabetes.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ Claims load.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ During the assessment, the disease manager reviewed the diabetic meal planning, meal patterns, and the pathophysiology of diabetes. The disease manager set up (1) a follow-up call with the member, (2) behavior change goals, and (3) another appointment in August 2014.

Recommendations:

- ◆ The disease case manager should assess for a personalized asthma action plan.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ The care plan was created and sent to the PCP.

Recommendations:

- ◆ None

Disease Management

5. Are disease management guidelines being used by the disease manager?

Observations:

- ◆ The CMO used guidelines related to an exchange list, four steps for controlling diabetes, and meal planning.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ The member received an enrollment packet after the assessment.

Recommendations:

- ◆ None.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ The member received an enrollment packet after the assessment.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ There was documentation that the member understood her condition, triggers, and medications.

Recommendations:

- ◆ None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- ◆ Yes. The self-care plan was online and stored in the disease management system.

Disease Management

Recommendations:

- ◆ The CMO may consider sending a copy of the printed care plan to the member. The disease case manager should obtain the care plan and align it with the asthma action plan.

10. How are the member and disease manager monitoring the member’s disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ The CMO completed scheduled follow-up calls with members.

Recommendations:

- ◆ None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member’s caregivers/family?

Observations:

- ◆ This was not demonstrated.

Recommendations:

- ◆ Document any collaboration or care coordination with providers, community agencies, and/or the member’s family and caregivers.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ No, the member did not require transition because the member did not deteriorate.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member health outcomes that could be related to disease management interventions.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 5
Diagnosis: Asthma
Synopsis: 7-year-old male

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Asthma.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was identified through claims history.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ The member and parent completed an assessment; the member had two ED visits for asthma. No comorbid conditions were found.

Recommendations:

- ◆ The disease case manager should assess for a personalized asthma action plan.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ A care plan was developed for the member during a home visit. The member received a peak flow meter and a spacer for use with the inhaler.
- ◆ The member had an additional visit one month later.

Recommendations:

- ◆ The disease case manager should obtain the care plan and align it with the asthma action plan.

Disease Management

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- ◆ Nationally approved disease-appropriate guidelines are being utilized.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ The member received an asthma tool kit, which was discussed during the two home visits.

Recommendations:

- ◆ None.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ The member received an asthma tool kit.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ There was documentation of the parent verbalizing a full understanding of the disease process and the triggers of asthma. The parent was also able to discuss the use of a peak flow meter.

Recommendations:

- ◆ None

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- ◆ The disease manager assisted the parent in developing a self-management plan as part of the care plan.

Disease Management

Recommendations:

- ◆ The disease case manager should assess for a personalized asthma action plan.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ After the second home visit, the disease manager lost contact with the member.

Recommendations:

- ◆ The disease manager should refer the member to case management and discuss the member in integrated care rounds.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- ◆ The disease manager was able to coordinate care with the parent until contact was lost.

Recommendations:

- ◆ None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ The member did not deteriorate.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member health outcomes that could be related to disease management interventions.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 6
Diagnosis: Diabetes
Synopsis: 44-year-old diabetic male

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ The member initially agreed to disease management, but the disease manager lost contact with the member.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was identified through claims history.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment? (Insert assessment findings.)

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Disease Management

Observations:

- ◆ Nationally approved disease-specific guidelines are being utilized by the CMO.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ The CMO should send educational flyers to the identified disease management member as an ongoing attempt to educate the member on his or her specific disease process, even if the CMO has been unable to reach the member.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ If the member had participated, he would have received a diabetic tool kit.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

Disease Management

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

10. How are the member and disease manager monitoring the member’s disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member’s caregivers/family?

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ No, the disease manager lost contact with the member.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) **and/or over-/under-utilization of resources** (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented. The disease manager lost contact with the member.

Recommendations:

- ◆ None.

Case Identifier: Case 7
Diagnosis: Asthma
Synopsis: 16-month-old male asthmatic

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Asthma.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was identified by case management after an ED visit. The parent was called multiple times during a three-month period before contact was finally made.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ During the assessment, the disease manager used an interpreter because the parent speaks Spanish. The disease manager was able to obtain information that the member had many symptoms. During a second visit which occurred in the home, the disease manager provided the parent with a mask for use with the nebulizer. The disease manager had the parent give a return demonstration on its use.

Recommendations:

- ◆ Document the use of an interpreter during home visits. The disease case manager should assess for a personalized action plan.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ A care plan was developed for the member and was sent to the PCP. The PCP approved the mask for the nebulizer.

Disease Management

Recommendations:

- ◆ An interpreter was used for the assessment but was not documented as being used during the home visit or follow-up calls. The disease case manager should obtain the care plan and align it with the asthma action plan.

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- ◆ National guidelines were approved and in use.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ The mother was taught during a home visit. The mother demonstrated competency by a return demonstration on the use of the mask and how to clean and maintain the nebulizer.

Recommendations:

- ◆ Document the use of an interpreter for home visits.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ The parent was sent an asthma enrollment kit in Spanish.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ The mother demonstrated competency by a return demonstration on the use of the mask and how to clean and maintain the nebulizer.

Recommendations:

- ◆ Document the use of an interpreter for home visits.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Disease Management

Observations:

- ◆ The disease manager documented a total of three coaching calls with the parent; each call contained information about the management of asthma and its triggers.

Recommendations:

- ◆ None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ After the three coaching calls and the home visit, the CMO lost contact with the parent and the member.

Recommendations:

- ◆ Refer the member back to case management for follow-up after losing contact. The member should be discussed in interdisciplinary rounds.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- ◆ The disease manager collaborated with the parent with coaching calls and a home visit.

Recommendations:

- ◆ None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ The member did not deteriorate.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member health outcomes that could be related to disease management interventions.



Appendix G. State of Georgia
Department of Community Health (DCH)
Disease Management File Review Tool
for Peach State Health Plan

Case Identifier: Case 8
Diagnosis: Asthma
Synopsis: 8-year-old male asthmatic

Disease Management

I. Program Type and Identification

1. In which disease management program is the member enrolled?

Observations:

- ◆ Asthma.

Recommendations:

- ◆ None.

2. How was the member identified or referred for disease management services?

Observations:

- ◆ The member was referred by case management. The member had an ED visit and subsequently missed three days of school.

Recommendations:

- ◆ None.

II. Assessment and Guidelines

3. Did the member undergo a comprehensive assessment?

(Insert assessment findings.)

Observations:

- ◆ The disease manager completed an assessment with the parent of the member.

Recommendations:

- ◆ The disease case manager should assess for a personalized asthma action plan.

4. Was a care plan created for the member?

(Insert care plan goals, interventions, outcomes, barriers, etc.)

Observations:

- ◆ A care plan was made for the member and sent to the PCP. Informed the PCP the member has an inhaler only. The disease manager suggested the parent make an appointment for the member with the PCP to discuss the potential need for a nebulizer.

Recommendations:

- ◆ The disease case manager should obtain the care plan and align it with the asthma action plan.

Disease Management

5. Are disease management guidelines being used by the disease manager? (Insert guidelines.)

Observations:

- ◆ Nationally approved guidelines are in use by disease management.

Recommendations:

- ◆ None.

III. Education

6. How is education provided to members in the disease management program? (e.g., online education, in-person trainings, leaflets/literature, teachable moments, telephone conversations)

Observations:

- ◆ Contacted family three times.
- ◆ Established call time again with family.

Recommendations:

- ◆ None.

7. Does the CMO provide members with disease “toolkits” and/or action plans? (e.g., Internet-based, interactive, journals, pocket guides, literature, written plans)

Observations:

- ◆ The member was sent a spacer and peak flow meter along with an asthma enrollment kit.

Recommendations:

- ◆ None.

8. As a result of education, did the member verbalize a full understanding of his/her condition, triggers, medications, and actions he/she can take to improve health?

Observations:

- ◆ There is documentation of the parent’s understanding of the disease process and the member’s triggers.

Recommendations:

- ◆ None.

IV. Monitoring

9. Did the disease manager help the member develop a plan of self-care and self-management? (i.e., how to incorporate disease education into daily routines.)

Observations:

- ◆ The disease manager assisted the parent in learning self-management for the member. The disease manager is to contact the member every 30 days.

Disease Management

Recommendations:

- ◆ None.

10. How are the member and disease manager monitoring the member's disease, conditions, and symptoms?

(Does the CMO offer tools and follow-up activities [e.g., Internet-based portal to log daily vitals and symptoms fed to the disease manager]?)

Observations:

- ◆ There were two calls with the parent.

Recommendations:

- ◆ None.

11. Does the disease manager collaborate and coordinate care with providers, community agencies, and/or the member's caregivers/family?

Observations:

- ◆ The disease manager tried to coordinate care between the member, the parent, and the PCP.

Recommendations:

- ◆ None.

12. Was the member transitioned from disease management to case management due to member deterioration?

Observations:

- ◆ The member did not deteriorate.

Recommendations:

- ◆ None.

V. Measureable Outcomes

13. Did the CMO measure member health outcomes (e.g., documented improvement shown by better lab, diagnostics) and/or over-/under-utilization of resources (e.g., utilization of appointments, ER, acute care)?

Observations:

- ◆ This was not documented.

Recommendations:

- ◆ The CMO should develop a method or process to measure member' health outcomes that could be related to disease management interventions.