State of Georgia
Department of Community Health

External Quality Review of Compliance With Standards

for

Peach State Health Plan

December 2016

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Overview

Background

The Georgia Department of Community Health (DCH) is responsible for administering the Medicaid program and the Children's Health Insurance Program (CHIP) in the State of Georgia. The State refers to its CHIP program as PeachCare for Kids®. 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 and CHIP programs. Children in state custody, children receiving adoption assistance, and certain children in the juvenile justice system are enrolled in the Georgia Families 360° (GF 360°) managed care program. The Georgia Families (GF) program serves all other Medicaid and CHIP managed care members not enrolled in the GF 360º program. Approximately 1.3 million beneficiaries are enrolled in the GF program.[1-1]

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

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

Description of the External Quality Review of Compliance with Standards

The DCH requires its CMOs to undergo annual compliance reviews that cover a third of the federal standards each year. This ensures that within a three-year period, a full comprehensive assessment is conducted to meet federal requirements. The review presented in this report covered the period of July 1, 2015–June 30, 2016, and marked the third year of the current three-year cycle of external quality reviews.

HSAG performed a desk review of Peach State CMO's (Peach State's) documents and an on-site review that included reviewing additional documents, conducting interviews with key Peach State staff members, and conducting file reviews. HSAG evaluated the degree to which Peach State complied with federal Medicaid managed care regulations and the associated DCH contract requirements in three performance categories. All three review areas included requirements associated with federal Medicaid managed care structure and operations standards found at 42 CFR §438.236–§438.240, and §438.242. A fourth

[1-1] Georgia Department of Community Health. "Georgia Families Monthly Adjustment Summary Report, Report Period: 12/2015."

performance category focused specifically on noncompliant standards from the prior review periods. The standards HSAG evaluated included requirements that addressed the following areas:

- Clinical Practice Guidelines
- Quality Assessment and Performance Improvement (QAPI)
- Health Information Systems
- Re-review of *Not Met* elements from the prior year's review.

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

- Section 2—A summary of HSAG's findings regarding Peach State's performance results, strengths, and areas requiring corrective action.
- Section 3—A description of the process and timeline Peach State will follow 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.

2. Performance Strengths and Areas Requiring Corrective Action

Summary of Overall Strengths and Areas Requiring Corrective Action

HSAG determined findings for the compliance review from its:

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

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

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

Table 2-1—Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Clinical Practice Guidelines	**11**	**11**	**10**	**1**	**0**	**90.9%**
II	Quality Assessment and Performance Improvement (QAPI)	**32**	**30**	**20**	**10**	**2**	**66.7%**
III	Health Information Systems	**8**	**8**	**8**	**0**	**0**	**100.0%**
NA	Follow-up Reviews From Previous Noncompliant Review Findings	**8**	**8**	**5**	**3**	**0**	**62.5%**
	Total Compliance Score	**59**	**57**	**43**	**14**	**2**	**75.4%**

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

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

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

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

Standard I—Clinical Practice Guidelines

Performance Strengths

Peach State adopted preventive guidelines and clinical practice guidelines (CPGs) in conjunction with the Peach State Quality Assessment and Performance Improvement (QAPI) goals and objectives. The CPGs are based on members' health needs and opportunities for improvement identified as part of the QAPI Program.

Peach State, under the direction of DCH, implemented a chart review program to audit providers' compliance with the CPGs. For calendar year (CY) 2015, Peach State reviewed 488 medical records across 100 audited providers for three CPGs: Diabetes, Asthma, and Attention Deficit Hyperactivity Disorder (ADHD).

Areas Requiring Corrective Action

Peach State must implement a process to ensure the decisions involving utilization management and coverage of services, made by the CMO's staff, are consistent with the clinical practice guidelines.

Standard II—Quality Assessment and Performance Improvement (QAPI)

Performance Strengths

Peach State used multiple approaches to ensure members received quality healthcare and improved outcomes. For example, the Utilization Management (UM) Program Description detailed how Peach State strove to optimize the member's health status through ongoing monitoring, and tracking and trending of care rendered to members. The Case Management Program served members with multiple, high-cost medical and psychosocial needs. The goal of the program was to assist these members in achieving the highest possible level of wellness, functioning, and quality of life.

Peach State reported in its QAPI Evaluation for disease management that for members who participated in the Disease Management program, the areas with the highest impact were emergency department use, inpatient stays, and the overall cost on a per member per month (PMPM) basis. The CMO also described its use of incentives, education, mailings, direct phone calls, automated phone calls, and alerts to provider offices, regarding members due for recommended services, in order to maintain or prevent a decline in member health.

Peach State coordinated utilization and care management activities with community practitioners in areas such as early childhood intervention; State protective and regulatory services; Women, Infants and Children (WIC) services; Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services; and services provided by local public health departments.

Peach State used a Quality Improvement (QI) Work Plan to track QI efforts. The work plan included the standard, objective, and description of the issue, who was accountable, the timeline for action, and how the issue would be monitored.

Peach State's QAPI Program Description and the QI Work Plan detailed the levels of executive and management staff and their involvement in QAPI projects. In addition, the QAPI Work Plan included executive and management staff as the accountable person(s) for each standard. During the compliance review interview, CMO staff discussed active involvement of the chief executive officer (CEO), chief medical officer/vice president of medical affairs, and senior-level staff. The CMO described weekly leadership meetings involving executive and senior leaders that included agenda items regarding QAPI activities. The CMO also described how executive staff championed individual QI projects to ensure the projects moved forward.

Peach State embraced a quality improvement environment within the organization. Peach State used the Institute for Healthcare Improvement's (IHI's) Triple Aim for Healthcare Improvement as a framework to evaluate the success of the QAPI Program and adopted Lean Six Sigma methodology and the Plan-Do-Study-Act (PDSA) processes developed by W. Edwards Deming. Senior leadership and all QI staff, as well as other staff members, were trained in Lean Six Sigma for both clinical and nonclinical processes. Twenty-five staff members achieved Green Belt status, and all senior management completed Lean Six Sigma Champion training.

The CMO used a process called My Health Direct to receive a block of appointments from primary care physicians (PCPs) in order to directly schedule members for appointments. Peach State indicated that this procedure was successful in getting members in for primary care appointments.

Peach State improved its QAPI Program Description when compared to the previous year. The QAPI Program Description stated that provider profiling was conducted and that Peach State used Centelligence Insight, a web-based reporting and management system, which included advanced capabilities for provider practice pattern and utilization reporting. The system generated summary and detailed views of clinical quality and cost profiling information, and supplied providers with practice and peer-level profiling information. In addition, Peach State provided examples of provider profiles. However, Peach State did not describe processes to use the information internally (e.g., to make network decisions).

Areas Requiring Corrective Action

Peach State must continue to improve its QAPI Program Description to ensure compliance with DCH guidelines. The QAPI Program Description should provide a comprehensive story of the effectiveness of Peach State's QAPI work.

Peach State must update its QAPI Program Description to describe processes and responsible resources used to develop interventions aimed at improving the health status of members. The description must also detail how Peach State maintains or prevents further decline or deterioration in a member's health status who is not eligible for Case Management or Disease Management programs.

Peach State must describe processes to include utilization management, case management, disease management, and other data sources when implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members in its QAPI Program Description. Peach State's policies and the QAPI Program Description must address implemented interventions and activities that are aimed at underutilization in areas such as chronic disease, preventive health services, and EPSDT services. The description must define data sources used to identify underutilization and how the interventions and activities focused on underutilization are resourced.

Peach State must implement processes to obtain input from families and guardians of members into QAPI activities. During the compliance review, Peach State described its plan to conduct focus groups in all six regions using external consultants to obtain member input and incorporate the feedback into program activities.

Peach State must redesign the content of the various program evaluations to include detailed discussions on methodologies, data sources, member and provider input, analysis of interventions, and a more thorough evaluation of the results of QAPI activities. The evaluation documents must be thorough so that Peach State may use them in developing its quality roadmap and quality improvement plans.

Peach State must include the process used to assess the quality of care furnished to members, including those with special healthcare needs, in its policies and QAPI Program Description. Peach State must describe processes used to evaluate care provided, for example, in the areas of chronic health conditions, discharged members, use of urgent care or emergency departments, or the use of outcomes data to evaluate the quality and appropriateness of care furnished to members, including those with special healthcare needs.

Peach State must have a documented methodology and process for conducting and maintaining provider profiling.

Peach must ensure that the QM Patient Safety Plan clearly distinguishes between grievances and the Grievance process. The QM Patient Safety Plan must be approved by DCH.

Standard III—Health Information Systems

Performance Strengths

Peach State maintained a health information system that was sufficient to support the collection, integration, tracking, analysis, and reporting of data. Peach State used an information system composed of relational and indexed databases to store claims, encounter, and utilization information. The CMO used the Amisys Advanced system as the primary claims system to administer medical claims. Peach State uploaded claims data into a data warehouse, Enterprise Data Warehouse (EDW). EDW was Peach State's proprietary business intelligence and data management platform and was the foundation of its internal and external data integration and reporting capabilities. Peach State developed an interface solution that allowed rapid processing of member, claim, and encounter data from any business partner or subcontractor in any format.

Areas Requiring Corrective Action

HSAG did not identify any opportunities for improvement that required Peach State to implement corrective actions for Standard III—Health Information Systems.

Follow-Up Reviews From Previous Noncompliant Review Findings

Performance Strengths

HSAG did not identify any unique Peach State performance strengths to reference in the "Follow-Up From Previous Noncompliant Review Findings" section.

Areas Requiring Corrective Action

The CMO must update its Distribution of Member Handbook Policy to state that it notifies existing members annually that the member handbook is available online and a hard copy is available upon request.

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

3. Corrective Action Plan Process

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

The DCH, in consultation with HSAG, will review, and when deemed sufficient, approve Peach State's CAP to ensure the CAP sufficiently addresses 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—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. The CMO has a minimum of three practice guidelines. *42CFR438.236(b)* *Contract: 4.12.7.1*	Peach State demonstrates compliance with this requirement through the adoption and distribution of Practice Guidelines that are relevant to our member population. Peach State demonstrates this through the following documents: • Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg. 1, 5e and Attachment 1 • Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-16 pg. 1, 4(2), Attachment 1 and Attachment 2. • Report: 2015 QAPI Program Evaluation, CPG Section pgs. 14-38	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State adopted preventive guidelines and CPGs from recognized sources for the provision of acute, chronic, and behavioral health services relevant to the populations served. Peach State implemented a minimum of three practice guidelines. Supporting documentation reviewed included the Preventive Health and Clinical Practice Guidelines Policy (CPG Policy) and the QAPI Program Evaluation.		
Required Actions: None.		
2. The guidelines: *42CFR438.236(b)* *Contract: 4.12.7.1*		
a. Are based on the health needs and opportunities for improvement identified as part of the quality assessment and performance improvement (QAPI) program. *Contract: 4.12.7.1*	Peach State demonstrates compliance with this requirement with its review of the Quality Improvement Program Evaluation, annual HEDIS rates and Performance Measures to Targets as defined by the Department of Community Health in addition to the review of data reports and member demographics.	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Peach State demonstrates this through the following documents: • Report: 2015 QAPI Program Evaluation, Population Served pgs. 14-38 • 2016 QAPI Program Description pg.21 • Report 2015 PS IDSS FINAL- Medicaid [HEDIS Rates] – audit table tab • Peach State - GF Performance Measures for CY 15 w targets and HEDIS Percentiles v2 10-1-15 (entire document) • Document: 2015 Cultural Competency Program Evaluation pg. 2 • Document: Cultural Competency Strategic Plan Year 2015 pg. 2, 16-18 • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg.2 (1a) • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-16 pg. 2b	
Findings: The Peach State CPG Policy stated that preventive guidelines and CPGs were adopted in conjunction with the Peach State QAPI goals and objectives and were based on the members' health needs and opportunities for improvement identified as part of the QAPI Program.		
Required Actions: None.		
b. Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field. *Contract: 4.12.7.1*	All PS guidelines are based on valid and reliable clinical evidence or consensus of health care professionals in the particular field; consider the needs of members; and are adopted in consultation with network providers through Plan Quality Oversight Committee (QOC) meetings. Source data is documented in the guidelines including the scientific basis or the authority upon which it is based. Peach State demonstrates this through the following documents: • 2016 QAPI Program Description pg.21	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg.2 (1a) • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-16 pg. 2b • Document: Medicaid QIC Minutes 4-22-15 – Final pg. 1 and 30	
Findings: Peach State's CPG Policy and the QAPI Program Description indicated that CPGs were adopted from disease-specific clinical practice or preventive health guidelines or other disease-specific scientific literature, accepted best-practice case management principles, and medical or behavioral health specialty society reports.		
Required Actions: None.		
c. Consider the needs of the CMO's members. *Contract: 4.12.7.1*	Peach State develops and implements guidelines based upon the needs of our members and also based upon contractual requirements in alignment with the DCH Quality Strategic Plan. These guidelines represent various aspects of our membership based on utilization of services, prevalence of disease and the age segments of the overall membership represented. Peach State demonstrates this through the following documents: • Report: 2015 QAPI Program Evaluation, Population Served: pgs. 14-38 • 2016 QAPI Program Description pg.21 • Document: 2015 Cultural Competency Program Evaluation pg. 2 • Document: Cultural Competency Strategic Plan Year 2015 pg. 2, 16-18 • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg.3G	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-16 pg. 2 (1A and 1C)	
Findings: The Peach State CPG Policy and the QAPI Program Description stated that CPGs were adopted in conjunction with the Peach State QAPI goals and objectives and were based on the members' health needs. Peach State included demographic, cultural, and epidemiological profiles and needs assessments in its Cultural Competency Strategic Plan, which was reviewed as part of the CPG review process.		
Required Actions: None.		
d. Are adopted in consultation with network providers. *Contract: 4.12.7.1*	Peach State presents, reviews, and adopts all guidelines through the Quality Oversight Committee (QOC). The practitioners provide input related to new and revised practice guidelines. The membership of the QOC is comprised of participating network practitioners and Plan leadership. Peach State demonstrates this through the following documents: • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-06-16 pg. 2 (1E) • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg. 2 (2G) • Provider Manual _July 2014 Most recent: page 54 • Document: Medicaid QIC Minutes 4-22-15 – Final pg. 1 and 30	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State adopted CPGs, in consultation with network providers, to support the use of evidence-based practices in the diagnosis, treatment, and management of health conditions in order to optimize patient care, as stated in the CPG Policy. Providers participated in the Medicaid Quality Improvement Committee (QIC) meetings during which CPGs were discussed. Information provided by DCH indicated that it worked with the CMOs to standardize three CPGs between January and June 2016.		
Required Actions: None.		
e. Are reviewed and updated periodically, as appropriate. *Contract: 4.12.7.1*	Peach State reviews and updates guidelines upon significant new scientific evidence or change in the national standards upon which they are based or at least every two years according to policy.	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Peach State utilizes Compliance 360 to track policy due dates and provides reminders to responsible parties on an annual basis. Peach State demonstrates this through the following documents: • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg. 1 • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-16 pg. 2 (B2) • Document: Screenshot of Compliance 360	
Findings: Peach State's CPG Policy stated that Peach State reviewed its CPGs at least every two years. Peach State also updated its CPGs when there was significant new scientific evidence or a change in national standards.		
Required Actions: None.		
3. The practice guidelines include a methodology for measuring and assessing compliance. *Contract: 4.12.7.2*	Peach State continues to follow the Department of Community Health requirement to perform medical record reviews that annually measure practitioner compliance with three guidelines: Asthma, ADHD, and Diabetes. Using the standardized guidelines and measurement tool methodology, medical record review is performed and analyzed on an annual basis and the report is submitted to DCH. According to methodology, practitioners that score below 80% are placed on a correction action plan. Peach State demonstrates this through the following documents: • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_03-15 pg. 4a • Policy: Policy: GA_QI_06_Preventive_Health and Clinical_Practice_Guidelines_06-16 pg. 3, 4(2) and Attachment 2	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Report: Quality Management Report Analysis PS Clinical Practice Guideline Compliance Monitoring – 2014 (entire document) • Report Quality Management Report Analysis PS Clinical Practice Guideline Compliance Monitoring – 2015 (entire document) • Document: Methodology Attachment B _ CPG Compliance Monitoring Audit Tools • Example: - Example CPG initial audit - Example CPG re-audit	
Findings: Peach State implemented a methodology for chart reviews to measure and assess compliance with CPGs. A process for measuring and assessing compliance with the guidelines was documented in the Quality Management Report Analysis PS CPG Compliance Monitoring Report and in the example audit tools. For CY 2015, Peach State reviewed 488 medical records across 100 audited providers for three CPGs—Diabetes, Asthma, and ADHD. Peach State assessed compliance for each CPG by evaluating five key components per medical record. The CMO scored key components as either met or not met. In cases when "not applicable" was considered appropriate by Peach State, such as a member's refusal for a vaccination, Peach State removed the key component from the denominator, ensuring that the CMO did not penalize the provider for a key component it would have completed if the member had not refused the care or service. For each CPG, Peach State calculated an overall score using the data gathered for all audited providers, which was the result of the sum of the numerators of all five key components divided by the sum of the denominators for all five key components. Peach State explained the methodology in the Quality Management Report Analysis PS CPG Compliance Monitoring Report and in the audit tool. During compliance review interviews, the CMO described its use of nurses, provider relations staff, and an external physician consultant to provide education and support to providers in implementing the CPGs.		
Required Actions: None.		
4. The CMO submitted clinical practice guidelines to DCH for review and approval as part of the QAPI program. *Contract: 4.12.7.2*	Peach State demonstrates compliance with this requirement with its review, submission and approval of the Quality Improvement Program Evaluation and Description by DCH. Peach State demonstrates this through the following documents:	☒ Met ☐ Not Met ☐ N/A

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Report: 2016 Program Description Medicaid (entire document) • Report: 2015 QAPI Program Evaluation, CPG Section pgs. 96-102	
Findings: Peach State provided documentation which verified that the CMO submitted its CPGs for DCH approval through submission of its QAPI Program Description and QAPI Evaluation.		
Required Actions: None.		
5. The CMO disseminates the guidelines to all affected providers, and upon request, to members. *42CFR438.236(c)* *Contract: 4.12.7.3*	Peach State disseminates guidelines to all affected practitioners via the Provider Web site, Provider Manual, and in Provider Newsletter articles. Provider Representatives are also available to educate providers on the guidelines and can distribute the guidelines in hard copy upon request. Dissemination of the clinical practice guidelines to members is upon request by calling the Plan's Member Services toll-free line as instructed in the Member Handbook. Peach State demonstrates this through the following documents: • Policy: Preventive Health and Clinical Practice Guideline policy, GA.QI.06 – 03-15 pg. 3-4 • Policy: Preventive Health and Clinical Practice Guideline policy, GA.QI.06 – 06-16 pg. 2-3 (F) • Provider Manual, pg. 54-55 • Member Handbook, pg. 34 • Example: Web Site Screenshot • Report: Provider Newsletter Fall 2015, pg. 1	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State provided outreach and education to providers (and in some cases, members) to increase the use of evidence-based CPGs. Peach State posted the CPGs on its website, provided information about the guidelines, and indicated how to obtain hard copies in the provider		

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
manual and in provider newsletters. Peach State's member newsletters and the member handbook explained how members may request a copy of the CPGs by calling the Peach State Customer Service telephone number.		
Required Actions: None.		
6. The CMO ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* *Contract: 4.12.7.4*	Peach State demonstrates compliance with this requirement by conducting an annual meeting with department leaders from Quality Improvement, Medical Management, Pharmacy, and Member Services to review the Clinical Practice Guidelines and to ensure that decisions to which the guidelines apply are made consistently. Further, the cross-departmental meetings review member and provider driven documents to ensure distributed content and materials are consistent with the guidelines. If guidelines are changed between annual meetings due to updates in the literature upon which they are based, an ad hoc meeting is held to review the specific guideline that changed, if needed. Peach State demonstrates this through the following document: • Policy: Preventive Health and Clinical Practice Guideline policy, GA.QI.06 – 03-15 pg. 2 (Internal Use of CPGs) and pg. 4 (References) • Policy: Preventive Health and Clinical Practice Guideline policy, GA.QI.06 – 06-16 pg. 2-3 (1B and 1G) and pg. 4 (References) • Document: Departmental CPG Form	☐ Met ☒ Not Met ☐ N/A
Findings: Peach State's documents, including the Quality Management Report Analysis PS CPG Compliance Monitoring Report, stated that it used evidence-based CPGs, preventive health guidelines, and other scientific evidence as applicable in the development, implementation, and maintenance of clinical systems used to support utilization and case management. Peach State reviewed member and provider educational materials and staff training materials for compliance or adherence with CPGs. During the compliance review interviews, the CMO also stated that staff were trained on CPG use in medical management processes during new employee orientation.		

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: Peach State must implement a process to ensure that decisions involving utilization management and coverage of services, made by the CMO's staff, are consistent with the clinical practice guidelines.		
7. 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*	Peach State was directed by the Department of Community Health to develop a medical record review program in collaboration with the other two Georgia CMOs that would measure practitioner compliance with three guidelines; Asthma, ADHD, and Diabetes. Medical Record review is performed and analyzed on an annual basis and the report is submitted to DCH. The overall goal for each guideline's compliance is 90%. Practitioners who score < 80 % are required to submit a corrective action plan to the Health Plan within 14 calendar days. Peach State demonstrates this through the following documents: • Policy: Preventive Health and Clinical Practice Guideline policy, GA.QI.06 – 03-15 pg. 4a • Policy: Preventive Health and Clinical Practice Guideline policy, GA.QI.06 – 06-16 pg. 3, 4(2) and Attachment 2 • Report: Quality Management Report Analysis PS Clinical Practice Guideline Compliance Monitoring – 2014 (entire document) • Report Quality Management Report Analysis PS Clinical Practice Guideline Compliance Monitoring – 2015 (entire document) • Document: Methodology Attachment B _ CPG Compliance Monitoring Audit Tools • Example: CPG audit and re-audit	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State encouraged providers to use the CPGs through its website, the provider manual, and provider newsletters. Peach State, under the direction of DCH, implemented a chart review program to audit providers' compliance with the CPGs. Peach State published the		

Standard I—Clinical Practice Guidelines		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
results of the chart audits annually in the Quality Management Report Analysis PS CPG Compliance Monitoring Report. The CPG Policy and the compliance monitoring audit tools were used by Peach State to measure provider compliance with CPG implementation.		
Required Actions: None.		

Results for Standard I—Practice Guidelines							
Total	Met	=	10	X	1.00	=	10
	Not Met	=	1	X	.00	=	0
	Not Applicable	=	0	X	N/A	=	N/A
Total Applicable		=	11	**Total Score**		=	10
				Total Score ÷ Total Applicable		=	90.9%

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. The CMO provides for the delivery of quality care with the primary goal of improving the health status of members and, where the member's condition is not amenable to improvement, maintain the member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. This includes the identification of members at risk of developing conditions, the implementation of appropriate interventions, and designation of adequate resources to support the intervention(s). *Contract: 4.12.1.1*	Peach State's Quality mission is to improve the health of all enrolled members utilizing a systematic approach to quality using reliable and valid methods of monitoring, analysis, evaluation, and improvement in the delivery of health care provided. Predictive modeling, Member Outreach, Case Management, and Disease Management programs are used to identify members at risk of developing acute or chronic conditions and to implement interventions for our members. In addition, monthly administrative Healthcare Effectiveness Data and Information Sets (HEDIS®) results and annual results are monitored. Adequate resources support the delivery of quality care as described in the Programs. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description, pg. 10 • Document: 2015 QAPI Program Evaluation (entire document) • Report: CY2015 Non-HEDIS Performance Measures • Report: CY2015 H2016 - 9227 IDSS Locked - Medicaid • Report: Peach State - GF Performance Measures for CY 15 w targets and HEDIS Percentiles v2 10-1-15 • Document: 2015 Nurtur Program Evaluation (entire document) • Document: 2015 UM Program Description • Document: 2015 Case Management Program Description • Document: Population Assessment • Example: ImpactPro Referral • Example: Health Risk Assessment	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Policy: GA.DM.01 Disease Management Program Description pg.1 • Policy: GA.CM.12 Care Coordination Care Management • Policy: GA.CM.11.01 Coordination with Nurtur DM Programs pg.1-2 • Report: Disease Management Participant List Sample CY2015	
Findings: Peach State used multiple approaches to ensure that members received quality healthcare that resulted in improved outcomes. For example, the UM Program Description detailed how Peach State tried to optimize members' health status through ongoing monitoring, and tracking and trending of care rendered to members. In addition, Peach State described how appropriate resources were used. The Case Management Program served members with multiple high-cost medical and psychosocial needs. The goal of the program was to assist members to achieve the highest possible level of wellness, functioning, and quality of life. Peach State used a High Risk Assessment Tool that identified if the member had a PCP, saw the dentist regularly, was pregnant, or met other potential high-risk elements. Peach State included in its 2016 Medicaid QAPI Program Description that its mission was to continuously improve and support member health through a member-centric and integrated system of care. The QAPI Program Description also stated that the mission drove its commitment to the provision of a robust QAPI Program. Peach State used Nurtur, a delegated entity, to provide disease management services. The Nurtur Program targeted the conditions of diabetes, asthma, smoking cessation, and chronic obstructive pulmonary disease (COPD). The objectives of the Disease Management program were to improve the health status of members with chronic conditions by educating members and enhancing their ability to self-manage their conditions or illness. The QAPI Evaluation for disease management reported that for members who participated in the Disease Management program, the areas with the highest impact were emergency department use, inpatient stays, and the overall cost on a per-member-per-month (PMPM) basis. Peach State used a health risk assessment form to assist in identifying members eligible for disease management. Peach State had system algorithms for predictive modeling that allowed the CMO to focus case management or disease management resources on members at risk of developing certain conditions. During the compliance review interview, Peach State described how demographic information and data analysis were used to push information out to work groups for QI purposes. The CMO also described its use of incentives, education, mailings, direct phone calls, automated phone calls, and alerts to provider offices of members due for recommended services in order to maintain or prevent a decline in member health.		
Required Actions: None.		
2. The CMO seeks input from and works with members, providers, and community resources and	Peach State seeks input from members, providers, and community resources in a variety of ways. Member grievances are tracked and trended, provider and member satisfaction surveys are conducted,	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
agencies to actively improve the quality of care provided to members. *Contract: 4.12.1.2*	and community health fairs are held in collaboration with external agencies. An internal Member Satisfaction Committee reviews and analyzes the member satisfaction survey results to identify opportunities and implement initiatives. Provider involvement and representation can be identified via the health plan's Committees which provide for analysis, recommendations, and action plans from participating practitioners in conjunction with the Plan's Performance Improvement Plans (PIPs) such as the Postpartum PIP that include collaboration and participation from health plan providers. Moreover, Peach State participates in over 25 community events per month on average. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description, Cultural Competency Committee pg. 8 • Document: 2015 QAPI Program Evaluation pgs. 38-39, 159-160 • Policy: GA.QI.08 Grievance Process pgs. 2&9 • Policy: GA.QI.24 Quality of Care Investigations pgs. 1&3 • Policy: GA.CRED.10 Ongoing Monitoring of Sanctions & Complaints pgs. 1&2 • Policy: GA.CRED.07 Practitioner Office Site Review pg. 1 • 2015 1 Medicaid Adult Survey- entire document • 2015 1 Medicaid Child Survey - entire document • Policy: GA_QI_02 Quality Improvement Member Experience Analysis pg. 1 • Community Event Calendar 2016 - entire document s -New Member Orientation	

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	-Diaper Day • Report: PIP Provider Satisfaction • Minutes: GA AAP Collaborative Meeting Minutes	
Findings: Peach State employed several methods to obtain input from and work with members, providers, and the community. Peach State documented this process in its QAPI Program Description, QAPI Evaluation, Grievance Process, and Quality of Care Investigation Process. For example, Peach State collected and analyzed data gathered from the annual Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1] survey for both children and adults. Peach State also collected information about providers,' members,' and the community's perceptions and experiences concerning obstacles to obtaining healthcare. The CMO used population-specific outreach to improve the goals and objectives of the QAPI Program. For example, Peach State identified an opportunity for improvement in EPSDT scores, so the CMO hosted an event with pediatric offices and surveyed members about barriers to scheduling and keeping well-child visits. Peach State had a grievance system that identified dissatisfaction at the member level and aggregated data and identified trends. Peach State reported this information to the Quality Oversight Committee (QOC) quarterly in an effort to discuss opportunities to eliminate dissatisfaction. Peach State informed members and providers about the results of its efforts to improve member satisfaction in newsletters, provider-specific practitioner results discussed during office visits, special mailings, or during meetings that were regularly scheduled on specific, related topics. Peach State also coordinated utilization/care management activities such as early childhood intervention, State protective and regulatory services, Women, Infant and Children (WIC) Services, EPSDT health check, and services provided by local public health departments with local community practitioners. During the compliance review interviews, Peach State described its work with its delegated behavioral health entity, Cenpatico, regarding care integration and coordination of care. The CMO described how the organizations worked collaboratively to look at data and trends in order to improve care coordination, reduce gaps in care, and improve outcomes.		
Required Actions: None.		
3. The CMO has a multidisciplinary Quality Oversight Committee to oversee all quality functions and activities. This committee meets at least quarterly, but more often if warranted.	The Board of Directors delegates daily oversight and operating authority to the Quality Oversight Committee (QOC). The Health Plan's senior management staff, clinical staff, and network providers are involved in the implementation, monitoring and direction of the	☒ Met ☐ Not Met ☐ N/A

[A-1] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Contract: 4.12.1.3	relative aspects of the program through the QOC. The purpose of the QOC is to provide oversight and direction in assessing the care provided to all members, including those with special health care needs. This is accomplished through a comprehensive plan wide system of ongoing, objective, and systematic monitoring and evaluation. The committee ensures practitioner participation in the QI Program through planning, implementation and review, evaluating effectiveness and trending and providing corrective action plans if needed. The Senior Vice President of Medical Affairs/Chief Medical Officer (SVPMA/CMO) functions as the designated physician that is actively involved in the QI Program. The QOC meetings are scheduled every other month, but no less than quarterly. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description, (Authority and Scope) pgs. 4&5, (meeting frequency) pg. 5 • Document: QOC Roster 2016 • Document: – QIC Agenda March 4, 2015 – QIC Agenda April 22, 1015- Medicaid – QOC Agenda 6-17-2015 Medicaid – QOC Agenda 10-7-15-Medicaid – QOC Agenda 12-9-2015 –Medicaid	
Findings: Peach State had a formal reporting structure for the QAPI Program which included a multidisciplinary QOC that reported to the Board of Directors each quarter. Multiple committees reported quarterly to the QOC, including the Utilization Management (UM), Credentialing, Cultural Competency, and Pharmacy and Therapeutics Committees. The QOC aligned organization-wide quality improvement goals, monitored		

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the performance and effectiveness of the QI infrastructure, monitored all QI projects, analyzed and evaluated results of QI activities, identified opportunities for improvement, and facilitated the development and evaluation of the QAPI Program.		
Required Actions: None.		
4. The CMO supports and complies with the Georgia Families Quality Strategic Plan by: *42CFR438.240(b)(1) through (4)* *Contract: 4.12.2.1*		
a. Monitoring and evaluating its service delivery system and provider network, as well as its own processes for quality management and performance improvement. *Contract: 4.12.2.2*	As defined in the QI Program Description, Evaluation and Work Plan, Peach State continuously monitors and evaluates our delivery system and Provider network. We also monitor service and clinical data reports on a weekly, monthly, quarterly, and annual basis as required by DCH. Performance Measures are also monitored and trended. Peach State demonstrates compliance with this requirement with the following documentation: • Policy:GA.CRED.10 Ongoing Monitoring of Sanctions and Complaints pg. 1-2 • Policy: GA.CRED.07 Practitioner Office Site Review pg. 1-2 • Report: 0653 PS EPSDT MRR Report (includes medical record audit tools and quarterly reporting template) • CY2015 H2016 - 9227 IDSS Locked - Medicaid • QI 4 Practitioner Availability Medicaid pg. 1,6 • Document: 2016 QAPI Program Description, pg. 18 • Document: 2015 QAPI Program Evaluation (entire document) • Document: 2016 QI Work Plan (entire document)	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Findings: Peach State used the Credentialing Ongoing Monitoring of Sanctions and Complaints Policy to apply a systematic process of monitoring practitioner sanctions, complaints, and quality issues that occur between recredentialing cycles. Peach State conducted provider office visits to investigate member complaints related to the office, such as accessibility and physical appearance. The CMO also used the office visits to assess the appointment availability and medical record-keeping practices. The CMO monitored its network access as required by DCH and identified gaps in regions for primary care, specialty, pharmacy, and dental care. The CMO continued to work to reduce the care gaps and to implement strategies to ensure members' needs were met. Peach State's documentation would be strengthened by recording how it monitored or evaluated its own processes for quality management and performance improvement. Additional documentation was provided in the QAPI Program Description and the QAPI Evaluation.		
Required Actions: None.		
b. Implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members. *Contract: 4.12.2.2*	Peach State implements action plans and activities as needed for those events/results that do not meet or exceed standards. We monitor CPG compliance and perform EPSDT Medical Record Reviews to ensure providers are documenting services appropriately to increase quality of care provided to members. Peach State conducts Performance Improvement Projects to increase quality of care. The Plan also responds to any State agency issued CAPs as directed by the Department for issues such as Geo-Access deficiencies. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2015 QAPI Program Evaluation (entire document) • Policy: GA_QI_21-_EPSDTMedical_Record_Review pg. 3 • Document: Iqbal EPSDT Scoring Sheet • Document: Iqbal EPSDT MRR Office Equipment Review Form • Document: Iqbal CAP_EPSDT MRR • Document: 2016 QI Work Plan (entire document)	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• GA.CRED.10 Ongoing Monitoring of Sanctions and Complaints pg. 1-2 • GA.CRED.07 Practitioner Office Site Review • QI 4 Practitioner Availability Medicaid pg.6-11 • Report: Managed Care Network Access Compliance Review Analysis for 3rd Quarter 2015	
Findings: Peach State conducted reviews of medical records in providers' offices to identify deficiencies and gaps and to implement opportunities to improve care and service delivery. Staff completed a medical record review using a set of standards. When one of the standards was not met, Peach State required the provider to submit a corrective action plan that described the intervention implemented to correct the deficiency. Peach State also used the QI Work Plan, the QAPI Program Evaluation, and EPSDT review and scoring tools to track QI efforts. The QI Work Plan included the standard, objective, description of the issue, who was accountable, the timeline for action, and how the issue would be monitored. Peach State provided limited information that described the use of data (e.g., utilization, case management, or disease management data) in implementing action plans and activities to correct deficiencies and/or improve the quality of care provided to enrolled members. During the compliance review interview, the CMO described data drill-down processes in the areas of obstetric care, the Healthcare Effectiveness Data and Information Set (HEDIS®)[A-2] postpartum performance measure, readmissions, and emergency department use to identify QI opportunities. Peach State described its processes that used predictive modeling to identify potential at-risk members and connect the members to care. Peach State also used the predictive modeling information for members who did not select a PCP and made outreach calls to the members to ensure they knew who would assist them in scheduling a first appointment. Peach State QI processes would be strengthened, in addition to its predictive modeling processes, by including utilization management, case management, disease management, and other data sources when identifying opportunities for improvement and in implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members.		
Required Actions: None.		
c. Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations	In addition to the activities detailed in items a) and b) above, Performance Improvement Projects are also implemented as directed by DCH. Grievances, including allegation of abuse, are tracked and trended and patterns are referred for re-credentialing purposes.	☒ Met ☐ Not Met ☐ N/A

[A-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

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of abuse, provider credentialing and profiling, and utilization management reviews. *Contract: 4.12.2.2*	Utilization Management trends subsequently resulted in ER and C-section improvement projects. Score cards are sent to OB specialists, PCPs, Pharmacy, and the Clinical Outcomes Department monitors members on controlled substances, manages the Pharmacy Lock-in program for members filling multiple prescriptions in multiple pharmacies or prescribed by multiple physicians, and conducts the Medication Therapy Management program. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2015 QAPI Program Evaluation, PIPs pgs. 124-140 • Document: Performance Improvement Projects: – PIP- Avoidable ER – PIP-Attention Deficit Hyperactivity Disorder – PIP-Dental Visits – PIP- Diabetes Care – PIP- Member Satisfaction – PIP- Provider Satisfaction – PIP-Bright Futures – PIP- Postpartum • 2015 UM Program Description • 2015 Readmission Rate Outcomes • 2015 UM Work plan	
Findings: Peach State had a UM Work Plan that described NCQA standards and DCH contract requirements related to the identification of topics and implementation of PIPs. The UM Work Plan included the methodology, performance goals, semiannual evaluation results, annual results, and any barriers and/or actions needed to improve results. The QAPI Program Evaluation included a section on PIPs. Peach State divided PIPs into five modules as required by DCH, including PIP initiation, data collection, intervention determination, PDSA, and PIP summary. Peach State had eight active PIPs. When PIP performance results decreased, Peach State had a resulting action plan to improve the performance. During		

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the compliance review interview session, Peach State described its processes, including discharge planning with the facilities, on-site concurrent review, follow-up calls with members after discharge, and home visits for the high-risk discharges to achieve a reduction in readmissions. Although self-selected PIP topics are not required, Peach State should consider reviewing data and trends related to complaints and allegations of abuse, utilization, provider credentialing, or provider profiling to identify opportunities for performance improvement.		
Required Actions: None.		
d. Describing in the CMO's QAPI program description how the CMO complies with Federal, State, and Georgia Families requirements. *Contract: 4.12.2.2*	Peach State is committed to complying with federal and state laws, rules and regulations. All work done as part of the contract between the Plan and the Department of Community Health (DCH) complies fully with applicable administrative and other requirements established by applicable federal and state laws, regulations and guidelines. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description pg. 23 • Policy: GA.COMP.28 Compliance with Federal and State Laws Rules and Regulations pg. 1-3	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State performed required quality of service, clinical performance, and utilization studies throughout the year based on contractual, State, and regulatory agency requirements, as well as NCQA requirements. Peach State used standards/guidelines from these sources and integrated them into the QAPI Program. The QI Department maintained a schedule of relevant reporting requirements for all State and federal regulations and submitted the deliverables according to regulatory requirements.		
Required Actions: None.		
e. Coordinating with State registries. *Contract: 4.12.2.2*	Peach State demonstrates compliance with this requirement via its monthly exchanges of data with the Georgia Healthy Homes and Lead Poisoning Prevention Program (GHHLPPP) and the Georgia Childhood Registry of Immunization Transactions and Services (GRITS) Program. This data exchange is uploaded into Peach	☒ Met ☐ Not Met ☐ N/A

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	States' IT system. The Lead data is also used to identify members with elevated lead levels for case management. Peach State demonstrates compliance with this requirement with the following documentation: • Examples: Lead Screening Files - Peach State Provider Lead File 11-12-15 - Peach State Member Lead File 11-12-15 • GRITS Screen Print • Report: Pharmacy Lock-in	
Findings: Peach State coordinated with the Georgia Registry of Immunization Transactions and Services (GRITS), the State's immunization registry. Documentation submitted indicated that coordination occurred primarily for purposes of the immunization audit. Peach State used the GRITS system to abstract missing immunization records for its members and submitted the data received to Inovalon for inclusion in HEDIS reporting. Peach State used the GRITS system as a data source for performance measure reporting. Peach State also provided information on how it worked with the Lead Poisoning Prevention Program. During the compliance review interview, Peach State described coordination work with the Lead Program. The CMO would strengthen its processes by considering additional opportunities, based on the capabilities of the system, to coordinate with and use information from the GRITS system (e.g., to identify providers that are not reporting administered immunizations to the registry, to identify members who are in need of immunizations, and to enhance the information in its systems to reflect a more complete immunization status of its members).		
Required Actions: None.		
f. Including CMO executive and management staff participation in the quality management and performance improvement processes. *Contract: 4.12.2.2*	The Quality Oversight Committee (QOC) is the senior management and physician member committee reporting to the Plan's Board of Directors. The QOC is supported by the Credentialing, Pharmacy, Utilization Management and the Delegated Oversight Committees, which are each led by management staff. All points of discussion at the QOC receive the benefit of involvement of a multidisciplinary team as we discuss improvement processes. This committee reviews	☒ Met ☐ Not Met ☐ N/A

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	results, identifies barriers and opportunities, and implements interventions. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description pg. 3-4 • Document: 2016 QI Work Plan (entire document) • Document: QOC 2016 Committee Roster • Minutes: Medicaid QOC Minutes 10-7-2015 pg. 3-5	
Findings: Peach State's QAPI Program Description and the QI Work Plan detailed the levels of executive and management staff and their involvement in QAPI projects. In addition, the QAPI Work Plan included executive and management staff as the accountable person(s) for each standard. During the compliance review interview, CMO staff discussed active involvement of the chief executive officer, chief medical officer/vice president of medical affairs, and senior-level staff. The CMO described weekly leadership meetings involving executive and senior leaders that included agenda items regarding QAPI activities. The CMO also described how executive staff championed individual QI projects to ensure the projects moved forward.		
Required Actions: None.		
g. Including information from participating providers and information from members, their families, and their guardians in the development and implementation of quality management and performance improvement activities. *Contract: 4.12.2.2*	Peach State includes feedback and information from providers, members, their families and their guardians when applicable in the development of quality management programs in various ways. Specifically, providers convey information through the Provider Satisfaction Survey and the Plan's committee structure which includes participating providers. Members are surveyed from both a quality and utilization perspective in an effort to identify areas within the Plan's delivery of services that could benefit from performance improvement activities. Moreover, member concerns are monitored by the tracking of grievance data which may be submitted by family members or guardians.	☐ Met ☒ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	The Plan demonstrates compliance with this requirement with the following documentation: • PIP-Member Satisfaction • PIP-Provider Satisfaction • 2015 1 Medicaid Adult Survey • 2015 1 Medicaid Child Survey • Document: 2015 CM Satisfaction Survey Analysis pg. 1,3 • Report: Grievance System DCH Quarterly Report January 2016 Analysis • Policy: GA.QI.02 Quality Improvement Member Experience Analysis pg. 1 • Report: 2015 CM Satisfaction Survey Analysis • Report: 2015 DM Satisfaction Survey Analysis • Report: 2015 Member Connections Survey Outcomes • Example: Case Management Satisfaction Survey • Example: Disease Management Satisfaction Survey • Example: Member Connections Satisfaction Survey	
Findings: Peach State conducted provider satisfaction surveys, including surveys for case management, disease management, and member experience, as well as a CAHPS member satisfaction survey for both children and adults. Peach State collected the data, analyzed the results, and implemented interventions to improve performance. Peach State initiated a PIP to improve the survey response rate in the Atlanta region. The policies, procedures, program descriptions, or evaluations did not specify methods, other than surveys, for obtaining information from members, their families, or their guardians for consideration in the development and implementation of QAPI activities. During the compliance review interviews, Peach State staff described a plan to conduct focus groups in each region. Peach State planned to use external consultants to conduct the focused groups to obtain additional member input. However, Peach State was in the planning process and had not implemented the focused groups.		

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Required Actions: Peach State must implement processes to obtain input from families and guardians of members into quality management and performance improvement activities.		
h. Using the CMO's best practices for performance and quality improvement. *Contract: 4.12.2.2*	Peach State's goal is to provide members with a level of care that meets and/or exceeds the recognized level of standards and is delivered in the safest and most appropriate settings. The Quality Assessment Performance Improvement (QAPI) Program incorporates an ongoing documentation cycle that applies a systematic process of quality assessment, barrier/root cause analysis, identification of opportunities, and implementation of interventions as indicated and evaluation. Process improvement is based upon the Deming Cycle, a.k.a. "PDSA" for Plan-Do-Study-Act developed by W. Edwards Deming. The Quality Improvement Department routinely researches nationally recognized web sites for the latest information on quality improvement such as the Agency for Healthcare Research and Quality (www.ahrq.gov), The National Committee for Quality Assurance (www.ncqa.org), and the Institute for Healthcare Improvement (www.ihi.org). Several key QI instruments demonstrate the continuous quality improvement cycle using a pre-determined documentation flow: the Quality Assurance Performance Improvement (QAPI) Program Description, the Quality Improvement (QI) Work Plan and the QAPI Program Evaluation. Peach State exhibits best practices throughout its QI Work Plan, which is based upon NCQA Standards and strives to ensure the Plan's provider network demonstrates a spirit of excellence by rewarding best practices. More specifically, Peach State's Summit Award honors exceptional providers who, compared to their peers, demonstrate the most exemplary care based on performance on a	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	number of key quality and efficiency metrics. Additionally, Peach State was the recipient of the following awards in 2015: • 2015 Dorland Platinum Award Winner (Category – Women/Children CM Program): Teen Education Awareness Program (T.E.A.M.) • 2015 Honorable Mentions (Category – Women/Children CM Program): Making Outcomes Memorable (M.O.M.) Breastfeeding Program • 2015 Honorable Mention (Category – Disease Management/Population Health Programs): Patient Safety Program Moreover, Peach State continuously reviews new technologies as a part of the organizations ongoing quest to improve member outcomes. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description, pg. 1,1 • Document: 2016 QI Work Plan, entire document • Document: Making Outcomes Memorable – Breast Feeding Program • Document: Teen Education Awareness Movement – Outreach Program • Report: Provider Newsletter-Provider Report-Spring 2016 • Report: Provider Newsletter-Provider Report-Fall 2015 • Report: Provider Newsletter-Provider Report-Summer 2015 • Report: Provider Report Card	

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Document: 2015 QAPI Program Evaluation pg. 7, 65 • Policy: GA.UM.10 Evaluation of New Technologies	
Findings: Peach State's QAPI Program used the PDSA cycle that was developed by W. Edwards Deming. In addition, Peach State used IHI's Triple Aim, adopted by CMS as the foundation of its QAPI Program. Processes were described in the QAPI Program Description, QAPI Program Evaluation, and the QI Work Plan. Peach State leadership met quarterly with other Centene (Peach State's parent company) CMOs to discuss best practices. Peach State published CPGs that were based on valid and reliable clinical evidence formulated by nationally recognized organizations and other sources in its provider newsletter. During the compliance review interview, Peach State described its review of other Centene markets' best practices, such as texting reminders for care to members. Peach State also described its success with face-to-face case management visits in complex cases. Peach State considered this procedure a best practice to improve outcomes. The CMO also described its use of My Health Direct to receive a block of appointments from primary care providers in order to directly schedule members for appointments. Peach State indicated that this procedure was successful in getting members in for primary care appointments. The CMO also described reviewing the CMS manual on best practices to identify successful practices not yet tried or implemented by Peach State.		
Required Actions: None.		
5. The CMO complies with Georgia Families quality management requirements to improve member health outcomes by using DCH-established performance measures to document results. *42CFR438.240(b)(2)* *Contract: 4.12.3.1*	Peach State complies with using DCH established performance measures. These measures are reported using the methodology and format required by DCH. The results are compared to DCH targets and interventions are implemented to increase results. The Performance Measures are HEDIS and non-HEDIS measures and the results are audited by an NCQA auditor (ATTEST) and Health Services Advisory Group (HSAG). Peach State demonstrates compliance with this requirement with the following documentation: • Report: CY2015 H2016 - 9227 IDSS Locked – Medicaid (entire document) • Report: CY2015 Non- HEDIS Performance Measures (entire document) • Policy: GA.QI.26 Performance Improvement Measures, pg.1	☒ Met ☐ Not Met ☐ N/A

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Document: Peach State - GF Performance Measures for CY 15 w targets and HEDIS Percentiles v2 10-1-15, (entire document)	
Findings: Peach State discussed using DCH-established performance measure documented results in the 2015 Georgia QAPI Evaluation. The Peach State 2015 Performance Measures Report Analysis provided a description of the targeted strategies and interventions used to improve member health outcomes, as well as an evaluation of the effectiveness of the strategies implemented.		
Required Actions: None.		
6. The CMO achieved DCH-established performance targets. *State-specified element*	Peach State continuously strives to meet or exceed DCH targets for performance measures. Peach State demonstrates this through the following documents: • Document: CY2015 H2016 - 9227 IDSS Locked – Medicaid • Document: Peach State - GF Performance Measures for CY 15 w targets and HEDIS Percentiles v2 10-1-15 • PIP- Adolescent Well Child Visits • PIP-Attention Deficit Hyperactivity Disorder • PIP-Dental Visits • PIP- Diabetes Care • PIP- Member Satisfaction • PIP- Provider Satisfaction • PIP-Bright Futures • PIP- Postpartum	☐ Met ☒ Not Met ☐ N/A
Findings: Peach State did not meet all of the DCH-established performance goals for CY 2014 and CY 2015. The CMO showed statistically significant increases in 10 measure rates. The CMO showed statistically significant decreases in 14 measure rates. The following results were noted:		

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Peach State Access to Care Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.26%	96.74%	↓	NC
25 Months–6 Years	89.96%	89.17%	↓	NC
7–11 Years	91.50%	91.17%	↔	NC
12–19 Years	88.63%	88.78%	↔	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.17%	77.87%	↓	88.52%
Annual Dental Visit				
2–3 Years	45.07%	44.05%	↓	54.20%
4–6 Years	74.66%	72.77%	↓	NC
7–10 Years	77.15%	76.03%	↓	NC
11–14 Years	69.94%	69.85%	↔	NC
15–18 Years	59.32%	59.19%	↔	NC
19–20 Years	—	37.57%	NT	34.04%[4]
Total	67.67%	66.97%	↓	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				
Initiation of AOD Treatment—Total	39.65%	35.24%	↓	43.48%
Engagement of AOD Treatment—Total	8.24%	6.82%	↔	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				

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Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Care Transition—Transition Record Transmitted to Health Care Professional	0.23%	0.00%	↔	NC
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	49.29%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	80.56%	82.38%	↔	85.23%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members age 19–21 years rather than 19–20 years.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Children's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	65.05%	67.79%	↔	64.30%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				

Standard II—Quality Assessment and Performance Improvement				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.91%	68.99%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.07%	47.60%	↔	48.90%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	79.63%	79.09%	↔	80.30%
Combination 6	43.52%	36.30%	↓	59.37%
Combination 10	40.28%	34.38%	↔	38.94%
Lead Screening in Children				
Lead Screening in Children	79.40%	80.05%	↔	75.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	80.31%	82.14%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	76.39%	88.90%	↑	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	69.21%	67.79%	↔	55.09%
Counseling for Nutrition—Total	64.81%	66.59%	↔	60.58%
*Counseling for Physical Activity—Total**	60.19%	57.21%	↔	51.38%
Developmental Screening in the First Three Years of Life				
Total	46.28%	50.60%	↔	46.36%
Percentage Of Eligibles Who Received Preventive Dental Services				
Percentage Of Eligibles Who Received Preventive Dental Services	52.17%	51.46%	↓	58.00%

Standard II—Quality Assessment and Performance Improvement				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk				
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk	—	20.09%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	83.50%	84.00%	↔	86.11%

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*
↑ indicates a statistically significant improvement in performance between CY 2014 and CY 2015.
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↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
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NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Women's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening				

Standard II—Quality Assessment and Performance Improvement					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
Cervical Cancer Screening	68.53%	68.56%	↔	76.64%	
Breast Cancer Screening					
Breast Cancer Screening	71.02%	66.90%	↔	71.35%	
Chlamydia Screening in Women					
Total	56.71%	59.83%	↑	54.93%	
Human Papillomavirus Vaccine for Female Adolescents					
Human Papillomavirus Vaccine for Female Adolescents	24.54%	21.93%	↔	23.62%	
Prenatal Care and Birth Outcomes					
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	82.13%	77.49%	↔	89.62%	
Postpartum Care	70.30%	59.72%	↓	69.47%	
Cesarean Section for Nulliparous Singleton Vertex[4]					
Cesarean Section for Nulliparous Singleton Vertex	NR	2.09%	NT	18.08%	
Cesarean Delivery Rate, Uncomplicated[4]					
Cesarean Delivery Rate, Uncomplicated	29.84%	29.32%	↔	28.70%	
Percentage of Live Births Weighing Less Than 2,500 Grams[4]					
Percentage of Live Births Weighing Less Than 2,500 Grams	9.04%	8.87%	↔	8.02%	
Behavioral Health Risk Assessment for Pregnant Women					
Behavioral Health Risk Assessment for Pregnant Women	0.00%	5.46%	↑	NC	
Early Elective Delivery[4]					
Early Elective Delivery	NR	2.32%	NT	2.00%	

Standard II—Quality Assessment and Performance Improvement				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Antenatal Steroids				
Antenatal Steroids	NR	0.00%	NT	NC
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	57.77%	59.00%	↔	60.10%

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[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

[4] *A lower rate indicates better performance for this measure.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that the CMO produced a CY 2014 rate that was materially biased or chose not to report results for this measure; therefore, the rate was not included in the performance calculation. The auditors confirmed that although the CMO calculated this measure properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.

Peach State Chronic Conditions Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				

Standard II—Quality Assessment and Performance Improvement					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
Comprehensive Diabetes Care*					
Hemoglobin A1c (HbA1c) Testing	83.63%	81.80%	↔	87.59%	
HbA1c Poor Control (>9.0%)[4]	53.17%	59.72%	↓	44.69%	
HbA1c Control (<8.0%)	37.32%	32.51%	↔	46.43%	
HbA1c Control (<7.0%)	27.73%	23.52%	↔	36.27%	
Eye Exam (Retinal) Performed	58.63%	59.36%	↔	54.14%	
Medical Attention for Nephropathy	77.82%	91.87%	↑	80.05%	
Blood Pressure Control (<140/90 mm Hg)	53.17%	52.83%	↔	61.31%	
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)					
Diabetes Short-Term Complications Admission Rate[4]	18.15	15.46	NT	--	
Respiratory Conditions					
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]					
Asthma in Younger Adults Admission Rate	4.55	3.19	NT	--	
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]					
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	28.70	23.78	NT	--	
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	—	80.70%	NT	74.94%	
Bronchodilator	—	82.46%	NT	83.82%	
Cardiovascular Conditions					
Heart Failure Admission Rate (Per 100,000 Member Months)[4]					
Heart Failure Admission Rate	5.45	4.54	NT	--	

Standard II—Quality Assessment and Performance Improvement				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Controlling High Blood Pressure				
Controlling High Blood Pressure	36.64%	43.14%	↑	56.46%
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	NT	NC

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[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015*

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

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NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Behavioral Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				

Standard II—Quality Assessment and Performance Improvement				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Initiation Phase	43.58%	43.84%	↔	53.03%
Continuation and Maintenance Phase	58.19%	58.82%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	56.78%	55.77%	↔	63.21%
30-Day Follow-Up	72.79%	72.53%	↔	80.34%
Antidepressant Medication Management				
Effective Acute Phase Treatment	39.57%	38.66%	↔	54.31%
Effective Continuation Phase Treatment	24.86%	23.89%	↔	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.86%	7.48%	↑	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33.33%	19.63%	↓	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	—	0.25%	NT	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

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Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Medication Management Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	87.24%	87.45%	↔	88.00%
Annual Monitoring for Members on Diuretics	86.63%	87.41%	↔	87.90%
Total	86.74%	87.41%	↔	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	44.06%	45.40%	↔	NC
Medication Compliance 50%—Ages 12–18 Years	39.67%	41.64%	↔	NC
Medication Compliance 50%—Ages 19–50 Years	44.19%	50.96%	↔	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 50%—Total	42.56%	44.34%	↔	NC
Medication Compliance 75%—Ages 5–11 Years	18.82%	20.95%	↔	32.32%

Standard II—Quality Assessment and Performance Improvement				
Requirements and References	**Evidence/Documentation as Submitted by the CMO**			**Score**
Medication Compliance 75%—Ages 12–18 Years	16.03%	16.58%	↔	NC
Medication Compliance 75%—Ages 19–50 Years	23.26%	19.75%	↔	NC
Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 75%—Total	18.03%	19.41%	↔	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
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NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Utilization Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	54.10	52.44	NT	52.31
Outpatient Visits—Total	309.79	303.03	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				

Standard II—Quality Assessment and Performance Improvement					
Requirements and References	**Evidence/Documentation as Submitted by the CMO**				**Score**
Total Inpatient—Average Length of Stay—Total	3.39	3.47	NT	NC	
Total Inpatient—Average Length of Stay—<1 Year	—	8.92	NT	NC	
Medicine—Average Length of Stay—Total	3.43	3.41	NT	NC	
Medicine—Average Length of Stay—<1 Year	—	4.61	NT	NC	
Surgery—Average Length of Stay—Total	8.43	8.37	NT	NC	
Surgery—Average Length of Stay—<1 Year	—	20.83	NT	NC	
Maternity—Average Length of Stay—Total	2.75	2.82	NT	NC	
Mental Health Utilization—Total					
Any Service—Total—Total	8.01%	7.68%	NT	NC	
Inpatient—Total—Total	0.38%	0.41%	NT	NC	
Intensive Outpatient or Partial Hospitalization—Total—Total	0.13%	0.12%	NT	NC	
Outpatient or ED—Total—Total	7.93%	7.59%	NT	NC	
Plan All-Cause Readmission Rate[4]					
Age 18–44	—	12.32%	NT	NC	
Age 45–54	—	11.21%	NT	NC	
Age 55–64	—	5.26%	NT	NC	
Age 18–64—Total	—	11.87%	NT	NC	
Age 65–74	—	NA	NT	NC	
Age 75–84	—	NA	NT	NC	
Age 85 and Older	—	NA	NT	NC	
Age 65 and Older—Total	—	NA	NT	NC	

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**

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[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
[4] A lower rate indicates better performance for this measure.
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Peach State Health Plan Descriptive Information Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.88%	13.16%	↔	NC
1–12 Weeks	13.19%	11.87%	↔	NC
13–27 Weeks	58.56%	52.61%	↓	NC
28+ Weeks	16.20%	14.53%	↔	NC
Unknown	1.16%	7.83%	↑	NC
Race/Ethnicity Diversity of Membership				
Total—White	19.73%	34.32%	↑	NC
Total—Black or African American	49.09%	53.57%	↑	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
↑ *indicates a statistically significant rate increase between CY 2014 and CY 2015.* ↓ *indicates a statistically significant rate decrease between CY 2014 and CY 2015.* ↔ *indicates no significant change between CY 2014 and CY 2015.* *NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.*		
Required Actions: The CMO must meet all DCH-established performance targets before this element will be given a *Met* status.		
7. The CMO has an ongoing QAPI program for the services it furnishes to its members. *42CFR438.240(a)* *Contract: 4.12.5.1*	Peach State has an ongoing QAPI program for the services furnished to our members. The program includes the structure, goals and objectives, activities, behavioral health aspects, patient safety, accountability to the Board of Directors, subcommittee structure and reporting, staffing, data sources and analytical resources, collaborative activities and objectives to address the cultural and linguistic needs of our membership. Peach State demonstrates compliance with this requirement with the following documentation: • 2016 QAPI Program Description (entire document) • 2016 Medicaid QI Work Plan • 2015 QAPI Program Evaluation entire document	☐ Met ☒ Not Met ☐ N/A
Findings: Peach State embraced a QI environment within the organization. Peach State used IHI's Triple Aim for Healthcare Improvement as a framework to evaluate the success of the QAPI Program. In addition, Peach State adopted Lean Six Sigma, as well as the PDSA processes developed by W. Edwards Deming. Peach State trained senior leadership and all QI staff, as well as other staff members, in the Lean Six Sigma methodology for both clinical and nonclinical processes. Twenty-five staff members achieved Green Belt status, and all senior management completed Lean Six Sigma Champion training. References were included in the QAPI Program Description, the QI Work Plan, and the QAPI Program Evaluation. During compliance review interviews, the CMO indicated that it also used the Define, Measure, Analyze, Improve, and Control (DMAIC) model for operational improvement. While the QAPI Program Description showed improvement from the previous year's document, Peach State must continue to develop its QAPI Program Description to ensure that it follows the DCH-required guidelines. Peach State's various program evaluations should include detailed descriptions on methodologies, data sources, member and provider input, analysis of		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
interventions, and evaluation of the results of QAPI activities. Peach State should strengthen its process by ensuring that evaluation documents are thorough so that they may be used to develop quality roadmaps for quality assessment and performance improvement.		
Required Actions: Peach State must continue to develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The CMO's QAPI Program Description must be approved by DCH as meeting the DCH guidelines.		
8. The CMO's QAPI program is based on the latest available research in the area of quality assurance. *Contract: 4.12.5.2*	The Peach State Quality Improvement Department routinely researches nationally recognized Web sites for the latest information on quality improvement such as the Agency for Healthcare Research and Quality (www.ahrq.gov/), The National Committee for Quality Assurance (www.ncqa.org), and the Institute for Healthcare Improvement (www.ihi.org). In addition, each year, the QI Program is based on the latest NCQA Quality Standards (See QI Work Plan.) The Plan also reviews new technology and incorporates it into member benefits as appropriate. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description, (entire document) • Policy: GA.UM.10 Evaluation of New Technology Policy pg. 1 • Policy: GA.PHAR.17 Pharmacy and Therapeutics Committee pg. 1 • Policy: GA.PHAR.03 Pharmaceutical Management pg. 2	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State used the IHI's Triple Aim Framework as a foundation for the QAPI Program. In addition, Peach State used the PDSA framework developed by W. Edwards Deming, Lean Six Sigma, and the DMAIC model for operational improvement. Peach State included a description of some of the work in the QAPI Program Description, the UM Evaluation of New Technology Policy, and the Pharmacy and Therapeutics Committee Policy. During the compliance review interview, staff members stated that they routinely searched the websites of nationally recognized programs in quality improvement for best practices. Peach State staff met quarterly with other Centene CMOs to discuss QI best practices and any issues that the particular CMO had resolved. Peach State's Evaluation of New Technology Policy described the manner		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
in which Peach State staff researched new developments in technology for medical and behavioral healthcare and services, as well as pharmaceuticals and other medical devices.		
Required Actions: None.		
9. The CMO's QAPI program includes mechanisms to detect both underutilization and overutilization. *42CFR438.240(b)(3)* *Contract: 4.12.5.2*	Peach State routinely monitors data to identify over and underutilization patterns and implements actions as needed. Utilization Management monitors under- and over-utilization through admission and readmission reports, length of stay reports, C-section rates and emergency room visits. Peach State demonstrates compliance with this requirement with the following documentation: • 2015 UM Program Description pg. 4,6,7 • 2016 QAPI Program Description pg. 18 • Policy: GA.UM.19 Monitoring Utilization • Document: 2016 UMC Agenda • Report: Under and Over–Utilization Reports: - 2015 ER Graph - 2015 UM Graph	☒ Met ☐ Not Met ☐ N/A
Findings: The QAPI Program Description included a section that described the manner in which Peach State conducted overutilization and underutilization reviews. For example, Peach State conducted data analysis using encounter data sources (e.g., medical services, pharmacy, dental, and vision) to identify patterns of potential or actual inappropriate utilization of services. The QI Department worked with the UM Committee, as well as other committees and staff as appropriate, to identify problem areas, conduct barrier analysis, identify opportunities for improvement, and provide improvement recommendations to the Quality Oversight Committee (QOC) for approval. One of the goals of the UM Program, as described in the UM Program Description, was to monitor for overutilization or underutilization of care/services and to implement action plans, as necessary. Peach State incorporated findings into the recredentialing program, if warranted. The Monitoring Utilization Policy provided a framework for reviewing utilization data, but described it as an annual process. During the compliance review interview, the CMO stated it monitored the CMS 416 data monthly and compared it to the HEDIS rates understanding the lack of comparability of the rates. Peach		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
State also described more frequent utilization monitoring than was detailed in the Monitoring Utilization Policy, such as daily emergency department utilization and inpatient daily census, monthly monitoring of pharmacy and outpatient services, as well as length of stay, bed days per 1000, and per member per month (PMPM) expenditures.		
Required Actions: None.		
10. The CMO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. *42CFR438.240(b)(4)* *Contract: 4.12.5.2*	Peach State recognizes that our members have complex needs that may require care and services across a continuum of multiple providers. Peach State includes mechanisms to assess quality and appropriateness of care to all members including those with special health care needs through program descriptions, policies, trending and performance measure improvements. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description pg.1 • Document: 2015 QAPI Program Evaluation, Population Served, pgs. 14-38	☐ Met ☒ Not Met ☐ N/A
Findings: The QAPI Program Description stated that members with special healthcare needs were not excluded from the QAPI Program; however, it did not describe how the special needs population was integrated into the QAPI activities. Peach State did not provide documentation of implemented processes to assess the quality of care furnished to members, including those with special healthcare needs. During the compliance review interview, Peach State described its EPSDT medical record review process that concentrated on identifying missed components of the EPSDT visit. Peach State completed approximately 400 EPSDT medical record reviews annually, and the most recent results indicated a 92 percent provider compliance rating. The CMO also described its process to tier physicians according to quality outliers, such as access to care and use of asthma action plans. However, Peach State did not define a population, such as the focus populations described by the CMO which included the EPSDT population, or asthma members as members with special healthcare needs.		
Required Actions: Peach State must strengthen its processes for the monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members in the areas of underutilization or receipt of chronic disease or preventive healthcare and services. Peach State must define members with special healthcare needs and include its method of monitoring, analysis, evaluation, and improvement for the delivery, quality, and appropriateness of healthcare furnished to members with special healthcare needs in its program		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
descriptions and evaluations. Peach State must consider use of data, such as outcome data, to evaluate the quality and appropriateness of care furnished to members, including those with special healthcare needs.		
11. The CMO has a method of monitoring, analysis, evaluation and improvement of the delivery, quality, and appropriateness of health care furnished to all members (including under- and over-utilization of services), including those with special health care needs. *Contract: 4.12.5.2*	Peach State continuously monitors, analyzes and evaluates the improvement of the delivery, quality, and appropriateness of health care furnished to all members (including under- and over-utilization of services), including those with special health care needs. We monitor and evaluate service and clinical data reports on a weekly, monthly, quarterly, and annual basis as required by DCH. Performance Measures are monitored and trended. The 2016 QAPI Program Description describes the QI program's governance, scope, goals, measureable objectives, structure and responsibilities to ensure an effective QAPI Program. The 2015 QAPI Program Evaluation provides the analysis of Peach State's monitoring and evaluating of efforts to improve the delivery, quality, and appropriateness of health care furnished to all members. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description (entire document) • Document: 2015 QAPI Program Evaluation (entire document) • Document: 2015 UM Program Description, pgs. 1-3	☐ Met ☒ Not Met ☐ N/A
Findings: The Peach State's UM Program Description stated: "The CMO may also use the Subacute/SNF Nursing guidelines to assist in determining medical necessity for subacute or skilled nursing care for members with catastrophic conditions or special health care needs." The UM Program Description included goals and objectives for ensuring the delivery, quality, and appropriateness of healthcare furnished to all members. However, the CMO did not link the goals and objectives to its processes for how it monitored, analyzed, or evaluated the delivery, quality, and appropriateness of healthcare furnished to members with special healthcare needs. In addition, Peach State did not provide documentation of implemented processes to assess the quality of care furnished to members, including those with special healthcare needs. During the compliance review interview, Peach State described its EPSDT medical record review process that focused on identifying missed		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
components of the EPSDT visit. Peach State completes approximately 400 EPSDT medical record reviews annually, and the most recent results indicated a 92 percent provider compliance rating in the area of EPSDT. The CMO also described during the interview session its process to tier physicians according to quality outliers such as access to care and use of asthma action plans. However, Peach State did not define populations of members with special healthcare needs.		
Required Actions: Peach State must define mechanisms to assess the quality and appropriateness of care furnished to its members, including those with special healthcare needs.		
12. The CMO's QAPI program includes written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically assessed for efficacy. *Contract: 4.12.5.2*	Peach State maintains an extensive library of policies for each department on Compliance 360, which, among many other features, generates automatic reminders to business process owners assigned to the policies notifying them when the policies are due for annual review and renewal. Peach State demonstrates compliance with this requirement with the following documentation: Document: 2016 QAPI Program Description, pg. 1 Document: 2015 UM Program Description, pg. 2 Policy: CC.COMP22_Procedural_Documentation_02-19-2016 (entire document)	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State's UM and QAPI Program Descriptions, Evaluations, and Work Plans were reviewed, evaluated, and revised as necessary and approved annually. Program descriptions included procedures for implementing UM and QAPI processes. The Procedural Documentation Policy described the way that policies and procedures were developed and approved. Peach State required all policies to be reviewed annually.		
Required Actions: None.		
13. The CMO's QAPI program includes designated staff members with expertise in quality assessment, utilization management, and continuous quality improvement. *Contract: 4.12.5.2*	Peach State's Senior Leadership (and hiring managers) work to ensure that Peach State recruits and retains employees based on their expertise in quality assessment, utilization management, and continuous quality improvement where applicable.	☒ Met ☐ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description pgs. 10-12 • Document: 2015 UM Program Description, pgs. 9-12 • Document: PS 2016 Leadership Org Chart • Document: Case Management Org Chart • Document: Medical Management Org Chart • Document: QI Org Chart • Document: 2016 Medical Management Org Chart • Document: Job Descriptions – Quality Improvement - Accreditation Specialist - Data Analyst III - Manager, QI Analytics - Manager, Quality Improvement - QI Coordinator I - QI Project Manager - Vice President, Quality Improvement • Document: Job Descriptions – Utilization Management - Concurrent Review Nurse I - Care Manager II (RN) - Director, Case Management - Director, Utilization Management - Manager, Case Management - Manager, Referral Specialist - Manager, Utilization Management - Medical Director - Pharmacy Coordinator - Prior Authorization Nurse I	

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	- Program Coordinator I - Referral Specialist I	
Findings: Peach State had designated staff involved in the QAPI Program. Peach State used Lean Six Sigma for quality improvement, and the QI staff and Peach State senior leadership completed Lean Six Sigma Green Belt training. Documentation of the position requirements were found in the QAPI Program Description, UM Program Description, organization charts, and job descriptions. During the compliance review interview, Peach State staff stated that 25 staff members have been trained in Six Sigma methodology and that Peach State leadership intended to continue to expand the number of staff members trained. All job descriptions reviewed included process improvement as one of the competencies.		
Required Actions: None.		
14. The CMO's QAPI program includes reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members. *Contract: 4.12.5.2*	In addition to the reports required by the Department of Community Health, Peach State also generates and reviews all reports found on the QI Work Plan, such as HEDIS data, practitioner access and availability data, service metrics, member and provider satisfaction and performance measures, and presents them to the Quality Oversight Committee (QOC) for review, identification of opportunities for improvement, and creation of interventions. The Plan informs providers and members of outcomes of the QI program via the respective newsletters. Peach State demonstrates compliance with this requirement with the following documentation: • Document: Provider Newsletter-Provider Report-Spring 2016 • Document: Provider Newsletter-Provider Report-Fall 2015 • Document: Provider Newsletter-Provider Report-Summer 2015 • Document: 2016 QI Work Plan, (entire document) • Report: PIP – Member Satisfaction (entire document) • Report: PIP – Provider Satisfaction (entire document) • Report: PIP – Postpartum Care Visit (entire document) • Report: PIP – Avoidable Emergency Room (entire document)	☐ Met ☒ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Report: PIP – Bright Futures Guidelines (entire document) • Report: PIP– Dental (entire document) • Report: PIP – ADHD (entire document) • Report: PIP – Diabetes (entire document) • Document: Medicaid QOC Minutes 10-7-15 pg. 21-23 • Report: CY2015 H2016 - 9227 IDSS Locked - Medicaid (entire document) • Document: 2015 QAPI Program Evaluation (entire document)	
Findings: Peach State's QAPI Program included reports with recommendations and actions taken; however, the feedback provided to members and network providers about these activities is limited. For instance, Peach State provided copies of member newsletters that included a statement about the member satisfaction survey. The narrative stated that Peach State would use the results of the survey to help improve, and that the CMO was working on the area of getting members an appointment with a specialist and in the area of customer service. During the compliance review interview, Peach State staff provided two newsletters that directed members where to call to receive more information about QAPI activities, and another newsletter described some of the results of QAPI activities. Peach State provided three copies of the provider newsletter during the compliance review interviews. Each provider newsletter described QAPI projects but did not include a summary of assessments of actions taken or recommendations that have been implemented. For example, the newsletter mentioned that providers improved the HEDIS scores and that Peach State conducted office reviews, which included medical record reviews, but Peach State did not inform the providers that a certain percentage of records were problematic, which improvements were implemented, which HEDIS scores were problematic, or which recommendations were implemented after review and analysis. Peach State documentation stated that "at least annually, Peach State provides information, including a description of the QAPI Program and a report on the Plan's progress in meeting QAPI Program goals to members and providers." At a minimum, the communication includes information about QI Program goals, processes, and outcomes as they relate to member care and services and must include plan-specific data results such as HEDIS and PIP results. Primary distribution is through the member/provider newsletter and via the CMO's website. Peach State's Quality Management Program Description describes goals and objectives to track, trend, and report data and outcomes. The documentation would be strengthened by including information on how, as a result of data analysis or evaluation, indicated recommendations are implemented.		
Required Actions: Peach State must update its QAPI Program Description to describe how it shares quality improvement results and provides feedback to members and providers. Peach State must document the results and feedback that are shared with members and providers, as well as the methods used (e.g., member and provider newsletters, individual or population-specific communications or website updates).		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
15. The CMO's QAPI program includes a methodology and process for conducting and maintaining provider profiling. *Contract: 4.12.5.2*	Peach State evaluates practice patterns of network physicians through utilization and quality data provided through a variety of methods. Semi-annually, Peach State distributes a PCP Scorecard with HEDIS-based measures that show the individual physician's score compared to the Plan average and the Medicaid 50th percentile. The Plan also utilizes Impact Intelligence for the generation of utilization based performance profiles by specialty type to identify practice variations. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Description, pg.13 • Document: Provider Report Card - PCP • Example: Impact Intelligence Profile- (PCP) • Example: Impact Intelligence Profile- (Pediatric) • Document: 2015 QAPI Program Evaluation	☐ Met ☒ Not Met ☐ N/A
Findings: The QAPI Program Description stated that provider profiling was conducted and that Peach State used Centelligence Insight, a web-based reporting and management system that included advanced capabilities for provider practice pattern and utilization reporting. Peach State provided an example of a provider report card and provider profiles from its Impact Intelligence system. The system generated summary and detailed views of clinical quality and cost profiling information. The system supplied the CMO with provider, practice, and peer-level profiling information. Peach State provided examples of provider profiles. Peach State did not have a documented methodology and process for conducting and maintaining provider profiling.		
Required Actions: Peach State must have a documented methodology and process for conducting and maintaining provider profiling.		
16. The CMO's QAPI program includes ad-hoc reports to the CMO's multidisciplinary Quality Oversight Committee and DCH on results, conclusions, recommendations, and implemented system changes, including:		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
Contract: 4.12.5.2		
a. Annual performance improvement projects (PIPs) that focus on clinical and non-clinical areas; and	Peach State develops Performance Improvement Projects (PIP) to improve compliance rates for specific performance measures and to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, and utilization management reviews. Ad-hoc reports are shared with the Quality Oversight Committee (QOC) and DCH that include results, conclusions, recommendations, and implemented system changes. Peach State demonstrates compliance with this requirement with the following documentation: • Report: PIP – Member Satisfaction (entire document) • Report: PIP – Provider Satisfaction (entire document) • Report: PIP – Postpartum Care Visit (entire document) • Report: PIP – Avoidable Emergency Room (entire document) • Report: PIP – Bright Futures Guidelines (entire document) • Report: PIP– Dental (entire document) • Report: PIP – ADHD (entire document) • Report: PIP – Diabetes (entire document) 2015 QAPI Evaluation, PIPs pgs.124-140	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State's QAPI Program included annual PIPs that focused on clinical and nonclinical areas. Peach State provided the PIP modules that described PIPs aimed at provider satisfaction, member satisfaction, postpartum care, avoidable emergency room visits, diabetes, ADHD, and dental benefit education. Peach State discussed PIP reports at committee meetings.		
Required Actions: None.		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
b. Annual Reports on performance improvement projects and a process for evaluation of the impact and assessment of the Contractor's QAPI program.	Peach State reports standard and ad hoc reports through the Quality Oversight Committee (QOC). DCH is invited to all QOC meetings as these reports are reviewed and analyzed. Peach State demonstrates compliance with this requirement with the following documentation: • Minutes: Medicaid QOC Minutes 10-7-2015 Document: 2015 QAPI Evaluation PIPs pgs. 124-140	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State's QAPI Program Evaluation for 2015 was presented to its QOC. The report included goals and objectives, as well as a report of the action plans that were implemented.		
Required Actions: None.		
17. The CMO has a process for evaluating the impact and effectiveness of the QAPI program. *42CFR438.240(e)(2)* *Contract: 4.12.5.2*	Peach State conducts an annual evaluation of the QI Program and Work Plan. Results are reviewed and discussed at the Quality Oversight Committee (QOC) for approval. Results are the basis for the next year's Work Plan and Program Description. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2015 QAPI Program Evaluation (entire document) • Document: 2016 QAPI Program Description pg. 23 • Document: 2016 QI Work plan (entire document)	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State included three documents to evaluate the impact and effectiveness of the QAPI Program; the QAPI Program Description, the QAPI Program Evaluation, and the QI Work Plan. The QAPI Program Description included a high-level description of the three documents used for the evaluation but did not include the process used to identify quality improvement opportunities and gaps in care or service delivery; the QAPI Program Evaluation included a listing of the activities related to the QAPI Program for the year, including a list of achievements, lessons learned, and priorities to change in the next year but did not provide a comprehensive summary describing the details of the QI work; the QI Work Plan listed the QI activities in a table that included the standard, objective, description of the project, who was accountable, the timeline, and the monitoring status. The 2015 QAPI Program Evaluation included broad statements indicating that areas of the QAPI Program which did		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
not meet goals were analyzed and activities were directed toward identified barriers. The QAPI Program Evaluation did not provide an in-depth analysis or evaluation to indicate that the CMO used its data to identify quality improvement opportunities or to determine whether specific outcomes from quality improvement work (e.g., disease and case management) or results gained by implementing CPGs improved care or services. HSAG recommends that the CMO continue to strengthen its processes for evaluating the impact and effectiveness of the QAPI program. The CMO should meet the DCH requirements and receive DCH approval of its QAPI Program Description and QAPI Program Evaluation.		
Required Actions: None.		
18. The CMO conducts focused studies that examine a specific aspect of health care for a defined point in time. These studies are usually based on information extracted from medical records or CMO administrative data such as enrollment files and encounter/claims data. *Contract: 4.12.8.1*	During this review period, Peach State was not required to conduct a focus study. The last focus study required was a Cesarean Focus Study. When Peach State is required to conduct focused studies, the Plan will use the approved forms that include the study topic, question, and indicators. Peach State will identify a study population; document sound sampling techniques (if used); and collect, analyze, and interpret the study results. However, in lieu of DCH-assigned focused studies, the Plan did conduct several Performance Improvement Projects. Peach State demonstrates compliance with this requirement with the following documentation: • Report: Cesarean Focus Study Summary (submitted June 30 2012) entire document • Report: PIP – Diabetes (entire document) • Report: PIP – Member Satisfaction (entire document) • Report: PIP – Provider Satisfaction (entire document) • Report: PIP – Postpartum Care Visit (entire document) • Report: PIP – Avoidable Emergency Room (entire document) • Report: PIP – Bright Futures Guidelines (entire document) • Report: PIP– Dental (entire document)	☐ Met ☐ Not Met ☒ N/A

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Report: PIP – ADHD (entire document)	
Findings: Peach State indicated in its response that DCH has not instructed Peach State to conduct focused studies since 2012. The focused study must be considered as an opportunity to acquire the information and data needed to determine if interventions are needed in order to improve operations, outcomes, or member/provider satisfaction.		
Required Actions: None.		
19. The CMO follows a structured process for conducting the focused studies, which includes: • Selecting the study topic(s). • Defining the study question(s). • Selecting the study indicator(s). • Identifying a representative and generalizable study population. • Documenting sound sampling techniques utilized (if applicable). • Collecting reliable data. • Analyzing data and interpreting study results. *Contract: 4.12.8.1*	During this review period, Peach State was not required to conduct a focus study. The last focus study required was a Cesarean Focus Study. When Peach State is required to conduct focused studies, the Plan will use the approved forms that include the study topic, question, and indicators. Peach State will identify a study population; document sound sampling techniques (if used); and collect, analyze, and interpret the study results. The CMO provided its Cesarean Section focused study documentation as an example. Peach State demonstrates compliance with this requirement with the following documentation: • Report: Cesarean Focus Study Summary (submitted June 30 2012) entire document	☐ Met ☐ Not Met ☒ N/A
Findings: Peach State indicated in its response that DCH has not instructed the CMO to conduct focused studies since 2012. The focused study must be considered as an opportunity to acquire needed information and data to determine if interventions are needed in order to improve operations, outcomes, or member/provider satisfaction.		
Required Actions: None.		
20. The CMO has a structured patient safety plan to address concerns or complaints regarding clinical care, which includes written policies and procedures for processing member complaints regarding the care they received. *Contract:*	Peach State's goals include the promotion of safe clinical practices in all aspects of clinical care and services. Moreover, Peach State identifies and monitors complaints related to potential quality of clinical care issues. The Peer Review process is initiated and followed for all potential quality of care issues. The reports are	☐ Met ☒ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
4.12.9.1	reviewed, trended and analyzed at the Quality Oversight Committee. Member and provider education is conducted as warranted. Peach State demonstrates compliance with this requirement with the following documentation: • Document: 2016 QAPI Program Description, pg. 17 • Document: Patient Safety Results Medicaid CY 2015, 2016 (entire document) • Policy: GA QI 24 QOC Investigations • Policy: GA QI 08 Grievance Process • Policy: GA QI 23 Peer Review	
Findings: Peach State had a structured Patient Safety Plan that described the processes for monitoring and improving patient safety in clinical care and service delivery. The Patient Safety Plan described how Peach State addressed concerns or complaints regarding clinical care. The QM Patient Safety Plan was written in a manner that may cause confusion between grievances (expressions of dissatisfaction) and the grievance system. The grievance policies and procedures included how Peach State classified complaints according to severity, the involvement of the medical director, a mechanism to determine whether additional review by other committees was required, and a summary of the incident (including the final disposition). Peach State also had several policies that addressed patient safety and complaints, including the Grievance Process, Quality of Care Investigations, and Peer Review. The CMO should ensure that the policies and plans are written to include a statement that there are no State fair hearings for grievance resolution.		
Required Actions: The QM Patient Safety Plan must clearly distinguish between grievances and the grievance system. The QM Patient Safety Plan must be approved by DCH.		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
21. Patient safety plan policies and procedures include: *Contract: 4.12.9.1*		
a. A system for classifying complaints according to severity. *Contract: 4.12.9.1*	Peach State has a system for classification of grievances. All grievances are classified in a five-level severity ranking system. Severity Levels 0, I, II, III and IV, as defined in the GA.QI.23 Peer Review policy and in the GA.QI.24 Quality of Care Investigations Policy. The Plan demonstrates compliance with this requirement with the following documentation: • Document: Patient Safety Plan Medicaid CY 2015 pg. 1-3 • Document: Patient Safety Plan Medicaid CY 2016 pg. 1-2 • Policy: Policy: GA.QI.24 Quality of Care Investigations, pg. 1 and Attachment B pg. 9 • Policy: GA_QI_23_Peer_Review 03-7-2016, pg. 2-5 and Attachment A, pg. 10	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State had a system to assign severity to complaints and grievances. Peach State defined the levels as follows in its Patient Safety Plan: • Level 0—no confirmed quality problem • Level I—confirmed quality problem with no adverse effect on the patient or the injury results in minor alteration in treatment plan • Level II—minimal clinical effect with temporary residual, without significant functional or cosmetic impairment or minimal injury to the patient, or some level of temporary disability expected (fracture, burns, and drug reaction/side effects resulting in increased length of stay [LOS]) • Level III—confirmed quality problem with minimal to moderate clinical effect that requires minimal to moderate clinical intervention, injury results in temporary disability, condition expected to improve (congestive heart failure [CHF], renal failure, return to operating room [OR] for surgical repair)		

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
• Level IV—confirmed quality problem with moderate to severe clinical effect with significant adverse effect on patient, permanent functional or cosmetic residual, injury results in major disability, patient morbidity and residual side effects not expected to improve (paraplegia, renal failure, or other organ failure), injury results in permanent alteration of body part/image (blindness, amputations, disfiguring scars organ loss, deafness), injury results in major alteration of treatment plan.		
Required Actions: None.		
b. A review by the Medical Director. *Contract: 4.12.9.1*	Peach State's system for processing grievances establishes that review of Quality of Care (QOC) grievances will be done by a Medical Director/ Sr. Vice President of Medical Affairs. The Plan demonstrates compliance with this requirement with the following documentation: • Document: Patient Safety Plan Medicaid CY 2015 pg. 2-3 • Document: Patient Safety Plan Medicaid CY 2016 pg. 2-3 • Policy: GA QI 08 Grievance Process, pg. 3 • Policy: GA.QI.24 Quality of Care Investigations, pg. 1 • Policy: GA_QI_23_Peer_Review 03-7-2016, pg. 1-2	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State's Patient Safety Plan and the Grievance Process Policy stated that the grievance and appeals coordinator routed all grievances that involved potential clinical or quality of care issues to the medical director. Peach State submitted a process flow for referring potential quality of care issues to the QI Department. The flow chart included the involvement of the medical director. The documents were consistent in describing the quality of care and peer review processes.		
Required Actions: None.		
c. A mechanism for determining which incidents will be forwarded to the Peer Review and Credentials Committees. *Contract: 4.12.9.1*	The Peach State Peer Review process is initiated upon receipt of a potential quality of care (QOC) issue. All potential QOC issues are forwarded to a Medical Director for review and assignment of a severity level. If a QOC case is assigned a severity level III, the case may be taken to the Peer Review Committee based on the judgment of the reviewing Medical Director. If a QOC case is assigned a severity level IV, the case must be presented to the Peer Review	☐ Met ☒ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Committee for a determination. All findings are presented to the Credentialing Committee. The Plan demonstrates compliance with this requirement with the following documentation: • Document: Patient Safety Plan Medicaid CY 2015 pg. 2-3 • Document: Patient Safety Plan Medicaid CY 2016 pg. 2-3 • Policy: GA.QI.24 Quality of Care Investigations, pg. 2-3 • Policy: GA_QI_23_Peer_Review 03-7-2016, pg. 3-5 • Example: Example of a Quality of Care Grievance Case	
Findings: Peach State had a process document in its Patient Safety Plan, Quality of Care Investigations Policy, and the Peer Review Policy that classified incidents using a severity level. The medical director reviewed Severity Level III incidents and referred them to the Peer Review Committee if warranted. The process indicated that Severity Level IV incidents were routinely referred to the Peer Review Committee for evaluation and further action, unless the case was already under review in a hospital's internal peer review process.		
Required Actions: Peach State must review all quality of care concerns, even those that are referred to and are being reviewed by another entity, such as a hospital. Peach State must make its own quality of care determination, refer to its peer review process, and report to boards and regulatory agencies, as appropriate, as a result of the CMO's investigation process.		
d. A summary of incident(s), including the final disposition, included in the provider profile. *Contract: 4.12.9.1*	Peach State's provider profile of grievances is electronic, i.e., housed in an electronic database rather than filed on paper. All grievances are logged into the database. The database contains fields for both the summary of the incident and the final disposition. In addition, summaries of all grievances and quality of care events are presented to the Credentialing Committee for individual practitioners at the time of re- credentialing. The Plan demonstrates compliance with this requirement with the following documentation: • Example: Grievance SharePoint Database	☐ Met ☒ Not Met ☐ N/A

Standard II—Quality Assessment and Performance Improvement		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Policy: GA.CRED.09_Recredentialing_of_Practitioners pg. 2&4 • Report: Grievance System DCH Quarterly Report January 2016 Analysis (entire document) • Report: Grievance System DCH Quarterly Report January 2016 (entire document) • Document: Medicaid QOC Minutes 10-7-15 pg. 21-23	
Findings: During the compliance review interview, Peach State indicated that it included the final disposition of quality of care cases and grievances in the provider profile. The CMO provided limited documentation that described which incidents or information were included in the provider profile or the process used to include profile information.		
Required Actions: The CMO must update its Patient Safety Plan and other documents to clearly state how incidents and the final disposition of grievances, quality improvement cases, and peer review results are included in the provider profile.		

Results for Standard II—Quality Assessment and Performance Improvement							
Total	Met	=	20	X	1.00	=	20
	Not Met	=	10	X	.00	=	0
	Not Applicable	=	2	X	N/A	=	N/A
Total Applicable		=	30	**Total Score**		=	20
				Total Score ÷ Total Applicable		=	66.7%

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
1. The CMO maintains a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data. *42CFR438.242(a)* *Contract: 4.12.5.2*	Peach State utilizes Centene relational and indexed databases to store claims, encounter and utilization information. The Plan utilizes Amisys Advanced as the primary claims system to administer medical claims. Claims data are housed in Amisys tables, which are uploaded into EDW. **Claims and Operational Process Reporting** The data interfaces load the data into the fully integrated Amisys Advance system. Using Amisys Advance's many subsystem features on this data, Peach State is able to monitor, manage, and report as required in the contract. The Interface Subsystem is made up of a combination of customized processes built by Centene programmers and Amisys Advance's standard data interface subsystem. Because Amisys Advance is a fully integrated managed care solution, it supports both incoming and outgoing data from any internal or external party. Amisys Advance contains a central database that contains many different tables. The tables contain detailed information regarding claims, members, providers, procedure codes, and other pertinent information. For example, the health database contains the service table where claims are stored and the provider table stores demographic information regarding the provider. Although there are many tables in Amisys Advance, there are subsystems that allow access to these tables. These different subsystems access the same tables that keep the data from being duplicated. Centene has developed an interface solution that allows rapid processing of member, claim, and encounter data from any business partner or	☒ Met ☐ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	subcontractor in any format and can standardize it before it reaches the Amisys Advance tables. Peach State currently supports daily, weekly, monthly, bi-monthly, quarterly, annual, and ad hoc transactions of all types from our business partners. The Plan will make use of these reports in fulfilling its management needs and DCH requirements. State Compliance Reporting is also supported through this system. **Operational and Analytic Reporting** Peach State claims, encounters, enrollment, provider and member data is loaded nightly into a TeraData database for operational and analytic reporting purposes. A MicroStrategy universe resides over that data to provide end user self-service access for ad hoc analysis. **HEDIS and CRMS Analytic Reporting** Peach State claims, encounters, enrollment, provider, and member data are also loaded into the QSI data warehouse for analytic reporting purposes. This supports HEDIS and other focused reporting needs. **Encounter Submission to DCH** Claims and Encounters are pulled from the claims database, using check run date parameters. The records are placed into an extract file and then put into the HIPAA 837 specified file layout. Custom developed programs format the claims into formats specified by DCH for submission.	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Peach State reviews encounter metrics against check run financial reports to validate completeness. Additional quality audits of the encounter data files are performed by IT and Finance. **<u>Information System Security</u>** Centene's data center is centrally located in St. Louis, MO and houses all system application services provided to our claims processing center, providers, and health plan offices. This data center is equipped with a fully redundant power distribution system to mitigate the risks associated with power fluctuations and loss. In addition, the IT infrastructure is backed up with a diesel generator capable of supporting all business functions for more than 66 hours (before refueling would be necessary) in an event of a power outage. Centene's systems, storage and network infrastructure is based on a modern multi-tiered design. At the heart of this architecture design are three fundamental principles: reliability, scalability and flexibility. This design approach allows us to rapidly scale our infrastructure and capacity requirements to more easily adapt to our growing business needs while also providing highly-available services to our customers. This is accomplished via redundant hardware services and clustering technologies used in everything from our enterprise storage to our application servers and our corporate network. Our claims processing systems are comprised of three integrated servers forming an application cluster. If any node, application, or database experiences a problem, the claim processing service would be redirected to one of the surviving nodes in the cluster thereby	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	averting an outage. This same technology is used to help manage scheduled maintenance activities to reduce the outages for our claims processing activities. In addition, Centene has developed a comprehensive and secure business continuity/disaster recovery plan. Centene, in partnership with SunGard Availability Services, Inc. has developed and implemented both a Business Continuity Plan (BCP) and a Disaster Recovery Plan (DRP) that meets operational requirements. Once a disaster has been declared, the necessary business recovery procedures would be invoked and restoration of all critical business functions would begin at the closest SunGard recovery facility. Critical services would be recovered within 48 hours of the declared disaster. The BCP and DRP are updated and tested annually. TSM (Tivoli Storage Manager) is utilized for our Enterprise backup and recovery operations. As part of these services, all production systems are backed up on a daily basis and copied to tape for offsite storage. The tapes are inventoried, picked up by our remote storage vendor, and then transported to their secured facility for storage. Onsite tape copies provide the primary method for restoring data. In the event of a disaster, our offsite tape copies provide an alternate means for recovery. Tape/Data retention specifics are depicted in the below table. The Plan demonstrates compliance with this requirement with the following documentation: • Report: Centene Recovery Agency Disaster Recovery Summary Results	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Document: Business Continuity Plan • Document: HEDIS Data flow chart Document: Claims Processing Data Flow Chart	
Findings: Peach State maintained a health information system sufficient to support the collection, integration, tracking, analysis, and reporting of data. Peach State's information systems were centrally located, in St. Louis, Missouri, and this location provided support functions for all CMO operations. Peach State used an information system composed of relational and indexed databases to store claims, encounter, and utilization information. The CMO used the Amisys Advanced system as the primary claims system to administer medical claims. Peach State uploaded claims data into a data warehouse, Enterprise Data Warehouse (EDW). The EDW, Peach State's proprietary business intelligence and data management platform, was the foundation of its internal and external data integration and reporting capabilities. In addition, Peach State developed an interface solution that allowed rapid processing of member, claim, and encounter data from any business partner or subcontractor in any format, and standardized the data before it reached the Amisys Advance tables. Peach State loaded claims, encounters, enrollment, provider, and member data nightly into a TeraData database for operational and analytic reporting purposes. Peach State also loaded claims, encounters, enrollment, provider, and member data into the QSI data warehouse for analytic reporting purposes.		
Required Actions: None.		
2. The CMO's health information system provides information on areas including: *42CFR438.242(a)*		
a. Utilization.	Peach State utilizes TruCare Healthcare Management System. TruCare is used by Centene and subsequent subsidiaries, to provide users the ability to create, track and store all required documentation relevant to clinical determinations made during the utilization process. Additionally, the system provides the same for case management, quality issues, appeals and all documentation that accompany such components of patient care as is outlined in the following: • Documentation to support prior authorization of elective inpatient and outpatient services. • Documentation of emergent services and related activities.	☒ Met ☐ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Authorization of continued stay inpatient services. • Medical Reviews for all service requests, appeals, and quality issues that require review. Utilization data is also collected through the claims processing system, Amysis, as described in #1 above. Vendor data such as pharmacy and dental services is directly imported into the EDW for use in evaluating and reporting overall utilization of services. Centene's Enterprise Data Warehouse (EDW), is our repository of service information data. The EDW is our innovative proprietary business intelligence and data management platform and is the foundation of our internal and external data integration and reporting capabilities. The EDW enables our health plan management teams to improve decision making, manage finances, ensure regulatory and contractual compliance, and support our efforts to provide better health outcomes. EDW is the central database of service information that underlies the reporting and decision support needs of our internal and external information consumers. Automated electronic feeds from Centene's core transaction systems, including our AMISYS claims transaction processing system, TruCare care management application, CRM inquiry tracking system, and Portico provider data management system supply EDW with near real time data updates. These feeds also include other key data sources such as electronic prescription drug claims information data from US Script, Peach State's Pharmacy Benefits Manager (PBM). Another important and related component of our reporting infrastructure is our CareEnhance Resource Management Software (CRMS). Medical, dental, vision, pharmacy and behavioral claims	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	data are electronically fed into CRMS. Using CRMS, we then produce NCQA-Accredited HEDIS reports. **Operational Reports** – for decision support in all areas of health plan operations such as claims, enrollment, call center, MIS; for example: • Utilization Management (UM) dashboard and UM authorization turnaround time reports • An extensive array of medical and case management reports • Utilization covering essentially the dollars, days, and health care units used by our membership **The Executive Dashboard: Affording PSHP Leadership a Consolidated View of Operations**. Building on our investment in EDW and Business Objects technology, our *Executive Dashboard* collects daily and monthly health plan data to create a self-service executive view. The Dashboard will also permit health plan management to perform robust drill down analysis, creating an environment in which summarized metrics can be broken down into detail level data. All metrics are calculated and stored for historical analysis and trending. Impact Pro is a healthcare information system tool designed for organizations to gain insight into factors that affect their members' health by: • Identifying, Analyzing and Stratifying plan members based on clinical episode predictive modeling and customized profiles	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• It combines theoretical framework, clinical knowledge and Evidence Based Medicine essential for implementing effective care plan strategies It allows Case Management the use of medical, pharmacy, and laboratory claims to identify patients with selected clinical conditions the ability to apply criteria to identify gaps in patient care, patient adherence to therapies, patient safety issues and potential services that may not be warranted. It also allows Case Management to focus on those members that will have the greatest impact with intervention services. The Plan demonstrates compliance with this requirement with the following documentation: • Document: Concept Guide Impact Pro • Example: Executive Dashboard Screen Shot • Example: Peach State Daily Inpatient Census report	
Findings: Peach State used an information system called TruCare Healthcare Management System for utilization management activities to provide the ability to create, track, and store all required documentation relevant to clinical determinations made during the utilization review process. Additionally, the system supported the case management, quality, and appeals processes and all documentation that accompanied such components of member care. For example, the TruCare system supported prior authorization of elective inpatient and outpatient services; documentation of emergent services and related activities; authorization of continued stay inpatient services; and medical reviews for all service requests, appeals, and quality issues that required review. Peach State also used a system called Impact Pro to identify, analyze and stratify members based on clinical episode predictive modeling and customized profiles. Impact Pro combined theoretical framework, clinical knowledge, and evidence-based medicine, which was essential to implement effective care plan strategies. The system also provided decision support in all areas of CMO operations such as claims and enrollment. The call center that supported the system generated a UM dashboard and UM authorization turnaround time reports; medical and case management reports; and UM reports that included the dollars, days, and healthcare units		

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
used by members. Peach State's documentation would be strengthened if it included information on how the systems are used to identify and support disease management, EPSDT, overutilization and underutilization reviews, and adherence to adopted CPGs.		
Required Actions: None.		
b. Grievances and appeals.	Peach State utilizes multiple systems to collect and store information about grievances and appeals. Formal, written grievance and non-clinical appeals are captured and indexed to appropriate member or provider records, scanned, assigned for follow-up, tracked and managed throughout the grievance process. The Customer Service call center staff document these calls directly into the Customer Relations Management (CRM) system and route them to the Grievance & Appeals (A&G) Department. Appeals are captured, maintained and routed to the Grievance & Appeals (A&G) Department via the TruCare system due to the clinical nature of appeals and the importance of linking them to services already documented in TruCare. Both grievances and appeals are logged into local SharePoint databases by the A&G staff where the substance of each issue and all details regarding the processing are documented. The Plan demonstrates compliance with this requirement with the following documentation: • Policy: GA.QI.08 Member Grievance Process • Policy: GA.QI.42 Administrative Reviews • Report: PSHP Grievance System Report • Report: 0653 PSHP Grievance System Report Analysis Form Q12013 • Example: Screen Shot of CRM – Grievance Routed from Member Services to A&G	☒ Met ☐ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	• Example: Screen Shot of Grievance SharePoint site	
Findings: The Peach State Customer Service staff documented grievances in the Customer Relations Management System and routed the issues to the Grievance and Appeals Department. The Grievance and Appeals Department used the TruCare system to link the grievance or appeal to services documented in the system. If the grievance was related to quality of care, the Grievance and Appeals Unit routed the grievance to the medical director.		
Required Actions: None.		
c. Disenrollment for other than loss of Medicaid eligibility.	Peach State collects and processes the disenrollment codes sent via the Lock in Assignment/Change Code field on the 834 file. We download the 834 to the following TeraData table: Tibco_834i_initial_data. The reason codes are downloaded to the following table fields: Lockin_reason_code and Change_reason_code. These Tibco tables are available for reporting purposes. Peach State utilizes the information to evaluate disenrollment reasons. The Plan demonstrates compliance with this requirement with the following documentation: • Policy: GA.MBRS.28 Plan Initiated Disenrollment • Policy: GA.MBRS.29 Member initiated Disenrollment • Document: Georgia Families 834 Companion Guide lists termination codes transmitted to the Plan • Report: Disenrollment Activity Report – June 2016	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State documentation indicated that the CMO confirmed that the person requesting disenrollment was a member of Peach State in the Medicaid Management Information Systems (MMIS). Peach State informed the member about the disenrollment process and referred the member to the Georgia Families (GF) Program for further assistance. Peach State maintained enrollment and disenrollment information in the member eligibility system.		
Required Actions: None.		

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
3. The CMO collects data on: *42CFR438.242(b)(1)*		
a. Member characteristics.	Peach State enrollee demographic information is captured in core applications and can be accessed through an integrated workflow by the appropriate CMO staff. Moreover, the Plan's claims processing system captures member demographic information from eligibility information as well as utilization information. A document library system captures documents such as submitted claims and submitted medical records by member. Lastly, Peach State utilizes predictive modeling software to store member health characteristics to improve care. The Plan demonstrates compliance with this requirement with the following documentation: • Eligibility Screen Shot from Amysis • Eligibility Training Materials • Report: Impact Pro Concept Guide • Report: 2015 QAPI Evaluation	☒ Met ☐ Not Met ☐ N/A
Findings: Peach State captured member demographic information transmitted by DCH using the 834 process. The CMO identified additional member characteristics through claims and encounters, utilization information such as authorizations, pharmacy utilization, care and service utilization, and case management systems. Peach State used data and information to do predictive modeling, to identify members who may benefit from case management or disease management, and to identify potential gaps in care.		
Required Actions: None.		
b. Provider characteristics.	Peach State Provider Data staff will enter new application data received into Portico. The data entered is delineated in the policy. Once a provider is in the system and begins to submit claims, additional information such as practice patterns and any issues with claims can be tracked and trended. This additional information such	☒ Met ☐ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	as billing patterns, compliance with clinical practice guidelines, comparison of utilization to peers, etc. can be extracted from the data and analyzed to gain knowledge of the provider. Many of these reports and data sets were discussed in above standards. The Plan demonstrates compliance with this requirement with the following documentation: • Policy: GA.PDAT.03 Data Entry Format Policy • Example: Portico Screen Shot • Example: Amysis Provider Screen Shot • Example: SIU Preliminary Investigation Report	
Findings: Peach State maintained provider demographic information (name, address, education, malpractice insurance, Drug Enforcement Administration [DEA] licenses, etc.) in its health information system. In addition, Peach State aggregated claims and encounters to identify, for example, care and treatment patterns, overutilization and underutilization of services, and claims and billing patterns. Irregularities in billing patterns, such as regular or consistent billing of codes of higher-intensity levels, could trigger an investigation through the fraud, waste, and abuse processes.		
Required Actions: None.		
c. Services furnished to members.	Peach State requires all providers to submit claims for services furnished to members. Each service is stored in the claims processing system. Services can be accessed through the claims processing system or through the Plan's data warehousing software. As described in Standard III 1 and 2a above various reports are available to analyze, monitor, and evaluate the services rendered. The Utilization Management Program includes various processes to ensure medically necessary services are delivered at appropriate levels of care.	☒ Met ☐ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	The Plan demonstrates compliance with this requirement with the following documentation: • Example: Executive Dashboard Screen Shot • Document: Impact Pro Concept Guide • Document: 2015 UM Program Description	
Findings: Peach State identified the services furnished to members through claims and encounters, utilization information such as authorizations, pharmacy utilization, care and service utilization, and case or care management systems. Additional information obtained included comorbidities, complications, progress of treatment, psychosocial situation, and the member's home environment. Peach State used the data and information to do predictive modeling, identify members who may benefit from case management or disease management, and identify potential gaps in care.		
Required Actions: None.		
4. The CMO's health information system includes a mechanism to ensure that data received from providers are accurate and complete by: • Verifying the accuracy and timeliness of reported data. • Screening the data for completeness, logic, and consistency. • Collecting service information in standardized formats to the extent feasible and appropriate. • Making all collected data available to the State and upon request to CMS. 42CFR438.242(b)(2) 42CFR438.242(b)(3) Contract: 4.17.3.1 4.17.3.6	The Peach State health information system includes a mechanism to ensure that data from providers is accurate and complete. Data sets submitted by providers to CMO are sent through an integrity and accuracy check process prior to being entered into CMO system. • Customized File Tracking System – Checks for partial files, tracks number of claims received, reconciles data between applications. • Balancing transaction counts – ensures that all segments & elements are accounted for from ST to SE. • Trading Partner Validation - Validates that the trading partner sending the transaction is a Centene/Health Plan approved trading partner before releasing transactions for translation to readable data. • Data Repository – Transactions are translated to a raw data storage database for (CDR –Central Data Repository) for data analysis. • Validating transactions conform to HIPAA level 5 • HIPAA level 5 includes situation loops and segments	☒ Met ☐ Not Met ☐ N/A

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	In addition, there are weekly processes executed to ensure data from sub-systems are accurate. The data reconciliation process consists of overall records check counts as well as a column by column comparison at the record level if necessary. Also, the Plan's Enterprise Claims systems execute an array of data pre- checks which are aligned with the State's compliance/regulatory rules for eligibility and encounters. Peach State's ancillary systems reviews codes to ensure comprehensive code auditing is performed as well as monitors for possible fraud or error associated with data submissions. Claims submitted with missing, incomplete or invalid data are rejected back to the Provider along with a letter of explanation for paper claims, or via Audit report for Electronic claims. Before a claim can be entered into the claims system, the claim must meet minimum data criteria, referred to as pre- edits. The first level of data edits ensures proper and timely filing of claims. During pre-adjudication, we are looking for fields that have too few or too many characters, invalid diagnosis or procedure codes, missing fields, and valid member and provider identification numbers. If these pre-adjudication requirements are not met, claims are rejected and returned to the provider with a request that the missing or incorrect data be corrected. In addition to these standard pre- edits, EDI claims are subjected to HIPAA level five edits, and paper claims are subjected to font size and legibility edits. The following are pre-payment automated functions. Centene's claim processing system provides multiple levels that build upon one	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	another logically. There are six primary steps that a claim must pass to get to a paid, denied, or internally pended status. 1. Field and general edits. Claim fields are verified by Amisys to determine whether the fields are consistent with the business rules outlined by State and Federal regulations as well as age and sex consistency edits, and duplicate checks. 2. Member Eligibility**.** Amisys analyses the Member regarding eligibility for the dates of service, and the type of coverage. When applicable (based on eligibility files). 3. Provider Eligibility and Status**.** Amisys verifies the eligibility and status of the provider who submitted the claims for the dates of service. 4. Valid Dates of Service. Amisys verifies that the claim/encounter is for a valid date of service. 5. Prior Authorization. Amisys verifies the presence of the proper prior authorization when applicable. 6. Covered Services. Amisys maps the benefits to the member and provider ensuring the benefits are indeed covered and within the specified counts. Centene's Special Investigations Unit (SIU) uses Health Care Fraud Shield (HCFS) to assist with the identification of providers who may be billing inappropriately. HCFS reports the number of occurrences and dollars that may be at risk for upcoding, unbundling, duplicates, ambulance upcoding, add-on codes billed without primary code, unusual high number of new patient visits, modifier misuse, etc. HCFS also reports provider outlier status for providers compared to peers within their area and specialty and is further explained below.	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	The reports are refreshed and reviewed quarterly. At least one provider per quarter is identified for further review. In addition, prior to payment, Centene's Compliance Coding Management (CCM) department uses our ClaimsXten® software to review claims against common coding standards established by the American Medical Association (AMA), the Centers for the Medicare and Medicaid Services (CMS) and medical specialty societies. ClaimsXten identifies potential fraud triggers for unbundling, mutually exclusive codes, procedure frequency-by day, and age/gender discrepancies. CCM regularly reviews edit results and reports any concerns to the SIU and the health plan. CCM also provides reports that assist with educating providers on appropriate coding practices. **Health Care Fraud Shield:** • CaseShield is a case management tool designed to give management and staff an organized and easy to navigate focal point, keeping track of current and historical case files, documentation storage, document template generation, case linking to external resources, medical record storage and tracking, extensive reporting capability, financial tracking in accordance with the National Health Care Anti-Fraud Association financial reporting standards, and state and federal regulatory reporting requirements. • PostShield is a tool that contains powerful fraud rules and algorithms developed by industry experts who understand the essentials of fraud detection and prevention. With an estimated 3-10% of claims dollars misappropriated due to	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Fraud, Waste and Abuse, it is essential to monitor claims from every phase of the claim cycle. Powerful algorithms producing smarter results and less false positives, unique external data sources incorporated into the analytics, rules uniquely designed to catch suspicious billing patterns, coding errors, policy and contract violations, collusion, ineligible providers and ineligible members, improved ROI by identifying actual fraud cases. PostShield is a system that does not require technologically advanced users and can be utilized by any members of the organization including the SIU, medical management, provider relations, quality improvement and legal Intuitive workflow and simple design Intelligence driven results continuously advancing the rules and predictive analytics. **Payment Integrity:** Centene's Payment Integrity (PI) department works with several different vendors and internal resources to identify potential waste. Once a claim is identified as potential waste, it is reviewed by the Payment Integrity department for accuracy and appropriateness. Things they review by include, but are not limited to, benefit configuration, contractual language, state/federal regulations, prepay policies, etc. Once PI validates that it looks like potential, it is sent to Peach State for final review. Once approved by the health plan, recovery letters are sent to the providers with a request for a refund and a brief explanation of the error identified. Providers have a right to appeal or submit payment with a certain time frame. If neither occur, the amount is placed into the	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	claim payment system as a receivable and will offset future payments. **McKesson Total Payment™ Solutions** ClaimsXten (CTX) - Software application that edits how a provider bills for services against correct coding principles. CXT logic is based on approximately 40 rules/edits. Each edit corresponds to a coding principle. CXT is customized to accommodate state provider manuals and contracts. Edits are based on CMS' National Correct Coding Initiative, AMA and several specialty societies' edits. **Verisk Health (VH)** Physician Claim Insight (PCI) - Compares submitted claims to correct coding rules/guidelines but also includes a clinical review component. A Verisk Health nurse reviews the claim and compares services to the member's history to determine if the service is medically likely. The process reviews both Outpatient Facility and Physician Claims. Edits are based on CMS, AMA/CPT and Specialty Societies. In addition, PCI reviews most commonly abused modifiers which break the edits of traditional products like ClaimsXten (i.e., modifiers 25, 59) Fraud Finder Pro (FFP) – Identifies aberrant billing patterns where providers are billing more than two (2) standard deviations from their peers. VH reviews and provides a preliminary assessment within 2-3 business days. A Centene investigator reviews VH's comments, the state provider manual and provider contract (if available). The health plan is notified of the billing pattern and	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	approves a full investigation. If approved, 20 -30 services are denied for medical records and undergo clinical review. Based on the findings of the review, the provider is educated, put on full prepay review for select services and/or a retrospective investigation is opened. **The Assist Group (TAG)** High Dollar Clean Claim Review – The review focuses on assuring payment is accurate and appropriate, based on the payer's right and fiduciary obligation to question facility charges prior to payment on a 'clean claim' basis. An itemized bill is requested and reviewed for inpatient hospital claims which reach a predetermined threshold (i.e., $100,000). The itemized bill is reviewed for billing errors, defects or other wasteful practices (i.e., unbundling supplies that must be included in normal room and board charges). Provider is paid for the clean portion of the claim; however, the burden is on the facility to provide documentation/explanation to support the flagged charges. Additional reimbursement is not payable until the hospital clears the defects. References used for the review include: CMS Provider Reimbursement Manual Section 2203 (providers billed charges must 'reasonably and consistently' relate to their underlying costs); Uniform Billing Editor; Billed Acuity Level (rev code) Complies with the Underlying Resource Consumption Threshold Specified in the UB Editor. **Health Management Systems - HMS (COB/Subrogation/Overpayments)** Overpayments: HMS reviews claims for overpayments occurring for numerous reasons, such as reimbursement by Plan after a third party	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	has already paid for the service or information, technology errors resulting in the same claim being paid twice by Plan and contractual errors or misinterpretations of pay schedule. HMS mines data to identify potential overpayments based on CMS regulations, state guidelines and plan provider contracts. An overpayment data file is generated and sent to the Corporate Cost Recovery Team for a preliminary audit of state specific business rules. Within 7 days of receipt, the file is sent to the plan for detailed review. The file must be reviewed and approved within 30 days and after approval a notification notice sent to provider. After 30 days with no repayment or appeal, overpayment is recovered. All appeals are handled by HMS. Subrogation refers to a health insurance company seeking reimbursement from the person or entity (third party) legally responsible for an accident or personal injury after the insurer has paid out money on behalf of its insured. <u>Subrogation</u>: HMS obtains paid claims files along with trauma case indicators, referrals, etc., directly from Health Plans. HMS identifies accidents/personal injury by date of injury, diagnosis/procedure codes and validates and case-manage those injuries with attorneys and insurers. HMS has negotiation and compromise authority for files except where paid claims are $20,000 or greater and in cases where the file will be settled for less than 70% of the value. Exceptions are sent to the Compliance Officers and their staff for sign-off/approval before any funds are received.	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	Determining Potential Recoupment: Following sample selection and record review and by utilizing RAT-STATS, the audit group is able to determine the potential overpayment. • To begin the process, the following items are determined for each stratum: – the sample size – the examined value - the total of the paid claims in the sample selected – the audit value – the total of the payment that would have been made if the claim line would have been billed utilizing the code per the clinical review. and – the audit difference - the total of the Examined Value less the total of the Audit Value. • The point estimate for each stratum is calculated based on the audit difference. The point estimate is calculated by multiplying the stratum's universe size by the audit difference mean. • The point estimate for each stratum is added together to determine the potential overpayment. *The point estimate is reduced to reflect a 12-month overpayment. **GA.COMP.16:** Recoupment and/or Education. Peach State will present the final results to the Department of Community Health, Office of Inspector General contact for approval to proceed with recoupment and/or education of the provider. The health plan will accept responsibility to collect the overpayment in accordance with Federal/State regulations and/or ensuring education is completed. The PI/SIU will be responsible for	

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
	providing any information requested by the health plan to assist with this process. Identified Overpayments are sent to Peach State for Plan and Department of Community Health (DCH) Approval. Once approved, the Demand Letter is sent to the Provider, who is given 30 days to appeal. The Provider has several options: 1. Submit a check for the overpayment or set up a payment plan; 2. Not respond, in which Peach State will proceed with a claims project (negative balance implemented); or 3. Appeal and submit records for clinical review. The Plan demonstrates compliance with this requirement with the following documentation: • Document: Medical Billing and Coding Basics • Policy: CC.CCM.08.19 Claim Coding Decisions Policy • Document: MicroStrategy Queries • Example: Claims Reporting Example • Example: Claim Denial Reason Codes	
Findings: Peach State sent data sets, such as claims or encounters submitted by providers, to Peach State through an integrity and accuracy check process prior to being entered into the CMO's system. The CMO's customized file tracking system checked for partial files, tracked the number of claims received, and reconciled the data. The system also ensured that all data segments and elements were accounted for in a balancing transaction. The system validated that the entity submitting the claim or encounter was a Peach State trading partner. Peach State had weekly processes to ensure data from sub-systems were accurate, valid, and reliable. The system rejected claims submitted with missing, incomplete, or invalid data back to the provider. Before a claim could be entered into the claims system, Peach State required it to pass the pre-edit process, as the claim must meet minimum data criteria. The first level of data edits ensured proper and timely filing of claims. During pre-adjudication		

Standard III—Health Information Systems		
Requirements and References	**Evidence/Documentation as Submitted by the CMO**	**Score**
processes, validation occurred for fields that had too few or too many characters, invalid diagnosis or procedure codes, missing fields, and invalid member and provider identification numbers. Claims received also completed six primary steps prior to adjudication which included age and sex consistency, duplicate checks, member eligibility, provider eligibility and status, valid dates of service, prior authorization, and a check to ensure that the services were covered. The system checked for up-coding, unbundling, duplicates, ambulance up-coding, add-on codes billed without a primary code, unusual high number of new patient visits, modifier misuse, etc. Peach State's process would be strengthened by documenting how it verifies that the services included in claims reflect information found in the provider's medical record through its medical record review process.		
Required Actions: None.		

Results for Standard III—Health Information Systems							
Total	Met	=	8	X	1.00	=	8
	Not Met	=	0	X	.00	=	0
	Not Applicable	=	0	X	N/A	=	NA
Total Applicable		=	8	**Total Score**		=	8
				Total Score ÷ Total Applicable		=	100%

Appendix B. Follow-Up Review Tool

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

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Information Requirements: *42CFR438.10(f)(3), Contract: 4.3.3.1* 1. The Contractor provides all newly enrolled members the member handbook within ten (10) calendar days after receiving notice of the enrollment from DCH or the State's agent and every other year thereafter unless requested sooner by the member.			
Findings: The Distribution of Member Handbook Policy and Procedure indicated that Peach State provided a member handbook to newly enrolled members within 10 days after receiving notice from DCH and every year thereafter unless requested sooner by the member. However, Peach State staff indicated that DCH granted approval to not include the handbook in the annual mailing provided that information regarding the handbook was included in the quarterly member newsletter. Peach State provided a newsletter that included the required information. The DCH confirmed that the requirement that members receive a hard copy handbook every other year had been waived. Members must be informed via a member newsletter or other mechanism that the handbook is available on the CMO's website and that a hard copy will be mailed upon request.			
Required Actions: Peach State must update the Distribution of Member Handbook policy and procedure to include a description of how the CMO notifies existing members (not newly enrolled members) that the member handbook is available on the CMO's website or how to obtain a hard copy. The policy and procedure must also reflect how often existing members receive the notice.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
To ensure the Distribution Of Member Handbook policy and procedure meets the requirements set forth in 42CFR438.10(f)(3), Peach State will implemented the following corrective actions: 1. Revisions were completed of the policy and procedure to clearly document how Peach State notifies existing members (not newly enrolled members) that the member handbook is available on our website and how to obtain a hard copy. 2. Customer Service Representatives attend bi-monthly team meetings for which the policy is reviewed for	The existing policy and procedure was revised and approved for review with staff.	Travis Brice, Manager of Customer Service	Ongoing

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
compliance purposes. The review includes an overview of the newsletter, the website and the process for which members can request a hard copy of the member handbook. Peach State demonstrates compliance with this element via the following documentation: • Policy: Distribution of Member Handbook • Member Services Quality Audit Log – May 2016	Monthly quality audits are conducted to ensure compliance with this requirement as a part of our ongoing quality monitoring. Specifically, random audits per CSR are reviewed against the policy. Staff members who fail to comply with the requirements set forth in the policy are subject to re-education and potential performance improvement plans.		
Other Evidence/Documentation:			
August 2016 Re-review Findings: Peach State updated its Distribution of Member Handbook Policy to state the following: "Peach State shall mail to all enrolled member households a Member Handbook **every** year thereafter unless requested sooner by the member. Peach State shall provide instructions to both new and existing members on the process to view all member materials (including the provider directory) via the web portal. Additionally, members will be instructed via newsletters, on hold messages and Peach State's website to contact Member Services to request a soft copy of all member materials." Information provided by DCH indicates that the requirement to provide a member handbook annually has been waived. CMOs are instead required to notify existing members annually that the member handbook is available online and a hard copy is available upon request.			
August 2016 Required Actions: The CMO must update its Distribution of Member Handbook Policy to state that it notifies existing members annually that the member handbook is available online and a hard copy is available upon request.			

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Information Requirements: *42CFR438.10(f)(3), Contract: 4.3.3.1* 2. The Contractor provides all newly enrolled members the provider directory within ten (10) calendar days of receiving the notice of enrollment from DCH or the State's Agent.			
Findings: The DCH has granted Peach State a waiver from providing a hard copy provider directory to newly enrolled members. The Peach State member handbook directed members to the CMO's website, which contained the provider directory, or to contact member services for assistance with provider selection. The Distribution of Member Handbook policy and procedure indicated that Peach State provided all new members a provider directory with the new member packet. The member handbook and the policy had conflicting information.			
Required Actions: Peach State must update the Distribution of Member Handbook policy and procedure to reflect the CMO's practice regarding informing members of the availability of the provider directory.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
To ensure the Distribution Of The Provider Directory policy and procedure meets the requirements set forth in 42CFR438.10(f)(3), Peach State will implement the following: 1. Revisions of current policy and procedure were completed to clearly document how Peach State notifies existing members (not newly enrolled members) that the provider directory is available on our website and how to obtain a hard copy. 2. Customer Service Representatives attend bi-monthly team meetings for which the policy is reviewed for compliance purposes. The review includes an overview of the newsletter, the website and the process for which	The existing policy and procedure was revised and approved for review with staff.	Travis Brice, Manager of Customer Service	Completed

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
members can request a hard copy of the member handbook. Peach State demonstrates compliance with this element via the following documentation: • Policy: Distribution of Member Handbook Member Services Quality Audit Log – May 2016	Monthly quality audits are conducted to ensure compliance with this requirement as a part of our ongoing quality monitoring. Specifically, random audits per CSR are reviewed against the policy. Staff members who fail to comply with the requirements set forth in the policy are subject to re-education and potential performance improvement plans.	Travis Brice, Manager of Customer Service	Ongoing
Other Evidence/Documentation:			
August 2016 Re-review Findings: Peach State updated its Member Materials Policy to state: "Peach State shall provide instructions to both new and existing members on the process to view all member materials (including the provider directory) via the web portal. Additionally, members will be instructed via newsletters, on hold messages and Peach State's website to contact Member Services to request a soft copy of all member materials."			
August 2016 Required Actions: Peach State must update the Distribution of Member Materials policy and procedure to reflect CMO practice regarding how it will inform members of the availability of the provider directory.			

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
Grievance System: *42CFR438.400(b), Contract: 1.4* 4. The Contractor defines appeal (administrative review) as a request for review of an action, as action is defined in *42CFR438.400(b).*
Findings: The Administrative Reviews and the Member Grievance and Administrative Review policies and procedures defined an "administrative review" as a request for review of an action. However, the Administrative Reviews policy and the Step by Step: Administrative Review procedure both stated: "If it is recognized that Peach State has failed to act within the required timeframe for resolution of an appeal, a Notice of Proposed Action letter will be sent explaining the handling of this case and **allowing 30 days to file a grievance**. The member will be offered **grievance rights for late resolution** by inserting the following verbiage in the letter's rationale: 'If you are unhappy with the processing of this appeal in any way, you may file a grievance by calling member services at 1-800-704-1484.'" As defined in Requirement 3 above, the failure to process a grievance or an appeal in a timely manner was an "action," and therefore required issuance of a notice of action and access to the appeal process, not the grievance process.
Required Actions: Peach State must ensure that its policies, processes, and communications to members are accurate and consistent and provide members access to the correct process (appeal) when Peach State fails to meet required timelines for resolution of grievances and appeals (an action).

Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
• Revise the Administrative Reviews policy and the Administrative Reviews Step by Step processes (SOP), and communications to members the correct process (appeals) when Peach State fails to meet required timelines for resolution of grievances and appeals (an action). • Grievance and Appeals Coordinators will receive training on the revisions regarding the specific policy and Standard	• The Administrative Reviews policy and Administrative Reviews SOP were revised and approved. Grievance and Appeals Manager will conduct random monthly audits from the SharePoint Database from each Grievance and Appeals Coordinator. The audits will evaluate cases (Grievance or Appeals) out of turnaround time (TAT) to ensure notice of action letter was sent to the member and provide access to the	• Lamar Watson, Grievance and Appeals Manager	• The Plan's policies, procedures, and SOP were revised on October 27, 2015. • November 18, 2015 training on the revised SOP was completed. • Audits on a monthly basis until June 30, 2016

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Operating Procedure (SOP) changes.	appeal process. Grievance and Appeals Coordinators who fail to meet the requirement are subject to re-education and potential performance improvement plans (PIP)		

Other Evidence/Documentation:

- Grievance & Appeals Team Training- Policy and SOP Revisions-11-18-2015
- Policy: Administrative Review, GA.QI.42, page 6. Sect C
- SOP: Administrative Review Process, page 3
- Policy: Grievance Process, GA.QI.08, page 4. Sect 3
- Appeals Notice of Proposed Action – Attachment A
- Grievance Notice of Proposed Action – Attachment E
- Member Handbook (Administrative Review Process): Pages 44-46 (English) and page 110-112 (Spanish) of the PDF
- Planning for Healthy Babies(P4HB) Member Handbook: Page 23-26 (English) and page 64-68 (Spanish) of the PDF
- Provider Manual: Page 42.

August 2016 Re-review Findings:
Peach State updated its Administrative Review Policy to include the following language:

"If it is recognized that Peach State has failed to act within the required timeframe for resolution of an appeal, a Notice of Proposed Action letter will be sent explaining the handling of this case and allowing 30 days to file an appeal. The member will be offered appeal rights for late resolution by inserting the following verbiage in the letter's rationale:

'If you are unhappy with the processing of this appeal in any way, you may file an appeal by calling member services at 1-800-704-1484.'

Once the appeal has been reviewed and determination made, an appeal resolution letter will be sent."

Peach State updated its Grievance Policy to include the following language:

"For Grievances not resolved within the timeframe required in contract §4.14.2.3 and 42CFR438.408(b) the Grievance Coordinator will notify the member in writing of their right to Appeal since this now constitutes a Proposed Action. PSHP shall provide written notice of the Proposed Action

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
(Attachment E -Grievance Notice of Proposed Action) to the member explaining their right to Appeal **within thirty (30) calendar** days from the date of the Notice of Proposed Action. This notice of Proposed Action will be mailed to the member on the date the grievance timeframe expires. If Peach State recognizes that a Grievance was not processed within the required timeframe, the Grievance will be immediately handled in an Expedited manner, with prompt processing and notification. A Notice of Proposed Action letter will be mailed to the member, by the Grievance Coordinator, on the date of this recognition outlining the proposed immediate handling of the grievance. Appeal rights will be offered in accordance with PSHP Administrative Review Policy & Procedure- GA.QI.42."
August 2016 Required Actions: None.

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
Grievance System: *Contract: 4.14.2.3* 8. Contractor shall provide written notice of the disposition of the grievance as expeditiously as the member's health condition requires but must be completed within 90 days but not to exceed 90 calendar days of the filing date.
Findings: The Grievance Process policy and procedure indicated that Peach State would provide written notice to the member, in his/her primary language, of the disposition of the grievance no longer than 90 calendar days after the filing date. However, the grievance acknowledgment letter stated, "You will receive written notice of our findings no later than 90 calendar days from the date we received your grievance. **However, <u>if we need additional time</u>, you will be notified when to expect a resolution.**" In addition, although the grievance disposition letters for the 10 grievance files reviewed were sent to the member within 90 calendar days, two of the letters did not address all of the member issues identified in the initial complaint.
Required Actions: Peach State must ensure that it processes all grievances and issues disposition letters within 90 calendar days with no extensions. Peach State must also remove language from the member acknowledgment letter indicating that the CMO may take additional time. Peach State must also address each member issue identified in the grievance in the disposition resolution letter.

Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
• Remove language **"However, <u>if we need additional time</u>, you will be notified when to expect a resolution"** from the member grievance acknowledgment letter indicating that the CMO may take additional time outside of the 90 calendar day timeframe. • Revised current Grievance SOP to document the requirement that each member issue identified in a	• Conduct monthly audits by randomly selecting grievance cases to evaluate the effectiveness of the training and appropriate processing of grievances to also include the 'addressing all member issues' element in the audit tool. Grievance & Appeals coordinators that fail this requirement will be reeducated on this standard and are subject to potential performance improvement plans (PIP).	• Lamar Watson, Grievance and Appeals Manager	• The audit tool was revised on November 1, 2015. • Audits on a monthly basis until June 30, 2016 November 18, 2015 training on the revised SOP was completed

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
grievance request is addressed in the disposition resolution letter. • Grievance & Appeals Coordinators received training on addressing all member issues in the grievance request and in the disposition resolution letter.			
Other Evidence/Documentation: • Grievance Audit Tool (11-01-2015) and File Audit Report (04-28-2016) • Grievance & Appeals Team Training- Policy and SOP Revisions-11-18-2015 • Policy: Member Grievance Process, GA.QI.08, pages 4. Sect 2&3 • Template Letter: Grievance Acknowledgment Letter, page 1of1 (Attachment A) • SOP: Grievance Process, page 2 Sect 7&10 • Member Handbook: page 43 (English) and 109 (Spanish). • P4HB Member Handbook: page 24 (English) and 65 (Spanish).			
August 2016 Re-review Findings: Peach State updated its Medicaid Grievance Standard Operating Procedure (SOP) to include the following language: "For all other grievances/concerns, the Grievance Coordinator gathers as much information as possible to assist the Plan in making an informed determination, and makes sure they address each member issue identified in the grievance request, in the acknowledgement and in the disposition resolution letter. " A review of a sample of grievance files indicated that Peach State processed grievances and issued disposition letters within 90 calendar days with no extensions. In the grievance files reviewed, Peach State did not include language in the member acknowledgment letter indicating that the CMO may take additional time to resolve the grievance. The sample file review results also verified that Peach State addressed each member issue identified in the grievance in the disposition resolution letter.			
August 2016 Required Actions: None.			

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
Resolution and Notification: Grievances and Appeals: *42CFR438.408(b), Contract: 4.14.4.8* 21. The Contractor must resolve each administrative review and provide written notice of the disposition as expeditiously as the member's health condition requires, not to exceed: • For standard resolution of appeals, 45 calendar days from the day the Contractor receives the appeal. • For expedited resolution of an appeal and notice to affected parties, three (3) working days after the Contractor receives the appeal.
Findings: The Administrative Reviews policy and procedure indicated that Peach State would resolve each request for a review and provide written notice of the resolution as expeditiously as the member's health condition required. The documentation indicated that the process would not exceed 30 calendar days from receipt of the appeal request and for expedited resolution of an appeal, it would not exceed three business days from receipt of the appeal. While 30 days is a stricter standard than (and therefore complies with) DCH's required time frame of 45 days, other Peach State documents (e.g., member and provider handbooks) indicated the time frames as 30 calendar days for pre-service and 45 calendar days for post-service appeal decisions. All of the administrative review (appeal) files reviewed during the on-site audit complied with the timeliness requirements described in this element.
Required Actions: Peach State must ensure that its documents (i.e., policies, procedures, manuals, and training materials) that communicate appeal decision time frames to members, providers, and its own staff are consistent and accurate.

Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
• Revise the current PSHP GA Member Handbook pdf format (pg. 47), PSHP GA P4HB Handbook pdf format (pg.28), and PSHP GA Provider Manual pdf format (pg.45) on the PSHP website, to reflect the appropriate internal administrative review timeframes that comply with DCH to ensure consistency with all Peach State documents that refer to appeal decision time	• The policy and procedure and other documents (handbooks/manual) were revised and approved	• Lamar Watson, Grievance & Appeals Manager. • Thailla Tisdale, Senior Marketing & Communication Specialist.	• February 29, 2016 the revisions were completed

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
frames (30 calendar for pre-service and 30 calendar days for post-service as opposed to 30 calendar days for pre-service and 45 calendar days for post-service). Spanish sections of both the Provider Manual and the Member Handbooks will be updated to reflect these changes as well. Updates to website that have member interfacing must be approved by DCH.			

Other Evidence/Documentation:

- Policy: Administrative Review, GA.QI.42, page4-5 (Sect: IV A&B)
- Member Handbook: Page 46 (English) and 113 (Spanish)
- Planning for Healthy Babies (P4HB) Member Handbook: Pages 27 (English) and pages 69 (Spanish)
- Provider Manual: Page 45

August 2016 Re-review Findings: Peach State updated its Administrative Review Policy to include the following language.

"Peach State will review, resolve, and provide the member with written or electronic notification of the decision within 30 calendar days of receipt for both pre-service and post-service appeals. **[UM 8 A-7]** If a Medical Director determines the issue is clinically urgent or if the member or an authorized representative requests expedited processing and the Medical Director approves, the case is resolved within 72 hours of receipt of the request. (See Section V.) **[RR 2 B-4, UM 8 A-9]"**

Peach State also submitted an updated Administrative Review Policy, member handbook, Planning for Healthy Babies® Member Handbook, and the provider manual, all of which had accurate and consistent appeal processes documented.

August 2016 Required Actions: None.

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
Resolution and Notification: Grievances and Appeals: *42CFR438.408(e), Contract: 4.14.5.2* 27. The written notice of adverse action shall meet the language and format requirements as specified in Section 4.3 and includes: • The results and date of the adverse action including the service or procedure that is subject to the action. • Additional information, if any, that could alter the decision. • The specific reason used as the basis of the action. • The right to request a State Administrative Law hearing within 30 calendar days – the time for filing will begin when the filing date is stamped. • The right to continue to receive benefits pending a State Administrative Law hearing. • How to request continuation of benefits. • Information explaining that the member may be held liable for the cost of any continued benefits if the Contractor's action is upheld in a State Administrative Law hearing. • Circumstances under which expedited resolution is available and how to request it.
Findings: The Administrative Reviews policy and procedure indicated that the written notice of adverse action would be translated into the member's primary language, and be produced in large print or alternative format as needed by the member. The Denials and Appeals Work Process specified what the written notice of adverse action must contain. The 10 administrative review (appeal) resolution letters reviewed included the required information; however, in some cases these letters did not meet the fifth-grade reading/understandability level. In three cases the rationale provided for upholding a denial was copied directly from the clinician reviewer notes.
Required Actions: Peach State must ensure that the rationale for upholding a denial is written in easily understood language in its administrative review resolution letters.

Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
• Senior Medical Director to send communication to Medical Directors, Appeals and Grievance Manager, and Denial and Appeals and Grievance Coordinators explaining the need to send rationales for upholding a denial in easily understood language to the members	• Senior Medial Director submitted written communication to appropriate staff	• Idalia Gonzalez, Senior Medical Director • Lamar Watson, Manager Grievance and Appeals	• Senior Medical Director instruction communicated to staff on October 29, 2015 regarding easily understood language.

Standard V—Grievance System			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Communication included a document entitled 'Medical Terminology Easily Understood' to assist staff with writing rationales in an easy to understand language. Additionally, staff were directed to refer to the medical terminology guide as needed when writing medical terminology in easily understood terms or to supplement the medical term with a more common lay-term. Please note that the Plan's denial letter template was created using the Flesch-Kinkaid software. • Plan will draft a policy that outlines the process for ensuring the rationale for upholding a denial is written in easily understood language in the Plan's administrative review resolution letters. • Training will be conducted for PSHP Senior Medical Director, Medical Directors, Manager Quality Improvement, Manager of Denial and Grievance/appeals and the Denial and Grievance/appeals coordinators on policy and procedure.	• The policy was revised and approved • PSHP Senior Medical Director, Medical Directors, Manager Quality Improvement, Manager of Denial and Grievance/appeals and the Denial and Grievance/appeals coordinators team participate in random audits of appeal files with NCQA Centene Consultants via teleconference to review appeal files against NCQA standards. During those random audits, ten (10) appeal files are reviewed to include the medical director's rationale to verify that the rationale provided in the Plan's resolution letters is in easily understood language.		• February 29, 2016 - Training conducted on the Plan's policy that outlines the process for ensuring the rationale for upholding a denial is written in easily understood language. • March 31, 2016 - Appeal file audits implemented within 30 calendar days of the training.
Other Evidence/Documentation: • Senior Medical Director-Easily Understood Directives- 10-29-16			

Standard V—Grievance System
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
• Rationale Medical Terminology Easily Understood PDF • SOP Rationales for Upholding Denials with Medical Terminology 02-01-16 • Training Sign-in Sheet- Easy to understand Language Rationales- 02-17-2016 • PSHP Appeals File Audit Report Due- 06-15-16
August 2016 Re-review Findings: Peach State updated its Standard Operating Procedure (SOP) Rationales for Upholding Denials with Medical Terminology to state the following: "All Medical Directors and denial and appeal coordinators who generate in TruCare and mail administrative review (appeal) resolution letters to members and providers need to utilize the "**Rationale Medical Terminology Easily Understood.pdf** (enclosed on this SOP) reference guide. A copy of the document was sent via email to Medical Directors and denial and appeal coordinators who generate administrative review letters in TruCare and/or mail the appeal resolution letters." A review of sample grievance files verified that Peach State grievance letters were written so that they were easily understood.
August 2016 Required Actions: None.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Access Standards: *42CFR438.206, Contract 4.8.14.4* 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:** 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			
July 2015 Re-review Findings: Peach State monitored the after-hours provider call back times and met DCH's goal for returning urgent calls within 20 minutes. During quarter 2, 2015, providers achieved a routine call back rate of 89 percent, one percentage point below the 90 percent goal			
July 2015 Required Actions: The CMO must continue implementing interventions with providers until the goal of returning routine calls within one hour is achieved at least 90 percent of the time.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
Providers are educated continuously on the after-hours return call standards. These standards are: 1. included in all monthly provider education packets and are discussed in all provider meetings 2. a required element within the Plan's New Provider Orientations, and 3. listed in the Plan's Provider Manual. Education is ongoing and targets all providers. Providers whose after-hours calls time frame exceeds any requirement will be re-	• The quarterly after-hours survey conducted by the Myers Group will be routinely assessed for provider compliance.	• Marty Fallon, Sr. Director Provider Relations • Yolanda Marsh, Sr. Director Provider Relations • Provider Relations Specialist	The interventions were approved by DCH in Quarter 1 2016 and are to be implemented within 90 calendar days of DCH approval of the interventions. Peach State is on track to implement the interventions with Q2 2016 survey data.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
educated via face-to-face visit by their assigned Provider Relations Representative on the after-hours return call requirements within 14 calendar days of receipt of the audit results. The Provider Relations Representative will ask the provider for feedback regarding barriers to maintaining compliance with the after-hours call requirements, and interventions will be proposed. The provider will be instructed to implement proposed interventions that will bring them into compliance within seven (7) calendar days. These providers will be re-surveyed the following quarter to ensure they have become compliant with the after-hours return calls standard. Providers failing to demonstrate compliance with the appointment timely access requirement after the second audit will receive a letter from PSHP explaining the area of non-compliance, and requiring them to submit a written Corrective Action Plan (CAP) that outlines the steps and process that will be implemented within the provider's practice to ensure they are able to meet the after-hours return call requirements. The non-compliant letters will be mailed out within 14 days of receipt of the audit results, and the CAP must be received from the providers within seven (7)	• Plan will monitor the percentage of non-compliant providers on a quarterly basis and implement additional strategies as necessary.		

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
calendar days of receipt of our letter. CAPs will be monitored by for compliance through the use of a secret shopper call(s) that will be made after-hours to the office by a Provider Relations for feedback regarding barriers to maintaining compliance Representative or Coordinator within 60 calendar days of the implementation of the provider's CAP. Providers who remain non-compliant will be reviewed by our Peer Review Committee for recommendation and action plan. Peach State's Provider Relations Staff, who regularly visit provider offices, conduct focused training during these visits related to after-hours return call requirements. Peach State will continue to conduct Practice Manager Advisory Groups to include education related to appointment timely access and after-hours return call requirements. Providers and staff will have the opportunity to provide feedback on the challenges and barriers they face in meeting the standards. Interventions will be proposed to assist with meet appointment timely access and after-hours standards during the meeting. Additionally, the feedback received during these meetings	• Providers who do not meet the standard will be logged and monitored via CRM. • Providers who fail to meet the standard will be re-surveyed monthly through secret shopper calls and during the next quarterly survey.		

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
will be used to create new/improved interventions that can be implemented throughout the network. Peach State will continue the use of regular e-mail "blasts" and provider newsletters to remind the provider community of the appointment timely access and after-hours return call requirements. Member education will be conducted to ensure members understand that urgent after-hours calls from providers should occur within 20 minutes and other calls within an hour. Member 1 quality surveys currently capture member input regarding the amount of time it takes for a provider to return their call after-hours, to include quarterly monitoring of member feedback related to the after-hours return call time standards. Additionally, member feedback related to after-hours return calls is captured through our member grievance process, and non-compliant providers identified through this process are educated via face-to-face visit and monitored as described above. Listed below are additional interventions that will be implemented to increase the compliance with this requirement. Analyze	• The requirements for after-hours calls are included in the provider orientation presentation and the provider visit checklist to ensure that all providers are educated on the requirement.		

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
the data on providers who do not meet the standard to identify trends (specialty type, group vs. solo practitioner, region, urban vs. rural designation, etc.) that may be contributing to the provider's ability to meet the standard. From there we will survey the providers to determine what barriers may exist to meeting the standard and solicit feedback and members understand that urgent after-hours calls from providers should occur within 20 minutes and other calls within an hour. Recommendations on ways in which the plan can assist or support the practice in meeting the requirement. We will present the findings to our Provider Advisory Group to obtain additional input and recommendations on targeted initiatives to increase compliance with the standard. The recommendations will be used with the non-compliant providers to increase compliance rates and if successful/scalable, rolled out to similar provider types who have experienced challenges meeting the standard.	• Monitoring will occur through monthly secret shopper surveys and we will continue to monitor the providers through the quarterly sample until they demonstrate sustained improvement and or compliance with the standard • Return calls are monitored via the 1 survey.		
Other Evidence/Documentation: • Document: After Hours Rates for 2016 • Document: Departmental Procedure – After Hours			

Standard II—Furnishing of Services
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
• Document: Provider Resource – After Hours QRG • Provider Manual, After Hours Standards
August 2016 Re-review Findings: Peach State monitored the after-hours provider call-back times and met DCH's goal for returning urgent calls within 20 minutes. During Quarter 1, 2016, providers achieved a routine call-back rate of 100 percent and an urgent call-back rate of 100 percent.
August 2016 Required Actions: None.

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

5. **August 2016 Required Actions: 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

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

- PCPs
- Specialists

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
• General dental providers • Dental subspecialty providers • Mental health providers • Pharmacies			
July 2015 Required Actions: The CMO must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies. Peach State must continue its efforts to close its network adequacy gaps and keep DCH informed of its progress.			
Evidence/Documentation Submitted by the CMO			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**
In 2015, Peach State aggressively pursued opportunities to recruit providers to meet geographic access standards. As a result of these efforts, Peach State's Q3 2015 results showed a decrease in the number of deficient specialty / county combinations by 14% versus Q4 2014. These gaps were decreased using the following strategies. • Use of the LOI process during the State reprocurement to identify providers interested in contracting with Peach State. • Use of the State 7400 file to identify and pursue non par providers • Refinement of internal strategies to have teams target specific geographic areas to close gaps. • Identify targeted non par providers noted on CVO to bring in to the network.	• Measurement will be based on the number of county/specialty gaps closed. This is tracked and measured each quarter as part of the geo reporting process.	• Clyde White, Vice President, Contracting Peach State	• All coordination efforts for the delivery of specialty services in the rural areas of telehealth originating sites and provider recruitment are ongoing.

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
• Executed new participation agreements with large health systems including Upson Regional and Grady Health System. • Maintain physician incentive programs to aid in the recruitment and retention of physicians with a strong commitment to quality. These processes will continue to be followed in 2015 and into 2016 to maximize every possible contracting opportunity. Peach State will continue to seek opportunities to contract with targeted providers to ensure that the needs of the populations served are met. Along with the items noted above, Peach State will continue to utilize Telehealth services and Single Case Agreements, where appropriate. to include the following RFP commitments: • Coordinate with other Georgia Families CMOs to promote telemedicine services, and improve access in areas with current specialist deficiencies. • Sponsor presentation equipment placement through GPT in access deficient areas	• The number of providers and members varies each quarter. The gaps will be reviewed each quarter to determine where there are gaps and where there are opportunities to close those gaps.	• Clyde White, Vice President, Contracting Peach State	Quarterly basis until June 30, 2016 • Quarterly basis until June 30, 2016

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
• Provide marketing support to existing Telehealth sites • Establish innovative reimbursement models for use of Telehealth Services • Develop a multi-faceted Member/Provider Education Campaign to increase awareness and utilization of telemedicine in Georgia Identify and contract with all qualified Providers that serve as specialists in the GPT network.	Measure percentage of members accessing care in those areas where sponsorship has occurred.	Clyde White, Vice President, Contracting Peach State	• Quarterly basis until June 30, 2016
Other Evidence/Documentation: • Report: Geo Access Deficiency Comparison • Report: Geo Access Combined Deficiency Report			
August 2016 Re-review Findings: Peach State 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. The CMO did not meet the requirements for either urban or rural areas in the following provider categories: • PCPs • Specialists • General dental providers • Dental subspecialty providers • Mental health providers • Pharmacies			
August 2016 Required Actions: Peach State must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies. Peach State must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.			

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	August 4, 2016

Participants

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

Table C-2—HSAG Reviewers and Peach State/Other Participants

HSAG Review Team		Title
Team Leader	Kim Elliott, PhD, CPHQ	Director, State & Corporate Services
Reviewer	Mary Wiley, RN, MEd	Director, State & Corporate Services
Peach State Participants		**Title**
Donna Mariney		Director, Medical Management Operations
Latonya Sesberry		Quality Improvement Manager
Shay Hawkins		Director, Quality Improvement
LaQuanda Brooks		Vice President, Medical Management
Cheryl Grant		Quality Improvement Manager
Deb Johnson		Senior Director, Compliance
Debra Peterson Smith		Senior Vice President, Operations
Alfred Miller		Manager, Quality Improvement Analytics
Idalia Gonzalez, MD		Senior Medical Director
Lamar Watson		Manager, Grievances and Appeals
Yolanda Spivey		Operations
Monet Harrell		Operations
Michael Strobal		Quality
Travice Brice		Member Services
Taneka Hawkins		Member Services
Lakeisha Moore		Member Services
Ashlee Heath		Centene
Lakeshia McKeown		Centene, Encounters
Paul Frances		Centene, Executive Dashboard
Chevron Cardenas		Vice President, Operations
Claudette Bazile, Esq.		Vice President, Compliance
Andrea Stuckey-Hundley		Compliance Manager

Clyde White	Senior Vice President, Compliance
J. Dean Greeson, MD, MBA	Senior Vice President, Medical Affairs Chief Medical Officer
Larry Santiago	Senior Director, Contracting
Leslie Naamon	Chief Operating Officer
Nick Hockenhull	Centene, TruCare
Yolanda Marsh	Director, Provider Services
Department of Community Health Participants	**Title**
Patricia Garcia	Compliance Specialist I
Sandra Middlebrooks	Compliance Manager
Janice Carson, MD, MSA	Assistant Chief, Performance, Quality and Outcomes
Anshu Misra, MBBS, MHA, PMP	Director I, Performance Quality and Outcomes
Tiffany Griffin, BSN	Compliance Specialist III

Appendix D. Review Methodology

Introduction

The following description of the manner in which HSAG conducted—in accordance with 42 CFR §438.358—the external quality review of compliance with standards for the DCH Georgia Families (GF) program 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 Peach State'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 CMO regarding compliance with State and federal requirements. 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 report related to the findings.

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 CMO's 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—Clinical Practice Guidelines
- Standard II—Quality Assessment and Performance Improvement (QAPI)
- Standard III—Health Information Systems
- Follow-up on areas of noncompliance from the prior year's review

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

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

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

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

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DCH and the CMO, 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 CMO 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 on-site review.
- Providing the detailed agenda and the data collection (compliance review) tool to the CMO to facilitate 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 CMO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the CMO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of sample cases plus an oversample for notices of action, grievances, and appeals cases for the on-site CMO audit from the list 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: Feb 19, 2013.

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

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- A review of the documents and files HSAG requested that the CMO have available on-site.
- Interviews conducted with the CMO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings.

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

Description of Data Obtained

To assess the CMO's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the CMO, 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 CMO's key staff members.

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

Table D-1—Description of the CMO's 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, 2015–June 30, 2016
Information obtained through interviews	August 4, 2016—the last day of the CMO's on-site review
Information obtained from a review of a sample of the CMO's records for file reviews	July 1, 2015–June 30, 2016

Data Aggregation and Analysis

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

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

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

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

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

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

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

To draw conclusions about the quality and timeliness of, and access to, care and services the CMO 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 CMO's performance in complying with each of the requirements.

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

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

Appendix E. Corrective Action Plan

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

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

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

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

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

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

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

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

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

Standard I—Clinical Practice Guidelines			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
6. The CMO ensures that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines. *42CFR438.236(d)* *Contract: 4.12.7.4*			
Findings: Peach State's documents, including the Quality Management Report Analysis PS CPG Compliance Monitoring Report, stated that it used evidence-based CPGs, preventive health guidelines, and other scientific evidence as applicable in the development, implementation, and maintenance of clinical systems used to support utilization and case management. Peach State reviewed member and provider educational materials and staff training materials for compliance or adherence with CPGs. During the compliance review interviews, the CMO also stated that staff were trained on CPG use in medical management processes during new employee orientation.			
Required Actions: Peach State must implement a process to ensure that decisions involving utilization management and coverage of services, made by the CMO's staff, are consistent with the clinical practice guidelines.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
4. The CMO supports and complies with the Georgia Families Quality Strategic Plan by: *42CFR438.240(b)(1) through (4)* *Contract: 4.12.2.1* g. Including information from participating providers and information from members, their families, and their guardians in the development and implementation of quality management and performance improvement activities. *Contract: 4.12.2.2*			
Findings: Peach State conducted provider satisfaction surveys, including surveys for case management, disease management, and member experience, as well as a CAHPS member satisfaction survey for both children and adults. Peach State collected the data, analyzed the results, and implemented interventions to improve performance. Peach State initiated a PIP to improve the survey response rate in the Atlanta region. The policies, procedures, program descriptions, or evaluations did not specify methods, other than surveys, for obtaining information from members, their families, or their guardians for consideration in the development and implementation of QAPI activities. During the compliance review interviews, Peach State staff described a plan to conduct focus groups in each region. Peach State planned to use external consultants to conduct the focused groups to obtain additional member input. However, Peach State was in the planning process and had not implemented the focused groups.			
Required Actions: Peach State must implement processes to obtain input from families and guardians of members into quality management and performance improvement activities.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

6. The CMO achieved DCH-established performance targets.

State-specified element

Findings: Peach State did not meet all of the DCH-established performance goals for CY 2014 and CY 2015. The CMO showed statistically significant increases in 10 measure rates. The CMO showed statistically significant decreases in 14 measure rates. The following results were noted:

Peach State Access to Care Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.26%	96.74%	↓	NC
25 Months–6 Years	89.96%	89.17%	↓	NC
7–11 Years	91.50%	91.17%	↔	NC
12–19 Years	88.63%	88.78%	↔	93.50%
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	81.17%	77.87%	↓	88.52%
Annual Dental Visit				
2–3 Years	45.07%	44.05%	↓	54.20%
4–6 Years	74.66%	72.77%	↓	NC
7–10 Years	77.15%	76.03%	↓	NC
11–14 Years	69.94%	69.85%	↔	NC
15–18 Years	59.32%	59.19%	↔	NC
19–20 Years	—	37.57%	NT	34.04%[4]
Total	67.67%	66.97%	↓	NC
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment				

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Initiation of AOD Treatment—Total	39.65%	35.24%	↓	43.48%
Engagement of AOD Treatment—Total	8.24%	6.82%	↔	14.97%
Care Transition—Transition Record Transmitted to Health Care Professional				
Care Transition—Transition Record Transmitted to Health Care Professional	0.23%	0.00%	↔	NC
Colorectal Cancer Screening				
Colorectal Cancer Screening	—	49.29%	NT	NC
Adult BMI Assessment				
Adult BMI Assessment	80.56%	82.38%	↔	85.23%

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.
[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.
[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.
[4] CY 2015 performance target is derived from previous CY 2014 rates, which included members age 19–21 years rather than 19–20 years.
↓ indicates a statistically significant decline in performance between CY 2014 and CY 2015.
↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.
— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.
NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.
NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Children's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Well-Child/Well-Care Visits				
Well-Child Visits in the First 15 Months of Life				

Standard II—Quality Assessment and Performance Improvement				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
Six or More Well-Child Visits	65.05%	67.79%	↔	64.30%
Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	69.91%	68.99%	↔	72.80%
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	49.07%	47.60%	↔	48.90%
Prevention and Screening				
Childhood Immunization Status				
Combination 3	79.63%	79.09%	↔	80.30%
Combination 6	43.52%	36.30%	↓	59.37%
Combination 10	40.28%	34.38%	↔	38.94%
Lead Screening in Children				
Lead Screening in Children	79.40%	80.05%	↔	75.34%
Appropriate Testing for Children with Pharyngitis				
Appropriate Testing for Children with Pharyngitis	80.31%	82.14%	↑	83.66%
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap/Td)	76.39%	88.90%	↑	71.43%
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—Total	69.21%	67.79%	↔	55.09%
Counseling for Nutrition—Total	64.81%	66.59%	↔	60.58%
*Counseling for Physical Activity—Total**	60.19%	57.21%	↔	51.38%
Developmental Screening in the First Three Years of Life				
Total	46.28%	50.60%	↔	46.36%
Percentage Of Eligibles Who Received Preventive Dental Services				

Standard II—Quality Assessment and Performance Improvement				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
Percentage Of Eligibles Who Received Preventive Dental Services	52.17%	51.46%	↓	58.00%
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk				
Dental Sealants for 6-9-Year-Old Children at Elevated Caries Risk	—	20.09%	NT	NC
Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection				
Appropriate Treatment for Children with Upper Respiratory Infection	83.50%	84.00%	↔	86.11%

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.*

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Women's Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Prevention and Screening				
Cervical Cancer Screening				

Standard II—Quality Assessment and Performance Improvement				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
Cervical Cancer Screening	68.53%	68.56%	↔	76.64%
Breast Cancer Screening				
Breast Cancer Screening	71.02%	66.90%	↔	71.35%
Chlamydia Screening in Women				
Total	56.71%	59.83%	↑	54.93%
Human Papillomavirus Vaccine for Female Adolescents				
Human Papillomavirus Vaccine for Female Adolescents	24.54%	21.93%	↔	23.62%
Prenatal Care and Birth Outcomes				
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.13%	77.49%	↔	89.62%
Postpartum Care	70.30%	59.72%	↓	69.47%
Cesarean Section for Nulliparous Singleton Vertex[4]				
Cesarean Section for Nulliparous Singleton Vertex	NR	2.09%	NT	18.08%
Cesarean Delivery Rate, Uncomplicated[4]				
Cesarean Delivery Rate, Uncomplicated	29.84%	29.32%	↔	28.70%
Percentage of Live Births Weighing Less Than 2,500 Grams[4]				
Percentage of Live Births Weighing Less Than 2,500 Grams	9.04%	8.87%	↔	8.02%
Behavioral Health Risk Assessment for Pregnant Women				
Behavioral Health Risk Assessment for Pregnant Women	0.00%	5.46%	↑	NC
Early Elective Delivery[4]				
Early Elective Delivery	NR	2.32%	NT	2.00%
Antenatal Steroids				

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Antenatal Steroids	NR	0.00%	NT	NC
Frequency of Ongoing Prenatal Care				
Frequency of Ongoing Prenatal Care				
≥81 Percent of Expected Visits	57.77%	59.00%	↔	60.10%

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.*

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

[4] *A lower rate indicates better performance for this measure.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

NR (i.e., Not Reported) indicates that the CMO produced a CY 2014 rate that was materially biased or chose not to report results for this measure; therefore, the rate was not included in the performance calculation. The auditors confirmed that although the CMO calculated this measure properly and according to CMS specifications, due to limitations with CMS specifications, the eligible population could not be appropriately ascertained. The resulting rate, therefore, was considered biased and not representative of the population.

Peach State Chronic Conditions Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Diabetes				
Comprehensive Diabetes Care*				
Hemoglobin A1c (HbA1c) Testing	83.63%	81.80%	↔	87.59%

Standard II—Quality Assessment and Performance Improvement				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
HbA1c Poor Control (>9.0%)[4]	53.17%	59.72%	↓	44.69%
HbA1c Control (<8.0%)	37.32%	32.51%	↔	46.43%
HbA1c Control (<7.0%)	27.73%	23.52%	↔	36.27%
Eye Exam (Retinal) Performed	58.63%	59.36%	↔	54.14%
Medical Attention for Nephropathy	77.82%	91.87%	↑	80.05%
Blood Pressure Control (<140/90 mm Hg)	53.17%	52.83%	↔	61.31%
Diabetes Short-Term Complications Admission Rate (Per 100,000 Member Months)				
Diabetes Short-Term Complications Admission Rate[4]	18.15	15.46	NT	--
Respiratory Conditions				
Asthma in Younger Adults Admission Rate (Per 100,000 Member Months)[4]				
Asthma in Younger Adults Admission Rate	4.55	3.19	NT	--
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate (Per 100,000 Member Months)[4]				
Chronic Obstructive Pulmonary Disease (COPD) or Asthma in Older Adults Admission Rate	28.70	23.78	NT	--
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	—	80.70%	NT	74.94%
Bronchodilator	—	82.46%	NT	83.82%
Cardiovascular Conditions				
Heart Failure Admission Rate (Per 100,000 Member Months)[4]				
Heart Failure Admission Rate	5.45	4.54	NT	--
Controlling High Blood Pressure				
Controlling High Blood Pressure	36.64%	43.14%	↑	56.46%
Persistence of Beta-Blocker Treatment After a Heart Attack				

Standard II—Quality Assessment and Performance Improvement				
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)				
Persistence of Beta-Blocker Treatment After a Heart Attack	—	NA	NT	NC

[1] CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.

[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015*

-- indicates the reporting unit for this measure was reported as per 100,000 member months for CY 2014 and CY 2015, and previous years were reported as per 100,000 members. Since the 2015 performance target was developed based on the previous year's reporting metrics, the 2015 performance target is not presented and caution should be used if comparing the CY 2015 rate to the 2015 performance target for this measure.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Behavioral Health Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	43.58%	43.84%	↔	53.03%
Continuation and Maintenance Phase	58.19%	58.82%	↔	63.10%
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up	56.78%	55.77%	↔	63.21%

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

30-Day Follow-Up	72.79%	72.53%	↔	80.34%
Antidepressant Medication Management				
Effective Acute Phase Treatment	39.57%	38.66%	↔	54.31%
Effective Continuation Phase Treatment	24.86%	23.89%	↔	38.23%
Screening for Clinical Depression and Follow-Up Plan				
Screening for Clinical Depression and Follow-Up Plan	2.86%	7.48%	↑	NC
Adherence to Antipsychotic Medications for Individuals with Schizophrenia*				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	33.33%	19.63%	↓	61.37%
Use of Multiple Concurrent Antipsychotics in Children and Adolescents				
Total	—	0.25%	NT	NC

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[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

** Due to changes in the technical measure specifications, use caution when comparing rates for this measure between CY 2014 and 2015.*

↑ *indicates a statistically significant improvement in performance between CY 2014 and CY 2015.*

↓ *indicates a statistically significant decline in performance between CY 2014 and CY 2015.*

↔ *indicates no statistically significant difference in performance between CY 2014 and CY 2015.*

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Peach State Medication Management Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Annual Monitoring for Patients on Persistent Medications				
Annual Monitoring for Members on ACE Inhibitors or ARBs	87.24%	87.45%	↔	88.00%
Annual Monitoring for Members on Diuretics	86.63%	87.41%	↔	87.90%
Total	86.74%	87.41%	↔	88.25%
Medication Management for People With Asthma				
Medication Compliance 50%—Ages 5–11 Years	44.06%	45.40%	↔	NC
Medication Compliance 50%—Ages 12–18 Years	39.67%	41.64%	↔	NC
Medication Compliance 50%—Ages 19–50 Years	44.19%	50.96%	↔	NC
Medication Compliance 50%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 50%—Total	42.56%	44.34%	↔	NC
Medication Compliance 75%—Ages 5–11 Years	18.82%	20.95%	↔	32.32%
Medication Compliance 75%—Ages 12–18 Years	16.03%	16.58%	↔	NC
Medication Compliance 75%—Ages 19–50 Years	23.26%	19.75%	↔	NC

Medication Compliance 75%—Ages 51–64 Years	NA	NA	NT	NC
Medication Compliance 75%—Total	18.03%	19.41%	↔	NC

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[2] CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.

[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

↔ indicates no statistically significant difference in performance between CY 2014 and CY 2015.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Peach State Utilization Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Improvement or Decline	2015 Performance Target[3]
Ambulatory Care (Per 1,000 Member Months)—Total				
ED Visits—Total[4]	54.10	52.44	NT	52.31
Outpatient Visits—Total	309.79	303.03	NT	NC
Inpatient Utilization—General Hospital/Acute Care—Total				
Total Inpatient—Average Length of Stay—Total	3.39	3.47	NT	NC
Total Inpatient—Average Length of Stay—<1 Year	—	8.92	NT	NC
Medicine—Average Length of Stay—Total	3.43	3.41	NT	NC
Medicine—Average Length of Stay—<1 Year	—	4.61	NT	NC
Surgery—Average Length of Stay—Total	8.43	8.37	NT	NC
Surgery—Average Length of Stay—<1 Year	—	20.83	NT	NC
Maternity—Average Length of Stay—Total	2.75	2.82	NT	NC

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Mental Health Utilization—Total				
Any Service—Total—Total	8.01%	7.68%	NT	NC
Inpatient—Total—Total	0.38%	0.41%	NT	NC
Intensive Outpatient or Partial Hospitalization—Total—Total	0.13%	0.12%	NT	NC
Outpatient or ED—Total—Total	7.93%	7.59%	NT	NC
Plan All-Cause Readmission Rate[4]				
Age 18–44	—	12.32%	NT	NC
Age 45–54	—	11.21%	NT	NC
Age 55–64	—	5.26%	NT	NC
Age 18–64—Total	—	11.87%	NT	NC
Age 65–74	—	NA	NT	NC
Age 75–84	—	NA	NT	NC
Age 85 and Older	—	NA	NT	NC
Age 65 and Older—Total	—	NA	NT	NC

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[3] CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.

[4] A lower rate indicates better performance for this measure.

— indicates that the CY 2014 rate was not presented in the previous year's technical report; therefore, this rate is not presented in this report.

NA (i.e., Small Denominator) indicates that the CMO followed the specifications, but the denominator was too small (<30) to report a valid rate.

NC (i.e., Not Compared) indicates that DCH did not establish a performance target for this indicator.

NT (i.e., Not Trended) indicates that statistical significance testing was not performed between CY 2014 and CY 2015.

Standard II—Quality Assessment and Performance Improvement

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

Peach State Health Plan Descriptive Information Results

Measure	CY 2014 Rate[1]	CY 2015 Rate[2]	Statistically Significant Increase or Decrease	2015 Performance Target[3]
Weeks of Pregnancy at Time of Enrollment				
<0 Weeks	10.88%	13.16%	↔	NC
1–12 Weeks	13.19%	11.87%	↔	NC
13–27 Weeks	58.56%	52.61%	↓	NC
28+ Weeks	16.20%	14.53%	↔	NC
Unknown	1.16%	7.83%	↑	NC
Race/Ethnicity Diversity of Membership				
Total—White	19.73%	34.32%	↑	NC
Total—Black or African American	49.09%	53.57%	↑	NC

[1] *CY 2014 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2014 through December 31, 2014.*

[2] *CY 2015 rates reflect CMO-reported and audited data for the measurement year, which is January 1, 2015 through December 31, 2015.*

[3] *CY 2015 performance targets reflect the DCH-established CMO performance targets for 2015.*

↑ *indicates a statistically significant rate increase between CY 2014 and CY 2015.*

↓ *indicates a statistically significant rate decrease between CY 2014 and CY 2015.*

↔ *indicates no significant change between CY 2014 and CY 2015.*

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

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

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
7. The CMO has an ongoing QAPI program for the services it furnishes to its members. *42CFR438.240(a)* *Contract: 4.12.5.1*			
Findings: Peach State embraced a QI environment within the organization. Peach State used IHI's Triple Aim for Healthcare Improvement as a framework to evaluate the success of the QAPI Program. In addition, Peach State adopted Lean Six Sigma, as well as the PDSA processes developed by W. Edwards Deming. Peach State trained senior leadership and all QI staff, as well as other staff members, in the Lean Six Sigma methodology for both clinical and nonclinical processes. Twenty-five staff members achieved Green Belt status, and all senior management completed Lean Six Sigma Champion training. References were included in the QAPI Program Description, the QI Work Plan, and the QAPI Program Evaluation. During compliance review interviews, the CMO indicated that it also used the Define, Measure, Analyze, Improve, and Control (DMAIC) model for operational improvement. While the QAPI Program Description showed improvement from the previous year's document, Peach State must continue to develop its QAPI Program Description to ensure that it follows the DCH-required guidelines. Peach State's various program evaluations should include detailed descriptions on methodologies, data sources, member and provider input, analysis of interventions, and evaluation of the results of QAPI activities. Peach State should strengthen its process by ensuring that evaluation documents are thorough so that they may be used to develop quality roadmaps for quality assessment and performance improvement.			
Required Actions: Peach State must continue to develop a comprehensive QAPI Program Description. The QAPI Program Description must be developed according to the DCH guidelines. The CMO's QAPI Program Description must be approved by DCH as meeting the DCH guidelines.			

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

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
10. The CMO's QAPI program includes mechanisms to assess the quality and appropriateness of care furnished to all members, including those with special health care needs. *42CFR438.240(b)(4)* *Contract: 4.12.5.2*			
Findings: The QAPI Program Description stated that members with special healthcare needs were not excluded from the QAPI Program; however, it did not describe how the special needs population was integrated into the QAPI activities. Peach State did not provide documentation of implemented processes to assess the quality of care furnished to members, including those with special healthcare needs. During the compliance review interview, Peach State described its EPSDT medical record review process that concentrated on identifying missed components of the EPSDT visit. Peach State completed approximately 400 EPSDT medical record reviews annually, and the most recent results indicated a 92 percent provider compliance rating. The CMO also described its process to tier physicians according to quality outliers, such as access to care and use of asthma action plans. However, Peach State did not define a population, such as the focus populations described by the CMO which included the EPSDT population, or asthma members as members with special healthcare needs.			
Required Actions: Peach State must strengthen its processes for the monitoring, analysis, and evaluation of the delivery, quality, and appropriateness of healthcare furnished to members in the areas of underutilization or receipt of chronic disease or preventive healthcare and services. Peach State must define members with special healthcare needs and include its method of monitoring, analysis, evaluation, and improvement for the delivery, quality, and appropriateness of healthcare furnished to members with special healthcare needs in its program descriptions and evaluations. Peach State must consider use of data, such as outcome data, to evaluate the quality and appropriateness of care furnished to members, including those with special healthcare needs.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
11. The CMO has a method of monitoring, analysis, evaluation and improvement of the delivery, quality, and appropriateness of health care furnished to all members (including under- and over-utilization of services), including those with special health care needs. *Contract: 4.12.5.2*			
Findings: The Peach State's UM Program Description stated: "The CMO may also use the Subacute/SNF Nursing guidelines to assist in determining medical necessity for subacute or skilled nursing care for members with catastrophic conditions or special health care needs." The UM Program Description included goals and objectives for ensuring the delivery, quality, and appropriateness of healthcare furnished to all members. However, the CMO did not link the goals and objectives to its processes for how it monitored, analyzed, or evaluated the delivery, quality, and appropriateness of healthcare furnished to members with special healthcare needs. In addition, Peach State did not provide documentation of implemented processes to assess the quality of care furnished to members, including those with special healthcare needs. During the compliance review interview, Peach State described its EPSDT medical record review process that focused on identifying missed components of the EPSDT visit. Peach State completes approximately 400 EPSDT medical record reviews annually, and the most recent results indicated a 92 percent provider compliance rating in the area of EPSDT. The CMO also described during the interview session its process to tier physicians according to quality outliers such as access to care and use of asthma action plans. However, Peach State did not define populations of members with special healthcare needs.			
Required Actions: Peach State must define mechanisms to assess the quality and appropriateness of care furnished to its members, including those with special healthcare needs.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)
14. The CMO's QAPI program includes reports that are evaluated, indicated recommendations that are implemented, and feedback provided to providers and members. *Contract: 4.12.5.2*
Findings: Peach State's QAPI Program included reports with recommendations and actions taken; however, the feedback provided to members and network providers about these activities is limited. For instance, Peach State provided copies of member newsletters that included a statement about the member satisfaction survey. The narrative stated that Peach State would use the results of the survey to help improve, and that the CMO was working on the area of getting members an appointment with a specialist and in the area of customer service. During the compliance review interview, Peach State staff provided two newsletters that directed members where to call to receive more information about QAPI activities, and another newsletter described some of the results of QAPI activities. Peach State provided three copies of the provider newsletter during the compliance review interviews. Each provider newsletter described QAPI projects but did not include a summary of assessments of actions taken or recommendations that have been implemented. For example, the newsletter mentioned that providers improved the HEDIS scores and that Peach State conducted office reviews, which included medical record reviews, but Peach State did not inform the providers that a certain percentage of records were problematic, which improvements were implemented, which HEDIS scores were problematic, or which recommendations were implemented after review and analysis. Peach State documentation stated that "at least annually, Peach State provides information, including a description of the QAPI Program and a report on the Plan's progress in meeting QAPI Program goals to members and providers." At a minimum, the communication includes information about QI Program goals, processes, and outcomes as they relate to member care and services and must include plan-specific data results such as HEDIS and PIP results. Primary distribution is through the member/provider newsletter and via the CMO's website. Peach State's Quality Management Program Description describes goals and objectives to track, trend, and report data and outcomes. The documentation would be strengthened by including information on how, as a result of data analysis or evaluation, indicated recommendations are implemented.
Required Actions: Peach State must update its QAPI Program Description to describe how it shares quality improvement results and provides feedback to members and providers. Peach State must document the results and feedback that are shared with members and providers, as well as the methods used (e.g., member and provider newsletters, individual or population-specific communications or website updates).

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

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
15. The CMO's QAPI program includes a methodology and process for conducting and maintaining provider profiling. *Contract: 4.12.5.2*			
Findings: The QAPI Program Description stated that provider profiling was conducted and that Peach State used Centelligence Insight, a web-based reporting and management system that included advanced capabilities for provider practice pattern and utilization reporting. Peach State provided an example of a provider report card and provider profiles from its Impact Intelligence system. The system generated summary and detailed views of clinical quality and cost profiling information. The system supplied the CMO with provider, practice, and peer-level profiling information. Peach State provided examples of provider profiles. Peach State did not describe the methodology it used to conduct and maintain provider profiling.			
Required Actions: Peach State must have a documented methodology and process for conducting and maintaining provider profiling.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
20. The CMO has a structured patient safety plan to address concerns or complaints regarding clinical care, which includes written policies and procedures for processing member complaints regarding the care they received. *Contract: 4.12.9.1*			
Findings: Peach State had a structured Patient Safety Plan that described the processes for monitoring and improving patient safety in clinical care and service delivery. The Patient Safety Plan described how Peach State addressed concerns or complaints regarding clinical care. The QM Patient Safety Plan was written in a manner that may cause confusion between grievances (expressions of dissatisfaction) and the grievance system. The grievance policies and procedures included how Peach State classified complaints according to severity, the involvement of the medical director, a mechanism to determine whether additional review by other committees was required, and a summary of the incident (including the final disposition). Peach State also had several policies that addressed patient safety and complaints, including the Grievance Process, Quality of Care Investigations, and Peer Review. The CMO should ensure that the policies and plans are written to include a statement that there are no State fair hearings for grievance resolution.			
Required Actions: The QM Patient Safety Plan must clearly distinguish between grievances and the grievance system. The QM Patient Safety Plan must be approved by DCH.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
21. Patient safety plan policies and procedures include: *Contract: 4.12.9.1* c. A mechanism for determining which incidents will be forwarded to the Peer Review and Credentials Committees. *Contract: 4.12.9.1*			
Findings: Peach State had a process document in its Patient Safety Plan, Quality of Care Investigations Policy, and the Peer Review Policy that classified incidents using a severity level. The medical director reviewed Severity Level III incidents and referred them to the Peer Review Committee if warranted. The process indicated that Severity Level IV incidents were routinely referred to the Peer Review Committee for evaluation and further action, unless the case was already under review in a hospital's internal peer review process.			
Required Actions: Peach State must review all quality of care concerns, even those that are referred to and are being reviewed by another entity, such as a hospital. Peach State must make its own quality of care determination, refer to its peer review process, and report to boards and regulatory agencies, as appropriate, as a result of the CMO's investigation process.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Quality Assessment and Performance Improvement			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
21. Patient safety plan policies and procedures include: *Contract: 4.12.9.1* d. A summary of incident(s), including the final disposition, included in the provider profile. *Contract: 4.12.9.1*			
Findings: During the compliance review interview, Peach State indicated that it included the final disposition of quality of care cases and grievances in the provider profile. The CMO provided limited documentation that described which incidents or information were included in the provider profile or the process used to include profile information.			
Required Actions: The CMO must update its Patient Safety Plan and other documents to clearly state how incidents and the final disposition of grievances, quality improvement cases, and peer review results are included in the provider profile. The processes must also describe how the provider profile information is used in operational areas such as network development, credentialing, and member provider assignment.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

The following pages are for Peach State's use in preparing its corrective action plan (CAP) for the elements scored *Not Met* in the "Follow-Up on Reviews From Previous Noncompliant Review Findings" section of this report. The elements that follow retain the numbering and labeling that were used when the elements were originally scored for the CMO's ease in comparing to prior years' reports.

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Information Requirements: *42CFR438.10(f)(3), Contract: 4.3.3.1* 1. The Contractor provides all newly enrolled members the member handbook within ten (10) calendar days after receiving notice of the enrollment from DCH or the State's agent and every other year thereafter unless requested sooner by the member.			
August 2016 Re-review Findings: Peach State updated its Distribution of Member Handbook Policy to state the following: "Peach State shall mail to all enrolled member households a Member Handbook **every** year thereafter unless requested sooner by the member. Peach State shall provide instructions to both new and existing members on the process to view all member materials (including the provider directory) via the web portal. Additionally, members will be instructed via newsletters, on hold messages and Peach State's website to contact Member Services to request a soft copy of all member materials." Information provided by DCH indicates that the requirement to provide a member handbook annually has been waived. CMOs are instead required to notify existing members annually that the member handbook is available online and a hard copy is available upon request.			
August 2016 Required Actions: The CMO must update its Distribution of Member Handbook Policy to state that it notifies existing members annually that the member handbook is available online and a hard copy is available upon request.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard IV—Member Information			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
Information Requirements: *42CFR438.10(f)(3), Contract: 4.3.3.1* 2. The Contractor provides all newly enrolled members the provider directory within ten (10) calendar days of receiving the notice of enrollment from DCH or the State's Agent.			
August 2016 Re-review Findings: Peach State updated its Member Materials Policy to state: "Peach State shall provide instructions to both new and existing members on the process to view all member materials (including the provider directory) via the web portal. Additionally, members will be instructed via newsletters, on hold messages and Peach State's website to contact Member Services to request a soft copy of all member materials."			
August 2016 Required Actions: Peach State must update the Distribution of Member Materials policy and procedure to reflect CMO practice regarding how it will inform members of the availability of the provider directory.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**

Standard II—Furnishing of Services

Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)

5. **August 2016 Required Actions: 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

3.

August 2016 Re-review Findings: Peach State 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. The CMO did not meet the requirements for either urban or rural areas in the following provider categories:

- PCPs
- Specialists

Standard II—Furnishing of Services			
Requirements—HSAG's Findings and CMO Required Corrective Actions (July 1, 2015–June 30, 2016)			
• General dental providers • Dental subspecialty providers • Mental health providers • Pharmacies			
August 2016 Required Actions: Peach State must meet the geographic access standards for both urban and rural areas for PCPs, specialists, general dental providers, dental subspecialty providers, mental health providers, and pharmacies. Peach State must continue efforts to close its network adequacy gaps and keep DCH informed of its progress.			
Interventions Planned	**Intervention Evaluation Method**	**Individual(s) Responsible**	**Proposed Completion Date**